2021 PrimeTime Health Plan
Summary of Benefits
Aultimate (HMO-POS) E00060 (includes drug coverage)
Classic (HMO-POS) E00055 (includes drug coverage)
Plus (HMO-POS) E00045 (includes drug coverage)
Basic MA – Only (HMO-POS) E00035 (no drug coverage)

This is a summary of drug and health services covered by plans offered by PrimeTime Health Plan January 1, 2021 – December 31, 2021. This Summary of Benefits doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please call Customer Service and request the "Evidence of Coverage" or view it online at www.pthp.com. You can reach Customer Service at 330-363-7407 or 1-800-577-5084 (TTY users 330-363-7460 or 1-800-617-7446). 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, you are a United States citizen or are lawfully present in the United States, and you live in our service area. Our service area includes the following counties in Ohio: Carroll, Columbiana, Harrison, Holmes, Medina, Mahoning, Portage, Summit, Stark, Trumbull, Tuscarawas, & Wayne.

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

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

For coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online www.Medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

PrimeTime Health Plan is an HMO-POS plan with a Medicare contract. Enrollment in PrimeTime Health Plan depends on contract renewal. This information is available in alternative formats such as large print, audio CD, or other alternate formats. Please call Customer Service if you need plan information in another format or language.

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

Benefit category	Aultimate (HMO-POS) includes Rx	Classic (HMO-POS) includes Rx	Plus (HMO-POS) includes Rx	Basic MA- Only (HMO-POS) No Rx coverage
Monthly plan premium You must continue to pay your Medicare Part B premium.	You pay $0	You pay $39	You pay $89	You pay $0
Medical deductible	This plan does not have a deductible.	This plan does not have a deductible.	This plan does not have a deductible.	This plan does not have a deductible.
Maximum Out-of-Pocket responsibility (does not include prescription drugs) The maximum you will pay in copays and coinsurance for the year**.**	In-network: $4,500 annually	In-network: $4,200 annually	In-network: $3,900 annually	In-network: $3,400 annually
Inpatient hospital coverage Prior authorization may be required for these services. Please contact the plan for more information. Our plan covers an unlimited number of days for an inpatient hospital stay.	In-network: Days 1-6: You pay $290 per day Days 7 and beyond: You pay a $0 copay	In-network: Days 1-6: You pay $280 per day Days 7 and beyond: You pay a $0 copay	In-network: Days 1-6: You pay $270 per day Days 7 and beyond: You pay a $0 copay	In-network: Days 1-6: You pay $275 per day Days 7 and beyond: You pay a $0 copay
Outpatient hospital coverage Prior authorization may be required for these services. Please contact the plan for more information.	In-network: You pay a $350 copay for outpatient surgery. You pay 25% of the cost for all other outpatient services including observation.	In-network: You pay a $300 copay for outpatient surgery. You pay 25% of the cost for all other outpatient services including observation.	In-network: You pay a $200 copay for outpatient surgery. You pay 25% of the cost for all other outpatient services including observation.	In-network: You pay 25% of the cost. Annual maximum out-of-pocket cost of $1,200 combined with outpatient surgery and ambulatory surgery center services.

Benefit category	Aultimate (HMO-POS) includes Rx	Classic (HMO-POS) includes Rx	Plus (HMO-POS) includes Rx	Basic MA- Only (HMO-POS) No Rx coverage
Ambulatory Surgery Center Prior authorization may be required for these services. Please contact the plan for more information.	In-network: You pay a $350 copay for an ambulatory surgery center.	In-network: You pay a $300 copay for an ambulatory surgery center.	In-network: You pay a $200 copay for an ambulatory surgery center.	In-network: You pay 25% of the cost. Annual maximum out-of-pocket cost of $1,200 combined with outpatient surgery and outpatient hospital services.
Doctor visits • **Primary Care Physician**	In-network: You pay a $5 copay per visit	In-network: You pay a $0 copay per visit	In-network: You pay a $0 copay per visit	In-network: You pay a $0 copay per visit
• **Specialist**	You pay a $40 copay per visit	You pay a $35 copay per visit	You pay a $30 copay per visit	You pay a $40 copay per visit
Preventive care Any additional preventive services approved by Medicare during the contract year will be covered.	In-network: You pay a $0 copay	In-network: You pay a $0 copay	In-network: You pay a $0 copay	In-network: You pay a $0 copay
Emergency care If you are admitted to the hospital within 23 hours, you do not have to pay your share of the cost for emergency care. World-wide coverage. *The plan covers emergency care that you get from an out-of-network provider.*	You pay a $90 copay per visit	You pay an $85 copay per visit	You pay a $75 copay per visit	You pay an $85 copay per visit

Benefit category	Aultimate (HMO-POS) includes Rx	Classic (HMO-POS) includes Rx	Plus (HMO-POS) includes Rx	Basic MA- Only (HMO-POS) No Rx coverage
Urgently needed services If you are admitted to the hospital within 23 hours, you do not have to pay your share of the cost for urgently needed services. World-wide coverage. *The plan covers urgently needed services that you get from an out-of-network provider.*	Inside the United States: You pay a $65 copay per visit Outside the United States: You pay a $90 copay per visit	Inside the United States: You pay a $65 copay per visit Outside the United States: You pay an $85 copay per visit	Inside the United States: You pay a $65 copay per visit Outside the United States: You pay a $75 copay per visit	Inside the United States: You pay a $65 copay per visit Outside the United States: You pay an $85 copay per visit
Diagnostic services/labs/ imaging Prior authorization may be required for these services. Please contact the plan for more information. • **Diagnostic radiology services (such as MRIs, CT scans)**	In-network: You pay a $190 copay	In-network: You pay a $190 copay	In-network: You pay a $175 copay	In-network: You pay a $250 copay
• **Diagnostic tests and procedures**	You pay a $100 copay	You pay a $80 copay	You pay a $60 copay	You pay a $100 copay
• **Lab services**	You pay a $35 copay *For lab services, you may use any in-network or out-of-network qualified provider.*	You pay a $30 copay *For lab services, you may use any in-network or out-of-network qualified provider.*	You pay a $25 copay *For lab services, you may use any in-network or out-of-network qualified provider.*	You pay a $35 copay *For lab services, you may use any in-network or out-of-network qualified provider.*

Benefit category	Aultimate (HMO-POS) includes Rx	Classic (HMO-POS) includes Rx	Plus (HMO-POS) includes Rx	Basic MA- Only (HMO-POS) No Rx coverage
Diagnostic services/labs/ imaging (continued) • **Outpatient x-rays**	You pay a $100 copay	You pay a $80 copay	You pay a $60 copay	You pay a $100 copay
• **Therapeutic radiology services (such as radiation treatment for cancer)**	You pay 20% of the cost	You pay 20% of the cost	You pay 20% of the cost	You pay 20% of the cost
Hearing services • **Medical exam** Exam to diagnose and treat hearing and balance issues	In-network: You pay a $25 copay	In-network: You pay a $5 copay	In-network: You pay a $0 copay	In-network: You pay a $0 copay
• **Routine exam**	You pay a $25 copay (one routine hearing exam every three years)	You pay a $5 copay (one routine hearing exam every three years)	You pay a $0 copay (one routine hearing exam every three years)	You pay a $0 copay (one routine hearing exam every three years)
• **Hearing aids** Call 1-866-921-2299 to access Amplifon's discounted hearing aid rates. Hearing aid copays do not count towards your out-of-pocket limit.	You pay a copayment of $595, $695, or $895 per hearing aid depending on the brand and model selected. 2 hearing aids every 3 years.	You pay a copayment of $595, $695, or $895 per hearing aid depending on the brand and model selected. 2 hearing aids every 3 years.	You pay a copayment of $595, $695, or $895 per hearing aid depending on the brand and model selected. 2 hearing aids every 3 years.	You pay a copayment of $595, $695, or $895 per hearing aid depending on the brand and model selected. 2 hearing aids every 3 years.
Dental services • **Medical exam** Prior authorization may be required for these services. Please contact the plan for more information.	In-network: You pay a $40 copay Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth).	In-network: You pay a $35 copay Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth).	In-network: You pay a $30 copay Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth).	In-network: You pay a $40 copay Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth).

Benefit category	Aultimate (HMO-POS) includes Rx	Classic (HMO-POS) includes Rx	Plus (HMO-POS) includes Rx	Basic MA- Only (HMO-POS) No Rx coverage
Dental services (continued) • **Supplemental dental coverage** Non-Medicare covered dental services do not count towards your out-of-pocket limit.	Reimbursement for non-Medicare covered dental services up to a maximum of $100 annually combined with non-Medicare covered vision. *For non-Medicare covered dental services, you may use any qualified dental provider.*	Reimbursement for non-Medicare covered dental services up to a maximum of $300 annually combined with non-Medicare covered vision. *For non-Medicare covered dental services, you may use any qualified dental provider.*	Reimbursement for non-Medicare covered dental services up to a maximum of $350 annually combined with non-Medicare covered vision. *For non-Medicare covered dental services, you may use any qualified dental provider.*	Reimbursement for non-Medicare covered dental services up to a maximum of $300 annually combined with non-Medicare covered vision. *For non-Medicare covered dental services, you may use any qualified dental provider.*
Vision services • **Medical exam** Exam to diagnose and treat diseases and conditions of the eye (including annual diabetic retinopathy exam).	In-network: You pay a $40 copay	In-network: You pay a $35 copay	In-network: You pay a $30 copay	In-network: You pay a $40 copay
• **Eyeglasses or contact lenses after cataract surgery**	You pay 20% of the cost	You pay 20% of the cost	You pay 20% of the cost	You pay 20% of the cost
• **Supplemental vision coverage** Non-Medicare covered vision services do not count towards your out-of-pocket limit.	Reimbursement for non-Medicare covered services up to a maximum of $100 annually combined with non-Medicare covered dental. *For non-Medicare covered vision services, you may use any qualified vision provider.*	Reimbursement for non-Medicare covered services up to a maximum of $300 annually combined with non-Medicare covered dental. *For non-Medicare covered vision services, you may use any qualified vision provider.*	Reimbursement for non-Medicare covered services up to a maximum of $350 annually combined with non-Medicare covered dental. *For non-Medicare covered vision services, you may use any qualified vision provider.*	Reimbursement for non-Medicare covered services up to a maximum of $300 annually combined with non-Medicare covered dental. *For non-Medicare covered vision services, you may use any qualified vision provider.*

Benefit category	Aultimate (HMO-POS) includes Rx	Classic (HMO-POS) includes Rx	Plus (HMO-POS) includes Rx	Basic MA- Only (HMO-POS) No Rx coverage
Mental health services • **Inpatient visit** Our plan covers an unlimited number of days for an inpatient hospital stay. Prior authorization may be required for these services. Please contact the plan for more information.	In-network: Days 1-10: You pay $150 per day Days 11 and beyond: You pay a $0 copay	In-network: Days 1-10: You pay $145 per day Days 11 and beyond: You pay a $0 copay	In-network: Days 1-10: You pay $145 per day Days 11 and beyond: You pay a $0 copay	In-network: Days 1-10: You pay $175 per day Days 11 and beyond: You pay a $0 copay
• **Outpatient group therapy visit**	You pay a $40 copay per visit	You pay a $35 copay per visit	You pay a $30 copay per visit	You pay a $35 copay per visit
• **Outpatient individual therapy visit**	You pay a $40 copay per visit	You pay a $35 copay per visit	You pay a $30 copay per visit	You pay a $35 copay per visit
Skilled nursing facility (SNF) Our plan covers up to 100 days in a SNF. Prior authorization may be required for these services. Please contact the plan for more information.	In-network: Days 1-20: You pay a $0 copay Days 21-45: You pay $150 per day Days 46-100: You pay a $0 copay	In-network: Days 1-20: You pay a $0 copay Days 21-45: You pay $135 per day Days 46-100: You pay a $0 copay	In-network: Days 1-20: You pay a $0 copay Days 21-45: You pay $120 per day Days 46-100: You pay a $0 copay	In-network: Days 1-20: You pay $20 per day Days 21-39: You pay $150 per day Days 40-100: You pay a $0 copay
Physical therapy visit Annual maximum out-of-pocket cost applies to Medicare-covered acupuncture, physical, occupational, speech and language therapies combined.	In-network: You pay a $35 copay per visit $1,050 annual out-of-pocket max	In-network: You pay a $30 copay per visit $900 annual out-of-pocket max	In-network: You pay a $20 copay per visit $600 annual out-of-pocket max	In-network: You pay a $35 copay per visit $1,050 annual out-of-pocket max

Benefit category	Aultimate (HMO-POS) includes Rx	Classic (HMO-POS) includes Rx	Plus (HMO-POS) includes Rx	Basic MA- Only (HMO-POS) No Rx coverage
Ambulance Prior authorization may be required for non-emergency services. Please contact the plan for more information. World-wide emergency coverage.	In-network: You pay a $230 copay per trip	In-network: You pay a $210 copay per trip	In-network: You pay a $200 copay per trip	In-network: You pay a $200 copay per trip
Transportation	Not covered	Not covered	Not covered	Not covered
Medicare Part B drugs Prior authorization may be required for these services. Please contact the plan for more information. • **Chemotherapy drugs**	In-Network: You pay 20% of the cost	In-Network: You pay 20% of the cost	In-Network: You pay 20% of the cost	In-Network: You pay 20% of the cost
• **Other Part B drugs**	You pay 20% of the cost	You pay 20% of the cost	You pay 20% of the cost	You pay 20% of the cost
Medical equipment/ supplies Prior authorization may be required for these services. Please contact the plan for more information. • **Durable medical equipment (wheel-chairs, oxygen, etc)**	In-network: You pay 20% of the cost	In-network: You pay 20% of the cost	In-network: You pay 20% of the cost	In-network: You pay 20% of the cost
• **Prosthetics/Medical supplies (braces, artificial limbs, etc)**	You pay 20% of the cost	You pay 20% of the cost	You pay 20% of the cost	You pay 20% of the cost

Benefit category	Aultimate (HMO-POS) includes Rx	Classic (HMO-POS) includes Rx	Plus (HMO-POS) includes Rx	Basic MA- Only (HMO-POS) No Rx coverage
Medical equipment/ supplies (continued) • **Medicare-covered diabetic testing supplies (lancets, strips, & certain glucometers)**	You pay 0% of the cost	You pay 0% of the cost	You pay 0% of the cost	You pay 0% of the cost
• **Medicare-covered diabetic supplies**	You pay 20% of the cost	You pay 20% of the cost	You pay 20% of the cost	You pay 20% of the cost
Home Delivered Meal benefit Benefit is limited to 5 days, up to 10 meals, and following an inpatient hospital stay at a network facility, with a doctor's order, and in our service area with a contracted provider.	You pay a $0 copay.	You pay a $0 copay.	You pay a $0 copay.	You pay a $0 copay.
Health and Wellness Education Programs • Tele-monitoring Services – Enrollees diagnosed with any of the conditions below may be eligible: o Heart Failure o Diabetes o Chronic Obstructive Pulmonary Disease (COPD) o Behavioral Health Conditions	You pay a $0 copay for Health and Wellness Education benefits	You pay a $0 copay for Health and Wellness Education benefits	You pay a $0 copay for Health and Wellness Education benefits	You pay a $0 copay for Health and Wellness Education benefits

Benefit category	Aultimate (HMO-POS) includes Rx	Classic (HMO-POS) includes Rx	Plus (HMO-POS) includes Rx	Basic MA- Only (HMO-POS) No Rx coverage
Health and Wellness Education Programs (continued) • Stroke Prevention Program – offered to members who have health conditions that put them at higher risk for stroke. • 24 Hour Nursing Hotline (330) 363-7600 or 1-800-686-9373 • The Silver&Fit® Exercise & Healthy Aging Program – offers members a fitness center membership at a participating fitness center or select YMCA and up to 2 home fitness kits each benefit year. • In-Home Safety Assessment - evaluates your home for potential safety concerns. For example: proper lighting, fall hazards, and grab bars.				

Benefit category	Aultimate (HMO-POS) includes Rx	Classic (HMO-POS) includes Rx	Plus (HMO-POS) includes Rx	Basic MA- Only (HMO-POS) No Rx coverage
Over-The-Counter (OTC) benefit Covered OTC items are health-related items and medications that are available without a prescription and are not covered by Medicare. With FirstLine Essentials you can purchase many over-the-counter products and they'll be delivered directly to your home at no additional cost. Shop toothpaste, pain relief, vitamins, cough drops and more. It's all included with your health plan.	Up to $50 per quarter on qualified OTC items.	Up to $50 per quarter on qualified OTC items.	Up to $75 per quarter on qualified OTC items.	Not Available

Outpatient Part D Prescription Drug

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

Phase 1: Deductible Stage*	You must pay the full cost of your Tier 3, Tier 4, and Tier 5 drugs until you have paid the deductible. The amount of the deductible is listed in the chart below. For drugs in Tier 1 and Tier 2, you do not pay a deductible and will receive coverage immediately at the copay amount listed below.
Phase 2: Initial Coverage Stage	During this stage, the plan pays its share of the cost of your generic drugs and you pay your share of the cost. After you (or others on your behalf) have met your Tiers 3, 4, and 5 deductible, the plan pays its share of the costs of your Tiers 3, 4, and 5 drugs and you pay your share. You pay the following copays/coinsurance until your total yearly drug costs reach $4,130. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.

The below copays/coinsurance are for prescriptions purchased from network pharmacies. Costs will differ based on whether the prescriptions are filled at a preferred pharmacy, standard pharmacy, or mail order pharmacy. Refer to your pharmacy directory for information on which pharmacies are preferred or standard. Cost will also differ based on the number of days' supply. Long-Term Care (LTC) pharmacies can fill up to a 31-day supply at the 30-day copays/ coinsurance listed below.

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

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

Tier and Name	**Aultimate (HMO-POS)**			**Classic (HMO-POS)**			**Plus (HMO-POS)**		
	30 day	**60 day**	**90 day**	**30 day**	**60 day**	**90 day**	**30 day**	**60 day**	**90 day**
1 - Preferred Generic Drugs	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay
2 - Generic Drugs	$15 copay	$30 copay	$45 copay	$8 copay	$16 copay	$24 copay	$6 copay	$12 copay	$18 copay
3 - Preferred Brand Drugs*	$42 copay	$84 copay	$126 copay	$42 copay	$84 copay	$126 copay	$42 copay	$84 copay	$126 copay
4 - Non-preferred Drugs*	$95 copay	$190 copay	$285 copay	$95 copay	$190 copay	$285 copay	$95 copay	$190 copay	$285 copay
5 - Specialty Drugs*	29% of the cost	Not available	Not available	30% of the cost	Not available	Not available	31% of the cost	Not available	Not available

Standard Pharmacy - Retail (up to a 90 day supply)									
Tier and Name	**Aultimate (HMO-POS)**			**Classic (HMO-POS)**			**Plus (HMO-POS)**		
	30 day	**60 Day**	**90 day**	**30 day**	**60 day**	**90 day**	**30 day**	**60 day**	**90 day**
1 - Preferred Generic Drugs	$10 copay	$20 copay	$30 copay	$10 copay	$20 copay	$30 copay	$10 copay	$20 copay	$30 copay
2 - Generic Drugs	$20 copay	$40 copay	$60 copay	$18 copay	$36 copay	$54 copay	$16 copay	$32 copay	$48 copay
3 - Preferred Brand Drugs*	$47 copay	$94 copay	$141 copay	$47 copay	$94 copay	$141 copay	$47 copay	$94 copay	$141 copay
4 - Non-preferred Drugs*	$100 copay	$200 copay	$300 copay	$100 copay	$200 copay	$300 copay	$100 copay	$200 copay	$300 copay
5 - Specialty Drugs*	29% of the cost	Not available	Not available	30% of the cost	Not available	Not available	31% of the cost	Not available	Not available
Mail Order Pharmacy (up to a 90 day supply)									
Tier and Name	**Aultimate (HMO-POS)**			**Classic (HMO-POS)**			**Plus (HMO-POS)**		
	30 day	60 day	90 day	30 day	60 day	90 day	30 day	60 day	90 day
1 - Preferred Generic Drugs	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay
2 - Generic Drugs	$15 copay	$30 copay	$45 copay	$8 copay	$16 copay	$20 copay	$6 copay	$12 copay	$15 copay
3 - Preferred Brand Drugs*	$45 copay	$90 copay	$125 copay	$45 copay	$90 copay	$125 copay	$45 copay	$90 copay	$125 copay
4 - Non-preferred Drugs*	$95 copay	$190 copay	$285 copay	$95 copay	$190 copay	$275 copay	$95 copay	$190 copay	$275 copay
5 - Specialty Drugs*	29% of the cost	Not available	Not available	30% of the cost	Not available	Not available	31% of the cost	Not available	Not available
***Tier 3, 4 and 5 copays apply after you have met the annual deductible**									
Phase 3: Coverage Gap Stage	The Coverage Gap begins after the total yearly drug cost reaches $4,130. If you reach the coverage gap, the plan pays 75% of the price for covered drugs and you pay the remaining 25% of the price. Not everyone will enter the Coverage Gap.								
Phase 4: Catastrophic Coverage Stage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $6,550, you pay the greater of: - 5% of the cost, or - $3.70 copay for generic (including brand drugs treated as generic) and a $9.20 copay for all other drugs. If you reach the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.								

Multi-language Interpreter Services

English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-577-5084 (TTY 1-800-617-7446).

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-577-5084 (TTY 1-800-617-7446).

繁體中文 (Chinese): 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-577-5084 (TTY 1-800-617-7446).

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-577-5084 (TTY 1-800-617-7446).

العربية (Arabic):
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-577-5084 (رقم هاتف الصم والبكم: 1-800-617-7446).

Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-577-5084 (TTY: 1-800-617-7446).

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-577-5084 (телетайп: 1-800-617-7446).

Français (French): ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-577-5084 (ATS : 1-800-617-7446).

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-577-5084 (TTY: 1-800-617-7446).

Oroomiffa (Chushite-Oromo): XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-577-5084 (TTY: 1-800-617-7446).

한국어 (Korean): 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-577-5084 (TTY: 1-800-617-7446) 번으로 전화해 주십시오.

Italiano (Italian): ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-577-5084 (TTY: 1-800-617-7446).

日本語 (Japanese): 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-577-5084 (TTY 1-800-617-7446).まで、お電話にてご連絡ください。

Nederlands (Dutch): AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 1-800-577-5084 (TTY: 1-800-617-7446).

Українська (Ukrainian): УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-577-5084 (телетайп: 1-800-617-7446).

Română (Romanian):
ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-577-5084 (TTY: 1-800-617-7446).

Non-discrimination Notice

PrimeTime Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. PrimeTime Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. PrimeTime Health Plan provides free aids and services to people with disabilities to communicate effectively with us, such as: Qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). PrimeTime Health Plan provides free language services to people whose primary language is not English, such as: Qualified interpreters and information written in other languages.

If you need these services, or if you believe that PrimeTime Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can contact or file a grievance with the: PrimeTime Health Plan Civil Rights Coordinator, 2600 6th St. S.W. Canton, OH 44710, 330-363-7456, CivilRightsCoordinator@aultcare.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights staff is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.