



2018 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 Plan (HMO-POS) January 1, 2018 – December 31, 2018.

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 Customer Service at the numbers below and request the "Evidence of Coverage" or view it online at www.PTHP.com.

For coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online 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.

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. With the exception of lab services, if you use providers that are not in our network, the plan may not pay for these services. For lab services, you may use any qualified provider.

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. Customer Service has free language interpreter services available for non-English speakers.

Visit our website at www.PTHP.com.

This information is available in alternative formats such as large print, audio CD, or other alternate formats. Please call Customer Service 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 \$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: \$325 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.
Outpatient hospital coverage*	In-network: You pay 25% of the cost	Annual maximum out-of-pocket cost of \$1,200 applies to outpatient surgery and ambulatory surgical center services. *Prior authorization may be required for these services. Please contact the plan for more information.
Doctor visits	In-network:	
<ul style="list-style-type: none"> • Primary 	You pay a \$35 copay per visit	
<ul style="list-style-type: none"> • Specialist 	You pay a \$50 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 \$85 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 \$65 copay per visit Outside the United States: You pay a \$85 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	In-network:	*Prior authorization may be required for these services. Please contact the plan for more information.
<ul style="list-style-type: none"> • Diagnostic radiology services (such as MRIs, CT scans)* 	You pay a \$250 copay	
<ul style="list-style-type: none"> • Diagnostic tests and procedures* 	You pay a \$100 copay	¹ For lab services, you may use any qualified provider.
<ul style="list-style-type: none"> • Lab services*¹ 	You pay a \$45 copay	
<ul style="list-style-type: none"> • Outpatient x-rays* 	You pay a \$100 copay	
<ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> • Medical exam¹ 	In-network: You pay a \$50 copay	¹ Exam to diagnose and treat hearing and balance issues.
<ul style="list-style-type: none"> • Routine exam 	Not covered	
<ul style="list-style-type: none"> • Hearing aids 	Not covered	
Dental services <ul style="list-style-type: none"> • Medical exam* 	In-network: You pay a \$50 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.
<ul style="list-style-type: none"> • Routine exam/cleaning/x-rays 	Not covered	
Vision services <ul style="list-style-type: none"> • Medical exam¹ 	In-network: You pay a \$50 copay	¹ Exam to diagnose and treat diseases and conditions of the eye (including annual diabetic retinopathy exam).
<ul style="list-style-type: none"> • Eyeglasses or contact lenses after cataract surgery 	You pay 20% of the cost	
<ul style="list-style-type: none"> • Routine exam 	Not covered	
<ul style="list-style-type: none"> • Glasses/contacts 	Not covered	
Mental health services <ul style="list-style-type: none"> • 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.
<ul style="list-style-type: none"> • Outpatient group therapy visit 	You pay a \$35 copay per visit	
<ul style="list-style-type: none"> • Outpatient individual therapy visit 	You pay a \$35 copay per visit	
Skilled nursing facility* (SNF)	In-network: Days 1-20: \$20 copay 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.
Physical therapy visit	In-network: You pay a \$35 copay per visit	Annual maximum out-of-pocket cost of \$1,050 applies to occupational, physical, and speech and language therapies combined.
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. World-wide emergency coverage.
Transportation	Not covered	

Benefit category	What you pay	What you should know
Medicare Part B drugs <ul style="list-style-type: none"> • 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.
<ul style="list-style-type: none"> • Other Part B drugs* 	You pay 20% of the cost	
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 <ul style="list-style-type: none"> • 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.
<ul style="list-style-type: none"> • Prosthetics (braces, artificial limbs, etc)* 	You pay 20% of the cost	
<ul style="list-style-type: none"> • Diabetes supplies* 	You pay 20% of the cost	
Wellness Programs <ul style="list-style-type: none"> • Telemonitoring Diabetes Program (for members that qualify) • Telemonitoring Heart Failure Program (for members that qualify) • 24 Hour Nursing Hotline • Silver&Fit[®] Exercise & Healthy Aging Program¹ 	\$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.
Outpatient Part D Prescription Drugs		
This plan does not cover Part D Prescription Drugs.		

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

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

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.

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).

العربية (Arabic):

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-577-5084 (رقم

هاتف الصم والبكم: 1-800-617-7446).

Wann du [Deutsch (Pennsylvania German / Dutch)] schwetzsch, kannsch 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: 1-800-617-7446).

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>.