2024 Summary of Benefits

MAPD Plans

Citrus | Hernando | Indian River | Pasco | St. Lucie
001 Premier by Ultimate (HMO)

Lake | Marion | Sumter
028 Premier by Ultimate (HMO)

Hillsborough | Pinellas | Polk
045 Premier by Ultimate (HMO)

Orange | Osceola | Seminole
046 Premier by Ultimate (HMO)

Manatee | Sarasota
047 Premier by Ultimate (HMO)

ULTIMATE HEALTH PLANS
Good health is where you live.

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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 the costs and benefits covered by our Premier by Ultimate (HMO) plan. 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).

Who can join?

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

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	Premier by Ultimate (HMO) 001	Premier by Ultimate (HMO) 028	Premier by Ultimate (HMO) 045
Service Area	Citrus, Hernando, Indian River, Pasco, St. Lucie	Lake, Marion, Sumter	Hillsborough, Pinellas, Polk

Your Benefits and Cost-Sharing

Premiums and Benefits	Premier by Ultimate (HMO) 001	Premier by Ultimate (HMO) 028	Premier by Ultimate (HMO) 045
Monthly Plan Premium	**$0**	**$0**	**$0**
Part B Premium Reduction	**$164.90**	**$150.00**	**$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 *(does not include prescription drugs)*	**$1,900**	**$2,500**	**$1,900**
Inpatient Hospital Coverage	**$60 copay per day for days 1 through 5** **$0 copay per day for days 6 through 90**	**$170 copay per day for days 1 through 5** **$0 copay per day for days 6 through 90**	**$90 copay per day for days 1 through 5** **$0 copay per day for days 6 through 90**
Outpatient Hospital Coverage	**$75 copay**	**$150 copay**	**$150 copay**
Ambulatory Surgery Center (ASC) Services	**$25 copay**	**$25 copay**	**$25 copay**
Doctor Visits *(Primary Care Providers and Specialists)*	**Primary Care Providers** **• $0 copay** **Specialists** **• $10 copay**	**Primary Care Providers** **• $0 copay** **Specialists** **• $20 copay**	**Primary Care Providers** **• $0 copay** **Specialists** **• $15 copay**

Plan Name	Premier by Ultimate (HMO) 046	Premier by Ultimate (HMO) 047
Service Area	Orange, Osceola, Seminole	Manatee, Sarasota

Your Benefits and Cost-Sharing

Premier by Ultimate (HMO) 046	Premier by Ultimate (HMO) 047	What You Need to Know
$0	**$0**	You must continue to pay your Medicare Part B Premium.
$160.00	**$155.00**	
This plan **does not** have a deductible.	This plan **does not** have a deductible.	
$2,900	**$3,200**	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.
$175 copay per day for days 1 through 5 **$0 copay per day for days 6 through 90**	**$175 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. Prior authorization is required for some services.
$195 copay	**$150 copay**	Prior authorization is required for some services.
$50 copay	**$25 copay**	A referral and prior authorization may be required for some services.
Primary Care Providers **• $0 copay** **Specialists** **• $15 copay**	**Primary Care Providers** **• $0 copay** **Specialists** **• $25 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.

Premiums and Benefits	Premier by Ultimate (HMO) 001	Premier by Ultimate (HMO) 028	Premier by Ultimate (HMO) 045
Preventive Care	**$0 copay**	**$0 copay**	**$0 copay**
Emergency Care	**In the United States** **• $75 copay** **Worldwide** **• $100 copay**	**In the United States** **• $75 copay** **Worldwide** **• $100 copay**	**In the United States** **• $75 copay** **Worldwide** **• $100 copay**
Urgently Needed Services	**$10 copay**	**$10 copay**	**$10 copay**
Diagnostic Services, Labs, and Imaging at a Free-standing Facility or in an Office • Lab services • Outpatient x-rays • Diagnostic tests and procedures • Diagnostic radiological services	**Lab Services** • 20% coinsurance for Genetic Testing • 0% coinsurance for all other labs **Outpatient X-Rays** • $0 copay **Diagnostic Tests and Procedures** • $25 copay for Colonoscopy, Endoscopy, and other diagnostic, “scopic” procedures, Pulmonary Function Tests, Thyroid Function Tests • $75 copay for Sleep Study, Psychological Tests **Diagnostic Radiological Services** • $25 copay for Ultrasounds and Echocardiography • $50 copay for Stress, Nerve Conduction, CT, MRI • $100 copay for CTA, MRA, PET, SPECT, other nuclear medicine tests	**Lab Services** • 20% coinsurance for Genetic Testing • 0% coinsurance for all other labs **Outpatient X-Rays** • $0 copay **Diagnostic Tests and Procedures** • $25 copay for Colonoscopy, Endoscopy, and other diagnostic, “scopic” procedures, Pulmonary Function Tests, Thyroid Function Tests • $150 copay for Sleep Study, Psychological Tests **Diagnostic Radiological Services** • $25 copay for Ultrasounds and Echocardiography • $50 copay for Stress, Nerve Conduction, CT, MRI • $150 copay for CTA, MRA, PET, SPECT, other nuclear medicine tests	**Lab Services** • 20% coinsurance for Genetic Testing • 0% coinsurance for all other labs **Outpatient X-Rays** • $0 copay **Diagnostic Tests and Procedures** • $25 copay for Colonoscopy, Endoscopy, and other diagnostic, “scopic” procedures, Pulmonary Function Tests, Thyroid Function Tests • $75 copay for Sleep Study, Psychological Tests **Diagnostic Radiological Services** • $25 copay for Ultrasounds and Echocardiography • $50 copay for Stress, Nerve Conduction, CT, MRI • $100 copay for CTA, MRA, PET, SPECT, other nuclear medicine tests

Premier by Ultimate (HMO) 046	Premier by Ultimate (HMO) 047	What You Need to Know
$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 **• $75 copay** **Worldwide** **• $100 copay**	**In the United States** **• $75 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 of 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. If you are admitted to the hospital outside the U.S. and its territories, you will have to pay your share of the cost of emergency care.
$10 copay	**$10 copay**	If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for urgently needed services.
Lab Services • 20% coinsurance for Genetic Testing • 0% coinsurance for all other labs **Outpatient X-Rays** • $0 copay **Diagnostic Tests and Procedures** • $0 copay for Colonoscopy, Endoscopy, and other diagnostic, “scopic” procedures, Pulmonary Function Tests, Thyroid Function Tests • 20% coinsurance for Sleep Studies **Diagnostic Radiological Services** • $25 copay for Ultrasounds and Echocardiography • $25 copay for Stress, Nerve Conduction, CT, MRI • $25 copay for CTA, MRA, PET, SPECT, other nuclear medicine tests	**Lab Services** • 20% coinsurance for Genetic Testing • 0% coinsurance for all other labs **Outpatient X-Rays** • $0 copay **Diagnostic Tests and Procedures** • $0 copay for Colonoscopy, Endoscopy, and other diagnostic, “scopic” procedures, Pulmonary Function Tests, Thyroid Function Tests • 20% coinsurance for Sleep Studies **Diagnostic Radiological Services** • $0 copay for Ultrasounds and Echocardiography • $0 copay for Stress, Nerve Conduction, CT, MRI • $0 copay for CTA, MRA, PET, SPECT, other nuclear medicine tests	Prior authorization is required for some services. All services performed at an outpatient hospital facility are subject to the outpatient hospital copayment.

Your Benefits and Cost-Sharing

Premiums and Benefits	Premier by Ultimate (HMO) 001	Premier by Ultimate (HMO) 028	Premier by Ultimate (HMO) 045	Premier by Ultimate (HMO) 046	Premier by Ultimate (HMO) 047	What You Need to Know
Diagnostic Services, Labs, and Imaging at an Outpatient Hospital • Lab services • Outpatient x-rays • Diagnostic tests and procedures • Diagnostic radiological services	**Lab Services** • 20% coinsurance for Genetic Testing • $75 copay for all other labs **Outpatient X-Rays** • $75 copay **Diagnostic Tests and Procedures** • $75 copay for Colonoscopy, Endoscopy, and other diagnostic, “scopic” procedures, Pulmonary Function Tests, Thyroid Function Tests • $75 copay for Sleep Study, Psychological Tests **Diagnostic Radiological Services** • $75 copay for Ultrasounds and Echocardiography • $75 copay for Stress, Nerve Conduction, CT, MRI • $100 copay for CTA, MRA, PET, SPECT, other nuclear medicine tests	**Lab Services** • 20% coinsurance for Genetic Testing • $150 copay for all other labs **Outpatient X-Rays** • $150 copay **Diagnostic Tests and Procedures** • $150 copay for Colonoscopy, Endoscopy, and other diagnostic, “scopic” procedures, Pulmonary Function Tests, Thyroid Function Tests • $150 copay for Sleep Study, Psychological Tests **Diagnostic Radiological Services** • $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	**Lab Services** • 20% coinsurance for Genetic Testing • $150 copay for all other labs **Outpatient X-Rays** • $150 copay **Diagnostic Tests and Procedures** • $150 copay for Colonoscopy, Endoscopy, and other diagnostic, “scopic” procedures, Pulmonary Function Tests, Thyroid Function Tests • $150 copay for Sleep Study, Psychological Tests **Diagnostic Radiological Services** • $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	**Lab Services** • 20% coinsurance for Genetic Testing • $195 copay for all other labs **Outpatient X-Rays** • $195 copay **Diagnostic Tests and Procedures** • $195 copay for Colonoscopy, Endoscopy, and other diagnostic, “scopic” procedures, Pulmonary Function Tests, Thyroid Function Tests • 20% coinsurance for Sleep Studies **Diagnostic Radiological Services** • $195 copay for Ultrasounds and Echocardiography • $195 copay for Stress, Nerve Conduction, CT, MRI • $195 copay for CTA, MRA, PET, SPECT, other nuclear medicine tests	**Lab Services** • 20% coinsurance for Genetic Testing • $150 copay for all other labs **Outpatient X-Rays** • $150 copay **Diagnostic Tests and Procedures** • $150 copay for Colonoscopy, Endoscopy, and other diagnostic, “scopic” procedures, Pulmonary Function Tests, Thyroid Function Tests • 20% coinsurance for Sleep Studies **Diagnostic Radiological Services** • $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	Prior authorization is required for some services. All services performed at an outpatient hospital facility are subject to the outpatient hospital copayment.
Hearing Services	**$0 copay** for • Routine hearing exam (1 every year) • Hearing aid fitting and evaluation (1 every year) • Hearing aids Our plan pays up to **$2,000** ($1,000 per hearing aid, per ear) every year.	**$0 copay** for • 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.	**$0 copay** for • 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.	**$0 copay** for • 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.	**$0 copay** for • 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.	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.

Your Benefits and Cost-Sharing

Premiums and Benefits	Premier by Ultimate (HMO) 001	Premier by Ultimate (HMO) 028	Premier by Ultimate (HMO) 045
Dental Services • Preventive dental services • Comprehensive dental services • Medicare-covered non-routine dental services	**$0 copay** for • 1 oral evaluation every 6 months • 1 cleaning every 6 months • 1 fluoride treatment every 6 months • 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 (deep cleaning), limited to 1 procedure per quadrant per year • 2 periodontal maintenance procedures following active surgery per year • 1 simple extraction per year • 1 surgical extraction per year	**$0 copay** for • 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 (deep cleaning), limited to 1 procedure per quadrant per year • 2 periodontal maintenance procedures following active surgery per year • 1 simple extraction per year • 1 surgical extraction per year	**$0 copay** for • 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 (deep cleaning), limited to 1 procedure per quadrant per year • 2 periodontal maintenance procedures following active surgery per year • 1 simple extraction per year • 1 surgical extraction per year

Your Benefits and Cost-Sharing

Premier by Ultimate (HMO) 046	Premier by Ultimate (HMO) 047	What You Need to Know
$0 copay for • 1 oral evaluation every 6 months • 1 cleaning every 6 months • 1 fluoride treatment every 6 months • 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 (deep cleaning), limited to 1 procedure per quadrant per year • 2 periodontal maintenance procedures following active surgery per year • 1 simple extraction per year • 1 surgical extraction per year	**$0 copay** for • 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 (deep cleaning), limited to 1 procedure per quadrant per year • 2 periodontal maintenance procedures following active surgery per year • 1 simple extraction per year • 1 surgical extraction per year	**X-rays may include:** • Intraoral, periapical first radiographic image • Intraoral, periapical each additional radiographic image • Bitewing, single radiographic image, or Bitewings, two, three, or four radiographic images • Intraoral, complete series of radiographic images 1 every 3 years • Panoramic radiographic images covered 1 every 3 years **Fillings may include:** • Amalgam, one or more surfaces, primary or permanent • Resin-based composite, one to three surfaces, anterior, four or more surfaces, involving incisal angle • Resin-based composite, one or more surfaces, posterior **Simple extractions may include:** • Extraction, erupted tooth, or exposed root • Extraction, erupted tooth requiring removal of bone and/or sectioning of the tooth **Surgical extractions may include:** • Removal of an impacted tooth • Removal of residual tooth roots (cutting procedure) **Additional Coverage:** • Medically necessary nonroutine dental services, as covered by Original Medicare • Necessary anesthesia with covered service **Some services may require prior authorization.**

Premiums and Benefits	Premier by Ultimate (HMO) 001	Premier by Ultimate (HMO) 028	Premier by Ultimate (HMO) 045	Premier by Ultimate (HMO) 046	Premier by Ultimate (HMO) 047	What You Need to Know

Vision Services
• Eye exams
• Eyewear and Contact Lenses
	Our plan covers:
	
	$0 copay for
	• 1 routine eye exam per year
	• Exam(s) to diagnose and treat diseases and conditions of the eye
	• Annual glaucoma screening
	
	Our plan provides a yearly benefit limit of up to a $200 retail value for eyewear:
	
	$0 copay for
	• 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
	• Standard progressive lenses
	
	$40 copay for
	• 1 pair of prescription sunglasses from a set selection with polarized (grey or brown) lenses OR
	$30 copay for
	• Photochromic lenses
	
	Post-cataract surgery benefits include:
	
	$0 copay for
	• 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
		Our plan covers:
		
		$0 copay for
		• 1 routine eye exam per year
		• Exam(s) to diagnose and treat diseases and conditions of the eye
		• Annual glaucoma screening
		
		Our plan provides a yearly benefit limit of up to a $300 retail value for eyewear:
		
		$0 copay for
		• 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
		• Standard progressive lenses
		
		$40 copay for
		• 1 pair of prescription sunglasses from a set selection with polarized (grey or brown) lenses OR
		$30 copay for
		• Photochromic lenses
		
		Post-cataract surgery benefits include:
		
		$0 copay for
		• 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
			Our plan covers:
			
			$0 copay for
			• 1 routine eye exam per year
			• Exam(s) to diagnose and treat diseases and conditions of the eye
			• Annual glaucoma screening
			
			Our plan provides a yearly benefit limit of up to a $350 retail value for eyewear:
			
			$0 copay for
			• 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
			• Standard progressive lenses
			
			$40 copay for
			• 1 pair of prescription sunglasses from a set selection with polarized (grey or brown) lenses OR
			$30 copay for
			• Photochromic lenses
			
			Post-cataract surgery benefits include:
			
			$0 copay for
			• 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
				Our plan covers:
				
				$0 copay for
				• 1 routine eye exam per year
				• Exam(s) to diagnose and treat diseases and conditions of the eye
				• Annual glaucoma screening
				
				Our plan provides a yearly benefit limit of up to a $200 retail value for eyewear:
				
				$0 copay for
				• 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
				• Standard progressive lenses
				
				$40 copay for
				• 1 pair of prescription sunglasses from a set selection with polarized (grey or brown) lenses OR
				$30 copay for
				• Photochromic lenses
				
				Post-cataract surgery benefits include:
				
				$0 copay for
				• 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
					Our plan covers:
					
					$0 copay for
					• 1 routine eye exam per year
					• Exam(s) to diagnose and treat diseases and conditions of the eye
					• Annual glaucoma screening
					
					Our plan provides a yearly benefit limit of up to a $300 retail value for eyewear:
					
					$0 copay for
					• 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
					• Standard progressive lenses
					
					$40 copay for
					• 1 pair of prescription sunglasses from a set selection with polarized (grey or brown) lenses OR
					$30 copay for
					• Photochromic lenses
					
					Post-cataract surgery benefits include:
					
					$0 copay for
					• 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
						The per-year benefit amount may be applied to lenses only, frame only, or both.
						• Standard eyeglass lenses include:
						  • Single Vision,
						  • Bifocal (FT 28) or
						  • Trifocal (7X28) lenses
						
						Contact lens fitting is not a covered benefit.
						
						Progressive Lenses
						Upgrade may be used once per year and can be used in addition to the Prescription Sunglasses OR Photochromic lenses upgrade.
						
						Prescription Sunglasses OR Photochromic Lenses
						Option to select Prescription Sunglasses with Polarized (Grey or Brown) Lenses from a special frame selection **OR** Photochromic Lenses.
						• The Prescription Sunglasses benefit may only be used once per year and cannot be combined with other upgrades.
						• The Photochromic lenses benefit may only be used once per year and cannot be combined with other upgrades.
						
						Upgrades do not impact the per-year limit on eyewear.

Your Benefits and Cost-Sharing

Your Benefits and Cost-Sharing

Premiums and Benefits	Premier by Ultimate (HMO) 001	Premier by Ultimate (HMO) 028	Premier by Ultimate (HMO) 045
Mental Health Services • Inpatient hospital stays • Outpatient group therapy visits • Outpatient individual therapy visits	**$60 copay per day for days 1 through 5** **$0 copay per day for days 6 through 90** **$10 copay** for group therapy visits **$10 copay** for individual therapy visits	**$170 copay per day for days 1 through 5** **$0 copay per day for days 6 through 90** **$10 copay** for group therapy visits **$20 copay** for individual therapy visits	**$90 copay per day for days 1 through 5** **$0 copay per day for days 6 through 90** **$10 copay** for group therapy visits **$15 copay** for individual therapy visits
Skilled Nursing Facility (SNF)	**$0 copay per day for days 1 through 20** **$150 copay per day for days 21 through 40** **$0 copay per day for days 41 through 100**	**$0 copay per day for days 1 through 20** **$150 copay per day for days 21 through 40** **$0 copay per day for days 41 through 100**	**$0 copay per day for days 1 through 20** **$150 copay per day for days 21 through 40** **$0 copay per day for days 41 through 100**
Physical Therapy • Physical therapy visit • Speech-language pathology services • Occupational therapy visit	**$20 copay** per visit • Physical therapy • Speech-language pathology **$20 copay** per visit • Occupational therapy	**$20 copay** per visit • Physical therapy • Speech-language pathology **$20 copay** per visit • Occupational therapy	**$15 copay** per visit • Physical therapy • Speech-language pathology **$15 copay** per visit • Occupational therapy
Ambulance	**$150 copay** for Medicare-covered one-way **ground ambulance** benefit **20% coinsurance** for Medicare-covered one-way **air ambulance** benefit	**$150 copay** for Medicare-covered one-way **ground ambulance** benefit **20% coinsurance** for Medicare-covered one-way **air ambulance** benefit	**$150 copay** for Medicare-covered one-way **ground ambulance** benefit **20% coinsurance** for Medicare-covered one-way **air ambulance** benefit

Your Benefits and Cost-Sharing

Premier by Ultimate (HMO) 046	Premier by Ultimate (HMO) 047	What You Need to Know
$175 copay per day for days 1 through 5 **$0 copay per day for days 6 through 90** **$15 copay** for group therapy visits **$15 copay** for individual therapy visits	**$175 copay per day for days 1 through 5** **$0 copay per day for days 6 through 90** **$10 copay** for group therapy visits **$25 copay** for individual therapy visits	Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. A referral or prior authorization is required for some services.
$0 copay per day for days 1 through 20 **$150 copay per day for days 21 through 40** **$0 copay per day for days 41 through 100**	**$0 copay per day for days 1 through 20** **$150 copay per day for days 21 through 40** **$0 copay per day for days 41 through 100**	Our plan covers up to 100 days in a SNF. The copays for Skilled Nursing Facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any skilled care in a SNF for 60 days in a row. If you go into a SNF after one benefit period has ended, a new benefit period begins. There's no limit to the number of benefit periods. A referral or prior authorization is required for some services.
$20 copay per visit • Physical therapy • Speech-language pathology **$20 copay** per visit • Occupational therapy	**$30 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.
$175 copay for Medicare-covered one-way **ground ambulance** benefit **20% coinsurance** for Medicare-covered one-way **air ambulance** benefit	**$150 copay** for Medicare-covered one-way **ground ambulance** benefit **20% coinsurance** for Medicare-covered one-way **air ambulance** benefit	Except in an emergency, this service may require prior authorization.

Premiums and Benefits	Premier by Ultimate (HMO) 001	Premier by Ultimate (HMO) 028	Premier by Ultimate (HMO) 045
Transportation	**$0 copay** for **20 one-way trips** per year to plan approved health-related locations	**$0 copay** for **20 one-way trips** per year to plan approved health-related locations	**$0 copay** for **20 one-way trips** per year to plan approved health-related locations
Medicare Part B Drugs	**20% coinsurance** for • Medicare Part B chemotherapy drugs • Part B medications and contrast agents injected during a service • Other Part B drugs **$35 copay** for • One-month supply of Medicare Part B covered insulin	**20% coinsurance** for • Medicare Part B chemotherapy drugs • Part B medications and contrast agents injected during a service • Other Part B drugs **$35 copay** for • One-month supply of Medicare Part B covered insulin	**20% coinsurance** for • Medicare Part B chemotherapy drugs • Part B medications and contrast agents injected during a service • Other Part B drugs **$35 copay** for • One-month supply of Medicare Part B covered insulin
Foot Care *(podiatry services)* Medicare-covered foot exams and treatment	**$10 copay**	**$20 copay**	**$15 copay**

Premier by Ultimate (HMO) 046	Premier by Ultimate (HMO) 047	What You Need to Know
$0 copay for **12 one-way trips** per year to plan approved health-related locations	**$0 copay** for **12 one-way trips** per year to plan approved health-related locations	Our plan covers health-related transport to the following plan-approved locations: • PCP/Specialist Appointments • Labs and Imaging Centers • Pharmacies • Gym/Fitness Locations • Bank • Food Pantry • Grocery Store • Post Office Please call 855-306-0700 (TTY 711) 72 hours in advance to schedule your trip. Have the following information readily available if applicable: • Appointment or expected arrival date and time • Address and phone number of destination • If visiting a provider, the name of the physician or practitioner
20% coinsurance for • Medicare Part B chemotherapy drugs • Part B medications and contrast agents injected during a service • Other Part B drugs **$35 copay** for • One-month supply of Medicare Part B covered insulin	**20% coinsurance** for • Medicare Part B chemotherapy drugs • Part B medications and contrast agents injected during a service • Other Part B drugs **$35 copay** for • One-month supply of Medicare Part B covered insulin	The applicable specialist copay applies when provided during a Physician/Specialist office visit. A referral or prior authorization is required for some services.
$15 copay	**$25 copay**	A referral is required.

Your Benefits and Cost-Sharing

Premiums and Benefits	Premier by Ultimate (HMO) 001	Premier by Ultimate (HMO) 028	Premier by Ultimate (HMO) 045	Premier by Ultimate (HMO) 046	Premier by Ultimate (HMO) 047	What You Need to Know
Wellness Program • SilverSneakers® Fitness Program • Health Education • Additional Smoking and Tobacco Use Cessation	**$0 copay**	**$0 copay**	**$0 copay**	**$0 copay**	**$0 copay**	
Over-the-Counter (OTC)	**$50 every month**	**$45 every month**	**$50 every month**	**$50 every month**	**$50 every month**	The monthly allowance is loaded to your Ultimate Benefit Card and does not roll over from month to month. Unused funds expire at the end of each month.
Meal Benefit	**$0 copay**	**$0 copay**	**$0 copay**	**$0 copay**	**$0 copay**	Immediately following an inpatient discharge to home, receive a maximum of 14 meals for a 1-week period. This benefit does not have a yearly maximum.
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 • Preferred 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 • Preferred 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 • Preferred diabetes monitoring supplies **$0 copay** for • Diabetes self-management training **$0 copay** for • Diabetic shoes	**20% coinsurance** for • Durable Medical Equipment (DME) • Prosthetics **0% to 20% coinsurance** for • Preferred diabetes monitoring supplies **$0 copay** for • Diabetes self-management training **20% coinsurance** for • Diabetic shoes	**20% coinsurance** for • Durable Medical Equipment (DME) • Prosthetics **0% to 20% coinsurance** for • Preferred diabetes monitoring supplies **$0 copay** for • Diabetes self-management training **20% coinsurance** for • Diabetic shoes	Authorization is required for some services.

How do I determine my Prescription Drug cost?

Our plan groups each medication into one of 4 "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 **$15-$35** 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 $5,030. Not everyone will enter the coverage gap. If you enter the coverage gap, our plans continue to cover drugs in **Tier 1 Generic**. For drugs in **Tier 1,** you pay the copay amounts shown in the prescription drug chart. Additionally, during the coverage gap stage, your out-of-pocket costs for a one-month supply of select insulins will be **$15-$35**.

For covered brand name drugs, you pay **25%** of the price (plus a portion of the dispensing fee) while in the coverage gap. You stay in the coverage gap stage until your costs total $8,000, which is the end of the coverage gap and the beginning of the catastrophic coverage stage. During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.

Cost-Sharing may change depending on the pharmacy you choose (i.e., in-network, out-of-network, mail order, retail, long-term care, home infusion, etc.), the day's supply (i.e., 30 days, 90 days, or 100 days for some Tier 1 drugs), 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 our Mail Order Pharmacy!

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.

	Cost-Sharing Tier	Retail Pharmacy Cost-Sharing (30-day supply)	Retail Pharmacy Cost-Sharing (90-day supply; Up to a 100-day supply for some Tier 1 drugs)	Mail Order Pharmacy Cost-Sharing (90-day supply; Up to a 100-day supply for some Tier 1 drugs)
Plan	**Premier by Ultimate (HMO) 001**			
Initial Coverage Stage	Tier 1	$0 copay	$0 copay	$0 copay
	Tier 2	$15 copay	$45 copay	$30 copay
	Tier 3	$60 copay	$180 copay	$120 copay
	Tier 4	33% coinsurance	Not Covered	Not Covered
Coverage Gap Stage	Tier 1	$0 copay	$0 copay	$0 copay
Plan	**Premier by Ultimate (HMO) 028, 046**			
Initial Coverage Stage	Tier 1	$0 copay	$0 copay	$0 copay
	Tier 2	$30 copay	$90 copay	$60 copay
	Tier 3	$60 copay	$180 copay	$120 copay
	Tier 4	33% coinsurance	Not Covered	Not Covered
Coverage Gap Stage	Tier 1	$0 copay	$0 copay	$0 copay
Plan	**Premier by Ultimate (HMO) 045**			
Initial Coverage Stage	Tier 1	$0 copay	$0 copay	$0 copay
	Tier 2	$25 copay	$75 copay	$50 copay
	Tier 3	$60 copay	$180 copay	$120 copay
	Tier 4	33% coinsurance	Not Covered	Not Covered
Coverage Gap Stage	Tier 1	$0 copay	$0 copay	$0 copay
Plan	**Premier by Ultimate (HMO) 047**			
Initial Coverage Stage	Tier 1	$0 copay	$0 copay	$0 copay
	Tier 2	$35 copay	$105 copay	$70 copay
	Tier 3	$85 copay	$255 copay	$170 copay
	Tier 4	33% coinsurance	Not Covered	Not Covered
Coverage Gap Stage	Tier 1	$0 copay	$0 copay	$0 copay

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, 2024.
- [ ] 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).
- [ ] **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 quí vị cần thông dịch viên xin gọi 1-888-657-4170 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. 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 답해 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 (يرقياً :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 दुभाषिया सेवाएं हैं। दुभाषिया प्राप्त करने के लिए, बस हमें 1-888-657-4170 (TTY: 711) पर कॉल करें। कोई हिंदी बोलने वाला आपकी मदद कर सकता है। यह एक निःशुल्क 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ございます。通訳をご用命になるには、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。

ULTIMATE HEALTH PLANS

To learn more, call

1-855-858-7526 (TTY 711)

October 1 - March 31:
Monday - Sunday, 8 a.m. - 8 p.m.

April 1 - September 30:
Monday - Friday, 8 a.m. - 8 p.m.

Community Outreach Offices

303 SE 17th St, STE 305
Ocala, FL 34471

2713 Forest Rd
Spring Hill, FL 34606

4058 Tampa Rd, STE 7
Oldsmar, FL 34677

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

Visit our website at
www.ChooseUltimate.com

Find us on: facebook