ULTIMATE HEALTH PLANS



Chronic Special Needs Plans

Indian River | Lake | Manatee | Marion | Orange Osceola | Sarasota | Seminole | St. Lucie | Sumter
023 Advantage Care COPD by Ultimate (HMO C-SNP)

Lake | Marion | Sumter
029 Advantage Care by Ultimate (HMO C-SNP)

Indian River | St. Lucie
033 Advantage Care by Ultimate (HMO C-SNP)

Orange | Osceola | Seminole
050 Advantage Care by Ultimate (HMO C-SNP)

Manatee | Sarasota
052 Advantage Care by Ultimate (HMO C-SNP)

2027 Summary of Benefits

H2962_SBCSNP1_CY27R082826_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 Care by Ultimate (HMO C-SNP) and Advantage Care COPD by Ultimate (HMO C-SNP) plans. It does not list every service covered by the plan or list every limitation or exclusion. For a complete list of services we cover, please refer to the plan's Evidence of Coverage (EOC) on our website at www.ChooseUltimate.com, or call us at 1-855-858-7526 (TTY 711) and we will mail you a copy. We are available from 8:00 am to 8:00 pm, Monday through Friday. Between October 1 and March 31, we are available Monday through Sunday from 8:00 am to 8:00 pm.

Ultimate Plan Types

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

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

Who can join?

To join our plan, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, be diagnosed with a qualifying chronic condition, and live in the plan's service area.

Which doctors, hospitals, and pharmacies can I use?

We have a network of doctors, hospitals, pharmacies, and other providers. Except in an emergency, you must use in-network providers and pharmacies. If you use providers that are not in our network, the plan may not pay for these services. You can view our plan's Provider and Pharmacy Directory on our website at www.ChooseUltimate.com or call us at 1-855-858-7526 (TTY 711) and we will mail you a copy.

Does this plan cover my Prescription Drugs?

To find out what drugs we cover and any restrictions, view our plan's List of Covered Drugs (also called the Formulary) on our website at www.ChooseUltimate.com or call us at 1-855-858-7526 (TTY 711), and we will mail you a copy.

How do I learn more about Original Medicare?

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at http://www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Ultimate Health Plans is an HMO with a Medicare contract and is contracted with the Florida State Medicaid program for Dual Special Needs Plans. Enrollment in Ultimate Health Plans depends on contract renewal.

Plan Name	Advantage Care by Ultimate (HMO C-SNP) 029	Advantage Care by Ultimate (HMO C-SNP) 033	Advantage Care by Ultimate (HMO C-SNP) 050
Service Area	Lake, Marion, Sumter	Indian River, St. Lucie	Orange, Osceola, Seminole
Special Needs Plan Eligibility Criteria	Diagnosed with Diabetes, Cardiovascular Disorders, and/or Chronic Heart Failure		

Your Benefits and Cost-Sharing

Premiums and Benefits	Advantage Care by Ultimate (HMO C-SNP) 029	Advantage Care by Ultimate (HMO C-SNP) 033	Advantage Care by Ultimate (HMO C-SNP) 050
Monthly Plan Premium	**$0**	**$0**	**$0**
Part B Premium Reduction	**$202.90**	**$202.90**	**$202.90**
Deductible	This plan **does not** have a deductible.	This plan **does not** have a deductible.	This plan **does not** have a deductible.
Maximum Out-of-Pocket Responsibility *(does not include prescription drugs)*	**$2,400**	**$2,800**	**$1,900**
Inpatient Hospital Coverage	**$155 copay per day for days 1 through 5** **$0 copay per day for days 6 through 90**	**$245 copay per day for days 1 through 5** **$0 copay per day for days 6 through 91**	**$175 copay per day for days 1 through 5** **$0 copay per day for days 6 through 90**
Outpatient Hospital Coverage	**$150 copay**	**$150 copay**	**$195 copay**
Ambulatory Surgery Center (ASC) Services	**$25 copay**	**$50 copay**	**$25 copay**
Doctor Visits *(Primary Care Providers and Specialists)*	**Primary Care Providers** **• $0 copay** **Specialists** **• $5 copay**	**Primary Care Providers** **• $0 copay** **Specialists** **• $10 copay**	**Primary Care Providers** **• $0 copay** **Specialists** **• $5 copay**

Plan Name	Advantage Care by Ultimate (HMO C-SNP) 052	Advantage Care COPD by Ultimate (HMO C-SNP) 023
Service Area	Manatee, Sarasota	Indian River, Lake, Manatee, Marion, Orange, Osceola, Sarasota, Seminole, St. Lucie, Sumter
Special Needs Plan Eligibility Criteria	Diagnosed with Diabetes, Cardiovascular Disorders, and/or Chronic Heart Failure	Diagnosed with Chronic Lung Disorders

Your Benefits and Cost-Sharing

Advantage Care by Ultimate (HMO C-SNP) 052	Advantage Care COPD by Ultimate (HMO C-SNP) 023	What You Need to Know
$0	**$0**	You must continue to pay your Medicare Part B Premium.
$202.90	**$202.90**	
This plan **does not** have a deductible.	This plan **does not** have a deductible.	
$3,400	**$2,600**	This amount is the most you'll pay for copays, coinsurance, and other costs for in-network medical services for the year. It does not include prescription drug costs, health expenses incurred during foreign travel, or supplemental benefit costs.
$170 copay per day for days 1 through 5 **$0 copay per day for days 6 through 90**	**$115 copay per day for days 1 through 5** **$0 copay per day for days 6 through 91**	Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. Prior authorization is required.
$195 copay	**$150 copay**	Prior authorization is required for some services.
$25 copay	**$25 copay**	Prior authorization may be required for some services.
Primary Care Providers **• $0 copay** **Specialists** **• $5 copay**	**Primary Care Providers** **• $0 copay** **Specialists** **• $5 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	Advantage Care by Ultimate (HMO C-SNP) 029	Advantage Care by Ultimate (HMO C-SNP) 033	Advantage Care by Ultimate (HMO C-SNP) 050
Preventive Care	**$0 copay**	**$0 copay**	**$0 copay**
Emergency Care	**In the United States** **• $150 copay** **Worldwide** **• $100 copay**	**In the United States** **• $150 copay** **Worldwide** **• $100 copay**	**In the United States** **• $150 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 copay 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 •$50 copay for Sleep Study, Psychological Tests **Diagnostic Radiological Services** •$0 copay for Ultrasounds and Echocardiography •$25 copay for Stress, Nerve Conduction, CT, MRI •$75 copay for CTA, MRA, PET, SPECT, other nuclear medicine tests	**Lab Services** •20% coinsurance for Genetic Testing •$0 copay 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 •$50 copay for Sleep Study, Psychological Tests **Diagnostic Radiological Services** •$0 copay for Ultrasounds and Echocardiography •$25 copay for Stress, Nerve Conduction, CT, MRI •$75 copay for CTA, MRA, PET, SPECT, other nuclear medicine tests	**Lab Services** •20% coinsurance for Genetic Testing •$0 copay 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

Your Benefits and Cost-Sharing

Advantage Care by Ultimate (HMO C-SNP) 052	Advantage Care COPD by Ultimate (HMO C-SNP) 023	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 **• $150 copay** **Worldwide** **• $100 copay**	**In the United States** **• $150 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 copay 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	**Lab Services** •20% coinsurance for Genetic Testing •$0 copay 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 •$50 copay for Sleep Study, Psychological Tests **Diagnostic Radiological Services** •$0 copay for Ultrasounds and Echocardiography •$25 copay for Stress, Nerve Conduction, CT, MRI •$75 copay for CTA, MRA, PET, SPECT, other nuclear medicine tests	Prior authorization is required for some services. 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.

Your Benefits and Cost-Sharing

Premiums and Benefits	Advantage Care by Ultimate (HMO C-SNP) 029	Advantage Care by Ultimate (HMO C-SNP) 033	Advantage Care by Ultimate (HMO C-SNP) 050
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 •$150 copay for all other labs **Outpatient X-Rays** •$150 copay **Diagnostic Tests and Procedures** •$150 copay for Colonoscopy, Endoscopy and other diagnostic, "scopic" procedures, Pulmonary Function Tests, Thyroid Function Tests •$150 copay for Sleep Study, Psychological Tests **Diagnostic Radiological Services** •$150 copay for Ultrasounds and Echocardiography •$150 copay for Stress, Nerve Conduction, CT, MRI •$150 copay for CTA, MRA, PET, SPECT, other nuclear medicine tests	**Lab Services** •20% coinsurance for Genetic Testing •$150 copay for all other labs **Outpatient X-Rays** •$150 copay **Diagnostic Tests and Procedures** •$150 copay for Colonoscopy, Endoscopy and other diagnostic, "scopic" procedures, Pulmonary Function Tests, Thyroid Function Tests •$150 copay for Sleep Study, Psychological Tests **Diagnostic Radiological Services** •$150 copay for Ultrasounds and Echocardiography •$150 copay for Stress, Nerve Conduction, CT, MRI •$150 copay for CTA, MRA, PET, SPECT, other nuclear medicine tests	**Lab Services** •20% coinsurance for Genetic Testing •$195 copay for all other labs **Outpatient X-Rays** •$195 copay **Diagnostic Tests and Procedures** •$195 copay for Colonoscopy, Endoscopy and other diagnostic, "scopic" procedures, Pulmonary Function Tests, Thyroid Function Tests •20% coinsurance for Sleep Studies **Diagnostic Radiological Services** •$195 copay for Ultrasounds and Echocardiography •$195 copay for Stress, Nerve Conduction, CT, MRI •$195 copay for CTA, MRA, PET, SPECT, other nuclear medicine tests
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

Advantage Care by Ultimate (HMO C-SNP) 052	Advantage Care COPD by Ultimate (HMO C-SNP) 023	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 •$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	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	Advantage Care by Ultimate (HMO C-SNP) 029	Advantage Care by Ultimate (HMO C-SNP) 033	Advantage Care by Ultimate (HMO C-SNP) 050
Dental Services • Preventive dental services • Comprehensive dental services • Medically necessary non-routine dental services, as covered by Original Medicare **Preventive services do not impact the Annual Dental Benefit Maximum Allowance.** **$2500 Annual Dental Benefit Maximum Allowance for Comprehensive Services.** **Once you reach the $2,500, you are responsible for 100% of the cost of additional comprehensive dental services for the remainder of the benefit year.**	**$0 copay for the following Preventive services:** • 1 oral evaluation every 6 months • 1 comprehensive oral exam every 3 years • 1 cleaning every 6 months • 1 fluoride treatment every 6 months • 2 dental x-rays every year **$0 copay for Comprehensive dental services, covered in-network, up to the annual dental benefit maximum allowance of $2,500, is reached each year:** • Fillings • Crowns • Root canals • Full mouth debridement • Periodontal scaling and root planing procedures (deep cleaning) • Periodontal maintenance • Simple extraction • Surgical extraction • Dentures include 1 per arch • Necessary anesthesia with covered services • 60 minutes of general anesthesia or IV sedation per date of service	**$0 copay for the following Preventive services:** • 1 oral evaluation every 6 months • 1 comprehensive oral exam every 3 years • 1 cleaning every 6 months • 1 fluoride treatment every 6 months • 2 dental x-rays every year **$0 copay for Comprehensive dental services, covered in-network, up to the annual dental benefit maximum allowance of $2,500, is reached each year:** • Fillings • Crowns • Root canals • Full mouth debridement • Periodontal scaling and root planing procedures (deep cleaning) • Periodontal maintenance • Simple extraction • Surgical extraction • Necessary anesthesia with covered services • 60 minutes of general anesthesia or IV sedation per date of service	**$0 copay for the following Preventive services:** • 1 oral evaluation every 6 months • 1 comprehensive oral exam every 3 years • 1 cleaning every 6 months • 1 fluoride treatment every 6 months • 2 dental x-rays every year **$0 copay for Comprehensive dental services, covered in-network, up to the annual dental benefit maximum allowance of $2,500, is reached each year:** • Fillings • Crowns • Root canals • Full mouth debridement • Periodontal scaling and root planing procedures (deep cleaning) • Periodontal maintenance • Simple extraction • Surgical extraction • Necessary anesthesia with covered services • 60 minutes of general anesthesia or IV sedation per date of service

Advantage Care by Ultimate (HMO C-SNP) 052	Advantage Care COPD by Ultimate (HMO C-SNP) 023	What You Need to Know
$0 copay for the following Preventive services: • 1 oral evaluation every 6 months • 1 comprehensive oral exam every 3 years • 1 cleaning every 6 months • 1 fluoride treatment every 6 months • 2 dental x-rays every year **$0 copay for Comprehensive dental services, covered in-network, up to the annual dental benefit maximum allowance of $2,500, is reached each year:** • Fillings • Crowns • Root canals • Full mouth debridement • Periodontal scaling and root planing procedures (deep cleaning) • Periodontal maintenance • Simple extraction • Surgical extraction • Necessary anesthesia with covered services • 60 minutes of general anesthesia or IV sedation per date of service	**$0 copay for the following Preventive services:** • 1 oral evaluation every 6 months • 1 comprehensive oral exam every 3 years • 1 cleaning every 6 months • 1 fluoride treatment every 6 months • 2 dental x-rays every year **$0 copay for Comprehensive dental services, covered in-network, up to the annual dental benefit maximum allowance of $2,500, is reached each year:** • Fillings • Crowns • Root canals • Full mouth debridement • Periodontal scaling and root planing procedures (deep cleaning) • Periodontal maintenance • Simple extraction • Surgical extraction • Dentures include 1 per arch • Necessary anesthesia with covered services • 60 minutes of general anesthesia or IV sedation per date of service	**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) Dental services must be received from a participating provider within our dental network. Comprehensive services require prior authorization.

Your Benefits and Cost-Sharing

Premiums and Benefits	Advantage Care by Ultimate (HMO C-SNP) 029	Advantage Care by Ultimate (HMO C-SNP) 033	Advantage Care by Ultimate (HMO C-SNP) 050
Vision Services • Eye exams • Eyewear and Contact Lenses	**Our plan covers:** **$0 copay** for • Each eye exam to diagnose and treat diseases and conditions of the eye • Routine eye exam • Annual glaucoma screening • One pair of eyeglasses or contact lenses after cataract surgery. **With this plan, each year, you receive:** • **$300** for prescription eyewear including contact lenses or eyeglasses (including lenses and frames). Any remaining annual eyewear allowance may be used towards eyewear upgrades. You are responsible for any costs that exceed the yearly allowance. OR • Eyeglasses: Up to **(2) two pairs** every year from iCare the covered-in full eyewear selection (standard frame and lenses) at no cost including Polycarbonate with UV protection and scratch coating upgrades.	**Our plan covers:** **$0 copay** for • Each eye exam to diagnose and treat diseases and conditions of the eye • Routine eye exam • Annual glaucoma screening • One pair of eyeglasses or contact lenses after cataract surgery. **With this plan, each year, you receive:** • **$300** for prescription eyewear including contact lenses or eyeglasses (including lenses and frames). Any remaining annual eyewear allowance may be used towards eyewear upgrades. You are responsible for any costs that exceed the yearly allowance. OR • Eyeglasses: Up to **(2) two pairs** every year from iCare the covered-in full eyewear selection (standard frame and lenses) at no cost including Polycarbonate with UV protection and scratch coating upgrades.	**Our plan covers:** **$0 copay** for • Each eye exam to diagnose and treat diseases and conditions of the eye • Routine eye exam • Annual glaucoma screening • One pair of eyeglasses or contact lenses after cataract surgery. **With this plan, each year, you receive:** • **$300** for prescription eyewear including contact lenses or eyeglasses (including lenses and frames). Any remaining annual eyewear allowance may be used towards eyewear upgrades. You are responsible for any costs that exceed the yearly allowance. OR • Eyeglasses: Up to **(2) two pairs** every year from iCare the covered-in full eyewear selection (standard frame and lenses) at no cost including Polycarbonate with UV protection and scratch coating upgrades.

Your Benefits and Cost-Sharing

Advantage Care by Ultimate (HMO C-SNP) 052	Advantage Care COPD by Ultimate (HMO C-SNP) 023	What You Need to Know
Our plan covers: **$0 copay** for • Each eye exam to diagnose and treat diseases and conditions of the eye • Routine eye exam • Annual glaucoma screening • One pair of eyeglasses or contact lenses after cataract surgery. **With this plan, each year, you receive:** • **$300** for prescription eyewear including contact lenses or eyeglasses (including lenses and frames). Any remaining annual eyewear allowance may be used towards eyewear upgrades. You are responsible for any costs that exceed the yearly allowance. OR • Eyeglasses: Up to **(2) two pairs** every year from iCare the covered-in full eyewear selection (standard frame and lenses) at no cost including Polycarbonate with UV protection and scratch coating upgrades.	**Our plan covers:** **$0 copay** for • Each eye exam to diagnose and treat diseases and conditions of the eye • Routine eye exam • Annual glaucoma screening • One pair of eyeglasses or contact lenses after cataract surgery. **With this plan, each year, you receive:** • **$300** for prescription eyewear including contact lenses or eyeglasses (including lenses and frames). Any remaining annual eyewear allowance may be used towards eyewear upgrades. You are responsible for any costs that exceed the yearly allowance. OR • Eyeglasses: Up to **(2) two pairs** every year from iCare the covered-in full eyewear selection (standard frame and lenses) at no cost including Polycarbonate with UV protection and scratch coating upgrades.	Covered-in-Full eyewear includes standard frames and lenses, including polycarbonate lenses with UV protection and scratch-resistant coating upgrades. **Limitations and Restrictions:** • Contact lens fitting services are not covered under this benefit. Members are responsible for all costs associated with contact lens fittings. • The benefit allowance is applied at the time of purchase. If the eyewear purchase is more than the yearly allowance amount, the member will be responsible for the difference. • Polycarbonate lenses with UV protection and scratch-resistant coating upgrades are only available when selecting the covered-in-full eyewear option. • Amounts you pay for additional eyewear services do not apply towards your maximum out-of-pocket amount. • Vision services must be received from a participating provider within our vision network. • Prior authorization rules may apply.

Your Benefits and Cost-Sharing

Premiums and Benefits	Advantage Care by Ultimate (HMO C-SNP) 029	Advantage Care by Ultimate (HMO C-SNP) 033	Advantage Care by Ultimate (HMO C-SNP) 050
Mental Health Services • Inpatient hospital stays • Outpatient group therapy visits • Outpatient individual therapy visits	**$155 copay per day for days 1 through 5** **$0 copay per day for days 6 through 90** **$5 copay** for group therapy visits **$5 copay** for individual therapy visits	**$245 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	**$175 copay per day for days 1 through 5** **$0 copay per day for days 6 through 90** **$5 copay** for group therapy visits **$5 copay** for individual therapy visits
Skilled Nursing Facility (SNF)	**$0 copay per day for days 1 through 20** **$221 copay per day for days 21 through 100**	**$0 copay per day for days 1 through 20** **$221 copay per day for days 21 through 100**	**$0 copay per day for days 1 through 20** **$221 copay per day for days 21 through 100**
Physical Therapy • Physical therapy visit • Speech-language pathology services • Occupational therapy visit	**$5 copay** per visit • Physical therapy • Speech-language pathology **$5 copay** per visit • Occupational therapy	**$10 copay** per visit • Physical therapy • Speech-language pathology **$10 copay** per visit • Occupational therapy	**$5 copay** per visit • Physical therapy • Speech-language pathology **$5 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	**$250 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
Transportation	**$0 copay for unlimited trips every year to plan-approved health-related locations**	**$0 copay for unlimited trips every year to plan-approved health-related locations**	**$0 copay for unlimited trips every year to plan-approved health-related locations**

Your Benefits and Cost-Sharing

Advantage Care by Ultimate (HMO C-SNP) 052	Advantage Care COPD by Ultimate (HMO C-SNP) 023	What You Need to Know
$170 copay per day for days 1 through 5 **$0 copay per day for days 6 through 90** **$5 copay** for group therapy visits **$5 copay** for individual therapy visits	**$115 copay per day for days 1 through 5** **$0 copay per day for days 6 through 91** **$5 copay** for group therapy visits **$5 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. Prior authorization is required when admitted to the hospital. A referral may also be required by your primary care provider for some services.
$0 copay per day for days 1 through 20 **$221 copay per day for days 21 through 100**	**$0 copay per day for days 1 through 20** **$221 copay per day for days 21 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. There's no limit to the number of benefit periods. A Medicare benefit period begins when you're admitted as an inpatient to a hospital or skilled nursing facility. It ends after you've gone 60 consecutive days without receiving inpatient hospital care or skilled nursing care. A referral and prior authorization are required.
$5 copay per visit • Physical therapy • Speech-language pathology **$5 copay** per visit • Occupational therapy	**$5 copay** per visit • Physical therapy • Speech-language pathology **$5 copay** per visit • Occupational therapy	Services performed at an outpatient hospital facility are subject to the outpatient hospital copayment. A referral and prior authorization may be required.
$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 requires prior authorization.
$0 copay for unlimited trips every year to plan-approved health-related locations	**$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 • In-Network Fitness Centers • 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: • Date & time of appointment • Pick-up & drop-off address • Provider/facility name

Your Benefits and Cost-Sharing

Premiums and Benefits	Advantage Care by Ultimate (HMO C-SNP) 029	Advantage Care by Ultimate (HMO C-SNP) 033	Advantage Care by Ultimate (HMO C-SNP) 050
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	**$5 copay**	**$10 copay**	**$5 copay**
Wellness Program • SilverSneakers® Fitness Program • Health Education • Additional Smoking and Tobacco Use Cessation	**$0 copay**	**$0 copay**	**$0 copay**
Flex Allowance for Dental, Vision, and Hearing	**$500 yearly allowance**	**$500 yearly allowance**	**$500 yearly allowance**
Over-the-Counter (OTC)	**$65 every month**	**$65 every month**	**$65 every month**

Advantage Care by Ultimate (HMO C-SNP) 052	Advantage Care COPD by Ultimate (HMO C-SNP) 023	What You Need to Know
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. Prior authorization is required.
$5 copay	**$5 copay**	A referral and prior authorization may be required for some services.
$0 copay	**$0 copay**	**SilverSneakers® Fitness Program:** Access 15,000+ participating fitness locations, instructor-led classes, at-home workouts, and online fitness resources. Classes and amenities vary by location. For more information, call **888-423-4632**.
$500 yearly allowance	**$500 yearly allowance**	Your allowance will be loaded onto your Ultimate Benefits Card to pay for out-of-pocket dental, vision, and hearing costs at eligible provider locations that accept Mastercard. Unused funds expire at the end of the calendar year or upon disenrollment. 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.
$65 every month	**$65 every month**	The monthly allowance is loaded to your Ultimate Benefit Card to pay for eligible OTC items. Unused funds expire at the end of each month or upon disenrollment.

Your Benefits and Cost-Sharing

Premiums and Benefits	Advantage Care by Ultimate (HMO C-SNP) 029	Advantage Care by Ultimate (HMO C-SNP) 033	Advantage Care by Ultimate (HMO C-SNP) 050
Healthy Foods & Utilities	**$125 every month**	**$125 every month**	**$125 every month**
Post Discharge 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	**10% coinsurance for standard doctor-ordered wheelchairs** **20% coinsurance for all other DME** for • Durable Medical Equipment (DME) • Prosthetics **$0 copay** for • Diabetic 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 • Diabetic 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 • Diabetic monitoring supplies **$0 copay** for • Diabetes self-management training **$0 copay** for • Diabetic shoes

Your Benefits and Cost-Sharing

Advantage Care by Ultimate (HMO C-SNP) 052	Advantage Care COPD by Ultimate (HMO C-SNP) 023	What You Need to Know
$125 every month	**$125 every month**	Special Supplemental Benefits for the Chronically Ill: The monthly allowance is loaded to your Ultimate Benefit Card to pay for eligible healthy foods and utility bills (electricity, gas, and water). Unused funds expire at the end of each month or upon disenrollment.
$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 • Diabetic monitoring supplies **$0 copay** for • Diabetes self-management training **$0 copay** for • Diabetic shoes	**20% coinsurance** for • Durable Medical Equipment (DME) • Prosthetics **0% coinsurance** for • Oxygen **$0 copay** for • Diabetic monitoring supplies **$0 copay** for • Diabetes self-management training **$0 copay** for • Diabetic shoes	Prior authorization is required. Contour® and Accu-Chek® are the preferred diabetic monitoring supplies available through retail pharmacy providers. Other diabetic monitoring products are available through DME providers.

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 **$2,400**. 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 **6** cost-sharing tiers with a corresponding cost-sharing amount depending on the plan:

- **Cost-Sharing Tier 1 (Preferred Generic)** includes generic drugs. This tier offers drugs at the lowest cost.
- **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. This is the highest-cost tier.
- **Cost-Sharing Tier 6 (Select Care Drugs)** includes **select** generic and brand drugs that treat Diabetes.

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 on select medication tiers.

Outpatient Prescription Drugs

	Cost-Sharing Tier	Retail Pharmacy Cost-Sharing (30-day supply copay)	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 Care by Ultimate (HMO C-SNP) 029 Advantage Care COPD by Ultimate (HMO C-SNP) 023**			
Initial Coverage Stage	Tier 1	$0 copay	$0 copay	$0 copay
	Tier 2	$0 copay	$0 copay	$0 copay
	Tier 3	$20 copay	$60 copay	$40 copay
	Tier 4	35% coinsurance	35% coinsurance	35% coinsurance
	Tier 5	33% coinsurance	Not Covered	Not Covered
	Tier 6	$10 copay	$30 copay	$20 copay
Plan	**Advantage Care by Ultimate (HMO C-SNP) 033**			
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
	Tier 6	$10 copay	$30 copay	$20 copay
Plan	**Advantage Care by Ultimate (HMO C-SNP) 050 Advantage Care by Ultimate (HMO C-SNP) 052**			
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
	Tier 6	$10 copay	$30 copay	$20 copay

Extra Help:

If you qualify for the Extra Help program, your cost for covered prescription drugs is determined by your Extra Help Low-Income Subsidy (LIS) level and whether the drug is a generic or brand-name medication. Please refer to your **LIS Rider** for your specific copayment amounts

Vaccine:

$0 copay for adult Part D covered vaccines recommended by the Advisory Committee on Immunization Practices (ACIP)

Insulin:

You will pay no more than 25% of the total claim cost, up to a maximum of **$35**, for a one-month supply of any covered insulin.

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, 2028.
- [ ] Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).
- [ ] This plan is a chronic condition special needs plan (C-SNP). Your ability to enroll will be based on verification that you have a qualifying specific severe or disabling chronic condition.
- [ ] **Effect on Current Coverage.** If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts. If you have Tricare, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact Tricare for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.

Notice Informing Individuals About Nondiscrimination and Accessibility Requirements: Discrimination is Against the Law

Ultimate Health Plans complies with applicable Federal civil rights laws and does not discriminate, exclude people or treat them differently on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, marital status, or religion.
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, 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 by mail, fax, email, or by completing the 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.

SCAN HERE

to Access our Provider/Pharmacy Directories

SCAN HERE

to Access our Formularies

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

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