2026 Summary of Benefits

Dual Special Needs Plans

Citrus | Hernando | Hillsborough | Indian River | Lake
Manatee | Marion | Orange | Osceola | Pasco| Pinellas
Polk | Sarasota | Seminole | St. Lucie | Sumter

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

ULTIMATE HEALTH PLANS
Good health is where you live.

H2962_SBDSNP_CY26R032125_M

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 Advantage Plus by Ultimate (Full) (HMO D-SNP) and Advantage Plus by Ultimate (Partial) (HMO D-SNP) plans. It does not list every service covered by the plan or list every limitation or exclusion. For a complete list of services we cover, please refer to the plan's Evidence of Coverage (EOC) on our website at www.ChooseUltimate.com, or call us at 1-855-858-7526 (TTY 711) and we will mail you a copy. We are available from 8:00 am to 8:00 pm, Monday through Friday. Between October 1 and March 31, we are available Monday through Sunday from 8:00 am to 8:00 pm.

Ultimate Plan Types

Medicare Health Maintenance Organization (HMO): A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage. Generally, you can only get your care from doctors or hospitals in the plan's network (except in emergencies).

Medicare HMO Special Needs Plan (HMO SNP): An HMO Medicare Advantage Plan that has a benefit package designed for people with special health care needs. Examples of the specific groups served include people who have both Medicare and Medicaid, people who reside in nursing homes, and people who have certain chronic medical conditions.

Who can join?

To join our plan, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, receive assistance from the Florida Medicaid Agency for Health Care Administration (AHCA), and live in the plan's service area.

Levels of Medicaid

Full-Benefit Dual Eligible (FBDE): An individual who is not QMB or SLMB but is eligible for full Medicaid benefits either categorically or through optional coverage groups.
Qualified Medicare Beneficiary (QMB): Medicaid helps pay Medicare Part A and Part B premiums and other cost-sharing (like deductibles, coinsurance, and copayments). These individuals do not receive full Medicaid benefits.
Qualified Medicare Beneficiary Plus (QMB+): Medicaid helps pay for Medicare Part A and Part B premiums and other cost-sharing (like deductibles, coinsurance, and copayments). These individuals receive full Medicaid benefits.
Specified Low-Income Medicare Beneficiary (SLMB): Medicaid helps pay Part B premiums. These individuals do not receive full Medicaid benefits.
Specified Low-Income Medicare Beneficiary Plus (SLMB+): Medicaid helps pays Part B premiums. These individuals receive full Medicaid benefits.
Qualifying Individual (QI): Medicaid helps pay Part B premiums. These individuals do not receive full Medicaid benefits.
Qualified Disabled & Working Individuals (QDWI): Medicaid helps pay Part A premiums. These individuals do not receive full Medicaid benefits.

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	**Advantage Plus by Ultimate (Full) (HMO D-SNP)** 035
Service Area	Citrus, Hernando, Hillsborough, Indian River, Lake, Manatee, Marion, Osceola, Orange, Pasco, Polk, Pinellas, St. Lucie, Sarasota, Seminole, Sumter
Special Needs Plan Eligibility Criteria	FBDE, QMB+, SLMB+ (Levels of Medicaid, refer to page 2)

Your Benefits and Cost-Sharing

Premiums and Benefits	Advantage Plus by Ultimate (Full) (HMO D-SNP) 035
Monthly Plan Premium	**$0**
Deductible	This plan **does not** have a deductible.
Maximum Out-of-Pocket Responsibility *(does not include prescription drugs)*	**$500**
Inpatient Hospital Coverage	**$0 copay for days 1 through 90**
Outpatient Hospital Coverage	**$0 copay**
Ambulatory Surgery Center (ASC) Services	**$0 copay**
Doctor Visits *(Primary Care Providers and Specialists)*	**Primary Care Providers** **• $0 copay** **Specialists** **• $0 copay**
Preventive Care	**$0 copay**

Plan Name	**Advantage Plus by Ultimate (Partial) (HMO D-SNP)** 036
Service Area	Citrus, Hernando, Hillsborough, Indian River, Lake, Manatee, Marion, Osceola, Orange, Pasco, Polk, Pinellas, St. Lucie, Sarasota, Seminole, Sumter
Special Needs Plan Eligibility Criteria	QMB, SLMB, QI, QDWI (Levels of Medicaid, refer to page 2)

Your Benefits and Cost-Sharing

Advantage Plus by Ultimate (Partial) (HMO D-SNP) 036	What You Need to Know
$0	You must continue to pay your Medicare Part B Premium unless your Part B Premium is paid for you by Florida State Medicaid or another third party.
This plan **does not** have a deductible.	
$500	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.
$0 copay for days 1 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.
$0 copay	Prior authorization is required for some services.
$0 copay	A referral and prior authorization may be required for some services.
Primary Care Providers **• $0 copay** **Specialists** **• $0 copay**	A referral or prior authorization is required for some services. A separate copay may apply for each additional service received at an office visit.
$0 copay	Any additional preventive services approved by Medicare during the contract year will be covered. A referral or prior authorization is required for some services.

Your Benefits and Cost-Sharing

Premiums and Benefits	Advantage Plus by Ultimate (Full) (HMO D-SNP) 035
Emergency Care	**In the United States** **• $0 copay** **Worldwide** **• $100 copay**
Urgently Needed Services	**$0 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 and X-Rays** •$25 copay for Genetic Testing •$0 copay for all other labs and x-rays **Diagnostic Tests and Procedures** •$0 copay for Colonoscopy, Endoscopy and other diagnostic, "scopic" procedures, Pulmonary Function Tests, Thyroid Function Tests •$0 copay for Sleep Study, Psychological Tests **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
Diagnostic Services, Labs, and Imaging at an Outpatient Hospital • Lab services • Outpatient x-rays • Diagnostic tests and procedures • Diagnostic radiological services	**Lab Services and X-Rays** •$25 copay for Genetic Testing •$0 copay for all other labs and x-rays **Diagnostic Tests and Procedures** •$0 copay for Colonoscopy, Endoscopy and other diagnostic, "scopic" procedures, Pulmonary Function Tests, Thyroid Function Tests •$0 copay for Sleep Study, Psychological Tests **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

Your Benefits and Cost-Sharing

Advantage Plus by Ultimate (Partial) (HMO D-SNP) 036	What You Need to Know
In the United States • **$0 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.
$0 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 and X-Rays •$25 copay for Genetic Testing •$0 copay for all other labs and x-rays **Diagnostic Tests and Procedures** •0% coinsurance for Colonoscopy, Endoscopy and other diagnostic, "scopic" procedures, Pulmonary Function Tests, Thyroid Function Tests •20% coinsurance for Sleep Study, Psychological Tests **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.
Lab Services and X-Rays •$25 copay for Genetic Testing •$0 copay for all other labs and x-rays **Diagnostic Tests and Procedures** •0% coinsurance for Colonoscopy, Endoscopy and other diagnostic, "scopic" procedures, Pulmonary Function Tests, Thyroid Function Tests •20% coinsurance for Sleep Study, Psychological Tests **Diagnostic Radiological Services** •$0 copay for Ultrasounds and Echocardiography •$0 copay for Stress, Nerve Conduction, CT, MRI •$0 copay for CTA, MRA, PET, SPECT, other nuclear medicine tests	Prior authorization is required for some services. All services performed at an outpatient hospital facility are subject to the outpatient hospital copayment. 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	Advantage Plus by Ultimate (Full) (HMO D-SNP) 035
Hearing Services	**$0 copay** for • Routine hearing exam (1 every year) • Hearing aid fitting and evaluation (1 every 2 years) Our plan pays up to **$2,000** ($1,000 per hearing aid, per ear) every year.
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 • 1 root canal per year • 1 full mouth debridement every 2 years • 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 • Member is responsible for the additional cost of necessary extractions needed to fit dentures $0 copay for: Dentures may include 1 of the following per arch every 5 years: • Complete denture, maxillary or mandibular • Immediate denture, maxillary or mandibular • Maxillary or mandibular partial denture, resin base • Maxillary or mandibular partial denture, cast metal, resin base • Maxillary or mandibular partial denture, flexible base • Maxillary or mandibular denture reline (1 per year)

Your Benefits and Cost-Sharing

Advantage Plus by Ultimate (Partial) (HMO D-SNP) 036	What You Need to Know
$0 copay for • Routine hearing exam (1 every year) • Hearing aid fitting and evaluation (1 every 2 years) 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)
$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 • 1 root canal per year • 1 full mouth debridement every 2 years • 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 • Member is responsible for the additional cost of necessary extractions needed to fit dentures $0 copay for: Dentures may include 1 of the following per arch every 5 years: • Complete denture, maxillary or mandibular • Immediate denture, maxillary or mandibular • Maxillary or mandibular partial denture, resin base • Maxillary or mandibular partial denture, cast metal, resin base • Maxillary or mandibular partial denture, flexible base • Maxillary or mandibular denture reline (1 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 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	Advantage Plus by Ultimate (Full) (HMO D-SNP) 035
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 $500 retail value for eyewear towards one of the following options: **Option 1 ($0 copay)** • Contact lenses, and contact lens fitting OR • 1 pair of standard single-vision, bifocal, or trifocal eyeglass lenses **Option 2 ($0 copay)** • Your choice of 3 standard pairs of select eyeglasses, frames and lenses **Our plan provides the following upgrades once per year:** • Standard progressive lenses, Photochromic lenses, Ultraviolet protection, or scratch resistant coating. **Post-cataract surgery benefits include:** • 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
Mental Health Services • Inpatient hospital stays • Outpatient group therapy visits • Outpatient individual therapy visits	**$0 copay for days 1 through 90** **$0 copay** for group therapy visits **$0 copay** for individual therapy visits

Advantage Plus by Ultimate (Partial) (HMO D-SNP) 036	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 $500 retail value for eyewear towards one of the following options:
 	
Option 1 ($0 copay)
• Contact lenses, and contact lens fitting OR
• 1 pair of standard single-vision, bifocal, or trifocal eyeglass lenses
 	
Option 2 ($0 copay)
• Your choice of 3 standard pairs of select eyeglasses, frames and lenses
 	
Our plan provides the following upgrades once per year:
• Standard progressive lenses, Photochromic lenses, Ultraviolet protection, or scratch resistant coating
 	
Post-cataract surgery benefits include:
• 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
	
	Progressive Lenses
	The Progressive Lenses benefit may only be used once per year and cannot be combined with other upgrades.
	
	Photochromic Lenses
	The Photochromic lenses benefit may only be used once per year and cannot be combined with other upgrades.
	
	Upgrades do not impact the per-year limit on eyewear.

$0 copay for days 1 through 90 **$0 copay** for group therapy visits **$0 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.

Your Benefits and Cost-Sharing

Premiums and Benefits	Advantage Plus by Ultimate (Full) (HMO D-SNP) 035
Skilled Nursing Facility (SNF)	**$0 copay for days 1 through 100**
Physical Therapy • Physical therapy visit • Speech-language pathology services • Occupational therapy visit	**$0 copay** per visit • Physical therapy • Speech-language pathology **$0 copay** per visit • Occupational therapy
Ambulance	**$0 copay** for Medicare-covered one-way **ground ambulance** benefit **$0 copay** for Medicare-covered one-way **air ambulance** benefit
Transportation	**$0 copay** for **unlimited trips** every year to plan-approved health-related locations
Medicare Part B Drugs	**$0 copay** for • Medicare Part B chemotherapy drugs • Part B medications and contrast agents injected during a service • Other Part B drugs **$0 copay** for • One-month supply of Medicare Part B covered insulin

Your Benefits and Cost-Sharing

Advantage Plus by Ultimate (Partial) (HMO D-SNP) 036	What You Need to Know
$0 copay for days 1 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 **$0 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.
$0 copay for Medicare-covered one-way **ground ambulance** benefit **$0 copay** for Medicare-covered one-way **air ambulance** benefit	Except in an emergency, this service may require prior authorization.
$0 copay for **unlimited 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 copay for • Medicare Part B chemotherapy drugs • Part B medications and contrast agents injected during a service • Other Part B drugs **$0 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.

Your Benefits and Cost-Sharing

Premiums and Benefits	Advantage Plus by Ultimate (Full) (HMO D-SNP) 035
Foot Care *(podiatry services)* Medicare-covered foot exams and treatment	**$0 copay**
Wellness Program • SilverSneakers® Fitness Program • Health Education • Additional Smoking and Tobacco Use Cessation	**$0 copay**
In-Home Support Service	**$0 copay** for up to **30 hours** per year of companion and caregiver support services
Flex Allowance (amount loaded onto your Ultimate Benefits Card, a Prepaid Mastercard)	**$700 allowance annually** to cover out-of-pocket hearing, dental, and vision expenses.
Over-the-Counter (OTC)	**$205 every month** to purchase approved Over-the-Counter items.
Special Supplemental Benefits for the Chronically Ill (with a verified qualifying condition) • Healthy Foods • Utilities (Electric, Gas, and Water)	**$225 every month** to purchase healthy foods at participating retailers and certain utility bills.
Meal Benefit	**$0 copay**
Medical Equipment/Supplies • Durable Medical Equipment (e.g., wheelchairs, oxygen) • Prosthetics (e.g., braces, artificial limbs) • Diabetic supplies	**$0 copay** 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

Advantage Plus by Ultimate (Partial) (HMO D-SNP) 036	What You Need to Know
$0 copay	A referral is required.
$0 copay	
$0 copay for up to **30 hours** per year of companion and caregiver support services	In-home companionship includes light household chores, board games, photo album viewing, and help with technology. Visits may be scheduled for 2-4 hours per day; 7 days a week. Please call 855-329-4858 (TTY 711) for assistance.
$630 allowance annually to cover out-of-pocket hearing, dental, and vision expenses.	Yearly allowance is loaded to you Benefits Mastercard® Prepaid 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. Monthly allowances are loaded to you Benefits Mastercard® Prepaid Card. Unused funds expire at the end of each month. Some restrictions may apply.
$210 every month to purchase approved Over-the-Counter items.	The monthly allowance is loaded to your Ultimate Benefit Card to pay for OTC items. Funds do not roll over from month to month. Unused funds expire at the end of each month.
$225 every month to purchase healthy foods at participating retailers and certain utility bills.	The monthly allowance is loaded to your Ultimate Benefit Card to pay for covered healthy foods and utility bills (electricity, gas, and water). Funds do not roll over from month to month. Unused funds expire at the end of each month.
$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.
$0 copay 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

The Formulary is Divided into 6 Tiers

Every drug on the plan's Drug List is in one of 6 cost-sharing tiers with a corresponding cost-sharing amount as shown below. In general, the higher the cost-sharing tier, the higher your cost for the drug.

- **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 Drugs)** includes non-preferred brand drugs and some generic drugs.
- **Cost-Sharing Tier 5 (Specialty Tier)** includes brand and generic drugs, which may require special handling and/or close monitoring.
- **Cost-Sharing Tier 6 (Excluded Drugs Only)** includes prescription drugs not normally covered in a Medicare Prescription Drug Plan.

	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	**Advantage Plus by Ultimate (Full) (HMO D-SNP) 035 Advantage Plus by Ultimate (Partial) (HMO D-SNP) 036**			
Initial Coverage Stage	Tier 1	$0 copay	$0 copay	$0 copay
	Tier 2	$0 copay	$0 copay	$0 copay
	Tier 3	25% coinsurance OR LIS approved Subsidy amount	25% coinsurance OR LIS approved Subsidy amount	25% coinsurance OR LIS approved Subsidy amount
	Tier 4	25% coinsurance OR LIS approved Subsidy amount	25% coinsurance OR LIS approved Subsidy amount	25% coinsurance OR LIS approved Subsidy amount
	Tier 5	25% coinsurance OR LIS approved Subsidy amount	Not Covered	Not Covered
	Tier 6	$0 copay	$0 copay	$0 copay

Summary of Medicaid-Covered Benefits

The table below contains a summary of the benefits covered by AHCA (Medicaid) and Advantage Plus by Ultimate Full & Partial. Medicaid is a joint Federal and state government program that helps with medical costs for certain people who have limited incomes and resources. Those that have both Medicaid and Medicare are known as dual eligible. What you pay for covered services may depend on your level of Medicaid eligibility. These benefits may be subject to prior authorization.

Service	Florida State Medicaid	Advantage Plus by Ultimate Full & Partial
Allergy Services	Covered	Covered
Ambulatory Surgical Center Services	Covered	Covered
Anesthesia Services	Covered	Covered
Assistive Care Services	Covered	Covered
Behavioral Health Assessment Services	Covered	Covered
Behavioral Health Community Support Services	Covered	Covered
Behavioral Health Intervention Services	Covered	Covered
Behavioral Health Medication Management	Covered	Covered
Behavioral Health Overlay	Covered	Covered
Behavioral Health Therapy Services	Covered	Covered
Cardiovascular Services	Covered	Covered
Child Health Services Targeted Case Management	Covered	Covered
Chiropractic Services	Covered	Covered
County Health Department (CHD) Services	Covered	Covered
Dental Services	Covered	Covered
Dialysis Services	Covered	Covered
Durable Medical Equipment and Medical Supplies	Covered	Covered
Early Intervention Services	Covered	Covered
Emergency Transportation Services	Covered	Covered
Evaluation and Management Services	Covered	Covered
Federally Qualified Health Center Services	Covered	Covered
Gastrointestinal Services	Covered	Covered
Genitourinary Services	Covered	Covered
Hearing Services	Covered	Covered
Home Health Services	Covered	Covered
Inpatient Hospital Services	Covered	Covered
Integumentary Services	Covered	Covered
Laboratory Services	Covered	Covered
Medical Foster Care Services	Covered	Covered
Mental Health Targeted Case Management	Covered	Covered
Neurology Services	Covered	Covered
Non-Emergency Transportation Services	Covered	Covered
Nursing Facility Services	Covered	Covered
Occupational Therapy	Covered	Covered
Oral and Maxillofacial Surgery Services	Covered	Covered
Orthopedic Services	Covered	Covered

Service	Florida State Medicaid	Advantage Plus by Ultimate Full & Partial
Outpatient Hospital Services	Covered	Covered
Pain Management Services	Covered	Covered
Personal Care Services	Covered	Covered
Physical Therapy Services	Covered	Covered
Podiatry Services	Covered	Covered
Prescribed Drug Services	Covered	Covered
Private Duty Nursing	Covered	Covered
Radiology and Nuclear Medicine Services	Covered	Covered
Regional Perinatal Intensive Care Center Services	Covered	Covered
Reproductive Services	Covered	Covered
Respiratory System Services	Covered	Covered
Respiratory Therapy Services	Covered	Covered
Rural Health Clinic Services	Covered	Covered
Specialized Therapeutic Services	Covered	Covered
Speech-Language Pathology	Covered	Covered
Statewide Inpatient Psychiatric Program	Covered	Covered
Transplant Services	Covered	Covered
Visual Aid Services	Covered	Covered
Visual Care Services	Covered	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).
- [ ] This plan is a dual-eligible special needs plan (D-SNP). Your ability to enroll will be based on verification that you are entitled to both Medicare and medical assistance from a state plan under Medicaid.
- [ ] **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