2017 Summary of Benefits
PrimeTime Health Plan Basic – MA Only (HMO-POS) E00035

This is a summary of drug and health services covered by PrimeTime Health Plan's Basic MA-Only (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 request the "Evidence of Coverage" or view it online at www.PrimeTimeHealthPlan.com.

To join PrimeTime Health Plan Basic - MA Only (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 Basic - MA Only (HMO-POS) has a network of doctors, hospitals 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.

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Benefit category	What you pay	What you should know
Monthly plan premium	You pay $0	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	In-network: $3,400 annually	The maximum you will pay in copays and coinsurance for the year.
Inpatient hospital coverage*	In-network: Days 1-6: $300 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 $35 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 $185 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 $45 copay	
• Lab services*	You pay a $5-$45 copay, depending on the lab 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.
• Routine exam	Not covered	
• 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 $50 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 $175 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: You pay a $20 copay per day Days 21-39: You pay a $150 copay per day Days 40-100: $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 $15 copay per visit	Annual maximum out-of-pocket cost of $450 applies to occupational, physical, and speech and language therapies combined.
• Physical therapy visit	You pay a $15 copay per visit	
• Speech and language therapy visit	You pay a $15 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		
This plan does not cover Part D Prescription Drugs.		

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

The provider network may change at any time. You will receive notice when necessary.

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.