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 (330) 363-7407 or 1-800-577-5084. TTY users call (330) 363-7460 or 1-800-617-7446. A Customer Service Representative is available to assist you at the above phone numbers, Monday through Friday from 8:00 a.m. to 8:00 p.m. (October 1st – March 31st, we are available 7 days a week, 8:00 a.m. to 8:00 p.m.)

Understanding the Benefits

☐ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services that you routinely see a doctor. Visit www.PTHP.com or call Customer Service at (330) 363-7407 or 1-800-577-5084 (TTY users call (330) 363-7460 or 1-800-617-7446) 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 medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

Understanding Important Rules

☐ In addition to your monthly plan premium, 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/co-insurance may change on January 1, 2020.

☐ 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).

☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for certain covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situations, non-contracted providers may deny care.

2019 PrimeTime Health Plan
Summary of Benefits

Aultimate (HMO-POS) E00060 (includes drug coverage)
Classic (HMO-POS) E00055 (includes drug coverage)
Plus (HMO-POS) E00045 (includes drug coverage)
Basic MA – Only (HMO-POS) E00035 (no drug coverage)

This is a summary of drug and health services covered by plans offered by PrimeTime Health Plan January 1, 2019 – December 31, 2019. This Summary of Benefits 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.

To join PrimeTime Health Plan, 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, Columbiana, Harrison, Holmes, Medina, Mahoning, Portage, Summit, Stark, Trumbull, Tuscarawas, & Wayne.

PrimeTime Health Plan has a network of doctors, hospitals, pharmacies, and other providers. You must receive your care from a network provider. In most cases, care you receive from an out-of-network provider (a provider who is not part of our plan's network) will not be covered. *Exceptions are noted in italics in the chart below.* To find participating providers and pharmacies, please call us or visit our website at www.PTHP.com.

Out-of-network/non-contracted providers are under no obligation to treat PrimeTime Health Plan members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost- sharing that applies to out-of-network services.

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.

This information is not a complete description of benefits. Call 330-363-7407 or 1-800-577-5084 (TTY users 330-363-7460 or 1-800-617-7446) for more information. Our Call Center is open Monday through Friday, from 8:00 a.m. to 8:00 p.m. From October 1 through March 31, the Call Center is open seven days a week, from 8:00 a.m. to 8:00 p.m. Or visit our website at www.PTHP.com. PrimeTime Health Plan is an HMO-POS plan with a Medicare contract. Enrollment in PrimeTime Health Plan depends on contract renewal. 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.

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Benefit category	Aultimate (HMO-POS) includes Rx	Classic (HMO-POS) includes Rx	Plus (HMO-POS) includes Rx	Basic MA- Only (HMO-POS) No Rx coverage
Monthly plan premium You must continue to pay your Medicare Part B premium.	You pay $0	You pay $39	You pay $89	You pay $0
Medical deductible	This plan does not have a 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) The maximum you will pay in copays and coinsurance for the year**.**	In-network: $4,900 annually	In-network: $4,200 annually	In-network: $3,600 annually	In-network: $3,400 annually
Inpatient hospital coverage 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.	In-network: Days 1-6: $300 copay per day Days 7 and beyond: $0 copay	In-network: Days 1-6: $290 copay per day Days 7 and beyond: $0 copay	In-network: Days 1-6: $275 copay per day Days 7 and beyond: $0 copay	In-network: Days 1-6: $275 copay per day Days 7 and beyond: $0 copay
Outpatient hospital coverage Prior authorization may be required for these services. Please contact the plan for more information.	In-network: You pay a $350 copay for outpatient surgery or ambulatory surgical center services. You pay 25% of the cost for observation services.	In-network: You pay a $300 copay for outpatient surgery or ambulatory surgical center services. You pay 25% of the cost for observation services.	In-network: You pay a $250 copay for outpatient surgery or ambulatory surgical center services. You pay 25% of the cost for observation services.	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.

Benefit category	Aultimate (HMO-POS) includes Rx	Classic (HMO-POS) includes Rx	Plus (HMO-POS) includes Rx	Basic MA- Only (HMO-POS) No Rx coverage
Doctor visits • **Primary Care Physician**	In-network: You pay a $25 copay per visit	In-network: You pay a $5 copay per visit	In-network: You pay a $0 copay per visit	In-network: You pay a $0 copay per visit
• **Specialist**	You pay a $45 copay per visit	You pay a $45 copay per visit	You pay a $40 copay per visit	You pay a $50 copay per visit
Preventive care Any additional preventive services approved by Medicare during the contract year will be covered.	In-network: You pay a $0 copay	In-network: You pay a $0 copay	In-network: You pay a $0 copay	In-network: You pay a $0 copay
Emergency care 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. *The plan covers emergency care that you get from an out-of-network provider.*	You pay a $90 copay per visit	You pay an $85 copay per visit	You pay a $75 copay per visit	You pay an $85 copay per visit
Urgently needed services 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. *The plan covers urgently needed services that you get from an out-of-network provider.*	Inside the United States: You pay a $65 copay per visit Outside the United States: You pay a $90 copay per visit	Inside the United States: You pay a $65 copay per visit Outside the United States: You pay an $85 copay per visit	Inside the United States: You pay a $65 copay per visit Outside the United States: You pay a $75 copay per visit	Inside the United States: You pay a $65 copay per visit Outside the United States: You pay an $85 copay per visit

Benefit category	Aultimate (HMO-POS) includes Rx	Classic (HMO-POS) includes Rx	Plus (HMO-POS) includes Rx	Basic MA- Only (HMO-POS) No Rx coverage
Diagnostic services/labs/ imaging Prior authorization may be required for these services. Please contact the plan for more information. • **Diagnostic radiology services (such as MRIs, CT scans)**	In-network: You pay a $190 copay	In-network: You pay a $190 copay	In-network: You pay a $175 copay	In-network: You pay a $250 copay
• **Diagnostic tests and procedures**	You pay a $100 copay	You pay a $80 copay	You pay a $60 copay	You pay a $100 copay
• **Lab services** *For lab services, you may use any qualified provider.*	You pay a $45 copay	You pay a $45 copay	You pay a $35 copay	You pay a $45 copay
• **Outpatient x-rays**	You pay a $100 copay	You pay a $80 copay	You pay a $60 copay	You pay a $100 copay
• **Therapeutic radiology services (such as radiation treatment for cancer)**	You pay 20% of the cost	You pay 20% of the cost	You pay 20% of the cost	You pay 20% of the cost
Hearing services • **Medical exam** Exam to diagnose and treat hearing and balance issues	In-network: You pay a $25 copay	In-network: You pay a $5 copay	In-network: You pay a $0 copay	In-network: You pay a $0 copay
• **Routine exam**	Not covered	Not covered	You pay a $40 copay (one routine hearing exam every three years)	Not covered

Benefit category	Aultimate (HMO-POS) includes Rx	Classic (HMO-POS) includes Rx	Plus (HMO-POS) includes Rx	Basic MA- Only (HMO-POS) No Rx coverage
Hearing services (continued) • **Hearing aids** Call 1-866-921-2299 to access Amplifon's discounted hearing aid rates of $595, $695, and $895 per device after plan allowance	$100 allowance per hearing aid device per ear every 3 years. You pay any amount over this plan allowed amount.	$100 allowance per hearing aid device per ear every 3 years. You pay any amount over this plan allowed amount.	$100 allowance per hearing aid device per ear every 3 years. You pay any amount over this plan allowed amount.	$100 allowance per hearing aid device per ear every 3 years. You pay any amount over this plan allowed amount.
Dental services • **Medical exam** Prior authorization may be required for these services. Please contact the plan for more information.	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).	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).	In-network: You pay a $40 copay Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth).	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).
• **Supplemental dental coverage**	Not covered	Reimbursement for non-Medicare covered dental services up to a maximum of $150 annually combined with non-Medicare covered vision**.** *For routine dental services, you may use any qualified dental provider.*	Reimbursement for non-Medicare covered dental services up to a maximum of $200 annually combined with non-Medicare covered vision**.** *For routine dental services, you may use any qualified dental provider.*	Not covered

Benefit category	Aultimate (HMO-POS) includes Rx	Classic (HMO-POS) includes Rx	Plus (HMO-POS) includes Rx	Basic MA- Only (HMO-POS) No Rx coverage
Vision services • **Medical exam** Exam to diagnose and treat diseases and conditions of the eye (including annual diabetic retinopathy exam).	In-network: You pay a $45 copay	In-network: You pay a $45 copay	In-network: You pay a $40 copay	In-network: You pay a $50 copay
• **Eyeglasses or contact lenses after cataract surgery**	You pay 20% of the cost	You pay 20% of the cost	You pay 20% of the cost	You pay 20% of the cost
• **Supplemental vision coverage**	Not covered	Reimbursement for non-Medicare covered services up to a maximum of $150 annually combined with non-Medicare covered dental. *For routine vision services, you may use any qualified vision provider.*	Reimbursement for non-Medicare covered services up to a maximum of $200 annually combined with non-Medicare covered dental. *For routine vision services, you may use any qualified vision provider.*	Not covered
Mental health services • **Inpatient visit** 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.	In-network: Days 1-10: You pay a $150 copay per day Days 11 and beyond: $0 copay	In-network: Days 1-10: You pay a $145 copay per day Days 11 and beyond: $0 copay	In-network: Days 1-10: You pay a $145 copay per day Days 11 and beyond: $0 copay	In-network: Days 1-10: You pay a $175 copay per day Days 11 and beyond: $0 copay

Benefit category	Aultimate (HMO-POS) includes Rx	Classic (HMO-POS) includes Rx	Plus (HMO-POS) includes Rx	Basic MA- Only (HMO-POS) No Rx coverage
Mental health services (continued) • **Outpatient group therapy visit**	You pay a $40 copay per visit	You pay a $40 copay per visit	You pay a $35 copay per visit	You pay a $35 copay per visit
• **Outpatient individual therapy visit**	You pay a $40 copay per visit	You pay a $40 copay per visit	You pay a $35 copay per visit	You pay a $35 copay per visit
Skilled nursing facility (SNF) 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.	In-network: Days 1-20: $0 copay Days 21-45: You pay a $150 copay per day Days 46-100: $0 copay	In-network: Days 1-20: $0 copay Days 21-45: You pay a $135 copay per day Days 46-100: $0 copay	In-network: Days 1-20: $0 copay Days 21-45: You pay a $120 copay per day Days 46-100: $0 copay	In-network: Days 1-20: $20 copay Days 21-39: You pay a $150 copay per day Days 40-100: $0 copay
Physical therapy visit Annual maximum out-of-pocket cost applies to occupational, physical, and speech and language therapies combined.	In-network: You pay a $35 copay per visit $1,050 annual out-of-pocket max	In-network: You pay a $30 copay per visit $900 annual out-of-pocket max	In-network: You pay a $20 copay per visit $600 annual out-of-pocket max	In-network: You pay a $35 copay per visit $1,050 annual out-of-pocket max
Ambulance Prior authorization may be required for non-emergency services. Please contact the plan for more information. World-wide emergency coverage.	In-network: You pay a $230 copay per trip	In-network: You pay a $210 copay per trip	In-network: You pay a $200 copay per trip	In-network: You pay a $200 copay per trip

Benefit category	Aultimate (HMO-POS) includes Rx	Classic (HMO-POS) includes Rx	Plus (HMO-POS) includes Rx	Basic MA- Only (HMO-POS) No Rx coverage
Transportation	Not covered	Not covered	Not covered	Not covered
Medicare Part B drugs Prior authorization may be required for these services. Please contact the plan for more information. • **Chemotherapy drugs**	In-Network: You pay 20% of the cost	In-Network: You pay 20% of the cost	In-Network: You pay 20% of the cost	In-Network: You pay 20% of the cost
• **Other Part B drugs**	You pay 20% of the cost	You pay 20% of the cost	You pay 20% of the cost	You pay 20% of the cost
Medical equipment/ supplies Prior authorization may be required for these services. Please contact the plan for more information. • **Durable medical equipment (wheel-chairs, oxygen, etc)**	In-network: You pay 20% of the cost	In-network: You pay 20% of the cost	In-network: You pay 20% of the cost	In-network: You pay 20% of the cost
• **Prosthetics/Medical supplies (braces, artificial limbs, etc)**	You pay 20% of the cost	You pay 20% of the cost	You pay 20% of the cost	You pay 20% of the cost
• **Medicare-covered diabetic testing supplies (lancets, strips, & glucometers)**	You pay 0% of the cost	You pay 0% of the cost	You pay 0% of the cost	You pay 0% of the cost
• **Medicare-covered diabetic supplies**	You pay 20% of the cost	You pay 20% of the cost	You pay 20% of the cost	You pay 20% of the cost

Benefit category	Aultimate (HMO-POS) includes Rx	Classic (HMO-POS) includes Rx	Plus (HMO-POS) includes Rx	Basic MA- Only (HMO-POS) No Rx coverage
Health and Wellness Education Programs • Tele-monitoring Services – Enrollees diagnosed with any of the conditions below may be eligible: o Heart Failure o Diabetes o Chronic Obstructive Pulmonary Disease (COPD) o Behavioral Health Conditions • Stroke Prevention Program – offered to members who have health conditions that put them at higher risk for stroke. • 24 Hour Nursing Hotline (330) 363-7600 or 1-800-686-9373 • The Silver&Fit® Exercise & Healthy Aging Program – offers members access to a participating fitness center or select YMCA at no additional cost.	You pay a $0 copay for Health and Wellness Education benefits	You pay a $0 copay for Health and Wellness Education benefits	You pay a $0 copay for Health and Wellness Education benefits	You pay a $0 copay for Health and Wellness Education benefits

Outpatient Part D Prescription Drug

Cost-sharing may change when you enter a new stage of the Part D benefit. For more information on the stages of the benefit, please contact the plan or view the Evidence of Coverage online at www.PTHP.com.

Phase 1: Deductible Stage*	You must pay the full cost of your Tier 3, Tier 4, and Tier 5 drugs until you have paid the deductible. The amount of the deductible is listed in the chart below. For drugs in Tier 1 and Tier 2, you do not pay a deductible and will receive coverage immediately at the copay/coinsurance 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 Tiers 3, 4, and 5 deductible, the plan pays its share of the costs of your Tiers 3, 4, and 5 drugs and you pay your share. You pay the following copays/coinsurance until your total yearly drug costs reach $3,820. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.

The below copays/coinsurance are for prescriptions purchased from a network retail pharmacy or our mail-order pharmacy. Long-Term Care (LTC) pharmacies can fill up to a 31 day supply at the 30 day copays/coinsurance listed below.

Tier/Drug Description	**Aultimate (HMO-POS)**	**Classic (HMO-POS)**	**Plus (HMO-POS)**	**Basic MA- Only (HMO-POS)**
*Deductible	$200	$150	$100	No Part D Prescription Coverage
Tier 1: Preferred Generic Retail • 30 Day Supply • 60 Day Supply • 90 Day Supply Mail Order • 30 Day Supply • 60 Day Supply • 90 Day Supply	 You pay $3 You pay $6 You pay $9 You pay $3 You pay $6 You pay $9	 You pay $2 You pay $4 You pay $6 You pay $2 You pay $4 You pay $6	 You pay $0 You pay $0 You pay $0 You pay $0 You pay $0 You pay $0	 No Part D Prescription Coverage

Tier/Drug Description	Aultimate (HMO-POS)	Classic (HMO-POS)	Plus (HMO-POS)	Basic MA- Only (HMO-POS)
Tier 2: Generic Retail • 30 Day Supply • 60 Day Supply • 90 Day Supply Mail Order • 30 Day Supply • 60 Day Supply • 90 Day Supply	 You pay $15 You pay $30 You pay $45 You pay $15 You pay $30 You pay $45	 You pay $8 You pay $16 You pay $24 You pay $8 You pay $16 You pay $20	 You pay $6 You pay $12 You pay $18 You pay $6 You pay $12 You pay $15	 No Part D Prescription Coverage
Tier 3: Preferred Brand Retail • 30 Day Supply • 60 Day Supply • 90 Day Supply Mail Order • 30 Day Supply • 60 Day Supply • 90 Day Supply	 You pay $45* You pay $90* You pay $135* You pay $45* You pay $90* You pay $135*	 You pay $45* You pay $90* You pay $135* You pay $45* You pay $90* You pay $125*	 You pay $45* You pay $90* You pay $135* You pay $45* You pay $90* You pay $125*	 No Part D Prescription Coverage
Tier 4: Non-preferred Drug Retail • 30 Day Supply • 60 Day Supply • 90 Day Supply Mail Order • 30 Day Supply • 60 Day Supply • 90 Day Supply	 You pay $95* You pay $190* You pay $285* You pay $95* You pay $190* You pay $285*	 You pay $95* You pay $190* You pay $285* You pay $95* You pay $190* You pay $275*	 You pay $95* You pay $190* You pay $285* You pay $95* You pay $190* You pay $275*	 No Part D Prescription Coverage
Tier 5: Specialty Tier • 30 Day Supply Only	You pay 29% of the cost*	You pay 30% of the cost*	You pay 31% of the cost*	No Part D Prescription Coverage
*Copay applies after you have met the annual deductible.				

Phase 3: Coverage Gap Stage	The Coverage Gap begins after the total yearly drug cost reaches $3,820. After you enter the Coverage Gap, you pay 25% of the plan's cost for covered brand name drugs and a portion of the dispensing fee and 37% of the plan's cost for covered generic drugs until your costs total $5,100, 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 $5,100, you pay the greater of: • 5% of the cost, or • $3.40 copay for generic (including brand drugs treated as generic) and an $8.50 copayment for all other drugs. If you reach the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.