2027 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, 2027 – December 31, 2027. 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 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. Or visit our website at www.pthp.com.

You are eligible for membership in our plan if 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, & 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.

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 $69	You pay $115
Part B Premium Reduction	$75 a month	Not Available	Not Available	Not Available
Medical deductible	No deductible	No deductible	$300 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: $5,900 annually	In-network: $4,750 annually	In-network: $4,250 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 $450 per day Days 7 and beyond: You pay a $0 copay	*In-network: Days 1-6: You pay $425 per day Days 7 and beyond: You pay a $0 copay *$300 annual deductible applies	In-network: Days 1-6: You pay $375 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 $500 copay for outpatient surgery.	*In-network: You pay a $400 copay for outpatient surgery. *$300 annual deductible applies	In-network: You pay a $275 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. *$300 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 $65 copay per visit	In-network: You pay a $50 copay per visit	In-network: You pay a $40 copay per visit
Preventive care	All plans in-network: You pay a $0 copay Any additional preventive services approved by Medicare during the contract year will be covered.			
Emergency care If you are admitted to the hospital within 23 hours, you do not have to pay your share of the cost for emergency care. *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 $0 - $250 copay	*In-network: You pay a $0 - $240 copay *$300 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 $150 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 - $8 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 $100 copay	*In-network: You pay a $75 copay *$300 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 *$300 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 $20 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 $2,000 annually.	Reimbursement for non-Medicare covered dental services up to a maximum of $850 annually.	Reimbursement for non-Medicare covered dental services up to a maximum of $1,300 annually.	Reimbursement for non-Medicare covered dental services up to a maximum of $2,500 annually.
	Routine exams, x-rays, cleanings, fluoride, diagnostic services reimbursed up to 100%. Restorative, endodontics, periodontics, oral and maxillofacial surgery, implants, orthodontia and prosthodontics reimbursed up to 50%. Limitations and annual limits apply. Please refer to the medical benefits chart in Chapter 4 of your Evidence of Coverage for additional 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
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 $55 copay	In-network: You pay a $50 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.*	Reimbursement up to a maximum of $300 annually.	Reimbursement up to a maximum of $150 every two years.	Reimbursement up to a maximum of $300 every two years.	Reimbursement up to a maximum of $300 every two years.

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 $385 per day Days 7 and beyond: You pay a $0 copay *$300 annual deductible applies	In-network: Days 1-6: You pay $335 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 21-100: You pay $221 per day	*In-network: Days 1-20: You pay a $0 copay Days 21-100: You pay $221 per day *$300 annual deductible applies	In-network: Days 1-20: You pay a $0 copay Days 21-100: You pay $221 per day
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 *$300 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 *$300 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 $325 copay per one-way trip	*In-network: You pay a $275 copay per one-way trip *$300 annual deductible applies	In-network: You pay a $225 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 *$300 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 *$300 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 $30 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 *$300 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 *$300 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 *$300 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 10 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) & Healthy Food 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 items. (Unused amounts do not carry-over to the next quarter.)	Not Available	Not Available	Up to $50 per quarter on qualified 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 $65 copay	Primary Care Doctor visit: You pay a $0 copay Specialist visit: You pay a $50 copay	Primary Care Doctor visit: You pay a $0 copay Specialist visit: You pay a $40 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. 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 $2,400.

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)**
	***$700** (applies to tiers 3, 4, & 5)	***$700** (applies to tiers 3, 4, & 5)	***$500** (applies to tiers 3, 4, & 5)

Preferred Pharmacy - Retail

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	$3 copay	$6 copay	$9 copay	$3 copay	$6 copay	$9 copay	$0 copay	$0 copay	$0 copay
3 - Preferred Brand Drugs*	25% of the cost	25% of the cost	25% of the cost	25% of the cost	25% of the cost	25% of the cost	25% of the cost	25% of the cost	25% of the cost
4 - Non-preferred Drugs*	25% of the cost	25% of the cost	25% of the cost	25% of the cost	25% of the cost	25% of the cost	25% of the cost	25% of the cost	25% of the cost
5 - Specialty Drugs*	25% of the cost	Not Available	Not Available	25% of the cost	Not Available	Not Available	28% of the cost	Not Available	Not Available
6 – Select Care Drugs (up to a 100-day supply available)	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay

Standard Pharmacy - Retail									
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	$8 copay	$16 copay	$24 copay
2 - Generic Drugs	$16 copay	$32 copay	$48 copay	$16 copay	$32 copay	$48 copay	$10 copay	$20 copay	$30 copay
3 - Preferred Brand Drugs*	25% of the cost	25% of the cost	25% of the cost	25% of the cost	25% of the cost	25% of the cost	25% of the cost	25% of the cost	25% of the cost
4 - Non-preferred Drugs*	25% of the cost	25% of the cost	25% of the cost	25% of the cost	25% of the cost	25% of the cost	25% of the cost	25% of the cost	25% of the cost
5 - Specialty Drugs*	25% of the cost	Not Available	Not Available	25% of the cost	Not Available	Not Available	28% of the cost	Not Available	Not Available
6 – Select Care Drugs (up to a 100-day supply available)	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay
Mail Order Pharmacy									
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	$3 copay	$6 copay	$8 copay	$3 copay	$6 copay	$8 copay	$0 copay	$0 copay	$0 copay
3 - Preferred Brand Drugs*	25% of the cost	25% of the cost	25% of the cost	25% of the cost	25% of the cost	25% of the cost	25% of the cost	25% of the cost	25% of the cost
4 - Non-preferred Drugs*	25% of the cost	25% of the cost	25% of the cost	25% of the cost	25% of the cost	25% of the cost	25% of the cost	25% of the cost	25% of the cost
5 - Specialty Drugs*	25% of the cost	Not Available	Not Available	25% of the cost	Not Available	Not Available	28% of the cost	Not Available	Not Available
6 – Select Care Drugs (up to a 100-day supply available)	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay

Phase 3: Catastrophic Coverage Stage	You enter the Catastrophic Coverage Stage when your out-of-pocket costs have reached the $2,400 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

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.

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.

AULTCARE'S PRIMETIME HEALTH PLAN

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.