

Summary of Benefits 2025



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)



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	\$174.70	\$174.00	\$170.00
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>	\$1,900	\$2,500	\$1,900
Inpatient Hospital Coverage	\$60 copay per day for days 1 through 5 \$0 copay per day for days 6 through 91	\$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 91
Outpatient Hospital Coverage	\$75 copay	\$150 copay	\$150 copay
Ambulatory Surgery Center (ASC) Services	\$25 copay	\$25 copay	\$25 copay
Doctor Visits <i>(Primary Care Providers and Specialists)</i>	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.
\$170.00	\$174.70	
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.

Your Benefits and Cost-Sharing

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

Your Benefits and Cost-Sharing

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. Some testing may require the use of injectable drugs or imaging agents. Please refer to “Medicare Part B Drugs” section for applicable cost share which is charged separately and in addition to the testing copay.

Your Benefits and Cost-Sharing

Premiums and Benefits	Premier by Ultimate (HMO) 001	Premier by Ultimate (HMO) 028	Premier by Ultimate (HMO) 045
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 <ul style="list-style-type: none"> • 20% coinsurance for Genetic Testing • \$75 copay for all other labs Outpatient X-Rays <ul style="list-style-type: none"> • \$75 copay Diagnostic Tests and Procedures <ul style="list-style-type: none"> • \$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 <ul style="list-style-type: none"> • \$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 <ul style="list-style-type: none"> • 20% coinsurance for Genetic Testing • \$150 copay for all other labs Outpatient X-Rays <ul style="list-style-type: none"> • \$150 copay 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 Study, Psychological 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 	Lab Services <ul style="list-style-type: none"> • 20% coinsurance for Genetic Testing • \$150 copay for all other labs Outpatient X-Rays <ul style="list-style-type: none"> • \$150 copay 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 Study, Psychological 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
	Hearing Services <ul style="list-style-type: none"> • \$0 copay for Routine hearing exam (1 every year) • Hearing aid fitting and evaluation (1 every year) <p>Our plan pays up to \$2,000 (\$1,000 per hearing aid, per ear) every year.</p>	\$0 copay for <ul style="list-style-type: none"> • Routine hearing exam (1 every year) • Hearing aid fitting and evaluation (1 every year) <p>Our plan pays up to \$2,000 (\$1,000 per hearing aid, per ear) every year.</p>	\$0 copay for <ul style="list-style-type: none"> • Routine hearing exam (1 every year) • Hearing aid fitting and evaluation (1 every year) <p>Our plan pays up to \$2,000 (\$1,000 per hearing aid, per ear) every year.</p>

Your Benefits and Cost-Sharing

Premier by Ultimate (HMO) 046	Premier by Ultimate (HMO) 047	What You Need to Know
Lab Services <ul style="list-style-type: none"> • 20% coinsurance for Genetic Testing • \$195 copay for all other labs Outpatient X-Rays <ul style="list-style-type: none"> • \$195 copay Diagnostic Tests and Procedures <ul style="list-style-type: none"> • \$195 copay for Colonoscopy, Endoscopy, and other diagnostic, “scopic” procedures, Pulmonary Function Tests, Thyroid Function Tests • 20% coinsurance for Sleep Studies Diagnostic Radiological Services <ul style="list-style-type: none"> • \$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 <ul style="list-style-type: none"> • 20% coinsurance for Genetic Testing • \$150 copay for all other labs Outpatient X-Rays <ul style="list-style-type: none"> • \$150 copay 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 • 20% coinsurance for Sleep Studies 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 	<p>Prior authorization is required for some services. All services performed at an outpatient hospital facility are subject to the outpatient hospital copayment.</p> <p>Some testing may require the use of injectable drugs or imaging agents. Please refer to the “Medicare Part B Drugs” section for applicable cost share which is charged separately and in addition to the testing copay.</p>
\$0 copay for <ul style="list-style-type: none"> • Routine hearing exam (1 every year) • Hearing aid fitting and evaluation (1 every year) <p>Our plan pays up to \$2,000 (\$1,000 per hearing aid, per ear) every year.</p>	\$0 copay for <ul style="list-style-type: none"> • Routine hearing exam (1 every year) • Hearing aid fitting and evaluation (1 every year) <p>Our plan pays up to \$2,000 (\$1,000 per hearing aid, per ear) every year.</p>	

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 <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 • 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 <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 (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 <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 (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 <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 (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 <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 (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: <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 the tooth Surgical extractions may include: <ul style="list-style-type: none"> • Removal of an 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. • 60 minutes of general anesthesia or IV sedation per date of service Some services may require prior authorization.

Your Benefits and Cost-Sharing

Premiums and Benefits	Premier by Ultimate (HMO) 001	Premier by Ultimate (HMO) 028	Premier by Ultimate (HMO) 045
<p>Vision Services</p> <ul style="list-style-type: none"> • Eye exams • Eyewear and Contact Lenses 	<p>Our plan covers:</p> <p>\$0 copay for</p> <ul style="list-style-type: none"> • 1 routine eye exam per year • Exam(s) to diagnose and treat diseases and conditions of the eye • Annual glaucoma screening <p>Our plan provides a yearly benefit limit of up to a \$200 retail value for eyewear:</p> <p>\$0 copay for</p> <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 <p>Our plan offers the following upgrades per year:</p> <p>\$50 copay for</p> <ul style="list-style-type: none"> • Standard progressive lenses <p>\$40 copay for</p> <ul style="list-style-type: none"> • 1 pair of prescription sunglasses from a set selection with polarized (grey or brown) lenses OR <p>\$30 copay for</p> <ul style="list-style-type: none"> • Photochromic lenses <p>Post-cataract surgery benefits include:</p> <p>\$0 copay for</p> <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 	<p>Our plan covers:</p> <p>\$0 copay for</p> <ul style="list-style-type: none"> • 1 routine eye exam per year • Exam(s) to diagnose and treat diseases and conditions of the eye • Annual glaucoma screening <p>Our plan provides a yearly benefit limit of up to a \$300 retail value for eyewear:</p> <p>\$0 copay for</p> <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 <p>Our plan offers the following upgrades per year:</p> <p>\$50 copay for</p> <ul style="list-style-type: none"> • Standard progressive lenses <p>\$40 copay for</p> <ul style="list-style-type: none"> • 1 pair of prescription sunglasses from a set selection with polarized (grey or brown) lenses OR <p>\$30 copay for</p> <ul style="list-style-type: none"> • Photochromic lenses <p>Post-cataract surgery benefits include:</p> <p>\$0 copay for</p> <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 	<p>Our plan covers:</p> <p>\$0 copay for</p> <ul style="list-style-type: none"> • 1 routine eye exam per year • Exam(s) to diagnose and treat diseases and conditions of the eye • Annual glaucoma screening <p>Our plan provides a yearly benefit limit of up to a \$350 retail value for eyewear:</p> <p>\$0 copay for</p> <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 <p>Our plan offers the following upgrades per year:</p> <p>\$50 copay for</p> <ul style="list-style-type: none"> • Standard progressive lenses <p>\$40 copay for</p> <ul style="list-style-type: none"> • 1 pair of prescription sunglasses from a set selection with polarized (grey or brown) lenses OR <p>\$30 copay for</p> <ul style="list-style-type: none"> • Photochromic lenses <p>Post-cataract surgery benefits include:</p> <p>\$0 copay for</p> <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

Premier by Ultimate (HMO) 046	Premier by Ultimate (HMO) 047	What You Need to Know
<p>Our plan covers:</p> <p>\$0 copay for</p> <ul style="list-style-type: none"> • 1 routine eye exam per year • Exam(s) to diagnose and treat diseases and conditions of the eye • Annual glaucoma screening <p>Our plan provides a yearly benefit limit of up to a \$200 retail value for eyewear:</p> <p>\$0 copay for</p> <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 <p>Our plan offers the following upgrades per year:</p> <p>\$50 copay for</p> <ul style="list-style-type: none"> • Standard progressive lenses <p>\$40 copay for</p> <ul style="list-style-type: none"> • 1 pair of prescription sunglasses from a set selection with polarized (grey or brown) lenses OR <p>\$30 copay for</p> <ul style="list-style-type: none"> • Photochromic lenses <p>Post-cataract surgery benefits include:</p> <p>\$0 copay for</p> <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 	<p>Our plan covers:</p> <p>\$0 copay for</p> <ul style="list-style-type: none"> • 1 routine eye exam per year • Exam(s) to diagnose and treat diseases and conditions of the eye • Annual glaucoma screening <p>Our plan provides a yearly benefit limit of up to a \$300 retail value for eyewear:</p> <p>\$0 copay for</p> <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 <p>Our plan offers the following upgrades per year:</p> <p>\$50 copay for</p> <ul style="list-style-type: none"> • Standard progressive lenses <p>\$40 copay for</p> <ul style="list-style-type: none"> • 1 pair of prescription sunglasses from a set selection with polarized (grey or brown) lenses OR <p>\$30 copay for</p> <ul style="list-style-type: none"> • Photochromic lenses <p>Post-cataract surgery benefits include:</p> <p>\$0 copay for</p> <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 	<p>The per-year benefit amount may be applied to lenses only, frame only, or both.</p> <ul style="list-style-type: none"> • Standard eyeglass lenses include: <ul style="list-style-type: none"> • Single Vision, • Bifocal (FT 28) or • Trifocal (7X28) lenses <p>Contact lens fitting is not a covered benefit.</p> <p>Progressive Lenses Upgrade may be used once per year and can be used in addition to the Prescription Sunglasses OR Photochromic lenses upgrade.</p> <p>Prescription Sunglasses OR Photochromic Lenses Option to select Prescription Sunglasses with Polarized (Grey or Brown) Lenses from a special frame selection OR Photochromic Lenses.</p> <ul style="list-style-type: none"> • 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. <p>Upgrades do not impact the per-year limit on eyewear.</p>

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 <ul style="list-style-type: none"> 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 91 \$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 91 \$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 <ul style="list-style-type: none"> Physical therapy visit Speech-language pathology services Occupational therapy visit 	\$20 copay per visit <ul style="list-style-type: none"> Physical therapy Speech-language pathology \$20 copay per visit <ul style="list-style-type: none"> Occupational therapy 	\$20 copay per visit <ul style="list-style-type: none"> Physical therapy Speech-language pathology \$20 copay per visit <ul style="list-style-type: none"> Occupational therapy 	\$15 copay per visit <ul style="list-style-type: none"> Physical therapy Speech-language pathology \$15 copay per visit <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> Physical therapy Speech-language pathology \$20 copay per visit <ul style="list-style-type: none"> Occupational therapy 	\$30 copay per visit <ul style="list-style-type: none"> Physical therapy Speech-language pathology \$30 copay per visit <ul style="list-style-type: none"> 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.

Your Benefits and Cost-Sharing

Premiums and Benefits	Premier by Ultimate (HMO) 001	Premier by Ultimate (HMO) 028	Premier by Ultimate (HMO) 045
Transportation	\$0 copay for up to 20 one-way trips every year to plan-approved health-related locations	\$0 copay for up to 20 one-way trips every year to plan-approved health-related locations	\$0 copay for up to 20 one-way trips every year to plan-approved health-related locations
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 \$35 copay for <ul style="list-style-type: none"> • One-month supply of Medicare Part B covered insulin 	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 \$35 copay for <ul style="list-style-type: none"> • One-month supply of Medicare Part B covered insulin 	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 \$35 copay for <ul style="list-style-type: none"> • One-month supply of Medicare Part B covered insulin
Foot Care (<i>podiatry services</i>) Medicare-covered foot exams and treatment	\$10 copay	\$20 copay	\$15 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

Your Benefits and Cost-Sharing

Premier by Ultimate (HMO) 046	Premier by Ultimate (HMO) 047	What You Need to Know
\$0 copay for up to 12 one-way trips every year to plan-approved health-related locations	\$0 copay for up to 12 one-way trips every year to plan-approved health-related locations	Our plan covers health-related transport to the following plan-approved locations: <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • 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 <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 \$35 copay for <ul style="list-style-type: none"> • One-month supply of Medicare Part B covered insulin 	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 \$35 copay for <ul style="list-style-type: none"> • 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.
\$0 copay	\$0 copay	

Your Benefits and Cost-Sharing

Premiums and Benefits	Premier by Ultimate (HMO) 001	Premier by Ultimate (HMO) 028	Premier by Ultimate (HMO) 045
Ultimate Benefits Card (Benefits Mastercard® Prepaid Card)	\$200 every year to cover hearing, dental, and vision services that exceed the plan-allowed benefits.	\$200 every year to cover hearing, dental, and vision services that exceed the plan-allowed benefits.	\$200 every year to cover hearing, dental, and vision services that exceed the plan-allowed benefits.
Meal Benefit	\$0 copay	\$0 copay	\$0 copay
Medical Equipment/Supplies <ul style="list-style-type: none"> • Durable Medical Equipment (e.g., wheelchairs, oxygen) • Prosthetics (e.g., braces, artificial limbs) • Diabetic supplies 	20% coinsurance for <ul style="list-style-type: none"> • Durable Medical Equipment (DME) • Prosthetics \$0 copay for <ul style="list-style-type: none"> • Preferred diabetes monitoring supplies • Diabetes self-management training • Diabetic shoes 	20% coinsurance for <ul style="list-style-type: none"> • Durable Medical Equipment (DME) • Prosthetics \$0 copay for <ul style="list-style-type: none"> • Preferred diabetes monitoring supplies • Diabetes self-management training • Diabetic shoes 	20% coinsurance for <ul style="list-style-type: none"> • Durable Medical Equipment (DME) • Prosthetics \$0 copay for <ul style="list-style-type: none"> • Preferred diabetes monitoring supplies • Diabetes self-management training • Diabetic shoes

Your Benefits and Cost-Sharing

Premier by Ultimate (HMO) 046	Premier by Ultimate (HMO) 047	What You Need to Know
\$200 every year to cover hearing, dental, and vision services that exceed the plan-allowed benefits.	\$200 every year to cover hearing, dental, and vision services that exceed the plan-allowed benefits.	Yearly allowance is loaded to your Ultimate Benefits Card and can be used where Mastercard® is accepted to cover hearing, dental, and vision services that exceed the plan-allowed benefits. A referral or prior authorization is required for some services. This card is issued by The Bancorp Bank N.A., Member FDIC.
\$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.
20% coinsurance for <ul style="list-style-type: none"> • Durable Medical Equipment (DME) • Prosthetics \$0 copay for <ul style="list-style-type: none"> • Preferred diabetes monitoring supplies • Diabetes self-management training • Diabetic shoes 	20% coinsurance for <ul style="list-style-type: none"> • Durable Medical Equipment (DME) • Prosthetics \$0 copay for <ul style="list-style-type: none"> • Preferred diabetes monitoring supplies • Diabetes self-management training • Diabetic shoes 	Authorization is required for some services.

Outpatient Prescription Drugs

What are the drug payment stages and how much do I pay in each stage?

Stage 1: Yearly Deductible Stage. This stage does not apply to you because our plans do not have a deductible.

Stage 2: Initial Coverage Stage. During this stage, the plan pays its share of the cost of your covered prescription drugs, and you pay your share (your copayment or coinsurance amount). Cost-Sharing may change depending on the drug, the pharmacy you choose (i.e., preferred, or non-preferred network, out of network, mail order, retail, long-term care, home infusion, etc.), or the day's supply (i.e., 30 days, 90 days, or 100 days). You stay in the Initial Coverage Stage until your out-of-pocket costs for the calendar year reach **\$2,000**. You then move on to the Catastrophic Coverage Stage.

Stage 3: Catastrophic Coverage Stage. During the Catastrophic Coverage Stage, you pay nothing for your covered Part D drugs. You will stay in this payment stage until the end of the calendar year.

How do I determine my Prescription Drug cost?

Every drug on the plan's Drug List is in one of **5** cost-sharing tiers with a corresponding cost-sharing amount depending on the plan:

- **Cost-Sharing Tier 1 (Preferred Generic)** includes generic drugs.
- **Cost-Sharing Tier 2 (Generic)** includes generic and brand drugs.
- **Cost-Sharing Tier 3 (Preferred Brand)** includes preferred brand drugs and some generic drugs.
- **Cost-Sharing Tier 4 (Non-preferred Drug)** includes non-preferred brand drugs and some generic drugs.
- **Cost-Sharing Tier 5 (Specialty Tier)** includes high-cost drugs, brand and generic drugs, which may require special handling and/or close monitoring. This is the highest-cost tier.

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. 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.

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

	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 and Tier 2 drugs)	Mail Order Pharmacy Cost-Sharing (90-day supply; Up to a 100-day supply for some Tier 1 and Tier 2 drugs)
Plan	Premier by Ultimate (HMO) 001, 045			
Initial Coverage Stage	Tier 1	\$0 copay	\$0 copay	\$0 copay
	Tier 2	\$0 copay	\$0 copay	\$0 copay
	Tier 3	\$30 copay	\$90 copay	\$60 copay
	Tier 4	\$70 copay	\$210 copay	\$140 copay
	Tier 5	33% coinsurance	Not Covered	Not Covered
Plan	Premier by Ultimate (HMO) 028, 046			
Initial Coverage Stage	Tier 1	\$0 copay	\$0 copay	\$0 copay
	Tier 2	\$0 copay	\$0 copay	\$0 copay
	Tier 3	\$35 copay	\$105 copay	\$70 copay
	Tier 4	\$85 copay	\$255 copay	\$170 copay
	Tier 5	33% coinsurance	Not Covered	Not Covered
Plan	Premier by Ultimate (HMO) 047			
Initial Coverage Stage	Tier 1	\$0 copay	\$0 copay	\$0 copay
	Tier 2	\$0 copay	\$0 copay	\$0 copay
	Tier 3	\$25 copay	\$75 copay	\$50 copay
	Tier 4	\$75 copay	\$225 copay	\$150 copay
	Tier 5	33% coinsurance	Not Covered	Not Covered

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at 1-855-858-7526 (TTY 711).

Understanding the Benefits

- 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, 2025.
- 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>.

**Multi-Language Insert
Multi-language Interpreter Services**

Form Approved
OMB# 0938-1421

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/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 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 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 (TTY: 711). سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-888-657-4170 (TTY: 711) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त 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。

Form CMS-10802
(Expires 12/31/25)



To learn more, call
1-855-858-7526 (TTY 711)

October 1 - March 31:
Monday - Sunday, 8:00 am - 8:00 pm

April 1 - September 30:
Monday - Friday, 8:00 am - 8:00 pm



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