AULTCARE'S PRIMETIME HEALTH PLAN

2017 Summary of Benefits
PrimeTime Health Plan Plus (HMO-POS) E00045

This is a summary of drug and health services covered by PrimeTime Health Plan's Plus Plan (HMO-POS) January 1, 2017 – December 31, 2017.

The benefit information provided is a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please call us and request the "Evidence of Coverage" or view it online at www.PrimeTimeHealthPlan.com.

To join PrimeTime Health Plan Plus (HMO-POS), you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

Our service area includes the following counties in Ohio:

Carroll	Mahoning	Summit
Columbiana	Medina	Trumbull
Harrison	Portage	Tuscarawas
Holmes	Stark	Wayne

PrimeTime Health Plan Plus (HMO-POS) has a network of doctors, hospitals, pharmacies, and other providers. If you use providers that are not in our network, the plan may not pay for these services. For some services, such as eyewear, you can use providers that are not in our network.

For additional information, call us at (330)363-7407 or 1-800-577-5084. TTY users call (330)363-7460 or 1-800-617-7446. From October 1 to February 14, you can call us 7 days a week from 8:00 a.m. to 8:00 p.m. Eastern time. From February 15 to September 30, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m. Eastern time. Our Service Center has free language interpreter services available for non-English speakers.

Visit our website at www.PrimeTimeHealthPlan.com.

This information is available in alternative formats such as large print, audio CD, or other alternate formats. Please call our Service Center if you need plan information in another format or language.

PrimeTime Health Plan is an HMO-POS plan with a Medicare contract. Enrollment in PrimeTime Health Plan depends on contract renewal.

Benefit category	What you pay	What you should know
Monthly plan premium	You pay $89 per month	You must continue to pay your Medicare Part B premium.
Medical deductible	In-network: No deductible	This plan does not have a deductible.
Maximum Out-of-Pocket responsibility (does not include prescription drugs)	In-network: $4,500 annually	The maximum you will pay in copays and coinsurance for the year.
Inpatient hospital coverage*	In-network: Days 1-6: $275 copay per day Days 7 and beyond: $0 copay	*Prior authorization may be required for these services. Please contact the plan for more information. Our plan covers an unlimited number of days for an inpatient hospital stay.
Doctor visits • Primary	In-network: You pay a $10 copay per visit	
• Specialist	You pay a $45 copay per visit	
Preventive care	In-network: $0 copay	Any additional preventive services approved by Medicare during the contract year will be covered.
Emergency care	You pay a $65 copay per visit	If you are admitted to the hospital within 23 hours, you do not have to pay your share of the cost for emergency care. World-wide coverage.
Urgently needed services	Inside the United States: You pay a $45 copay per visit Outside the United States: You pay a $65 copay per visit	If you are admitted to the hospital within 23 hours, you do not have to pay your share of the cost for urgently needed services. World-wide coverage.
Diagnostic services/labs/ imaging • Diagnostic radiology services (such as MRIs, CT scans)*	In-network: You pay a $150 copay	*Prior authorization may be required for these services. Please contact the plan for more information. Costs for these services may vary based on place of service.
• Diagnostic tests and procedures*	You pay a $35-$50 copay, depending on the procedure	
• Lab services*	You pay a $5-$35 copay, depending on the service	
• Outpatient x-rays*	You pay a $45 copay	
• Therapeutic radiology services (such as radiation treatment for cancer)*	You pay 20% of the cost	

Benefit category	What you pay	What you should know
Hearing services • Medical exam[1]	In-network: You pay a $30 copay	[1]Exam to diagnose and treat hearing and balance issues. [2]You are covered for up to one routine hearing exam every three years.
• Routine exam[2]	You pay a $45 copay	
• Hearing aids	Not covered	
Dental services • Medical exam[1*]	In-network: You pay a $45 copay	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth). *Prior authorization may be required for these services. Please contact the plan for more information. [1]Services may require a referral from your doctor.
• Routine exam/cleaning/x-rays	Not covered	
Vision services • Medical exam[1]	In-network: You pay a $45 copay	You must see a network provider for exams and glasses/contacts after cataract surgery. [1]Exam to diagnose and treat diseases and conditions of the eye (including annual diabetic retinopathy exam).
• Eyeglasses or contact lenses after cataract surgery	You pay 20% of the cost	
• Routine exam	Not covered	
• Glasses/contacts	In-network or Out-of-network: Reimbursement up to $25 annually	For $25 reimbursement of glasses or contacts (not following cataract surgery) you may see the qualified provider of your choice.
Mental health services • Inpatient visit*	In-network: Days 1-10: You pay a $145 copay per day Days 11 and beyond: $0 copay	Our plan covers an unlimited number of days for an inpatient hospital stay. *Prior authorization may be required for these services. Please contact the plan for more information.
• Outpatient group therapy visit	You pay a $35 copay per visit	
• Outpatient individual therapy visit	You pay a $35 copay per visit	
Skilled nursing facility*[1] (SNF)	In-network: Days 1-20: $0 copay Days 21-45: You pay a $120 copay per day Days 46-100: $0 copay	Our plan covers up to 100 days in a SNF. *Prior authorization may be required for these services. Please contact the plan for more information. [1]Services may require a referral from your doctor.

Benefit category	What you pay	What you should know
Rehabilitation services • Occupational therapy visit	In-network: You pay a $10 copay per visit	Annual maximum out-of-pocket cost of $300 applies to occupational, physical, and speech and language therapies combined.
• Physical therapy visit	You pay a $10 copay per visit	
• Speech and language therapy visit	You pay a $10 copay per visit	
• Cardiac (heart) rehab services*	$0 copay	A maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks (Phase I and/or Phase 2). Phase 3 is not covered. *Prior authorization may be required for these services. Please contact the plan for more information.
Ambulance*	In-network: You pay a $200 copay per trip	*Prior authorization may be required for non-emergency services. Please contact the plan for more information.
Transportation	Not covered	
Foot care (podiatry services)	In-network: You pay a $35 copay	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions.
Medical equipment/ supplies • Durable medical equipment (wheelchairs, oxygen, etc)*	In-network: You pay 20% of the cost	*Prior authorization may be required for these services. Please contact the plan for more information.
• Prosthetics (braces, artificial limbs, etc)*	You pay 20% of the cost	
• Diabetes supplies*	You pay 20% of the cost	
Wellness Programs • Glucocom Diabetes Monitoring System (for members that qualify) • Cardiocom Telescale (for members that qualify) • 24 Hour Nursing Hotline • Silver&Fit® Exercise & Healthy Aging Program[1]	$0 copay	Contact the plan for more information on these programs. [1]Offers members access to participating fitness facilities and instructor led classes. Alternatively, members have the option to receive up to 2 Home Fitness Kits per year. Members may also choose to receive health information, track their fitness activity, participate in health challenges, and earn rewards.

Benefit category	What you pay	What you should know
Medicare Part B drugs • Chemotherapy drugs*	In-Network: You pay 20% of the cost	*Prior authorization may be required for these services. Please contact the plan for more information.
• Other Part B drugs*	You pay 20% of the cost	

Outpatient Part D Prescription Drugs				
Phase 1: Deductible Stage	You must pay the full cost of your Tier 3, Tier 4, and Tier 5 drugs until you have paid $100. $100 is the amount of your annual prescription deductible. For drugs in Tier 1 and Tier 2, you do not pay a deductible and will receive coverage immediately at the co-pay amount listed in the chart below.			
Phase 2: Initial Coverage Stage	During this stage, the plan pays its share of the cost of your generic drugs and you pay your share of the cost. After you (or others on your behalf) have met your brand name deductible, the plan pays its share of the costs of your brand name drugs and you pay your share. You pay the following copays until your total yearly drug costs reach $3,700. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.			
The below copays are for prescriptions purchased from a network retail pharmacy or our mail-order pharmacy.				
Tier/Drug Description		**30 Day Supply**	**60 Day Supply**	**90 Day Supply**
• Tier 1: Preferred Generic		You pay $0	You pay $0	You pay $0
• Tier 2: Generic		You pay $8	You pay $16	You pay $24
• Tier 3: Preferred Brand*		You pay $45	You pay $90	You pay $135
• Tier 4: Non-preferred Brand*		You pay $95	You pay $190	You pay $285
• Tier 5: Specialty Drugs*		You pay 31% of the cost	You pay 31% of the cost	You pay 31% of the cost
*Copay applies after you have met the annual deductible of $100.				
Phase 3: Coverage Gap Stage	The Coverage Gap begins after the total yearly drug cost reaches $3,700. After you enter the Coverage Gap, you pay 40% of the plan's cost for covered brand name drugs and 51% of the plan's cost for covered generic drugs until your costs total $4,950, which is the end of the Coverage Gap. Not everyone will enter the Coverage Gap.			
Phase 4: Catastrophic Coverage Stage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $4,950, you pay the greater of: • 5% of the cost, or • $3.30 copay for generic (including brand drugs treated as generic) and a $8.25 copayment for all other drugs.			

For more information on the phases of the benefit, please contact the plan or view the Evidence of Coverage online at www.PrimeTimeHealthPlan.com.

If you reside in a long-term care facility, you pay the same as at a retail pharmacy.

You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, www.PrimeTimeHealthPlan.com. Or, call us and we will send you a copy of the formulary. You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

To find participating providers and pharmacies, please call us or visit our website at www.PrimeTimeHealthPlan.com/myproviders.

You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or co-payments/co-insurance may change on January 1 of each year.

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.

Multi-language Interpreter Services

English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-577-5084 (TTY 1-800-617-7446).

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-577-5084 (TTY 1-800-617-7446).

繁體中文 (Chinese): 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-577-5084 (TTY 1-800-617-7446).

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-577-5084 (TTY 1-800-617-7446).

(Arabic): العربية
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-775-4805 (رقم هاتف الصم والبكم: 1-800-716-6447).

Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-577-5084 (TTY: 1-800-617-7446).

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-577-5084 (телетайп: 1-800-617-7446).

Français (French): ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-577-5084 (ATS : 1-800-617-7446).

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-577-5084 (TTY: 1-800-577-5084).

Oroomiffa (Chushite-Oromo): XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-577-5084 (TTY: 1-800-617-7446).

한국어 (Korean): 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-577-5084 (TTY: 1-800-617-7446)번으로 전화해 주십시오.

Italiano (Italian): ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-577-5084 (TTY: 1-800-617-7446).

日本語 (Japanese): 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-577-5084 (TTY 1-800-617-7446).まで、お電話にてご連絡ください。

Nederlands (Dutch): AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 1-800-577-5084 (TTY: 1-800-617-7446).

Українська (Ukrainian): УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-577-5084 (телетайп: 1-800-617-7446).

Română (Romanian):
ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-577-5084 (TTY: 1-800-617-7446).

Non-discrimination Notice

PrimeTime Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. PrimeTime Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. PrimeTime Health Plan provides free aids and services to people with disabilities to communicate effectively with us, such as: Qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). PrimeTime Health Plan provides free language services to people whose primary language is not English, such as: Qualified interpreters and information written in other languages.

If you need these services, or if you believe that PrimeTime Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can contact or file a grievance with the: PrimeTime Health Plan Civil Rights Coordinator, 2600 6th St. S.W. Canton, OH 44710, 330-363-7456, CivilRightsCoordinator@aultcare.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights staff 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, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.