AULTCARE'S PRIMETIME HEALTH PLAN

Medicare Advantage Plans 2026

ACCREDITED NCQA HEALTH PLAN ACCREDITED MEDICARE HMO-POS

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AULTCARE'S PRIMETIME HEALTH PLAN

You'll love our...

- Excellent, local customer service
- Vision and dental benefits
- Silver Sneakers' gym membership
- Worldwide coverage for emergent care
- Focus on YOU in everything we do!

DEAR

MEDICARE BENEFICIARY:

TO JOIN PRIMETIME, YOU MUST:

1. Reside within our service area counties (Carroll, Columbiana, Harrison, Holmes, Mahoning, Medina, Portage, Stark, Summit, Tuscarawas and Wayne) for up to six months.
2. Be a United States citizen or lawfully present in the United States.
3. Have both Medicare Part A and Part B coverage and continue to pay your Medicare Part B premium.

Welcome to PrimeTime Health Plan, locally based and priced to provide you with exceptional service and value. When we consider our members, we see the faces of neighbors, friends and family.

As you page through this guide, please know you can reach out with questions at any time, knowing you will be answered by a knowledgeable, LOCAL PrimeTime team member. We live in the same communities as the people we serve, which helps us respond better to your needs and questions. We believe in helping whichever way works best for you, including in-person service, which is often missing in business today.

Please call 330-363-7407 or 1-800-577-5084 (TTY: 711). From Oct. 1 through March 31, our call center is open from 8 a.m. through 8 p.m., seven days a week. Outside of those dates, our call center is open Monday through Friday, from 8 a.m. to 8 p.m. Drop in for face-to-face service Monday through Friday from 8 a.m. to 4:30 p.m. Visit us online at pthp.com.

We look forward to welcoming you to the PrimeTime family!

PrimeTime Health Plan is an HMO-POS plan with a Medicare contract. Enrollment in PrimeTime Health Plan depends on contract renewal. This information is not a complete description of the benefits.

WHAT IS THE PRIMETIME HEALTH PLAN HMO-POS PLAN?

PrimeTime Health Plan HMO-POS plan is a Medicare Advantage Plan, sometimes called Medicare Part C. It is a plan offered by a private company contracted with Medicare to provide you with the Medicare Part A and Part B benefits. When you enroll in a Medicare Advantage Plan, Medicare services are covered through the plan, and are not paid by Original Medicare. In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). Everyone who has both Medicare Part A and Part B and is a United States citizen or is lawfully present in the United States, is eligible to join any Medicare health plan offered in their area.

Unlike traditional HMO plans where it is a requirement to see a primary care physician (PCP) to obtain referrals to other providers, PrimeTime Health Plan allows you to visit any provider participating in our plan. For example, if you would like to see an orthopaedic provider, you are not required to visit your PCP before making an appointment. You have the choice to see any orthopaedic provider participating within the PrimeTime Health Plan.

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.

Here are four exceptions:*

- The plan covers emergency care or urgently needed services from an out-of-network provider.
- If you need medical care that Medicare requires our plan to cover and the providers in our network cannot provide this care, you can get this care from an out-of-network provider. You must receive authorization from PrimeTime Health Plan prior to receiving care. In this situation, you will pay the same as you would pay if you got the care from a network provider.
- The plan covers kidney dialysis services you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area.
- HMO-POS means Health Maintenance Organization with a Point of Service option. The Point of Service option, or POS, gives you additional flexibility to use a Medicare-approved provider not found within the PrimeTime Health Plan network for certain covered services. Please refer to the Summary of Benefits for a listing of services each plan allows under the POS option.

**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.*

Like us on Facebook

To obtain information about doctors & providers participating with our plan, please visit our website at pthp.com and click on "Find a Doctor" or contact customer service (see page 1 for contact info).

AULTCARE'S PRIMETIME HEALTH PLAN

NETWORK HOSPITALS

NORTHEAST OHIO

ASHLAND COUNTY *

UH Samaritan Medical Center	Ashland

ASHTABULA COUNTY *

UH Conneaut Medical Center	Conneaut
UH Geneva Medical Center	Geneva

COLUMBIANA COUNTY

Salem Community Hospital (Salem Regional Medical)	Salem

CUYAHOGA COUNTY*

Cleveland Clinic Euclid Hospital	Euclid
Cleveland Clinic Fairview Hospital	Cleveland
Cleveland Clinic Hillcrest Hospital	Mayfield Heights
Cleveland Clinic Lutheran Hospital	Cleveland
Cleveland Clinic Main Campus	Cleveland
Cleveland Clinic Marymount Hospital	Garfield Heights
Cleveland Clinic Rehabilitation Hospital	Beachwood
Lake Health Beachwood Medical Center	Beachwood
South Pointe Hospital	Warrensville Heights
UH Ahuja Medical Center	Beachwood
UH Cleveland Medical Center	Cleveland
UH Rehabilitation Hospital	Beachwood
UH Parma Medical Center	Parma
UH St. John Medical Center	Westlake

GEAUGA COUNTY *

UH Geauga Medical Center	Chardon

HARRISON COUNTY*

Harrison Community Hospital	Cadiz

HOLMES COUNTY

Pomerene Hospital	Millersburg

JEFFERSON COUNTY *

Trinity Medical Center West	Steubenville

LAKE COUNTY*

Cleveland Clinic Mentor Hospital	Mentor
Lake Hospital System Inc – Tripoint Medical Center	Painesville
Lake Hospital System Inc – West Medical Center	Willoughby

LORAIN COUNTY *

Cleveland Clinic Avon Hospital	Avon
Cleveland Clinic Rehabilitation Hospital	Avon
UH Avon Rehabilitation Hospital	Avon
UH Elyria Medical Center	Elyria

MAHONING COUNTY

Mercy Health Youngstown LLC (St. Elizabeth Boardman Hospital)	Boardman
Mercy Hospital Youngstown LLC (St Elizabeth Youngstown Hospital)	Youngstown

NETWORK HOSPITALS

AULTCARE'S PRIMETIME HEALTH PLAN

NORTHEAST OHIO

MEDINA COUNTY

Cleveland Clinic Akron General Lodi Hospital	Lodi
Cleveland Clinic Medina Hospital	Medina

PORTAGE COUNTY

UH Portage Medical Center	Ravenna

STARK COUNTY

Aultman Alliance Community Hospital	Alliance
Aultman Hospital	Canton
Cleveland Clinic Mercy Hospital	Canton

SUMMIT COUNTY

Cleveland Clinic Akron General Medical Center	Akron
Cleveland Clinic Rehabilitation Hospital Edwin Shaw	Copley
Summa Health System Akron City Hospital	Akron
Summa Health System Barberton Citizens Hospital	Barberton
Western Reserve Hospital	Cuyahoga Falls

TRUMBULL COUNTY*

Mercy Health – St. Joseph Warren Hospital	Warren

TUSCARAWAS COUNTY

Cleveland Clinic Union Hospital	Dover
Trinity Hospital Twin City	Dennison

WAYNE COUNTY

Aultman Orrville Hospital	Orrville
Wooster Community Hospital	Wooster

FLORIDA*

BROWARD COUNTY

Cleveland Clinic Florida Weston	Weston

INDIAN RIVER COUNTY

Cleveland Clinic Indian River	Vero Beach

MARTIN COUNTY

Cleveland Clinic Martin North Hospital	Stuart
Cleveland Clinic Martin South Hospital	Stuart

ST. LUCIE COUNTY

Cleveland Clinic Tradition Hospital	Port Saint Lucie

UH = University Hospitals

**The below counties are not part of the service area for enrollment, but the facilities are in-network. Ashland, Ashtabula, Cuyahoga, Geauga, Jefferson, Lake, Lorain, Trumbull and Florida counties.*

Updated July 2025. To ensure a hospital is in-network, visit the complete and updated provider directory at pthp.com

2026 PRIMETIME HEALTH PLAN BENEFITS COMPARISON

PLAN BENEFITS	BASIC MA-ONLY (HMO-POS) E00035 NO PART D COVERAGE	AULTIMATE (HMO-POS) E00060 WITH PART D COVERAGE
Monthly Premium	$0 - includes Medicare Part B premium reduction of $75	$0
Annual Deductible*	None	None
Out-of-Pocket Max	$3,900	$4,900
Inpatient Hospital**	$275 copay per day for days 1-6	$385 copay per day for days 1-6
Skilled Nursing Facility	Days 1-20: $20 copay per day; Days 21-39: $150 copay per day; Days 40-100: $0 copay per day	Days 1-20: $0 copay per day; Days 21-45: $215 copay per day; Days 46-100: $0 copay per day
Home Health	$20 copay	$0 copay
Office Visits	$0 primary care / $40 specialist	$0 primary care / $40 specialist
Chiropractor	$20 copay	$15 copay
Podiatry	$30 copay	$35 copay
Outpatient Surgery / Ambulatory Surgery Center***	25% coinsurance up to $1,200 annual coinsurance maximum	$350 copay
Ambulance Services******	$200 copay per trip	$230 copay per trip
Emergency Care******	$140 copay	$130 copay
Urgent Care******	$60 copay inside the U.S. $140 copay outside the U.S.	$40 copay inside the U.S. $130 copay outside the U.S.
Outpatient Rehabilitation Therapy	$35 copay per visit up to a $1,050 annual copay maximum	$45 copay per visit
Durable Medical Equipment	20% coinsurance	20% coinsurance
Diagnostic X-Rays and Tests	$100 or $250 copay based on complexity	$50, $125 or $250 copay based on complexity
Diagnostic Labs	$0 - $35 copay	$0 copay
Dialysis	20% coinsurance	20% coinsurance
Radiation/Chemotherapy	20% coinsurance	20% coinsurance
Supplemental Dental********	$1,100 annual reimbursement	$600 annual reimbursement
Routine Eye Exam/Glasses/Contacts	$0 copay annual exam, $300 allowance for glasses/contacts	$0 copay annual exam, $300 allowance for glasses/contacts
Over-the-Counter (OTC) Benefit	$75 per quarter	$50 per quarter
Silver Sneakers	Included - see page 23 & 24	Included - see page 23 & 24
TruHearing Benefit	Included - see page 25 & 26	Included - see page 25 & 26
Telehealth	Included - see page 27	Included - see page 27
AultmanNow	Included - see page 28	Included - see page 28

You must continue to pay your Medicare Part B premium.

Copay: A fixed portion of the medical expense you pay. *Example: $40 copay for specialist office visits.*

Coinsurance: The percentage of the benefit you pay. *Example: Plan pays 80%, you pay 20%.*

***Deductible:** The amount you must pay for healthcare or prescriptions before our plan begins to pay.

Out-of-Pocket Max: The accumulated amount of copays and coinsurances you pay toward covered medical services within the calendar year. Upon reaching the specified amount in out-of-pocket expenses, your plan will begin to pay covered medical expenses at 100%.

2026 PRIMETIME HEALTH PLAN BENEFITS COMPARISON

PLAN BENEFITS	CLASSIC (HMO-POS) E00055 WITH PART D COVERAGE	PLUS (HMO-POS) E00045 WITH PART D COVERAGE
Monthly Premium	$60	$115
Annual Deductible*	$175	None
Out-of-Pocket Max	$4,500	$4,000
Inpatient Hospital**	$375* copay per day for days 1-6	$325 copay per day for days 1-6
Skilled Nursing Facility	Days 1-20: $0 copay per day; Days 21-45: $200* copay per day; Days 46-100: $0 copay per day	Days 1-20: $0 copay per day; Days 21-45: $200 copay per day; Days 46-100: $0 copay per day
Home Health	$0* copay	$0 copay
Office Visits	$0 primary care / $35 specialist	$0 primary care / $30 specialist
Chiropractor	$15 copay	$20 copay
Podiatry	$35 copay	$30 copay
Outpatient Surgery / Ambulatory Surgery Center***	$300* copay	$250 copay
Ambulance Services******	$210* copay per trip	$200 copay per trip
Emergency Care******	$130 copay	$140 copay
Urgent Care******	$40 copay inside the U.S. $130 copay outside the U.S.	$40 copay inside the U.S. $140 copay outside the U.S.
Outpatient Rehabilitation Therapy	$40 copay per visit	$30 copay per visit
Durable Medical Equipment	20%* coinsurance	20% coinsurance
Diagnostic X-Rays and Tests	$50*, $105 or $240* copay based on complexity	$50, $75 or $225 copay based on complexity
Diagnostic Labs	$0 - $5 copay	$0 - $5 copay
Dialysis	20%* coinsurance	20% coinsurance
Radiation/Chemotherapy	20%* coinsurance	20% coinsurance
Supplemental Dental*******	$1,000 annual reimbursement	$1,250 annual reimbursement
Routine Eye Exam/Glasses/Contacts	$0 copay annual exam, $300 allowance for glasses/contacts	$0 copay annual exam, $300 allowance for glasses/contacts
Over-the-Counter (OTC) Benefit	$100 per quarter	$100 per quarter
Silver Sneakers	Included - see page 23 & 24	Included - see page 23 & 24
TruHearing Benefit	Included - see page 25 & 26	Included - see page 25 & 26
Telehealth	Included - see page 27	Included - see page 27
AultmanNow	Included - see page 28	Included - see page 28

**Limited meal services offered at no cost to member. Two meals a day for up to 5 days. This benefit is only available in the plan's contracted network, within our service area, and within 30 days of being discharged from an inpatient or observation stay at an in-network hospital.

***Surgery done in the provider's office is subject to the applicable office visit copay.

****When necessary, ambulance, emergency and urgent care are covered outside our coverage area.

*****Supplemental Dental Allowance:** PrimeTime Health Plan will reimburse you up to the stated annual maximum for non-Medicare covered dental services. For example: reimbursement for non-Medicare covered exams, cleanings, flouride, X-rays, diagnostic services, orthodontics, restorative, endodontics, periodontics, extractions and prosthodontics. Charges in excess of the stated plan annual maximum are not covered.

HEALTH & WELLNESS

These Preventive Services Are Covered 100%!*

*For all preventive services covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you also are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment may apply for the care received for the existing medical condition.

- Abdominal aortic aneurysm screening
- Annual wellness visit
- Bone mass measurement
- Breast cancer screening *(mammograms)*
- Cardiovascular disease risk reduction visit *(therapy for cardiovascular disease)*
- Cardiovascular disease testing
- Cervical and vaginal cancer screening
- Colorectal cancer screening
- Depression screening
- Diabetes screening
- Diabetes self-management training
- Glaucoma tests for high-risk patients
- Health and wellness education programs
- Hepatitis B screening test
- HIV screening
- Lung cancer screening
- Medicare-covered immunizations (*COVID-19 shots, flu shots, hepatitis B shots, pneumococcal shots)*
- Medical nutrition therapy
- Medicare Diabetes Prevention Program
- Obesity screening and therapy to promote sustained weight loss
- Prostate cancer screening exams
- Screening and counseling to reduce alcohol misuse
- Screening for Sexually Transmitted Infections (STIs) and counseling to prevent STIs
- Smoking and tobacco use cessation *(counseling to stop smoking or tobacco use)*
- "Welcome to Medicare" preventive visit

SERVICES THAT ARE NOT COVERED:

This is not a complete list of non-covered items, only a sample. For questions on a specific service, please call customer service (see page 1 for contact info).

Services Covered Only Under Specific Conditions

- Experimental medical and surgical procedures, equipment and medications are not covered. Experimental procedures and items are those items and procedures determined by our plan and Original Medicare to not be generally accepted by the medical community. May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan.
- Private room in a hospital is not covered. Covered only when medically necessary.
- Non-routine dental care required to treat illness or injury may be covered as inpatient or outpatient care.
- Cosmetic surgery or procedures are covered in cases of an accidental injury or for improvement of the functioning of a malformed body member. Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
- Home-delivered meals: May be covered after an inpatient or observation confinement. Limitations apply.
- Routine foot care is not covered. Some limited coverage provided according to Medicare guidelines, e.g., if you have diabetes.
- Orthopedic shoes only if shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease.
- Routine chiropractic care: Manual manipulation of the spine to correct a subluxation is covered.
- Radial keratotomy, LASIK surgery, vision therapy and other low vision aids are not covered. Eye exam and one pair of eyeglasses (or contact lenses) are covered for people after cataract surgery.
- Services provided to veterans in Veterans Affairs (VA) facilities are not covered. When emergency services are received at VA hospital and the VA cost-sharing is more than the cost-sharing under our plan, we will reimburse veterans for the difference. Members are still responsible for our cost-sharing amounts.
- Acupuncture is covered for chronic low back pain under certain circumstances.

Services Not Covered Under Any Condition

- Services considered not reasonable and necessary, according to the standards of Original Medicare.
- Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.
- Full-time nursing care in your home.
- Custodial care: care provided in a nursing home, hospice or other facility setting when you do not require skilled medical care or skilled nursing care. Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.
- Homemaker services include basic household assistance, including light housekeeping or light meal preparation.
- Fees charged for care by your immediate relatives or members of your household.
- Reversal of sterilization procedures, and/or non-prescription contraceptive supplies.
- Naturopath services (uses natural or alternative treatments).
- Non-Medicare covered dental or vision care over the plan maximum benefit.
- Ambulette services and/or ambulance transports to a doctor's office.
- Driving evaluations.
- Sales tax.

2026 PRESCRIPTION DRUG COMPARISON

Annual Deductible*	Aultimate		Classic		Plus	
	$270 for tiers 3,4,5		$200 for tiers 3,4,5		$0	

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

TIER	Aultimate ($0 Plan)		Classic ($60 Plan)		Plus ($115 Plan)	
	30 Day	90 Day	30 Day	90 Day	30 Day	90 Day
1 - Preferred Generic Drugs	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay
2 - Generic Drugs	$8 copay	$24 copay	$6 copay	$18 copay	$0 copay	$0 copay
3 - Preferred Brand Drugs	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	$47 copay or 20% whichever is greater	$141 copay or 20% whichever is greater
Covered Insulin*	$35 copay or 20% whichever is less	$105 copay or 20% whichever is less	$35 copay or 20% whichever is less	$105 copay or 20% whichever is less	$35 copay or 20% whichever is less	$105 copay or 20% whichever is less
4 - Non-preferred Drugs	40% coinsurance	40% coinsurance	40% coinsurance	40% coinsurance	50% coinsurance	50% coinsurance
5 - Specialty Drugs	30% of the cost	Not available	30% of the cost	Not available	33% of the cost	Not available

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

TIER	Aultimate ($0 Plan)		Classic ($60 Plan)		Plus ($115 Plan)	
	30 Day	90 Day	30 Day	90 Day	30 Day	90 Day
1 - Preferred Generic Drugs	$7 copay	$21 copay	$10 copay	$30 copay	$8 copay	$24 copay
2 - Generic Drugs	$15 copay	$45 copay	$16 copay	$48 copay	$10 copay	$30 copay
3 - Preferred Brand Drugs	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	$47 copay or 20% whichever is greater	$141 copay or 20% whichever is greater
Covered Insulin*	$35 copay or 20% whichever is less	$105 copay or 20% whichever is less	$35 copay or 20% whichever is less	$105 copay or 20% whichever is less	$35 copay or 20% whichever is less	$105 copay or 20% whichever is less
4 - Non-preferred Drugs	40% coinsurance	40% coinsurance	40% coinsurance	40% coinsurance	50% coinsurance	50% coinsurance
5 - Specialty Drugs	30% of the cost	Not available	30% of the cost	Not available	33% of the cost	Not available

Mail Order Pharmacy (up to a 90-day supply)

TIER	Aultimate ($0 Plan)		Classic ($60 Plan)		Plus ($115 Plan)	
	30 Day	90 Day	30 Day	90 Day	30 Day	90 Day
1 - Preferred Generic Drugs	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay
2 - Generic Drugs	$8 copay	$20 copay	$6 copay	$16 copay	$0 copay	$0 copay
3 - Preferred Brand Drugs	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	$47 copay or 20% whichever is greater	$141 copay or 20% whichever is greater
Covered Insulin*	$35 copay or 20% whichever is less	$105 copay or 20% whichever is less	$35 copay or 20% whichever is less	$105 copay or 20% whichever is less	$35 copay or 20% whichever is less	$105 copay or 20% whichever is less
4 - Non-preferred Drugs	40% coinsurance	40% coinsurance	40% coinsurance	40% coinsurance	50% coinsurance	50% coinsurance
5 - Specialty Drugs	30% of the cost	Not available	30% of the cost	Not available	33% of the cost	Not available

Some of our preferred pharmacies: Discount Drug Mart • Giant Eagle • Sam's Club • Walgreens • Marc's
Please refer to the Pharmacy Directory at pthp.com for a complete list of preferred and standard pharmacies.

*Insulin tier exceptions will be tier 4 and the copay will be the appropriate day supply copay or 25%, whichever is less.

THE 2026 MEDICARE PART D COVERAGE STAGES

DEDUCTIBLE STAGE

You begin in this payment stage when you fill your first prescription of the year. If your plan has a deductible, during this stage, you pay the full cost of your tier 3, tier 4 and tier 5 drugs. You stay in this stage until you have paid the deductible amount for tiers 3, 4 and 5. There is no deductible for PrimeTime Health Plan covered insulins or vaccines that are recommended by the Advisory Committee on Immunization Practices (ACIP).

INITIAL COVERAGE STAG

During this stage, you will pay your plan copays on Part D drugs until you reach a maximum out-of-pocket amount of $2,100. You will then move to the Catastrophic Coverage Phase.

CATASTROPHIC COVERAGE STAGE

During this stage, you pay $0 for your covered Part D drugs.

MEDICARE PRESCRIPTION PAYMENT PLAN

The Medicare Prescription Payment Plan option, which may help you manage your out-of-pocket drug costs, is continuing for plan year 2026. This plan is voluntary. If you opt in, you are allowed to make a monthly payment to PrimeTime Health Plan for your prescription drugs instead of paying at the pharmacy. Each month, you'll pay your plan premium (if you have one) and you'll get a separate bill for your prescription drugs. You may opt out at any time.

Not everyone will benefit from the Prescription Payment Plan. Here are some reasons why:

- You get "extra help" from Medicare.
- You qualify for a Medicare savings program.
- Your yearly drug costs are low.
- You don't want to change how you pay for your drugs.

For more information, please visit our website or call us at the information listed in this brochure.

PrimeTime Health Plan will be here for you every step of the way!

AULTCARE'S PRIMETIME HEALTH PLAN

PRIMETIME HEALTH PLAN
Monthly Plan Premium for People who get Extra Help from Medicare to Help Pay for their Prescription Drug Costs

If you get Extra Help from Medicare to help pay for your Medicare prescription drug plan costs, your monthly plan premium will be lower than what it would be if you did not get Extra Help from Medicare.

If you get Extra Help, your monthly plan premium will be lower for any of the plans below. (This does not include any Medicare Part B premium you may have to pay.) The table below shows you what your monthly plan premium will be if you get Extra Help.

Monthly Premium for PrimeTime Health Plan **Classic** (HMO-POS)	Monthly Premium for PrimeTime Health Plan **Plus** (HMO-POS)
$28.60	$83.60

If you get Extra Help from Medicare to help pay for your Medicare prescription drug plan costs, your monthly plan premium will be $0 for the plan below. (This does not include any Medicare Part B premium you may have to pay.)

Monthly Premium for PrimeTime Health Plan **Aultimate** (HMO-POS)
$0.00

PrimeTime Health Plan's premium includes coverage for both medical services and prescription drug coverage.

If you aren't getting Extra Help, you can see if you qualify by calling:

- 1-800-Medicare or TTY users call 1-877-486-2048 (24 hours a day/7 days a week),
- Your State Medicaid Office, or
- The Social Security Administration at 1-800-772-1213. TTY users should call 1-800-325-0778 between 8 a.m. and 7 p.m., Monday through Friday.

If you have any questions, please call Customer Service at 1-800-577-5084, (TTY/TDD users should call 711) from 8:00 a.m. to 8:00 p.m., E.S.T., Monday through Friday (October 1st – March 31, we are available 7 days a week, 8 a.m. to 8 p.m., E.S.T.)

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PRESCRIPTION DRUG TERMS

Prior Authorization: PrimeTime Health Plan requires you or your physician to get prior authorization for certain drugs. This means you will need to get approval from PrimeTime Health Plan before you fill your prescriptions. If you don't get approval, PrimeTime Health Plan may not cover the drug.

Quantity Limits: For certain drugs, PrimeTime Health Plan limits the amount of the drug PrimeTime Health Plan will cover. For example, if it is normally considered safe to take only one pill per day for a certain drug, PrimeTime Health Plan may limit coverage for your prescription to no more than one pill per day.

Step Therapy: In some cases, PrimeTime Health Plan requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, PrimeTime Health Plan may not cover Drug B unless you try Drug A first. If Drug A does not work for you, PrimeTime Health Plan will then cover Drug B.

Late Enrollment Penalty: An amount added to your monthly premium for Medicare drug coverage if you go without creditable prescription coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more. You pay this higher amount as long as you have a Medicare drug plan. There are some exceptions. For example, if you receive "extra help" from Medicare to pay your prescription drug plan costs, you will not pay a late enrollment penalty.

Extra Help: A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premium, deductibles and coinsurance.

Medication Therapy Management: Medication Therapy Management (MTM) is an opportunity to have a specially trained MTM pharmacist thoroughly review and maximize the benefits of your medications. This is a valuable program provided to you at no cost and is not considered a benefit. All PrimeTime Health Plan members are provided with services that monitor the safety of their medications, such as drug-drug interactions, drug-disease state interactions, medication dosages and high-risk medications even if you are not enrolled in the MTM program. By being enrolled in the MTM program, you receive a more personal and interactive medication management, such as a Comprehensive Medication Review (CMR). MTM can help ensure you receive the absolute best results from your medications while keeping your out-of-pocket costs low.

TO BE ELIGIBLE FOR A COMPREHENSIVE MEDICATION REVIEW (CMR), MEMBERS MUST MEET THE BELOW CRITERIA.

- Have at least 3 chronic medical conditions such as Alzheimer's disease, Bone disease - Arthritis (Osteoporosis, Osteoarthritis and Rheumatoid Arthritis), Chronic Heart Failure, Diabetes, Dyslipidemia, End-stage Renal Disease (ESRD), HIV/AIDS, Hypertension, Mental Health (Depression, Schizophrenia, Bipolar disorder and other Chronic Disabling Mental Health conditions), Respiratory Disease (Asthma, Chronic Obstructive Pulmonary Disease (COPD) and other chronic lung disorders) AND
- Be taking at least eight Part D maintenance drugs AND
- Have an anticipated annual prescription spending of $1,276 or more in 2026 AND/OR
- Be considered an at-risk beneficiary (ARB), a member with an active coverage limitation under a drug management program.

All members who meet the requirements are automatically enrolled. You will receive a letter from PrimeTime Health Plan confirming your enrollment in the MTM program and your eligibility to receive a CMR. Your letter will let you know who to contact to have your CMR completed.

FOR MORE INFORMATION ON EXTRA HELP, PLEASE CALL:

The Social Security Office: 1-800-772-1213; 8 a.m.-7 p.m. Monday through Friday.
TTY/TDD users call 1-800-325-0778.
Medicare: 1-800-MEDICARE (1-800-633-4227) TTY/TDD users call 1-877-486-2048,
24 hours a day, seven days a week or call your Medicaid office.

PHARMACY EXCEPTIONS

How do I request an exception to the PrimeTime Health Plan formulary?

You can ask us to make an exception to our coverage rules. There are several types of exceptions you can ask us to make.

- **Non-Formulary Exception** - You can ask us to cover your drug even if it's not on our formulary. Please note, if we grant approval of a non-formulary drug, it will be allowed at our non-preferred drug tier, tier four, and you may not ask for an exception to lower the copay for the drug.

- **Formulary Exception** - You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, PrimeTime Health Plan limits the amount of the drug we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover more.

- **Tier Exception** -You can ask us to provide a higher level of coverage (lower the copay) for your drug. For example, if your drug is usually considered a non-preferred tier drug, you may ask us to cover it at a lower cost-sharing tier instead. This would lower the amount you pay for the drug.

Typically, our drug list includes more than one drug for treating a particular condition. These different possibilities are called "alternative" drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally not approve your request for an exception.

You, your doctor or your representative may contact us to ask for an initial coverage request for an exception. When you are requesting an exception, your physician will need to submit a statement supporting the medical reasons for your request. Generally, we must make our decision within 72 hours of getting your prescribing physician's supporting statement. You can request an expedited (fast) exception if you or your doctor believe your health could be seriously harmed by waiting up to 72 hours for a decision. If your request to expedite is granted, we must give you a decision no later than 24 hours after we get your prescribing physician's supporting statement.

FOR PHARMACY EXCEPTIONS:

PrimeTime Health Plan
Pharmacy Department

PO Box 6905
Canton, OH 44706
Phone: 330-363-7407
or 1-800-577-5084
Fax: 330-580-6764
TTY 711

TALKING TO YOUR DOCTOR ABOUT CHANGING MEDICATIONS AND TEMPORARY FILLS

As a new or existing member on our plan, you may be taking drugs not on our formulary or drugs that have restrictions. For example, you may need to request prior authorization from us before you can fill your prescription. You should talk to your doctor to decide if you should switch to an appropriate drug that is on our formulary or request a formulary exception. While you talk to your doctor to determine the right course of action for you, we may cover your drug in certain cases during the first 90 days you are a member of our plan or during the first 90 days of the calendar year if you are already a member.

According to PrimeTime Health Plan's transition process, we may cover a temporary supply of a drug that you are already taking. This is called a transition supply and is for a maximum amount of a 30-day supply. However, if your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of a 30-day supply of medication. The prescription must be filled at an in-network pharmacy. After your transition fill, we will not pay for these drugs unless you receive an approved coverage determination (also known as a formulary exception). This transition process does not provide for coverage of any medication excluded from the Part D benefit.

If you are a resident of a long-term care facility, we will cover a temporary 31-day transition supply (unless you have a prescription written for fewer days). If you need a drug not on our formulary or your ability to get your drugs is limited, but you are past the first 90 days of membership on our plan, we will cover a 31-day emergency supply of that drug (unless you have a prescription for fewer days) while you pursue a formulary exception. This transition process does not provide for coverage of any medication excluded from the Part D benefit.

ELECTION PERIODS & HOW TO ENROLL

Initial Coverage Election Period:
The period during which people who are newly eligible for Medicare can enroll in a Medicare Advantage plan. You can join during the 7-month period that begins three months before the month you turn 65, includes the month you turn 65 and ends three months after the month you turn 65. This election can only be used once.

Annual Enrollment Period:
A set time each fall when members can change their health or drug plans or switch to Original Medicare. The Annual Enrollment Period is from Oct. 15 until Dec. 7. Your coverage change will begin on Jan. 1.

Medicare Advantage Open Enrollment Period:
You have the opportunity to make one change to your health coverage during the Medicare Advantage Open Enrollment Period. This happens every year from Jan. 1 to March 31.

During this time, you can:

- Switch to another Medicare Advantage Plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
- Disenroll from our plan and obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you have until March 31 to join a separate Medicare prescription drug plan to add drug coverage.

Special Enrollment Period:
In most cases, you must stay enrolled for the calendar year. However, in certain situations, you may be able to join, switch, or drop a Medicare Advantage Plan during a Special Election Period (limitations apply).
Some examples are:

- You move into or out of your plan's service area
- You gain, lose or have a change in your dual-eligible or low-income subsidy (LIS) status
- You are losing or gaining employer-sponsored coverage

HOW TO ENROLL:

ONLINE
You can enroll online by visiting our website at pthp.com.

- Medicare beneficiaries may also enroll in PrimeTime Health Plan through the CMS Medicare Online Enrollment Center located at http://www.medicare.gov.

BY MAIL
You can complete the enclosed enrollment application(s). When completed, mail to our office in the enclosed self-addressed and stamped envelope.

IN PERSON
Additionally, a PrimeTime Health Plan staff member is available to meet with you to discuss your plan options. You can complete an enrollment application during this appointment or take one with you to fill out and return.

BY TELEPHONE
Our sales agents can walk you through your enrollment over the phone, using an approved script from the Centers for Medicare and Medicaid Services (CMS).

To schedule an appointment, please call 330-363-7407 or 1-800-577-5084. TTY users call 711. Customer Service is available Monday through Friday from 8 a.m. to 8 p.m. (Oct. 1 - March 31, we are available seven days a week, 8 a.m. to 8 p.m.).

INCOME RELATED MONTHLY ADJUSTMENT AMOUNT (IRMAA):

If your modified adjusted gross income as reported on your IRS tax return from two years ago is above a certain amount, you'll pay the standard premium amount and an Income-Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium. If you have to pay an extra amount, Social Security, not your Medicare plan, will send you a letter telling you what that extra amount will be and how to pay it. For more information on the extra amount you may have to pay based on your income, visit medicare.gov/part-d/costs/premiums/drug-plan-premiums.html.

ENROLLEE RIGHTS & RESPONSIBILITIES

Quality healthcare and benefits are responsibilities you share with your providers and your plan. We want you to know your responsibilities and rights. They are based on common sense, courtesy and honest communication. You can request an Evidence of Coverage, which contains a full description. If you have a question, concern or a recommendation on improving PrimeTime Health Plan policies for promoting enrollee responsibilities and rights, contact us through our website at pthp.com or call customer service at the numbers provided on page 1.

You have a right to:

- Receive information about the organization, its services, practitioners, providers and member rights and responsibilities.
- Receive information about your coverage.
- A list of doctors, hospitals and other PrimeTime Health Plan network providers.
- Be treated with dignity and respect.
- Acitvely participate with your providers in making decisions about your healthcare.
- A candid discussion with your provider about your medical condition, including appropriate and medically necessary treatment options, regardless of cost or benefit coverage. Your providers are independent from PrimeTime Health Plan. They are not restricted or prohibited from discussing treatment options with you, including those not covered.
- Privacy of your healthcare and claims information. Your Protected Health Information will be used to pay claims, as permitted by Health Insurance Portability and Accountability Act *(HIPAA)* and as described in your Notice of Privacy Practices. Except as allowed by federal law, Protected Health Information will not be disclosed to others without your authorization.
- Ask questions, raise concerns, make complaints and appeal denials.
- Make recommendations about PrimeTime Health Plan's Enrollee Rights and Responsibilities Policy.

You have a responsibility to:

- Bring your PrimeTime Health Plan ID card when you go to the doctor, hospital, drug store or healthcare provider. It contains important information. Having your card may help save time and prevent mistakes.
- Tell the provider or nurse about your condition. Tell your provider what medications you are taking. Answer any questions the provider or nurse may ask completely and truthfully. This information may help your provider form treatment goals and alternatives. Understand your health problems and participate in developing mutually agreed-upon goals.
- Ask questions if you do not understand something about your medical condition and the treatment alternatives *(including medications)* the provider is recommending.
- Follow your providers medical advice and instructions. Take medications as directed. Let the provider know if you have a bad reaction. Let your provider know if your symptoms do not get better, or if they get worse. Schedule recommended follow-up appointments.
- Live a healthy lifestyle.
- Check your benefit chart *(Evidence of Coverage)*.
- Get all required pre-approvals *(pre-certification)* and second opinions.
- Call PrimeTime Health Plan if you have questions about your coverage or responsibilities.

DISEASE & CASE MANAGEMENT SERVICES

Helping you make the right choices.

Disease Management Program

Receiving a diagnosis of diabetes, high blood pressure or any other chronic condition changes your life. PrimeTime Health Plan is here to provide helpful health information and reliable resources to help you manage your condition.

Our disease management program is available at no cost to PrimeTime Health Plan members.

The program provides:

- Phone calls with a nurse who specializes in managing care for health conditions.
- Informative mailings and handouts about your condition.
- Telemonitoring services to improve member quality of life and empower members to work with their physicians and other care providers to better manage their care. Enrollees diagnosed with any of the conditions below may be eligible:
  - Heart Failure
  - Diabetes
  - Chronic Obstructive Pulmonary Disease (COPD)
  - Hypertension
- A stroke prevention program, offered to members who have health conditions that put them at higher risk for stroke. A registered nurse is available to provide education and resources on stroke prevention/recovery to assist our members.
- Dedicated staff to guide you in the right direction and help you work with your providers to improve your health.
- Our behavioral health program to provide support, education and resources for members with conditions such as depression, bipolar disorder and substance use disorder.
- Reliable referrals to service agencies in the community.

Case Management Services

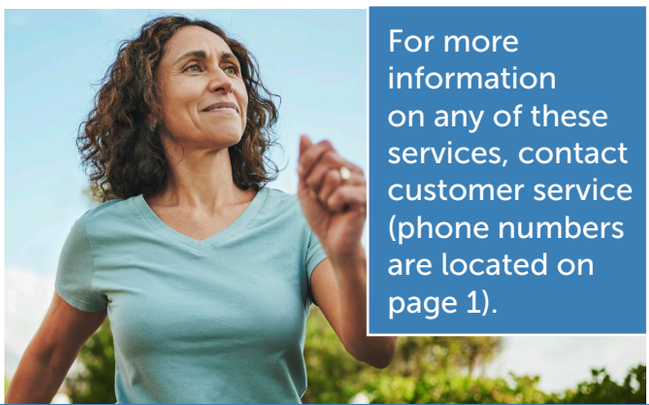
When you are faced with a serious health concern, trust PrimeTime Health Plan. Our plan offers case managers who can help you get the care, information and community services you need.

Case management is available at no cost to PrimeTime Health Plan members. Our services include providing medical information as it relates to your health, referrals to community resources and help navigating the complex healthcare system.

You may benefit if you:

- Have complex medical issues
- Are in need of a transplant
- Have a new cancer diagnosis
- Have experienced a trauma or other catastrophic illness
- Are receiving specialty care outside of the network

PrimeTime Health Plan's Case Management also offers an in-home safety assessment. The in-home safety assessment evaluates your home for potential safety concerns. For example: proper lighting, fall hazards and grab bars.



For more information on any of these services, contact customer service (phone numbers are located on page 1).

NURSING HOTLINE
330-363-7600 or 1-855-409-6448

Our hotline is staffed 24 hours a day, seven days a week with registered nurses. We can assist you with questions and advice regarding medical conditions or help you determine the necessity for urgent or emergency care. Please feel free to call!

UTILIZATION MANAGEMENT

Prior authorization, or pre-approval, is the process of notifying your health plan and requesting services prior to receiving them to determine if requirements are met and coverage exists. Examples of services requiring prior authorization are: elective hospital stays, elective surgeries, genetic testing and certain procedures. This process helps to determine all medical care possibilities have been explored and are within acceptable time limits.

HOW TO SUBMIT A REQUEST FOR PRIOR AUTHORIZATION:

Requests may be submitted by phone, fax or in writing.

PrimeTime Health Plan
Utilization Management
PO Box 6905
Canton, OH 44706
1-800-577-5084
Fax: 330-363-2350
TTY: 711

The prior authorization process has two parts:

1. **Notification** - PrimeTime Health Plan receives a request for services from you or your provider.
2. **Determination of Coverage** - We review your eligibility, plan coverage and clinical information as it relates to your request for services.

Contact PrimeTime Health Plan Customer Service to determine if your particular plan has additional prior authorization requirements. You may also obtain a list of items and services that require prior authorization.

You may contact PrimeTime Health Plan Utilization Management to discuss the utilization management (UM) process or any issue relating to the UM process. Professional staff members are available from 8 a.m. to 4:30 p.m. Monday - Friday by contacting customer service at the numbers listed on page 1. If you call after business hours, please leave a message and we will respond to your call the next business day.

Evaluation of New Technology

PrimeTime Health Plan investigates all requests for coverage of new technology using a medical technology assessment company. The assessment is utilized as a resource for scientifically sound and evidence-based information. This assessment, current Medicare guidelines, input from the Food and Drug Administration and peer-reviewed literature are taken into consideration. This information is reviewed and evaluated by our medical director and other physician UM advisors in order to determine if a new technology is appropriate for coverage under your plan.

Members and providers may request a certain new technology be investigated for coverage by contacting the UM department during regular business hours.

UM decisions are based on whether the requested care and service are appropriate and if there is coverage for the request. Decision makers are not rewarded for issuing denials of coverage or care, nor are there any incentives paid to decision makers that result in barriers to care and service for our members.

Responses are made according to the following time lines:

- Expedited (fast) requests: within 72 hours of receipt of the request
- Standard pre-service requests: within seven days of receipt of the request
- If you ask for more time or if we need to gather more information that may benefit you, we can take up to seven more days

Denials are documented in the form of a letter to you and the requesting provider.

The letter includes:

- The specific reason for denial
- Reference to the benefit provision, guideline, protocol or other criterion on which the denial was based
- Additional information needed for the request
- Notification that you can obtain a copy of the actual criteria on which the denial was based *(this is upon request and at no cost to you)*
- Description of your appeal rights and appeal process, including your right to have an authorized representative act on your behalf

If the denial is based on medical necessity, a reviewer is available to discuss the decision with your physician or provider.

You may get care from specialty physicians without prior authorization from PrimeTime Health Plan, if you use plan providers. Please refer to pthp.com or the provider directory for a list of specialty physicians in your plan. If you require care offered outside the PrimeTime Health Plan network of providers, you may need to request prior authorization before receiving care. Utilization management will review your request and determine if the services may be covered.

GRIEVANCE & APPEALS

Members of PrimeTime Health Plan have the right to file a grievance or an appeal.

GRIEVANCES

A grievance is a written or spoken complaint from a member or his/her authorized representative. A grievance is a complaint you make about us or our network providers or pharmacies. This type of complaint does not involve coverage or disputes in how much we paid. For example, you would file a grievance if you have a problem such as the quality of your care, wait times for appointments, wait times when you fill a prescription, the way your doctors or others behave, or the cleanliness or condition of a doctor's office or network pharmacy.

There are different types of grievances you can request:

Fast (24 hours) - You disagree with our decision not to give you a fast decision on medical care or prescription drug coverage, or our decision to take a time extension on initial decisions or appeals. We must respond to this type of grievance within 24 hours from the time we receive it.

Standard - Any other type of complaint. If possible, we will answer you right away. If you call us with a complaint, we may be able to answer during the phone call. Complaints are generally responded to within 30 days.

APPEALS

An appeal is something you do if you disagree with a decision to deny a request for healthcare services, prescription drugs or payment for services or drugs you already received. You may also make an appeal if you disagree with a decision to stop services you are receiving. For example, you may ask for an appeal if our plan doesn't pay for a drug, item or service you think you should be able to receive.

There are different types of appeals you can request:

FAST APPEAL - *MEDICAL*

You can ask for a fast appeal if your health requires it (you can make an oral request). You and/or your provider will need to decide if you need a fast appeal. If your provider tells us your health requires a fast appeal, we will automatically agree to give you a fast appeal. We must give you our answer within 72 hours after we receive your appeal. We will give you an answer sooner if your health requires us to do so. However, if you ask for more time or if we need to gather more information that may benefit you, we can take up to 14 more days. If we decide to take extra days to make the decision, we will tell you in writing.

STANDARD APPEAL - *MEDICAL*

Request for Service - You can ask for a standard appeal in writing requesting we authorize or approve a service you have not yet received. We must give you a decision no later than 30 days after we get your appeal. (If you ask for more time or if we need to gather more information that may benefit you, we can take up to 14 more calendar days.)

Request for Payment - You can ask for a standard appeal in writing requesting payment for a service you have already received. We must give you a decision no later than 60 days after we get your appeal.

If you would like a form to assist with your appeal request, please visit the PrimeTime website, primetimehealthplan.com/assets/PDFs/Fillable-Form_H3664_23_PTHP-Appeal-Request.pdf, and select Member Resources, 2026 Forms.

GRIEVANCE & APPEALS

Fast Appeal - *Prescription Drugs*

You can ask for a fast appeal if your health requires it. If you are appealing a decision our plan made about a drug you have not yet received, you and your provider or other prescriber may request a fast appeal in writing. We must give you our answer within 72 hours after we receive your appeal.

Standard Appeal - *Prescription Drugs*

If you are appealing a decision our plan made about a drug you have not yet received, you and your provider or other prescriber may request a standard appeal in writing. We must give you a decision no later than seven calendar days after we receive your appeal.

If you are appealing a payment decision on a drug already received, we must give you a decision no later than 14 calendar days after we receive your appeal.

If we approve a request to pay you back for a drug you already bought, we are required to send payment to you within 30 calendar days after we receive your appeal request.

For further information on how to submit either a grievance or an appeal please contact customer service (Phone numbers are on page 1.) You can send your written grievance or appeal by mail to:

GRIEVANCE & APPEALS
PO Box 6029
Canton, OH 44706
or by fax to 330-363-3066.

NOTICE OF PRIVACY PRACTICES

PrimeTime Health Plan maintains a Notice of Privacy Practices that provides information on the use and disclosure of Protected Health Information (PHI). This notice is available on our website at pthp.com. If you would like a copy, please contact customer service. We pride ourselves on ensuring our members' PHI is maintained. All employees are held to internal standards of protecting written, oral and electronic PHI through the Corporate Confidentiality Statement and Agreement. Use and disclosure of PHI to plan sponsors is handled with security and certification. The plan sponsor agrees to PrimeTime Health Plan's policies on PHI. Highlights from the notice are outlined below.

Uses and Disclosures

We are permitted by law to make certain uses and disclosures of your PHI without your authorization. For a detailed list of the uses and disclosures that do not require your authorization, please review the Notice of Privacy Practices. Except for the reasons listed below or as required/permitted by law, we will not use or disclose your PHI for any purpose unless you have signed a form authorizing the use or disclosure. You have the right to revoke authorization in writing unless we have taken any action in reliance on the authorization.

- Treatment
- Payment
- Health-related products or services
- Research
- Business associates
- Healthcare operations
- Family and friends involved in your care

Access to your Protected Health Information (PHI)

You have the right to copy and/or inspect much of the PHI we retain on your behalf. All requests for access must be made in writing and signed by you or your representative.

Restrictions on Use and Disclosure of your Protected Health Information (PHI)

You have the right to request restrictions on certain uses and disclosures of your PHI for treatment, payment or healthcare operations by notifying us of your request for a restriction in writing.

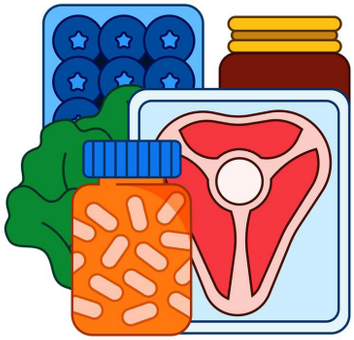
Amendments to your Protected Health Information (PHI)

You have the right to request in writing an amendment or correction to the PHI we maintain about you. We are not obligated to make all requested amendments, but we will give each request careful consideration. All amendment requests should be in writing, signed by you or your representative and must state the reasons for the amendment/correction request.

Accounting for Disclosures of your Protected Health Information (PHI)

You have the right to receive an accounting of certain disclosures made by us of your PHI after April 14, 2003. Requests should be made in writing and signed by you or your representative. Please review the Notice of Privacy Practices for more detailed information on our Use and Disclosure of PHI. The Notice of Privacy Practices and the necessary request forms are available on our website, pthp.com. If you would like a copy of the notice or the request forms, please contact customer service. Phone numbers for customer service are on page 1.

AULTCARE'S PRIMETIME HEALTH PLAN



HealthyBenefits+

Shop over-the-counter (OTC) items and healthy food at no cost to you

Healthy Benefits+ is an OTC and Healthy Food benefit that gives you credits to spend on over-the-counter items and healthy food. Shop fruit, vegetables, vitamins, toothpaste and more. Shop with the OTC and Healthy Food program guide, go online or visit the store to use your benefit the way you choose. As a member, it's all included with your PrimeTime Health Plan.

How it works

1. Funds will be added to your PrimeTime Health Plan OTC and Healthy Food card every three months
2. Use your card to buy approved OTC items and healthy food online, by phone or in-store
3. Funds will expire at the end of the quarter

* Activate your PrimeTime Health Plan card before you start shopping by calling 1-833-832-7306 (TTY 711).

Questions?

Call us toll-free at **1-866-412-2879 (TTY 711)**, available 8 a.m. - 8 p.m., seven days a week October - March; 8 a.m. - 8 p.m. Monday - Friday, April - September. Or visit **HealthyBenefitsPlus.com/PTHP**

PrimeTime Health Plan is an HMO-POS plan with a Medicare contract. Enrollment in PrimeTime Health Plan depends on contract renewal. Check your balance or get support at HealthyBenefitsPlus.com/PTHP or 1-866-412-2879 (TTY 711). No Cash (except as required by law) or ATM Access. See cardholder agreement for fees and terms of use. Issued by Optum Bank Inc., Member FDIC. Program managed by Optum Financial, Inc. Funds expire. See cardholder agreement at HealthyBenefitsPlus.com/PTHP. In-network retailers are subject to change. Apple and the Apple logo are trademarks of Apple Inc. Google Play and the Google Play logo are trademarks of Google LLC. "Healthy Benefits+" refers to any OTC, Healthy Food and other benefit program(s), and Healthy Benefits+ is offered by Optum Financial, Inc., on behalf of itself and its affiliates. Your participation in a Healthy Benefits+ program is voluntary and subject to eligibility rules and other restrictions included in the Healthy Benefits+ Cardholder Agreement. Funds made available for your use in the program(s) are subject to use restrictions, are not cash, and are not owned by you. You may only be eligible to participate in certain benefit programs as determined by your health plan or Optum Financial. All brands listed are trademarked by their respective manufacturers. Brands and item eligibility are subject to change. Healthy Benefits+ benefits must be utilized at participating retailers and may only be used to purchase specific items in accordance with your benefit program. OTC funds may be used for items such as fiber supplements, first aid supplies, incontinence supplies, medicines, ointments and sprays with active medical ingredients that alleviate symptoms, topical sunscreen, and mouth care. Healthy Food funds may be used for items such as beans, legumes, canned fruits and vegetables, dairy items, fresh fruit and vegetables, fresh salad kits, frozen produce and meals, healthy grains, meat and seafood, pantry staples, soups, water and vitamin-enhanced water. Other restrictions may apply. Prices are subject to change. Printed materials may not reflect current pricing. Please contact 1-866-412-2879 (TTY 711) for the most up-to-date pricing information.

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SilverSneakers

AULTCARE'S PRIMETIME HEALTH PLAN

Now's Your Time to Move With SilverSneakers

SilverSneakers® is more than a traditional fitness program. It's an opportunity to improve your health, gain confidence and connect with your community. Plus, it's included **at no additional cost** when you enroll in **PrimeTime Health Plan.**

In the gym

- Thousands of participating locations[1] nationwide with various amenities
- Ability to enroll at multiple locations at any time
- SilverSneakers classes[2] designed for all levels

In your community

- Group activities and classes[2] offered outside the gym
- Events including shared meals, holiday celebrations and class socials and abilities

At home or on the go

- SilverSneakers LIVE online classes and workshops led by specially trained instructors, 7 days a week
- SilverSneakers On-Demand videos available 24/7
- SilverSneakers GO mobile app with personalized program resources, adjustable workout plans and more

You can get your SilverSneakers member ID number and start using the program once you enroll in PrimeTime Health Plan.

SilverSneakers.com/StartHere

Questions? Call us. 1-888-423-4632 (TTY:711) Monday-Friday 8 a.m. - 8 p.m. ET

Notes:

Always talk with your doctor before starting an exercise program.

1. Participating locations (“PL”) are not owned or operated by Tivity Health, Inc. or its affiliates. Use of PL facilities and amenities are limited to terms and conditions of PL basic membership. Facilities and amenities vary by PL. Inclusion of specific PLs is not guaranteed.
2. Membership includes SilverSneakers instructor-led group fitness classes. Some locations offer members additional classes. Classes vary by location.

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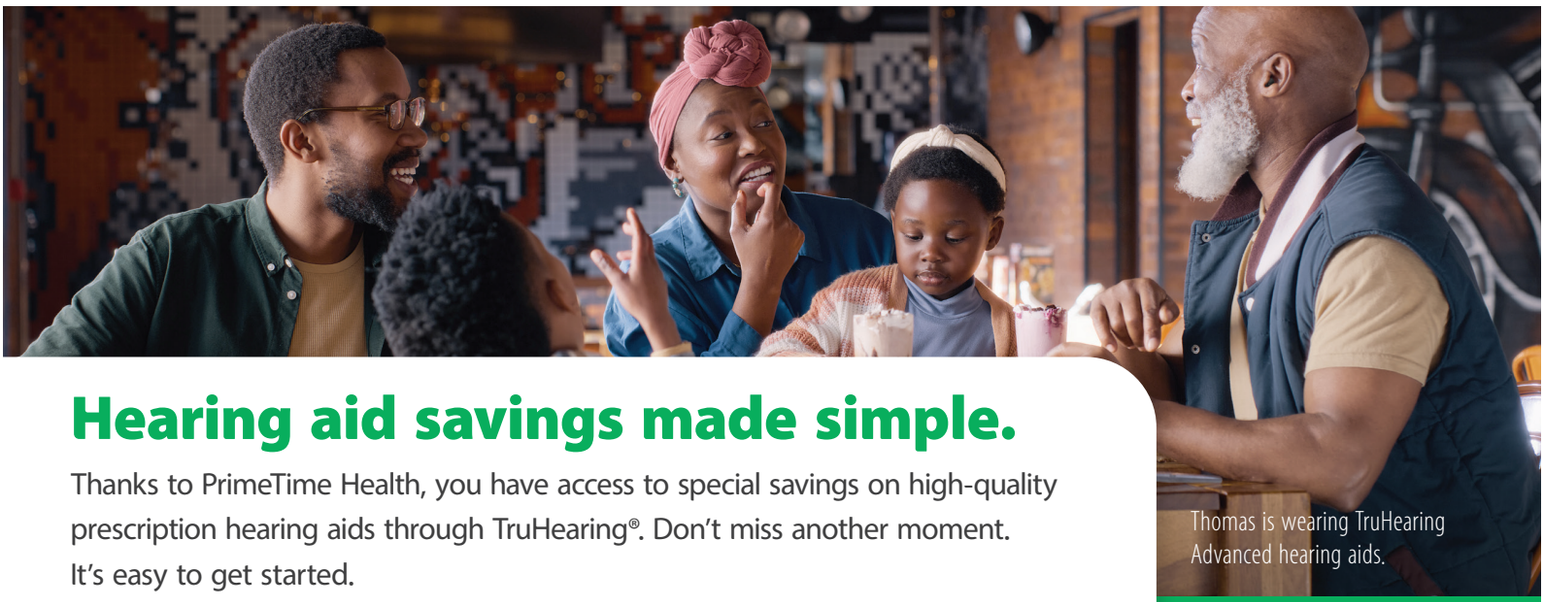
PrimeTime Health Plan is an HMO-POS plan with a Medicare contract. Enrollment in PrimeTime Health Plan depends on contract renewal. For more information, please contact PrimeTime Health Plan at 330-363-7407 or 1-800-577-5084 (TTY users should call 711). Our call center is open Monday through Friday, from 8 a.m. to 8 p.m. From October 1 through March 31, the call center is open seven days a week, from 8 a.m. to 8 p.m.

AULTCARE'S PRIMETIME HEALTH PLAN | TruHearing®

1-833-723-1356 | TTY: 711



Thomas is wearing TruHearing Advanced hearing aids.

Hearing aid savings made simple.

Thanks to PrimeTime Health, you have access to special savings on high-quality prescription hearing aids through TruHearing®. Don't miss another moment. It's easy to get started.

Your 2026 hearing benefit covers up to two TruHearing Premium, Advanced, or Standard hearing aids per year with low copayments.

	Hearing aid	Orig Medicare price per aid	Savings per aid	**Your cost per aid**
Basic MA Only, Aultimate, Classic, and Plus Plans **Exam: $0 copay**	TruHearing Premium	$3,250	$2,251	**$999**
	TruHearing Advanced	$2,720	$2,021	**$699**
	TruHearing Standard	$1,719	$1,220	**$499**

Rechargeable battery option available on select styles for an additional $50 per hearing aid.
Exam must be performed by a TruHearing network provider.

Your hearing aid purchase includes

- **60-day,** risk-free trial
- **1 year** of follow-up visits
- **80 free batteries** per non-rechargeable hearing aid
- **3-year** full manufacturer warranty

Start by calling TruHearing.

1-833-723-1356 | TTY: 711

Hours: 8am–8pm, Monday–Friday

TruHearing makes it easy.

Scan with your smartphone to see how it works.
TruHearing.com/how-it-works

1. Call 1-833-723-1356

2. Schedule an exam

3. Go to your exam

4. Order hearing aids

5. Fitting and follow-up

Call TruHearing to get started.

1-833-723-1356 | TTY: 711

Hours: 8am–8pm, Monday–Friday

Learn more: TruHearing.com/Primetime-HS

PrimeTime Health Plan is an HMO-POS plan with a Medicare contract. Enrollment in PrimeTime Health Plan depends on contract renewal. For more information, please contact PrimeTime Health Plan at 330-363-7407 or 1-800-577-5084 (TTY users should call 711). Our call center is open Monday through Friday, from 8 a.m. to 8 p.m. From Oct. 1 through March 31, the call center is open seven days a week, from 8 a.m. to 8 p.m.

 Savings and retail pricing based on a survey of national average hearing aid prices of equivalent aids compared to TruHearing pricing. Actual savings may vary. Follow-up provider visits included for one year following hearing aid purchase. Free battery offer is not applicable to the purchase of rechargeable hearing aid models. Three-year warranty includes repairs and one-time loss and damage replacement. Hearing aid repairs and replacements are subject to provider and manufacturer fees. For questions regarding fees, contact a TruHearing Hearing Consultant. 611900-4-0425
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AULTCARE'S PRIMETIME HEALTH PLAN

TELEHEALTH
VISIT YOUR PHYSICIAN FROM YOUR HOME!

WHAT IS TELEHEALTH?

Using your computer, tablet or mobile device, you can access healthcare services without having to visit your physician's office. Through a built-in video camera and speaker, your physician can evaluate, diagnose and care for you without stepping foot into their office.

You can use telehealth with your established primary care physician or healthcare specialists.

WHEN TO USE TELEHEALTH?

Telehealth is a popular option to speak with your physician from your home. It is frequently used for primary care and simple follow-up visits. Telehealth is not required, but you can opt in to this service if it is more convenient for you and your schedule.

Instead of visiting the emergency department or an urgent care clinic, try a telehealth service for non-emergency situations.

Advantages of Telehealth

- Attend your appointment without leaving your home.
- In inclement weather, stay inside without having to miss or cancel your scheduled appointment.
- Save time driving to and from a physician's office.
- Avoid the risk of exposure to illness in an office setting.

Telehealth Options Offered by your Health Plan

- Primary Care Physician
- Physician Specialist Services
- Individual Sessions for Mental Health Specialty Services
- Individual Sessions for Psychiatric Services
- Opioid Treatment Program Services
- Individual Sessions for Outpatient Substance Abuse

Copays apply toward your telehealth appointment.
Telehealth is only available through PrimeTime Health Plan's in-network physicians.

Before scheduling a telehealth appointment, please confirm your primary care provider or specialist offers telehealth services as an option.

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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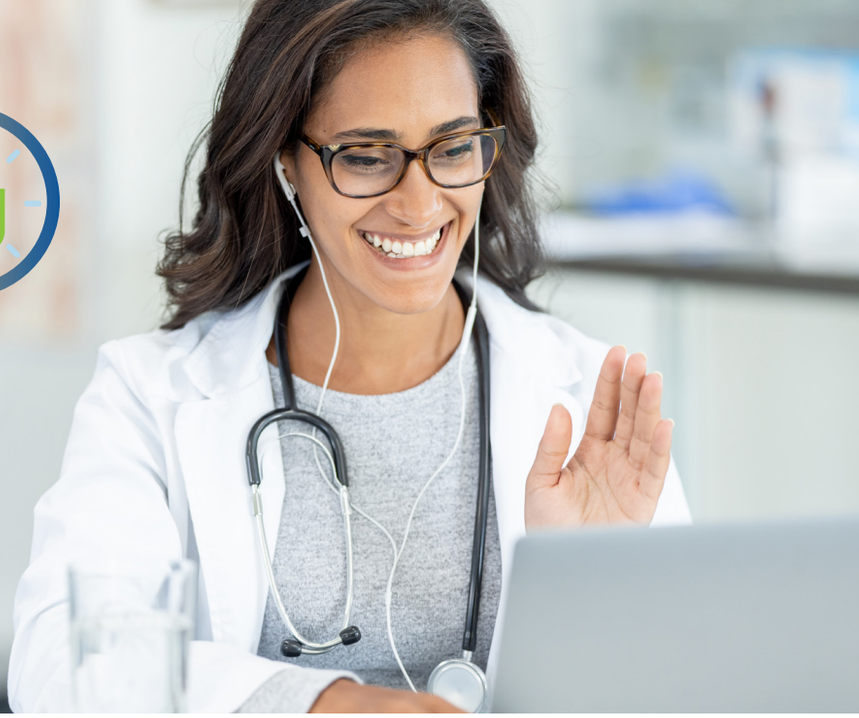
AULTMAN now
TELEHEALTH



A faster, easier way to see a provider.

Register for free on AultmanNow!

PrimeTime Health Plan members: Register with AultmanNow and download the app to see a licensed provider via video 24/7/365.

You can use AultmanNow when:

- You need to see a doctor, but can't fit it into your schedule.
- Your doctor's office is closed.
- You feel too sick to leave the house.
- You're traveling and forgot a prescription or need a provider.

Download the AultmanNow app and enroll from your device app store.

Visit aultmannow.com or call 844-606-1603 for technical help.

Download on the App Store | GET IT ON Google Play

PrimeTime Health Plan is an HMO-POS plan with Medicare contract. Enrollment in PrimeTime Health Plan depends on contract renewal. Other providers are in our network.

AULTCARE'S PRIMETIME HEALTH PLAN

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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, 2027.

☐ 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.

H3664_PEC26_C

2026 PrimeTime Health Plan
Summary of Benefits
Basic MA – Only (HMO-POS) E00035 (no drug coverage)
Aultimate (HMO-POS) E00060 (includes drug coverage)
Classic (HMO-POS) E00055 (includes drug coverage)
Plus (HMO-POS) E00045 (includes drug coverage)

This is a summary of drug and health services covered by plans offered by PrimeTime Health Plan for January 1, 2026 – December 31, 2026. This Summary of Benefits does not 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, Mahoning, Medina, Portage, Stark, Summit, 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. Our plan offers a point-of-service (POS) option for lab services, non-Medicare covered dental, and non-Medicare covered vision services. *Out-of-network provider 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.

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

Benefit category	Basic MA- Only (HMO-POS) No Rx coverage	Aultimate (HMO-POS) includes Rx	Classic (HMO-POS) includes Rx	Plus (HMO-POS) includes Rx
Monthly plan premium You must continue to pay your Medicare Part B premium.	You pay $0	You pay $0	You pay $60	You pay $115
Part B Premium Reduction	$75 a month	Not Available	Not Available	Not Available
Medical deductible	No deductible	No deductible	$175 annual deductible applies*	No 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: $3,900 annually	In-network: $4,900 annually	In-network: $4,500 annually	In-network: $4,000 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 $275 per day Days 7 and beyond: You pay a $0 copay	In-network: Days 1-6: You pay $385 per day Days 7 and beyond: You pay a $0 copay	*In-network: Days 1-6: You pay $375 per day Days 7 and beyond: You pay a $0 copay *$175 annual deductible applies	In-network: Days 1-6: You pay $325 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.				

Benefit category	Basic MA- Only (HMO-POS) No Rx coverage	Aultimate (HMO-POS) includes Rx	Classic (HMO-POS) includes Rx	Plus (HMO-POS) includes Rx
Outpatient hospital coverage (continued) • **Outpatient Hospital or Ambulatory Surgical Center**	In-network: You pay 25% of the cost. Annual combined out-of-pocket maximum of $1,200.	In-network: You pay a $350 copay for outpatient surgery.	*In-network: You pay a $300 copay for outpatient surgery. *$175 annual deductible applies	In-network: You pay a $250 copay for outpatient surgery.
• **Outpatient Observation**	In-network: You pay 25% of the cost. Annual combined out-of-pocket maximum of $1,200.	In-network: You pay 25% of the cost for observation services.	*In-network: You pay 25% of the cost for observation services. *$175 annual deductible applies	In-network: You pay 25% of the cost for observation services.
Doctor visits • **Primary Care Physician**	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	In-network: You pay a $0 copay per visit
• **Specialist**	In-network: You pay a $40 copay per visit	In-network: You pay a $40 copay per visit	In-network: You pay a $35 copay per visit	In-network: You pay a $30 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. *The plan covers emergency care that you get from an out-of-network provider.*	You pay a $140 copay per visit World-wide coverage	You pay a $130 copay per visit World-wide coverage	You pay a $130 copay per visit World-wide coverage	You pay a $140 copay per visit World-wide coverage

Benefit category	Basic MA- Only (HMO-POS) No Rx coverage	Aultimate (HMO-POS) includes Rx	Classic (HMO-POS) includes Rx	Plus (HMO-POS) includes Rx
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 $60 copay per visit Outside the United States: You pay a $140 copay per visit	Inside the United States: You pay a $40 copay per visit Outside the United States: You pay a $130 copay per visit	Inside the United States: You pay a $40 copay per visit Outside the United States: You pay a $130 copay per visit	Inside the United States: You pay a $40 copay per visit Outside the United States: You pay a $140 copay per visit
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 $250 copay	In-network: You pay a $250 copay	*In-network: You pay a $240 copay *$175 annual deductible applies	In-network: You pay a $225 copay
• **Diagnostic tests and procedures**	In-network: You pay a $100 copay	In-network: You pay a $125 copay	In-network: You pay a $105 copay	In-network: You pay a $75 copay
• **Lab services** *For lab services, you may use any Medicare qualified provider.*	You pay a $0 - $35 copay	You pay a $0 copay	You pay a $0 - $5 copay	You pay a $0 - $5 copay
• **Outpatient x-rays**	In-network: You pay a $100 copay	In-network: You pay a $50 copay	*In-network: You pay a $50 copay *$175 annual deductible applies	In-network: You pay a $50 copay
• **Therapeutic radiology services** (such as radiation treatment for cancer)	In-network: You pay 20% of the cost	In-network: You pay 20% of the cost	*In-network: You pay 20% of the cost *$175 annual deductible applies	In-network: You pay 20% of the cost

Benefit category	Basic MA- Only (HMO-POS) No Rx coverage	Aultimate (HMO-POS) includes Rx	Classic (HMO-POS) includes Rx	Plus (HMO-POS) includes Rx
Hearing services • **Medical exam** Exam to diagnose and treat hearing and balance issues	In-network: You pay a $0 copay	In-network: You pay a $25 copay	In-network: You pay a $5 copay	In-network: You pay a $0 copay
• **Routine exam** One routine hearing exam annually *You must use a TruHearing provider.*	All plans: You pay a $0 copay You must see a TruHearing provider to use this benefit. Call 1-833-723-0422 to schedule an appointment.			
• **Hearing aids** Up to two TruHearing-branded hearing aids every year	All plans: $499 copay per aid for Standard Aids, $699 copay per aid for Advanced Aids, $999 copay per aid for Premium Aids. You must see a TruHearing provider to use this benefit. Call 1-833-723-0422 to schedule an appointment. Hearing aid purchase includes: First year of follow-up provider visits; 60-day trial period; 3-year extended warranty; 80 batteries per aid for non-rechargeable models. Hearing aids do not count towards your out-of-pocket limit.			
Dental services • **Medicare-covered dental exam** Prior authorization is required for these services. Please contact the plan for more information.	In-network: You pay a $40 copay	In-network: You pay a $40 copay	In-network: You pay a $35 copay	In-network: You pay a $30 copay
• **Supplemental dental coverage** These services do not count towards your out-of-pocket limit. *You may use any qualified dental provider.*	Reimbursement for non-Medicare covered dental services up to a maximum of $1,100 annually.	Reimbursement for non-Medicare covered dental services up to a maximum of $600 annually.	Reimbursement for non-Medicare covered dental services up to a maximum of $1,000 annually.	Reimbursement for non-Medicare covered dental services up to a maximum of $1,250 annually.
	Routine exams, x-rays, cleanings, fluoride, diagnostic services, restorative, endodontics, periodontics, oral and maxillofacial surgery, implants, orthodontia and prosthodontics.			

Benefit category	Basic MA- Only (HMO-POS) No Rx coverage	Aultimate (HMO-POS) includes Rx	Classic (HMO-POS) includes Rx	Plus (HMO-POS) includes Rx
Vision services • **Medicare-covered eye exam** To diagnose and treat diseases or conditions of the eye (including annual diabetic retinopathy exam).	In-network: You pay a $40 copay	In-network: You pay a $40 copay	In-network: You pay a $35 copay	In-network: You pay a $30 copay
• **Eyeglasses or contact lenses after cataract surgery**	All plans in-network: You pay 20% of the cost			
• **Annual routine eye exam** These services do not count towards your out-of-pocket limit. *You may use any qualified vision provider.*	All plans: You pay a $0 copay			
• **Glasses/Contact Lenses** These services do not count towards your out-of-pocket limit. *You may use any qualified vision provider.*	All plans: Reimbursement up to a maximum of $300 annually.			

Benefit category	Basic MA- Only (HMO-POS) No Rx coverage	Aultimate (HMO-POS) includes Rx	Classic (HMO-POS) includes Rx	Plus (HMO-POS) includes Rx
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 1-6: You pay $275 per day Days 7 and beyond: You pay a $0 copay	In-network: Days 1-6: You pay $385 per day Days 7 and beyond: You pay a $0 copay	*In-network: Days 1-6: You pay $375 per day Days 7 and beyond: You pay a $0 copay *$175 annual deductible applies	In-network: Days 1-6: You pay $325 per day Days 7 and beyond: You pay a $0 copay
• **Outpatient group or individual therapy visit**	In-network: You pay a $35 copay per visit	In-network: You pay a $40 copay per visit	In-network: You pay a $35 copay per visit	In-network: You pay a $30 copay per visit
Skilled nursing facility (SNF) Our plan covers up to 100 days per admission in a SNF. Prior authorization is required for services. Please contact the plan for more information.	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	In-network: Days 1-20: You pay a $0 copay Days 21-45: You pay $215 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 $200 per day Days 46-100: You pay a $0 copay *$175 annual deductible applies	In-network: Days 1-20: You pay a $0 copay Days 21-45: You pay $200 per day Days 46-100: You pay a $0 copay
Rehabilitation Services • **Cardiac Rehab** Prior authorization required after 36 visits	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 *$175 annual deductible applies	In-network: You pay a $0 copay per visit
• **Pulmonary Rehab** Prior authorization required after 36 visits	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 *$175 annual deductible applies	In-network: You pay a $0 copay per visit

Benefit category	Basic MA- Only (HMO-POS) No Rx coverage	Aultimate (HMO-POS) includes Rx	Classic (HMO-POS) includes Rx	Plus (HMO-POS) includes Rx
• **Occupational, Physical, Speech & Language Therapy, & Acupuncture**	In-network: You pay a $35 copay per visit $1,050 combined annual out-of-pocket max	In-network: You pay a $45 copay per visit	In-network: You pay a $40 copay per visit	In-network: You pay a $30 copay per visit
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 $200 copay per one-way trip	In-network: You pay a $230 copay per one-way trip	*In-network: You pay a $210 copay per one-way trip *$175 annual deductible applies	In-network: You pay a $200 copay per one-way 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**	In-network: You pay 0% - 20% of the cost	In-network: You pay 0% - 20% of the cost	*In-network: You pay 0% - 20% of the cost *$175 annual deductible applies	In-network: You pay 0% - 20% of the cost
• **Other Part B drugs** You will pay no more than $35 for a one-month supply of insulin furnished with durable medical equipment insulin pump supplies.	In-network: You pay 0% - 20% of the cost	In-network: You pay 0% - 20% of the cost	*In-network: You pay 0% - 20% of the cost *$175 annual deductible applies	In-network: You pay 0% - 20% of the cost
Foot Care (Podiatry Services) Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions.	In-network: You pay a $30 copay	In-network: You pay a $35 copay	In-network: You pay a $35 copay	In-network: You pay a $30 copay

Benefit category	Basic MA- Only (HMO-POS) No Rx coverage	Aultimate (HMO-POS) includes Rx	Classic (HMO-POS) includes Rx	Plus (HMO-POS) includes Rx
Medical equipment/ supplies Prior authorization may be required for 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 *$175 annual deductible applies	In-network: You pay 20% of the cost
• **Prosthetics/Medical supplies** (braces, artificial limbs, 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 *$175 annual deductible applies	In-network: You pay 20% of the cost
• **Medicare-covered diabetic testing supplies** (lancets, strips, & glucometers)	All plans in-network: You pay 0% of the cost			
• **Other Medicare-covered diabetic supplies**	In-network: You pay 20% of the cost	In-network: You pay 20% of the cost	*In-network: You pay 20% of the cost *$175 annual deductible applies	In-network: You pay 20% of the cost
Home Delivered Meals	All plans in-network: You pay a $0 copay. Benefit is limited to 5 days, up to 10 meals, and within 30 days of an inpatient or observation hospital stay at a network facility and in our service area with a contracted provider.			

Benefit category	Basic MA- Only (HMO-POS) No Rx coverage	Aultimate (HMO-POS) includes Rx	Classic (HMO-POS) includes Rx	Plus (HMO-POS) includes Rx
Health and Wellness Education Programs • **SilverSneakers**	All plans: You pay a $0 copay for Health and Wellness Education benefits You are covered for a fitness benefit through SilverSneakers at participating locations			
• **Tele-monitoring Services** Members diagnosed with these conditions may be eligible.	○ Heart Failure ○ Diabetes ○ Chronic Obstructive Pulmonary Disease (COPD) ○ Hypertension			
• **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			
• **In-Home Safety Assessment**	Evaluates your home for potential safety concerns. For example: proper lighting, fall hazards, and grab bars			
• **Behavioral Health Program**	Provides support, education and resources for members with conditions such as depression, bipolar disorder, and substance use disorder			
Over-The-Counter (OTC) benefit Covered items are health-related items, medications that are available without a prescription and are not covered by Medicare, and healthy food.	Up to $75 per quarter on qualified OTC items. (Unused amounts do not carry-over to the next quarter.)	Up to $50 per quarter on qualified OTC items. (Unused amounts do not carry-over to the next quarter.)	Up to $100 per quarter on qualified OTC items. (Unused amounts do not carry-over to the next quarter.)	Up to $100 per quarter on qualified OTC items. (Unused amounts do not carry-over to the next quarter.)
AultmanNow Telehealth To access go to www.aultmannow.com or download the smart phone app	Primary Care Doctor visit: You pay a $0 copay Specialist visit: You pay a $40 copay	Primary Care Doctor visit: You pay a $0 copay Specialist visit: You pay a $40 copay	Primary Care Doctor visit: You pay a $0 copay Specialist visit: You pay a $35 copay	Primary Care Doctor visit: You pay a $0 copay Specialist visit: You pay a $30 copay

Outpatient Part D Prescription Drug Coverage

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	The Deductible Stage is the first payment stage for your drug coverage. For our plans that have a deductible, you must pay the full cost of your Tiers 3, 4, and 5 drugs until you reach our plan's deductible amount. For all other drugs, you won't have to pay any deductible. Once you have met the deductible amount, you leave the Deductible Stage and move on to the Initial Coverage Stage.
Phase 2: Initial Coverage Stage	The plan pays its share of the cost of your covered prescription drugs, and you pay your share (your copayment or coinsurance amount). Your share of the cost will vary depending on the drug and where you fill your prescription. You pay the following copays/coinsurance until your total yearly drug costs reach $2,100.

You won't pay more than $35 for a one-month supply, $70 for a two-month supply, $105 for a three-month supply, or 25% of the cost (whichever is lower) of each covered insulin product even if you haven't paid your deductible.

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)**		
	***$270** (applies to tiers 3, 4, & 5)			***$200** (applies to tiers 3, 4, & 5)			**No deductible**		
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	$8 copay	$16 copay	$24 copay	$6 copay	$12 copay	$18 copay	$0 copay	$0 copay	$0 copay
3 - Preferred Brand Drugs*	20% of the cost	20% of the cost	20% of the cost	20% of the cost	20% of the cost	20% of the cost	$47 copay or 20% whichever is greater	$94 copay or 20% whichever is greater	$141 copay or 20% whichever is greater
4 - Non-preferred Drugs*	40% of the cost	40% of the cost	40% of the cost	40% of the cost	40% of the cost	40% of the cost	50% of the cost	50% of the cost	50% of the cost
5 - Specialty Drugs*	30% of the cost	Not Available	Not Available	30% of the cost	Not Available	Not Available	33% 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	$7 copay	$14 copay	$21 copay	$10 copay	$20 copay	$30 copay	$8 copay	$16 copay	$24 copay
2 - Generic Drugs	$15 copay	$30 copay	$45 copay	$16 copay	$32 copay	$48 copay	$10 copay	$20 copay	$30 copay
3 - Preferred Brand Drugs*	20% of the cost	20% of the cost	20% of the cost	20% of the cost	20% of the cost	20% of the cost	$47 copay or 20% whichever is greater	$94 copay or 20% whichever is greater	$141 copay or 20% whichever is greater
4 - Non-preferred Drugs*	40% of the cost	40% of the cost	40% of the cost	40% of the cost	40% of the cost	40% of the cost	50% of the cost	50% of the cost	50% of the cost
5 - Specialty Drugs*	30% of the cost	Not Available	Not Available	30% of the cost	Not Available	Not Available	33% 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	$8 copay	$16 copay	$20 copay	$6 copay	$12 copay	$16 copay	$0 copay	$0 copay	$0 copay
3 - Preferred Brand Drugs*	20% of the cost	20% of the cost	20% of the cost	20% of the cost	20% of the cost	20% of the cost	$47 copay or 20% whichever is greater	$94 copay or 20% whichever is greater	$141 copay or 20% whichever is greater
4 - Non-preferred Drugs*	40% of the cost	40% of the cost	40% of the cost	40% of the cost	40% of the cost	40% of the cost	50% of the cost	50% of the cost	50% of the cost
5 - Specialty Drugs*	30% of the cost	Not Available	Not Available	30% of the cost	Not Available	Not Available	33% of the cost	Not Available	Not Available
Phase 3: Catastrophic Coverage Stage	You enter the Catastrophic Coverage Stage when your out-of-pocket costs have reached the $2,100 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year. • During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.								

AULTCARE'S PRIMETIME HEALTH PLAN

Form Approved
OMB# 0938-1421

Notice of Availability

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-577-5084 (TTY 711). Someone who speaks English can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-577-5084 (TTY 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-800-577-5084 (TTY 711)。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-800-577-5084 (TTY 711)。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-577-5084 (TTY 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-577-5084 (TTY 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-800-577-5084 (TTY 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-577-5084 (TTY 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-577-5084 (TTY 711)번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

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Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-577-5084 (TTY 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-800-577-5084 (TTY 711). سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-577-5084 (TTY 711) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-577-5084 (TTY 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-577-5084 (TTY 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-577-5084 (TTY 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-577-5084 (TTY 711). Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、1-800-577-5084 (TTY 711)にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

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.

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