

ULTIMATE HEALTH PLANS

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)

2027 Summary of Benefits

H2962_SBDSNP_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 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.
$0 copay	Prior authorization is required for some services.
$0 copay	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 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

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 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 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 Plus by Ultimate (Full) (HMO D-SNP) 035
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.
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
Skilled Nursing Facility (SNF)	**$0 copay for days 1 through 100**

Your Benefits and Cost-Sharing

Advantage Plus by Ultimate (Partial) (HMO D-SNP) 036	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.	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.
$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. 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 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. 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.

Your Benefits and Cost-Sharing

Premiums and Benefits	Advantage Plus by Ultimate (Full) (HMO D-SNP) 035
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
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**

Your Benefits and Cost-Sharing

Advantage Plus by Ultimate (Partial) (HMO D-SNP) 036	What You Need to Know
$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 and prior authorization may be required.
$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 requires 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 • 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
$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. Prior authorization is required.
$0 copay	A referral and prior authorization may be required for some services.
$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**.

Your Benefits and Cost-Sharing

Premiums and Benefits	Advantage Plus by Ultimate (Full) (HMO D-SNP) 035
In-Home Support Service	**$0 copay** for up to **30 hours** per year of companion and caregiver support services
Flex Allowance for Dental, Vision, and Hearing	**$500 allowance annually**
Over-the-Counter (OTC)	**$185 every month**
Healthy Foods & Utilities (with a verified qualifying condition)	**$200 every month**
Post Discharge 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 • Diabetic 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 for up to **30 hours** per year of companion and caregiver support services	In Home Support Assistance for services such as: • Household chores: light cleaning, organization, laundry • Technical Guidance: assist with learning telehealth services to connect with physician, help install devices Must use the plan's contracted provider/vendor. Please call 855-329-4858 (TTY 711) to scheduling.
$500 allowance annually	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. 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.
$185 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.
$200 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	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 • 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. If you receive Extra Help, the Part D deductible does not apply to you.

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 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. This tier also 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 Drugs)** includes non-preferred brand drugs and some generic drugs.
- **Cost-Sharing Tier 5 (Specialty Tier)** includes high cost brand and generic drugs. This is the highest-cost tier.
- **Cost-Sharing Tier 6 (Excluded Drugs Only)** includes prescription drugs not normally covered in a Medicare Prescription Drug Plan.

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.

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.

	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

Extra Help:

Most of our members qualify for and receive Medicare Extra Help, which assists with prescription drug plan costs. If you qualify for the Extra Help program, your deductible will be **$0**. The amount you pay for covered drugs is determined by your Extra Help Low-Income Subsidy (LIS) level and whether the drug is generic or brand-name. Please refer to your **LIS Rider** for your specific copayment amounts. The table above provides information about your cost-sharing responsibilities during the Initial Coverage Stage.

Vaccine:

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

Insulin:

If you receive Extra Help, you pay $0.00 - $14.40 for a one-month supply of any covered insulin. If you do not qualify for Extra Help, you will not pay more than $35.00 for a one-month supply of any covered insulin.

Mail Order:

Get more convenience and savings with Ultimate Health Plans' Mail Order Pharmacy Service. Enjoy a three-month supply of medication delivered right to your home for the same copay you would normally pay at your local retail pharmacy.

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
Behavior Analysis	Covered	Covered
Behavioral Health Assessment Services	Covered	Covered
Behavioral Health Community Support Services	Covered	Covered
Behavioral Health Intervention Services	Covered	Covered
Behavioral Health Medicaid Management	Covered	Covered
Behavioral Health Overlay	Covered	Covered
Behavioral Health Therapy Services	Covered	Covered
Cardiovascular Services	Covered	Covered
Chiropractic Services	Covered	Covered
County Health Department (CHD) Services	Covered	Covered
Dental Services	Covered	Covered
Dialysis Services	Covered	Covered
Durable Medical Equipment (DME) and Medical Supplies: Specialized, Respiratory, Wheelchairs, Hospital Beds, Ambulatory Aids, Continence, Ostomy, Wound Care, Enteral and Parenteral Nutrition	Covered	Covered
Emergency Transportation Services	Covered	Covered
Evaluation and Management Services	Covered	Covered
Federally Qualified Health Center (FQHC) 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
Medicaid Forms	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

Service	Florida State Medicaid	Advantage Plus by Ultimate Full & Partial
Occupational Therapy	Covered	Covered
Oral and Maxillofacial Surgery Services	Covered	Covered
Orthopedic Services	Covered	Covered
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
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
Therapeutic Group Care Services	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, 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 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.
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



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www.ChooseUltimate.com

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