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 should call 711. 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 for which you routinely see a doctor. Visit www.pthp.com or call Customer Service at (330) 363-7407 or 1-800-577-5084 (TTY users should call 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.

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, 2023.

☐ 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.

2022 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, 2022 – December 31, 2022. 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 and request the "Evidence of Coverage" or view it online at www.pthp.com. You can reach Customer Service at 330-363-7407 or 1-800-577-5084 (TTY users call 711). 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.

You are eligible for membership in our plan as long as you have both Medicare Part A and Part B, you are a United States citizen or are lawfully present in the United States, and you 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.* 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.

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.

Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits.

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: $4,500 annually	In-network: $4,200 annually	In-network: $3,900 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: You pay $310 per day Days 7 and beyond: You pay a $0 copay	In-network: Days 1-6: You pay $295 per day Days 7 and beyond: You pay a $0 copay	In-network: Days 1-6: You pay $285 per day Days 7 and beyond: You pay a $0 copay	In-network: Days 1-6: You pay $275 per day Days 7 and beyond: You pay a $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. You pay 25% of the cost for all other outpatient services including observation.	In-network: You pay a $300 copay for outpatient surgery. You pay 25% of the cost for all other outpatient services including observation.	In-network: You pay a $200 copay for outpatient surgery. You pay 25% of the cost for all other outpatient services including observation.	In-network: You pay 25% of the cost. Annual maximum out-of-pocket cost of $1,200 combined with outpatient surgery and ambulatory surgery 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
Ambulatory Surgery Center Prior authorization may be required for these services. Please contact the plan for more information.	In-network: You pay a $350 copay for an ambulatory surgery center.	In-network: You pay a $300 copay for an ambulatory surgery center.	In-network: You pay a $200 copay for an ambulatory surgery center.	In-network: You pay 25% of the cost. Annual maximum out-of-pocket cost of $1,200 combined with outpatient surgery and outpatient hospital services.
Doctor visits • **Primary Care Physician**	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	In-network: You pay a $0 copay per visit
• **Specialist**	You pay a $40 copay per visit	You pay a $35 copay per visit	You pay a $30 copay per visit	You pay a $40 copay per visit
Preventive care	All plans In-network: You pay a $0 copay Any additional preventive services approved by Medicare during the contract year will be covered.			
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 a copay for urgent care. World-wide coverage. *The plan covers urgent care 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 in-network or out-of-network qualified provider.*	You pay a $0 - $35 copay	You pay a $0 - $30 copay	You pay a $0 - $25 copay	You pay a $0 - $35 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)	All plans: 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**	You pay a $25 copay (one routine hearing exam every three years)	You pay a $5 copay (one routine hearing exam every three years)	You pay a $0 copay (one routine hearing exam every three years)	You pay a $0 copay (one routine hearing exam every three years)
• **Hearing aids** We will allow two hearing aid devices every three years.	All plans: You pay a copayment of $595, $695, or $895 per hearing aid depending on the brand and model selected. Call Amplifon at 1-866-921-2299 to access these copayment rates. Hearing aids purchased from a non-Amplifon provider are eligible for reimbursement of $100 per hearing aid. Hearing aid copays do not count towards your out-of-pocket limit.			

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
Dental services • **Medical exam** Prior authorization may be required for these services. Please contact the plan for more information.	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 $35 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 $30 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).
• **Supplemental dental coverage** Non-Medicare covered dental services do not count towards your out-of-pocket limit. *For non-Medicare covered dental services, you may use any qualified dental provider.*	Reimbursement for non-Medicare covered dental services up to a maximum of $500 annually combined with non-Medicare covered vision.	Reimbursement for non-Medicare covered dental services up to a maximum of $750 annually combined with non-Medicare covered vision.	Reimbursement for non-Medicare covered dental services up to a maximum of $1,000 annually combined with non-Medicare covered vision.	Reimbursement for non-Medicare covered dental services up to a maximum of $300 annually combined with non-Medicare covered vision.
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 $40 copay	In-network: You pay a $35 copay	In-network: You pay a $30 copay	In-network: You pay a $40 copay
• **Eyeglasses or contact lenses after cataract surgery**	All plans: You pay 20% of the cost			

Vision services (continued) • **Supplemental vision coverage** Non-Medicare covered vision services do not count towards your out-of-pocket limit. *For non-Medicare covered vision services, you may use any qualified vision provider.*	Reimbursement for non-Medicare covered services up to a maximum of $500 annually combined with non-Medicare covered dental.	Reimbursement for non-Medicare covered services up to a maximum of $750 annually combined with non-Medicare covered dental.	Reimbursement for non-Medicare covered services up to a maximum of $1,000 annually combined with non-Medicare covered dental.	Reimbursement for non-Medicare covered services up to a maximum of $300 annually combined with non-Medicare covered dental.
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 $150 per day Days 11 and beyond: You pay a $0 copay	In-network: Days 1-10: You pay $145 per day Days 11 and beyond: You pay a $0 copay	In-network: Days 1-10: You pay $145 per day Days 11 and beyond: You pay a $0 copay	In-network: Days 1-10: You pay $175 per day Days 11 and beyond: You pay a $0 copay
• **Outpatient group therapy visit**	You pay a $40 copay per visit	You pay a $35 copay per visit	You pay a $30 copay per visit	You pay a $35 copay per visit
• **Outpatient individual therapy visit**	You pay a $40 copay per visit	You pay a $35 copay per visit	You pay a $30 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 services. Please contact the plan for more information.	In-network: Days 1-20: You pay a $0 copay Days 21-45: You pay $150 per day Days 46-100: You pay a $0 copay	In-network: Days 1-20: You pay a $0 copay Days 21-45: You pay $135 per day Days 46-100: You pay a $0 copay	In-network: Days 1-20: You pay a $0 copay Days 21-45: You pay $120 per day Days 46-100: You pay a $0 copay	In-network: Days 1-20: You pay $20 per day Days 21-39: You pay $150 per day Days 40-100: You pay a $0 copay

Physical therapy visit Annual maximum out-of-pocket cost applies to Medicare-covered acupuncture, physical, occupational, 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
Transportation	All plans: Not covered			
Medicare Part B drugs Prior authorization may be required for services. Please contact the plan for more information. • **Chemotherapy drugs**	All plans In-Network: You pay 20% of the cost			
• **Other Part B drugs**	All plans: You pay 20% of the cost			
Medical equipment/ supplies Prior authorization may be required for services. Please contact the plan for more information. • **Durable medical equipment** (wheel-chairs, oxygen, etc)	All plans In-network: You pay 20% of the cost			
• **Prosthetics/Medical supplies** (braces, artificial limbs, etc)	All plans: You pay 20% of the cost			

Medical equipment/ supplies (continued) • **Medicare-covered diabetic testing supplies** (lancets, strips, & certain glucometers)	All plans: You pay 0% of the cost			
• **Medicare-covered diabetic supplies**	All plans: You pay 20% of the cost			
Home Delivered Meal benefit	All plans: You pay a $0 copay. Benefit is limited to 5 days, up to 10 meals, and following an inpatient hospital stay at a network facility, with a doctor's order, and in our service area with a contracted provider.			
Health and Wellness Education Programs	All plans: You pay a $0 copay for Health and Wellness Education benefits • 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 1-855-409-6448 • The Silver&Fit® Exercise & Healthy Aging Program – offers members a fitness center membership at a participating fitness center or select YMCA and up to 2 home fitness kits each benefit year. • In-Home Safety Assessment - evaluates your home for potential safety concerns. For example: proper lighting, fall hazards, and grab bars.			
FirstLine Essentials Over-The-Counter (OTC) benefit Covered OTC items are health-related items and medications that are available without a prescription and are not covered by Medicare.	Up to $50 per quarter on qualified OTC items.	Up to $50 per quarter on qualified OTC items.	Up to $75 per quarter on qualified OTC items.	Not Available

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, Tier 2, or the Insulin Savings Program you do not pay a deductible and will receive coverage immediately at the copay amount listed 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 $4,430. 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 network pharmacies. Costs will differ based on whether the prescriptions are filled at a preferred pharmacy, standard pharmacy, or mail order pharmacy. Refer to your pharmacy directory for information on which pharmacies are preferred or standard. Cost will also differ based on the number of days' supply. Long-Term Care (LTC) pharmacies can fill up to a 31-day supply at the 30-day copays/ coinsurance listed below.

Annual Deductible*	**Aultimate (HMO-POS)**	**Classic (HMO-POS)**	**Plus (HMO-POS)**
*Applies to drugs in Tiers 3, 4, & 5	$200	$150	$100

Preferred Pharmacy - Retail (up to a 90 day supply)

Tier and Name	**Aultimate (HMO-POS)**			**Classic (HMO-POS)**			**Plus (HMO-POS)**		
	30 day	**60 day**	**90 day**	**30 day**	**60 day**	**90 day**	**30 day**	**60 day**	**90 day**
1 - Preferred Generic Drugs	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay
2 - Generic Drugs	$15 copay	$30 copay	$45 copay	$8 copay	$16 copay	$24 copay	$8 copay	$16 copay	$24 copay
3 - Preferred Brand Drugs*	$42 copay	$84 copay	$126 copay	$42 copay	$84 copay	$126 copay	$42 copay	$84 copay	$126 copay
Insulin Savings Program	$35 copay	$70 copay	$105 copay	$35 copay	$70 copay	$105 copay	$35 copay	$70 copay	$105 copay
4 - Non-preferred Drugs*	$95 copay	$190 copay	$285 copay	$95 copay	$190 copay	$285 copay	$95 copay	$190 copay	$285 copay
5 - Specialty Drugs*	29% of the cost	Not available	Not available	30% of the cost	Not available	Not available	31% of the cost	Not available	Not available

Standard Pharmacy - Retail (up to a 90 day supply)									
Tier and Name	**Aultimate (HMO-POS)**			**Classic (HMO-POS)**			**Plus (HMO-POS)**		
	30 day	**60 Day**	**90 day**	**30 day**	**60 day**	**90 day**	**30 day**	**60 day**	**90 day**
1 - Preferred Generic Drugs	$10 copay	$20 copay	$30 copay	$10 copay	$20 copay	$30 copay	$10 copay	$20 copay	$30 copay
2 - Generic Drugs	$20 copay	$40 copay	$60 copay	$18 copay	$36 copay	$54 copay	$16 copay	$32 copay	$48 copay
3 - Preferred Brand Drugs*	$47 copay	$94 copay	$141 copay	$47 copay	$94 copay	$141 copay	$47 copay	$94 copay	$141 copay
Insulin Savings Program	$35 copay	$70 copay	$105 copay	$35 copay	$70 copay	$105 copay	$35 copay	$70 copay	$105 copay
4 - Non-preferred Drugs*	$100 copay	$200 copay	$300 copay	$100 copay	$200 copay	$300 copay	$100 copay	$200 copay	$300 copay
5 - Specialty Drugs*	29% of the cost	Not available	Not available	30% of the cost	Not available	Not available	31% of the cost	Not available	Not available
Mail Order Pharmacy (up to a 90 day supply)									
Tier and Name	**Aultimate (HMO-POS)**			**Classic (HMO-POS)**			**Plus (HMO-POS)**		
	30 day	60 day	90 day	30 day	60 day	90 day	30 day	60 day	90 day
1 - Preferred Generic Drugs	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay
2 - Generic Drugs	$15 copay	$30 copay	$45 copay	$8 copay	$16 copay	$20 copay	$8 copay	$16 copay	$20 copay
3 - Preferred Brand Drugs*	$45 copay	$90 copay	$125 copay	$45 copay	$90 copay	$125 copay	$45 copay	$90 copay	$125 copay
Insulin Savings Program	$35 copay	$70 copay	$105 copay	$35 copay	$70 copay	$105 copay	$35 copay	$70 copay	$105 copay
4 - Non-preferred Drugs*	$95 copay	$190 copay	$285 copay	$95 copay	$190 copay	$275 copay	$95 copay	$190 copay	$275 copay
5 - Specialty Drugs*	29% of the cost	Not available	Not available	30% of the cost	Not available	Not available	31% of the cost	Not available	Not available
***Tier 3, 4 and 5 copays apply after you have met the annual deductible. The Insulin Savings Program is not subject to deductible.**									
Phase 3: Coverage Gap Stage	The Coverage Gap begins after the total yearly drug cost reaches $4,430. If you reach the coverage gap, the plan pays 75% of the price for covered drugs and you pay the remaining 25% of the price. 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 $7,050, you pay the greater of: - 5% of the cost, or - $3.95 copay for generic (including brand drugs treated as generic) and a $9.85 copay 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.