2026 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	**$185.00**	**$185.00**	**$185.00**
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 *(does not include prescription drugs)*	**$1,900**	**$2,500**	**$1,900**
Inpatient Hospital Coverage	**$80 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** **• $10 copay**	**Primary Care Providers** **• $0 copay** **Specialists** **• $10 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.
$185.00	**$185.00**	
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** **• $10 copay**	**Primary Care Providers** **• $0 copay** **Specialists** **• $10 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** **• $120 copay** **Worldwide** **• $100 copay**	**In the United States** **• $120 copay** **Worldwide** **• $100 copay**	**In the United States** **• $120 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 **• $120 copay** **Worldwide** **• $100 copay**	**In the United States** **• $120 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 • 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
Hearing Services	**$0 copay** for • Routine hearing exam (1 every year) • Hearing aid fitting and evaluation (1 every year) 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) 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) Our plan pays up to **$2,000** ($1,000 per hearing aid, per ear) every year.

Your Benefits and Cost-Sharing

Premier by Ultimate (HMO) 046	Premier by Ultimate (HMO) 047	What You Need to Know
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. 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.
$0 copay for • Routine hearing exam (1 every year) • Hearing aid fitting and evaluation (1 every year) 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) 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 offered a selection of hearing aids to choose from. • 60-day money-back guarantee • 3-year manufacturer's warranty • 60 batteries per year, per aid (3-year supply)

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 • Medically necessary nonroutine dental services, as covered by Original Medicare	$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:** • Necessary anesthesia with covered service. • 60 minutes of general anesthesia or IV sedation per date of service **Some services may require prior authorization.** **Limitations/Restrictions:** • Periodontal maintenance, gingival irrigation, and localized delivery of antimicrobial agents, like Arestin®, are not covered, and the member is responsible for the additional charge, even though scaling/root planing is covered.

Your Benefits and Cost-Sharing

Premiums and Benefits	Premier by Ultimate (HMO) 001	Premier by Ultimate (HMO) 028	Premier by Ultimate (HMO) 045
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 $400 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 provides the following upgrades once per year:** **$50 copay** for • Standard progressive lenses OR **$40 copay** for • 1 pair of prescription sunglasses 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 $400 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 provides the following upgrades once per year:** **$50 copay** for • Standard progressive lenses OR **$40 copay** for • 1 pair of prescription sunglasses 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 $400 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 provides the following upgrades once per year:** **$50 copay** for • Standard progressive lenses OR **$40 copay** for • 1 pair of prescription sunglasses 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

Your Benefits and Cost-Sharing

Premier by Ultimate (HMO) 046	Premier by Ultimate (HMO) 047	What You Need to Know

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 $400 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 provides the following upgrades once per year:
 	
$50 copay for
• Standard progressive lenses
OR
$40 copay for
• 1 pair of prescription sunglasses 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 provides the following upgrades once per year:
	
	$50 copay for
	• Standard progressive lenses
	OR
	$40 copay for
	• 1 pair of prescription sunglasses 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.
		
		Our plan provides the following upgrades once per year:
		Photochromic Lenses OR Prescription Sunglasses with Polarized (Grey or Brown) Lenses OR Progressive Lenses.
		
		Upgrades do not impact the per-year limit on eyewear.

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	**$80 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 **$10 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 **$10 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	**$0 copay** per visit • Physical therapy • Speech-language pathology **$10 copay** per visit • Occupational therapy	**$0 copay** per visit • Physical therapy • Speech-language pathology **$10 copay** per visit • Occupational therapy	**$0 copay** per visit • Physical therapy • Speech-language pathology **$10 copay** per visit • Occupational therapy
Ambulance	**$200 copay** for Medicare-covered one-way **ground ambulance** benefit **20% coinsurance** for Medicare-covered one-way **air ambulance** benefit	**$200 copay** for Medicare-covered one-way **ground ambulance** benefit **20% coinsurance** for Medicare-covered one-way **air ambulance** benefit	**$200 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** **$10 copay** for group therapy visits **$10 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 **$10 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.
$0 copay per visit • Physical therapy • Speech-language pathology **$10 copay** per visit • Occupational therapy	**$0 copay** per visit • Physical therapy • Speech-language pathology **$10 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.
$200 copay for Medicare-covered one-way **ground ambulance** benefit **20% coinsurance** for Medicare-covered one-way **air ambulance** benefit	**$200 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 20 one-way trips every year to plan-approved health-related locations**	**$0 copay for 20 one-way trips every year to plan-approved health-related locations**	**$0 copay for 20 one-way trips every year to plan-approved health-related locations**
Medicare Part B Drugs	**0% to 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	**0% to 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	**0% to 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**	**$10 copay**	**$10 copay**
Wellness Program • 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 12 one-way trips every year to plan-approved health-related locations	**$0 copay for 12 one-way trips every 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 • Veterans Affairs (VA) • 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
0% to 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	**0% to 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.
$10 copay	**$10 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
Flex Allowance (amount loaded onto your Ultimate Benefits Card, a Prepaid Mastercard)	**$660 yearly allowance** to cover out-of-pocket hearing, dental, and vision expenses.	**$580 yearly allowance** to cover out-of-pocket hearing, dental, and vision expenses.	**$500 yearly allowance** to cover out-of-pocket hearing, dental, and vision expenses.
Over-the-Counter (OTC)	**$90 every month**	**$80 every month**	**$90 every month**
Meal Benefit	**$0 copay**	**$0 copay**	**$0 copay**
Medical Equipment/Supplies • Durable Medical Equipment (e.g., wheelchairs, oxygen) • Prosthetics (e.g., braces, artificial limbs) • Diabetic supplies	**20% coinsurance** for • Durable Medical Equipment (DME) • Prosthetics **$0 copay** for • 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

Your Benefits and Cost-Sharing

Premier by Ultimate (HMO) 046	Premier by Ultimate (HMO) 047	What You Need to Know
$620 yearly allowance to cover out-of-pocket hearing, dental, and vision expenses.	**$500 yearly allowance** to cover out-of-pocket hearing, dental, and vision expenses.	The Benefits Mastercard® Prepaid Card is issued by The Bancorp Bank N.A., Member FDIC, pursuant to license by Mastercard International Incorporated and card can be used for eligible expenses wherever Mastercard is accepted. Valid only in the U.S. No cash access. This is not a gift card or gift certificate. You will receive this card as a gratuity without the payment of any monetary value or consideration.
$95 every month	**$70 every month**	The monthly allowance is loaded to your Ultimate Benefit Card to pay for OTC items. Unused funds expire at the end of each month.
$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 • 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	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 drugs tier, 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 **$2,100**. 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)** This tier also offers drugs at the lowest cost.
- **Cost-Sharing Tier 2 (Generic)** includes generic 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 drug list (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, 028, 045, 046**			
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	35% coinsurance	35% coinsurance	35% coinsurance
	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	35% coinsurance	35% coinsurance	35% coinsurance
	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, 2027.
- ☐ 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, by mail, fax, email, or by completing online form at: https://request.uhp.health. 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.

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

ATTENTION: If you speak any of these languages, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 888-657-4170 (TTY: 711) or speak to your provider.

Español

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 888-657-4170 (TTY: 711) o hable con su proveedor.

العربية

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 888-657-4170 (711) أو تحدث إلى مقدم الخدمة".

Français

D'avis de disponibilité des services d'assistance linguistique et des aides et services auxiliaires

ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 888-657-4170 (TTY: 711) ou parlez à votre fournisseur. »

Deutsch

Bekanntmachung über die Verfügbarkeit von Sprachassistenzdiensten und Hilfsmitteln und -diensten

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 888-657-4170 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.

Kreyòl Ayisyen

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd aladispozisyon w gratis pou lang ou pale a. Èd ak sèvis siplemantè apwopriye pou bay enfòmasyon nan fòma aksesib yo disponib gratis tou. Rele nan 888-657-4170 (TTY: 711) oswa pale avèk founisè w la.

हिंदी

ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 888-657-4170 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।

Italiano

Di avviso di disponibilità di servizi di assistenza linguistica e di ausili e servizi ausiliari

ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l'888-657-4170 (TTY: 711) o parla con il tuo fornitore.

日本語

注：日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル（誰もが利用できるよう配慮された）な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。888-657-4170 (TTY: 711) **までお電話ください。または、ご利用の事業者にご相談ください。**

한국어

주의: 한국어를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 888-657-4170 (TTY: 711) 번으로 전화하거나 서비스 제공업체에 문의하십시오.

POLSKI

UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 888-657-4170 (TTY: 711) lub porozmawiaj ze swoim dostawcą.

Português do Brasil

De aviso de disponibilidade de serviços de assistência linguística e auxílios e serviços auxiliares

ATENÇÃO: Se você fala Português do Brasil, serviços gratuitos de assistência linguística estão disponíveis para você. Auxílios e serviços auxiliares apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 888-657-4170 (TTY: 711) ou fale com seu provedor.

РУССКИЙ

ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 888-657-4170 (TTY: 711) или обратитесь к своему поставщику услуг.

中文

注意：如果您说 中文，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 888-657-4170（文本电话：711）或咨询您的服务提供商。

Tagalog

PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 888-657-4170 (TTY: 711) o makipag-usap sa iyong provider.

台語

注意：如果您說 台語，我們可以爲您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 888-657-4170 (TTY: 711) 或與您的提供者討論。」

Việt

LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 888-657-4170 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

ULTIMATE HEALTH PLANS

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

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

Visit our website at
www.ChooseUltimate.com