PriorityHealth

2018 Evidence of Coverage

PriorityMedicare[SM] (Employer HMO-POS)

Michigan Public School Employees Retirement System

Your Medicare Health Benefits and Services and prescription drug coverage as a Member of **Priority**Medicare

January 1, 2018 – December 31, 2018

NCMS_ 1000_1110_1826AA 10232017

Evidence of Coverage:

Your Medicare Health Benefits and Services and Prescription Drug Coverage as a Member of **Priority**Medicare (Employer HMO-POS)

This booklet gives you the details about your Medicare health care and prescription drug coverage from January 1, 2018 - December 31, 2018. It explains how to get coverage for the health care services and prescription drugs you need. **This is an important legal document. Please keep it in a safe place.**

This plan, **Priority**Medicare (Employer HMO-POS), is offered by Priority Health Medicare. (When this Evidence of Coverage says "we," "us," or "our," it means Priority Health Medicare. When it says "plan" or "our plan," it means **Priority**Medicare (Employer HMO-POS).)

Priority Health has HMO-POS and PPO plans with a Medicare contract. Enrollment in Priority Health Medicare depends on contract renewal.

Please contact our Customer Service number at 888.389.6648, option 3 for additional information. (TTY users should call 711.) Hours are 7 days a week, 8 am to 8 pm.

This information is available in a different format, including Braille and large print. Please call Customer Service if you need plan information in another format.

Benefits, premium, deductible, and/or copayments/coinsurance may change on January 1, 2019.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

Multi-Language Insert

Multi-language Interpreter Services

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Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول بمساعدتك. هذه على مترجم فوري، ليس عليك سوى الاتصال بنا على 888.983. 8466 سيقوم شخص ما يتحدث العربية خدمة مجانية.

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2018 Evidence of Coverage

Table of Contents

This list of chapters and page numbers is your starting point. For more help in finding information you need, go to the first page of a chapter. **You will find a detailed list of topics at the beginning of each chapter.**

CHAPTER 1

Getting started as a member

Chapter 1. Getting started as a member

SECTION 1 Introduction

Section 1.1 You are enrolled in **Priority**Medicare (Employer HMO-POS), which is a Medicare HMO Point-of-Service (POS) Plan

You are covered by Medicare, and you have chosen to get your Medicare health care and your prescription drug coverage through our plan, **Priority**Medicare (Employer HMO-POS).

There are different types of Medicare health plans. **Priority**Medicare (Employer HMO-POS) is a Medicare Advantage HMO Plan (HMO stands for Health Maintenance Organization) with a Point-of-Service (POS) option approved by Medicare and run by a private company. "Point-of-Service" means you can use providers outside the plan's network for an additional cost. (See Chapter 3, Section 2.4 for information about using the Point-of-Service option.)

Section 1.2 What is the *Evidence of Coverage* booklet about?

This *Evidence of Coverage* booklet tells you how to get your Medicare medical care and prescription drugs covered through our plan. This booklet explains your rights and responsibilities, what is covered, and what you pay as a member of the plan.

The word "coverage" and "covered services" refers to the medical care and services and the prescription drugs available to you as a member of **Priority**Medicare (Employer HMO-POS).

It's important for you to learn what the plan's rules are and what services are available to you. We encourage you to set aside some time to look through this *Evidence of Coverage* booklet.

If you are confused or concerned or just have a question, please contact our plan's Customer Service (phone numbers are printed on the back cover of this booklet).

Section 1.3 Legal information about the *Evidence of Coverage*

It's part of our contract with you

This *Evidence of Coverage* is part of our contract with you about how **Priority**Medicare (Employer HMO-POS) covers your care. Other parts of this contract include your enrollment form, the *List of Covered Drugs (Formulary)*, and any notices you receive from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called "riders" or "amendments."

The contract is in effect for months in which you are enrolled in **Priority**Medicare (Employer HMO-POS) between January 1, 2018 - December 31, 2018.

Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of **Priority**Medicare (Employer HMO-POS) after

December 31, 2018. We can also choose to stop offering the plan, or to offer it in a different service area, after December 31, 2018. If this were to happen, you would be notified in advance of the termination and be given a special election period (SEP) to choose another plan.

Medicare must approve our plan each year

Medicare (the Centers for Medicare & Medicaid Services) must approve **Priority**Medicare (Employer HMO-POS) each year. You can continue to get Medicare coverage as a member of our plan as long as we choose to continue to offer the plan and Medicare renews its approval of the plan.

SECTION 2 What makes you eligible to be a plan member?

Section 2.1 Your eligibility requirements

You are eligible for membership in our plan as long as:

- You are not enrolled in any other group or individual health coverage.
    - -- *and* -- you have both Medicare Part A and Medicare Part B (section 2.2 tells you about Medicare Part A and Medicare Part B)
- -- *and* -- you live in our geographic service area (section 2.3 below describes our service area)
- -- *and* -- you are a United States citizen or are lawfully present in the United States
- -- *and* -- you do not have End-Stage Renal Disease (ESRD), with limited exceptions, such as if you develop ESRD when you are already a member of a plan that we offer, or you were a member of a different plan that was terminated.

Section 2.2 What are Medicare Part A and Medicare Part B?

When you first signed up for Medicare, you received information about what services are covered under Medicare Part A and Medicare Part B. Remember:

- Medicare Part A generally helps cover services provided by hospitals (for inpatient services, skilled nursing facilities, or home health agencies).
- Medicare Part B is for most other medical services (such as physician’s services and other outpatient services) and certain items (such as durable medical equipment (DME) and supplies).

Section 2.3 Here is the plan service area for **Priority**Medicare (Employer HMO-POS)

Although Medicare is a Federal program, **Priority**Medicare (Employer HMO-POS) is available only to Michigan Public School Employees' Retirement System individuals who live in our plan service area. To remain a member of our plan, you must continue to reside in the plan service area at least 6 months out of the year. The service area is described below.

Our service area includes the State of Michigan.

If you plan to move out of the service area, please contact the Office of Retirement Services (address and other demographic updates can be provided online at *www.michigan.gov/orsmiaccount*) and Customer Service (phone numbers are printed on the back cover of this booklet). When you move, you may have a Special Enrollment Period that will allow you to switch to Original Medicare or enroll in a Medicare health or drug plan that is available in your new location.

It is also important that you call or email Priority Health Medicare and contact Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5. You can find phone numbers and contact information for Priority Health Medicare on the back cover of this booklet.

Section 2.4 U.S. Citizen or Lawful Presence

A member of a Medicare health plan must be a U.S. citizen or lawfully present in the United States. Medicare (the Centers for Medicare & Medicaid Services) will notify Priority Health Medicare if you are not eligible to remain a member on this basis. Priority Health Medicare must disenroll you if you do not meet this requirement.

SECTION 3 What other materials will you get from us?

Section 3.1 Your plan membership card – Use it to get all covered care and prescription drugs

While you are a member of our plan, you must use your membership card for our plan whenever you get any services covered by this plan and for prescription drugs you get at network pharmacies. You should also show the provider your Medicaid card, if applicable. Here's a sample membership card to show you what yours will look like:

As long as you are a member of our plan **you must <u>not</u> use your red, white, and blue Medicare card** to get covered medical services (with the exception of routine clinical research studies and hospice services). Keep your red, white, and blue Medicare card in a safe place in case you need it later.

Here's why this is so important: If you get covered services using your red, white, and blue Medicare card instead of using your **Priority**Medicare (Employer HMO-POS) membership card while you are a plan member, you may have to pay the full cost yourself.

If your plan membership card is damaged, lost, or stolen, call Customer Service right away and we will send you a new card. (Phone numbers for Customer Service are printed on the back cover of this booklet.)

Section 3.2 The *Provider/Pharmacy Directory*: Your guide to all providers and pharmacies in the plan's network

You can find the most current *Provider/Pharmacy Directory* at *prioritythealth.com/mpsers*, or download it from this website.

The *Provider/Pharmacy Directory* lists our network providers, durable medical equipment suppliers and pharmacies.

What are "network providers"?

Network providers are the doctors and other health care professionals, medical groups, durable medical equipment suppliers, hospitals, and other health care facilities that have an agreement with us to accept our payment and any plan cost-sharing as payment in full. We have arranged for these providers to deliver covered services to members in our plan. The most recent list of providers and suppliers is available on our website at *priorityhealth.com/mpsers*.

Why do you need to know which providers are part of our network?

It is important to know which providers are part of our network because, with limited exceptions, while you are a member of our plan you may be required to use network providers to get your medical care and services. The only exceptions are emergencies, urgently needed services when the network is not available (generally, when you are out of the area), out-of-area dialysis services, and cases in which Priority Health Medicare authorizes use of out-of-network providers. See Chapter 3 (*Using the plan's coverage for your medical services*) for more specific information about emergency, out-of-network, and out-of-area coverage.

You also have Point-of-Service (POS) or "out-of-network" benefits. Under this coverage, you may see any provider who accepts Medicare payments within the United States and its territories. When you use your POS benefits, you are subject to a deductible and will pay more for services than when you would if you used a "network provider." See Chapter 3 (*Using the plan's coverage for your medical services*) for details.

If you don't have your copy of the *Provider/Pharmacy Directory*, you can request a copy from Customer Service (phone numbers are printed on the back cover of this booklet). You may ask Customer Service for more information about our network providers, including their qualifications. You can also see the *Provider/Pharmacy Directory* at *priorityhealth.com/mpsers,* or download it from this website. Both Customer Service and the website can give you the most up-to-date information about changes in our network providers.

What are "network pharmacies"?

Network pharmacies are all of the pharmacies that have agreed to fill covered prescriptions for our plan members.

Why do you need to know about network pharmacies?

You can use the *Provider/Pharmacy Directory* to find the network pharmacy you want to use. There are changes to our network of pharmacies for next year. An updated *Provider/Pharmacy Directory* is located on our website at *priorityhealth.com/mpsers*. You may also call Customer Service for updated provider information or to ask us to mail you a *Provider/Pharmacy Directory*. **Please review the 2018 *Provider/Pharmacy Directory* to see which pharmacies are in our network**.

The *Provider/Pharmacy Directory* will also tell you which of the pharmacies in our network have preferred cost-sharing, which may be lower than the standard cost-sharing offered by other network pharmacies for some drugs.

If you don't have the Provider/Pharmacy Directory, you can request a copy from Customer Service (phone numbers are printed on the back cover of this booklet). You may call Customer Service to ask for more information about our network providers, including their qualifications and to get up-to-date information about changes in the pharmacy network. You can also see the Provider/Pharmacy Directory at *priorityhealth.com/mpsers*, or download it from this website. Both Customer Service and the website can give you the most up-to-date information about changes in our network providers.

Section 3.3 The plan's List of Covered Drugs *(Formulary)*

The plan has a *List of Covered Drugs (Formulary)*. We call it the "Drug List" for short. It tells which Part D prescription drugs are covered under the Part D benefit included in **Priority**Medicare (Employer HMO-POS). The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the **Priority**Medicare (Employer HMO-POS) Drug List.

The Drug List also tells you if there are any rules that restrict coverage for your drugs.

We will send you a copy of the Drug List. The Drug List we send you includes information for the covered drugs that are most commonly used by our members. However, we cover additional drugs that are not included in the printed Drug List. If one of your drugs is not listed in the Drug List, you should visit our website or contact Customer Services to find out if we cover it. To get the most complete and current information about which drugs are covered, you can visit the plan's website (*priorityhealth.com/mpsers*) or call Customer Service (phone numbers are printed on the back cover of this booklet).

Section 3.4 The *Part D Explanation of Benefits* (the "Part D EOB"): Reports with a summary of payments made for your Part D prescription drugs

When you use your Part D prescription drug benefits, we will send you a summary report to help you understand and keep track of payments for your Part D prescription drugs. This summary report is called the *Part D Explanation of Benefits* (or the "Part D EOB").

The *Part D Explanation of Benefits* tells you the total amount you, or others on your behalf, have spent on your Part D prescription drugs and the total amount we have paid for each of your Part D prescription drugs during the month. Chapter 6 (*What you pay for your Part D prescription drugs*) gives more information about the *Part D Explanation of Benefits* and how it can help you keep track of your drug coverage.

A *Part D Explanation of Benefits* summary is also available upon request. To get a copy, please contact Customer Service (phone numbers are printed on the back cover of this booklet).

Or, you can go online to view it. Go to *priorityhealth.com/mpsers* and log in to your account to access your *Part D Explanation of Benefits.*

SECTION 4 Your monthly premium for **Priority**Medicare (Employer HMO-POS)

Section 4.1 How much is your plan premium?

Your coverage is provided through a contract with the Michigan Public School Employees' Retirement System. Please contact the Office of Retirement Services for information about your plan premium. In addition, you must continue to pay your Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

In some situations, your plan premium could be <u>less</u>

The "Extra Help" program helps people with limited resources pay for their drugs. Chapter 2, Section 7 tells more about this program. If you qualify, enrolling in the program might lower your monthly plan premium.

If you are *already enrolled* and getting help from one of these programs, **the information about premiums in this *Evidence of Coverage* may not apply to you**. We have included a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also known as the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug coverage. If you don't have this insert, please call or email Customer Service and ask for the "LIS Rider." (Phone numbers or email for Customer Service are printed on the back cover of this booklet.)

In some situations, your plan premium could be <u>more</u>

In some situations, your plan premium could be more than the amount listed above in Section 4.1. These situations are described below.

- Some members are required to pay a Part D **late enrollment penalty** because they did not join a Medicare drug plan when they first became eligible or because they had a continuous period of 63 days or more when they didn't have "creditable" prescription drug coverage. ("Creditable" means the drug coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) For these members, the Part D late enrollment penalty is added to the plan's monthly premium. Their premium amount will be the monthly plan premium plus the amount of their Part D late enrollment penalty. The Office of Retirement Services pays this penalty on your behalf.

- If you are required to pay the Part D late enrollment penalty, the amount of your penalty depends on how long you waited before you enrolled in drug coverage or how many months you were without drug coverage after you became eligible. Chapter 1, Section 5 explains the Part D late enrollment penalty.
- If you have a Part D late enrollment penalty and do not pay it, you could be disenrolled from the plan.

Many members are required to pay other Medicare premiums

In addition to paying the monthly plan premium, many members are required to pay other Medicare premiums. As explained in Section 2 above, in order to be eligible for our plan, you must be entitled to Medicare Part A and enrolled in Medicare Part B. For that reason, some plan members (those who aren't eligible for premium-free Part A) pay a premium for Medicare Part A. And most plan members pay a premium for Medicare Part B. You must continue paying your Medicare premiums to remain a member of the plan.

To learn more or determine if you qualify for assistance paying your Part B premium, you can contact My Advocate at 1-866-783-0896, between 9 am to 6 pm, Monday through Friday. TTY users should call 1-855-368-9643. For additional information please go to *MyAdvocateHelps.com*.

Some people pay an extra amount for Part D because of their yearly income. This is known as Income Related Monthly Adjustment Amounts, also known as IRMAA. If your income is greater than $85,000 for an individual (or married individuals filing separately) or greater than $170,000 for married couples, **you must pay an extra amount directly to the government (not the Medicare plan)** for your Medicare Part D coverage.

- **If you are required to pay the extra amount and you do not pay it, you <u>will</u> be disenrolled from the plan and lose prescription drug coverage.**
- 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.
- For more information about Part D premiums based on income, go to Chapter 1, Section 6 of this booklet. You can also visit *http://www.medicare.gov* on the Web or call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or you may call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

Your copy of *Medicare & You 2018* gives information about the Medicare premiums in the section called "2018 Medicare Costs." This explains how the Medicare Part B and Part D premiums differ for people with different incomes. Everyone with Medicare receives a copy of *Medicare & You* each year in the fall. Those new to Medicare receive it within a month after first signing up. You can also download a copy of *Medicare & You 2018* from the Medicare website *(http://www.medicare.gov)*. Or, you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

SECTION 5 Do you have to pay the Part D "late enrollment penalty"?

Section 5.1 What is the Part D "late enrollment penalty"?

Note: If you receive "Extra Help" from Medicare to pay for your prescription drugs, you will not pay a Part D late enrollment penalty.

The Part D late enrollment penalty is an amount that is added to your Part D premium. You may owe a Part D late enrollment penalty if at any time after your initial enrollment period is over, there is a period of 63 days or more in a row when you did not have Part D or other creditable prescription drug coverage. "Creditable prescription drug coverage" is coverage that meets Medicare's minimum standards since it is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. The amount of the penalty depends on how long you waited to enroll in a creditable prescription drug coverage plan any time after the end of your initial enrollment period or how many full calendar months you went without creditable prescription drug coverage. You will have to pay this penalty for as long as you have Part D coverage.

The Part D late enrollment penalty is added to your monthly premium. When you first enroll in **Priority**Medicare (Employer HMO-POS) we let you know the amount of the penalty.

Your Part D late enrollment penalty is considered part of your plan premium. If you do not pay your Part D late enrollment penalty, you could lose your prescription drug benefits for failure to pay your plan premium.

Section 5.2 How much is the Part D late enrollment penalty?

Medicare determines the amount of the penalty. Here is how it works:

- First count the number of full months that you delayed enrolling in a Medicare drug plan, after you were eligible to enroll. Or count the number of full months in which you did not have creditable prescription drug coverage, if the break in coverage was 63 days or more. The penalty is 1% for every month that you didn't have creditable coverage. For example, if you go 14 months without coverage, the penalty will be 14%.
- Then Medicare determines the amount of the average monthly premium for Medicare drug plans in the nation from the previous year. For 2018, this average premium amount is $35.02.
- To calculate your monthly penalty, you multiply the penalty percentage and the average monthly premium and then round it to the nearest 10 cents. In the example here it would be 14% times $35.02, which equals $4.9028. This rounds to $4.90. This amount would be added **to the monthly premium for someone with a Part D late enrollment penalty**.

There are three important things to note about this monthly Part D late enrollment penalty:

- First, **the penalty may change each year**, because the average monthly premium can change each year. If the national average premium (as determined by Medicare) increases, your penalty will increase.
- Second, **you will continue to pay a penalty** every month for as long as you are enrolled in a plan that has Medicare Part D drug benefits.
- Third, if you are under 65 and currently receiving Medicare benefits, the Part D late enrollment penalty will reset when you turn 65. After age 65, your Part D late enrollment penalty will be based only on the months that you don't have coverage after your initial enrollment period for aging into Medicare.

Section 5.3 In some situations, you can enroll late and not have to pay the penalty

Even if you have delayed enrolling in a plan offering Medicare Part D coverage when you were first eligible, sometimes you do not have to pay the Part D late enrollment penalty.

You will not have to pay a penalty for late enrollment if you are in any of these situations:

- If you already have prescription drug coverage that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. Medicare calls this "**creditable drug coverage**." Please note:
    - Creditable coverage could include drug coverage from a former employer or union, TRICARE, or the Department of Veterans Affairs. Your insurer or your human resources department will tell you each year if your drug coverage is creditable coverage. This information may be sent to you in a letter or included in a newsletter from the plan. Keep this information, because you may need it if you join a Medicare drug plan later.
        - Please note: If you receive a "certificate of creditable coverage" when your health coverage ends, it may not mean your prescription drug coverage was creditable. The notice must state that you had "creditable" prescription drug coverage that expected to pay as much as Medicare's standard prescription drug plan pays.
    - The following are *not* creditable prescription drug coverage: prescription drug discount cards, free clinics, and drug discount websites.
    - For additional information about creditable coverage, please look in your *Medicare & You 2018* Handbook or call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.
- If you were without creditable coverage, but you were without it for less than 63 days in a row.

- If you are receiving "Extra Help" from Medicare.

Section 5.4 What can you do if you disagree about your Part D late enrollment penalty?

If you disagree about your Part D late enrollment penalty, you or your representative can ask for a review of the decision about your late enrollment penalty. Generally, you must request this review **within 60 days** from the date on the letter you receive stating you have to pay a late enrollment penalty. Call Customer Service to find out more about how to do this (phone numbers are printed on the back cover of this booklet).

Important: Do not stop paying your Part D late enrollment penalty while you're waiting for a review of the decision about your late enrollment penalty. If you do, you could be disenrolled for failure to pay your plan premiums.

SECTION 6 Do you have to pay an extra Part D amount because of your income?

Section 6.1 Who pays an extra Part D amount because of income?

Most people pay a standard monthly Part D premium. However, some people pay an extra amount because of their yearly income. If your income is $85,000 or above for an individual (or married individuals filing separately) or $170,000 or above for married couples, you must pay an extra amount directly to the government for your Medicare Part D coverage.

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. The extra amount will be withheld from your Social Security, Railroad Retirement Board, or Office of Personnel Management benefit check, no matter how you usually pay your plan premium, unless your monthly benefit isn't enough to cover the extra amount owed. If your benefit check isn't enough to cover the extra amount, you will get a bill from Medicare. **You must pay the extra amount to the government. It cannot be paid with your monthly plan premium.**

Section 6.2 How much is the extra Part D amount?

If your modified adjusted gross income (MAGI) as reported on your IRS tax return is above a certain amount, you will pay an extra amount in addition to your monthly plan premium.

The chart below shows the extra amount based on your income.

If you filed an individual tax return and your income in 2016 was:	If you were married but filed a separate tax return and your income in 2016 was:	If you filed a joint tax return and your income in 2016 was:	This is the monthly cost of your extra Part D amount (to be paid in addition to your plan premium)
Equal to or less than $85,000	Equal to or less than $85,000	Equal to or less than $170,000	$0
Greater than $85,000 and less than or equal to $107,000		Greater than $170,000 and less than or equal to $214,000	$13.00
Greater than $107,000 and less than or equal to $133,500		Greater than $214,000 and less than or equal to $267,000	$33.60
Greater than $133,500 and less than or equal to $160,000		Greater than $267,000 and less than or equal to $320,000	$54.20
Greater than $160,000	Greater than $85,000	Greater than $320,000	$74.80

Section 6.3 What can you do if you disagree about paying an extra Part D amount?

If you disagree about paying an extra amount because of your income, you can ask Social Security to review the decision. To find out more about how to do this, contact Social Security at 1-800-772-1213 (TTY 1-800-325-0778).

Section 6.4 What happens if you do not pay the extra Part D amount?

The extra amount is paid directly to the government (not your Medicare plan) for your Medicare Part D coverage. If you are required to pay the extra amount and you do not pay it, you will be disenrolled from the plan and lose prescription drug coverage.

SECTION 7 More information about your monthly premium

Many members are required to pay other Medicare premiums

In addition to paying the monthly plan premium, many members are required to pay other Medicare premiums. As explained in Section 2 above, in order to be eligible for our plan, you must be entitled to Medicare Part A and enrolled in Medicare Part B. For that reason, some plan members (those who aren't eligible for premium-free Part A) pay a premium for Medicare Part A. And most plan members pay a premium for Medicare Part B. **You must continue paying your Medicare premiums to remain a member of the plan.**

To learn more or determine if you qualify for assistance paying your Part B premium, you can contact My Advocate at 1-866-783-0896, between 9 am to 6 pm, Monday through Friday. TTY users should call 1-855-368-9643. For additional information please go to *MyAdvocateHelps.com*.

Some people pay an extra amount for Part D because of their yearly income. This is known as Income Related Monthly Adjustment Amounts, also known as IRMAA. If your income is greater than $85,000 for an individual (or married individuals filing separately) or greater than $170,000 for married couples, **you must pay an extra amount directly to the government (not the Medicare plan)** for your Medicare Part D coverage.

- **If you are required to pay the extra amount and you do not pay it, you <u>will</u> be disenrolled from the plan and lose prescription drug coverage.**
- 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.
- For more information about Part D premiums based on income, go to Chapter 1, Section 6 of this booklet. You can also visit *https://www.medicare.gov* on the Web or call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or you may call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

Your copy of *Medicare & You 2018* gives information about the Medicare premiums in the section called "2018 Medicare Costs." This explains how the Medicare Part B and Part D premiums differ for people with different incomes. Everyone with Medicare receives a copy of *Medicare & You* each year in the fall. Those new to Medicare receive it within a month after first signing up. You can also download a copy of *Medicare & You 2018* from the Medicare website (*https://www.medicare.gov*). Or, you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

Section 7.1 Can we change your monthly plan premium during the year?

No. We are not allowed to change the amount we charge for the plan's monthly plan premium during the year.

However, in some cases the part of the premium that you have to pay can change during the year. This happens if you become eligible for the "Extra Help" program or if you lose your eligibility for the "Extra Help" program during the year. If a member qualifies for "Extra Help" with their prescription drug costs, the "Extra Help" program will pay part of the member's monthly plan premium. A member who loses their eligibility during the year will need to start paying their full monthly premium. You can find out more about the "Extra Help" program in Chapter 2, Section 7.

SECTION 8 Please keep your plan membership record up to date

Section 8.1 How to help make sure that we have accurate information about you

Your membership record has information from your enrollment form, including your address and telephone number. It shows your specific plan coverage including your Primary Care Provider (PCP).

The doctors, hospitals, pharmacists, and other providers in the plan's network need to have correct information about you. **These network providers use your membership record to know what services and drugs are covered and the cost-sharing amounts for you**. Because of this, it is very important that you help us keep your information up to date.

Let us know about these changes:

- Changes to your name, your physical/mailing address, your phone number, your email address or your primary care provider
- Changes in any other health insurance coverage you have (such as from your employer, your spouse's employer, workers' compensation, or Medicaid)
- If you have any liability claims, such as claims from an automobile accident
- If you have been admitted to a nursing home
- If you receive care in an out-of-area or out-of-network hospital or emergency room
- If your designated responsible party (such as a caregiver or medical power of attorney) changes
- If you are participating in a clinical research study

If any of this information changes, please let the Office of Retirement Services know by calling them at 1-800-381-5111 and call or email our Customer Service (phone numbers and our email address are printed on the back cover of this booklet). *Note:* If you only need to change your PCP, you can do that online at *priorityhealth.com/mpsers*. Just log-in to your member center account and click on "Change your doctor."

It is also important to contact Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

Read over the information we send you about any other insurance coverage you have

Medicare requires that we collect information from you about any other medical or drug insurance coverage that you have. That's because we must coordinate any other coverage you have with your benefits under our plan. (For more information about how our coverage works when you have other insurance, see Section 10 in this chapter.)

Once each year, we will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. If it is correct, you don't need to do anything. If the information is incorrect, or if you have other coverage that is not listed, please call or email Customer Service (phone numbers and our email address are printed on the back cover of this booklet).

Note: If you (or your spouse) are enrolled in other group health insurance from an employer or a retiree group other than the Michigan Public School Employees' Retirement System, you are not eligible for enrollment in this plan and you must contact Office of Retirement Services at 1-800-381-5111.

SECTION 9 We protect the privacy of your personal health information

Section 9.1 We make sure that your health information is protected

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

For more information about how we protect your personal health information, please go to Chapter 8, Section 1.4 of this booklet.

SECTION 10 How other insurance works with our plan

Section 10.1 Which plan pays first when you have other insurance?

When you have other insurance (like employer group health coverage), there are rules set by Medicare that decide whether our plan or your other insurance pays first. The insurance that pays first is called the "primary payer" and pays up to the limits of its coverage. The one that pays second, called the "secondary payer," only pays if there are costs left uncovered by the primary coverage. The secondary payer may not pay all of the uncovered costs.

These rules apply for employer or union group health plan coverage:

- If you have retiree coverage, Medicare pays first.
- If your group health plan coverage is based on your or a family member's current employment, who pays first depends on your age, the number of people employed by your employer, and whether you have Medicare based on age, disability, or End-stage Renal Disease (ESRD):
    - If you're under 65 and disabled and you or your family member is still working, your group health plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan that has more than 100 employees.
    - If you're over 65 and you or your spouse is still working, your group health plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan that has more than 20 employees.
- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

These types of coverage usually pay first for services related to each type:

- No-fault insurance (including automobile insurance)
- Liability (including automobile insurance)
- Black lung benefits
- Workers' compensation

Medicaid and TRICARE never pay first for Medicare-covered services. They only pay after Medicare, employer group health plans, and/or Medigap have paid.

If you have other insurance, tell your doctor, hospital, and pharmacy. If you have questions about who pays first, or you need to update your other insurance information, call or email Customer Service (phone numbers and our email address are printed on the back cover of this booklet). You may need to give your plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

Note: If you (or your spouse) are enrolled in other group health insurance from an employer or a retiree group other than the Michigan Public School Employees' Retirement System, you are not eligible for enrollment in this plan and you must contact Office of Retirement Services at 1-800-381-5111.

CHAPTER 2

Important phone numbers and resources

Chapter 2. Important phone numbers and resources

SECTION 1 **Priority**Medicare (Employer HMO-POS) **contacts** (how to contact us, including how to reach Customer Service at the plan)

How to contact our plan's Customer Service

For assistance with claims, billing, or member card questions, please call or write to **Priority**Medicare (Employer HMO-POS) Customer Service. We will be happy to help you.

Method	Customer Service – Contact Information
CALL	888.389.6648, option 3 Calls to this number are free, 8 a.m. to 8 p.m., 7 days a week. Customer Service also has free language interpreter services available for non-English speakers.
TTY	711 Calls to this number are free, 8 a.m. to 8 p.m., 7 days a week.
FAX	616.975.8826
WRITE	Customer Service Department, MS 1115 Priority Health Medicare 1231 East Beltline Ave, NE Grand Rapids, MI 49525 *MedicareCS@priorityhealth.com*
WEBSITE	*priorityhealth.com/mpsers*

How to contact us when you are asking for a coverage decision about your medical care

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services. For more information on asking for coverage decisions about your medical care, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints*)).

You may call us if you have questions about our coverage decision process.

Method	Coverage Decisions For Medical Care – Contact Information
CALL	888.389.6648, option 3 Calls to this number are free, 8 a.m. to 8 p.m., 7 days a week.
TTY	711 Calls to this number are free, 8 a.m. to 8 p.m., 7 days a week.
WRITE	Health Management Department, MS 1255 Priority Health Medicare 1231 East Beltline Ave, NE Grand Rapids, MI 49525
WEBSITE	*priorityhealth.com/mpsers*

How to contact us when you are asking for a coverage decision about your Part D prescription drugs

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your prescription drugs covered under the Part D benefit included in your plan. For more information on asking for coverage decisions about your Part D prescription drugs, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints*).

Method	Coverage Decisions for Part D Prescription Drugs – Contact Information
CALL	888.389.6648, option 3 Calls to this number are free, 8 a.m. to 8 p.m., 7 days a week.
TTY	711 Calls to this number are free, 8 a.m. to 8 p.m., 7 days a week.
FAX	877.974.4411
WRITE	Medicare Part D, MS 1260 Priority Health Medicare 1231 East Beltline Ave, NE Grand Rapids, MI 49525
WEBSITE	*priorityhealth.com/mpsers*

How to contact us when you are making an appeal about your medical care or Part D prescription drugs

An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on making an appeal about your medical care or Part D prescription drugs, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints*)).

Method	Appeals For Medical Care or Part D prescription drugs – Contact Information
CALL	888.389.6648, option 3 Calls to this number are free, 8 a.m. to 8 p.m., 7 days a week.
TTY	711 Calls to this number are free, 8 a.m. to 8 p.m., 7 days a week.
FAX	616.975.8827
WRITE	Appeals Coordinator, MS 1150 Priority Health Medicare 1231 East Beltline Ave, NE Grand Rapids, MI 49525
WEBSITE	*priorityhealth.com/mpsers*

How to contact us when you are making a complaint about your medical care or Part D prescription drugs

You can make a complaint about us or one of our network providers or network pharmacies, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. (If your problem is about the plan's coverage or payment, you should look at the section above about making an appeal.) For more information on making a complaint about your medical care or Part D prescription drugs, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints*)).

Method	Complaints About Medical Care or Part D prescription drugs – Contact Information
CALL	888.389.6648, option 3 Calls to this number are free, 8 a.m. to 8 p.m., 7 days a week.
TTY	711 Calls to this number are free, 8 a.m. to 8 p.m., 7 days a week.
FAX	616.975.8827
WRITE	Medicare Grievance Coordinator, MS 1150 Priority Health Medicare 1231 East Beltline Ave, NE Grand Rapids, MI 49525
MEDICARE WEBSITE	You can submit a complaint about **Priority**Medicare (Employer HMO-POS) directly to Medicare. To submit an online complaint to Medicare go to *https://www.medicare.gov/MedicareComplaintForm/home.aspx.*

Where to send a request asking us to pay for our share of the cost for medical care or a drug you have received

For more information on situations in which you may need to ask us for reimbursement or to pay a bill you have received from a provider, see Chapter 7 (*Asking us to pay our share of a bill you have received for covered medical services or drugs*).

Please note: If you send us a payment request and we deny any part of your request, you can appeal our decision. See Chapter 9 *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints))* for more information.

Method	Payment Requests for Medical Care – Contact Information
CALL	888.389.6648, option 3 Calls to this number are free, 8 a.m. to 8 p.m., 7 days a week.
TTY	711 Calls to this number are free, 8 a.m. to 8 p.m., 7 days a week.
FAX	616.975.8826
WRITE	Customer Service Department, MS 1115 Priority Health Medicare 1231 East Beltline Ave, NE Grand Rapids, MI 49525
WEBSITE	*priorityhealth.com/mpsers*

Method	Payment Requests for Part D prescription drugs – Contact Information
CALL	888.389.6648, option 3 Calls to this number are free, 8 a.m. to 8 p.m., 7 days a week.
TTY	711 Calls to this number are free, 8 a.m. to 8 p.m., 7 days a week.
FAX	616.975.8867
WRITE	Medicare Part D, MS 1260 Priority Health 1231 East Beltline Ave NE Grand Rapids, MI 49525
WEBSITE	*priorityhealth.com/mpsers*

SECTION 2 Medicare
(how to get help and information directly from the Federal Medicare program)

Medicare is the Federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

The Federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (sometimes called "CMS"). This agency contracts with Medicare Advantage organizations including us.

Method	Medicare – Contact Information
CALL	1-800-MEDICARE, or 1-800-633-4227 Calls to this number are free. 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WEBSITE	*https://www.medicare.gov* This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print directly from your computer. You can also find Medicare contacts in your state. The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools: • **Medicare Eligibility Tool:** Provides Medicare eligibility status information. • **Medicare Plan Finder:** Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an *estimate* of what your out-of-pocket costs might be in different Medicare plans. You can also use the website to tell Medicare about any complaints you have about **Priority**Medicare (Employer HMO-POS): • **Tell Medicare about your complaint:** You can submit a complaint about **Priority**Medicare (Employer HMO-POS) directly to Medicare. To submit a complaint to Medicare, go to *https://www.medicare.gov/MedicareComplaintForm/home.aspx*. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

Method	Medicare – Contact Information
	If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare and tell them what information you are looking for. They will find the information on the website, print it out, and send it to you. (You can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)

SECTION 3 State Health Insurance Assistance Program (free help, information, and answers to your questions about Medicare)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In Michigan, the SHIP is called Michigan Medicare/Medicaid Assistance Program (MMAP).

MMAP is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

MMAP counselors can help you with your Medicare questions or problems. They can help you understand your Medicare rights, help you make complaints about your medical care or treatment, and help you straighten out problems with your Medicare bills. MMAP counselors can also help you understand your Medicare plan choices and answer questions about switching plans.

Method	Michigan Medicare/Medicaid Assistance Program (MMAP) – Contact Information
CALL	800.803.7174
WRITE	MMAP 6105 W St. Joseph Hwy, Suite 204 Lansing, MI 48917-4850
WEBSITE	*mmapinc.org*

SECTION 4 Quality Improvement Organization
(paid by Medicare to check on the quality of care for people with Medicare)

There is a designated Quality Improvement Organization for serving Medicare beneficiaries in each state. For Michigan, the Quality Improvement Organization is called Keystone Peer Review Organization (KEPRO).

KEPRO has a group of doctors and other health care professionals who are paid by the Federal government. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. KEPRO is an independent organization. It is not connected with our plan.

You should contact KEPRO in any of these situations:

- You have a complaint about the quality of care you have received.
- You think coverage for your hospital stay is ending too soon.
- You think coverage for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon.

Method	Keystone Peer Review Organization (KEPRO) – Contact Information
CALL	855.408.8557, Monday-Friday, 9 a.m. - 7 p.m. EST, Saturday/Sunday 9 a.m. - 5 p.m. EST
TTY	855-843-4776 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	KEPRO 5201 W. Kennedy Blvd., Suite 900 Tampa, FL 33609
WEBSITE	*https://www.keproqio.com/*

SECTION 5 Social Security

Social Security is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens and lawful permanent residents who are 65 or older, or who have a disability or End-Stage Renal Disease and meet certain conditions, are eligible for Medicare. If you are already getting Social Security checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare. Social Security

handles the enrollment process for Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

Social Security is also responsible for determining who has to pay an extra amount for their Part D drug coverage because they have a higher income. If you got a letter from Social Security telling you that you have to pay the extra amount and have questions about the amount or if your income went down because of a life-changing event, you can call Social Security to ask for a reconsideration.

If you move or change your mailing address, it is important that you contact Social Security to let them know.

Method	Social Security– Contact Information
CALL	1-800-772-1213 Calls to this number are free. Available 7:00 am to 7:00 pm, Monday through Friday. You can use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	1-800-325-0778 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 7:00 am to 7:00 pm, Monday through Friday.
WEBSITE	*https://www.ssa.gov*

SECTION 6 Medicaid
(a joint Federal and state program that helps with medical costs for some people with limited income and resources)

Medicaid is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid.

In addition, there are programs offered through Medicaid that help people with Medicare pay their Medicare costs, such as their Medicare premiums. These "Medicare Savings Programs" help people with limited income and resources save money each year:

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other cost-sharing (like deductibles, coinsurance, and copayments). (Some people with QMB are also eligible for full Medicaid benefits (QMB+).)

- **Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums. (Some people with SLMB are also eligible for full Medicaid benefits (SLMB+).)
- **Qualifying Individual (QI):** Helps pay Part B premiums.
- **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums.

To find out more about Medicaid and its programs, contact Michigan Department of Health and Human Services, Michigan's Medicaid program.

Method	Michigan Department of Health and Human Services – Contact Information
CALL	517.373.3740, Monday-Friday, 8 a.m. - 5 p.m.
TTY	800.649.3777 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	Michigan Department of Health and Human Services Capitol View Building 201 Townsend Street Lansing, MI 48913
WEBSITE	*michigan.gov/mdhhs*

SECTION 7 Information about programs to help people pay for their prescription drugs

Medicare's "Extra Help" Program

Medicare provides "Extra Help" to pay prescription drug costs for people who have limited income and resources. Resources include your savings and stocks, but not your home or car. If you qualify, you get help paying for any Medicare drug plan's monthly premium, yearly deductible, and prescription copayments. This "Extra Help" also counts toward your out-of-pocket costs.

People with limited income and resources may qualify for "Extra Help." Some people automatically qualify for "Extra Help" and don't need to apply. Medicare mails a letter to people who automatically qualify for "Extra Help."

You may be able to get "Extra Help" to pay for your prescription drug premiums and costs. To see if you qualify for getting "Extra Help," call:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
- The Social Security Office at 1-800-772-1213, between 7 am to 7 pm, Monday through Friday. TTY users should call 1-800-325-0778 (applications); or
- Your State Medicaid Office (applications) (See Section 6 of this chapter for contact information);
- MyAdvocate at 1-866-783-0896, between 9 am to 6 pm, Monday through Friday. TTY users should call 1-855-368-9643. Priority Health works with MyAdvocate to help members identify and apply for programs that they may qualify for. For additional information please go to *MyAdvocateHelps.com*.

If you believe you have qualified for "Extra Help" and you believe that you are paying an incorrect cost-sharing amount when you get your prescription at a pharmacy, our plan has established a process that allows you to either request assistance in obtaining evidence of your proper copayment level, or, if you already have the evidence, to provide this evidence to us.

- The plan will first check the CMS system for an updated Low Income Subsidy (LIS) status. If the CMS system does not indicate an LIS status, the plan will require one of the following:
    - A copy of your Medicaid card;
    - A copy of a state document containing Medicaid status;
    - Other documentation provided by the State showing Medicaid status such as a letter;
    - Remittance from an institution showing Medicaid payments; or
    - A copy of a state document confirming Medicaid payment to a facility.

  You should send your document to the plan within 10 to 14 days after you have contacted us regarding the discrepancy in your LIS status.
- When we receive the evidence showing your copayment level, we will update our system so that you can pay the correct copayment when you get your next prescription at the pharmacy. If you overpay your copayment, we will reimburse you. Either we will forward a check to you in the amount of your overpayment or we will offset future copayments. If the pharmacy hasn't collected a copayment from you and is carrying your copayment as a debt owed by you, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Please contact Customer Service if you have questions (phone numbers are printed on the back cover of this booklet).

Medicare Coverage Gap Discount Program

The Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs to Part D members who have reached the coverage gap and are not receiving "Extra Help." For brand name drugs, the 50% discount provided by manufacturers excludes any

dispensing fee for costs in the gap. Members pay 35% of the negotiated price and a portion of the dispensing fee for brand name drugs.

If you reach the coverage gap, we will automatically apply the discount when your pharmacy bills you for your prescription and your Part D Explanation of Benefits (Part D EOB) will show any discount provided. Both the amount you pay and the amount discounted by the manufacturer count toward your out-of-pocket costs as if you had paid them and move you through the coverage gap. The amount paid by the plan (15%) does not count toward your out-of-pocket costs.

You also receive some coverage for generic drugs. If you reach the coverage gap, the plan pays 56% of the price for generic drugs and you pay the remaining 44% of the price. For generic drugs, the amount paid by the plan (56%) does not count toward your out-of-pocket costs. Only the amount you pay counts and moves you through the coverage gap. Also, the dispensing fee is included as part of the cost of the drug.

The Medicare Coverage Gap Discount Program is available nationwide. Because **Priority**Medicare (Employer HMO-POS) offers additional gap coverage during the Coverage Gap Stage, your out-of-pocket costs will sometimes be lower than the costs described here. Please go to Chapter 6, Section 6 for more information about your coverage during the Coverage Gap Stage.

If you have any questions about the availability of discounts for the drugs you are taking or about the Medicare Coverage Gap Discount Program in general, please contact Customer Service (phone numbers are printed on the back cover of this booklet).

What if you have coverage from an AIDS Drug Assistance Program (ADAP)?
What is the AIDS Drug Assistance Program (ADAP)?

The AIDS Drug Assistance Program (ADAP) helps ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the Michigan HIV/AIDS Drug Assistance Program (MIDAP). Note: To be eligible for the ADAP operating in your State, individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status.

If you are currently enrolled in an ADAP, it can continue to provide you with Medicare Part D prescription cost-sharing assistance for drugs on the ADAP formulary. In order to be sure you continue receiving this assistance, please notify your local ADAP enrollment worker of any changes in your Medicare Part D plan name or policy number, please call 888.826.6565.

For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 888.826.6565.

What if you get "Extra Help" from Medicare to help pay your prescription drug costs? Can you get the discounts?

No. If you get "Extra Help," you already get coverage for your prescription drug costs during the coverage gap.

What if you don't get a discount, and you think you should have?

If you think that you have reached the coverage gap and did not get a discount when you paid for your brand name drug, you should review your next *Part D Explanation of Benefits* (Part D EOB) notice. If the discount doesn't appear on your *Part D Explanation of Benefits*, you should contact us to make sure that your prescription records are correct and up-to-date. If we don't agree that you are owed a discount, you can appeal. You can get help filing an appeal from your State Health Insurance Assistance Program (SHIP) (telephone numbers are in Section 3 of this Chapter) or 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.

SECTION 8 How to contact the Railroad Retirement Board

The Railroad Retirement Board is an independent Federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

If you receive your Medicare through the Railroad Retirement Board, it is important that you let them know if you move or change your mailing address.

Method	Railroad Retirement Board – Contact Information
CALL	1-877-772-5772 Calls to this number are free. Available 9:00 am to 3:30 pm, Monday through Friday If you have a touch-tone telephone, recorded information and automated services are available 24 hours a day, including weekends and holidays.
TTY	1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are *not* free.
WEBSITE	*https://secure.rrb.gov/*

SECTION 9 Do you have "group insurance" or other health insurance from an employer?

If you (or your spouse) are enrolled in other group health insurance from an employer or a retiree group other that the Michigan Public School Employees' Retirement System, you are not eligible for enrollment in this plan and you must contact the Office of Retirement Services at 1-800-381-5111.

If you have other prescription drug coverage through your (or your spouse's) employer or retiree group, please contact **that group's benefits administrator.** The benefits administrator can help you determine how your current prescription drug coverage will work with our plan.

CHAPTER 3

Using the plan's coverage for your medical services

Chapter 3. Using the plan's coverage for your medical services

SECTION 1 Things to know about getting your medical care covered as a member of our plan

This chapter explains what you need to know about using the plan to get your medical care covered. It gives definitions of terms and explains the rules you will need to follow to get the medical treatments, services, and other medical care that are covered by the plan.

For the details on what medical care is covered by our plan and how much you pay when you get this care, use the benefits chart in the next chapter, Chapter 4 (*Medical Benefits Chart, what is covered and what you pay*).

Section 1.1 What are "network providers" and "covered services"?

Here are some definitions that can help you understand how you get the care and services that are covered for you as a member of our plan:

- **"Providers"** are doctors and other health care professionals licensed by the state to provide medical services and care. The term "providers" also includes hospitals and other health care facilities.
- **"Network providers"** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and your cost-sharing amount as payment in full. We have arranged for these providers to deliver covered services to members in our plan. The providers in our network bill us directly for care they give you. When you see a network provider, you pay only your share of the cost for their services.
- **"Covered services"** include all the medical care, health care services, supplies, and equipment that are covered by our plan. Your covered services for medical care are listed in the benefits chart in Chapter 4.

Section 1.2 Basic rules for getting your medical care covered by the plan

As a Medicare health plan, **Priority**Medicare (Employer HMO-POS) must cover all services covered by Original Medicare and must follow Original Medicare's coverage rules.

PriorityMedicare (Employer HMO-POS) will generally cover your medical care as long as:

- **The care you receive is included in the plan's Medical Benefits Chart** (this chart is in Chapter 4 of this booklet).
- **The care you receive is considered medically necessary**. "Medically necessary" means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- **You have a network primary care provider (a PCP) who is providing and overseeing your care.** As a member of our plan, you must choose a network PCP (for more information about this, see Section 2.1 in this chapter).
    - Your network PCP may recommend other providers in the plan's network, such as specialists, hospitals, skilled nursing facilities, or home health care agencies. For more information about this, see Section 2.3 of this chapter.
    - Referrals from your PCP are not required.
- **You can receive your care from in-network and out-of-network providers however, you will typically pay less if you use an in-network provider** (for more information about this, see Section 2 in this chapter). When you receive care from an in-network provider (a provider who is part of our plan's network) you will be covered under your in-network benefit (HMO). When you receive care from an out-of-network provider (a provider who is not part of our plan's network) you will be covered under your out-of-network benefit (POS). *Here are three exceptions:*
    - The plan covers emergency care or urgently needed services that you get from an out-of-network provider. In this situation, you will pay the same as you would pay if you got the care from an in-network provider. For more information about this, and to see what emergency or urgently needed services means, see Section 3 in this chapter.
    - 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. **Prior authorization should be obtained from Priority Health Medicare before seeking care when the service(s) require prior authorization.** In this situation, you will pay the same as you would pay if you got the care from an in-network provider. For information about getting approval to see an out-of-network doctor, see Section 2.4 in this chapter.
    - The plan covers kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area.

SECTION 2 Use providers in the plan's network to get your medical care

Section 2.1 You must choose a Primary Care Provider (PCP) to provide and oversee your medical care

What is a "PCP" and what does the PCP do for you?

When you become a member of **Priority**Medicare (Employer HMO-POS), your first step is to choose a primary care provider (PCP). Your PCP may be a family practitioner, a general practitioner, an internal medicine physician, an obstetrician/gynecologist, a nurse practitioner and/or a physician assistant working in a primary care setting who meets state requirements and is trained to give you basic medical care in a primary care setting. Your PCP is your partner in helping you stay healthy and will help you learn how to take control of your health. Because he or she knows your health history, you can get the care you need, when you need it.

Your PCP is able to help arrange or coordinate your services, including checking or consulting with other providers about your care and how it is going. If you need certain types of covered services or supplies, you may obtain a recommendation from your PCP to see a specialist or other provider. This may include x-rays, laboratory tests, therapies, care from doctors who are specialists, hospital admissions and follow-up care. In some cases, your PCP will need to get prior authorization (prior approval) from us. See Chapter 4 for details on the services that require prior authorization. When your PCP provides and coordinates your medical care, you should have all of your past medical records sent to your PCP's office.

How do you choose your PCP?

If you have a PCP selected, just call Customer Service to let them know the name of your PCP so we have it on record. If you need to find a new PCP, you can use our Find a Doctor tool on our website at *priorityhealth.com/mpsers*. It provides a list of physicians to choose from. If you need help choosing a PCP, please contact Customer Service (phone numbers are printed on the back inside cover of this booklet).

Changing your PCP

You may change your PCP for any reason, at any time. Also, it's possible that your PCP might leave our plan's network of providers and you would have to find a new PCP.

To change your PCP, please contact Customer Service or make your PCP change online through your member account at *priorityhealth.com/mpsers*. You will find a list of PCPs to choose from on our website at *priorityhealth.com/mpsers*. If you need a hard copy of our list of PCPs, or if you need help choosing a PCP, please contact Customer Service (phone numbers are printed on the back cover of this booklet). When you make a request to change your PCP, we will either make the change immediately or on the first day of the month following your request. The timing will depend on your needs.

Section 2.2 What kinds of medical care can you get without getting approval in advance from your PCP?

You can get the services listed below without getting approval in advance from your PCP.

- Routine women's health care, which includes breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams.
- Flu shots, Hepatitis B vaccinations, and pneumonia vaccinations.
- Emergency services from in-network providers or from out-of-network providers.
- Urgently needed services from in-network providers or from out-of-network providers when network providers are temporarily unavailable or inaccessible, (e.g., when you are temporarily outside of the plan's service area).
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area. (If possible, please call Customer Service before you leave the service area so we can help arrange for you to have maintenance dialysis while you are away. Phone numbers for Customer Service are printed on the back cover of this booklet.)

Section 2.3 How to get care from specialists and other network providers

A specialist is a doctor who provides health care services for a specific disease or part of the body. There are many kinds of specialists. Here are a few examples:

- Oncologists care for patients with cancer.
- Cardiologists care for patients with heart conditions.
- Orthopedists care for patients with certain bone, joint, or muscle conditions.

You may ask your PCP to recommend specialists and other network providers or you may search them out on your own. If you are uncertain as to whether the provider participates with our plan, call Customer Service (phone numbers are on the back of this booklet) or go to *priorityhealth.com/mpsers* and use our Find a Doctor tool. Remember that when you use in-network providers, you will pay less. When you use out-of-network providers, you will pay a deductible and you could pay a higher cost share for the same service.

Prior authorization requirements may apply for some services whether obtained in-network or out-of-network. See Chapter 4, Section 2.1, for details about the services that require prior authorization. Prior authorization decisions are made by Priority Health Medicare and other delegated entities. To obtain prior authorization, you or your provider should contact Priority Health Medicare. You may contact Customer Service (phone numbers are printed on the back cover of this booklet) to learn more about prior authorization requirements and how to ask for prior authorization of a service.

It is important to know what Medicare will or will not cover. Be sure to ask your in-network provider if a service is covered. Providers should give you a written notice or tell you verbally when Medicare does not cover a service.

What if a specialist or another network provider leaves our plan?

We may make changes to the hospitals, doctors, and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan but if your doctor or specialist does leave your plan you have certain rights and protections that are summarized below:

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider and managing your care.

If your specialist, hospital, or clinic leaves the plan, you should contact one of the following for assistance in finding a new provider:

- Primary care provider (PCP) to see if they can make a recommendation,
- Go to *priorityhealth.com/mpsers* and use our Find a Doctor tool or,
- Call Customer Service (phone numbers are printed on the back cover of this booklet)

Note: You may also be able to continue care with this specialist for up to 90 days if you are undergoing care with the specialist who is leaving the plan. Contact Customer Service (phone numbers can be found on the back of this booklet) to learn how to obtain a prior authorization for the continued services. Priority Health Medicare will not be able to pay any bills at the in-network benefit level from your current physician for services you receive after the Priority Health Medicare contract has ended unless you call us to make these temporary care plans before you receive services. If you choose to continue to see your current physician after the temporary arrangement, these services will be paid at the out-of-network benefit level after the deductible is met.

Section 2.4 How to get care from out-of-network providers

As a member of our plan, you can choose to receive care from out-of-network providers. However, if you use an out-of-network provider, you will pay an out-of-network deductible and your share of the costs for your covered services will be higher. See Chapter 4 (*Medicare benefits chart (what is covered and what you pay)* for details on what you'll pay out-of-network (POS).

Here are some important things to know about using out-of-network providers:

- The out-of-network provider must participate with Medicare. We cannot pay a provider who has decided not to participate with Medicare, except in emergent situations. You will be responsible for the full cost of the services you receive if the provider does not participate with Medicare. Check with the provider before receiving care to confirm that they have not opted out of or are not under sanction by Medicare.
- You don't need a referral when you get care from out-of-network providers, but prior authorization is required on certain services. See Chapter 4 (Medicare benefits chart (what is covered and what you pay)) for details. Remember that if you don't get prior authorization on a service that requires prior authorization that service may not be covered by us. Before getting services from out-of-network providers you may want to confirm that the services you are getting are covered and are medically necessary. This is important because:
    - If we later determine that the services are not covered or were not medically necessary, we may deny coverage and you will be responsible for the entire cost. If we say we will not cover your services, you have the right to appeal our decision not to cover your care. See Chapter 9 (What to do if you have a problem or complaint) to learn how to appeal.
- It is best to ask an out-of-network provider to bill the plan first. But, if you have already paid for the covered services, we will reimburse you for our share of the cost of the covered service as allowed under Medicare Fee-for-Service schedules of payment. Or if an out-of-network provider sends you a bill that you think we should pay, you can send it to us for payment. See Chapter 7 (Asking the plan to pay its share of a bill you have received for medical services or drugs) for information about what to do if you receive a bill or if you need to ask for reimbursement.
- If you are using an out-of-network provider for ambulance, emergency care, urgently needed care or out-of-area dialysis, you may not have to pay a higher cost-sharing amount. See Section 3 for more information about these situations.

It is important to know what Medicare will or will not cover. Be sure to ask your provider if a service is covered. Providers should give you a written notice or tell you verbally when Medicare does not cover a service.

SECTION 3 How to get covered services when you have an emergency or urgent need for care or during a disaster

Section 3.1 Getting care if you have a medical emergency

What is a "medical emergency" and what should you do if you have one?

A **"medical emergency"** is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do *not* need to get approval or a referral first from your PCP.
- **As soon as possible, make sure that our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. You can find our phone number on the back of your membership card.

What is covered if you have a medical emergency?

You may get covered emergency medical care whenever you need it, anywhere in the United States or world-wide emergency/urgent coverage. Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. For more information, see the Medical Benefits Chart in Chapter 4 of this booklet.

When you have an emergency outside the United States, you may have to pay for these services and seek reimbursement from Priority Health Medicare. We will reimburse you for your covered services less your emergency room copay. See Chapter 4 (*Medicare benefits chart what is covered and what you pay)* for details.

If you have an emergency, we will talk with the doctors who are giving you emergency care to help manage and follow up on your care. The doctors who are giving you emergency care will decide when your condition is stable and the medical emergency is over.

After the emergency is over you are entitled to follow-up care to be sure your condition continues to be stable. Your follow-up care will be covered by our plan. If your emergency care is provided by out-of-network providers, we will try to arrange for in-network providers to take over your care as soon as your medical condition and the circumstances allow. Your in-network benefit would apply for medically necessary acute follow-up care after an emergency or urgent care event if the care cannot be delayed without adverse medical effects. Your out-of-network (or POS) benefit would apply for acute follow-up care after an emergency or urgent care event if the care can be delayed without adverse medical effects and you are physically or reasonably able to return to the service area to receive care from contracted providers. If you are physically or reasonably able to return to the service area but choose to remain outside the service area after the event, the care you receive will be under your out-of-network (or POS) benefit. The out-of-network (or POS) benefit applies for treatment or follow-up care for a chronic or existing condition. See Chapter 4 (*Medicare benefits chart what is covered and what you pay)* for details on your POS (out-of-network) cost-share.

What if it wasn't a medical emergency?

Sometimes it can be hard to know if you have a medical emergency. For example, you might go in for emergency care – thinking that your health is in serious danger – and the doctor may say that it wasn't a medical emergency after all. If it turns out that it was not an emergency, as long as you reasonably thought your health was in serious danger, we will cover your care.

However, after the doctor has said that it was *not* an emergency, we will cover additional care *only* if you get the additional care in one of these two ways:

- You go to a network provider to get the additional care.
- – *or* – The additional care you get is considered "urgently needed services" and you follow the rules for getting this urgently needed services (for more information about this, see Section 3.2 below).

Section 3.2 Getting care when you have an urgent need for services

What are "urgently needed services"?

"Urgently needed services" are non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by in-network providers or by out-of-network providers when in-network providers are temporarily unavailable. The unforeseen condition could, for example, be an unforeseen flare-up of a known condition that you have.

What if you are in the plan's service area when you have an urgent need for care?

You should always try to obtain urgently needed services from network providers. However, if providers are temporarily unavailable or inaccessible and it is not reasonable to wait to obtain

care from your network provider when the network becomes available, we will cover urgently needed services that you get from an out-of-network provider.

When an urgent (non-emergent) situation arises and services are needed, go to an urgent care center. You may also contact your primary care provider (PCP) for direction. Your PCP may see you in his/her office or suggest you go to a participating urgent care center to be treated. Some hospitals have urgent care centers which you can access. You may also contact Customer Service (phone numbers are printed on the back cover of this booklet).

What if you are outside the plan's service area when you have an urgent need for care?

When you are outside the service area and cannot get care from an in-network provider, our plan will cover urgently needed services that you get from any provider at the lower in-network cost-sharing amount.

Our plan covers world-wide urgently needed services and emergency medical care when you receive the care outside of the United States. You are also covered for urgently needed services and emergency medical care anywhere in the United States.

Section 3.3 Getting care during a disaster

If the Governor of your state, the U.S. Secretary of Health and Human Services, or the President of the United States declares a state of disaster or emergency in your geographic area, you are still entitled to care from your plan.

Please visit the following website: *priorityhealth.com/mpsers* for information on how to obtain needed care during a disaster.

Generally, if you cannot use a network provider during a disaster, your plan will allow you to obtain care from out-of-network providers at in-network cost-sharing. If you cannot use a network pharmacy during a disaster, you may be able to fill your prescription drugs at an out-of-network pharmacy. Please see Chapter 5, Section 2.5 for more information.

SECTION 4 What if you are billed directly for the full cost of your covered services?

Section 4.1 You can ask us to pay our share of the cost of covered services

If you have paid more than your share for covered services, or if you have received a bill for the full cost of covered medical services, go to Chapter 7 (*Asking us to pay our share of a bill you have received for covered medical services or drugs*) for information about what to do.

Section 4.2 If services are not covered by our plan, you must pay the full cost

PriorityMedicare (Employer HMO-POS) covers all medical services that are medically necessary, are listed in the plan's Medical Benefits Chart (this chart is in Chapter 4 of this booklet), and are obtained consistent with plan rules. You are responsible for paying the full cost of services that aren't covered by our plan, either because they are not plan covered services, or they were obtained out-of-network and were not authorized.

If you have any questions about whether we will pay for any medical service or care that you are considering, you have the right to ask us whether we will cover it before you get it. You also have the right to ask for this in writing. If we say we will not cover your services, you have the right to appeal our decision not to cover your care.

Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) has more information about what to do if you want a coverage decision from us or want to appeal a decision we have already made. You may also call Customer Service to get more information (phone numbers are printed on the back cover of this booklet).

For covered services that have a benefit limitation, you pay the full cost of any services you get after you have used up your benefit for that type of covered service. Once a benefit limit has been reached any further service beyond the benefit limit will not count toward your out-of-pocket maximum. You can call Customer Service when you want to know how much of your benefit limit you have already used.

SECTION 5 How are your medical services covered when you are in a "clinical research study"?

Section 5.1 What is a "clinical research study"?

A clinical research study (also called a "clinical trial") is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. They test new medical care procedures or drugs by asking for volunteers to help with the study. This kind of study is one of the final stages of a research process that helps doctors and scientists see if a new approach works and if it is safe.

Not all clinical research studies are open to members of our plan. Medicare first needs to approve the research study. If you participate in a study that Medicare has *not* approved, *you will be responsible for paying all costs for your participation in the study*.

Once Medicare approves the study, someone who works on the study will contact you to explain more about the study and see if you meet the requirements set by the scientists who are running the study. You can participate in the study as long as you meet the requirements for the study

and you have a full understanding and acceptance of what is involved if you participate in the study.

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for the covered services you receive as part of the study. When you are in a clinical research study, you may stay enrolled in our plan and continue to get the rest of your care (the care that is not related to the study) through our plan.

If you want to participate in a Medicare-approved clinical research study, you do *not* need to get approval from us or your provider. The providers that deliver your care as part of the clinical research study do *not* need to be part of our plan's network of providers.

Although you do not need to get our plan's permission to be in a clinical research study, **you do need to tell us before you start participating in a clinical research study.**

If you plan on participating in a clinical research study, contact Customer Service (phone numbers are printed on the back cover of this booklet) to let them know that you will be participating in a clinical trial and to find out more specific details about what your plan will pay.

Section 5.2 When you participate in a clinical research study, who pays for what?

Once you join a Medicare-approved clinical research study, you are covered for routine items and services you receive as part of the study, including:

- Room and board for a hospital stay that Medicare would pay for even if you weren't in a study.
- An operation or other medical procedure if it is part of the research study.
- Treatment of side effects and complications of the new care.

Original Medicare pays most of the cost of the covered services you receive as part of the study. After Medicare has paid its share of the cost for these services, our plan will also pay for part of the costs. We will pay the difference between the cost-sharing in Original Medicare and your cost-sharing as a member of our plan. This means you will pay the same amount for the services you receive as part of the study as you would if you received these services from our plan.

> *Here's an example of how the cost-sharing works:* Let's say that you have a lab test that costs $100 as part of the research study. Let's also say that your share of the costs for this test is $20 under Original Medicare, but the test would be $10 under our plan's benefits. In this case, Original Medicare would pay $80 for the test and we would pay another $10. This means that you would pay $10, which is the same amount you would pay under our plan's benefits.

In order for us to pay for our share of the costs, you will need to submit a request for payment. With your request, you will need to send us a copy of your Medicare Summary Notices or other documentation that shows what services you received as part of the study and how much you owe. Please see Chapter 7 for more information about submitting requests for payment.

When you are part of a clinical research study, **neither Medicare nor our plan will pay for any of the following:**

- Generally, Medicare will *not* pay for the new item or service that the study is testing unless Medicare would cover the item or service even if you were *not* in a study.
- Items and services the study gives you or any participant for free.
- Items or services provided only to collect data, and not used in your direct health care. For example, Medicare would not pay for monthly CT scans done as part of the study if your medical condition would normally require only one CT scan.

Do you want to know more?

You can get more information about joining a clinical research study by reading the publication "Medicare and Clinical Research Studies" on the Medicare website (*https://www.medicare.gov*). You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTION 6 Rules for getting care covered in a "religious non-medical health care institution"

Section 6.1 What is a religious non-medical health care institution?

A religious non-medical health care institution is a facility that provides care for a condition that would ordinarily be treated in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against a member's religious beliefs, we will instead provide coverage for care in a religious non-medical health care institution. You may choose to pursue medical care at any time for any reason. This benefit is provided only for Part A inpatient services (non-medical health care services). Medicare will only pay for non-medical health care services provided by religious non-medical health care institutions.

Section 6.2 What care from a religious non-medical health care institution is covered by our plan?

To get care from a religious non-medical health care institution, you must sign a legal document that says you are conscientiously opposed to getting medical treatment that is "non-excepted."

- "Non-excepted" medical care or treatment is any medical care or treatment that is *voluntary* and *not required* by any federal, state, or local law.

- "Excepted" medical treatment is medical care or treatment that you get that is *not* voluntary or *is required* under federal, state, or local law.

To be covered by our plan, the care you get from a religious non-medical health care institution must meet the following conditions:

- The facility providing the care must be certified by Medicare.
- Our plan's coverage of services you receive is limited to *non-religious* aspects of care.
- If you get services from this institution that are provided to you in a facility, the following conditions apply:
    - You must have a medical condition that would allow you to receive covered services for inpatient hospital care or skilled nursing facility care.
    - – *and* – you must get approval in advance from our plan before you are admitted to the facility or your stay will not be covered.

Refer to the benefits chart in Chapter 4, Section 2.1, *Medical benefits chart,* under Inpatient care for information about cost-share. You have unlimited hospital days for this benefit.

SECTION 7 Rules for ownership of durable medical equipment

Section 7.1 Will you own the durable medical equipment after making a certain number of payments under our plan?

Durable medical equipment (DME) includes items such as oxygen equipment and supplies, wheelchairs, walkers, powered mattress systems, crutches, diabetic supplies, speech generating devices, IV infusion pumps, nebulizers, and hospital beds ordered by a provider for use in the home. The member always owns certain items, such as prosthetics. In this section, we discuss other types of DME that you must rent.

In Original Medicare, people who rent certain types of durable medical equipment own the equipment after paying copayments for the item for 13 months. As a member of **Priority**Medicare (Employer HMO-POS), you may acquire ownership of certain rented durable medical equipment items while a member of our plan after 13 consecutive payments. Call Customer Service (phone numbers are printed on the back cover of this booklet) to find out about the requirements you must meet and the documentation you need to provide.

Oxygen equipment and accessories: If you use oxygen, Medicare rules require you to rent oxygen equipment from a Medicare-approved supplier for 36 months. After 36 months, your supplier must continue to provide oxygen equipment and related supplies for an additional 24 months. Your supplier must provide equipment and supplies for up to a total of 5 years, as long as you have a medical need for oxygen. Oxygen equipment and accessories cannot be purchased.

What happens to payments you made for durable medical equipment if you switch to Original Medicare?

If you did not acquire ownership of the DME item while in our plan, you will have to make 13 new consecutive payments after you switch to Original Medicare in order to own the item. Payments you made while in our plan do not count toward these 13 consecutive payments.

If you made fewer than 13 payments for the DME item under Original Medicare *before* you joined our plan, your previous payments also do not count toward the 13 consecutive payments. You will have to make 13 new consecutive payments after you return to Original Medicare in order to own the item. There are no exceptions to this case when you return to Original Medicare.

CHAPTER 4

Medical Benefits Chart (what is covered and what you pay)

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

SECTION 1 Understanding your out-of-pocket costs for covered services

This chapter focuses on your covered services and what you pay for your medical benefits. It includes a Medical Benefits Chart that lists your covered services and shows how much you will pay for each covered service as a member of **Priority**Medicare (Employer HMO-POS). Later in this chapter, you can find information about medical services that are not covered. It also explains limits on certain services.

Section 1.1 Types of out-of-pocket costs you may pay for your covered services

To understand the payment information we give you in this chapter, you need to know about the types of out-of-pocket costs you may pay for your covered services.

- The **"deductible"** is the amount you must pay for medical services before our plan begins to pay its share. (Section 1.2 tells you more about your plan deductible.)
- A **"copayment"** is the fixed amount you pay each time you receive certain medical services. You pay a copayment at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your copayments.)
- **"Coinsurance"** is the percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your coinsurance.)

Most people who qualify for Medicaid or for the Qualified Medicare Beneficiary (QMB) program should never pay deductibles, copayments or coinsurance. Be sure to show your proof of Medicaid or QMB eligibility to your provider, if applicable. If you think that you are being asked to pay improperly, contact Customer Service.

Section 1.2 What is your plan deductible?

Your in-network deductible is $250. This is the amount you have to pay out-of-pocket before we will pay our share for your covered in-network medical services.

Until you have paid the in-network deductible amount, you must pay the full cost of your covered in-network services. Once you have paid your in-network deductible, we will begin to pay our share of the costs for covered in-network medical services and you will pay your share (your copayment or coinsurance amount) for the rest of the plan year.

Your out-of-network (POS) deductible is $500. This is the amount you have to pay out-of-pocket before we will pay our share for your covered out-of-network (POS) medical services.

Until you have paid the out-of-network deductible amount, you must pay the full cost of your covered out-of-network services. Once you have paid your out-of-network deductible, we will begin to pay our share of the costs for covered out-of-network medical services and you will pay your share (your coinsurance amount) for the rest of the plan year.

The deductible does not apply to some services. This means that we will pay our share of the costs for these services even if you haven't paid your deductible yet. The deductible does not apply to the following services:

- In- and out-of-network emergency room services
- In-and out-of-network Medicare Part B prescription drugs (except home infusion drugs)
- In- and out-of-network blood services
- In- and out-of-network urgently needed services
- In-network annual preventive physical exam
- In-network cardiac rehabilitation services
- In-network chiropractic services
- In-network diabetic self-management training, diabetic services and supplies
- In-network dialysis services and out-of-network dialysis services when temporarily outside the service area
- In-network enhanced disease management
- In-network health education
- In-network fitness (Silver&Fit®) membership and Silver&Fit home fitness kits
- In-network in-home safety assessment
- In-network kidney disease education
- In-network Medicare-covered hearing exam
- In-network Medicare-covered hospice consultation
- In-network Medicare-covered vision exam
- In-network nutritional education
- In-network outpatient mental health care
- In-network outpatient rehabilitation services
- In-network outpatient substance abuse services
- In-network Physician/Practitioner services with a PCP
- In-network Physician/Practitioner services with a specialist
- In-network podiatry services
- In-network post-discharge in-home medication reconciliation
- In-network preventive services
- In-network pulmonary rehabilitation services
- In-network remote access technologies
- In-network telemonitoring services
- Non-Medicare covered hearing aids/services
- Non-Medicare covered hearing exam

The following services are not covered and do not apply to your out-of-network deductible:

- Non-Medicare covered hearing aids received from a non-TruHearing provider.
- Out-of-network enhanced disease management
- Out-of-network health education
- Out-of-network fitness
- Out-of-network in-home safety assessment
- Out-of-network infertility treatment
- Out-of-network non-Medicare covered hearing exams
- Out-of-network nutritional education
- Out-of-network post-discharge in-home medication reconciliation
- Out-of-network remote access technologies
- Out-of-network telemonitoring
- Out-of-network tubal ligation
- Out-of-network vasectomy

Section 1.3 What is the most you will pay for covered medical services?

Because you are enrolled in a Medicare Advantage Plan, there is a limit to how much you have to pay out-of-pocket each year for in-network medical services that are covered by our plan (see the Medical Benefits Chart in Section 2, below). This limit is called the maximum out-of-pocket amount for medical services.

As a member of **Priority**Medicare (Employer HMO-POS), the most you will have to pay out-of-pocket for in-network covered plan services in 2018 is $2,100. The amounts you pay for deductibles, copayments and coinsurance for in-network covered plan services count toward this in-network maximum out-of-pocket amount. (The amounts you pay for your plan premiums and for your Part D prescription drugs do not count toward your in-network maximum out-of-pocket amount.) In addition, amounts you pay for some services do not count toward your in-network maximum out-of-pocket amount. These services are marked with an asterisk in the Medical Benefits Chart.) If you reach the in-network maximum out-of-pocket amount of $2,100, you will not have to pay any out-of-pocket costs for the rest of the year for in-network covered plan services. However, you must continue to pay your plan premium (if applicable) and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

As a member of **Priority**Medicare (Employer HMO-POS), the most you will have to pay out-of-pocket for out-of-network covered plan services in 2018 is $3,000. The amounts you pay for deductibles, copayments, and coinsurance for out-of-network covered plan services count toward this maximum out-of-pocket amount. The amounts you pay for your plan premiums and for your Part D prescription drugs do not count toward your maximum out-of-pocket amount. In addition, amounts you pay for some services do not count toward your maximum out-of-pocket amount. These services are marked with an asterisk in the Medical Benefits Chart.) If you reach the maximum out-of-pocket amount of $3,000, you will not have to pay any out-of-pocket costs for the rest of the year for out-of-network covered plan services. However, you must continue to pay your plan premium (if applicable) and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Section 1.4 What is the lifetime maximum benefit we will pay for POS (out-of-network) medical services?

There is a limit to how much we will pay for your POS (out-of-network) health care services in your lifetime. Your lifetime maximum benefit is $1,000,000 for covered services. After you reach this level, you will pay 100% for POS (out-of-network) services with the exception of ambulance, emergency care, urgently needed care, and post-stabilization care.

Section 1.5 Our plan does not allow providers to "balance bill" you

As a member of **Priority**Medicare (Employer HMO-POS), an important protection for you is that, after you meet any deductibles, you only have to pay your cost-sharing amount when you get services covered by our plan. We do not allow providers to add additional separate charges, called "balance billing." This protection (that you never pay more than your cost-sharing amount) applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don't pay certain provider charges.

Here is how this protection works.

- If your cost-sharing is a copayment (a set amount of dollars, for example, $15.00), then you pay only that amount for any covered services from a network provider.
- If your cost-sharing is a coinsurance (a percentage of the total charges), then you never pay more than that percentage. However, your cost depends on which type of provider you see:
    - If you receive the covered services from a network provider, you pay the coinsurance percentage multiplied by the plan's reimbursement rate (as determined in the contract between the provider and the plan).
    - If you receive the covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers. (Remember, the plan covers services from out-of-network providers only in certain situations, such as when you get a referral.)
    - If you receive the covered services from an out-of-network provider who does not participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers. (Remember, the plan covers services from out-of-network providers only in certain situations, such as when you get a referral.)
- If you believe a provider has "balance billed" you, call Customer Service (phone numbers are printed on the back cover of this booklet).

SECTION 2 Use the *Medical Benefits Chart* to find out what is covered for you and how much you will pay

Section 2.1 Your medical benefits and costs as a member of the plan

The Medical Benefits Chart on the following pages lists the services **Priority**Medicare (Employer HMO-POS) covers and what you pay out-of-pocket for each service. The services listed in the Medical Benefits Chart are covered only when the following coverage requirements are met:

- Your Medicare covered services must be provided according to the coverage guidelines established by Medicare.
- Your services (including medical care, services, supplies, and equipment) *must* be medically necessary. "Medically necessary" means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- You have a primary care provider (a PCP) who is providing and overseeing your care.
- Some of the services listed in the Medical Benefits Chart are covered *only* if your doctor or other provider gets approval in advance (sometimes called "prior authorization") from us.
- Covered services that need approval in advance are listed in the "*Prior Authorization Reference Chart*" below and are marked by a footnote in the medical benefits chart.

PRIOR AUTHORIZATION REFERENCE CHART	
Prior authorization is required for the following:	Look for this service in the *Medical Benefits Chart* below for details:
Artificial intervertebral disc	Outpatient hospital Outpatient surgery
Bariatric surgery	Outpatient hospital Outpatient surgery
Bone-anchored hearing aid	Outpatient hospital Outpatient surgery
Bronchial thermoplasty	Outpatient hospital Outpatient surgery
Cochlear implants	Outpatient hospital Outpatient surgery
Computed Tomography Angiography (CTA)	Outpatient diagnostic tests/therapeutic services
Computerized Tomography (CT) scan	Outpatient diagnostic tests/therapeutic services
Continuous glucose monitors (CGM)	Durable medical equipment (DME)
Cosmetic and reconstructive surgery	Outpatient hospital Outpatient surgery

PRIOR AUTHORIZATION REFERENCE CHART	
Prior authorization is required for the following:	Look for this service in the *Medical Benefits Chart* below for details:
Dental services (Medicare-covered)	Outpatient hospital Outpatient surgery Physician/practitioner services (specialist)
Diabetic shoes and/or shoe inserts	Diabetic services & supplies
Dialysis (initiation)	Services to treat kidney disease and conditions
Dialysis (vascular access)	Services to treat kidney disease and conditions
DME purchased for greater than $1,000	Durable medical equipment (DME)
DME rentals	Durable medical equipment (DME)
Echocardiography	Outpatient diagnostic tests/therapeutic services
Experimental or investigational services	Outpatient hospital Outpatient surgery
Fixed winged air transportation	Ambulance
Gender reassignment surgery	Outpatient hospital Outpatient surgery
Genetic testing	Outpatient diagnostic tests/therapeutic services
Heart catheterization	Outpatient hospital Outpatient surgery (not Medicare approved in an ambulatory surgical center)
Home infusion services	Home infusion services
Hysterectomy	Outpatient hospital Outpatient surgery
Implanted cardiac devices	Outpatient hospital Outpatient surgery Physician/practitioner services (specialist)
Infusion pumps (implantable)	Outpatient hospital Outpatient surgery
Injectable drugs	Medicare Part B prescription drugs
Inpatient hospital care (elective)	Inpatient hospital care
Inpatient mental health care admissions (elective)	Inpatient mental health care
Insulin pumps	Durable medical equipment (DME)
Magnetic Resonance Angiography (MRA)	Outpatient diagnostic tests/therapeutic services
Magnetic Resonance Imaging (MRI)	Outpatient diagnostic tests/therapeutic services
Neurosurgeon office visits for spinal conditions	Physician/practitioner services
Non emergent ambulance services	Ambulance
Nuclear cardiology studies	Outpatient diagnostic tests/therapeutic services
Oncology treatment, radiation and medical	Outpatient diagnostic tests/therapeutic services Outpatient hospital Outpatient surgery
Orthopedic office visits for spinal conditions	Physician/practitioner services

PRIOR AUTHORIZATION REFERENCE CHART	
Prior authorization is required for the following:	Look for this service in the *Medical Benefits Chart* below for details:
Orthopedic procedures (such as but not limited to, joint arthroplasties, joint arthroscopies, laminectomies and related decompression procedures, shoulder repairs, vertebral fusions and associated procedures)	Outpatient hospital Outpatient surgery Physician/practitioner services (specialist)
Oxygen and related supplies	Durable medical equipment (DME)
Pain management procedures for back and neck	Outpatient hospital Outpatient surgery Physician/practitioner services (specialist)
Parenteral/enteral feedings	Prosthetic devices
Partial hospitalization	Partial hospitalization
Positron Emission Tomography (PET) scan	Outpatient diagnostic tests/therapeutic services
Prosthetics and orthotics purchased for greater than $1,000	Prosthetic devices
Radiofrequency catheter ablation for cardiac arrhythmia	Outpatient hospital Outpatient surgery
Skilled nursing facility admissions	Skilled nursing facility (SNF) care
Skilled nursing visits after the first 30 visits	Home health
Sleep studies (done in a facility)	Outpatient diagnostic tests/therapeutic services
Stimulators	Durable medical equipment (DME)
Stimulators (implanted)	Outpatient hospital Outpatient surgery
Transcatheter heart procedures	Outpatient hospital Outpatient surgery
Transcranial magnetic stimulation	Outpatient hospital Outpatient surgery Physician/practitioner services (specialist)
Transesophageal	Outpatient diagnostic tests/therapeutic services
Transplant surgery and transplant evaluation (except corneal transplants)	Inpatient hospital care Outpatient hospital Outpatient surgery
Transplant evaluations (except corneal transplant evaluations)	Physician/practitioner services (specialist)
Transthoracic	Outpatient diagnostic tests/therapeutic services

- You may also be charged “administrative fees” for missed appointments or for not paying your required cost-sharing at the time of service. Call Customer Service if you have questions regarding these administrative fees. (Phone numbers for Customer Service are printed on the back cover of this booklet.)

Other important things to know about our coverage:

- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay *more* in our plan than you would in Original Medicare. For others, you pay *less.* (If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You 2018* Handbook. View it online at *https://www.medicare.gov* or ask for 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.)
- For all in-network preventive services that are 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 will apply for the care received for the existing medical condition.
- Sometimes, Medicare adds coverage under Original Medicare for new services during the year. If Medicare adds coverage for any services during 2018, either Medicare or our plan will cover those services.

You will see this apple next to the preventive services in the benefits chart.

You will see this star next to benefits that our plan offers above Medicare-covered services (supplemental).

* You will see an asterisk on services that do not apply to your in-network or out-of-network maximum out-of-pocket amount.

Medical Benefits Chart

Services that are covered for you	**What you must pay** when you get these services	
Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist. See Chapter 12 for the *Definitions of important words*.	**HMO (in-network)**: $0 for a Medicare-covered abdominal aortic aneurysm screening. If you receive additional services, cost-sharing for those services may apply. Deductible does not apply.	**POS (out-of-network)**: After your yearly deductible is met, you pay 30% for a Medicare-covered abdominal aortic aneurysm screening. If you receive additional services, cost-sharing for those services may apply.

Services that are covered for you	**What you must pay** when you get these services	
Allergy shots and serum You are covered for allergy shots and Medicare-covered Part B serum (antigen) when medically necessary. **Note:** For Medicare-covered allergy testing, see Outpatient diagnostic tests and therapeutic services and supplies.	**HMO (in-network)**: 10% for each Medicare-covered Part B drug obtained in a plan provider's office. $0 for administration of Medicare-covered Part B drug. If you receive additional services, cost-sharing for those services may apply. Deductible does not apply.	**POS (out-of-network)**: 30% for each Medicare-covered Part B drug obtained in a provider's office. $0 for administration of Medicare-covered Part B drug. If you receive additional services, cost-sharing for those services may apply. Deductible does not apply.
Ambulance services • Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by the plan. • Non-emergency transportation by ambulance is appropriate if it is documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required. **Note:** The Medicare ambulance benefit is a transportation benefit and without a transport we cannot pay for the ambulance service. Therefore, if you refuse ambulance transport or your care is stabilized in your home or another residence and you are not transported to a facility, your ambulance service will not be covered.	**HMO (in-network)**: After your yearly deductible is met, you pay $100 for each Medicare-covered one-way ambulance trip.	**POS (out-of-network)**: After your yearly deductible is met, you pay $100 for each Medicare-covered one-way ambulance trip. Out-of-network cost-sharing will apply toward your in-network out-of-pocket maximum.

Services that are covered for you	**What you must pay** when you get these services	
Ambulance services *(continued)* Emergent ambulance services furnished outside the U.S. and its territories are covered when furnished in connection with an emergent transport. Payment is made for necessary ambulance services that meet the other coverage requirements of the Medicare program, and are furnished in connection with an emergent facility. Return trips from a foreign hospital are not covered. Prior authorization may apply. See the *Prior Authorization Reference Chart* at the beginning of Chapter 4, Section 2.1 for more information. See Chapter 12 for the *Definitions of important words*.		
★ **Annual preventive physical exam** We cover an annual preventive physical exam. The exam includes measurement of height, weight, body mass index, blood pressure, visual acuity screening and other routine measurements. The annual preventive physical exam DOES NOT include lab tests and immunizations. See "Outpatient diagnostic tests and therapeutic services and supplies" and "Immunizations" for cost-share. **Note:** An immunization not directly related to the treatment of an injury or direct exposure to a disease or condition received in a provider's office or outpatient setting is generally considered a Part D drug. When this happens, you will pay the cost of the immunization and administration to the provider. You should then ask us to reimburse you (see Chapter 7 on how to do this). We will reimburse you as described in Chapter 6, Section 8.1.	**HMO (in-network)**: $0 for an annual preventive physical exam. If you receive additional services, cost-sharing for those services may apply. Deductible does not apply.	**POS (out-of-network)**: After your yearly deductible is met, you pay 30% for an annual preventive physical exam. If you receive additional services, cost-sharing for those services may apply.

Services that are covered for you	**What you must pay** when you get these services	
Annual wellness visit If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. You also have the option to discuss advanced care planning. This is covered once every 12 months. The annual wellness visit DOES NOT include lab tests and immunizations. See "Outpatient diagnostic tests and therapeutic services and supplies" and "Immunizations" for cost-share. **Note:** An immunization not directly related to the treatment of an injury or direct exposure to a disease or condition received in a provider's office or outpatient setting is generally considered a Part D drug. When this happens, you will pay the cost of the immunization and administration to the provider. You should then ask us to reimburse you (see Chapter 7 on how to do this). We will reimburse you as described in Chapter 6, Section 8.1. Your first annual wellness visit can't take place within 12 months of your "Welcome to Medicare" preventive visit. However, you don't need to have had a "Welcome to Medicare" visit to be covered for annual wellness visits after you've had Part B for 12 months.	**HMO (in-network)**: $0 for a Medicare-covered annual wellness visit. If you receive additional services, cost-sharing for those services may apply. Deductible does not apply.	**POS (out-of-network)**: After your yearly deductible is met, you pay 30% for a Medicare-covered annual wellness visit. If you receive additional services, cost-sharing for those services may apply.
Bone mass measurement For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results. See Chapter 12 for the *Definitions of important words*.	**HMO (in-network)**: $0 for Medicare-covered screening bone mass measurements. If you receive additional services, cost-sharing for those services may apply. Deductible does not apply.	**POS (out-of-network)**: After your yearly deductible is met, you pay 30% for Medicare-covered screening bone mass measurements. If you receive additional services, cost-sharing for those services may apply.

Services that are covered for you	**What you must pay** when you get these services	
Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women age 40 and older • Clinical breast exams once every 24 months A breast cancer screening mammogram is done based on your age or family history and when you have no signs or symptoms (asymptomatic) of breast disease. A diagnostic mammogram is done when you do have signs or symptoms of breast disease or a personal history of breast cancer or personal history of biopsy-proven benign breast disease. If you have a lump removed and sent to the lab for testing, this is considered diagnostic, regardless of whether you were having a routine or screening mammogram or a diagnostic mammogram. See "Outpatient diagnostic tests and therapeutic services and supplies." See Chapter 12, *Definitions of important words*, for the definition of screening and diagnostic.	**HMO (in-network)**: $0 for a Medicare-covered breast cancer screening. If you receive additional services, cost-sharing for those services may apply. Deductible does not apply.	**POS (out-of-network)**: After your yearly deductible is met, you pay 30% for a Medicare-covered breast cancer screening. If you receive additional services, cost-sharing for those services may apply.
Cardiac rehabilitation services Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.	**HMO (in-network)**: $0 for each Medicare-covered cardiac rehabilitation service and intensive cardiac rehabilitation service. If you receive additional services, cost-sharing for those services may apply. Deductible does not apply.	**POS (out-of-network)**: After your yearly deductible is met, you pay 30% for each Medicare-covered cardiac rehabilitation service and intensive cardiac rehabilitation service. Limited to 60 visits per plan year.

Services that are covered for you	**What you must pay** when you get these services	
Cardiac rehabilitation services *(continued)*		If you receive additional services, cost-sharing for those services may apply.
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating well.	**HMO (in-network):** $0 for an annual Medicare-covered cardiovascular disease risk reduction visit with a primary care provider. If you receive additional services, cost-sharing for those services may apply. Deductible does not apply.	**POS (out-of-network):** After your yearly deductible is met, you pay 30% for an annual Medicare-covered cardiovascular disease risk reduction visit with a primary care provider. If you receive additional services, cost-sharing for those services may apply.
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months). See Chapter 12 for the *Definitions of important words*.	**HMO (in-network)**: $0 for a Medicare-covered cardiovascular disease screening. If you receive additional services, cost-sharing for those services may apply. Deductible does not apply.	**POS (out-of-network)**: After your yearly deductible is met, you pay 30% for a Medicare-covered cardiovascular disease screening. If you receive additional services, cost-sharing for those services may apply.

Services that are covered for you	**What you must pay** when you get these services	
Cervical and vaginal cancer screening Covered services include: • For all women: Pap tests and pelvic exams are covered once every 24 months • If you are at high risk of cervical or vaginal cancer or you are of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months See Chapter 12, *Definitions of important words*, for the definition of screening and diagnostic.	**HMO (in-network)**: $0 for Medicare-covered Pap and pelvic screenings. If you receive additional services, cost-sharing for those services may apply. Deductible does not apply.	**POS (out-of-network)**: After your yearly deductible is met, you pay 30% for Medicare-covered Pap and pelvic screenings. If you receive additional services, cost-sharing for those services may apply.
Chiropractic services Covered services include: • We cover only manual manipulation of the spine to correct subluxation • X-rays are not covered	**HMO (in-network)**: $20 for each Medicare-covered service. If you receive additional services, cost-sharing for those services may apply. Deductible does not apply.	**POS (out-of-network)**: After your yearly deductible is met, you pay 50% for each Medicare-covered service. Limited to a maximum of $300 per plan year, after that you pay 100% for services. If you receive additional services, cost-sharing for those services may apply.
Colorectal cancer screening For people 50 and older, the following are covered: • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months One of the following every 12 months: • Guaiac-based fecal occult blood test (gFOBT) • Fecal immunochemical test (FIT) DNA based colorectal screening every 3 years	**HMO (in-network)**: $0 for each Medicare-covered colorectal cancer screening. If you receive additional services, cost-sharing for those services may apply. Deductible does not apply.	**POS (out-of-network)**: After your yearly deductible is met, you pay 30% for each Medicare-covered colorectal cancer screening.

Services that are covered for you	**What you must pay** when you get these services	
Colorectal cancer screening *(continued)* For people at high risk of colorectal cancer, we cover: • Screening colonoscopy (or screening barium enema as an alternative) every 24 months For people not at high risk of colorectal cancer, we cover: • Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy For people who are ages 50-85, have no symptoms and are at an average risk of developing colorectal cancer, we cover: • Cologuard® – a non-invasive colon cancer at-home test every 3 years. **Note:** In certain circumstances a screening colonoscopy can become a diagnostic colonoscopy during the procedure itself. • A **screening colonoscopy** is a procedure to find colon polyps, cancer, or other colorectal related conditions in individuals with no signs or symptoms of either and it is no cost to you. • A **diagnostic colonoscopy** is performed in order to explain symptoms identified by your physician (for example, blood in stools, change in bowel movements, iron deficiency due to anemia, persistent abdominal pain, etc.) or other colorectal related conditions. If your physician orders a diagnostic colonoscopy your outpatient hospital cost share applies. See “Outpatient diagnostic tests and therapeutic services and supplies” and/or “Outpatient surgery,		If you receive additional services, cost-sharing for those services may apply.

Services that are covered for you	**What you must pay** when you get these services	
Colorectal cancer screening *(continued)* including services provided at hospital outpatient facilities and ambulatory surgical centers" for cost-share. See Chapter 12, *Definitions of important words*, for the definition screening and diagnostic.		
Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and referrals. See Chapter 12 for the *Definitions of important words*.	**HMO (in-network)**: $0 for an annual Medicare-covered depression screening with a primary care provider. If you receive additional services, cost-sharing for those services may apply. Deductible does not apply.	**POS (out-of-network)**: After your yearly deductible is met, you pay 30% for an annual Medicare-covered depression screening with a primary care provider. If you receive additional services, cost-sharing for those services may apply.
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months. See Chapter 12 for the *Definitions of important words*.	**HMO (in-network)**: $0 for a Medicare-covered diabetes screening. If you receive additional services, cost-sharing for those services may apply. Deductible does not apply.	**POS (out-of-network)**: After your yearly deductible is met, you pay 30% for a Medicare-covered diabetes screening. If you receive additional services, cost-sharing for those services may apply.

Services that are covered for you	**What you must pay** when you get these services	
Diabetes self-management training, diabetic services and supplies For all people who have diabetes (insulin and non-insulin users). Covered services include: • Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors. • For people with diabetes who have severe diabetic foot disease: One pair per plan year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. • Diabetes self-management training is covered under certain conditions. • For other diabetic equipment and supplies (examples include but are not limited to insulin pumps and continuous glucose monitor (CGM)) see "Durable medical equipment and related supplies." Prior authorization may apply. See the *Prior Authorization Reference Chart* at the beginning of Chapter 4, Section 2.1 for more information.	**HMO (in-network)**: $0 for Medicare-covered diabetes self-management training. $0 for diabetic services and supplies (for example; blood glucose supplies and therapeutic shoes & inserts). Diabetic test strips are limited to One Touch (JJHCS) and Breeze/Contour (Bayer) products when dispensed by a retail pharmacy or mail-order pharmacy. If you receive additional services, cost-sharing for those services may apply. Deductible does not apply.	**POS (out-of-network)**: After your yearly deductible is met, you pay 30% for Medicare-covered diabetes self-management training, diabetic services and supplies (for example; blood glucose supplies and therapeutic shoes & inserts). If you receive additional services, cost-sharing for those services may apply.
Durable medical equipment (DME) and related supplies (For a definition of "durable medical equipment," see Chapter 12 of this booklet.) Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, walkers, wound care	**HMO (in-network)**: After your yearly deductible is met, you pay 20% for Medicare-covered equipment and supplies. If you receive additional services, cost-sharing for those services may apply.	**POS (out-of-network)**: After your yearly deductible is met, you pay 50% for Medicare-covered equipment and supplies. If you receive additional services, cost-sharing for those services may apply.

Services that are covered for you	**What you must pay** when you get these services	
Durable medical equipment (DME) and related supplies *(continued)* supplies, and insulin pumps and continuous glucose monitors (CGM). We cover all medically necessary DME covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you. Our *Provider/Pharmacy Directory* includes DME suppliers. The most recent list of suppliers is available on our website at *priorityhealth.com/mpsers*. We also follow Medicare rules related to criteria for coverage of Medicare-covered items or supplies. For some equipment Medicare requires a certain amount of usage in order to continue a rental (for example, CPAP, etc.). If you do not meet the Medicare requirements for usage, you may not be able to continue the rental of this device. You must obtain DME & related supplies from a licensed DME provider. Prior authorization may apply. See the *Prior Authorization Reference Chart* at the beginning of Chapter 4, Section 2.1 for more information.		
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb.	**In- and out-of-service area**: $75 for each Medicare-covered emergency room visit. Deductible does not apply. Out-of-network cost-sharing will apply toward your in-network out-of-pocket maximum. You do not pay this amount if you are admitted to the hospital within 24 hours for the same condition.	

Services that are covered for you	**What you must pay** when you get these services	
Emergency care *(continued)* The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network. ★ You have emergency care coverage in the United States and worldwide. Note: If you get Part D Medicare-covered self-administered drugs in an outpatient setting, they may be covered under your prescription drug benefit on this plan, not under your medical benefit. Examples include but are not limited to inhalers, insulin, oral antibiotics, oral pain relievers, topical medications (i.e. eye drops), and certain vaccines. See Chapter 6, Section 8.1, for more information on what happens when you get a Part D drug in a medical setting.	If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must have your inpatient care at the out-of-network hospital authorized by the plan and your cost is the cost-sharing you would pay at an in-network hospital.	
★ **Enhanced disease management** Priority Health Medicare care managers are available to provide education, care coordination and support for all health conditions, with a particular emphasis on the management of chronic conditions. Care managers focus on assisting members in improving their health outcomes, quality of life and improving their functional capabilities. See Chapter 12, for the *Definitions of important words*.	**HMO (in-network)**: $0 for these services. Deductible does not apply.	**POS (out-of-network)**: Not covered

Services that are covered for you	**What you must pay** when you get these services	
Health and wellness education programs These are programs focused on health conditions such as high blood pressure, cholesterol, asthma, COPD, diabetes, heart failure, kidney disease, and special diets for specific conditions. Support for stress, anxiety, and depression is also available. We offer these programs to enrich the health and lifestyles of our members. • Enhanced disease management • Fitness (Silver&Fit®) • Health education • In-home safety assessment • Nutritional education • Post-discharge in-home medication reconciliation • Remote access technologies • Telemonitoring For more information, please refer to the individual program listed in this medical benefits chart.	**HMO (in-network)**: $0 for enhanced disease management, fitness center membership or up to two fitness kits (Silver&Fit®)*, health education, in-home safety assessment, nutritional education, post-discharge in-home medication reconciliation, remote access technologies & telemonitoring. Deductible does not apply.	**POS (out-of-network)**: Not covered
Health education • The Health Journal, a wellness magazine outlining appropriate care for wellness, prevention, and chronic illness. • Reminder mailings regarding missed preventive or chronic illness services. • Members have access to a personalized online experience to participate in health challenges, view fitness instructional videos, and learn more about a variety of health topics through articles, quizzes and more. Look for this in your MyHealth account at *priorityhealth.com*.	**HMO (in-network)**: $0 for these services. Deductible does not apply.	**POS (out-of-network)**: Not covered

Services that are covered for you	**What you must pay** when you get these services	
Hearing services **Medicare-covered hearing services:** Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider. **Routine hearing services** (Administered by TruHearing. Call 855.205.6382 (TTY: 711), Monday through Friday 8 a.m. to 8 p.m. to locate a TruHearing provider and to schedule an appointment for a hearing exam or to discuss hearing aids.) Hearing Exam: One routine hearing exam every two years with a TruHearing provider. Hearing Aids: Up to two TruHearing Flyte hearing aids every year (one per ear per year). Benefit is limited to the TruHearing Flyte Advanced and Premium hearing aids, which come in various styles and colors. You must see a TruHearing provider to use this benefit. Call 855.205.6382 to schedule an appointment. Hearing aid purchases includes: • 3 provider visits within first year of hearing aid purchase • 45 day trial period • 3 year extended warranty • 48 batteries per aid Benefit does not include or cover any of the following: • Ear molds • Hearing aid accessories • Additional provider visits • Extra batteries	**HMO (in-network)**: $0 for each Medicare-covered diagnostic hearing exam. If you receive additional services, cost-sharing for those services may apply. Deductible does not apply.	**POS (out-of-network)**: After your yearly deductible is met, you pay 30% for each Medicare-covered diagnostic hearing exam. If you receive additional services, cost-sharing for those services may apply.
	In-network (TruHearing provider): $0 for one routine hearing exam every 2 years* Hearing aids – *you pay the following:* $499 per aid for Flyte Advanced Aids* $799 per aid for Flyte Premium Aids* **Out-of-network (non-TruHearing provider):** Not covered	

Services that are covered for you	**What you must pay** when you get these services	
Hearing services *(continued)* • Hearing aids that are not the TruHearing Flyte hearing aids • Hearing aid return fees • Loss & damage warranty claims Costs associated with excluded items are the responsibility of the member and not covered by the plan. If you would like more details about your routine hearing benefits, view the Priority Health Hearing plan certificate at *priorityhealth.com/mpsers*. You can also request a copy be mailed to you by calling Customer Service.		
Hepatitis C screening For people who are at high risk for Hepatitis C infection, including persons with a current or past history of illicit injection drug use; and persons who have a history of receiving a blood transfusion prior to 1992, we cover: • One screening exam for those born between 1945 and 1965 • Additional screenings every 12 months for persons who have continued illicit injection drug use since the prior negative screening test See Chapter 12, for the *Definitions of important words*.	**HMO (in-network)**: $0 for Medicare-covered Hepatitis C screenings. If you receive additional services, cost-sharing for those services may apply. Deductible does not apply.	**POS (out-of-network)**: After your yearly deductible is met, you pay 30% for Medicare-covered Hepatitis C screenings. If you receive additional services, cost-sharing for those services may apply.

Services that are covered for you	**What you must pay** when you get these services	
HIV screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: • One screening exam every 12 months For women who are pregnant, we cover: • Up to three screening exams during a pregnancy See Chapter 12, for the *Definitions of important words*.	**HMO (in-network)**: $0 for Medicare-covered HIV screenings. If you receive additional services, cost-sharing for those services may apply. Deductible does not apply.	**POS (out-of-network)**: After your yearly deductible is met, you pay 30% for Medicare-covered HIV screenings. If you receive additional services, cost-sharing for those services may apply.
Home health agency care Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but are not limited to: • Routine medical supplies (e.g. supplies customarily used in small quantities during the course of home health care) • Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies **Note:** Non-routine medical supplies used to treat a specific illness or injury ordered by a physician such as but not limited to wound care and DME equipment (for example oxygen equipment, nebulizer, etc.) are not covered	**HMO (in-network)**: After your yearly deductible is met, you pay $0 for each Medicare-covered service. If you receive additional services, cost-sharing for those services may apply.	**POS (out-of-network)**: After your yearly deductible is met, you pay 30% for each Medicare-covered service. If you receive additional services, cost-sharing for those services may apply.

Services that are covered for you	**What you must pay** when you get these services	
Home health agency care *(continued)* under the home health benefit. See "Durable medical equipment and related supplies" for details. Prior authorization may apply. See the *Prior Authorization Reference Chart* at the beginning of Chapter 4, Section 2.1 for more information.		
Home infusion services This benefit includes supplies/services associated with home infusion drugs and only drugs classified as home infusion drugs are covered under the home infusion services benefit (see your 2018 Drug List). See Medicare-covered Part B drugs for cost-sharing associated with other drugs that may be administered in the home. You must be home-bound which means leaving home is a major effort, in order to receive this benefit. Prior authorization may apply. See the *Prior Authorization Reference Chart* at the beginning of Chapter 4, Section 2.1 for more information.	**HMO (in-network)**: After your yearly deductible is met, you pay $0 for home infusion services.	**POS (out-of-network)**: After your yearly deductible is met, you pay 30% for home infusion services.
Hospice care You may receive care from any Medicare-certified hospice program. You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • Drugs for symptom control and pain relief • Short-term respite care • Home care	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not **Priority**Medicare (Employer HMO-POS).	
	HMO (in-network): $0 for the initial Medicare-covered hospice consultation. If you receive additional services, cost-sharing for those services may apply. Deductible does not apply.	**POS (out-of-network):** After your yearly deductible is met, you pay 30% for the initial Medicare-covered hospice consultation. If you receive additional services, cost-sharing for those services may apply.

Services that are covered for you	**What you must pay** when you get these services	
Hospice care *(continued)* For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis: Original Medicare (rather than our plan) will pay for your hospice services and any Part A and Part B services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for. For services that are covered by Medicare Part A or B and are not related to your terminal prognosis: If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network: • If you obtain the covered services from a network provider, you only pay the plan cost-sharing amount for in-network services • If you obtain the covered services from an out-of-network provider, you pay the cost-sharing under Fee-for-Service Medicare (Original Medicare) For services that are covered by **Priority**Medicare (Employer HMO-POS) but are not covered by Medicare Part A or B: **Priority**Medicare (Employer HMO-POS) will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost-sharing amount for these services. For drugs that may be covered by the plan's Part D benefit: Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5, Section 9.4 *(What if you're in Medicare-certified hospice*).		

Services that are covered for you	**What you must pay** when you get these services	
Hospice care *(continued)* **Note:** If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services. Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.		
Immunizations Covered Medicare Part B services include: • Pneumonia vaccine • Flu shots, once a year in the fall or winter • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B • Other vaccines if you are at risk and they meet Medicare Part B coverage rules We also cover some vaccines under our Part D prescription drug benefit. **Note:** An immunization **not** directly related to the treatment of an injury or direct exposure to a disease or condition received in a provider's office or outpatient setting is generally considered a Part D drug. When this happens, you will pay the cost of the immunization and administration to the provider. You should then ask us to reimburse you (see Chapter 7 on how to do this). We will reimburse you as described in Chapter 6, Section 8.1.	**HMO (in-network):** $0 for Medicare-covered Part B immunizations. If you receive additional services, cost-sharing for those services may apply. Deductible does not apply.	**POS (out-of-network):** After your yearly deductible is met, you pay 30% for Medicare-covered Part B immunizations. If you receive additional services, cost-sharing for those services may apply.

Services that are covered for you	**What you must pay** when you get these services	
★ **Infertility treatment** Diagnostic evaluation of infertility is covered if the procedure has been determined to be appropriate and medically necessary to diagnose the underlying cause of infertility. Infertility treatment, such as a laparoscopy for surgical intervention for females or a varicocelectomy for males, is covered if you are diagnosed as infertile and have not had an elective sterilization. Assisted reproduction or artificial conception procedures or related services and supplies are not covered.	**HMO (in-network)**: After your yearly deductible is met, you pay 50% for infertility counseling and treatment services.	**POS (out-of-network):** Not covered
★ **In-home safety assessment** An in-home safety assessment will be performed by a health care provider if you do not qualify for one under original Medicare's home health benefit. The assessment will focus on both medical & behavioral hazards, such as your risk for falls or injuries and how to prevent them and identify and/or modify home hazards throughout your home.	**HMO (in-network):** $0 for these services. Deductible does not apply.	**POS (out-of-network):** Not covered
Inpatient hospital care Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day. Covered services include but are not limited to: • Semi-private room (or a private room if medically necessary) • Meals including special diets • Physician services • Regular nursing services	**HMO (in-network):** For each Medicare-covered hospital admission/stay, after your yearly deductible is met, you pay 10% per stay. There is no limit to the number of days covered by the plan.	**POS (out-of-network):** For each Medicare-covered hospital admission/stay, after your yearly deductible is met, you pay 30% per stay. There is no limit to the number of days covered by the plan.

Services that are covered for you	**What you must pay** when you get these services	
Inpatient hospital care *(continued)* • Costs of special care units (such as intensive care or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy • Inpatient substance abuse services • Blood - We cover all blood (whole blood and packed red cells) and all other components (plasma, red blood cells, white blood cells, and platelets), including storage and administration, that you need in a plan year. Coverage begins with the first pint of blood that you need. • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If **Priority**Medicare (Employer HMO-POS) provides transplant services at a location outside the pattern of care for transplants in your community and you chose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. We will cover reimbursement		If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at an in-network hospital.

Services that are covered for you	**What you must pay** when you get these services	
Inpatient hospital care *(continued)* for reasonable transportation (personal car, rental car, bus or air) up to a combined maximum total of $60 per day, not to exceed 4 days of land travel to/from the Medicare-approved facility or $300 per person for air travel. We will cover reimbursement for lodging (hotel, motel, extended stay facilities, or apartments leased during the period of the episode of care) up to a combined maximum total of $100 per day for episode of care (i.e., hospitalization for the actual transplant). The daily combined maximum for the member and/or eligible companion are payable up to a combined maximum of $160 per day for lodging and travel per person for the episode of care period. The maximum total reimbursement for reasonable transportation and lodging related to the episode of care for a Medicare-approved transplant is $6,000. The following services are not considered directly related to travel or lodging and are not covered: meals, alcoholic beverages, car maintenance or repairs; travel, room/board incurred by the live donor; transportation for the potential cadaveric donor to the transplant hospital. The episode of care is defined as the period beginning four (4) days prior to the Medicare-approved transplant and ending one year after the date of the transplant if the member is still covered under a Priority Health Medicare plan. **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an "outpatient" or under "observation." If you are not sure if you are an outpatient or under observation, you should ask the hospital staff. See Chapter 12, *Definitions of important words*,		

Services that are covered for you	**What you must pay** when you get these services	
Inpatient hospital care *(continued)* for the definitions of "**Hospital Inpatient Stay," "Observation"** and "**Outpatient."** You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at *https://www.medicare.gov/Pubs/pdf/11435.pdf* or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week. Prior authorization may apply. See the *Prior Authorization Reference Chart* at the beginning of Chapter 4, Section 2.1 for more information. *Pre-surgical education is recommended for new elective implantable cardioverter defibrillators (ICD's) with or without biventricular pacing, total hip replacement, total knee replacement, and spinal surgeries. The education is an interactive, online program for members to fully understand their elective procedures, the risks and complications, and what they can do before and after surgery for optimal results.*		
Inpatient mental health care Covered services include mental health care services that require a hospital stay. There is a 190-day lifetime limit for inpatient services in a psychiatric hospital. The 190-day limit does not apply to inpatient mental health services provided in a psychiatric unit of a general hospital. Prior authorization may apply. See the *Prior Authorization Reference Chart* at the beginning of Chapter 4, Section 2.1 for more information. *Call our Behavioral Health department toll-free at 800.673.8043.*	**HMO (in-network):** For each Medicare-covered hospital admission/stay, after your yearly deductible is met, you pay 10% per stay.	**POS (out-of-network):** For each Medicare-covered hospital admission/stay, after your yearly deductible is met, you pay 30% per stay.

Services that are covered for you	**What you must pay** when you get these services	
Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF). Covered services include, but are not limited to: • Physician services • Diagnostic tests (like lab tests) • X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings • Splints, casts and other devices used to reduce fractures and dislocations • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy, speech therapy, and occupational therapy Prior authorization may apply. See the *Prior Authorization Reference Chart* at the beginning of Chapter 4, Section 2.1 for more information.	**HMO (in-network):** After your yearly deductible is met, you pay: $0 for Medicare-covered services received from the inpatient facility. $0 for Medicare-covered prosthetic devices and supplies received from an outpatient provider when implanted as part of a surgery. 20% for all other Medicare-covered prosthetic devices and supplies and Medicare-covered DME received from an outpatient provider. If you receive additional services, cost-sharing for those services may apply.	**POS (out-of-network):** After your yearly deductible is met, you pay: 30% per stay for Medicare-covered services received from the inpatient facility. 50% for all Medicare-covered prosthetic devices and supplies and Medicare-covered DME received from an outpatient provider. If you receive additional services, cost-sharing for those services may apply.

Services that are covered for you	**What you must pay** when you get these services	
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor. We cover 3 hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next plan year.	**HMO (in-network)**: $0 for Medicare-covered medical nutrition therapy. If you receive additional services, cost-sharing for those services may apply. Deductible does not apply.	**POS (out-of-network)**: After your yearly deductible is met, you pay 30% for Medicare-covered medical nutrition therapy. If you receive additional services, cost-sharing for those services may apply.
Medicare Diabetes Prevention Program (MDPP) MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	**HMO (in-network)**: $0 for Medicare-covered MDPP services. If you receive additional services, cost-sharing for those services may apply. Deductible does not apply.	**POS (out-of-network)**: After your yearly deductible is met, you pay 30% for Medicare-covered MDPP services. If you receive additional services, cost-sharing for those services may apply.
Medicare Part B prescription drugs These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include: • Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital	**HMO (in-network)**: **Part B home infusion drugs:** After your yearly deductible is met, you pay $0.	**POS (out-of-network)**: **Part B home infusion drugs:** After your yearly deductible is met, you pay 30%.

Services that are covered for you	**What you must pay** when you get these services	
Medicare Part B prescription drugs *(continued)* outpatient, or ambulatory surgical center services. **Note:** For drugs infused in the home refer to **Home Infusion Services** in this *Medical Benefits Chart.* • Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan • Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive Drugs, if you were enrolled in Medicare Part A at the time of the organ transplant • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug • Antigens • Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases Chapter 5 explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is explained in Chapter 6. Prior authorization may apply. See the *Prior Authorization Reference Chart* at the beginning of Chapter 4, Section 2.1 for more information.	**Part B chemotherapy:** $0 for each Medicare-covered Part B drug. $0 for administration of chemotherapy drugs. Deductible does not apply. **Other Part B drugs:** 10% for each Medicare-covered Part B drug obtained in a plan provider's office, deductible does not apply. If you receive additional services, cost-sharing for those services may apply. 20% for each Medicare-covered Part B drug obtained at a plan pharmacy or plan mail-order service, deductible does not apply.	**Part B chemotherapy:** $0 for each Medicare-covered Part B drug. $0 for administration of chemotherapy drugs. Deductible does not apply. **Other Part B drugs:** 30% for each Medicare-covered Part B drug obtained in a provider's office, deductible does not apply. If you receive additional services, cost-sharing for those services may apply. 20% for each Medicare-covered Part B drug obtained at a pharmacy or mail-order service, deductible does not apply.

Services that are covered for you	**What you must pay** when you get these services	
★ **Nutrition education** This general nutrition education includes up to 6, half-hour, classes or counseling sessions in-home or in an outpatient setting provided by a registered dietician, if recommended by a physician. For people with diabetes, renal (kidney) disease or after a kidney transplant, see "Medical Nutrition Therapy."	**HMO (in-network):** $0 for nutrition education. Deductible does not apply.	**POS (out-of-network):** Not covered
Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	**HMO (in-network):** $0 for Medicare-covered obesity screenings and therapy when provided in a primary care setting. If you receive additional services, cost-sharing for those services may apply. Deductible does not apply.	**POS (out-of-network):** After your yearly deductible is met, you pay 30% for Medicare-covered obesity screenings and therapy when provided in a primary care setting. If you receive additional services, cost-sharing for those services may apply.
★ **Orthognathic surgery** Orthognathic surgery, also known as jaw surgery, is covered when medically/ clinically necessary to correct functional impairment. Covered services include referral care for evaluation and treatment, cephalometric x-rays, surgery and post-operative care, including post-operative radiographs, and the surgical facility/hospital.	**HMO (in-network):** After your yearly deductible is met, you pay 20% for orthognathic services.	**POS (out-of-network):** After your yearly deductible is met, you pay 50% for orthognathic services.

Services that are covered for you	**What you must pay** when you get these services	
Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but are not limited to: • X-rays • Radiation (radium and isotope) therapy including technician materials and supplies. A daily specialist copay/coinsurance will also apply for radiation therapy management. Other radiation copay/coinsurance may apply. (See Chapter 12, *Definitions of important words*, for the definition of radiation therapy management.) • Surgical supplies, such as dressings • Splints, casts and other devices used to reduce fractures and dislocations • Laboratory tests • Pathology • Blood - We cover all blood (whole blood and packed red cells) and all other components (plasma, red blood cells, white blood cells, and platelets), including storage and administration, that you need in a plan year. Coverage begins with the first pint of blood that you need. • Other outpatient diagnostic tests (for example; allergy testing, genetic testing, sleep studies) • Diagnostic radiology services (for example; MRI, CT) Prior authorization may apply. See the *Prior Authorization Reference Chart* at the beginning of Chapter 4, Section 2.1 for more information.	**HMO (in-network):** After your yearly deductible is met, you pay: 10% per day, per provider, for Medicare-covered x-ray services. $0 for Medicare-covered surgical supplies, splints, casts and other devices used to reduce fractures & dislocations. 10% per day, per provider, for Medicare-covered lab services. 10% per day, per provider, for Medicare-covered, radiation therapy services. A daily specialist copay will also apply for radiation therapy management. $150 for each Medicare-covered diagnostic radiology service (such as a CT scan or MRI). 10% per day, per provider, for Medicare-covered pathology services. 10% per day, per provider, for diagnostic procedures & tests.	**POS (out-of-network):** After your yearly deductible is met, you pay: 30% per day, per provider, for Medicare-covered x-ray services. $0 for Medicare-covered surgical supplies, splints, casts and other devices used to reduce fractures & dislocations. 30% per day, per provider, for Medicare-covered lab services. 30% per day, per provider, for Medicare-covered, radiation therapy services. A daily specialist coinsurance will also apply for radiation therapy management. 30% for each Medicare-covered diagnostic radiology service (such as a CT scan or MRI). 30% per day, per provider, for Medicare-covered pathology services.

Services that are covered for you	**What you must pay** when you get these services	
Outpatient diagnostic tests and therapeutic services and supplies *(continued)*	$0 for blood, deductible does not apply. If you receive additional services, cost-sharing for those services may apply.	30% per day, per provider, for diagnostic procedures & tests. $0 for blood, deductible does not apply. If you receive additional services, cost-sharing for those services may apply.
Outpatient hospital services We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but are not limited to the following and cost-sharing may apply: • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery • Laboratory and diagnostic tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it • X-rays and other radiology services billed by the hospital • Medical supplies such as splints and casts • Certain drugs and biologicals that you can't give yourself **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient" or under	**HMO (in-network):** After your yearly deductible is met, you pay: 10% for each Medicare-covered outpatient hospital facility visit. $0 for each observation visit. For specific covered services performed in an outpatient hospital or observation visit & the cost-sharing associated with those services, see applicable sections within this medical benefits chart.	**POS (out-of-network):** After your yearly deductible is met, you pay 30% for each Medicare-covered outpatient hospital facility visit and observation visit. For specific covered services performed in an outpatient hospital or observation visit & the cost-sharing associated with those services, see applicable sections within this medical benefits chart.

Services that are covered for you	**What you must pay** when you get these services	
Outpatient hospital services *(continued)* "observation." If you are not sure if you are an outpatient or under observation, you should ask the hospital staff. See Chapter 12, *Definitions of important words*, for the definitions of "**Hospital Inpatient Stay," "Observation"** and "**Outpatient."** You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at *https://www.medicare.gov/Pubs/pdf/11435.pdf* or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week. **Note:** If you get Part D Medicare-covered self-administered drugs in an outpatient setting, they may be covered under your prescription drug benefit on this plan, not under your medical benefit. Examples include but are not limited to inhalers, insulin, oral antibiotics, oral pain relievers, topical medications (i.e. eye drops), and certain vaccines. See Chapter 6, Section 8.1, for more information on what happens when you get a Part D drug in a medical setting. Prior authorization may apply. See the *Prior Authorization Reference Chart* at the beginning of Chapter 4, Section 2.1 for more information.		

Services that are covered for you	**What you must pay** when you get these services	
Outpatient mental health care Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws. **Note:** If you get Part D Medicare-covered self-administered drugs in an outpatient setting, they may be covered under your prescription drug benefit on this plan, not under your medical benefit. Examples include but are not limited to inhalers, insulin, oral antibiotics, oral pain relievers, topical medications (i.e. eye drops), and certain vaccines. See Chapter 6, Section 8.1, for more information on what happens when you get a Part D drug in a medical setting.	**HMO (in-network):** $20 for each Medicare-covered individual visit. $20 for each Medicare-covered group visit. Deductible does not apply.	**POS (out-of-network):** After your yearly deductible is met, you pay 30% for each Medicare-covered individual and group visit.
Outpatient rehabilitation services Covered services include: physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs). Original Medicare therapy limits apply to rehabilitation services. See Chapter 12, *Definition of important words,* Therapy cap limits.	**HMO (in-network):** $35 per day for Medicare-covered physical therapy services. $35 per day for Medicare-covered occupational therapy services. $35 per day for Medicare-covered speech language therapy services.	**POS (out-of-network):** After your yearly deductible is met, you pay: 30% per day for Medicare-covered physical therapy services. 30% per day for Medicare-covered occupational therapy services.

Services that are covered for you	**What you must pay** when you get these services	
Outpatient rehabilitation services *(continued)*	Deductible does not apply.	30% per day for Medicare-covered speech language therapy services. Limited to 60 total visits per plan year.
Outpatient substance abuse services Medically necessary services to treat alcohol or drug abuse are covered when provided in an outpatient setting (i.e., provider office, clinic, or hospital outpatient department). **Note:** If you get Part D Medicare-covered self-administered drugs in an outpatient setting, they may be covered under your prescription drug benefit on this plan, not under your medical benefit. Examples include but are not limited to inhalers, insulin, oral antibiotics, oral pain relievers, topical medications (i.e. eye drops), and certain vaccines. See Chapter 6, Section 8.1, for more information on what happens when you get a Part D drug in a medical setting.	**HMO (in-network):** $20 for each Medicare-covered individual visit. $20 for each Medicare-covered group visit. Deductible does not apply.	**POS (out-of-network):** After your yearly deductible is met, you pay 30% for each Medicare-covered individual and group visit.
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers **Please note the following:** • If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an "outpatient" or under "observation." If you are not sure if you are an outpatient or under observation, you should ask the hospital staff.	**HMO (in-network):** After your yearly deductible is met, you pay: 10% for each Medicare-covered ambulatory surgical center visit. 10% for each Medicare-covered outpatient hospital facility visit. $0 for each observation visit.	**POS (out-of-network):** After your yearly deductible is met, you pay: 30% for each Medicare-covered ambulatory surgical center visit. 30% for each Medicare-covered outpatient hospital facility visit and observation visit.

Services that are covered for you	**What you must pay** when you get these services	
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers *(continued)* See Chapter 12, *Definitions of important words,* for the definitions of "**Hospital Inpatient Stay," "Observation"** and "**Outpatient."** • An ambulatory surgery center or outpatient hospital facility visit copay/coinsurance may apply for surgical procedures in an outpatient setting. • If you get Part D Medicare-covered self-administered drugs in an outpatient setting, they may be covered under your prescription drug benefit on this plan, not under your medical benefit. Examples include but are not limited to inhalers, insulin, oral antibiotics, oral pain relievers, topical medications (i.e. eye drops), and certain vaccines. See Chapter 6, Section 8.1, for more information on what happens when you get a Part D drug in a medical setting. Prior authorization may apply. See the *Prior Authorization Reference Chart* at the beginning of Chapter 4, Section 2.1 for more information. *Pre-surgical education is recommended for new elective implantable cardioverter defibrillators (ICD's) with or without biventricular pacing, total hip replacement, total knee replacement, and spinal surgeries. The education is an interactive, online program for members to fully understand their elective procedures, the risks and complications, and what they can do before and after surgery for optimal results.* See Chapter 12, for the *Definitions of important words*.	For specific covered services performed in observation, an outpatient hospital facility, or ambulatory surgical center & for the cost-sharing associated with those services, see applicable sections within this medical benefits chart.	For specific covered services performed in observation, an outpatient hospital facility, or ambulatory surgical center & for the cost-sharing associated with those services, see applicable sections within this medical benefits chart.

Services that are covered for you	**What you must pay** when you get these services	
Partial hospitalization services "Partial hospitalization" is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center, that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization. Prior authorization may apply. See the *Prior Authorization Reference Chart* at the beginning of Chapter 4, Section 2.1 for more information. *Call our Behavioral Health department toll-free at 800.673.8043.*	**HMO (in-network):** After your yearly deductible is met, you pay 10% for Medicare-covered partial hospitalization services.	**POS (out-of-network):** After your yearly deductible is met, you pay 30% for Medicare-covered partial hospitalization services.
Physician/Practitioner services, including doctor's office visits Covered services include: • Medically-necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams performed by your PCP or specialist, if your doctor orders it to see if you need medical treatment • Certain telehealth services including consultation, diagnosis, and treatment by a physician or practitioner for patients in certain rural areas or other locations approved by Medicare • Second opinion prior to surgery • Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician)	**HMO (in-network):** $20 for each Medicare-covered visit with a PCP. $35 for each Medicare-covered visit with a specialist. $0 for surgical procedures performed by a physician/practitioner in a provider's office. $45 for each urgently needed Medicare-covered visit in a physician's office after hours. If you receive additional services, cost-sharing for those services may apply. Deductible does not apply.	**POS (out-of-network):** After your yearly deductible is met, you pay: 30% for each Medicare-covered visit. 30% for surgical procedures performed by a physician/practitioner in a provider's office. $45 for each urgently needed Medicare-covered visit in a physician's office after hours, deductible does not apply. If you receive additional services, cost-sharing for those services may apply.

Services that are covered for you	**What you must pay** when you get these services	
Physician/Practitioner services, including doctor's office visits *(continued)* **Note:** To determine if your provider is a PCP or a Specialist, see Chapter 3, Section 2.1 (You must choose a Primary Care Provider (PCP) to provide and oversee your medical care). *Pre-surgical education is recommended for new elective implantable cardioverter defibrillators (ICD's) with or without biventricular pacing, total hip replacement, total knee replacement, and spinal surgeries. The education is an interactive, online program that will help you understand your procedure, the risks and complications, and what you can do before and after surgery to ensure the best results.* Prior authorization may apply. See the *Prior Authorization Reference Chart* at the beginning of Chapter 4, Section 2.1 for more information.		
Podiatry services Covered services include: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs). • Routine foot care (limit of 6 nail debridement and 6 callous removal per plan year) for members with specific medical conditions affecting the lower limbs, such as diabetes with circulation compromised. See Chapter 12, *Definitions of important words*, for the definition of debridement.	**HMO (in-network):** $0 for each Medicare-covered visit. $0 for nail debridement & callous removal, for members with specific medical conditions affecting the lower limbs. If you receive additional services, cost-sharing for those services may apply. Deductible does not apply.	**POS (out-of-network):** After your yearly deductible is met, you pay: 30% for each Medicare-covered visit. 30% for nail debridement & callous removal, for members with specific medical conditions affecting the lower limbs. If you receive additional services, cost-sharing for those services may apply.

Services that are covered for you	**What you must pay** when you get these services	
★ **Post-discharge in-home medication reconciliation** Immediately following a medical or behavioral hospitalization or SNF inpatient stay, a qualified health care provider, in cooperation with your physician, will review/reconcile a complete medication regimen prior to, and post, inpatient stay. They will ensure new medications are obtained and discontinued medications are discarded. Medication reconciliation may be done in the home with a goal of eliminating side effects and interactions that could result in illness or injury.	**HMO (in-network):** $0 for a post-discharge in-home medication reconciliation. Deductible does not apply.	**POS (out-of-network):** Not covered
Prostate cancer screening exams For men age 50 and older, covered services include the following - once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test You get a PSA screening if you have no signs or symptoms (asymptomatic) of prostate cancer or related prostate conditions. If you've had a previous PSA that was elevated, or are being treated for conditions which may lead to prostate cancer which include but are not limited to prostatitis (inflammation of the prostate) or benign prostatic hyperplasia (enlargement of the prostate), or have had prostate cancer, your PSA test may be considered diagnostic. See "Outpatient diagnostic tests and therapeutic services and supplies. See Chapter 12, *Definitions of important words*, for the definition of screening and diagnostic.	**HMO (in-network):** $0 for an annual Medicare-covered prostate cancer screening. If you receive additional services, cost-sharing for those services may apply. Deductible does not apply.	**POS (out-of-network):** After your yearly deductible is met, you pay 30% for an annual Medicare-covered prostate cancer screening. If you receive additional services, cost-sharing for those services may apply.

Services that are covered for you	**What you must pay** when you get these services	
Prosthetic devices and related supplies Devices (other than dental) that replace all or part of a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see "Vision Care" later in this section for more detail. Prior authorization may apply. See the *Prior Authorization Reference Chart* at the beginning of Chapter 4, Section 2.1 for more information. See Chapter 12, *Definitions of important words*.	**HMO (in-network):** After your yearly deductible is met, you pay: $0 for devices implanted as part of a surgery in an ambulatory surgery center or outpatient hospital facility. 20% for all other Medicare-covered prosthetic devices and supplies. If you receive additional services, cost-sharing for those services may apply.	**POS (out-of-network):** After your yearly deductible is met, you pay 50% for Medicare-covered prosthetic devices and supplies. If you receive additional services, cost-sharing for those services may apply.
Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.	**HMO (in-network):** $35 for each Medicare-covered pulmonary rehabilitation service. If you receive additional services, cost-sharing for those services may apply. Deductible does not apply.	**POS (out-of-network):** After your yearly deductible is met, you pay 30% for each Medicare-covered pulmonary rehabilitation service. Limited to 60 visits per plan year. If you receive additional services, cost-sharing for those services may apply.

Services that are covered for you	**What you must pay** when you get these services	
★ **Remote access technologies** This offers you the opportunity to meet with your doctor through electronic forms of communication for an appointment, assessment or evaluation in support of your health concerns. This does not replace an in-person visit, but allows you and your doctor to connect when it is not possible for you to meet in person. See Chapter 12, *Definitions of important words*, for the definition of remote access technologies.	**HMO (in-network):** $0 for each appointment, assessment or evaluation. Deductible does not apply.	**POS (out-of-network):** Not covered
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol, but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting. See Chapter 12, *Definitions of important words*.	**HMO (in-network):** $0 for Medicare-covered screening and counseling to reduce alcohol misuse visits in a primary care setting. If you receive additional services, cost-sharing for those services may apply. Deductible does not apply.	**POS (out-of-network):** After your yearly deductible is met, you pay 30% for Medicare-covered screening and counseling to reduce alcohol misuse visits in a primary care setting. If you receive additional services, cost-sharing for those services may apply.
Screening for lung cancer with low dose computed tomography (LDCT) For qualified individuals, a LDCT is covered every 12 months. **Eligible members are:** people aged 55 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 30 pack-years and who currently smoke or have quit smoking within the last 15 years, who receive a written order for LDCT during a lung cancer screening	**HMO (in-network):** $0 for the Medicare covered counseling and shared decision-making visit or for the LDCT. If you receive additional services, cost-sharing for those services may apply. Deductible does not apply.	**POS (out-of-network):** After your yearly deductible is met, you pay 30% for the Medicare covered counseling and shared decision-making visit or for the LDCT.

Services that are covered for you	**What you must pay** when you get these services	
Screening for lung cancer with low dose computed tomography (LDCT) *(continued)* counseling and shared decision making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. *For LDCT lung cancer screenings after the initial LDCT screening*: the member must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.		If you receive additional services, cost-sharing for those services may apply.
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to 2 individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office. See Chapter 12, *Definitions of important words*.	**HMO (in-network):** $0 for Medicare-covered screening for sexually transmitted infections (STIs) and counseling for STIs in a primary care setting. If you receive additional services, cost-sharing for those services may apply. Deductible does not apply.	**POS (out-of-network):** After your yearly deductible is met, you pay 30% for Medicare-covered screening for sexually transmitted infections (STIs) and counseling for STIs in a primary care setting. If you receive additional services, cost-sharing for those services may apply.

<table>
<tr><th>Services that are covered for you</th><th colspan="2">What you must pay when you get these services</th></tr>
<tr><td rowspan="2">Services to treat kidney disease and conditions
Covered services include:
• Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime.
• Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3)
• Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care)
• Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments)
• Home dialysis equipment and supplies
• Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply)

Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section, “Medicare Part B prescription drugs.”</td><td><u>HMO (in-network)</u>:
$0 for Medicare-covered kidney disease education services.

If you receive additional services, cost-sharing for those services may apply.

Deductible does not apply.</td><td><u>POS (out-of-network)</u>:
After your yearly deductible is met, you pay 30% for Medicare-covered kidney disease education services.

If you receive additional services, cost-sharing for those services may apply.</td></tr>
<tr><td colspan="2"><u>Kidney dialysis services</u>

<u>HMO (in-network) and out-of-service-area</u>:
• $0 for each Medicare-covered renal dialysis service with an in-network provider. Deductible does not apply.
• $0 for each Medicare-covered renal dialysis service with an out-of-network provider when you are temporarily out of the service area. Deductible does not apply.
<u>In-area out-of-network provider (POS)</u>:
After your yearly deductible is met, you pay $0 for each Medicare-covered renal dialysis service with an out-of-network provider within the service area.</td></tr>
<tr><td>Silver&Fit® (Fitness)

The Silver&Fit Exercise and Healthy Aging Program strives to help members achieve their exercise goals and supports them on their journey to better health by including the following:
• Membership at a local participating Silver&Fit fitness center</td><td><u>HMO (in-network)</u>:
$0 for a fitness membership at a participating Silver&Fit® center or up to two Silver&Fit® home fitness kits.*

Deductible does not apply.</td><td><u>POS (out-of-network)</u>:
Not covered</td></tr>
</table>

Services that are covered for you	**What you must pay** when you get these services	
★ **Silver&Fit® (Fitness)** ***(continued)*** • Group fitness classes, designed specifically for Silver&Fit members, at the fitness center (may not be available at all centers) • Healthy aging educational materials available online or, if requested, mailed to your home • The Silver&Fit Home Fitness Program for members who are unable to participate in a fitness center or prefer to workout at home • A website designed specifically for Silver&Fit members. Go to *www.silverandfit.com.* • A customer service hotline to answer your questions about the program. Call Silver&Fit® at 888.894.0525 (TTY 711), Monday – Friday 8 a.m. – 9 p.m. (Eastern Time).		
Skilled nursing facility (SNF) care (For a definition of "skilled nursing facility care," see Chapter 12 of this booklet. Skilled nursing facilities are sometimes called "SNFs.") The number of days covered per benefit period† is based on medical and rehab necessity determined prior to admission and on an ongoing basis. ★ **No prior hospital stay is required.** Covered services include but are not limited to: • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs administered to you as part of your plan of care (This includes substances that	**HMO (in-network):** For Medicare-covered services for each benefit period†, after your yearly deductible is met, you pay 10% per stay. Limited to 100 days per benefit period renewable after 60 days of non-confinement.	**POS (out-of-network):** For Medicare-covered services for each benefit period†, after your yearly deductible is met, you pay 30% per stay. Limited to 45 days per benefit period renewable after 60 days of non-confinement.

Services that are covered for you	**What you must pay** when you get these services	
Skilled nursing facility (SNF) care *(continued)* are naturally present in the body, such as blood clotting factors.) • Blood - We cover all blood (whole blood and packed red cells) and all other components (plasma, red blood cells, white blood cells, and platelets), including storage and administration, that you need in a plan year. Coverage begins with the first pint of blood that you need. • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to pay in-network cost-sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment. • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care). • A SNF where your spouse is living at the time you leave the hospital. †A benefit period starts the day you go into a skilled nursing facility. The benefit period ends when you go for 60 days in a row without skilled nursing care. If you go into a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.		

Services that are covered for you	**What you must pay** when you get these services	
Skilled nursing facility (SNF) care *(continued)* Prior authorization may apply. See the *Prior Authorization Reference Chart* at the beginning of Chapter 4, Section 2.1 for more information.		
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) If you use tobacco, but do not have signs or symptoms of tobacco-related disease: We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits. If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period, however, you will pay the applicable cost-sharing. Each counseling attempt includes up to four face-to-face visits.	**HMO (in-network):** $0 for Medicare-covered smoking and tobacco use cessation counseling. If you receive additional services, cost-sharing for those services may apply. Deductible does not apply.	**POS (out-of-network):** After your yearly deductible is met, you pay 30% for Medicare-covered smoking and tobacco use cessation counseling. If you receive additional services, cost-sharing for those services may apply.
Telemonitoring services Telemonitoring services for heart failure, uncontrolled diabetes, chronic obstructive pulmonary dysfunction (COPD), cardiovascular conditions and hypertension include specially adapted equipment, telecommunications and technology to monitor health conditions across a distance.	**HMO (in-network)**: $0 for telemonitoring services. Deductible does not apply.	**POS (out-of-network)**: Not covered

Services that are covered for you	**What you must pay** when you get these services	
★ **Temporomandibular joint disorder** Medical care or services provided to evaluate or treat temporomandibular joint dysfunction (TMJD) or temporomandibular joint syndrome (TMJS) are covered. Dental care or dental services for temporomandibular joint disorders are not covered.	**HMO (in-network):** After your yearly deductible is met, you pay 20% for TMJD or TMJS services.	**POS (out-of-network):** After your yearly deductible is met, you pay 50% for TMJD or TMJS services.
★ **Tubal ligation** †Inpatient facility charges are only covered when in connection with delivery or other inpatient surgery.	**HMO (in-network):** After your yearly deductible is met, you pay: 10% for physician services. 10% outpatient facility services. 10% for inpatient facility charges.†	**POS (out-of-network):** Not covered
Urgently needed services Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible. Cost sharing for necessary urgently needed services furnished out-of-network is the same as for such services furnished in-network. ★ You have coverage for urgently needed services in the United States and worldwide.	**In- and out-of-service area:** $45 for each Medicare-covered urgent care provider visit. Deductible does not apply. Out-of-network cost-sharing will apply toward your in-network out-of-pocket maximum. You do not pay this amount if you are admitted to the hospital within 24 hours for the same condition.	

Services that are covered for you	**What you must pay** when you get these services	
Urgently needed services *(continued)* Urgent care services are generally services furnished within a relatively short period of time (Medicare defines this as 12 hours) in order to avoid the likely onset of an emergency medical condition. **Note:** If you get Part D Medicare-covered self-administered drugs in an outpatient setting, they may be covered under your prescription drug benefit on this plan, not under your medical benefit. Examples include but are not limited to inhalers, insulin, oral antibiotics, oral pain relievers, topical medications (i.e. eye drops), and certain vaccines. See Chapter 6, Section 8.1, for more information on what happens when you get a Part D drug in a medical setting.		
★ **Vasectomy** Covered only when performed in a physician's office or when in connection with other covered inpatient or outpatient surgery.	**HMO (in-network):** After your yearly deductible is met, you pay 10% for a vasectomy.	**POS (out-of-network):** Not covered
Vision care Covered services include: • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts. See Section 3.1 of this chapter, *Benefits we do not cover (exclusions)*. • For people who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African-Americans who are age 50 and older and Hispanic Americans who are 65 or older.	**HMO (in-network):** $0 for annual glaucoma screenings for people at risk. $0 for Medicare-covered eyeglasses or contact lenses after cataract surgery. $35 for each Medicare-covered exam to diagnose and treat diseases or conditions of the eye.	**POS (out-of-network):** After your yearly deductible is met, you pay 30% for annual glaucoma screenings for people at risk, Medicare-covered eyeglasses or contact lenses after cataract surgery and each Medicare-covered exam to diagnose and treat diseases or conditions of the eye.

Services that are covered for you	**What you must pay** when you get these services	
Vision care *(continued)* • For people with diabetes, screening for diabetic retinopathy is covered once per year. • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) • If corrective lenses/frames (and replacements) are needed after a cataract removal without a lens implant we will cover one pair of eyeglasses or contact lenses.	If you receive additional services, cost-sharing for those services may apply. Deductible does not apply.	If you receive additional services, cost-sharing for those services may apply.
"Welcome to Medicare" Preventive Visit The plan covers the one-time "Welcome to Medicare" preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed. **Important:** We cover the "Welcome to Medicare" preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you would like to schedule your "Welcome to Medicare" preventive visit.	**HMO (in-network):** $0 for your one-time "Welcome to Medicare" visit. If you receive additional services, cost-sharing for those services may apply. Deductible does not apply.	**POS (out-of-network):** After your yearly deductible is met, you pay 30% for your one-time "Welcome to Medicare" visit. If you receive additional services, cost-sharing for those services may apply.

SECTION 3 What services are not covered by the plan?

Section 3.1 Services we do *not* cover (exclusions)

This section tells you what services are "excluded" from Medicare coverage and therefore, are not covered by this plan. If a service is "excluded," it means that this plan doesn't cover the service.

The chart below lists services and items that either are not covered under any condition or are covered only under specific conditions.

If you get services that are excluded (not covered), you must pay for them yourself. We won't pay for the excluded medical services listed in the chart below except under the specific conditions listed. The only exception: we will pay if a service in the chart below is found upon appeal to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 9, Section 5.3 in this booklet.)

All exclusions or limitations on services are described in the Benefits Chart or in the chart below.

Even if you receive the excluded services at an emergency facility, the excluded services are still **not covered and our plan will not pay for them**.

Service not covered by Medicare	Category service falls under	Not covered under any condition	When covered
Acupuncture	Complementary or alternative medicine	X	
Adaptive equipment **-** see Chapter 12, *Definitions of important words*	Convenience items	X	
Air cleaners	Environmental Control Equipment	X	
Air conditioners	Environmental Control Equipment	X	
Air-fluidized beds	Durable Medical Equipment (DME)/Prosthetics		Covered with prescription for bed sores based and Priority Health determination of medical necessity
Air purifiers	Environmental Control Equipment	X	
Ambulance - staff provides care when no transportation is provided. See *Ambulance Services* section of the Medical Benefits Chart in Chapter 4, Section 2.1.	Transportation	X	
Ambulance - mileage for ambulance transport beyond nearest facility or to/from facility preferred by member and/or family	Transportation	X	

Service not covered by Medicare	Category service falls under	Not covered under any condition	When covered
Alternating pressure pads - mattress and lamb's wool pads	Durable Medical Equipment (DME)/Prosthetics		Covered with prescription and Priority Health determination of medical necessity of member with high susceptibility to decubitus ulcers
Anticoagulation management fee	Provider, non-covered	X	
Assistive listening devices - including but not limited to telephone amplifiers and alerting devices	Convenience items	X	
Augmentative communication device	**Speech-generating devices**		Covered with prescription and member suffers from severe speech impairment, the device meet the definition of a speech generating device and Priority Health determines device is medically necessary
Bathroom safety devices – including but not limited to lifts, raised toilets, transfer benches, and grab bars	Convenience Items	X	
Bathtub lifts	Convenience Item	X	
Bathtub seats	Convenience Item	X	
Bead beds	Durable Medical Equipment (DME)/Prosthetics		Covered with prescription for bed sores and Priority Health determination of medical necessity
Beds (oscillating)	Durable Medical Equipment (DME)/Prosthetics	X	
Bed baths (home type)	Durable Medical Equipment (DME)/Prosthetics	X	
Bed boards	Convenience Item	X	
Bed lifter (bed elevators)	Convenience Item	X	
Bed lounges (power or manual)	Convenience Item	X	
Bed pans (autoclave hospital type)	Durable Medical Equipment (DME)/Prosthetics		Covered with prescription and for members meeting medical necessary criteria for bed confinement

Service not covered by Medicare	Category service falls under	Not covered under any condition	When covered
Bed side rails	Durable Medical Equipment (DME)/Prosthetics		Covered with prescription for members meeting medical necessity for hospital bed
Bidet toilet seats	Convenience Items	X	
Biofeedback - including when used in counseling or psychiatric therapy	Complementary or alternative medicine		Covered under Medicare when reasonable and necessary for muscle re-education or treating pathological muscle abnormalities; member should request pre-service organization determination
Blood Glucose Analyzers - reflectance colorimeter	Durable Medical Equipment (DME)/Prosthetics	X	
Blood pressure cuff (i.e. pulse tachometer)	Durable Medical Equipment (DME)/Prosthetics	X	
Braille teaching texts	Vision	X	
Canes - see also white cane	Durable Medical Equipment (DME)/Prosthetics		Covered with prescription when member's condition impairs participation in mobility-related activities of daily living
Carafes	Convenience Item	X	
Catheters	Durable Medical Equipment (DME)/Prosthetics		Covered with prescription for permanent urinary incontinence or urinary retention.
Chair portion of chair lift system	Durable Medical Equipment (DME)/Prosthetics	X	
Chelation therapy	Complementary or alternative medicine		Covered for treatment of heavy metal poisoning
Chiropractic care - maintenance care	Chiropractic	X	
Chiropractic care - x-rays, labs, other services in a chiropractor's office	Chiropractic	X	
Clapper - sound activated on/off switch	Convenience items	X	
Commodes (toilet)	Durable Medical Equipment (DME)/Prosthetics		Covered with prescription for member confined to bed or room and is physically

Service not covered by Medicare	Category service falls under	Not covered under any condition	When covered
			incapable of using regular toilet facilities.
Communicators			Covered with prescription for individuals with severe speech impediments if Priority Health determines member meets Medicare medically necessary criteria
Concierge care	Complementary or alternative medicine	X	
Continuous Glucose Monitoring (CGM) devices	Durable Medical Equipment (DME)/Prosthetics		The only covered device is Dexcom G5 mobile.
Continuous Passive Motion Devices	Durable Medical Equipment (DME)/Prosthetics		Covered with prescription for members who have received a total knee replacement. Subject to Medicare usage guidelines.
Continuous Positive Airway Pressure (CPAP) Devices	Durable Medical Equipment (DME)/Prosthetics		Covered with prescription for obstructive sleep apnea if Priority Health determines member meets medically necessary criteria
Continuous Positive Airway Pressure (CPAP) Device - rental if you do not meet the Medicare requirements for usage	Durable Medical Equipment (DME)/Prosthetics	X	
Contact lenses (hydrophilic) - other than post-cataract surgery	Vision		Covered with prescription for an aphakic patient and for treatment of acute or chronic corneal pathology
Cosmetic surgery or procedures - see Chapter 12, *Definitions of important words*, for cosmetic surgery	Surgeries & Procedures		Unless because of an accidental injury or to improve a malformed part of the body.
Cooling plants	Environmental Control Equipment	X	
Counseling services - not covered by Original Medicare including but not limited to geriatric day care programs, individual psychophysiological therapy including biofeedback, marriage counseling, pastoral counseling	Behavioral health	X	

Service not covered by Medicare	Category service falls under	Not covered under any condition	When covered
Crutches	Durable Medical Equipment (DME)/Prosthetics		Covered with prescription and member's condition impairs participation in mobility-related activities of daily living
Cushion Lift Power Seats	Durable Medical Equipment (DME)/Prosthetics		Covered with prescription and Priority Health determines member meets Medicare medical necessity
Custodial care – see Chapter 12, *Definitions of important words* for custodial care	In-home care	X	
Dehumidifiers	Environmental Control Equipment	X	
Dental services	Dental, Medicare-covered		If related to reconstruction of the jaw due to accident/injury or for preparation for treatment of neoplastic diseases of the jaw. Medicare will also make payment for oral examinations, but not treatment, preceding kidney transplantation or heart valve replacement, under certain circumstances. Contact Priority Health for a pre-service organization determination.
Dental services – inpatient or outpatient care	Dental, Medicare-covered		Dental care required to treat illness or injury may be covered as inpatient or outpatient care.
Dental services (routine) - outpatient facility & professional dental expenses for routine dental services	Dental, non-Medicare covered	X	
Dental services (routine) - for the care, treatment, filling, removal (extraction) or replacement of teeth or the structures directly supporting the teeth. Other examples of routine services not covered are preventive cleanings, exams,	Dental, non-Medicare covered	X	

Service not covered by Medicare	Category service falls under	Not covered under any condition	When covered
bitewing x-rays (radiographic images), dentures, crowns, removal of impacted teeth, dental appliances, periodontal cleanings and orthodontia.			
Dental splints	Dental, Medicare-covered		Covered to treat a dislocated upper/lower jaw joints and sleep apnea and approved by Priority Health
Detox in an outpatient setting	Behavioral health	X	
Diabetic supplies - test strips (blood glucose monitors) and lancet exceeding Medicare allowed amounts	Diabetic supplies		Additional test strips and lancets covered for insulin/non-insulin diabetics with prior approval by Priority Health
Diathermy machines (standard pulse wave types)	Durable Medical Equipment (DME)/Prosthetics	X	
Diagnostic lab tests - not medically necessary under Medicare coverage criteria	Physical exams & screenings		Labs ordered to diagnose, treat or evaluate a medical condition allowed by Medicare. Discuss labs with your physician to find out if covered or call customer service for more information.
Disposable sheets and bags	Durable Medical Equipment (DME)/Prosthetics	X	
DME upgrades - including but not limited to ostomy supplies and electric wheelchairs	Durable Medical Equipment (DME)/Prosthetics		Covered with prescription if Priority Health determines member meets Medicare medical necessity criteria
Drugs (Part B under your medical benefit) - (non-chemotherapy and biologicals) used for conditions not approved by Food and Drug Administration (FDA), such as biomedical hormones, and not covered under Medicare.	Drugs/Immunizations	X	
Drugs (Part D under your prescription drug benefit) - purchased from or obtained while in another country including those obtained on a	Drugs/Immunizations	X	

Service not covered by Medicare	Category service falls under	Not covered under any condition	When covered
cruise ship that are considered self-administered. These are considered non-FDA approved.			
Drugs (Part D covered self-administered drugs) - provided in an outpatient setting such as an outpatient hospital, ER room or physician office. See also Chapter 4, Section 2.1, Medical Benefits Chart and Chapter 12, *Definitions of important words,* for self-administered.	Drugs/Immunizations		You may be covered for these under your prescription drug coverage
Elastic (Jobst) stockings - not used to treat burns	Durable Medical Equipment (DME)/Prosthetics	X	
Electric hospital bed (total)	Durable Medical Equipment (DME)/Prosthetics	X	
Electric stimulators for wounds (home use)	Durable Medical Equipment (DME)/Prosthetics	X	
Elective - voluntary enhancement procedures and/or services including but not limited to weight loss, hair growth, sexual performance, athletic performance, and to improve appearance	Surgeries & Procedures	X	
Electrostatic machines	Environmental Control Equipment	X	
Elevators including in stairway	Convenience items	X	
Emergency Communication Systems - such as Personal Emergency Response System (PERS), medical alert devices, in-home telephone alert systems	Convenience items	X	
Emesis basins	Convenience Items	X	
Esophageal dilators	Durable Medical Equipment (DME)/Prosthetics	X	
Exercise equipment	Fitness	X	
Eyeglass (add-ons) - such as antireflective coating, tints, oversize lenses, and UV protection for glasses post cataract surgery	Vision		May be covered for post cataract surgery eyeglass wear with prescription for these and if according to Medicare billing rules

Service not covered by Medicare	Category service falls under	Not covered under any condition	When covered
Eyewear and eye examinations (routine)	Vision	X	
Experimental or investigational clinical trials/services - see Chapter 3, Section 5.1	Clinical Trials/Experimental or Investigational procedures	X	
Fabric supports	Durable Medical Equipment (DME)/Prosthetics	X	
Face mask (oxygen)	Durable Medical Equipment (DME)/Prosthetics		Covered with prescription for a diagnosis of a disease requiring use of home oxygen
Face mask (surgical)	Durable Medical Equipment (DME)/Prosthetics	X	
FDA - services not approved by the federal Food and Drug Administration including but not limited to drugs, supplements, tests, vaccines, devices, radioactive materials, and any other items/services that by law require federal Food and Drug Administration (FDA) approval in order to be sold in the U.S., but are not approved by the FDA. This exclusion applies to services provided anywhere, even outside the U.S. It does not apply to Medicare-covered clinical trials or covered emergency care you receive outside the U.S.	FDA	X	
Fees - charged by your immediate relatives or members of your household services	In-home care	X	
Flow meters	Durable Medical Equipment (DME)/Prosthetics		Covered if oxygen is prescribed for a diagnosis requiring home oxygen use
Fluidic breathing assisters	Durable Medical Equipment (DME)/Prosthetics		Covered if prescribed by physician due to severe impairment of breathing.
Fomentation devices	Durable Medical Equipment (DME)/Prosthetics		Covered with prescription to relieve certain types of pain

Service not covered by Medicare	Category service falls under	Not covered under any condition	When covered
			and meets coverage Medicare criteria
Foot - flat foot care	Foot care/services	X	
Foot care - routine			See Chapter 4, Section 2.1 *Podiatry services*
Foot - supportive devices for the feet, such as custom-molded orthotics or removable shoe inserts (non-diabetic or Medicare-covered condition)	Foot care/services	X	
Full-time nursing care in your home	In-home care	X	
Gel flotation pads and mattresses	Durable Medical Equipment (DME)/Prosthetics		Covered with prescription and Priority Health determination of medical necessity of member with high susceptibility to decubitus ulcers
Gender reassignment - surgery and gender reassignment hormones	Surgeries & Procedures		If determined by Priority Health to meet medical necessity criteria
Grab bars	Convenience Items	X	
Grabbing device	Durable Medical Equipment (DME)/Prosthetics	X	
Hearing - Hearing aids and provider visits to service hearing aids (except as specifically described in the Covered Benefits), ear molds, hearing aid accessories, return fees, warranty claim fees, and hearing aid batteries.		X	
Hearing - repairs or modifications of aids and/or supplies (batteries)	Hearing	X	
Hearing (routine) - hearing aid exams, hearing aids or evaluations including the fitting and checking of hearing aids	Hearing		Other than those described in the *Hearing services* section of the Medical Benefits Chart in Chapter 4.
Heat - infrared heating pads/systems	Convenience Items	X	
Heating - pads, steam packs	Durable Medical Equipment (DME)/Prosthetics		Covered with prescription to relieve certain types of pain

Service not covered by Medicare	Category service falls under	Not covered under any condition	When covered
			and meets coverage Medicare criteria
Heat lamps - (in-home)	Durable Medical Equipment (DME)/Prosthetics	X	
Heating plants	Environmental Control Equipment	X	
HEPA filters	Environmental Control Equipment	X	
Homemaker services - including household assistance, light housekeeping or light meal preparation	In-home care	X	
Homeopathic services	Complementary and Alternative Medicine	X	
Hospital beds	Durable Medical Equipment (DME)/Prosthetics		Covered with prescription and determination by Priority Health member meets Medicare medically necessary criteria
Hot packs	Durable Medical Equipment (DME)/Prosthetics		Covered with prescription to relieve certain types of pain, decrease joint and soft tissue stiffness, relax muscles, or reduce inflammation.
Hormone replacement therapy - including but not limited to pellet implantation and bioidenticals done solely for purposes of combating aging and/or improving sexual function	Complementary and Alternative Medicine	X	
Humidifiers	Environmental Control Equipment	X	
Humidifiers -non-oxygen including home and central heating types	Environmental Control Equipment	X	
Hydraulic or patient lifts	Durable Medical Equipment (DME)/Prosthetics		Covered with prescription and Priority Health determines member's condition is such that periodic movement is necessary to effect improvement or to

Service not covered by Medicare	Category service falls under	Not covered under any condition	When covered
			arrest/retard deterioration condition
Immunizations (when covered under Part D) - including but not limited to Zostavax. See Chapter 6, Section 8, to find out more about obtaining immunizations at a pharmacy.	Drugs/Immunizations	X	
Incontinent - pads or supplies	Durable Medical Equipment (DME)/Prosthetics	X	
Infertility diagnosis and treatment	Surgeries & Procedures		Covered if Priority Health has determined medical necessity to diagnose the underlying cause of infertility. Infertility treatment is covered if you are diagnosed as infertile and have not had an elective sterilization.
Infertility diagnosis and treatment, assisted reproduction and artificial conception	Surgeries & Procedures	X	
Infusion pumps - implantable or external	Durable Medical Equipment (DME)/Prosthetics		Covered with prescription for use according to Medicare criteria; contact Priority Health
Injector (hypodermic jet)	Durable Medical Equipment (DME)/Prosthetics	X	
Intermittent positive pressure breathing machines	Durable Medical Equipment (DME)/Prosthetics		Covered with prescription and Priority Health determines member's ability to breathe is severely impaired
Iron lungs	Durable Medical Equipment (DME)/Prosthetics		Covered with prescription for treatment of neuromuscular diseases and a condition causing a significant impairment of chest wall and/or diaphragmatic movement.
Irrigating kit	Durable Medical Equipment (DME)/Prosthetics	X	

Service not covered by Medicare	Category service falls under	Not covered under any condition	When covered
Knee walker	Durable Medical Equipment (DME)/Prosthetics	X	
Labs (routine) - ordered solely as part of an annual physical exam and not to diagnose a medical condition.	Physical exams & screenings	X	
Licensure - any treatment or services rendered by, or at the direction, of a provider of health care services who is not licensed to provide the services, or who is not operating within the scope of that license	Provider, non-covered	X	
Life Line Screening - and similar services	Physical exams & screenings	X	
Long-term care - see Chapter 12, *Definitions of important words*, for long-term care	In-home care	X	
Lymphedema pumps	Durable Medical Equipment (DME)/Prosthetics		Covered with prescription for the treatment of lymphedema or chronic venous insufficiency
Massage - devices	Durable Medical Equipment (DME)/Prosthetics	X	
Massage – foam cushion pads	Convenience Items	X	
Massage therapy - performed by a massage therapist	Complementary or alternative medicine	X	
Mattresses (non-hospital)	Durable Medical Equipment (DME)/Prosthetics	X	
Meals - delivered to your home	In-home care	X	
Medical necessity - services considered not reasonable and medically necessary, according to the standards of Original Medicare, see Chapter 9, about obtaining a coverage decision	DME/Physical exams and services/Physician services/Surgeries and Procedures	X	
Methadone - outpatient methadone clinics	Behavioral health	X	
Mobile Geriatric Chairs	Durable Medical Equipment (DME)/Prosthetics		Covered with prescription and Priority Health determines if member meets mobility assistive equipment clinical criteria

Service not covered by Medicare	Category service falls under	Not covered under any condition	When covered
Muscle stimulators	Durable Medical Equipment (DME)/Prosthetics		Covered with prescription and Priority Health determines member Medicare meets medically necessary criteria
Naturopathic services	Complementary or alternative medicine	X	
Nebulizers	Durable Medical Equipment (DME)/Prosthetics		Covered if Priority Health determines member's ability to breathe is severely impaired
Non-covered service - when a service or item is not covered, all services related to the non-covered service or item are excluded	Provider, non-covered		Except for complications due to the non-covered service if occurring after discharge from the hospital for the non-covered procedure
Non-governmental provider: Items and services furnished by a nongovernmental provider, physician or supplier if the charges have been paid for by a government program other than Medicare, or if the provider, physician or supplier intends to look to another government program for payment unless payment by the other program is limited to the Medicare deductible and coinsurance amount such as but not limited to the VA, incarceration, etc.	Provider, non-covered	X	
Opt-out providers - see Chapter 12 for *Definitions of important words* for opt-out provider	Provider, non-covered		Except for services provided in an emergency/urgent care situation
Orthognathic surgery	Surgeries & Procedures		Covered if Priority Health has determined medical necessity for treatment.
Orthognathic surgery, dental	Surgeries & Procedures	X	
Orthopedic shoes - not an integral part of a leg brace	Foot care/services	X	
Over-bed tables	Convenience Items	X	
Over-the-counter (OTC) contraceptive products	Drugs/Immunizations	X	

Service not covered by Medicare	Category service falls under	Not covered under any condition	When covered
Over-the-counter (OTC) items (Part D)	Drugs/Immunizations	X	
Oxygen	Durable Medical Equipment (DME)/Prosthetics		Covered with prescription for a disease requiring home use of oxygen
Oxygen - airline-approved portable oxygen concentrator	Durable Medical Equipment (DME)/Prosthetics	X	
Oxygen - equipment and accessories	Durable Medical Equipment (DME)/Prosthetics	X	
Oxygen humidifiers	Durable Medical Equipment (DME)/Prosthetics		Covered with prescription for use with oxygen equipment
Oxygen - Medical oxygen regulators	Durable Medical Equipment (DME)/Prosthetics		Covered if Priority Health determines member's ability to breathe is severely impaired
Oxygen - spare tanks in addition to any oxygen tank(s)/supplies ordered by your physician	Durable Medical Equipment (DME)/Prosthetics	X	
Oxygen tents	Durable Medical Equipment (DME)/Prosthetics		Covered with prescription by physician for a diagnosis of a disease requiring use of home oxygen
Pacemaker - audible/visible signal and self-contained monitors	Durable Medical Equipment (DME)/Prosthetics		Covered with prescription for member with cardiac pace maker
Paraffin bath units (portable)			Covered with prescription when member has undergone a successful trial period of paraffin therapy ordered by a physician and the member's condition is expected to be relieved by long term use of this modality
Paraffin bath units (standard)	Durable Medical Equipment (DME)/Prosthetics	X	
Parallel bars	Durable Medical Equipment (DME)/Prosthetics	X	
Patient lifts	Durable Medical Equipment (DME)/Prosthetics		Covered with prescription and Priority Health determines member's condition is such that

Service not covered by Medicare	Category service falls under	Not covered under any condition	When covered
			periodic movement is necessary to effect improvement or to arrest/retard deterioration condition
Percussors	Durable Medical Equipment (DME)/Prosthetics		Covered with prescription for mobilizing respiratory tract secretions in patients with chronic obstructive lung disease, chronic bronchitis, or emphysema, when patient or operator of powered percussor receives appropriate training by a physician or therapist, and no one competent to administer manual therapy is available
Personal items - in your room at a hospital or SNF including but not limited to a telephone or television	Convenience items	X	
Personal trainers	Fitness	X	
Physical exams and other services - required by third parties for such things obtaining or maintaining employment or participation in employee programs, required for insurance or licensing, requested sports physicals, or on court order or required for parole or probation.	Physical exams & screenings	X	
Portable oxygen systems - regulated	Durable Medical Equipment (DME)/Prosthetics		Covered if Priority Health determines member meets Medicare medically necessary criteria
Portable oxygen units -preset	Durable Medical Equipment (DME)/Prosthetics	X	
Portable room heaters	Environmental Control Equipment	X	
Postural drainage boards	Durable Medical Equipment (DME)/Prosthetics		Covered if Priority Health determines member has a chronic pulmonary condition

Service not covered by Medicare	Category service falls under	Not covered under any condition	When covered
Pressure leotards	Durable Medical Equipment (DME)/Prosthetics	X	
Private duty nurses	In-home care	X	
Private room - when semi-private rooms are available	Private room	X	
Pre-operative testing - including but not limited to labs, x-rays, EKGs, EEGs, and cardiac monitoring that are performed strictly for pre-operative clearance when no underlying medical condition exists for testing	Surgeries & Procedures	X	
Psychology/Neuropsychology testing - performed by a Limited Licensed Psychologist	Provider, non-covered	X	
Psychophysiological therapy	Behavioral health/ complimentary medicine	X	
Quad-canes	Durable Medical Equipment (DME)/Prosthetics		Covered if member meets mobility assistive equipment clinical criteria
Raised toilet seats	Durable Medical Equipment (DME)/Prosthetics	X	
Reaching or grabbing device	Durable Medical Equipment (DME)/Prosthetics	X	
Refrigerators	Environmental Control Equipment	X	
Residential Treatment - whose main purpose is to remove the member from his/her environment to prevent the reoccurrence of a condition such as but not limited to eating disorders, alcohol addiction, etc.	Behavioral Health	X	
Respirators	Durable Medical Equipment (DME)/Prosthetics		Covered with prescription and prior authorized for treatment of neuromuscular diseases, thoracic restrictive diseases, and chronic respiratory failure consequent to chronic obstructive pulmonary disease. Includes both

Service not covered by Medicare	Category service falls under	Not covered under any condition	When covered
			positive and negative pressure types.
Reversal of sterilization	Surgeries & Procedures	X	
Rolling chairs	Durable Medical Equipment (DME)/Prosthetics		Covered with prescription for patient who meets mobility assistive equipment clinical criteria. Contact Priority Health for organization determination.
Safety rollers	Durable Medical Equipment (DME)/Prosthetics		Covered if patient meets mobility assistive equipment clinical criteria
Sales tax – medical services and/or items and prescription drugs	Governmental	X	
Sanctioned or excluded providers - items or services furnished, ordered, or prescribed by any provider listed or identified on any of the following lists or databases: The U.S. Department of Health & Human Services Office of Inspector List of Excluded Individuals and Entities (LEIE), the U.S. General Services Administration Excluded Parties List System (EPLS), the U.S. Department of Treasury Office of Foreign Assets Control Specially Designated Nationals (SDN) List, or on any individual state provider exclusion or sanction list or database including, but not limited to, state Office of Medicaid Inspector exclusion lists.	Provider, non-covered		Except for services provided in an emergency/urgent care situation
Sauna baths	Convenience items	X	
Seat lift	Durable Medical Equipment (DME)/Prosthetics		Covered with prescription and Priority Health determines member meets Medicare medically necessary criteria

Service not covered by Medicare	Category service falls under	Not covered under any condition	When covered
Sitz bath	Durable Medical Equipment (DME)/Prosthetics		Covered with prescription for an infection or injury of the perineal area as part of a home care treatment
Smart devices - (smart phones, tablets, personal computers, etc.)	Durable Medical Equipment (DME)/Prosthetics	X	
Speech teaching machines	Durable Medical Equipment (DME)/Prosthetics	X	
Standing table	Durable Medical Equipment (DME)/Prosthetics	X	
Structural modifications - including but not limited to ramps, doorways, elevators and stairway elevators	Convenience items	X	
Suction machines	Durable Medicare Equipment (DME)/Prosthetics		Covered with prescription and determined by Priority Health to be medically necessary
Support hose	Durable Medical Equipment (DME)/Prosthetics	X	
Surgical leggings	Durable Medical Equipment (DME)/Prosthetics	X	
Surgical treatment for morbid obesity	Weight Management		Except when it is considered medically necessary and covered under Original Medicare
Temporomandibular joint disorders	Surgeries & Procedures		Covered if Priority Health has determined medical necessity for treatment.
Temporomandibular joint disorders, dental care or services	Surgeries & Procedures	X	
Toilet seats	Durable Medical Equipment (DME)/Prosthetics	X	
Therapeutic shoes - not an integral part of a leg brace	Foot care/services	X	
Third party insurance coverage: Services that may be covered under other types of insurance, see also Chapter 11, Legal Notices, Section 3, for more details	Provider, non-covered	X	

Service not covered by Medicare	Category service falls under	Not covered under any condition	When covered
Traction equipment	Durable Medical Equipment (DME)/Prosthetics		Covered with prescription for orthopedic impairment requiring traction equipment that prevents ambulation during the period of use
Trapeze bars	Durable Medical Equipment (DME)/Prosthetics		Covered with prescription for member with hospital bed.
Transportation – including commercial or private air transport, car, taxi, bus, gurney van, and wheelchair van even if it is the only way to travel to a network provider.	Transportation	X	
Ultraviolet cabinets	Durable Medical Equipment (DME)/Prosthetics		Covered with prescription for selected patients with generalized intractable psoriasis and if Priority Health determines member meets Medicare medically necessary criteria
Urinals - autoclavable, non-hospital bed confined	Durable Medical Equipment (DME)/Prosthetics	X	
VA - services provided to veterans in Veterans Affairs (VA) facilities	Veterans	X	
Vaccinations - not covered under Part B (medical benefit) and not directly related to the treatment of an illness or injury of direct exposure to a disease	Drugs/Immunizations	X	
Vaporizers	Durable Medical Equipment (DME)/Prosthetics		Covered with prescription for member with a respiratory illness
Ventilators	Durable Medical Equipment (DME)/Prosthetics		Covered with prescription and prior authorized for treatment of neuromuscular diseases, thoracic restrictive diseases, and chronic respiratory failure consequent to chronic obstructive pulmonary disease. Includes both

Service not covered by Medicare	Category service falls under	Not covered under any condition	When covered
			positive and negative pressure types.
Vision (aids) - including but not limited to handheld low vision aids and other non-spectacle mounted aids	Vision	X	
Vision (refraction) - as part of an eye exam, see Chapter 12, *Definitions of important words*, for refraction	Vision	X	
Vision (refractive surgical procedures) - performed for the sole purpose of reducing dependence on glasses or contact lenses including but not limited to laser astigmatism correction, radial keratotomy and keratoplasty to treat refractive defects, LASIK or LASEK surgery, keratophakia and keratomileusis.	Vision	X	
Vision (routine) - eye exam for the purpose of prescribing, fitting or changing eyeglasses	Vision	X	
Vision (services) - nonconventional intraocular lenses (IOLs) following cataract surgery (for example, a presbyopia-correcting IOL)	Vision	X	
Vision (services)- radial keratotomy, keratoplasty for purpose of refractive error compensation, and LASIK surgery	Vision	X	
Vision (therapy) - (e.g., ocular exercises, visual training, vision training, orthoptics and any associated supplemental testing); low vision aids	Vision	X	
Walkers	Durable Medical Equipment (DME)/Prosthetics		Covered with prescription and member has mobility limitations that prevent participation in mobility-

Service not covered by Medicare	Category service falls under	Not covered under any condition	When covered
			related activities of daily living
War related - items or services needed whether due or related to injuries caused by war or an act of war are not covered.	War-related	X	
Water purifiers	Environmental Control Equipment	X	
Weight loss - treatment, including but not limited to medications, self-help groups, non-Medicare covered weight loss programs, meal programs and dietary supplements	Weight Management	X	
Wheelchairs – including motorized, manual, power operated, scooter/POV, specially-sized	Durable Medical Equipment (DME)/Prosthetics		Covered if member meets Medicare mobility assistive equipment clinical criteria
Whirlpool baths - non-home bound member	Durable Medical Equipment (DME)/Prosthetics	X	
Whirlpool pumps (portable)	Durable Medical Equipment (DME)/Prosthetics	X	
White cane	Durable Medical Equipment (DME)/Prosthetics	X	
Wigs	Durable Medical Equipment (DME)/Prosthetics	X	

*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.

CHAPTER 5

Using the plan's coverage for your Part D prescription drugs

Chapter 5. Using the plan's coverage for your Part D prescription drugs

Did you know there are programs to help people pay for their drugs?

The "Extra Help" program helps people with limited resources pay for their drugs. For more information, see Chapter 2, Section 7.

Are you currently getting help to pay for your drugs?

If you are in a program that helps pay for your drugs, **some information in this *Evidence of Coverage* about the costs for Part D prescription drugs may not apply to you.** We have included or will send you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also known as the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug coverage. If you don't have this insert, please call Customer Service and ask for the "LIS Rider." (Phone numbers for Customer Service are printed on the back cover of this booklet.)

SECTION 1 Introduction

Section 1.1 This chapter describes your coverage for Part D drugs

This chapter **explains rules for using your coverage for Part D drugs**. The next chapter tells what you pay for Part D drugs (Chapter 6, *What you pay for your Part D prescription drugs*).

In addition to your coverage for Part D drugs, **Priority**Medicare (Employer HMO-POS) also covers some drugs under the plan's medical benefits. Through its coverage of Medicare Part A benefits, our plan generally covers drugs you are given during covered stays in the hospital or in a skilled nursing facility. Through its coverage of Medicare Part B benefits, our plan covers drugs including certain chemotherapy drugs, certain drug injections you are given during an office visit, and drugs you are given at a dialysis facility. Chapter 4 (*Medical Benefits Chart, what is covered and what you pay*) tells about the benefits and costs for drugs during a covered hospital or skilled nursing facility stay, as well as your benefits and costs for Part B drugs.

Your drugs may be covered by Original Medicare if you are in Medicare hospice. Our plan only covers Medicare Parts A, B, and D services and drugs that are unrelated to your terminal prognosis and related conditions and therefore not covered under the Medicare hospice benefit. For more information, please see Section 9.4 *(What if you're in Medicare-certified hospice).* For information on hospice coverage, see the hospice section of Chapter 4 (*Medical Benefits Chart, what is covered and what you pay*).

The following sections discuss coverage of your drugs under the plan's Part D benefit rules. Section 9, *Part D drug coverage in special situations* includes more information on your Part D coverage and Original Medicare.

Section 1.2 Basic rules for the plan's Part D drug coverage

The plan will generally cover your drugs as long as you follow these basic rules:

- You must have a provider (a doctor, dentist or other prescriber) write your prescription.
- Your prescriber must either accept Medicare or file documentation with CMS showing that he or she is qualified to write prescriptions, or your Part D claim will be denied. You should ask your prescribers the next time you call or visit if they meet this condition. If not, please be aware it takes time for your prescriber to submit the necessary paperwork to be processed.
- You generally must use a network pharmacy to fill your prescription. (See Section 2, *Fill your prescriptions at a network pharmacy or through the plan's mail-order service*.)
- Your drug must be on the plan's *List of Covered Drugs (Formulary)* (we call it the "Drug List" for short). (See Section 3, *Your drugs need to be on the plan's "Drug List*.")
- Your drug must be used for a medically accepted indication. A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. (See Section 3 for more information about a medically accepted indication.)

SECTION 2 Fill your prescription at a network pharmacy or through the plan's mail-order service

Section 2.1 To have your prescription covered, use a network pharmacy

In most cases, your prescriptions are covered *only* if they are filled at the plan's network pharmacies. (See Section 2.5 for information about when we would cover prescriptions filled at out-of-network pharmacies.)

A network pharmacy is a pharmacy that has a contract with the plan to provide your covered prescription drugs. The term "covered drugs" means all of the Part D prescription drugs that are covered on the plan's Drug List.

Our network includes pharmacies that offer standard cost-sharing and pharmacies that offer preferred cost-sharing. You may go to either type of network pharmacy to receive your covered prescription drugs. Your cost-sharing may be less at pharmacies with preferred cost-sharing.

Section 2.2 Finding network pharmacies

How do you find a network pharmacy in your area?

To find a network pharmacy, you can look in your *Provider/Pharmacy Directory*, visit our website (*priorityhealth.com/mpsers*), or call Customer Service (phone numbers are printed on the back cover of this booklet).

You may go to any of our network pharmacies. However, your costs may be even less for your covered drugs if you use a network pharmacy that offers preferred cost-sharing rather than a network pharmacy that offers standard cost-sharing. The *Provider/Pharmacy Directory* will tell you which of the network pharmacies offer preferred cost-sharing. You can find out more about how your out-of-pocket costs could be different for different drugs by contacting us.

If you switch from one network pharmacy to another, and you need a refill of a drug you have been taking, you can ask either to have a new prescription written by a provider or to have your prescription transferred to your new network pharmacy.

What if the pharmacy you have been using leaves the network?

If the pharmacy you have been using leaves the plan's network, you will have to find a new pharmacy that is in the network. To find another network pharmacy in your area, you can get help from Customer Service (phone numbers are printed on the back cover of this booklet) or use the *Provider/Pharmacy Directory*. You can also find information on our website at *priorityhealth.com/mpsers*.

What if you need a specialized pharmacy?

Sometimes prescriptions must be filled at a specialized pharmacy. Specialized pharmacies include:

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care (LTC) facility. Usually, a LTC facility (such as a nursing home) has its own pharmacy. If you are in an LTC facility, we must ensure that you are able to routinely receive your Part D benefits through our network of LTC pharmacies, which is typically the pharmacy that the LTC facility uses. If you have any difficulty accessing your Part D benefits in an LTC facility, please contact Customer Service.
- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.
- Pharmacies that dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (Note: This scenario should happen rarely.)

To locate a specialized pharmacy, look in your *Provider/Pharmacy Directory* or call Customer Service (phone numbers are printed on the back cover of this booklet).

Section 2.3 Using the plan's mail-order services

Our plan's mail-order service allows you to order **up to a 90-day supply** with the exception of drugs in Tier 5.

To get order forms and information about filling your prescriptions by mail, call Customer Service or visit our website at *priorityhealth.com/mpsers*. If you use a mail-order pharmacy that is not in the plan's network, your prescription will not be covered.

Usually a mail-order pharmacy order will get to you in no more than 14 days. However, sometimes your mail-order may be delayed. If your order does not arrive before you run out of medication, please call Customer Service (phone numbers are printed on the back cover of this booklet) in order to get permission to obtain up to a 30-day supply of your prescription from a local network retail pharmacy.

New prescriptions the pharmacy receives directly from your doctor's office.
The pharmacy will automatically fill and deliver new prescriptions it receives from health care providers, without checking with you first, if either:

- You used mail-order services with this plan in the past, or
- You sign up for automatic delivery of all new prescriptions received directly from health care providers. You may request automatic delivery of all new prescriptions now or at any time by phone or email, just call 888.378.2589 or go online to *express-scripts.com* and create an online account to send a secure email.

If you receive a prescription automatically by mail that you do not want, and you were not contacted to see if you wanted it before it shipped, you may be eligible for a refund.

If you used mail-order in the past and do not want the pharmacy to automatically fill and ship each new prescription, please contact us by phone or email, just call 888.378.2589 or go online to *express-scripts.com* and create an online account to send a secure email.

If you have never used our mail-order delivery and/or decide to stop automatic fills of new prescriptions, the pharmacy will contact you each time it gets a new prescription from a health care provider to see if you want the medication filled and shipped immediately. This will give you an opportunity to make sure that the pharmacy is delivering the correct drug (including strength, amount, and form) and, if necessary, allow you to cancel or delay the order before you are billed and it is shipped. It is important that you respond each time you are contacted by the pharmacy, to let them know what to do with the new prescription and to prevent any delays in shipping.

To opt out of automatic deliveries of new prescriptions received directly from your health

care provider's office, please contact ExpressScripts by phone or email. Call 888.378.2589 or go online to *express-scripts.com* and create an online account to send a secure email.

Refills on mail-order prescriptions. For refills, please contact your mail-order pharmacy 21 days before you think the drugs you have on hand will run out to make sure your next order is shipped to you in time.

So the mail-order pharmacy can reach you to confirm your order before shipping, please make sure to let the pharmacy know the best ways to contact you. Our pharmacy, Express Scripts, can either reach you by phone or by email. It's your preference. To let them know whether you want to be contacted by phone or email, just call 888-378-2589 or go online to *express-scripts.com* and create an online account.

Section 2.4 How can you get a long-term supply of drugs?

When you get a long-term supply of drugs, your cost-sharing may be lower. The plan offers two ways to get a long-term supply (also called an "extended supply") of "maintenance" drugs on our plan's Drug List. (Maintenance drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition.) You may order this supply through mail-order (see Section 2.3) or you may go to a retail pharmacy.

1. **Some retail pharmacies** in our network allow you to get a long-term supply of maintenance drugs. Your *Provider/Pharmacy Directory* tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call Customer Service for more information (phone numbers are printed on the back cover of this booklet).
2. You can use the plan's network **mail-order services.** Our plan's mail-order service allows you to order up to a 90-day supply. See Section 2.3 for more information about using our mail-order services.

Section 2.5 When can you use a pharmacy that is not in the plan's network?

Your prescription may be covered in certain situations

Generally, we cover drugs filled at an out-of-network pharmacy *only* when you are not able to use a network pharmacy. To help you, we have network pharmacies outside of our service area where you can get your prescriptions filled as a member of our plan. If you cannot use a network pharmacy, here are the circumstances when we would cover prescriptions filled at an out-of-network pharmacy:

- If you are unable to obtain a covered drug in a timely manner within the service area because there are no network pharmacies within a reasonable driving distance that provide 24-hour service.
- If you are trying to fill a prescription drug that is not regularly stocked at an accessible network retail or mail-order pharmacy (including high-cost and unique drugs).
- If you get a vaccine or other Medicare Part D-covered drug in a provider office or outpatient facility that is not covered under Medicare Part B (e.g., emergency room, urgent care setting, etc). See Chapter 6, Section 8.1 for further information.
- If the Governor of your state, the U.S. Secretary of Health and Human Services, or the President of the United States declares a state of disaster or emergency in your geographic area.

In these situations, **please check first with Customer Service** to see if there is a network pharmacy nearby. (Phone numbers for Customer Service are printed on the back cover of this booklet.) You may be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost that we would cover at an in-network pharmacy.

How do you ask for reimbursement from the plan?

If you must use an out-of-network pharmacy, you will generally have to pay the full cost (rather than your normal share of the cost) at the time you fill your prescription. You can ask us to reimburse you for our share of the cost. (Chapter 7, Section 2.1 explains how to ask the plan to pay you back.)

SECTION 3 Your drugs need to be on the plan's "Drug List"

Section 3.1 The "Drug List" tells which Part D drugs are covered

The plan has a "*List of Covered Drugs (Formulary).*" In this *Evidence of Coverage*, **we call it the "Drug List" for short.**

The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the plan's Drug List.

The drugs on the Drug List are only those covered under Medicare Part D (earlier in this chapter, Section 1.1 explains about Part D drugs).

We will generally cover a drug on the plan's Drug List as long as you follow the other coverage rules explained in this chapter and the use of the drug is a medically accepted indication. A "medically accepted indication" is a use of the drug that is *either*:

- approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- -- *or* -- supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information; the DRUGDEX Information System; and the USPDI or its successor; and, for cancer, the National Comprehensive Cancer Network and Clinical Pharmacology or their successors.)

The Drug List includes both brand name and generic drugs

A generic drug is a prescription drug that has the same active ingredients as the brand name drug. Generally, it works just as well as the brand name drug and usually costs less. There are generic drug substitutes available for many brand name drugs.

What is *not* on the Drug List?

The plan does not cover all prescription drugs.

- In some cases, the law does not allow any Medicare plan to cover certain types of drugs (for more information about this, see Section 7.1 in this chapter).
- In other cases, we have decided not to include a particular drug on the Drug List.

Section 3.2 There are five "cost-sharing tiers" for drugs on the Drug List

Every drug on the plan's Drug List is in one of five cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug:

- **Tier 1 – Preferred generic drug.** This is the lowest tier and includes preferred generic drugs.
- **Tier 2 – Generic drug.** This tier includes generic drugs and some self-administered insulin.
- **Tier 3 – Preferred brand drug.** This tier includes preferred brand drugs.
- **Tier 4 – Non-preferred drug.** This tier includes non-preferred drugs and some high-cost generic drugs.
- **Tier 5 – Specialty drugs.** This is the highest tier and includes specialty drugs, which are limited to a maximum of a 30-day supply per prescription or refill.

To find out which cost-sharing tier your drug is in, look it up in the plan's Drug List.

The amount you pay for drugs in each cost-sharing tier is shown in Chapter 6 (*What you pay for your Part D prescription drugs*).

Section 3.3 How can you find out if a specific drug is on the Drug List?

You have three ways to find out:

1. Check the most recent Drug List we sent you in the mail.
2. Visit the plan's website (*priorityhealth.com/mpsers*). The Drug List on the website is always the most current.
3. Call Customer Service to find out if a particular drug is on the plan's Drug List or to ask for a copy of the list. (Phone numbers for Customer Service are printed on the back cover of this booklet.)

SECTION 4 There are restrictions on coverage for some drugs

Section 4.1 Why do some drugs have restrictions?

For certain prescription drugs, special rules restrict how and when the plan covers them. A team of doctors and pharmacists developed these rules to help our members use drugs in the most effective ways. These special rules also help control overall drug costs, which keeps your drug coverage more affordable.

In general, our rules encourage you to get a drug that works for your medical condition and is safe and effective. Whenever a safe, lower-cost drug will work just as well medically as a higher-cost drug, the plan's rules are designed to encourage you and your provider to use that lower-cost option. We also need to comply with Medicare's rules and regulations for drug coverage and cost-sharing.

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. If you want us to waive the restriction for you, you will need to use the coverage decision process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 9, Section 6.2 for information about asking for exceptions.)

Please note that sometimes a drug may appear more than once in our drug list. This is because different restrictions or cost-sharing may apply based on factors such as the strength, amount, or form of the drug prescribed by your health care provider (for instance, 10 mg versus 100 mg; one per day versus two per day; tablet versus liquid).

Section 4.2 What kinds of restrictions?

Our plan uses different types of restrictions to help our members use drugs in the most effective ways. The sections below tell you more about the types of restrictions we use for certain drugs.

Restricting brand name drugs when a generic version is available

Generally, a "generic" drug works the same as a brand name drug and usually costs less. **In most cases, when a generic version of a brand name drug is available, our network pharmacies will provide you the generic version.** We usually will not cover the brand name drug when a generic version is available. However, if your provider has told us the medical reason that neither the generic drug nor other covered drugs that treat the same condition will work for you, then we will cover the brand name drug. (Your share of the cost may be greater for the brand name drug than for the generic drug.)

Getting plan approval in advance

For certain drugs, you or your provider need to get approval from the plan before we will agree to cover the drug for you. This is called "**prior authorization**." Sometimes the requirement for getting approval in advance helps guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by the plan.

Trying a different drug first

This requirement encourages you to try less costly but just as effective drugs before the plan covers another drug. For example, if Drug A and Drug B treat the same medical condition, the plan may require you to try Drug A first. If Drug A does not work for you, the plan will then cover Drug B. This requirement to try a different drug first is called **"step therapy."**

Quantity limits

For certain drugs, we limit the amount of the drug that you can have by limiting how much of a drug you can get each time you fill your prescription. For example, if it is normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day.

Section 4.3 Do any of these restrictions apply to your drugs?

The plan's Drug List includes information about the restrictions described above. To find out if any of these restrictions apply to a drug you take or want to take, check the Drug List. For the most up-to-date information, call Customer Service (phone numbers are printed on the back cover of this booklet) or check our website (*priorityhealth.com/mpsers*).

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. If there is a restriction on the drug you want to take, you should contact Customer Service to learn what you or your provider would need to do to get coverage for the drug. If you want us to waive the restriction for you, you will need to use the coverage decision process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 9, Section 6.2 for information about asking for exceptions.)

SECTION 5 What if one of your drugs is not covered in the way you'd like it to be covered?

Section 5.1 There are things you can do if your drug is not covered in the way you'd like it to be covered

We hope that your drug coverage will work well for you. But it's possible that there could be a prescription drug you are currently taking, or one that you and your provider think you should be taking that is not on our formulary or is on our formulary with restrictions. For example:

- The drug might not be covered at all. Or maybe a generic version of the drug is covered but the brand name version you want to take is not covered.
- The drug is covered, but there are extra rules or restrictions on coverage for that drug. As explained in Section 4, some of the drugs covered by the plan have extra rules to restrict their use. For example, you might be required to try a different drug first, to see if it will work, before the drug you want to take will be covered for you. Or there might be limits on what amount of the drug (number of pills, etc.) is covered during a particular time period. In some cases, you may want us to waive the restriction for you.
- The drug is covered, but it is in a cost-sharing tier that makes your cost-sharing more expensive than you think it should be. The plan puts each covered drug into one of five different cost-sharing tiers. How much you pay for your prescription depends in part on which cost-sharing tier your drug is in.

There are things you can do if your drug is not covered in the way that you'd like it to be covered. Your options depend on what type of problem you have:

- If your drug is not on the Drug List or if your drug is restricted, go to Section 5.2 to learn what you can do.
- If your drug is in a cost-sharing tier that makes your cost more expensive than you think it should be, go to Section 5.3 to learn what you can do.

Section 5.2 What can you do if your drug is not on the Drug List or if the drug is restricted in some way?

If your drug is not on the Drug List or is restricted, here are things you can do:

- You may be able to get a temporary supply of the drug (only members in certain situations can get a temporary supply). This will give you and your provider time to change to another drug or to file a request to have the drug covered.
- You can change to another drug.

- You can request an exception and ask the plan to cover the drug or remove restrictions from the drug.

You may be able to get a temporary supply

Under certain circumstances, the plan can offer a temporary supply of a drug to you when your drug is not on the Drug List or when it is restricted in some way. Doing this gives you time to talk with your provider about the change in coverage and figure out what to do.

To be eligible for a temporary supply, you must meet the two requirements below:

1. The change to your drug coverage must be one of the following types of changes:

- The drug you have been taking is **no longer on the plan's Drug List**.
- or -- the drug you have been taking is **now restricted in some way** (Section 4 in this chapter tells about restrictions).

2. You must be in one of the situations described below:

- **For those members who are new or who were in the plan last year and aren't in a long-term care (LTC) facility:**

  We will cover a temporary supply of your drug **during the first 90 days of your membership in the plan if you were new and during the first 90 days of the plan year if you were in the plan last year**. This temporary supply will be for a maximum of a 30-day supply. 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 a network pharmacy.

- **For those members who are new or who were in the plan last year and reside in a long-term care (LTC) facility:**

  We will cover a temporary supply of your drug **during the first 90 days of your membership in the plan if you are new and during the first 90 days of the plan year if you were in the plan last year**. The total supply will be for a maximum of a 93-day supply. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of a 93-day supply of medication. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)

- **For those members who have been in the plan for more than 90 days and reside in a long-term care (LTC) facility and need a supply right away:**

  We will cover one 31-day supply of a particular drug, or less if your prescription is written for fewer days. This is in addition to the above long-term care transition supply.

- Per CMS regulations, **Priority**Medicare (Employer HMO-POS) provides members experiencing a level-of-care change with a transition supply of at least 30 days of medication unless the prescription is written for fewer days.

To ask for a temporary supply, call Customer Service (phone numbers are printed on the back cover of this booklet).

During the time when you are getting a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug. The sections below tell you more about these options.

You can change to another drug

Start by talking with your provider. Perhaps there is a different drug covered by the plan that might work just as well for you. You can call Customer Service to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you. (Phone numbers for Customer Service are printed on the back cover of this booklet.)

You can ask for an exception

You and your provider can ask the plan to make an exception for you and cover the drug in the way you would like it to be covered. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception to the rule. For example, you can ask the plan to cover a drug even though it is not on the plan's Drug List. Or you can ask the plan to make an exception and cover the drug without restrictions.

If you are a current member and a drug you are taking will be removed from the formulary or restricted in some way for next year, we will allow you to request a formulary exception in advance for next year. We will tell you about any change in the coverage for your drug for next year. You can ask for an exception before next year and we will give you an answer within 72 hours after we receive your request (or your prescriber's supporting statement). If we approve your request, we will authorize the coverage before the change takes effect.

If you and your provider want to ask for an exception, Chapter 9, Section 6.4 tells what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

Section 5.3 What can you do if your drug is in a cost-sharing tier you think is too high?

If your drug is in a cost-sharing tier you think is too high, here are things you can do:

You can change to another drug

If your drug is in a cost-sharing tier you think is too high, start by talking with your provider. Perhaps there is a different drug in a lower cost-sharing tier that might work just as well for you. You can call Customer Service to ask for a list of covered drugs that treat the same medical

condition. This list can help your provider find a covered drug that might work for you. (Phone numbers for Customer Service are printed on the back cover of this booklet.)

You can ask for an exception

For some drugs you and your provider can ask the plan to make an exception in the cost-sharing tier for the drug so that you pay less for it. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception to the rule.

If you and your provider want to ask for an exception, Chapter 9, Section 6.4 tells what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

Drugs in our generic tiers and specialty tiers are not eligible for this type of exception. We do not lower the cost-sharing amount for drugs in these tiers.

SECTION 6 What if your coverage changes for one of your drugs?

Section 6.1 The Drug List can change during the year

Most of the changes in drug coverage happen at the beginning of each year (January 1). However, during the year, the plan might make changes to the Drug List. For example, the plan might:

- **Add or remove drugs from the Drug List**. New drugs become available, including new generic drugs. Perhaps the government has given approval to a new use for an existing drug. Sometimes, a drug gets recalled and we decide not to cover it. Or we might remove a drug from the list because it has been found to be ineffective.
- **Move a drug to a higher or lower cost-sharing tier**.
- **Add or remove a restriction on coverage for a drug** (for more information about restrictions to coverage, see Section 4 in this chapter).
- **Replace a brand name drug with a generic drug.**

In almost all cases, we must get approval from Medicare for changes we make to the plan's Drug List.

Section 6.2 What happens if coverage changes for a drug you are taking?

How will you find out if your drug's coverage has been changed?

If there is a change to coverage *for a drug you are taking*, the plan will send you a notice to tell you. Normally, **we will let you know at least 60 days ahead of time**.

Once in a while, a drug is **suddenly recalled** because it's been found to be unsafe or for other reasons. If this happens, the plan will immediately remove the drug from the Drug List. We will let you know of this change right away. Your provider will also know about this change, and can work with you to find another drug for your condition.

Do changes to your drug coverage affect you right away?

If any of the following types of changes affect a drug you are taking, the change will not affect you until January 1 of the next year if you stay in the plan:

- If we move your drug into a higher cost-sharing tier.
- If we put a new restriction on your use of the drug.
- If we remove your drug from the Drug List, but not because of a sudden recall or because a new generic drug has replaced it.

If any of these changes happen for a drug you are taking, then the change won't affect your use or what you pay as your share of the cost until January 1 of the next year. Until that date, you probably won't see any increase in your payments or any added restriction to your use of the drug. However, on January 1 of the next year, the changes will affect you.

In some cases, you will be affected by the coverage change before January 1:

- If a **brand name drug you are taking is replaced by a new generic drug**, the plan must give you at least 60 days' notice or give you a 60-day refill of your brand name drug at a network pharmacy.
    - During this 60-day period, you should be working with your provider to switch to the generic or to a different drug that we cover.
    - Or you and your provider can ask the plan to make an exception and continue to cover the brand name drug for you. For information on how to ask for an exception, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).*
- Again, if a drug is **suddenly recalled** because it's been found to be unsafe or for other reasons, the plan will immediately remove the drug from the Drug List. We will let you know of this change right away.

- Your provider will also know about this change, and can work with you to find another drug for your condition.

SECTION 7 What types of drugs are *not* covered by the plan?

Section 7.1 Types of drugs we do not cover

This section tells you what kinds of prescription drugs are "excluded." This means Medicare does not pay for these drugs.

If you get drugs that are excluded, you must pay for them yourself. We won't pay for the drugs that are listed in this section. The only exception: If the requested drug is found upon appeal to be a drug that is not excluded under Part D and we should have paid for or covered it because of your specific situation. (For information about appealing a decision we have made to not cover a drug, go to Chapter 9, Section 6.5 in this booklet.)

Here are three general rules about drugs that Medicare drug plans will not cover under Part D:

- Our plan's Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
- Our plan cannot cover a drug purchased outside the United States and its territories.
- Our plan usually cannot cover off-label use. "Off-label use" is any use of the drug other than those indicated on a drug's label as approved by the Food and Drug Administration.
    - Generally, coverage for "off-label use" is allowed only when the use is supported by certain reference books. These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, for cancer, the National Comprehensive Cancer Network and Clinical Pharmacology, or their successors. If the use is not supported by any of these reference books, then our plan cannot cover its "off-label use."

Also, by law, these categories of drugs are not covered by Medicare drug plans:

- Non-prescription drugs (also called over-the-counter drugs)
- Drugs when used to promote fertility
- Drugs when used for the relief of cough or cold symptoms
- Drugs when used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs when used for the treatment of sexual or erectile dysfunction, such as Viagra, Cialis, Levitra, and Caverject

- Drugs when used for treatment of anorexia, weight loss, or weight gain
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale

We offer additional coverage of some prescription drugs not normally covered in a Medicare prescription drug plan (enhanced drug coverage). They are noted in your formulary with an "ED" (excluded drug).

- Drugs when used to promote fertility. You pay 50% coinsurance for infertility drugs.
- Some drugs used for the relief of cough or cold symptoms. These types of drugs follow our Part D drug tiers. This means, they will fall into tier 1, 2, 3, 4 or 5 and you pay accordingly.

The amount you pay when you fill a prescription for these drugs does not count towards qualifying you for the Catastrophic Coverage Stage. (The Catastrophic Coverage Stage is described in Chapter 6, Section 7 of this booklet).

If you receive "Extra Help" paying for your drugs, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Please contact your state Medicaid program to determine what drug coverage may be available to you. (You can find phone numbers and contact information for Medicaid in Chapter 2, Section 6.)

SECTION 8 Show your plan membership card when you fill a prescription

Section 8.1 Show your membership card

To fill your prescription, show your plan membership card at the network pharmacy you choose. When you show your plan membership card, the network pharmacy will automatically bill the plan for *our* share of your covered prescription drug cost. You will need to pay the pharmacy *your* share of the cost when you pick up your prescription.

Section 8.2 What if you don't have your membership card with you?

If you don't have your plan membership card with you when you fill your prescription, ask the pharmacy to call the plan to get the necessary information.

If the pharmacy is not able to get the necessary information, **you may have to pay the full cost of the prescription when you pick it up**. (You can then **ask us to reimburse you** for our share. See Chapter 7, Section 2.1 for information about how to ask the plan for reimbursement.)

SECTION 9 Part D drug coverage in special situations

Section 9.1 What if you're in a hospital or a skilled nursing facility for a stay that is covered by the plan?

If you are admitted to a hospital or to a skilled nursing facility for a stay covered by the plan, we will generally cover the cost of your prescription drugs during your stay. Once you leave the hospital or skilled nursing facility, the plan will cover your drugs as long as the drugs meet all of our rules for coverage. See the previous parts of this section that tell about the rules for getting drug coverage. Chapter 6 (*What you pay for your Part D prescription drugs*) gives more information about drug coverage and what you pay.

Please Note: When you enter, live in, or leave a skilled nursing facility, you are entitled to a Special Enrollment Period. During this time period, you can switch plans or change your coverage. (Chapter 10, *Ending your membership in the plan*, tells when you can leave our plan and join a different Medicare plan.)

Section 9.2 What if you're a resident in a long-term care (LTC) facility?

Usually, a long-term care (LTC) facility (such as a nursing home) has its own pharmacy, or a pharmacy that supplies drugs for all of its residents. If you are a resident of a long-term care facility, you may get your prescription drugs through the facility's pharmacy as long as it is part of our network.

Check your *Provider/Pharmacy Directory* to find out if your long-term care facility's pharmacy is part of our network. If it isn't, or if you need more information, please contact Customer Service (phone numbers are printed on the back cover of this booklet).

What if you're a resident in a long-term care (LTC) facility and become a new member of the plan?

If you need a drug that is not on our Drug List or is restricted in some way, the plan will cover a **temporary supply** of your drug during the first 90 days of your membership. The total supply will be for a maximum of 93-day supply, or less if your prescription is written for fewer days. (Please note that the long-term care (LTC) pharmacy may provide the drug in smaller amounts at a time to prevent waste.) If you have been a member of the plan for more than 90 days and need a drug that is not on our Drug List or if the plan has any restriction on the drug's coverage, we will cover one 31-day supply, or less if your prescription is written for fewer days.

During the time when you are getting a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. Perhaps there is a different drug covered by the plan that might work just as well for you. Or you and your provider can ask the plan to make an exception for you and cover the drug in the way you would like it to be

covered. If you and your provider want to ask for an exception, Chapter 9, Section 6.4 tells what to do.

Section 9.3 What if you're also getting drug coverage from an employer or retiree group plan?

Do you currently have other prescription drug coverage through your (or your spouse's) employer or retiree group? If so, please contact the Office of Retirement Services at 1-800-381-5111. He or she can help you determine how your current prescription drug coverage will work with our plan.

Special note about 'creditable coverage':

Each year your employer or retiree group should send you a notice that tells if your prescription drug coverage for the next plan year is "creditable" and the choices you have for drug coverage.

If the coverage from the group plan is "**creditable**," it means that the plan has drug coverage that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.

Keep these notices about creditable coverage, because you may need them later. If you enroll in a Medicare plan that includes Part D drug coverage, you may need these notices to show that you have maintained creditable coverage. If you didn't get a notice about creditable coverage from your retirement system, you can get a copy from your retiree plan's benefits administrator at the Office of Retirement Services.

Section 9.4 What if you're in Medicare-certified hospice?

Drugs are never covered by both hospice and our plan at the same time. If you are enrolled in Medicare hospice and require an anti-nausea, laxative, pain medication or anti-anxiety drug that is not covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must receive notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent delays in receiving any unrelated drugs that should be covered by our plan, you can ask your hospice provider or prescriber to make sure we have the notification that the drug is unrelated before you ask a pharmacy to fill your prescription.

In the event you either revoke your hospice election or are discharged from hospice our plan should cover all your drugs. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, you should bring documentation to the pharmacy to verify your revocation or discharge. See the previous parts of this section that tell about the rules for getting drug coverage under Part D Chapter 6 (*What you pay for your Part D prescription drugs*) gives more information about drug coverage and what you pay.

SECTION 10 Programs on drug safety and managing medications

Section 10.1 Programs to help members use drugs safely

We conduct drug use reviews for our members to help make sure that they are getting safe and appropriate care. These reviews are especially important for members who have more than one provider who prescribes their drugs.

We do a review each time you fill a prescription. We also review our records on a regular basis. During these reviews, we look for potential problems such as:

- Possible medication errors
- Drugs that may not be necessary because you are taking another drug to treat the same medical condition
- Drugs that may not be safe or appropriate because of your age or gender
- Certain combinations of drugs that could harm you if taken at the same time
- Prescriptions written for drugs that have ingredients you are allergic to
- Possible errors in the amount (dosage) of a drug you are taking.

If we see a possible problem in your use of medications, we will work with your provider to correct the problem.

Section 10.2 Medication Therapy Management (MTM) program to help members manage their medications

We have a program that can help our members with complex health needs. For example, some members have several medical conditions, take different drugs at the same time, and have high drug costs.

This program is voluntary and free to members. A team of pharmacists and doctors developed the program for us. This program can help make sure that our members get the most benefit from the drugs they take.

Our program is called a Medication Therapy Management (MTM) program. Some members who take medications for different medical conditions may be able to get services through an MTM program. A pharmacist or other health professional will give you a comprehensive review of all your medications. You can talk about how best to take your medications, your costs, and any problems or questions you have about your prescription and over-the-counter medications. You'll get a written summary of this discussion. The summary has a medication action plan that recommends what you can do to make the best use of your medications, with space for you to

take notes or write down any follow-up questions. You'll also get a personal medication list that will include all the medications you're taking and why you take them.

It's a good idea to have your medication review before your yearly "Wellness" visit, so you can talk to your doctor about your action plan and medication list. Bring your action plan and medication list with you to your visit or anytime you talk with your doctors, pharmacists, and other health care providers. Also, keep your medication list with you (for example, with your ID) in case you go to the hospital or emergency room.

If we have a program that fits your needs, we will automatically enroll you in the program and send you information. If you decide not to participate, please notify us and we will withdraw you from the program. If you have any questions about these programs, please contact Customer Service (phone numbers are printed on the back cover of this booklet).

CHAPTER 6

What you pay for your Part D prescription drugs

Chapter 6. What you pay for your Part D prescription drugs

Did you know there are programs to help people pay for their drugs?

The "Extra Help" program helps people with limited resources pay for their drugs. For more information, see Chapter 2, Section 7.

Are you currently getting help to pay for your drugs?

If you are in a program that helps pay for your drugs, **some information in this *Evidence of Coverage* about the costs for Part D prescription drugs may not apply to you.** We have included or will send you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also known as the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug coverage. If you don't have this insert, please call Customer Service and ask for the "LIS Rider." (Phone numbers for Customer Service are printed on the back cover of this booklet.)

SECTION 1 Introduction

Section 1.1 Use this chapter together with other materials that explain your drug coverage

This chapter focuses on what you pay for your Part D prescription drugs. To keep things simple, we use "drug" in this chapter to mean a Part D prescription drug. As explained in Chapter 5, not all drugs are Part D drugs – some drugs are covered under Medicare Part A or Part B and other drugs are excluded from Medicare coverage by law.

To understand the payment information we give you in this chapter, you need to know the basics of what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Here are materials that explain these basics:

- **The plan's *List of Covered Drugs (Formulary).*** To keep things simple, we call this the "Drug List."
  - This Drug List tells which drugs are covered for you.
  - It also tells which of the five "cost-sharing tiers" the drug is in and whether there are any restrictions on your coverage for the drug.
  - If you need a copy of the Drug List, call Customer Service (phone numbers are printed on the back cover of this booklet). You can also find the Drug List on our website at *priorityhealth.com/mpsers*. The Drug List on the website is always the most current.
- **Chapter 5 of this booklet.** Chapter 5 gives the details about your prescription drug coverage, including rules you need to follow when you get your covered drugs. Chapter 5 also tells which types of prescription drugs are not covered by our plan.

- **The plan's *Provider/Pharmacy Directory.*** In most situations you must use a network pharmacy to get your covered drugs (see Chapter 5 for the details). The *Provider/Pharmacy Directory* has a list of pharmacies in the plan's network. It also tells you which pharmacies in our network can give you a long-term supply of a drug (such as filling a prescription for a three-month's supply).

Section 1.2 Types of out-of-pocket costs you may pay for covered drugs

To understand the payment information we give you in this chapter, you need to know about the types of out-of-pocket costs you may pay for your covered services. The amount that you pay for a drug is called "cost-sharing" and there are three ways you may be asked to pay.

- **"Copayment"** means that you pay a fixed amount each time you fill a prescription.
- **"Coinsurance"** means that you pay a percent of the total cost of the drug each time you fill a prescription.

SECTION 2 What you pay for a drug depends on which "drug payment stage" you are in when you get the drug

Section 2.1 What are the drug payment stages for **Priority**Medicare (Employer HMO-POS) members?

As shown in the table below, there are "drug payment stages" for your prescription drug coverage under **Priority**Medicare (Employer HMO-POS). How much you pay for a drug depends on which of these stages you are in at the time you get a prescription filled or refilled. Keep in mind you are always responsible for the plan's monthly premium (if applicable) regardless of the drug payment stage.

Stage 1 *Yearly Deductible Stage*	**Stage 2** *Initial Coverage Stage*	**Stage 3** *Coverage Gap Stage*	**Stage 4** *Catastrophic Coverage Stage*
Because there is no deductible for the plan, this payment stage does not apply to you.	You begin in this stage when you fill your first prescription of the year. During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.** You stay in this stage until your year-to-date **"total drug costs"** (your payments plus any Part D plan's payments) total $3,750. (Details are in Section 5 of this chapter.)	Because your plan is sponsored by the Michigan Public School Employees' Retirement System, you are only responsible for **your share of the cost**. You stay in this stage until your year-to-date **"out-of-pocket costs"** (your payments) reach a total of $5,000. This amount and rules for counting costs toward this amount have been set by Medicare. (Details are in Section 6 of this chapter.)	During this stage, **the plan will pay most of the cost** of your drugs for the rest of the plan year. (Details are in Section 7 of this chapter.)

SECTION 3 We send you reports that explain payments for your drugs and which payment stage you are in

Section 3.1 We send you a monthly report called the "Part D Explanation of Benefits" (the "Part D EOB")

Our plan keeps track of the costs of your prescription drugs and the payments you have made when you get your prescriptions filled or refilled at the pharmacy. This way, we can tell you when you have moved from one drug payment stage to the next. In particular, there are two types of costs we keep track of:

- We keep track of how much you have paid. This is called your "**out-of-pocket**" cost.
- We keep track of your "**total drug costs**." This is the amount you pay out-of-pocket or others pay on your behalf plus the amount paid by the plan.

Our plan will prepare a written report called the *Part D Explanation of Benefits* (it is sometimes called the "Part D EOB") when you have had one or more prescriptions filled through the plan during the previous month. It includes:

- **Information for that month**. This report gives the payment details about the prescriptions you have filled during the previous month. It shows the total drug costs, what the plan paid, and what you and others on your behalf paid.
- **Totals for the plan year.** This is called "year-to-date" information. It shows you the total drug costs and total payments for your drugs since the plan year began.

Section 3.2 Help us keep our information about your drug payments up to date

To keep track of your drug costs and the payments you make for drugs, we use records we get from pharmacies. Here is how you can help us keep your information correct and up to date:

- **Show your membership card when you get a prescription filled.** To make sure we know about the prescriptions you are filling and what you are paying, show your plan membership card every time you get a prescription filled.
- **Make sure we have the information we need.** There are times you may pay for prescription drugs when we will not automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, you may give us copies of receipts for drugs that you have purchased. (If you are billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 7, Section 2 of this booklet.) Here are some types of situations when you may want to give us copies of your drug receipts to be sure we have a complete record of what you have spent for your drugs:
    - When you purchase a covered drug at a network pharmacy at a special price or using a discount card that is not part of our plan's benefit.
    - When you made a copayment for drugs that are provided under a drug manufacturer patient assistance program.
    - Any time you have purchased covered drugs at out-of-network pharmacies or other times you have paid the full price for a covered drug under special circumstances.
- **Send us information about the payments others have made for you.** Payments made by certain other individuals and organizations also count toward your out-of-pocket costs and help qualify you for catastrophic coverage. For example, payments made by an AIDS drug assistance program (ADAP), the Indian Health Service, and most charities count toward your out-of-pocket costs. You should keep a record of these payments and send them to us so we can track your costs.
- **Check the written report we send you.** When you receive a *Part D Explanation of Benefits* (a "Part D EOB") in the mail or online, please look it over to be sure the information is

complete and correct. If you think something is missing from the report, or you have any questions, please call us at Customer Service (phone numbers are printed on the back cover of this booklet). Be sure to keep these reports. They are an important record of your drug expenses.

SECTION 4 There is no deductible for **Priority**Medicare (Employer HMO-POS)

Section 4.1 You do not pay a deductible for your Part D drugs

There is no deductible for **Priority**Medicare (Employer HMO-POS). You begin in the Initial Coverage Stage when you fill your first prescription of the year. See Section 5 for information about your coverage in the Initial Coverage Stage.

SECTION 5 During the Initial Coverage Stage, the plan pays its share of your drug costs and you pay your share

Section 5.1 What you pay for a drug depends on the drug and where you fill your prescription

During the 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.

The plan has five cost-sharing tiers

Every drug on the plan's Drug List is in one of five cost-sharing tiers. In general, the higher the cost-sharing tier number, the higher your cost for the drug:

- **Tier 1 – Preferred generic drug.** This is the lowest tier and includes preferred generic drugs.
- **Tier 2 – Generic drug.** This tier includes generic drugs and some self-administered insulin.
- **Tier 3 – Preferred brand drug.** This tier includes preferred brand drugs.
- **Tier 4 – Non-preferred drug.** This tier includes non-preferred brand drugs and some high-cost generic drugs.
- **Tier 5 – Specialty drugs.** This is the highest tier and includes specialty drugs, which are limited to a maximum of a 30-day supply per prescription or refill.

To find out which cost-sharing tier your drug is in, look it up in the plan's Drug List.

Your pharmacy choices

How much you pay for a drug depends on whether you get the drug from:

- A network retail pharmacy that offers standard cost-sharing
- A network retail pharmacy that offers preferred cost-sharing
- A pharmacy that is not in the plan's network
- The plan's mail-order pharmacy

For more information about these pharmacy choices and filling your prescriptions, see Chapter 5 in this booklet and the plan's *Provider/Pharmacy Directory.*

Generally, we will cover your prescriptions *only* if they are filled at one of our network pharmacies. Some of our network pharmacies also offer preferred cost-sharing. You may go to either network pharmacies that offer preferred cost-sharing or other network pharmacies that offer standard cost-sharing to receive your covered prescription drugs. Your costs may be less at pharmacies that offer preferred cost-sharing.

Section 5.2 A table that shows your costs for a *one-month* supply of a drug

During the Initial Coverage Stage, your share of the cost of a covered drug will be either a copayment or coinsurance.

- **"Copayment"** means that you pay a fixed amount each time you fill a prescription.
- **"Coinsurance"** means that you pay a percent of the total cost of the drug each time you fill a prescription.

As shown in the table below, the amount of the copayment or coinsurance depends on which cost-sharing tier your drug is in. Please note:

- If your covered drug costs less than the copayment amount listed in the chart, you will pay that lower price for the drug. You pay *either* the full price of the drug *or* the copayment amount, *whichever is lower*.

- We cover prescriptions filled at out-of-network pharmacies in only limited situations. Please see Chapter 5, Section 2.5 for information about when we will cover a prescription filled at an out-of-network pharmacy.

Your share of the cost when you get a *one-month* supply of a covered Part D prescription drug:

	Standard retail cost-sharing (in-network) (up to a 30-day supply)	**Preferred retail cost-sharing (in-network)** (up to a 30-day supply)	**Mail-order cost-sharing** (up to a 30-day supply)	**Long-term care (LTC) cost-sharing** (up to a 31-day supply)	**Out-of-network cost-sharing** (Coverage is limited to certain situations; see Chapter 5 for details.) (up to a 30-day supply)
Cost-Sharing Tier 1 (*preferred generic drugs*)	$15	$9	$9	$15	$15
Cost-Sharing Tier 2 (*generic drugs*)	$15	$9	$9	$15	$15
Cost-Sharing Tier 3 (*preferred brand drugs*)	$45	$40	$40	$45	$45
Cost-Sharing Tier 4 (*non-preferred drugs*)	$75	$70	$70	$75	$75
Cost-Sharing Tier 5 (*specialty drugs*)	20% of the cost up to a $100 maximum	20% of the cost up to a $100 maximum	20% of the cost up to a $100 maximum	20% of the cost up to a $100 maximum	20% of the cost up to a $100 maximum

Note: A two-month supply is available for 31-60 days (retail or mail-order). The cost is two 30-day cost-shares. A two-month supply is not available for drugs in tier 5.

Section 5.3 If your doctor prescribes less than a full month's supply, you may not have to pay the cost of the entire month's supply

Typically, the amount you pay for a prescription drug covers a full month's supply of a covered drug. However your doctor can prescribe less than a month's supply of drugs. There may be times when you want to ask your doctor about prescribing less than a month's supply of a drug (for example, when you are trying a medication for the first time that is known to have serious side effects). If your doctor prescribes less than a full month's supply, you will not have to pay for the full month's supply for certain drugs.

The amount you pay when you get less than a full month's supply will depend on whether you are responsible for paying coinsurance (a percentage of the total cost) or a copayment (a flat dollar amount).

- If you are responsible for coinsurance, you pay a *percentage* of the total cost of the drug. You pay the same percentage regardless of whether the prescription is for a full month's supply or for fewer days. However, because the entire drug cost will be lower if you get less than a full month's supply, the *amount* you pay will be less.
- If you are responsible for a copayment for the drug, your copay will be based on the number of days of the drug that you receive. We will calculate the amount you pay per day for your drug (the "daily cost-sharing rate") and multiply it by the number of days of the drug you receive.
    - Here's an example: Let's say the copay for your drug for a full month's supply (a 30-day supply) is $30. This means that the amount you pay per day for your drug is $1. If you receive a 7 days' supply of the drug, your payment will be $1 per day multiplied by 7 days, for a total payment of $7.

Daily cost-sharing allows you to make sure a drug works for you before you have to pay for an entire month's supply. You can also ask your doctor to prescribe, and your pharmacist to dispense, less than a full month's supply of a drug or drugs, if this will help you better plan your refill dates for different prescriptions so that you can take fewer trips to the pharmacy. The amount you pay will depend upon the days' supply you receive.

Section 5.4 A table that shows your costs for a *long-term* up to a 90-day supply of a drug

For some drugs, you can get a long-term supply (also called an "extended supply") when you fill your prescription. A long-term supply is up to a 90-day supply. (For details on where and how to get a long-term supply of a drug, see Chapter 5, Section 2.4.)

The table below shows what you pay when you get a long-term (up to a 90-day) supply of a drug.

- Please note: If your covered drug costs are less than the copayment amount listed in the chart, you will pay that lower price for the drug. You pay *either* the full price of the drug *or* the copayment amount, *whichever is lower*.

Your share of the cost when you get a *long-term* supply of a covered Part D prescription drug:

Tier	Standard retail cost-sharing (in-network) (90-day supply)	Preferred retail cost-sharing (in-network) (90-day supply)	Mail-order cost-sharing (90-day supply)
Cost-Sharing Tier 1 (*preferred generic drugs*)	$45	$27	$18
Cost-Sharing Tier 2 (*generic drugs*)	$45	$27	$18
Cost-Sharing Tier 3 (*preferred brand drugs*)	$135	$120	$80
Cost-Sharing Tier 4 (*non-preferred drugs*)	$225	$210	$140
Cost-Sharing Tier 5 (*specialty drugs*)	A long-term supply is not available for drugs in Tier 5.	A long-term supply is not available for drugs in Tier 5.	A long-term supply is not available for drugs in Tier 5.

Section 5.5 You stay in the Initial Coverage Stage until your total drug costs for the year reach $3,750

You stay in the Initial Coverage Stage until the total amount for the prescription drugs you have filled and refilled reaches the **$3,750 limit for the Initial Coverage Stage**.

Your total drug cost is based on adding together what you have paid and what any Part D plan has paid:

- **What <u>you</u> have paid** for all the covered drugs you have gotten since you started with your first drug purchase of the year. (See Section 6.2 for more information about how Medicare calculates your out-of-pocket costs.) This includes:

  - The total you paid as your share of the cost for your drugs during the Initial Coverage Stage.

- **What the plan has paid** as its share of the cost for your drugs during the Initial Coverage Stage. (If you were enrolled in a different Part D plan at any time during 2018, the amount that plan paid during the Initial Coverage Stage also counts toward your total drug costs.)

We offer additional coverage on some prescription drugs that are not normally covered in a Medicare Prescription Drug Plan. Payments made for these drugs will not count towards your initial coverage limit or total out-of-pocket costs. To find out which drugs our plan covers, refer to your formulary.

The *Part D Explanation of Benefits* (Part D EOB) that we send to you will help you keep track of how much you and the plan, as well as any third parties, have spent on your behalf during the year. Many people do not reach the $3,750 limit in a year.

We will let you know if you reach this $3,750 amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Coverage Gap Stage.

SECTION 6 During the Coverage Gap Stage, you are only responsible for your share of the cost

Section 6.1 You stay in the Coverage Gap Stage until your out-of-pocket costs reach $5,000

Because your plan is sponsored by the Michigan Public School Employees' Retirement System, when you are in the Coverage Gap Stage, you are only responsible for your share of the cost for prescription drugs. We still record your cost and the drug cost total and track the amount toward the total amount to reach the catastrophic coverage stage. Only the amount you pay counts and moves you through the coverage gap.

Medicare has rules about what counts and what does *not* count as your out-of-pocket costs. When you reach an out-of-pocket limit of $5,000, you leave the Coverage Gap Stage and move on to the Catastrophic Coverage Stage.

Section 6.2 How Medicare calculates your out-of-pocket costs for prescription drugs

Here are Medicare's rules that we must follow when we keep track of your out-of-pocket costs for your drugs.

These payments <u>are included</u> in your out-of-pocket costs

When you add up your out-of-pocket costs, **<u>you can include</u>** the payments listed below (as long as they are for Part D covered drugs and you followed the rules for drug coverage that are explained in Chapter 5 of this booklet):

- The amount you pay for drugs when you are in any of the following drug payment stages:
  - The Initial Coverage Stage.
  - The Coverage Gap Stage.
- Any Part D payments you made during this plan year as a member of a different Medicare prescription drug plan before you joined our plan.

It matters who pays:

- If you make these payments **yourself**, they are included in your out-of-pocket costs.
- These payments are *also included* if they are made on your behalf by **certain other individuals or organizations.** This includes payments for your drugs made by a friend or relative, by most charities, by AIDS drug assistance programs, or by the Indian Health Service. Payments made by Medicare's "Extra Help" Program are also included.
- Some of the payments made by the Medicare Coverage Gap Discount Program are included. The amount the manufacturer pays for your brand name drugs is included. But the amount the plan pays for your generic drugs is not included.

Moving on to the Catastrophic Coverage Stage:

When you (or those paying on your behalf) have spent a total of $5,000 in out-of-pocket costs within the plan year, you will move from the Coverage Gap Stage to the Catastrophic Coverage Stage.

These payments <u>are not included</u> in your out-of-pocket costs

When you add up your out-of-pocket costs, you are **<u>not</u> allowed to include** any of these types of payments for prescription drugs:

- The amount you pay for your monthly premium.
- Drugs you buy outside the United States and its territories.
- Drugs that are not covered by our plan.
- Drugs you get at an out-of-network pharmacy that do not meet the plan's requirements for out-of-network coverage.
- Non-Part D drugs, including prescription drugs covered by Part A or Part B and other drugs excluded from coverage by Medicare.

- Payments you make toward prescription drugs not normally covered in a Medicare Prescription Drug Plan.
- Payments made by the plan for your brand or generic drugs while in the Coverage Gap.
- Payments for your drugs that are made by group health plans including employer health plans.
- Payments for your drugs that are made by certain insurance plans and government-funded health programs such as TRICARE and the Veterans Affairs.
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Workers' Compensation).

Reminder: If any other organization such as the ones listed above pays part or all of your out-of-pocket costs for drugs, you are required to tell our plan. Call Customer Service to let us know (phone numbers are printed on the back cover of this booklet).

How can you keep track of your out-of-pocket total?

- **We will help you.** The *Part D Explanation of Benefits* (Part D EOB) report we send to you includes the current amount of your out-of-pocket costs (Section 3 in this chapter tells about this report). When you reach a total of $5,000 in out-of-pocket costs for the year, this report will tell you that you have left the Coverage Gap Stage and have moved on to the Catastrophic Coverage Stage.
- **Make sure we have the information we need**. Section 3.2 tells what you can do to help make sure that our records of what you have spent are complete and up to date.

SECTION 7 During the Catastrophic Coverage Stage, the plan pays most of the cost for your drugs

Section 7.1 Once you are in the Catastrophic Coverage Stage, you will stay in this stage for the rest of the year

You qualify for the Catastrophic Coverage Stage when your out-of-pocket costs have reached the $5,000 limit for the plan year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the plan year.

During this stage, because you have an employer-sponsored plan, you will pay:

- **No more than the amount you pay in the initial coverage stage** per prescription.
- **Our plan pays the rest** of the cost.

SECTION 8 What you pay for vaccinations covered by Part D depends on how and where you get them

Section 8.1 Our plan may have separate coverage for the Part D vaccine medication itself and for the cost of giving you the vaccine

Our plan provides coverage for a number of Part D vaccines. We also cover vaccines that are considered medical benefits. You can find out about coverage of these vaccines by going to the Medical Benefits Chart in Chapter 4, Section 2.1.

There are two parts to our coverage of Part D vaccinations:

- The first part of coverage is the cost of **the vaccine medication itself**. The vaccine is a prescription medication.
- The second part of coverage is for the cost of **giving you the vaccine**. (This is sometimes called the "administration" of the vaccine.)

What do you pay for a Part D vaccination?

What you pay for a Part D vaccination depends on three things:

1. **The type of vaccine** (what you are being vaccinated for).
    - Some vaccines are considered medical benefits. You can find out about your coverage of these vaccines by going to Chapter 4, *Medical Benefits Chart (what is covered and what you pay).*
    - Other vaccines are considered Part D drugs. You can find these vaccines listed in the plan's *List of Covered Drugs (Formulary).*
2. **Where you get the vaccine medication.**
3. **Who gives you the vaccine.**

What you pay at the time you get the Part D vaccination can vary depending on the circumstances. For example:

- Sometimes when you get your vaccine, you will have to pay the entire cost for both the vaccine medication and for getting the vaccine. You can ask our plan to pay you back for our share of the cost.
- Other times, when you get the vaccine medication or the vaccine, you will pay only your share of the cost.

To show how this works, here are three common ways you might get a Part D vaccine.

Situation 1: You buy the Part D vaccine at the pharmacy and you get your vaccine at the network pharmacy. (Whether you have this choice depends on where you live. Some states do not allow pharmacies to administer a vaccination.)

- You will have to pay the pharmacy the amount of your copayment or coinsurance for the vaccine and the cost of giving you the vaccine.
- Our plan will pay the remainder of the costs.

Situation 2: You get the Part D vaccination at your doctor's office.

- When you get the vaccination, you will pay for the entire cost of the vaccine and its administration.
- You can then ask our plan to pay our share of the cost by using the procedures that are described in Chapter 7 of this booklet (*Asking us to pay our share of a bill you have received for covered medical services or drugs*).
- You will be reimbursed the amount you paid less your normal copayment or coinsurance for the vaccine (including administration)

Situation 3: You buy the Part D vaccine at your pharmacy, and then take it to your doctor's office where they give you the vaccine.

- You will have to pay the pharmacy the amount of your copayment or coinsurance for the vaccine itself.
- When your doctor gives you the vaccine, you will pay the entire cost for this service. You can then ask our plan to pay our share of the cost by using the procedures described in Chapter 7 of this booklet.
- You will be reimbursed the amount charged by the doctor for administering the vaccine

What do you pay for other Medicare-Part D drugs in an outpatient setting?

Medicare Part D drugs are usually considered self-administered drugs. A self-administered drug is one you would normally take on your own either orally, putting it on your skin (topical), injecting subcutaneously, or by inhaling it. You usually get these drugs at a pharmacy. However, there are times when you may also get Medicare-covered Part D self-administered drugs in an outpatient setting (e.g. PCP or specialist office, outpatient facility such as an ambulatory surgery center, outpatient surgery in a hospital, ER, urgent care, etc.).

If you get a Medicare-covered Part D self-administered drug in an outpatient setting you are not covered under your Part B or medical benefit. You are, however, covered under your Part D prescription drug benefit under this plan.

Here's how it works when you get Medicare-covered Part D self-administered drugs provided in an outpatient setting.

You get the Part D covered drug at your doctor's office or in an outpatient setting (for example, outpatient facility, urgent care, ER, etc).

- When you get the Part D covered drug, you will pay for the entire cost of the drug.
- You can then ask our plan to pay our share of the cost by using the procedures that are described in Chapter 7 of this booklet (*Asking us to pay our share of a bill you have received for covered medical services or drugs*).

You will be reimbursed the amount you paid less your normal copayment for the Part D covered drug less any difference between the amount the doctor or outpatient facility charges and what we normally pay. (If you get Extra Help, we will reimburse you for this difference.)

Section 8.2 You may want to call us at Customer Service before you get a vaccination

The rules for coverage of vaccinations are complicated. We are here to help. We recommend that you call us first at Customer Service whenever you are planning to get a vaccination. (Phone numbers for Customer Service are printed on the back cover of this booklet.)

- We can tell you about how your vaccination is covered by our plan and explain your share of the cost.
- We can tell you how to keep your own cost down by using providers and pharmacies in our network.
- If you are not able to use a network provider and pharmacy, we can tell you what you need to do to get payment from us for our share of the cost.

CHAPTER 7

Asking us to pay our share of a bill you have received for covered medical services or drugs

Chapter 7. Asking us to pay our share of a bill you have received for covered medical services or drugs

SECTION 1 Situations in which you should ask us to pay our share of the cost of your covered services or drugs

Section 1.1 If you pay our plan's share of the cost of your covered services or drugs, or if you receive a bill, you can ask us for payment

Sometimes when you get medical care or a prescription drug, you may need to pay the full cost right away. Other times, you may find that you have paid more than you expected under the coverage rules of the plan. In either case, you can ask our plan to pay you back (paying you back is often called "reimbursing" you). It is your right to be paid back by our plan whenever you've paid more than your share of the cost for medical services or drugs that are covered by our plan.

There may also be times when you get a bill from a provider for the full cost of medical care you have received. In many cases, you should send this bill to us instead of paying it. We will look at the bill and decide whether the services should be covered. If we decide they should be covered, we will pay the provider directly.

Here are examples of situations in which you may need to ask our plan to pay you back or to pay a bill you have received:

1. When you've received emergency or urgently needed medical care from a provider who is not in our plan's network

You can receive emergency services from any provider, whether or not the provider is a part of our network. When you receive emergency or urgently needed services from a provider who is not part of our network, you are only responsible for paying your share of the cost, not for the entire cost. You should ask the provider to bill the plan for our share of the cost.

- If you pay the entire amount yourself at the time you receive the care, you need to ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you have made.
- At times you may get a bill from the provider asking for payment that you think you do not owe. Send us this bill, along with documentation of any payments you have already made.
    - If the provider is owed anything, we will pay the provider directly.
    - If you have already paid more than your share of the cost of the service, we will determine how much you are owed and pay you back for our share of the cost.
- **Please note:** While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who is not eligible to participate in Medicare. If the provider is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive.

2. When a network provider sends you a bill you think you should not pay

Network providers should always bill the plan directly, and ask you only for your share of the cost. But sometimes they make mistakes, and ask you to pay more than your share.

- You only have to pay your cost-sharing amount when you get services covered by our plan. We do not allow providers to add additional separate charges, called "balance billing." This protection (that you never pay more than your cost-sharing amount) applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don't pay certain provider charges. For more information about "balance billing," go to Chapter 4, Section 1.5.
- Whenever you get a bill from a network provider that you think is more than you should pay, send us the bill. We will contact the provider directly and resolve the billing problem.
- If you have already paid a bill to a network provider, but you feel that you paid too much, send us the bill along with documentation of any payment you have made and ask us to pay you back the difference between the amount you paid and the amount you owed under the plan.

3. If you are retroactively enrolled in our plan.

Sometimes a person's enrollment in the plan is retroactive. (Retroactive means that the first day of their enrollment has already passed. The enrollment date may even have occurred last year.)

If you were retroactively enrolled in our plan and you paid out-of-pocket for any of your covered services or drugs after your enrollment date, you can ask us to pay you back for our share of the costs. You will need to submit paperwork for us to handle the reimbursement.

Please call Customer Service for additional information about how to ask us to pay you back and deadlines for making your request. (Phone numbers for Customer Service are printed on the back cover of this booklet.)

4. When you use an out-of-network pharmacy to get a prescription filled

If you go to an out-of-network pharmacy and try to use your membership card to fill a prescription, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription. (We cover prescriptions filled at out-of-network pharmacies only in a few special situations. Please go to Chapter 5, Section 2.5 to learn more.)

Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost.

5. When you pay the full cost for a prescription because you don't have your plan membership card with you

If you do not have your plan membership card with you, you can ask the pharmacy to call the plan or to look up your plan enrollment information. However, if the pharmacy cannot get the enrollment information they need right away, you may need to pay the full cost of the prescription yourself.

Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost.

6. When you pay the full cost for a prescription in other situations

You may pay the full cost of the prescription because you find that the drug is not covered for some reason.

- For example, the drug may not be on the plan's *List of Covered Drugs (Formulary)*; or it could have a requirement or restriction that you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.
- Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back for our share of the cost.

All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can appeal our decision. Chapter 9 of this booklet (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) has information about how to make an appeal.

SECTION 2 How to ask us to pay you back or to pay a bill you have received

Section 2.1 How and where to send us your request for payment

Send us your request for payment, along with your bill and documentation of any payment you have made. It's a good idea to make a copy of your bill and receipts for your records.

To make sure you are giving us all the information we need to make a decision, you can fill out our claim form to make your request for payment.

- You don't have to use the form, but it will help us process the information faster.
- Either download a copy of the form from our website (*priorityhealth.com/mpsers*) or call Customer Service and ask for the form. (Phone numbers for Customer Service are printed on the back cover of this booklet.)

For medical claims: Mail your request for payment together with any bills or receipts to us at this address:

Attn: Priority Health Claims
Priority Health
P.O. Box 232
Grand Rapids, MI 49501-0232

For Part D prescription drug claims: Mail your request for payment together with any bills or receipts to us at this address:

Attn: Medicare Part D MS 1260
Priority Health Medicare
1231 East Beltline Ave NE
Grand Rapids, MI 49525

You must submit your claim to us within one year of the date you received the service, item, or drug.

Contact Customer Service if you have any questions (phone numbers are printed on the back cover of this booklet). If you don't know what you should have paid, or you receive bills and you don't know what to do about those bills, we can help. You can also call if you want to give us more information about a request for payment you have already sent to us.

SECTION 3 We will consider your request for payment and say yes or no

Section 3.1 We check to see whether we should cover the service or drug and how much we owe

When we receive your request for payment, we will let you know if we need any additional information from you. Otherwise, we will consider your request and make a coverage decision.

- If we decide that the medical care or drug is covered and you followed all the rules for getting the care or drug, we will pay for our share of the cost. If you have already paid for the service or drug, we will mail your reimbursement of our share of the cost to you. If you have not paid for the service or drug yet, we will mail the payment directly to the provider. (Chapter 3 explains the rules you need to follow for getting your medical services covered. Chapter 5 explains the rules you need to follow for getting your Part D prescription drugs covered.)
- If we decide that the medical care or drug is *not* covered, or you did *not* follow all the rules, we will not pay for our share of the cost. Instead, we will send you a letter that

explains the reasons why we are not sending the payment you have requested and your rights to appeal that decision.

Section 3.2 If we tell you that we will not pay for all or part of the medical care or drug, you can make an appeal

If you think we have made a mistake in turning down your request for payment or you don't agree with the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment.

For the details on how to make this appeal, go to Chapter 9 of this booklet *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints))*. The appeals process is a formal process with detailed procedures and important deadlines. If making an appeal is new to you, you will find it helpful to start by reading Section 4 of Chapter 9. Section 4 is an introductory section that explains the process for coverage decisions and appeals and gives definitions of terms such as "appeal." Then after you have read Section 4, you can go to the section in Chapter 9 that tells what to do for your situation:

- If you want to make an appeal about getting paid back for a medical service, go to Section 5.3 in Chapter 9.
- If you want to make an appeal about getting paid back for a drug, go to Section 6.5 of Chapter 9.

SECTION 4 Other situations in which you should save your receipts and send copies to us

Section 4.1 In some cases, you should send copies of your receipts to us to help us track your out-of-pocket drug costs

There are some situations when you should let us know about payments you have made for your drugs. In these cases, you are not asking us for payment. Instead, you are telling us about your payments so that we can calculate your out-of-pocket costs correctly. This may help you to qualify for the Catastrophic Coverage Stage more quickly.

Here are two situations when you should send us copies of receipts to let us know about payments you have made for your drugs:

1. When you buy the drug for a price that is lower than our price

Sometimes when you are in the Coverage Gap Stage you can buy your drug **at a network pharmacy** for a price that is lower than our price.

- For example, a pharmacy might offer a special price on the drug. Or you may have a discount card that is outside our benefit that offers a lower price.
- Unless special conditions apply, you must use a network pharmacy in these situations and your drug must be on our Drug List.
- Save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage Stage.
- **Please note:** If you are in the Coverage Gap Stage, we may not pay for any share of these drug costs. But sending a copy of the receipt allows us to calculate your out-of-pocket costs correctly and may help you qualify for the Catastrophic Coverage Stage more quickly.

2. When you get a drug through a patient assistance program offered by a drug manufacturer

Some members are enrolled in a patient assistance program offered by a drug manufacturer that is outside the plan benefits. If you get any drugs through a program offered by a drug manufacturer, you may pay a copayment to the patient assistance program.

- Save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage Stage.
- **Please note:** Because you are getting your drug through the patient assistance program and not through the plan's benefits, we will not pay for any share of these drug costs. But sending a copy of the receipt allows us to calculate your out-of-pocket costs correctly and may help you qualify for the Catastrophic Coverage Stage more quickly.

Since you are not asking for payment in the two cases described above, these situations are not considered coverage decisions. Therefore, you cannot make an appeal if you disagree with our decision.

CHAPTER 8

Your rights and responsibilities

Chapter 8. Your rights and responsibilities

SECTION 1 Our plan must honor your rights as a member of the plan

Section 1.1 We must provide information in a way that works for you (in languages other than English, in Braille, in large print, or other alternate formats, etc.)

To get information from us in a way that works for you, please call Customer Service (phone numbers are printed on the back cover of this booklet).

Our plan has people and free interpreter services available to answer questions from disabled and non-English speaking members. We can also give you information in Braille, in large print, or other alternate formats at no cost if you need it. We are required to give you information about the plan's benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, please call Customer Service (phone numbers are printed on the back cover of this booklet).

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, please call to file a grievance with Customer Service at 888.389.6648, option 3. You may also file a complaint with Medicare by calling Medicare at 1-800-MEDICARE (1-800-633-4227), or directly with the Office of Civil Rights. Contact information is included in the Evidence of Coverage or with this mailing, or you may contact Customer Service for additional information.

Section 1.2 We must treat you with fairness and respect at all times

Our plan must obey laws that protect you from discrimination or unfair treatment. **We do not discriminate** based on a person's race, ethnicity, national origin, religion, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights.

If you have a disability and need help with access to care, please call us at Customer Service (phone numbers are printed on the back cover of this booklet). If you have a complaint, such as a problem with wheelchair access, Customer Service can help.

Section 1.3 We must ensure that you get timely access to your covered services and drugs

As a member of our plan, you have the right to choose a primary care provider (PCP) in the plan's network to provide and arrange for your covered services (Chapter 3 explains more about this). Call Customer Service to learn which doctors are accepting new patients (phone numbers are printed on the back cover of this booklet). You also have the right to go to a women's health specialist (such as a gynecologist) without a referral. We do not require you to get referrals to go to in-network providers.

As a plan member, you have the right to get appointments and covered services from the plan's network of providers *within a reasonable amount of time*. This includes the right to get timely services from specialists when you need that care. You also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays.

If you think that you are not getting your medical care or Part D drugs within a reasonable amount of time, Chapter 9, Section 10 of this booklet tells what you can do. (If we have denied coverage for your medical care or drugs and you don't agree with our decision, Chapter 9, Section 4 tells what you can do.)

Section 1.4 We must protect the privacy of your personal health information

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

- Your "personal health information" includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.
- The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We give you a written notice, called a "Notice of Privacy Practice," that tells about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- In most situations, if we give your health information to anyone who isn't providing your care or paying for your care, *we are required to get written permission from you first.* Written permission can be given by you or by someone you have given legal power to make decisions for you.
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.

- For example, we are required to release health information to government agencies that are checking on quality of care.
- Because you are a member of our plan through Medicare, we are required to give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations.

You can see the information in your records and know how it has been shared with others

You have the right to look at your medical records held at the plan, and to get a copy of your records. We are allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will work with your healthcare provider to decide whether the changes should be made.

You have the right to know how your health information has been shared with others for any purposes that are not routine.

If you have questions or concerns about the privacy of your personal health information, please call Customer Service (phone numbers are printed on the back cover of this booklet).

See Section 7 of Chapter 11, *Legal Notices*, for our complete privacy policy.

Section 1.5 We must give you information about the plan, its network of providers, and your covered services

As a member of **Priority**Medicare (Employer HMO-POS), you have the right to get several kinds of information from us. (As explained above in Section 1.1, you have the right to get information from us in a way that works for you. This includes getting the information in languages other than English and in large print or other alternate formats.)

If you want any of the following kinds of information, please call Customer Service (phone numbers are printed on the back cover of this booklet):

- **Information about our plan**. This includes, for example, information about the plan's financial condition. It also includes information about the number of appeals made by members and the plan's performance ratings, including how it has been rated by plan members and how it compares to other Medicare health plans.
- **Information about our network providers including our network pharmacies.**
  - For example, you have the right to get information from us about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.

  - For a list of the providers and pharmacies in the plan's network, see the *Provider/Pharmacy Directory.*
  - For more detailed information about our providers or pharmacies, you can call Customer Service (phone numbers are printed on the back cover of this booklet) or visit our website at *priorityhealth.com/mpsers*.

- **Information about your coverage and the rules you must follow when using your coverage.**
  - In Chapters 3 and 4 of this booklet, we explain what medical services are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered medical services.
  - To get the details on your Part D prescription drug coverage, see Chapters 5 and 6 of this booklet plus the plan's *List of Covered Drugs (Formulary).* These chapters, together with the *List of Covered Drugs (Formulary)*, tell you what drugs are covered and explain the rules you must follow and the restrictions to your coverage for certain drugs.
  - If you have questions about the rules or restrictions, please call Customer Service (phone numbers are printed on the back cover of this booklet).
- **Information about why something is not covered and what you can do about it.**
  - If a medical service or Part D drug is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the medical service or drug from an out-of-network provider or pharmacy.
  - If you are not happy or if you disagree with a decision we make about what medical care or Part D drug is covered for you, you have the right to ask us to change the decision. You can ask us to change the decision by making an appeal. For details on what to do if something is not covered for you in the way you think it should be covered, see Chapter 9 of this booklet. It gives you the details about how to make an appeal if you want us to change our decision. (Chapter 9 also tells about how to make a complaint about quality of care, waiting times, and other concerns.)
  - If you want to ask our plan to pay our share of a bill you have received for medical care or a Part D prescription drug, see Chapter 7 of this booklet.

Section 1.6 We must support your right to make decisions about your care

You have the right to know your treatment options and participate in decisions about your health care

You have the right to get full information from your doctors and other health care providers when you go for medical care. Your providers must explain your medical condition and your treatment choices *in a way that you can understand*.

You also have the right to participate fully in decisions about your health care. To help you make decisions with your doctors about what treatment is best for you, your rights include the following:

- **To know about all of your choices.** This means that you have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say "no.**" You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.
- **To receive an explanation if you are denied coverage for care.** You have the right to receive an explanation from us if a provider has denied care that you believe you should receive. To receive this explanation, you will need to ask us for a coverage decision. Chapter 9 of this booklet tells how to ask the plan for a coverage decision.

You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself

Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in this situation. This means that, *if you want to*, you can:

- Fill out a written form to give **someone the legal authority to make medical decisions for you** if you ever become unable to make decisions for yourself.
- **Give your doctors written instructions** about how you want them to handle your medical care if you become unable to make decisions for yourself.

The legal documents that you can use to give your directions in advance in these situations are called "**advance directives**." There are different types of advance directives and different names for them. Documents called "**living will**" and "**power of attorney for health care**" are examples of advance directives.

If you want to use an "advance directive" to give your instructions, here is what to do:

- **Get the form.** If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also contact Customer Service to ask for the forms (phone numbers are printed

on the back cover of this booklet). See Chapter 12, Definitions of important words, for *Advance directive*.

- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, **take a copy with you to the hospital**.

- If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you.
- If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive.

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with the Department of Licensing and Regulatory Affairs, Bureau of Health Care Services, Enforcement Division, P.O. Box 30670, Lansing, MI 48909-8170 or call 517-373-9196.

Section 1.7 You have the right to make complaints and to ask us to reconsider decisions we have made

If you have any problems or concerns about your covered services or care, Chapter 9 of this booklet tells what you can do. It gives the details about how to deal with all types of problems and complaints. What you need to do to follow up on a problem or concern depends on the situation. You might need to ask our plan to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we are required to treat you fairly**.

You have the right to get a summary of information about the appeals and complaints that other members have filed against our plan in the past. To get this information, please call Customer Service (phone numbers are printed on the back cover of this booklet).

Section 1.8 What can you do if you believe you are being treated unfairly or your rights are not being respected?

If it is about discrimination, call the Office for Civil Rights

If you believe you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, you should call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 or TTY 1-800-537-7697, or call your local Office for Civil Rights.

Is it about something else?

If you believe you have been treated unfairly or your rights have not been respected, *and* it's *not* about discrimination, you can get help dealing with the problem you are having:

- You can **call or email Customer Service** (phone numbers and email address are printed on the back cover of this booklet).
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- Or, **you can call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Section 1.9 You have the right to make recommendations about the **Priority**Medicare (Employer HMO-POS) **rights and responsibility policy**

You have the right to make recommendations about our member rights and responsibilities policy. Contact Customer Service (phone numbers are on the back of this booklet) on how to do this.

Section 1.10 How to get more information about your rights

There are several places where you can get more information about your rights:

- You can **call or email Customer Service** (phone numbers and email address are printed on the back cover of this booklet).
- You can **call the SHIP**. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- You can contact **Medicare**.
    - You can visit the Medicare website to read or download the publication "Your Medicare Rights & Protections." (The publication is available at: *https://www.medicare.gov/Pubs/pdf/11534.pdf*.)

- Or, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTION 2 You have some responsibilities as a member of the plan

Section 2.1 What are your responsibilities?

Things you need to do as a member of the plan are listed below. If you have any questions, please call Customer Service (phone numbers are printed on the back cover of this booklet). We're here to help.

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this *Evidence of Coverage* booklet to learn what is covered for you and the rules you need to follow to get your covered services.
    - Chapters 3 and 4 give the details about your medical services, including what is covered, what is not covered, rules to follow, and what you pay.
    - Chapters 5 and 6 give the details about your coverage for Part D prescription drugs.
- **If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to** contact the Office of Retirement Services at 1-800-381-5111.
    - We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called "**coordination of benefits**" because it involves coordinating the health and drug benefits you get from our plan with any other health and drug benefits available to you. We'll help you coordinate your benefits. (For more information about coordination of benefits, go to Chapter 1, Section 10.)
    - **Note:** If you (or your spouse) are enrolled in other group health insurance from an employer or a retiree group other than the Michigan Public School Employees' Retirement System, you are not eligible for enrollment in this plan and you must contact Office of Retirement Services at 1-800-381-5111.
- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan membership card whenever you get your medical care or Part D prescription drugs.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
    - To help your doctors and other health providers give you the best care, learn as much as you are able to about your health problems and give them the

information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.

- Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
- If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again.

- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.

Pay what you owe. As a plan member, you are responsible for these payments:

- You must pay your plan premiums (if applicable) to continue being a member of our plan.
- In order to be eligible for our plan, you must have Medicare Part A and Medicare Part B. For that reason, some plan members must pay a premium for Medicare Part A and most plan members must pay a premium for Medicare Part B to remain a member of the plan.
- For most of your medical services or drugs covered by the plan, you must pay your share of the cost when you get the service or drug. This will be a copayment (a fixed amount) or coinsurance (a percentage of the total cost). Chapter 4 tells what you must pay for your medical services. Chapter 6 tells what you must pay for your Part D prescription drugs.
- If you get any medical services or drugs that are not covered by our plan or by other insurance you may have, you must pay the full cost.
  - If you disagree with our decision to deny coverage for a service or drug, you can make an appeal. Please see Chapter 9 of this booklet for information about how to make an appeal.
- If you are required to pay a Part D late enrollment penalty, you must pay the penalty to keep your prescription drug coverage.
- If you are required to pay the extra amount for Part D because of your yearly income, you must pay the extra amount directly to the government to remain a member of the plan.

- **Tell us and the Office of Retirement Services if you move.** If you are going to move, it's important to tell us right away. Call Customer Service (phone numbers are printed on the back cover of this booklet) and the Office of Retirement Services at 1-800-381-5111.
- **If you move *outside* of our plan service area, you cannot remain a member of our plan.** (Chapter 1 tells about our service area.) We can help you figure out whether you are moving outside our service area. If you are leaving our service area, you will have a Special

Enrollment Period when you can join any Medicare plan available in your new area. We can let you know if we have a plan in your new area.

  - **If you move *within* our service area, we still need to know** so we can keep your membership record up to date and know how to contact you.
  - If you move, it is also important to tell Social Security (or the Railroad Retirement Board). You can find phone numbers and contact information for these organizations in Chapter 2.

- **Help us protect yours and others privacy.**
  - Tell us if you have lost your ID card or it has been stolen to prevent anyone from receiving your Priority Health Medicare benefits.
  - Let us know immediately if you receive information or material intended for others by mistake and cooperating with us in returning this information or materials as soon as possible.
- **Call Customer Service for help if you have questions or concerns.** We also welcome any suggestions you may have for improving our plan.
  - Phone numbers and calling hours for Customer Service are printed on the back cover of this booklet.
  - For more information on how to reach us, including our mailing address, please see Chapter 2.

CHAPTER 9

What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

BACKGROUND

SECTION 1 Introduction

Section 1.1 What to do if you have a problem or concern

This chapter explains two types of processes for handling problems and concerns:

- For some types of problems, you need to use the **process for coverage decisions and appeals**.
- For other types of problems, you need to use the **process for making complaints**.

Both of these processes have been approved by Medicare. To ensure fairness and prompt handling of your problems, each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

Which one do you use? That depends on the type of problem you are having. The guide in Section 3 will help you identify the right process to use.

Section 1.2 What about the legal terms?

There are technical legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people and can be hard to understand.

To keep things simple, this chapter explains the legal rules and procedures using simpler words in place of certain legal terms. For example, this chapter generally says “making a complaint” rather than “filing a grievance,” “coverage decision” rather than “organization determination,” or “coverage determination,” and “Independent Review Organization” instead of “Independent Review Entity.” It also uses abbreviations as little as possible.

However, it can be helpful – and sometimes quite important – for you to know the correct legal terms for the situation you are in. Knowing which terms to use will help you communicate more clearly and accurately when you are dealing with your problem and get the right help or information for your situation. To help you know which terms to use, we include legal terms when we give the details for handling specific types of situations.

SECTION 2 You can get help from government organizations that are not connected with us

Section 2.1 Where to get more information and personalized assistance

Sometimes it can be confusing to start or follow through the process for dealing with a problem. This can be especially true if you do not feel well or have limited energy. Other times, you may not have the knowledge you need to take the next step.

Get help from an independent government organization

We are always available to help you. But in some situations you may also want help or guidance from someone who is not connected with us. You can always contact your **State Health Insurance Assistance Program (SHIP)**. This government program has trained counselors in every state. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free. You will find phone numbers in Chapter 2, Section 3 of this booklet.

You can also get help and information from Medicare

For more information and help in handling a problem, you can also contact Medicare. Here are two ways to get information directly from Medicare:

- You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- You can visit the Medicare website (*https://www.medicare.gov*).

SECTION 3 To deal with your problem, which process should you use?

Section 3.1 Should you use the process for coverage decisions and appeals? Or should you use the process for making complaints?

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The guide that follows will help.

To figure out which part of this chapter will help with your specific problem or concern, **START HERE**

Is your problem or concern about your benefits or coverage?

(This includes problems about whether particular medical care or prescription drugs are covered or not, the way in which they are covered, and problems related to payment for medical care or prescription drugs.)

Yes. My problem is about benefits or coverage.

Go on to the next section of this chapter, **Section 4, "A guide to the basics of coverage decisions and appeals."**

No. My problem is not about benefits or coverage.

Skip ahead to **Section 10** at the end of this chapter: **"How to make a complaint about quality of care, waiting times, customer service or other concerns."**

COVERAGE DECISIONS AND APPEALS

SECTION 4 A guide to the basics of coverage decisions and appeals

Section 4.1 Asking for coverage decisions and making appeals: the big picture

The process for coverage decisions and appeals deals with problems related to your benefits and coverage for medical services and prescription drugs, including problems related to payment. This is the process you use for issues such as whether something is covered or not and the way in which something is covered.

Asking for coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services or drugs. For example, your plan network doctor makes a (favorable) coverage decision for you whenever you receive medical care from him or her or if your network doctor refers you to a medical specialist. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we will cover a particular

medical service or refuses to provide medical care you think that you need. In other words, if you want to know if we will cover a medical service before you receive it, you can ask us to make a coverage decision for you.

We are making a coverage decision for you whenever we decide what is covered for you and how much we pay. In some cases we might decide a service or drug is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision and you are not satisfied with this decision, you can "appeal" the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made.

When you appeal a decision for the first time, this is called a Level 1 Appeal. In this appeal, we review the coverage decision we made to check to see if we were following all of the rules properly. Your appeal is handled by different reviewers than those who made the original unfavorable decision. When we have completed the review we give you our decision. Under certain circumstances, which we discuss later, you can request an expedited or "fast coverage decision" or fast appeal of a coverage decision.

If we say no to all or part of your Level 1 Appeal, you can go on to a Level 2 Appeal. The Level 2 Appeal is conducted by an independent organization that is not connected to us. (In some situations, your case will be automatically sent to the independent organization for a Level 2 Appeal. If this happens, we will let you know. In other situations, you will need to ask for a Level 2 Appeal.) If you are not satisfied with the decision at the Level 2 Appeal, you may be able to continue through additional levels of appeal.

Section 4.2 How to get help when you are asking for a coverage decision or making an appeal

Would you like some help? Here are resources you may wish to use if you decide to ask for any kind of coverage decision or appeal a decision:

- You **can call us at Customer Service** (phone numbers are printed on the back cover of this booklet).
- To **get free help from an independent organization** that is not connected with our plan, contact your State Health Insurance Assistance Program (see Section 2 of this chapter).
- **Your doctor can make a request for you.**
    - For medical care, your doctor can request a coverage decision or a Level 1 Appeal on your behalf. If your appeal is denied at Level 1, it will be automatically

forwarded to Level 2. To request any appeal after Level 2, your doctor must be appointed as your representative.

- For Part D prescription drugs, your doctor or other prescriber can request a coverage decision or a Level 1 or Level 2 Appeal on your behalf. To request any appeal after Level 2, your doctor or other prescriber must be appointed as your representative.

- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your "representative" to ask for a coverage decision or make an appeal.
  - There may be someone who is already legally authorized to act as your representative under State law.
  - If you want a friend, relative, your doctor or other provider, or other person to be your representative, call Customer Service (phone numbers are printed on the back cover of this booklet) and ask for the "Appointment of Representative" form. (The form is also available on Medicare's website at *https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf* or on our website at *priorityhealth.com/mpsers*. The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give us a copy of the signed form.
- **You also have the right to hire a lawyer to act for you.** You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 4.3 Which section of this chapter gives the details for your situation?

There are four different types of situations that involve coverage decisions and appeals. Since each situation has different rules and deadlines, we give the details for each one in a separate section:

- **Section 5** of this chapter: "Your medical care: How to ask for a coverage decision or make an appeal"
- **Section 6** of this chapter: "Your Part D prescription drugs: How to ask for a coverage decision or make an appeal"
- **Section 7** of this chapter: "How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon"

- **Section 8** of this chapter: "How to ask us to keep covering certain medical services if you think your coverage is ending too soon" (*Applies to these services only*: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

If you're not sure which section you should be using, please call Customer Service (phone numbers are printed on the back cover of this booklet). You can also get help or information from government organizations such as your SHIP (Chapter 2, Section 3, of this booklet has the phone numbers for this program).

SECTION 5 Your medical care: How to ask for a coverage decision or make an appeal

Have you read Section 4 of this chapter (*A guide to "the basics" of coverage decisions and appeals*)? If not, you may want to read it before you start this section.

Section 5.1 This section tells what to do if you have problems getting coverage for medical care or if you want us to pay you back for our share of the cost of your care

This section is about your benefits for medical care and services. These benefits are described in Chapter 4 of this booklet: *Medical Benefits Chart (what is covered and what you pay*). To keep things simple, we generally refer to "medical care coverage" or "medical care" in the rest of this section, instead of repeating "medical care or treatment or services" every time.

This section tells what you can do if you are in any of the five following situations:

1. You are not getting certain medical care you want, and you believe that this care is covered by our plan.
2. Our plan will not approve the medical care your doctor or other medical provider wants to give you, and you believe that this care is covered by the plan.
3. You have received medical care or services that you believe should be covered by the plan, but we have said we will not pay for this care.
4. You have received and paid for medical care or services that you believe should be covered by the plan, and you want to ask our plan to reimburse you for this care.
5. You are being told that coverage for certain medical care you have been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health.

   NOTE: **If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services**, you need to read a separate section of

this chapter because special rules apply to these types of care. Here's what to read in those situations:

- Chapter 9, Section 7: *How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon.*
- Chapter 9, Section 8: *How to ask us to keep covering certain medical services if you think your coverage is ending too soon.* This section is about three services only: home health care, skilled nursing facility care, and CORF services.

For *all other* situations that involve being told that medical care you have been getting will be stopped, use this section (Section 5) as your guide for what to do.

Which of these situations are you in?

If you are in this situation:	This is what you can do:
Do you want to find out whether we will cover the medical care or services you want?	You can ask us to make a coverage decision for you. Go to the next section of this chapter, **Section 5.2**.
Have we already told you that we will not cover or pay for a medical service in the way that you want it to be covered or paid for?	You can make an **appeal**. (This means you are asking us to reconsider.) Skip ahead to **Section 5.3** of this chapter.
Do you want to ask us to pay you back for medical care or services you have already received and paid for?	You can send us the bill. Skip ahead to **Section 5.5** of this chapter.

Section 5.2 Step-by-step: How to ask for a coverage decision (how to ask our plan to authorize or provide the medical care coverage you want)

Legal Terms
When a coverage decision involves your medical care, it is called an **"organization determination."**

Step 1: You ask our plan to make a coverage decision on the medical care you are requesting. If your health requires a quick response, you should ask us to make a **"fast coverage decision."**

Legal Terms
A "fast coverage decision" is called an **"expedited determination."**

How to request coverage for the medical care you want

- Start by calling, writing, or faxing our plan to make your request for us to authorize or provide coverage for the medical care you want. You, your doctor, or your representative can do this.
- For the details on how to contact us, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are asking for a coverage decision about your medical care*.

Generally we use the standard deadlines for giving you our decision

When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "fast" deadlines. **A standard coverage decision means we will give you an answer within 14 calendar days** after we receive your request.

- **However, we can take up to 14 more calendar days** if you ask for more time, or if we need information (such as medical records from out-of-network providers) that may benefit you. If we decide to take extra days to make the decision, we will tell you in writing.
- If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.)

If your health requires it, ask us to give you a "fast coverage decision"

- **A fast coverage decision means we will answer within 72 hours.**
  - **However, we can take up to 14 more calendar days** if we find that some information that may benefit you is missing (such as medical records from out-of-network providers), or if you need time to get information to us for the review. If we decide to take extra days, we will tell you in writing.
  - If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. (For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.) We will call you as soon as we make the decision.
- **To get a fast coverage decision, you must meet two requirements:**
  - You can get a fast coverage decision *only* if you are asking for coverage for medical care *you have not yet received*. (You cannot get a fast coverage decision if your request is about payment for medical care you have already received.)
  - You can get a fast coverage decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function.*
- **If your doctor tells us that your health requires a "fast coverage decision," we will automatically agree to give you a fast coverage decision.**
- If you ask for a fast coverage decision on your own, without your doctor's support, we will decide whether your health requires that we give you a fast coverage decision.
  - If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead).
  - This letter will tell you that if your doctor asks for the fast coverage decision, we will automatically give a fast coverage decision.
  - The letter will also tell how you can file a "fast complaint" about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. (For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.)

<u>Step 2:</u> We consider your request for medical care coverage and give you our answer.

Deadlines for a "fast coverage decision"

- Generally, for a fast coverage decision, we will give you our answer **within 72 hours**.

- As explained above, we can take up to 14 more calendar days under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing.
- If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.)
- If we do not give you our answer within 72 hours (or if there is an extended time period, by the end of that period), you have the right to appeal. Section 5.3 below tells how to make an appeal.

- **If our answer is yes to part or all of what you requested,** we must authorize or provide the medical care coverage we have agreed to provide within 72 hours after we received your request. If we extended the time needed to make our coverage decision, we will authorize or provide the coverage by the end of that extended period.
- **If our answer is no to part or all of what you requested,** we will send you a detailed written explanation as to why we said no.

Deadlines for a "standard coverage decision"

- Generally, for a standard coverage decision, we will give you our answer **within 14 calendar days of receiving your request.**
  - We can take up to 14 more calendar days ("an extended time period") under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing.
  - If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.)
  - If we do not give you our answer within 14 calendar days (or if there is an extended time period, by the end of that period), you have the right to appeal. Section 5.3 below tells how to make an appeal.
- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage we have agreed to provide within 14 calendar days after we received your request. If we extended the time needed to make our coverage decision, we will authorize or provide the coverage by the end of that extended period.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

Step 3: If we say no to your request for coverage for medical care, you decide if you want to make an appeal.

- If we say no, you have the right to ask us to reconsider – and perhaps change – this decision by making an appeal. Making an appeal means making another try to get the medical care coverage you want.
- If you decide to make an appeal, it means you are going on to Level 1 of the appeals process (see Section 5.3 below).

Section 5.3 Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a medical care coverage decision made by our plan)

Legal Terms
An appeal to the plan about a medical care coverage decision is called a plan **"reconsideration."**

Step 1: You contact us and make your appeal. If your health requires a quick response, you must ask for a **"fast appeal."**

What to do

- **To start an appeal you, your doctor, or your representative, must contact us.** For details on how to reach us for any purpose related to your appeal, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are making an appeal about your medical care.*
- **If you are asking for a standard appeal, make your standard appeal in writing by submitting a request.** You may also ask for an appeal by calling us at the phone number shown in Chapter 2, Section 1 (*How to contact us when you are making an appeal about your medical care*).
    - If you have someone appealing our decision for you other than your doctor, your appeal must include an Appointment of Representative form authorizing this person to represent you. To get the form, call Customer Service (phone numbers are printed on the back cover of this booklet) and ask for the "Appointment of Representative" form. It is also available on Medicare's website at *https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf* or on our website at *priorityhealth.com/mpsers*. While we can accept an appeal request without the form, we cannot begin or complete our review until we receive it. If we

do not receive the form within 44 calendar days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be dismissed. If this happens, we will send you a written notice explaining your right to ask the Independent Review Organization to review our decision to dismiss your appeal.

- **If you are asking for a fast appeal, make your appeal in writing or call us** at the phone number shown in Chapter 2, Section 1 (*How to contact us when you are making an appeal about your medical care*).
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information regarding your medical decision and add more information to support your appeal.**
  - You have the right to ask us for a copy of the information regarding your appeal. We are allowed to charge a fee for copying and sending this information to you.
  - If you wish, you and your doctor may give us additional information to support your appeal.

If your health requires it, ask for a "fast appeal" (you can make a request by calling us)

Legal Terms
A "fast appeal" is also called an **"expedited reconsideration."**

- If you are appealing a decision we made about coverage for care you have not yet received, you and/or your doctor will need to decide if you need a "fast appeal."
- The requirements and procedures for getting a "fast appeal" are the same as those for getting a "fast coverage decision." To ask for a fast appeal, follow the instructions for asking for a fast coverage decision. (These instructions are given earlier in this section.)
- If your doctor tells us that your health requires a "fast appeal," we will give you a fast appeal.

Step 2: We consider your appeal and we give you our answer.

- When our plan is reviewing your appeal, we take another careful look at all of the information about your request for coverage of medical care. We check to see if we were following all the rules when we said no to your request.
- We will gather more information if we need it. We may contact you or your doctor to get more information.

Deadlines for a "fast appeal"

- When we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our 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 calendar days.** If we decide to take extra days to make the decision, we will tell you in writing.
    - If we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we tell you about this organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will send you a written denial notice informing you that we have automatically sent your appeal to the Independent Review Organization for a Level 2 Appeal.

Deadlines for a "standard appeal"

- If we are using the standard deadlines, we must give you our answer **within 30 calendar days** after we receive your appeal if your appeal is about coverage for services you have not yet received. We will give you our decision sooner if your health condition requires us to.
    - 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 calendar days.** If we decide to take extra days to make the decision, we will tell you in writing.
    - If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.)

- If we do not give you an answer by the deadline above (or by the end of the extended time period if we took extra days), we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. Later in this section, we talk about this review organization and explain what happens at Level 2 of the appeals process.

- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage we have agreed to provide within 30 calendar days after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you a written denial notice informing you that we have automatically sent your appeal to the Independent Review Organization for a Level 2 Appeal.

Step 3: If our plan says no to part or all of your appeal, your case will *automatically* be sent on to the next level of the appeals process.

- To make sure we were following all the rules when we said no to your appeal, **we are required to send your appeal to the "Independent Review Organization."** When we do this, it means that your appeal is going on to the next level of the appeals process, which is Level 2.

Section 5.4 Step-by-step: How a Level 2 Appeal is done

If we say no to your Level 1 Appeal, your case will *automatically* be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Independent Review Organization** reviews our decision for your first appeal. This organization decides whether the decision we made should be changed.

Legal Terms
The formal name for the "Independent Review Organization" is the **"Independent Review Entity."** It is sometimes called the **"IRE."**

Step 1: The Independent Review Organization reviews your appeal.

- **The Independent Review Organization is an independent organization that is hired by Medicare**. This organization is not connected with us and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- We will send the information about your appeal to this organization. This information is called your "case file." **You have the right to ask us for a copy of your case file**. We are allowed to charge you a fee for copying and sending this information to you.

- You have a right to give the Independent Review Organization additional information to support your appeal.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.

If you had a "fast appeal" at Level 1, you will also have a "fast appeal" at Level 2

- If you had a fast appeal to our plan at Level 1, you will automatically receive a fast appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal **within 72 hours** of when it receives your appeal.
- However, if the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**.

If you had a "standard appeal" at Level 1, you will also have a "standard appeal" at Level 2

- If you had a standard appeal to our plan at Level 1, you will automatically receive a standard appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal **within 30 calendar days** of when it receives your appeal.
- However, if the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**.

Step 2: The Independent Review Organization gives you their answer.

The Independent Review Organization will tell you its decision in writing and explain the reasons for it.

- **If the review organization says yes to part or all of what you requested,** we must authorize the medical care coverage within 72 hours or provide the service within 14 calendar days after we receive the decision from the review organization for standard requests or within 72 hours from the date the plan receives the decision from the review organization for expedited requests.
- **If this organization says no to part or all of your appeal**, it means they agree with us that your request (or part of your request) for coverage for medical care should not be approved. (This is called "upholding the decision." It is also called "turning down your appeal.")
  - If the Independent Review Organization "upholds the decision" you have the right to a Level 3 appeal. However, to make another appeal at Level 3, the dollar value of the medical care coverage you are requesting must meet a certain minimum. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal, which means that the decision at Level 2 is final. The written notice you get from the Independent Review Organization will tell you how to find out the dollar amount to continue the appeals process.

Step 3: If your case meets the requirements, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. The details on how to do this are in the written notice you got after your Level 2 Appeal.
- The Level 3 Appeal is handled by an administrative law judge. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 5.5 What if you are asking us to pay you for our share of a bill you have received for medical care?

If you want to ask us for payment for medical care, start by reading Chapter 7 of this booklet: *Asking us to pay our share of a bill you have received for covered medical services or drugs.* Chapter 7 describes the situations in which you may need to ask for reimbursement or to pay a bill you have received from a provider. It also tells how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from us

If you send us the paperwork that asks for reimbursement, you are asking us to make a coverage decision (for more information about coverage decisions, see Section 4.1 of this chapter). To make this coverage decision, we will check to see if the medical care you paid for is a covered service (see Chapter 4: *Medical Benefits Chart (what is covered and what you pay)*). We will also check to see if you followed all the rules for using your coverage for medical care (these rules are given in Chapter 3 of this booklet: *Using the plan's coverage for your medical services*).

We will say yes or no to your request

- If the medical care you paid for is covered and you followed all the rules, we will send you the payment for our share of the cost of your medical care within 60 calendar days after we receive your request. Or, if you haven't paid for the services, we will send the payment directly to the provider. When we send the payment, it's the same as saying *yes* to your request for a coverage decision.)
- If the medical care is *not* covered, or you did *not* follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the services and the reasons why in detail. (When we turn down your request for payment, it's the same as saying *no* to your request for a coverage decision.)

What if you ask for payment and we say that we will not pay?

If you do not agree with our decision to turn you down, **you can make an appeal**. If you make an appeal, it means you are asking us to change the coverage decision we made when we turned down your request for payment.

To make this appeal, follow the process for appeals that we describe in Section 5.3. Go to this section for step-by-step instructions. When you are following these instructions, please note:

- If you make an appeal for reimbursement, we must give you our answer within 60 calendar days after we receive your appeal. (If you are asking us to pay you back for medical care you have already received and paid for yourself, you are not allowed to ask for a fast appeal.)
- If the Independent Review Organization reverses our decision to deny payment, we must send the payment you have requested to you or to the provider within 30 calendar days. If the answer to your appeal is yes at any stage of the appeals process after Level 2, we must send the payment you requested to you or to the provider within 60 calendar days.

SECTION 6 Your Part D prescription drugs: How to ask for a coverage decision or make an appeal

Have you read Section 4 of this chapter (*A guide to "the basics" of coverage decisions and appeals*)? If not, you may want to read it before you start this section.

Section 6.1 This section tells you what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits as a member of our plan include coverage for many prescription drugs. Please refer to our plan's *List of Covered Drugs (Formulary)*. To be covered, the drug must be used for a medically accepted indication. (A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. See Chapter 5, Section 3 for more information about a medically accepted indication.)

- **This section is about your Part D drugs only.** To keep things simple, we generally say "drug" in the rest of this section, instead of repeating "covered outpatient prescription drug" or "Part D drug" every time.
- For details about what we mean by Part D drugs, the *List of Covered Drugs (Formulary)*, rules and restrictions on coverage, and cost information, see Chapter 5 (*Using our plan's coverage for your Part D prescription drugs*) and Chapter 6 (*What you pay for your Part D prescription drugs*).

Part D coverage decisions and appeals

As discussed in Section 4 of this chapter, a coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs.

Legal Terms
An initial coverage decision about your Part D drugs is called a **"coverage determination."**

Here are examples of coverage decisions you ask us to make about your Part D drugs:

- You ask us to make an exception, including:
    - Asking us to cover a Part D drug that is not on the plan's *List of Covered Drugs (Formulary)*
    - Asking us to waive a restriction on the plan's coverage for a drug (such as limits on the amount of the drug you can get)
    - Asking to pay a lower cost-sharing amount for a covered drug on a higher cost-sharing tier
- You ask us whether a drug is covered for you and whether you satisfy any applicable coverage rules. (For example, when your drug is on the plan's *List of Covered Drugs (Formulary)* but we require you to get approval from us before we will cover it for you.)
    - *Please note:* If your pharmacy tells you that your prescription cannot be filled as written, you will get a written notice explaining how to contact us to ask for a coverage decision.
- You ask us to pay for a prescription drug you already bought. This is a request for a coverage decision about payment.

If you disagree with a coverage decision we have made, you can appeal our decision.

This section tells you both how to ask for coverage decisions and how to request an appeal. Use the chart below to help you determine which part has information for your situation:

Which of these situations are you in?

Do you need a drug that isn't on our Drug List or need us to waive a rule or restriction on a drug we cover?	Do you want us to cover a drug on our Drug List and you believe you meet any plan rules or restrictions (such as getting approval in advance) for the drug you need?	Do you want to ask us to pay you back for a drug you have already received and paid for?	Have we already told you that we will not cover or pay for a drug in the way that you want it to be covered or paid for?
You can ask us to make an exception. (This is a type of coverage decision.) Start with **Section 6.2** of this chapter.	You can ask us for a coverage decision. Skip ahead to **Section 6.4** of this chapter.	You can ask us to pay you back. (This is a type of coverage decision.) Skip ahead to **Section 6.4** of this chapter.	You can make an appeal. (This means you are asking us to reconsider.) Skip ahead to **Section 6.5** of this chapter.

Section 6.2 What is an exception?

If a drug is not covered in the way you would like it to be covered, you can ask us to make an "exception." An exception is a type of coverage decision. Similar to other types of coverage decisions, if we turn down your request for an exception, you can appeal our decision.

When you ask for an exception, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. We will then consider your request. Here are three examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a Part D drug for you that is not on our *List of Covered Drugs (Formulary)*.** (We call it the "Drug List" for short.)

Legal Terms
Asking for coverage of a drug that is not on the Drug List is sometimes called asking for a **"formulary exception."**

   - If we agree to make an exception and cover a drug that is not on the Drug List, you will need to pay the cost-sharing amount that applies to drugs in tier 4 for non-preferred drugs. You cannot ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.

2. **Removing a restriction on our coverage for a covered drug**. There are extra rules or restrictions that apply to certain drugs on our *List of Covered Drugs (Formulary)* (for more information, go to Chapter 5 and look for Section 4).

Legal Terms
Asking for removal of a restriction on coverage for a drug is sometimes called asking for a **"formulary exception."**

   - The extra rules and restrictions on coverage for certain drugs include:
     - *Being required to use the generic version* of a drug instead of the brand name drug.
     - *Getting plan approval in advance* before we will agree to cover the drug for you. (This is sometimes called "prior authorization.")
     - *Being required to try a different drug first* before we will agree to cover the drug you are asking for. (This is sometimes called "step therapy.")
     - *Quantity limits*. For some drugs, there are restrictions on the amount of the drug you can have.
   - If we agree to make an exception and waive a restriction for you, you can ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.

3. **Changing coverage of a drug to a lower cost-sharing tier.** Every drug on our Drug List is in one of five cost-sharing tiers. In general, the lower the cost-sharing tier number, the less you will pay as your share of the cost of the drug.

Legal Terms
Asking to pay a lower price for a covered non-preferred drug is sometimes called asking for a **"tiering exception."**

   - You cannot ask us to change the cost-sharing tier for any drug in a generic tier or in the specialty tier.

Section 6.3 Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

Your doctor or other prescriber must give us a statement that explains the medical reasons for requesting an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

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. If you ask us for a tiering exception, we will generally *not* approve your request for an exception unless all the alternative drugs in the lower cost-sharing tier(s) won't work as well for you.

We can say yes or no to your request

- If we approve your request for an exception, our approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say no to your request for an exception, you can ask for a review of our decision by making an appeal. Section 6.5 tells how to make an appeal if we say no.

The next section tells you how to ask for a coverage decision, including an exception.

Section 6.4 Step-by-step: How to ask for a coverage decision, including an exception

Step 1: You ask us to make a coverage decision about the drug(s) or payment you need. If your health requires a quick response, you must ask us to make a "fast coverage decision." You cannot ask for a fast coverage decision if you are asking us to pay you back for a drug you already bought.

What to do

- **Request the type of coverage decision you want.** Start by calling, writing, or faxing us to make your request. You, your representative, or your doctor (or other prescriber) can do this. You can also access the coverage decision process through our website. For the details, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are asking for a coverage decision about your Part D prescription drugs*. Or if you are asking us to pay you back for a drug, go to the section called, *Where to send a request that asks us to pay for our share of the cost for medical care or a drug you have received.*
- **You or your doctor or someone else who is acting on your behalf** can ask for a coverage decision. Section 4 of this chapter tells how you can give written permission to someone else to act as your representative. You can also have a lawyer act on your behalf.
- **If you want to ask us to pay you back for a drug,** start by reading Chapter 7 of this booklet: *Asking us to pay our share of a bill you have received for covered medical services or drugs.* Chapter 7 describes the situations in which you may need to ask for reimbursement. It also tells how to send us the paperwork that asks us to pay you back for our share of the cost of a drug you have paid for.

- **If you are requesting an exception, provide the "supporting statement."** Your doctor or other prescriber must give us the medical reasons for the drug exception you are requesting. (We call this the "supporting statement.") Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary. See Sections 6.2 and 6.3 for more information about exception requests.
- **We must accept any written request,** including a request submitted on the CMS Model Coverage Determination Request Form or on our plan's form, which is available on our website.

Legal Terms
A "fast coverage decision" is called an **"expedited coverage determination."**

If your health requires it, ask us to give you a "fast coverage decision"

- When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "fast" deadlines. A standard coverage decision means we will give you an answer within 72 hours after we receive your doctor's statement. A fast coverage decision means we will answer within 24 hours after we receive your doctor's statement.
- **To get a fast coverage decision, you must meet two requirements:**
  - You can get a fast coverage decision *only* if you are asking for a *drug you have not yet received*. (You cannot get a fast coverage decision if you are asking us to pay you back for a drug you have already bought.)
  - You can get a fast coverage decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function.*
- **If your doctor or other prescriber tells us that your health requires a "fast coverage decision," we will automatically agree to give you a fast coverage decision.**
- If you ask for a fast coverage decision on your own (without your doctor's or other prescriber's support), we will decide whether your health requires that we give you a fast coverage decision.
  - If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead).
  - This letter will tell you that if your doctor or other prescriber asks for the fast coverage decision, we will automatically give a fast coverage decision.

- The letter will also tell how you can file a complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. It tells how to file a "fast complaint," which means you would get our answer to your complaint within 24 hours of receiving the complaint. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, see Section 10 of this chapter.)

Step 2: We consider your request and we give you our answer.

Deadlines for a "fast coverage decision"

- If we are using the fast deadlines, we must give you our answer **within 24 hours**.
  - Generally, this means within 24 hours after we receive your request. If you are requesting an exception, we will give you our answer within 24 hours after we receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires us to.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no. We will also tell you how to appeal.

Deadlines for a "standard coverage decision" about a drug you have not yet received

- If we are using the standard deadlines, we must give you our answer **within 72 hours.**
  - Generally, this means within 72 hours after we receive your request. If you are requesting an exception, we will give you our answer within 72 hours after we receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires us to.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested –**

- If we approve your request for coverage, we must **provide the coverage** we have agreed to provide **within 72 hours** after we receive your request or doctor's statement supporting your request.

- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how to appeal.

Deadlines for a "standard coverage decision" about payment for a drug you have already bought

- We must give you our answer **within 14 calendar days** after we receive your request.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested,** we are also required to make payment to you within 14 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how to appeal.

Step 3: If we say no to your coverage request, you decide if you want to make an appeal.

- If we say no, you have the right to request an appeal. Requesting an appeal means asking us to reconsider – and possibly change – the decision we made.

Section 6.5 Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a coverage decision made by our plan)

Legal Terms
An appeal to the plan about a Part D drug coverage decision is called a plan **"redetermination."**

Step 1: You contact us and make your Level 1 Appeal. If your health requires a quick response, you must ask for a **"fast appeal."**

What to do

- **To start your appeal, you (or your representative or your doctor or other prescriber) must contact us.**

- For details on how to reach us by phone, fax, or mail, or on our website, for any purpose related to your appeal, go to Chapter 2, Section 1, and look for the section called, *How to contact us when you are making an appeal about your Part D prescription drugs.*

- **If you are asking for a standard appeal, make your appeal by submitting a written request.** You may also ask for an appeal by calling us at the phone number shown in Chapter 2, Section 1 (*How to contact our plan when you are making an appeal about your Part D prescription drugs*).
- **If you are asking for a fast appeal, you may make your appeal in writing or you may call us at the phone number shown in Chapter 2, Section 1** (How to contact us when you are making an appeal about your part D prescription drugs).
- **We must accept any written request,** including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website.
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information in your appeal and add more information.**
  - You have the right to ask us for a copy of the information regarding your appeal. We are allowed to charge a fee for copying and sending this information to you.
  - If you wish, you and your doctor or other prescriber may give us additional information to support your appeal.

Legal Terms
A “fast appeal” is also called an **“expedited redetermination.”**

If your health requires it, ask for a “fast appeal”

- If you are appealing a decision we made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a “fast appeal.”
- The requirements for getting a “fast appeal” are the same as those for getting a “fast coverage decision” in Section 6.4 of this chapter.

Step 2: We consider your appeal and we give you our answer.

- When we are reviewing your appeal, we take another careful look at all of the information about your coverage request. We check to see if we were following all the rules when we said no to your request. We may contact you or your doctor or other prescriber to get more information.

Deadlines for a "fast appeal"

- If we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires it.
  - If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we talk about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no and how to appeal our decision.

Deadlines for a "standard appeal"

- If we are using the standard deadlines, we must give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so. If you believe your health requires it, you should ask for "fast appeal."
  - If we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested –**
  - If we approve a request for coverage, we must **provide the coverage** we have agreed to provide as quickly as your health requires, but **no later than 7 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.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no and how to appeal our decision.

Step 3: If we say no to your appeal, you decide if you want to continue with the appeals process and make *another* appeal.

- If we say no to your appeal, you then choose whether to accept this decision or continue by making another appeal.
- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process (see below).

Section 6.6 Step-by-step: How to make a Level 2 Appeal

If we say no to your appeal, you then choose whether to accept this decision or continue by making another appeal. If you decide to go on to a Level 2 Appeal, the **Independent Review Organization** reviews the decision we made when we said no to your first appeal. This organization decides whether the decision we made should be changed.

Legal Terms
The formal name for the "Independent Review Organization" is the **"Independent Review Entity."** It is sometimes called the **"IRE."**

Step 1: To make a Level 2 Appeal, you (or your representative or your doctor or other prescriber) must contact the Independent Review Organization and ask for a review of your case.

- If we say no to your Level 1 Appeal, the written notice we send you will include **instructions on how to make a Level 2 Appeal** with the Independent Review Organization. These instructions will tell who can make this Level 2 Appeal, what deadlines you must follow, and how to reach the review organization.
- When you make an appeal to the Independent Review Organization, we will send the information we have about your appeal to this organization. This information is called your "case file." **You have the right to ask us for a copy of your case file**. We are allowed to charge you a fee for copying and sending this information to you.
- You have a right to give the Independent Review Organization additional information to support your appeal.

Step 2: The Independent Review Organization does a review of your appeal and gives you an answer.

- **The Independent Review Organization is an independent organization that is hired by Medicare**. This organization is not connected with us and it is not a government agency. This organization is a company chosen by Medicare to review our decisions about your Part D benefits with us.

- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal. The organization will tell you its decision in writing and explain the reasons for it.

Deadlines for "fast appeal" at Level 2

- If your health requires it, ask the Independent Review Organization for a "fast appeal."
- If the review organization agrees to give you a "fast appeal," the review organization must give you an answer to your Level 2 Appeal **within 72 hours** after it receives your appeal request.
- **If the Independent Review Organization says yes to part or all of what you requested,** we must provide the drug coverage that was approved by the review organization **within 24 hours** after we receive the decision from the review organization.

Deadlines for "standard appeal" at Level 2

- If you have a standard appeal at Level 2, the review organization must give you an answer to your Level 2 Appeal **within 7 calendar days** after it receives your appeal.
- **If the Independent Review Organization says yes to part or all of what you requested –**
  - If the Independent Review Organization approves a request for coverage, we must **provide the drug coverage** that was approved by the review organization **within 72 hours** after we receive the decision from the review organization.
  - If the Independent Review Organization approves 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 the decision from the review organization.

What if the review organization says no to your appeal?

If this organization says no to your appeal, it means the organization agrees with our decision not to approve your request. (This is called "upholding the decision." It is also called "turning down your appeal.")

If the Independent Review Organization "upholds the decision" you have the right to a Level 3 appeal. However, to make another appeal at Level 3, the dollar value of the drug coverage you are requesting must meet a minimum amount. If the dollar value of the drug coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final. The notice you get from the Independent Review Organization will tell you the dollar value that must be in dispute to continue with the appeals process.

Step 3: If the dollar value of the coverage you are requesting meets the requirement, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. If you decide to make a third appeal, the details on how to do this are in the written notice you got after your second appeal.
- The Level 3 Appeal is handled by an administrative law judge. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 7 How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon

When you are admitted to a hospital, you have the right to get all of your covered hospital services that are necessary to diagnose and treat your illness or injury. For more information about our coverage for your hospital care, including any limitations on this coverage, see Chapter 4 of this booklet: *Medical Benefits Chart (what is covered and what you pay).*

During your covered hospital stay, your doctor and the hospital staff will be working with you to prepare for the day when you will leave the hospital. They will also help arrange for care you may need after you leave.

- The day you leave the hospital is called your "**discharge date**."
- When your discharge date has been decided, your doctor or the hospital staff will let you know.
- If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay and your request will be considered. This section tells you how to ask.

Section 7.1 During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights

During your covered hospital stay, you will be given a written notice called *An Important Message from Medicare about Your Rights.* Everyone with Medicare gets a copy of this notice whenever they are admitted to a hospital. Someone at the hospital (for example, a caseworker or nurse) must give it to you within two days after you are admitted. If you do not get the notice, ask any hospital employee for it. If you need help, please call Customer Service (phone numbers are printed on the back cover of this booklet). You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

1. **Read this notice carefully and ask questions if you don't understand it.** It tells you about your rights as a hospital patient, including:
   - Your right to receive Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
   - Your right to be involved in any decisions about your hospital stay, and know who will pay for it.
   - Where to report any concerns you have about quality of your hospital care.
   - Your right to appeal your discharge decision if you think you are being discharged from the hospital too soon.

Legal Terms
The written notice from Medicare tells you how you can **"request an immediate review."** Requesting an immediate review is a formal, legal way to ask for a delay in your discharge date so that we will cover your hospital care for a longer time. (Section 7.2 below tells you how you can request an immediate review.)

2. **You must sign the written notice to show that you received it and understand your rights.**
   - You or someone who is acting on your behalf must sign the notice. (Section 4 of this chapter tells how you can give written permission to someone else to act as your representative.)
   - Signing the notice shows *only* that you have received the information about your rights. The notice does not give your discharge date (your doctor or hospital staff will tell you your discharge date). Signing the notice **does *not* mean** you are agreeing on a discharge date.

3. **Keep your copy** of the signed notice so you will have the information about making an appeal (or reporting a concern about quality of care) handy if you need it.
   - If you sign the notice more than two days before the day you leave the hospital, you will get another copy before you are scheduled to be discharged.
   - To look at a copy of this notice in advance, you can call Customer Service (phone numbers are printed on the back cover of this booklet) or 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. You can also see it online at *https://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html*.

Section 7.2 Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date

If you want to ask for your inpatient hospital services to be covered by us for a longer time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do.
- **Ask for help if you need it**. If you have questions or need help at any time, please call Customer Service (phone numbers are printed on the back cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 of this chapter).

During a Level 1 Appeal, the Quality Improvement Organization reviews your appeal. It checks to see if your planned discharge date is medically appropriate for you.

Step 1: Contact the Quality Improvement Organization for your state and ask for a "fast review" of your hospital discharge. You must act quickly.

What is the Quality Improvement Organization?

- This organization is a group of doctors and other health care professionals who are paid by the Federal government. These experts are not part of our plan. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare.

How can you contact this organization?

- The written notice you received (*An Important Message from Medicare About Your Rights*) tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2, Section 4, of this booklet.)

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than your planned discharge date.** (Your "planned discharge date" is the date that has been set for you to leave the hospital.)

- If you meet this deadline, you are allowed to stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision on your appeal from the Quality Improvement Organization.
- If you do *not* meet this deadline, and you decide to stay in the hospital after your planned discharge date, *you may have to pay all of the costs* for hospital care you receive after your planned discharge date.

- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to our plan instead. For details about this other way to make your appeal, see Section 7.4.

Ask for a "fast review":

- You must ask the Quality Improvement Organization for a **"fast review"** of your discharge. Asking for a "fast review" means you are asking for the organization to use the "fast" deadlines for an appeal instead of using the standard deadlines.

Legal Terms
A "**fast review**" is also called an "**immediate review**" or an "**expedited review**."

<u>Step 2:</u> The Quality Improvement Organization conducts an independent review of your case.

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them "the reviewers" for short) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- The reviewers will also look at your medical information, talk with your doctor, and review information that the hospital and we have given to them.

- By noon of the day after the reviewers informed our plan of your appeal, you will also get a written notice that gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

Legal Terms
This written explanation is called the "**Detailed Notice of Discharge."** You can get a sample of this notice by calling Customer Service (phone numbers are printed on the back cover of this booklet) or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.) Or you can see a sample notice online at *https://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html*.

Step 3: Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal.

What happens if the answer is yes?

- If the review organization says *yes* to your appeal, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered hospital services. (See Chapter 4 of this booklet).

What happens if the answer is no?

- If the review organization says *no* to your appeal, they are saying that your planned discharge date is medically appropriate. If this happens, **our coverage for your inpatient hospital services will end** at noon on the day *after* the Quality Improvement Organization gives you its answer to your appeal.
- If the review organization says *no* to your appeal and you decide to stay in the hospital, then **you may have to pay the full cost** of hospital care you receive after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

Step 4: If the answer to your Level 1 Appeal is no, you decide if you want to make another appeal.

- If the Quality Improvement Organization has turned down your appeal, *and* you stay in the hospital after your planned discharge date, then you can make another appeal. Making another appeal means you are going on to "Level 2" of the appeals process.

Section 7.3 Step-by-step: How to make a Level 2 Appeal to change your hospital discharge date

If the Quality Improvement Organization has turned down your appeal, *and* you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal. If the Quality Improvement Organization turns down your Level 2 Appeal, you may have to pay the full cost for your stay after your planned discharge date.

Here are the steps for Level 2 of the appeal process:

Step 1: You contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 calendar days** after the day the Quality Improvement Organization said *no* to your Level 1 Appeal. You can ask for this review only if you stayed in the hospital after the date that your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: Within 14 calendar days of receipt of your request for a second review, the Quality Improvement Organization reviewers will decide on your appeal and tell you their decision.

If the review organization says yes:

- **We must reimburse you** for our share of the costs of hospital care you have received since noon on the day after the date your first appeal was turned down by the Quality Improvement Organization. **We must continue providing coverage for your inpatient hospital care for as long as it is medically necessary**.
- You must continue to pay your share of the costs and coverage limitations may apply.

If the review organization says no:

- It means they agree with the decision they made on your Level 1 Appeal and will not change it. This is called "upholding the decision."
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge.

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further by going on to Level 3.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If the review organization turns down your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.
- Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 7.4 What if you miss the deadline for making your Level 1 Appeal?

You can appeal to us instead

As explained above in Section 7.2, you must act quickly to contact the Quality Improvement Organization to start your first appeal of your hospital discharge. ("Quickly" means before you leave the hospital and no later than your planned discharge date.) If you miss the deadline for contacting this organization, there is another way to make your appeal.

If you use this other way of making your appeal, *the first two levels of appeal are different.*

Step-by-Step: How to make a Level 1 *Alternate* Appeal

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

Legal Terms
A "fast review" (or "fast appeal") is also called an **"expedited appeal**.**"**

Step 1: Contact us and ask for a "fast review."

- For details on how to contact us, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are making an appeal about your medical care*.
- **Be sure to ask for a "fast review**." This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines.

Step 2: We do a "fast review" of your planned discharge date, checking to see if it was medically appropriate.

- During this review, we take a look at all of the information about your hospital stay. We check to see if your planned discharge date was medically appropriate. We will

check to see if the decision about when you should leave the hospital was fair and followed all the rules.

- In this situation, we will use the "fast" deadlines rather than the standard deadlines for giving you the answer to this review.

Step 3: We give you our decision within 72 hours after you ask for a "fast review" ("fast appeal").

- **If we say yes to your fast appeal,** it means we have agreed with you that you still need to be in the hospital after the discharge date, and will keep providing your covered inpatient hospital services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say no to your fast appeal,** we are saying that your planned discharge date was medically appropriate. Our coverage for your inpatient hospital services ends as of the day we said coverage would end.
  - If you stayed in the hospital *after* your planned discharge date, then **you may have to pay the full cost** of hospital care you received after the planned discharge date.

Step 4: If we say *no* to your fast appeal, your case will *automatically* be sent on to the next level of the appeals process.

- To make sure we were following all the rules when we said no to your fast appeal, **we are required to send your appeal to the "Independent Review Organization."** When we do this, it means that you are *automatically* going on to Level 2 of the appeals process.

Step-by-Step: Level 2 *Alternate* Appeal Process

If we say no to your Level 1 Appeal, your case will *automatically* be sent on to the next level of the appeals process. During the Level 2 Appeal, an **Independent Review Organization** reviews the decision we made when we said no to your "fast appeal." This organization decides whether the decision we made should be changed.

Legal Terms
The formal name for the "Independent Review Organization" is the **"Independent Review Entity."** It is sometimes called the **"IRE."**

Step 1: We will automatically forward your case to the Independent Review Organization.

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. Section 10 of this chapter tells how to make a complaint.)

Step 2: The Independent Review Organization does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.

- **The Independent Review Organization is an independent organization that is hired by Medicare**. This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal of your hospital discharge.
- **If this organization says *yes* to your appeal,** then we must reimburse you (pay you back) for our share of the costs of hospital care you have received since the date of your planned discharge. We must also continue the plan's coverage of your inpatient hospital services for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says *no* to your appeal,** it means they agree with us that your planned hospital discharge date was medically appropriate.
    - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It

will give you the details about how to go on to a Level 3 Appeal, which is handled by a judge.

Step 3: If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If reviewers say no to your Level 2 Appeal, you decide whether to accept their decision or go on to Level 3 and make a third appeal.
- Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 8 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

Section 8.1 *This section is about three services only:* Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services

This section is about the following types of care *only*:

- **Home health care services** you are getting.
- **Skilled nursing care** you are getting as a patient in a skilled nursing facility. (To learn about requirements for being considered a "skilled nursing facility," see Chapter 12, *Definitions of important words*.)
- **Rehabilitation care** you are getting as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). Usually, this means you are getting treatment for an illness or accident, or you are recovering from a major operation. (For more information about this type of facility, see Chapter 12, *Definitions of important words*.)

When you are getting any of these types of care, you have the right to keep getting your covered services for that type of care for as long as the care is needed to diagnose and treat your illness or injury. For more information on your covered services, including your share of the cost and any limitations to coverage that may apply, see Chapter 4 of this booklet: *Medical Benefits Chart (what is covered and what you pay).*

When we decide it is time to stop covering any of the three types of care for you, we are required to tell you in advance. When your coverage for that care ends, *we will stop paying our share of the cost for your care.*

If you think we are ending the coverage of your care too soon, **you can appeal our decision**. This section tells you how to ask for an appeal.

Section 8.2 We will tell you in advance when your coverage will be ending

1. **You receive a notice in writing.** At least two days before our plan is going to stop covering your care, you will receive a notice.

   - The written notice tells you the date when we will stop covering the care for you.
   - The written notice also tells what you can do if you want to ask our plan to change this decision about when to end your care, and keep covering it for a longer period of time.

Legal Terms

In telling you what you can do, the written notice is telling how you can request a **"fast-track appeal."** Requesting a fast-track appeal is a formal, legal way to request a change to our coverage decision about when to stop your care. (Section 8.3 below tells how you can request a fast-track appeal.)

The written notice is called the "**Notice of Medicare Non-Coverage."** To get a sample copy, call Customer Service (phone numbers are printed on the back cover of this booklet) or 1-800-MEDICARE (1-800-633-4227, 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.). Or see a copy online at *https://www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices.html*

2. **You must sign the written notice to show that you received it.**
   - You or someone who is acting on your behalf must sign the notice. (Section 4 tells how you can give written permission to someone else to act as your representative.)
   - Signing the notice shows *only* that you have received the information about when your coverage will stop. **Signing it does <u>not</u> mean you agree** with the plan that it's time to stop getting the care.

Section 8.3 Step-by-step: How to make a Level 1 Appeal to have our plan cover your care for a longer time

If you want to ask us to cover your care for a longer period of time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.

- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our plan must follow. (If you think we are not meeting our deadlines, you can file a complaint. Section 10 of this chapter tells you how to file a complaint.)
- **Ask for help if you need it**. If you have questions or need help at any time, please call Customer Service (phone numbers are printed on the back cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 of this chapter).

If you ask for a Level 1 Appeal on time, the Quality Improvement Organization reviews your appeal and decides whether to change the decision made by our plan.

Step 1: Make your Level 1 Appeal: contact the Quality Improvement Organization for your state and ask for a review. You must act quickly.

What is the Quality Improvement Organization?

- This organization is a group of doctors and other health care experts who are paid by the Federal government. These experts are not part of our plan. They check on the quality of care received by people with Medicare and review plan decisions about when it's time to stop covering certain kinds of medical care.

How can you contact this organization?

- The written notice you received tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2, Section 4, of this booklet.)

What should you ask for?

- Ask this organization for a "fast-track appeal" (to do an independent review) of whether it is medically appropriate for us to end coverage for your medical services.

Your deadline for contacting this organization.

- You must contact the Quality Improvement Organization to start your appeal *no later than noon of the day after you receive the written notice telling you when we will stop covering your care*.
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to us instead. For details about this other way to make your appeal, see Section 8.5.

Step 2: The Quality Improvement Organization conducts an independent review of your case.

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them "the reviewers" for short) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- The review organization will also look at your medical information, talk with your doctor, and review information that our plan has given to them.
- By the end of the day the reviewers inform us of your appeal, and you will also get a written notice from us that explains in detail our reasons for ending our coverage for your services.

Legal Terms
This notice of explanation is called the "**Detailed Explanation of Non-Coverage."**

Step 3: Within one full day after they have all the information they need, the reviewers will tell you their decision.

What happens if the reviewers say yes to your appeal?

- If the reviewers say *yes* to your appeal, then **we must keep providing your covered services for as long as it is medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered services (see Chapter 4 of this booklet).

What happens if the reviewers say no to your appeal?

- If the reviewers say *no* to your appeal, then **your coverage will end on the date we have told you.** We will stop paying our share of the costs of this care on the date listed on the notice.
- If you decide to keep getting the home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* this date when your coverage ends, then **you will have to pay the full cost** of this care yourself.

Step 4: If the answer to your Level 1 Appeal is no, you decide if you want to make another appeal.

- This first appeal you make is "Level 1" of the appeals process. If reviewers say *no* to your Level 1 Appeal – and you choose to continue getting care after your coverage for the care has ended – then you can make another appeal.
- Making another appeal means you are going on to "Level 2" of the appeals process.

Section 8.4 Step-by-step: How to make a Level 2 Appeal to have our plan cover your care for a longer time

If the Quality Improvement Organization has turned down your appeal and you choose to continue getting care after your coverage for the care has ended, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal. If the Quality Improvement Organization turns down your Level 2 Appeal, you may have to pay the full cost for your home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end.

Here are the steps for Level 2 of the appeal process:

Step 1: You contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 days** after the day when the Quality Improvement Organization said *no* to your Level 1 Appeal. You can ask for this review only if you continued getting care after the date that your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: Within 14 days of receipt of your appeal request, reviewers will decide on your appeal and tell you their decision.

What happens if the review organization says yes to your appeal?

- **We must reimburse you** for our share of the costs of care you have received since the date when we said your coverage would end. **We must continue providing coverage** for the care for as long as it is medically necessary.
- You must continue to pay your share of the costs and there may be coverage limitations that apply.

What happens if the review organization says no?

- It means they agree with the decision we made to your Level 1 Appeal and will not change it.

- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge.

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers turn down your Level 2 Appeal, you can choose whether to accept that decision or to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.
- Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 8.5 What if you miss the deadline for making your Level 1 Appeal?

You can appeal to us instead

As explained above in Section 8.3, you must act quickly to contact the Quality Improvement Organization to start your first appeal (within a day or two, at the most). If you miss the deadline for contacting this organization, there is another way to make your appeal. If you use this other way of making your appeal, *the first two levels of appeal are different.*

Step-by-Step: How to make a Level 1 *Alternate* Appeal

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us up to and including the date of your planned discharge, asking for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines. If you are past the date you were discharged from skilled services (you may still be at the facility) you should contact us to make a request for additional services or to get information on how you can submit a claim for payment.

Here are the steps for a Level 1 Alternate Appeal:

Legal Terms
A "fast review" (or "fast appeal") is also called an **"expedited appeal."**

Step 1: Contact us and ask for a "fast review."

- For details on how to contact us, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are making an appeal about your medical care*.
- **Be sure to ask for a "fast review**." This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines.

Step 2: We do a "fast review" of the decision we made about when to end coverage for your services.

- During this review, we take another look at all of the information about your case. We check to see if we were following all the rules when we set the date for ending the plan's coverage for services you were receiving.
- We will use the "fast" deadlines rather than the standard deadlines for giving you the answer to this review.

Step 3: We give you our decision within 72 hours after you ask for a "fast review" ("fast appeal").

- **If we say yes to your fast appeal,** it means we have agreed with you that you need services longer, and will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say no to your fast appeal,** then your coverage will end on the date we told you and we will not pay any share of the costs after this date.

- If you continued to get home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end, then **you will have to pay the full cost** of this care yourself.

Step 4: If we say *no* to your fast appeal, your case will *automatically* go on to the next level of the appeals process.

- To make sure we were following all the rules when we said no to your fast appeal, **we are required to send your appeal to the "Independent Review Organization."** When we do this, it means that you are *automatically* going on to Level 2 of the appeals process.

Step-by-Step: Level 2 *Alternate* Appeal Process

If we say no to your Level 1 Appeal, your case will *automatically* be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Independent Review Organization** reviews the decision we made when we said no to your "fast appeal." This organization decides whether the decision we made should be changed.

Legal Terms
The formal name for the "Independent Review Organization" is the **"Independent Review Entity."** It is sometimes called the **"IRE."**

Step 1: We will automatically forward your case to the Independent Review Organization.

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. Section 10 of this chapter tells how to make a complaint.)

Step 2: The Independent Review Organization does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.

- **The Independent Review Organization is an independent organization that is hired by Medicare**. This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.

- **If this organization says *yes* to your appeal,** then we must reimburse you (pay you back) for our share of the costs of care you have received since the date when we said your coverage would end. We must also continue to cover the care for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says *no* to your appeal,** it means they agree with the decision our plan made to your first appeal and will not change it.
    - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal.

Step 3: If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers say no to your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.
- Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 9 Taking your appeal to Level 3 and beyond

Section 9.1 Levels of Appeal 3, 4, and 5 for Medical Service Appeals

This section may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the dollar value of the item or medical service you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, the written response you receive to your Level 2 Appeal will explain who to contact and what to do to ask for a Level 3 Appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 Appeal: **A judge who works for the Federal government** will review your appeal and give you an answer. This judge is called an "Administrative Law Judge."

- **If the Administrative Law Judge says yes to your appeal, the appeals process *may* or *may not* be over** - We will decide whether to appeal this decision to Level 4. Unlike a

decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 3 decision that is favorable to you.

- If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the judge's decision.
- If we decide to appeal the decision, we will send you a copy of the Level 4 Appeal request with any accompanying documents. We may wait for the Level 4 Appeal decision before authorizing or providing the service in dispute.

- **If the Administrative Law Judge says no to your appeal, the appeals process *may* or *may not* be over**.
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you can continue to the next level of the review process. If the administrative law judge says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

Level 4 Appeal: The **Appeals Council** will review your appeal and give you an answer. The Appeals Council works for the Federal government.

- **If the answer is yes, or if the Appeals Council denies our request to review a favorable Level 3 Appeal decision, the appeals process *may* or *may not* be over** - We will decide whether to appeal this decision to Level 5. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 4 decision that is favorable to you.
  - If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the Appeals Council's decision.
  - If we decide to appeal the decision, we will let you know in writing.
- **If the answer is no or if the Appeals Council denies the review request, the appeals process *may* or *may not* be over**.
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Appeals Council says no to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 Appeal: A judge at the **Federal District Court** will review your appeal.

- This is the last step of the administrative appeals process.

Section 9.2 Levels of Appeal 3, 4, and 5 for Part D Drug Appeals

This section may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the value of the drug you have appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. If the dollar amount is less, you cannot appeal any further. The written response you receive to your Level 2 Appeal will explain who to contact and what to do to ask for a Level 3 Appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 Appeal: **A judge who works for the Federal government** will review your appeal and give you an answer. This judge is called an "Administrative Law Judge."

- **If the answer is yes, the appeals process is over**. What you asked for in the appeal has been approved. We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, the appeals process *may* or *may not* be over**.
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you can continue to the next level of the review process. If the administrative law judge says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

Level 4 Appeal The **Appeals Council** will review your appeal and give you an answer. The Appeals Council works for the Federal government.

- **If the answer is yes, the appeals process is over**. What you asked for in the appeal has been approved. We must **authorize or provide the drug coverage** that was approved by the Appeals Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, the appeals process *may* or *may not* be over**.
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Appeals Council says no to your appeal or denies your request to review the appeal, the notice you get will tell you whether the rules allow you to go on to Level 5 Appeal. If the rules allow you to go on, the written

notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 Appeal A judge at the **Federal District Court** will review your appeal.

- This is the last step of the appeals process.

MAKING COMPLAINTS

SECTION 10 How to make a complaint about quality of care, waiting times, customer service, or other concerns

If your problem is about decisions related to benefits, coverage, or payment, then this section is *not for you*. Instead, you need to use the process for coverage decisions and appeals. Go to Section 4 of this chapter.

Section 10.1 What kinds of problems are handled by the complaint process?

This section explains how to use the process for making complaints. The complaint process is used for certain types of problems *only*. This includes problems related to quality of care, waiting times, and the customer service you receive. Here are examples of the kinds of problems handled by the complaint process.

If you have any of these kinds of problems, you can "make a complaint"

Complaint	Example
Quality of your medical care	• Are you unhappy with the quality of the care you have received (including care in the hospital)?
Respecting your privacy	• Do you believe that someone did not respect your right to privacy or shared information about you that you feel should be confidential?
Disrespect, poor customer service, or other negative behaviors	• Has someone been rude or disrespectful to you? • Are you unhappy with how our Customer Service has treated you? • Do you feel you are being encouraged to leave the plan?

Complaint	Example
Waiting times	• Are you having trouble getting an appointment, or waiting too long to get it? • Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our Customer Service or other staff at the plan? o Examples include waiting too long on the phone, in the waiting room, when getting a prescription, or in the exam room.
Cleanliness	• Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
Information you get from us	• Do you believe we have not given you a notice that we are required to give? • Do you think written information we have given you is hard to understand?
Timeliness (These types of complaints are all related to the timeliness of our actions related to coverage decisions and appeals)	The process of asking for a coverage decision and making appeals is explained in sections 4-9 of this chapter. If you are asking for a decision or making an appeal, you use that process, not the complaint process. However, if you have already asked us for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can also make a complaint about our slowness. Here are examples: • If you have asked us to give you a "fast coverage decision" or a "fast appeal," and we have said we will not, you can make a complaint. • If you believe we are not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have made, you can make a complaint. • When a coverage decision we made is reviewed and we are told that we must cover or reimburse you for certain medical services or drugs, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint. • When we do not give you a decision on time, we are required to forward your case to the Independent Review Organization. If we do not do that within the required deadline, you can make a complaint.

Section 10.2 The formal name for "making a complaint" is "filing a grievance"

Legal Terms

- What this section calls a **"complaint"** is also called a **"grievance."**
- Another term for **"making a complaint"** is **"filing a grievance."**
- Another way to say "**using the process for complaints"** is "**using the process for filing a grievance."**

Section 10.3 Step-by-step: Making a complaint

Step 1: Contact us promptly – either by phone or in writing.

- **Usually, calling Customer Service is the first step.** If there is anything else you need to do, Customer Service will let you know. Call toll free 888.389.6648. TTY users should call 711. We can be reached 7 days a week from 8 a.m. to 8 p.m.
- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing.
- We have a formal process for reviewing your complaints, the Priority Health Medicare Grievance process. This process includes resolving your complaint over the phone. If you ask for a written response, file a written grievance, or make a complaint related to quality of care, we will respond in writing. We attempt to resolve concerns during the first point of contact. If we cannot resolve on first contact, we will attempt to resolve no more than 30 calendar days from the date of receipt of your grievance. We may extend the time frame by up to 14 calendar days if you ask for an extension or if we justify a need for additional information and delay our response in your best interest. All grievances must be submitted within 60 calendar days of the event or incident. Any grievance outside this time frame cannot be accepted.

  You may request an expedited grievance whenever Priority Health Medicare extends the time frame to make an organization or coverage determination, extends the time frame to make a reconsideration or redetermination, denies your request for an expedited appeal, or denies your request for an expedited organization determination. If you wish to file an expedited grievance you may contact Customer Service (phone numbers can be found on the back of this booklet). Expedited grievances will be responded to verbally within 24 hours of receipt at Priority Health Medicare.

If upon review of your request we determine that based on your medical or health status delaying our decision will not seriously harm you and we will not accept the request. We will proceed to handle your request according to standard organization or coverage determinations, or reconsideration or redeterminations time frames. We will notify you of our decision verbally and a written response will be sent within three (3) calendar days after our verbal notification.

- **Whether you call or write, you should contact Customer Service right away.** The complaint must be made within 60 calendar days after you had the problem you want to complain about.

- **If you are making a complaint because we denied your request for a "fast coverage decision" or a "fast appeal," we will automatically give you a "fast complaint."** If you have a "fast complaint," it means we will give you **an answer within 24 hours**.

Legal Terms
What this section calls a **"fast complaint"** is also called an **"expedited grievance."**

Step 2: We look into your complaint and give you our answer.

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.

- **Most complaints are answered in 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we will tell you in writing.

- **If we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

Section 10.4 You can also make complaints about quality of care to the Quality Improvement Organization

You can make your complaint about the quality of care you received to us by using the step-by-step process outlined above.

When your complaint is about *quality of care*, you also have two extra options:

- **You can make your complaint to the Quality Improvement Organization**. If you prefer, you can make your complaint about the quality of care you received directly to this organization (*without* making the complaint to us).

- The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.

- To find the name, address, and phone number of the Quality Improvement Organization for your state, look in Chapter 2, Section 4, of this booklet. If you make a complaint to this organization, we will work with them to resolve your complaint.

- **Or you can make your complaint to both at the same time**. If you wish, you can make your complaint about quality of care to us and also to the Quality Improvement Organization.

Section 10.5 You can also tell Medicare about your complaint

You can submit a complaint about **Priority**Medicare (Employer HMO-POS) directly to Medicare. To submit a complaint to Medicare, go to *https://www.medicare.gov/MedicareComplaintForm/home.aspx*. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the plan is not addressing your issue, please call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048.

CHAPTER 10

Ending your membership in the plan

Chapter 10. Ending your membership in the plan

SECTION 1 Introduction

Section 1.1 This chapter focuses on ending your membership in our plan

Ending your membership in **Priority**Medicare (Employer HMO-POS) may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you have decided that you *want* to leave.
  - Section 2 tells you *when* you can end your membership in the plan.
  - The process for voluntarily ending your membership varies depending on what type of new coverage you are choosing. Section 3 tells you *how* to end your membership in each situation.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. Section 5 tells you about situations when we must end your membership.

If you are leaving our plan, you must continue to get your medical care through our plan until your membership ends. Contact the Office of Retirement Services at 1-800-381-5111 for information about ending your plan.

SECTION 2 When can you end your membership in our plan?

You may end your membership in our plan only during certain times of the year, known as enrollment periods. All members have the opportunity to leave the plan during the Annual Enrollment Period and during the annual Medicare Advantage Disenrollment Period. In certain situations, you may also be eligible to leave the plan at other times of the year. Contact your benefits administrator for information about ending your plan.

Section 2.1 You can end your membership during the Annual Enrollment Period

You can end your membership during the **Annual Enrollment Period** (also known as the "Annual Coordinated Election Period"). This is the time when you should review your health and drug coverage and make a decision about your coverage for the upcoming year.

- **When is the Annual Enrollment Period?** This happens from October 15 to December 7.
- **What type of plan can you switch to during the Annual Enrollment Period?** You can choose to keep your current coverage or make changes to your coverage for the upcoming year. If you decide to change to a new plan, you can choose any of the following types of plans:

- Another Medicare health plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
- Original Medicare *with* a separate Medicare prescription drug plan.
- – *or* – Original Medicare *without* a separate Medicare prescription drug plan.
    - **If you receive "Extra Help" from Medicare to pay for your prescription drugs:** If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage, you may need to pay a Part D late enrollment penalty if you join a Medicare drug plan later. ("Creditable" coverage means the coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) See Chapter 1, Section 5 for more information about the Part D late enrollment penalty.

- **When will your membership end?** Your membership will end when your new plan's coverage begins on January 1.

Section 2.2 You can end your membership during the annual Medicare Advantage Disenrollment Period, but your choices are more limited

You have the opportunity to make *one* change to your health coverage during the annual **Medicare Advantage Disenrollment Period**.

- **When is the annual Medicare Advantage Disenrollment Period?** This happens every year from January 1 to February 14.
- **What type of plan can you switch to during the annual Medicare Advantage Disenrollment Period?** During this time, you can cancel your Medicare Advantage Plan enrollment and switch to Original Medicare. If you choose to switch to Original Medicare during this period, you have until February 14 to join a separate Medicare prescription drug plan to add drug coverage.
- **When will your membership end?** Your membership will end on the first day of the month after we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare prescription drug plan, your membership in the drug plan will begin the first day of the month after the drug plan gets your enrollment request.

Section 2.3 In certain situations, you can end your membership during a Special Enrollment Period

In certain situations, members of **Priority**Medicare (Employer HMO-POS) may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period**.

- **Who is eligible for a Special Enrollment Period?** If any of the following situations apply to you, you are eligible to end your membership during a Special Enrollment Period. These are just examples, for the full list you can contact the plan, call Medicare, or visit the Medicare website (*https://www.medicare.gov*):
    - When you have moved outside the plan's service area (see Chapter 1, Section 4.1 for the service area).
    - If you have Medicaid.
    - If you are eligible for "Extra Help" with paying for your Medicare prescriptions.
    - If we violate our contract with you.
    - If you are getting care in an institution, such as a nursing home or long-term care (LTC) hospital.
    - If you enroll in the Program of All-inclusive Care for the Elderly (PACE).
- **When are Special Enrollment Periods?** The enrollment periods vary depending on your situation.
- **What can you do?** To find out if you are eligible for a Special Enrollment Period, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048. If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. This means you can choose any of the following types of plans:
    - Another Medicare health plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
    - Original Medicare *with* a separate Medicare prescription drug plan.
    - – *or* – Original Medicare *without* a separate Medicare prescription drug plan.
        - **If you receive "Extra Help" from Medicare to pay for your prescription drugs:** If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

    Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for a continuous period of 63 days or more, you may need to pay a Part D late enrollment penalty if you join a Medicare drug

plan later. ("Creditable" coverage means the coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) See Chapter 1, Section 5 for more information about the Part D late enrollment penalty.

- **When will your membership end?** Your membership will usually end on the first day of the month after your request to change your plan is received.

Section 2.4 Where can you get more information about when you can end your membership?

If you have any questions or would like more information on when you can end your membership:

- You can **call or email Customer Service** (phone numbers are printed on the back cover of this booklet).
- You can find the information in the ***Medicare & You 2018*** Handbook.
    - Everyone with Medicare receives a copy of *Medicare & You* each fall. Those new to Medicare receive it within a month after first signing up.
    - You can also download a copy from the Medicare website (*https://www.medicare.gov*). Or, you can order a printed copy by calling Medicare at the number below.
- You can contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTION 3 How do you end your membership in our plan?

Section 3.1 Usually, you end your membership by enrolling in another plan

Usually, to end your membership in our plan, you simply enroll in another Medicare plan during one of the enrollment periods (see Section 2 in this chapter for information about the enrollment periods). However, if you want to switch from our plan to Original Medicare *without* a Medicare prescription drug plan or Original Medicare and add a Medicare Supplement plan (or "Medigap plan") without a Medicare prescription drug plan, you must ask to be disenrolled from our plan. There are three ways you can ask to be disenrolled:

- You need to contact the Office of Retirement Services at 1-800-381-5111, Monday through Friday from 8:30 a.m. to 5:00 p.m.
- --*or*--You can contact Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage, for a continuous period of 63 days or more, you may need to pay a Part D late enrollment penalty if you join a Medicare drug plan later. ("Creditable" coverage means the coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) See Chapter 1, Section 5 for more information about the Part D late enrollment penalty.

The table below explains how you should end your membership in our plan.

If you would like to switch from our plan to:	**This is what you should do:**
• Another Medicare health plan.	• Enroll in the new Medicare health plan. You will automatically be disenrolled from **Priority**Medicare (Employer HMO-POS) when your new plan's coverage begins.
• Original Medicare *with* a separate Medicare prescription drug plan.	• Enroll in the new Medicare prescription drug plan. You will automatically be disenrolled from **Priority**Medicare (Employer HMO-POS) when your new plan's coverage begins.
• Original Medicare *without* a separate Medicare prescription drug plan. o **Note:** If you disenroll from a Medicare prescription drug plan and go without creditable prescription drug coverage, you may need to pay a Part D late enrollment penalty if you join a Medicare drug plan later. See Chapter 1, Section 5 for more information about the Part D late enrollment penalty.	• **Contact the Office of Retirement Services** by calling them at 1-800-381-5111, Monday through Friday from 8:30 a.m. to 5:00 p.m. • You can also contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048. • You will be disenrolled from **Priority**Medicare (Employer HMO-POS) when your coverage in Original Medicare begins.
• Original Medicare and add a Medicare supplement plan (or "Medigap plan") without a separate Medicare prescription drug plan.	• **Contact the Office of Retirement Services** by calling them at 1-800-381-5111, Monday through Friday from 8:30 a.m. to 5:00 p.m.

If you would like to switch from our plan to:	This is what you should do:
• **Note:** If you disenroll from a Medicare prescription drug plan and go without creditable prescription drug coverage, you may need to pay a Part D late enrollment penalty if you join a Medicare drug plan later. See Chapter 6, Section 10 for more information about the Part D late enrollment penalty.	• You will not be disenrolled from **Priority**Medicare (Employer HMO-POS) until we receive a valid written request.

SECTION 4 Until your membership ends, you must keep getting your medical services and drugs through our plan

Section 4.1 Until your membership ends, you are still a member of our plan

If you leave **Priority**Medicare (Employer HMO-POS), it may take time before your membership ends and your new Medicare coverage goes into effect. (See Section 2 for information on when your new coverage begins.) During this time, you must continue to get your medical care and prescription drugs through our plan.

- **You should continue to use our network pharmacies to get your prescriptions filled until your membership in our plan ends.** Usually, your prescription drugs are only covered if they are filled at a network pharmacy including through our mail-order pharmacy services.
- **If you are hospitalized on the day that your membership ends, your hospital stay will usually be covered by our plan until you are discharged** (even if you are discharged after your new health coverage begins).

SECTION 5 **Priority**Medicare (Employer HMO-POS) **must end your membership in the plan in certain situations**

Section 5.1 When must we end your membership in the plan?

PriorityMedicare (Employer HMO-POS) **must end your membership in the plan if any of the following happen:**

- If you no longer have Medicare Part A and Part B.
- If you move out of our service area.
- If you are away from our service area for more than six months.
    - If you move or take a long trip, you need to call Customer Service to find out if the place you are moving or traveling to is in our plan's area. (Phone numbers for Customer Service are printed on the back cover of this booklet.)
- If you become incarcerated (go to prison).
- If you are not a United States citizen or lawfully present in the United States.
- If you lie about or withhold information about other insurance you have that provides prescription drug coverage.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get medical care. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
    - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you do not pay the plan premiums, we reserve the right to end your membership.
    - We must notify you in writing that you have not paid your premium. This will act as your written notice that we will end your membership in 60 days if you do not pay your plan premium before we end your membership.
- If you are required to pay the extra Part D amount because of your income and you do not pay it, Medicare will disenroll you from our plan and you will lose prescription drug coverage.

Where can you get more information?

If you have questions or would like more information on when we can end your membership:

- You can call or email **Customer Service** for more information (phone numbers and email address are printed on the back cover of this booklet).

Section 5.2 We cannot ask you to leave our plan for any reason related to your health

PriorityMedicare (Employer HMO-POS) is not allowed to ask you to leave our plan for any reason related to your health.

What should you do if this happens?

If you feel that you are being asked to leave our plan because of a health-related reason, you should call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may call 24 hours a day, 7 days a week.

Section 5.3 You have the right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership. You can look in Chapter 9, Section 10 for information about how to make a complaint.

CHAPTER 11

Legal notices

Chapter 11. Legal notices

SECTION 1 Notice about governing law

Many laws apply to this *Evidence of Coverage* and some additional provisions may apply because they are required by law. This may affect your rights and responsibilities even if the laws are not included or explained in this document. The principal law that applies to this document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other Federal laws may apply and, under certain circumstances, the laws of the state you live in.

SECTION 2 Notice about non-discrimination

We don't discriminate based on race, ethnicity, national origin, color, religion, sex, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location. All organizations that provide Medicare Advantage plans, like our plan, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

Priority Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Priority Health does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Priority Health:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact Priority Health Medicare customer service at 888.389.6648 (TTY users call 711), 8 a.m. - 8 p.m., 7 days a week.

If you believe that Priority Health 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 file a grievance with: Priority Health Medicare Customer Service, 1231 East Beltline Ave. NE, Grand Rapids, MI 49525-4501, phone: 888.389.6648 (TTY users should call 711), fax: 616.975.8826, email: MedicareCS@priorityhealth.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, a customer service representative 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, DC 20201, 1-800-868-1019, 800-537-7697 (TDD).

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 888.389.6648 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 888.389.8466 (رقم هاتف الصم والبكم: 117).

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 888.389.6648（TTY：711）。

ܬܚܝ ܒܕܬܘܢ ܕܡܦܠܚܝܬܘܢ ܒܝܠܚܘܕܐ ܕܗܝܪܬܐ ܠܫܢܢܝܐ ܡܓܢܐܝܬ، ܙܘܗܪܐ: ܐܢ ܐܢܫܬܘܢ ܟܐ ܡܗܡܙܡܝܬܘܢ ܠܫܢܐ ܐܬܘܪܝܐ.
ܩܪܘܢ ܥܠ ܡܢܝܢܐ 888.389.6648 (TTY: 711)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 888.389.6648 (TTY: 711).

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 888.389.6648 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 888.389.6648 (TTY: 711)번으로 전화해 주십시오.

লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-888.389.6648 (TTY: 711)।

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 888.389.6648 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 888.389.6648 (TTY: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 888.389.6648 (TTY: 711).

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。888.389.6648（TTY: 711）まで、お電話にてご連絡ください。

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 888.389.6648 (телетайп: 711).

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 888.389.6648 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 888.389.6648 (TTY: 711).

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, **Priority**Medicare (Employer HMO-POS), as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any State laws.

SECTION 4 Notice about coordinating benefits with Third Party Payers

Section 4.1 Recovery Rights

As explained in Chapter 1, Section 7 ("How other insurance works with our plan"), we coordinate benefits with third party payers under rules established by Medicare. We incorporate those Medicare rules into this Evidence of Coverage (see "More Information," below) to the extent permitted by law. Third-party payers include (but are not limited to) other health plan coverage, liability insurance (such as automobile liability or homeowners insurance), underinsured/uninsured motorist coverage, "Med-Pay" coverage, workers' compensation plans or insurance, no-fault insurance, self-funded entities that provide such coverage, and any other entity or person who would be a primary payer under the Medicare Secondary Payer provisions. Under the Medicare rules, we have rights to recover amounts we pay for services for which third-party payers are responsible, including amounts third-party payers pay to you.

Section 4.2 Subrogation and Reimbursement

Our recovery rights include a right to subrogation (which means that we can stand in your shoes and sue a third party directly for amounts we pay for services provided to you as a result of an illness or injury) and a right of reimbursement (which means that we have a right to be reimbursed out of any recoveries you will receive or have received from third parties for amounts we pay for services provided to you as a result of an illness or injury). We are entitled to the subrogation and reimbursement rights that Medicare has under the Medicare Secondary Payer provision, to the extent permitted by law. The Social Security Act preempts State laws and State requirements that might otherwise interfere with these rights. Our recovery rights are not limited by stipulations in settlement agreements unless we are a party to the agreement. When

we act as a provider of medical services, our recovery will be based on the reasonable value of the benefits provided.

Section 4.3 Lien on Proceeds

We will have a lien on the proceeds of any judgment, settlement, or other reward or recovery you receive from a third party payer to the extent of any payment we made for health care services provided to you that are related to the proceeds. Our lien will be the first priority claim on the proceeds. You must hold the proceeds in trust for us. Transfer of the proceeds to a third party does not defeat our recovery rights if the proceeds were or are intended for your benefit.

Section 4.4 Notice of Possible Third-Party Payer

You must provide us notice as soon as practicable, but in any event within thirty (30) days, of filing a claim with or a legal action against a person or entity that may be a third-party payer with respect to services provided to you as a result of an illness or injury. Your notice must be in writing and explain the basis for the claim. Send your notice to:

Priority Health
Medicare Advantage Subrogation Unit, MS 2205
1231 East Beltline NE
Grand Rapids, Michigan 49525

Section 4.5 Cooperation

You are required, when requested, to acknowledge our recovery rights in writing. Our recovery rights, however, are not dependent upon your acknowledgement. You must tell us as soon as practicable, in writing, about any situation that might involve our rights under this section. You must cooperate with us to help protect our rights under this section. Neither you, nor anyone acting for you, may do anything to harm our rights under this section. We may recover from you expenses we incur because of your failure to cooperate in enforcing our rights under this section.

Section 4.6 More Information

This Section 4 contains a summary of our rights under the Medicare Secondary Payer provisions. We incorporate the Medicare Secondary Payer provisions into this Evidence of Coverage to the extent permitted by law. For more information, see the Medicare Secondary Payer provisions in § 1862(b) of the Social Security Act (42 C.F.R. § 1395y(b)) and 42 C.F.R. Part 411, subparts B – H.

Section 4.7 Definition

For purposes of this Section 4, “you” means you, your estate, your guardian, or any other person acting on your behalf.

SECTION 5 Notice about Evidence of Coverage - Terms are Binding

By enrolling in our plan and accepting benefits under this Evidence of Coverage, you agree to the terms of this Evidence of Coverage, including the terms of this Chapter 11.

SECTION 6 Notice about Coverage Decisions and Appeal Rights

If you would like to contest any coverage decision we make concerning your benefits, including any coverage decision involving the rules for coordinating benefits, you must follow the procedures in Chapter 9, "What to do if you have a problem or complaint (coverage decisions, appeals, complaints)."

SECTION 7 Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our commitment to you

Priority Health understands the importance of handling protected health information with care. We are committed to protecting the privacy of our members' health information in every setting. State and federal laws require us to make sure that your health information is kept private. When you enroll with Priority Health or use services provided by one of the Priority Health plans, your protected health information may be disclosed to Priority Health and by Priority Health. This information is used and disclosed to coordinate and oversee your medical treatment, pay your medical claims, and for the other purposes described below.

Federal law requires that we provide you with this Notice of Privacy Practices. This Notice states our legal duties and privacy practices regarding your protected health information. It also states your rights under these laws with respect to the use and disclosure of your health information. Priority Health is required by law to follow the terms of the Notice currently in effect. We are also required to notify affected individuals following a breach of unsecured protected health information.

Use and disclosure of your health information

The sections below describe the ways Priority Health uses and discloses your health information. Your health information is not shared with anyone who does not have a "need to know" to perform one of the tasks below.

Disclosures to you. Priority Health may use and disclose your protected health information to communicate with you for purposes of customer service or to provide you with information you

request. Priority Health may use and disclose information about you for the access and disclosure accounting purposes described in the "Your rights regarding your health information" section of this Notice.

Disclosures to your family and friends. Priority Health may disclose your protected health information to a family member, friend, or any other person you identify as being involved in your health care or payment for your health care if you agree in advance to the disclosure or we infer from the circumstances that you do not object to the disclosure. Priority Health may also disclose information about you to one of these people if you are not present or if you are unable to provide the required permission because of a medical emergency, accident, or similar situation and we determine that disclosure would be in your best interests. In these situations, Priority Health may disclose only the protected health information directly relevant to the person's involvement with your health care or payment for health care. Priority Health may also disclose your protected health information to anyone based on your written authorization (see section on "Other uses of health information—by authorization only," below).

Treatment. Priority Health may use your health information or disclose it to third parties to coordinate and oversee your medical care. For example, we may disclose information about your prescription medications to your doctor so that s/he can better understand how to provide you medical care.

Payment. Priority Health may use your health information or disclose it to third parties to collect premiums or pay for your medical care. For example, we may use your health information when we receive a claim for payment. Your claim tells us what services you received and may include a diagnosis. We may also disclose this information to another insurer if you are covered under more than one health plan.

Health care operations. Priority Health may use your health information and disclose it to third parties in order to assist in Priority Health's everyday work activities, such as looking at the quality of your care, carrying out utilization review, and conducting disease management programs. For example, your health information (along with other Priority Health members' information) may be used by Priority Health's staff to review the quality of care furnished by health care providers. Priority Health may also use and disclose your health information for underwriting, enrollment, and other activities related to creating, renewing, or replacing a benefits plan. Priority Health may not, however, use or disclose genetic information for underwriting purposes.

Other permitted or required uses and disclosures. Priority Health may also use or disclose your health information**:**

- When required by law.
- For law enforcement purposes.
- To report or prevent abuse, neglect or domestic violence.
- For public health activities, such as disease control or public health investigations.
- To prevent a serious threat to an individual or a community's health and safety.
- When necessary for judicial or administrative (i.e., court) proceedings.

- For health oversight activities led by governmental agencies and authorized by law.
- As necessary for a coroner, medical examiner, law enforcement official, or funeral director to carry out their legal duties with respect to a deceased individual or to cadaveric organ, eye or tissue donation and transplant organizations.
- For research purposes (as long as applicable research privacy standards are met).
- To make a collection of "de-identified" information that cannot be traced back to you.
- For compliance with workers' compensation requirements, as authorized by applicable law.
- For various government functions, such as disclosures to the Armed Forces for active personnel, to Intelligence Agencies for national security, and the Department of State for foreign services reasons (e.g., security clearance).

Disclosures to health plan sponsors

(This section of the Notice of Privacy Practices applies to only to group health plans).
Priority Health may share information with the sponsor of your group plan (usually, your employer) about whether you are enrolled or disenrolled in the plan. Priority Health may also share "summary health information" with the sponsor. Summary health information has most identifying information (such as your name, your age and address except for zip code) removed, and it summarizes the amount, type, and history of claims paid under the sponsor's group health plan. The sponsor may use this information to obtain premium bids for health insurance coverage or to decide whether to modify, amend or terminate the plan. If the sponsor of your group health plan takes appropriate steps to comply with federal privacy regulations, Priority Health may also disclose your protected health information to the sponsor for the sponsor's administration of the group health plan.

Other uses of health information – by authorization only

Except as described in this Notice, Priority Health may not use or disclose your protected health information without your written authorization. You may give us written authorization to use your protected health information or to disclose it to anyone for any purpose. If you give us written authorization, you may revoke it (take it back) at any time by notifying Priority Health's Compliance department in writing (see Contact information section). If you revoke your authorization, we will no longer use or disclose your health information for the reasons covered by your authorization, but it will not affect any use or disclosure permitted by the authorization while it was in effect. We need your written authorization to use or disclose psychotherapy notes, except in limited circumstances such as when the disclosure is required by law. We also must obtain your written authorization to sell information about you to a third party or, in most circumstances, to use or disclose your protected health information to send you communications about products and services. We do not need your written authorization, however, to send you communications about health related products or services, as long as the products or services are associated with your coverage or are offered by us.

We can provide you with a Sample Authorization Form.

A parent, legal guardian, or properly named patient advocate may represent you and provide us with an authorization (or may revoke an authorization) to use or disclose health information about you if you cannot provide an authorization. Court documents may be required to verify this authority.

Potential impact of other applicable laws

HIPAA (the federal privacy law) generally does not preempt, or override other laws that give people greater privacy protections. Therefore, if any state or federal privacy law requires us to provide you with more privacy protections, we are obligated to comply with that law in addition to HIPAA.

Our policies and procedures

We have policies and procedures in place that protect the privacy of your information.

- Every employee receives training when they are hired and on an annual basis.
- Every employee must acknowledge that they understand they are required to keep member information private. They also learn about the actions the company will take if the privacy policies are not followed.

Priority Health has strict control of access to electronic and paper information specific to members. Only those users authorized with a password have access to electronic information. Paper information is stored in secure locations. Access is only given to those who need it to manage care for members or for administrative purposes.

Your rights regarding your health information

You have the following rights:

Right to inspect and copy. You have a right to look at and get a copy of health information that may be used to make decisions about your care and payment for your care. There are limited circumstances in which we may deny your request to inspect and copy these records. If you are denied access to health information, you may request that the denial be reviewed. If you request a copy of the information, we may charge a fee for the cost of copying, mailing, and other costs associated with your request.
To inspect and copy health information, contact Priority Health's Compliance department in writing (see Contact Information section).

Right to amend. You have the right to request that Priority Health amend any information that we use to make decisions about you. Generally, Priority Health will not amend these records if we did not create them or we determine that they are accurate and complete. To request that we amend your health information, you must write to Priority Health's Compliance department (See Contact Information section) and include a reason to support the change.

Right to know about disclosures. You have the right to know about certain disclosures of your health information. Priority Health is not required to inform you of disclosures we make for

treatment, payment, health care operations, and disclosures for certain other purposes. But, you may request a list of other disclosures going back six years from the date of your request. The list will include, for example, disclosures that are required by law, for judicial or administrative proceedings, or for research purposes (unless the disclosure is also our health care operation). To request a list of disclosures, you must send your request in writing to Priority Health's Compliance department (see Contact Information section). Your request must specify the time period desired. There will be no charge for the first list you request within a 12-month period. There may be a fee for any further requests.

Right to request restrictions. You have the right to request a limit on the health information that we use or disclose about you. We are not required by law to agree to your request. If we do agree to your request for restriction, we will comply with it unless the information is needed to provide emergency treatment. To request restrictions, you must make your request in writing to Priority Health's Compliance department (see Contact Information section). In your request, you must tell us:

- What information you want to limit.
- Whether you want to limit our use, disclosure or both.
- To whom you want the limits to apply.

Priority Health will notify you (either in writing or by telephone) when we receive your request and of any restrictions to which we agree.

Right to request confidential communications. You may request that Priority Health communicate with you through alternative means or an alternative location. Priority Health will agree to your request if you clearly state in writing that communicating with you without using the alternative means or location could endanger you. Priority Health will accommodate your request if it is reasonable, specifies the alternative means or location, and permits us to collect premiums and pay claims.

To request confidential communications, you must make your request in writing to Priority Health's Compliance department (see Contact Information section).

Right to a paper copy of this Notice. You have the right to a paper copy of Priority Health's current Notice upon request. To obtain a paper copy of this Notice, please call our Customer Service department (see Contact Information section). Otherwise, you may also print a copy of this Notice from our website at *priorityhealth.com*.

Changes to this Notice

Priority Health has the right to change our privacy practices and the terms of this Notice at any time. Any new terms of our Notice will be effective for all protected health information that we maintain, including protected health information that we created or received before we make the changes. Before we make any material change in our privacy practices, we will change this Notice and post the new Notice on our website. We will provide a copy of the new Notice (or

information about the changes to our privacy practices and how to obtain the new Notice) in our next annual mailing to members who are then covered by one of our health plans.

Complaints
If you believe your privacy rights have been violated, you may file a complaint with Priority Health and/or the Office for Civil Rights at the U.S. Department of Health and Human Services. To file a complaint with Priority Health, please call or send a written explanation of the issue to Priority Health's Compliance department (see Contact Information section). You will not be retaliated against for filing a complaint.

Contact information
If you have any questions or complaints, please contact Priority Health's Compliance department or Customer Service department as noted above at:

Priority Health
1231 East Beltline NE
Grand Rapids MI 49525
616 942-0954
800 942-0954

If this information is unclear or if you do not understand it, please call Priority Health for assistance at 888.975.8102 (for TTY service, please call 711).

This Notice is effective: September 23, 2013

The term "Priority Health" refers to four corporations: "Priority Health Government Programs, Inc. (a Michigan non-profit corporation), "Priority Health" (a Michigan non-profit corporation), "Priority Health Insurance Company (a Michigan non-profit corporation) and "Priority Health Managed Benefits, Inc." (a Michigan business corporation).

CHAPTER 12

Definitions of important words

Chapter 12. Definitions of important words

Adaptive equipment – Adaptive devices are items used to assist with completing activities of daily living. Bathing, dressing, grooming, toileting and feeding are self-care activities that are included in the spectrum of activities of daily living (ADLs). Examples of adaptive equipment include but are not limited to bathroom grab bars, bath seats, elevators, carafes, grabbers, and personal emergency systems. These items do not contribute meaningfully to the treatment of an illness or injury or the functioning of a malformed body member and are not covered and do not meet medical necessity.

Admission – A hospital or inpatient facility admission involves formally being admitted by a physician as an inpatient to a hospital/facility and you stay for at least one night. NOTE: You may sometimes stay overnight at the hospital but not have been admitted. See "**Observation"** for more information.

Advance directive – A written statement of a person's wishes regarding medical treatment, often including a living will, made to ensure those wishes are carried out should the person be unable to communicate them to a doctor. For additional information, see Chapter 8, Section 1.6.

Allowed Amount – An allowed amount is the maximum amount of the billed charge the plan will pay for covered services or supplies rendered by providers, suppliers and facilities, including skilled nursing facilities and home health agencies. The allowed amount is accepted as payment in full for covered services by participating providers, suppliers and facilities. For non-participating providers, the allowed amount is the amount Original Medicare allows for the geographic region in which the provider renders services. Non-participating providers who accept or participate with Medicare must accept our payment as payment in full consistent with Sections 1852(a)(2) and 1852(k)(1) of the Social Security Act.

Ambulatory Surgical Center – An Ambulatory Surgical Center is a health care facility focused on providing same-day surgical care, including diagnostic and preventive procedures. It operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center does not exceed 24 hours. An ASC is different than an outpatient hospital facility. ASC's are a separate identifiable legal entity from any other health care facility, such as a hospital, and outpatient hospital facilities are a legal entity of the hospital. See **"Outpatient Hospital Facility."** Contact the plan to find an ASC in your area.

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 October 15 until December 7. Since you are enrolled in an employer sponsored health plan, you will automatically be enrolled in the following year's plan when the renewal period occurs for your employer. You can still switch to Original Medicare during annual enrollment period (AEP), but it is important to check with your employer's benefits administrator as some will not allow you to re-enter the employer sponsored health plan once you leave.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or prescription drugs or payment for services or drugs you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving. For example, you may ask for an appeal if we don't pay for a drug, item, or service you think you should be able to receive. Chapter 9 explains appeals, including the process involved in making an appeal.

AxiaLIF surgery – Axial lumbar interbody fusion (AxiaLIF®) surgery is a type of lumbar interbody fusion (LIF) surgery performed to treat lower back and leg pain caused by degenerative disc disease, spinal stenosis, and/or low grade spondylolisthesis. The AxiaLIF procedure specifically treats L5-S1 using minimally invasive techniques. Sometimes the procedure is performed on an outpatient basis, meaning you go home the same day as your surgery. AxiaLIF is an alternative to traditional open back surgery.

Balance Billing – When a provider (such as a doctor or hospital) bills a patient more than the plan's allowed cost-sharing amount. As a member of **Priority**Medicare (Employer HMO-POS), you only have to pay our plan's cost-sharing amounts when you get services covered by our plan. We do not allow providers to "balance bill" or otherwise charge you more than the amount of cost-sharing your plan says you must pay. See Chapter 4, Section 1.5 for more information about balance billing.

Benefit Period –The way that both our plan and Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. For Priority Health Medicare a benefit period only applies to a skilled nursing facility. A benefit period begins the day you go into a skilled nursing facility. The benefit period ends when you haven't received any skilled care in a SNF for 60 days in a row. If you go into a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

Brand Name Drug – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit where you pay a low copayment or coinsurance for your drugs after you or other qualified parties on your behalf have spent $5,000 in covered drugs during the covered year.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that administers Medicare. Chapter 2 explains how to contact CMS.

Certified Nurse Midwife (CNM) - An individual who is a registered nurse professional who is authorized by the State in which the services are furnished to practice as a registered nurse in midwifery (i.e., the nursing care of women during pregnancy, the postpartum period, newborn care and some routine care (e.g., gynecological exams) accordance with State law and be certified as a CNRA by a recognized national certifying body that has established standards for nurse practitioners (e.g., American Academy of Nurse Practitioners, American Nurses Credentialing Center, National Certification Corporation for Obstetric, Gynecologic and Neonatal Nursing Specialties, etc.) and/or meets any other requirements specified by Medicare.

Certified Nurse Specialist (CNS) - An individual who is currently licensed to practice in the State where h/she practices and is authorized to furnish the services of a clinical nurse specialist in according with State law; have a master's degree in a defined clinical area of nursing from an accredited educational institution; and be certified as a clinical nurse specialist by a recognized national certifying body that has established standards for CNSs) meets any other requirements specified by Medicare.

Certified Registered Nurse Aanesthetist (CRNA) - An individual who is a registered nurse professional who is authorized by the State in which the services are furnished to practice as a registered nurse anesthetist (CNRA) in accordance with State law, has graduated from a nurse anesthesia education program that meets the standards of the Council on Accreditation of Nurse Anesthesia Programs or other such accreditation body recognized by Medicare, has passed a certification exam of the Council on Certification of Nurse Anesthetists, the Council on Recertification of Nurse Anesthetists, or any certification organization recognized by Medicare and/or meets any other requirements specified by Medicare.

Clinic – A clinic is often associated with a hospital or medical school that is devoted to the diagnosis and care of patients who are admitted for treatment that does not require an overnight stay. It may also be a medical establishment run by several physicians working in cooperation and sharing the same facilities. Or it can be a group session offering counsel or instructions about a particular health condition. A clinic may be located within a hospital, on hospital grounds, or at a site outside the hospital such as a physician's office. A clinic, as defined here, is different than a Rural Health Clinic – see the definition for **"Rural Health Clinic"** in this chapter.

Clinical Nurse Specialist (CNS) - An individual who is currently licensed to practice in the State where h/she practices and is authorized to furnish the services of a clinical nurse specialist in according with State law; have a master's degree in a defined clinical area of nursing from an accredited educational institution; and be certified as a clinical nurse specialist by a recognized national certifying body that has established standards for CNSs) meets any other requirements specified by Medicare.

Clinical Psychologist (CP) - An individual who holds a doctoral degree in psychology, is licensed or certified on the basis of the doctoral degree in psychology by the State in which h/she practices at the independent practice level to furnish diagnostic, assessment, preventive and therapeutic service directly to individuals and meets any other requirements specified by Medicare.

Clinical Social Worker (CSW) - An individual who possesses a master's or doctor's degree in social work, has performed at least two years of supervised clinical social work and is licensed or certified as a clinical social worker by the State in which the services are performed, furnishes services for the diagnosis and treatment of mental illness, and meets any other requirements specified by Medicare.

Coinsurance – An amount you may be required to pay as your share of the cost for services or prescription drugs after you pay any deductibles. Coinsurance is usually a percentage (for example, 20%).

Colonoscopy – A medical procedure in which a special tube-shaped instrument is used to take pictures of the inside of someone's colon used to detect changes or abnormalities in the large intestine (colon) and rectum. There are two kinds of screening colonoscopies: preventive and diagnostic. A preventive screening colonoscopy is a procedure to find colon polyps or cancer in individuals with no signs or symptoms of either and it is no cost to you. A diagnostic screening colonoscopy is performed in order to explain symptoms identified by your physician (for example, blood in stools, change in bowel movements, iron deficiency due to anemia, persistent abdominal pain, etc.) or, because you have had a previous colonoscopy that resulted in removal of polyps. If your physician orders a diagnostic screening colonoscopy your outpatient hospital cost share applies. Also, in certain circumstances a preventive screening colonoscopy can become a diagnostic screening colonoscopy during the procedure itself. This happens when a physician finds a polyp or other abnormal findings that require removal of the polyp or a biopsy. If this happens you become responsible for any out-of-pocket costs, such as but not limited to your diagnostic test copay or coinsurance, costs for physician and facility fees, etc.

Complaint - The formal name for "making a complaint" is "filing a grievance." The complaint process is used for certain types of problems *only.* This includes problems related to quality of care, waiting times, and the customer service you receive. See also "Grievance," in this list of definitions.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, and provides a variety of services including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

Concierge care - is when a doctor or group of doctors charges you a membership fee before they'll see you or accept you into their practice. When you pay this fee, you may get some services or amenities that Medicare doesn't cover. You pay 100% of the membership fee for concierge care if the provider is not contracted with Priority Health. Contracted Priority Health providers cannot charge a concierge membership fee.

Continuous glucose monitoring (CGM) devices – Continuous glucose monitoring (CGM) is a process that allows you to track your glucose continuously throughout the day and night, notifying you of highs and lows so you can take action. This is covered when a member meets certain criteria for Medicare-approved devices.

Continuous Positive Airway Pressure (CPAP) – Continuous positive airway pressure or CPAP is a technique for relieving breathing problems such as those associated with sleep apnea or congestive heart failure. CPAP keeps your airways open by providing a continuous flow of air through a face mask. The face mask is connected to a pump that forces air into the nasal passages at pressures high enough to overcome obstructions in your airway and stimulate normal breathing.

Coordination of Benefits ("COB") – Coordination of Benefits is the process of determining which of two or more insurance policies will have the primary responsibility of processing/paying a claim and the extent to which the other policies will contribute. Medicare never pays first if another plan is primary. COB is intended to prevent the duplication of benefits when a member is covered by more than one insurance carrier, including other health insurance, retiree benefits, auto insurance, workers compensation, etc.

Copayment (or "copay") – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription drug. A copayment is a set amount, rather than a percentage. For example, you might pay $10 or $20 for a doctor's visit or prescription drug.

Cosmetic surgery – Reconstruction of cutaneous or underlying tissues, performed to improve and correct a structural defect or to remove a scar, birthmark, or normal evidence of aging. Kinds of cosmetic surgery include blepharoplasty, rhinoplasty and rhytidoplasty. Some cosmetic surgeries may not be medically necessary. See Chapter 4, Section 3.1 for *Benefits we do not cover (exclusions)*.

Cost-sharing – Cost-sharing refers to amounts that a member has to pay when services or drugs are received. (This is in addition to the plan's monthly premium.) Cost-sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before services or drugs are covered; (2) any fixed "copayment" amount that a plan requires when a specific service or drug is received; or (3) any "coinsurance" amount, a percentage of the total amount paid for a service or drug, that a plan requires when a specific service or drug is received. A "daily cost-sharing rate" may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copayment.

Cost-Sharing Tier – Every drug on the list of covered drugs is in one of five cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.

Coverage Determination – A decision about whether a drug prescribed for you is covered by the plan and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under your plan, that isn't a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage. Coverage determinations are called "coverage decisions" in this booklet. Chapter 9 explains how to ask us for a coverage decision.

Covered Drugs – The term we use to mean all of the prescription drugs covered by our plan.

Covered Services – The general term we use to mean all of the health care services and supplies that are covered by our plan.

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

Custodial Care – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you do not need skilled medical care or skilled nursing care. Custodial care is personal care that can be provided by people who don't have professional skills or training, such as help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

Customer Service – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Chapter 2 for information about how to contact Customer Service.

Daily cost-sharing rate – A "daily cost-sharing rate" may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copayment. A daily cost-sharing rate is the copayment divided by the number of days in a month's supply. Here is an example: If your copayment for a one-month supply of a drug is $30, and a one-month's supply in your plan is 30 days, then your "daily cost-sharing rate" is $1 per day. This means you pay $1 for each day's supply when you fill your prescription.

Debridement – The medical removal of dead, damaged or infected tissue to improve healing potential of the remaining healthy tissue.

Deductible – The amount you must pay for health care or prescriptions before our plan begins to pay.

Diagnostic – A diagnostic test, procedure, or lab done to establish the presence or absence of a disease or other condition. Diagnostic tests, procedures or labs can be performed at any time if there are symptoms and/or signs that suggest that a condition or disease may be present and a test is needed to confirm the diagnosis. Many times it is done in order to explain symptoms identified by your physician. This test is then used as a basis for on-going treatment decisions when you have been diagnosed or confirmed as having a certain disease or condition. A diagnostic test is not the same as a screening. And, sometimes a screening can turn diagnostic during the screening procedure. For example, if you go in for a screening colonoscopy and during the procedure your physician finds a polyp or other abnormal findings that require removal of the polyp or a biopsy the screening becomes diagnostic.

Discharge – A discharge happens when you are released from an inpatient hospital, skilled nursing or other hospital setting to go home or go to another care setting. This includes when you are physically discharged from the hospital to another facility or a unit and/or bed within the same facility as well as when you are discharged "on paper," meaning that you remain in the hospital but at a higher or lower level of care. For example when you are moved to custodial care or a hospital with more advanced treatment options. See also **Custodial Care** for further information.

Disenroll or **Disenrollment** – The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Dispensing Fee – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription. The dispensing fee covers costs such as the pharmacist's time to prepare and package the prescription.

Drug List – See "Formulary."

Durable Medical Equipment (DME) – Certain medical equipment that is ordered by your doctor for medical reasons. Examples include walkers, wheelchairs, crutches, powered mattress systems, diabetic supplies, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, or hospital beds ordered by a provider for use in the home.

Elective surgery – An elective surgery is a planned, non-emergency surgical procedure. It may be medically required (e.g. cataract surgery) or optional (e.g. cosmetic procedure) surgery. It may or may not require a prior authorization.

Emergency – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

Emergency Care – Covered services that are: 1) rendered by a provider qualified to furnish emergency services; and 2) needed to treat, evaluate, or stabilize an emergency medical condition.

Employer Sponsored Health Plan – a program supported totally or in part by an employer or union group to provide health benefits for employees. The plan may be administered directly by the employer and/or health plan group, such as Priority Health, under a contractual arrangement.

Enhanced Disease Management (EDM) – Qualified care managers, with specialized knowledge about a member's chronic conditions, including asthma and diabetes, will contact the member to provide additional care management and monitoring services.

Enteral Feeding – Nutrients delivered directly into the stomach, duodenum or jejunum through a feeding tube. Also referred to as Enteral Nutrition.

Evidence of Coverage (EOC) and Disclosure Information – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

Exception – A type of coverage determination that, if approved, allows you to get a drug that is not on your plan sponsor's formulary (a formulary exception), or get a non-preferred drug at a lower cost-sharing level (a tiering exception). You may also request an exception if your plan sponsor requires you to try another drug before receiving the drug you are requesting, or the plan limits the quantity or dosage of the drug you are requesting (a formulary exception)

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

Facility – A medical facility is, in general, any location at which medicine is practiced regularly. Medical facilities range from small clinics and doctor's offices to urgent care centers and large hospitals with elaborate emergency rooms and trauma centers.

Fixed Wing Air Transportation – This service is furnished when your medical condition is such that transport by ground ambulance, in whole or in part, is not appropriate. Generally, transport by fixed wing air ambulance may be necessary because your condition requires rapid transport to a treatment facility, and either great distances or other obstacles, for example, heavy traffic, preclude such rapid delivery. Transport by fixed wing air ambulance may also be necessary because you are inaccessible by land or water ambulance vehicle. Priority Health Medicare requires a prior authorization for transport by fixed wing air transportation.

Follow-up care – Medically necessary care after an emergency or urgent care event. See Chapter 3, Section 3.1 for details on what's covered if you have a medical emergency.

Formulary ("Drug List" or "List of Covered Drugs") – A list of prescription drugs covered by the plan. The drugs on this list are selected by the plan with the help of doctors and pharmacists. The list includes both brand name and generic drugs.

Generic Drug – A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand name drug. Generally, a "generic" drug works the same as a brand name drug and usually costs less.

Grievance – A type of complaint you make about us or pharmacies, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

Home Health Aide – A home health aide provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides do not have a nursing license or provide therapy.

Home Infusion – Home infusion is the intravenous (IV) administration of therapeutic drugs such as analgesics, antibiotics, chemotherapy, parenteral nutrition given outside a formal health care setting in your home. You must be homebound to receive home infusion services.

Home Infusion Provider – A home infusion provider is a state-licensed pharmacy that specializes in the provision of infusion drug therapies to you in your home after your doctor has written a prescription for the drug. Generally you receive your home infusion drug through a home health agency that coordinates the delivery of the drug to you but you can also receive this from a home infusion pharmacy.

Hospice – A member who has 6 months or less to live has the right to elect hospice. We, your plan, must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums you are still a member of our plan. You can still obtain all medically necessary services as well as the supplemental benefits we offer. The hospice will provide special treatment for your state.

Hospital-Based Outpatient Billing – See "Provider-Based Billing."

Hospital Inpatient Stay – A hospital stay when you have been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an "outpatient" or under "observation." See also "**Observation"** and "**Outpatient."**

Implantable Devices - An **instrument, apparatus, implant** that is placed into a surgically or naturally formed cavity of the human body that is used to diagnose, prevent, or treat disease or other conditions. In some cases implants contain electronics. Some implants are bioactive, such as subcutaneous drug delivery devices in the form of implantable pills with the intent to remain there for a period of 30 days or more.

Income Related Monthly Adjustment Amount (IRMAA) – If your income is above a certain limit, you will pay an income-related monthly adjustment amount in addition to your plan premium. For example, individuals with income greater than $85,000 and married couples with income greater than $170,000 must pay a higher Medicare Part B (medical insurance) and Medicare prescription drug coverage premium amount. This additional amount is called the income-related monthly adjustment amount. Less than 5% of people with Medicare are affected, so most people will not pay a higher premium.

Initial Coverage Limit – The maximum limit of coverage under the Initial Coverage Stage.

Initial Coverage Stage – This is the stage before your total drug costs including amounts you have paid and what your plan has paid on your behalf for the year have reached $3,750.

Initial Enrollment Period – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. For example, if you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

Inpatient – See "Hospital Inpatient Stay."

List of Covered Drugs– See "**Formulary"**

Long-Term Acute Care Hospital – A long-term acute care hospital (LTACH) provides acute care services when a member is critically ill and often has a medically complex condition with multiple complications and who requires long hospital stay.

Long term care – Long-term care is a range of services and support for your personal care needs. Most long-term care isn't medical care, but rather help with basic personal tasks of everyday life, sometimes called activities of daily living (ADLs). Long term services excluded are room and board and services not medically related.

Low Income Subsidy (LIS) – See "Extra Help."

Mammography (Mammogram) – A photograph of the breasts made by X-rays. A preventive mammogram is done based on your age or family history and when you have no signs or symptoms (asymptomatic) of breast disease. A diagnostic mammogram is done when you do have signs or symptoms of breast disease or a personal history of breast cancer or personal history of biopsy-proven benign breast disease. If you have a lump removed and sent to the lab for testing, this is considered diagnostic, regardless of whether you were having a preventive mammogram or a diagnostic mammogram.

Maximum Out-of-Pocket Amount – The most that you pay out-of-pocket during the plan year for in-network covered Part A and Part B services. Amounts you pay for your plan premiums, Medicare Part A and Part B premiums and prescription drugs do not count toward the maximum out-of-pocket amount. See Chapter 4, Section 1.3 for information about your maximum out-of-pocket amount.

Medicaid (or Medical Assistance) – A joint Federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid. See Chapter 2, Section 6 for information about how to contact Medicaid in your state.

Medically Accepted Indication – A use of a drug that is either approved by the Food and Drug Administration or supported by certain reference books. See Chapter 5, Section 3 for more information about a medically accepted indication.

Medically Necessary – Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

Medicare – The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare, a PACE plan, or a Medicare Advantage Plan.

Medicare Advantage Disenrollment Period – A set time each year when members in a Medicare Advantage plan can cancel their plan enrollment and switch to Original Medicare. The Medicare Advantage Disenrollment Period is from January 1 until February 14, 2018.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an HMO, PPO, a Private Fee-for-Service (PFFS) plan, or a Medicare Medical Savings Account (MSA) plan. When you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan, and are not paid for under Original Medicare. In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**. Everyone who has Medicare Part A and Part B is eligible to join any Medicare health plan that is offered in their area, except people with End-Stage Renal Disease (unless certain exceptions apply).

Medicare Beneficiary Identifier (MBI) - This is your Medicare identification number that's unique to you. For current Medicare participants, Medicare will issue this new identification card between April 2018 and April 2019. This will replace your Original Medicare card (also known as the Red, White, and Blue card). Current cardholders do not need to take any action to get your new Medicare card.

Medicare Coverage Gap Discount Program – A program that provides discounts on most covered Part D brand name drugs to Part D members who have reached the Coverage Gap Stage and who are not already receiving "Extra Help." Discounts are based on agreements between the Federal government and certain drug manufacturers. For this reason, most, but not all, brand name drugs are discounted.

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans, including our plan, must cover all of the services that are covered by Medicare Part A and B.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Medicare Prescription Drug Coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

"Medigap" (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill "gaps" in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

Member (Member of our Plan, or "Plan Member") – A person with Medicare who is eligible to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Network Pharmacy – A network pharmacy is a pharmacy where members of our plan can get their prescription drug benefits. We call them "network pharmacies" because they contract with our plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Network Provider – "Provider" is the general term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. We call them "**network providers**" when they have an agreement with our plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Our plan pays network providers based on the agreements it has with the providers or if the providers agree to provide you with plan-covered services. Network providers may also be referred to as "plan providers."

Nurse Practitioner (NP) - An individual who is a registered nurse professional who is authorized by the State in which the services are furnished to practice as a nurse practitioner in accordance with State law and be certified as a nurse practitioner by a recognized national certifying body that has established standards for nurse practitioners (e.g., American Academy of Nurse Practitioners, American Nurses Credentialing Center, National Certification Corporation for Obstetric, Gynecologic and Neonatal Nursing Specialties, etc.) and/or meets any other requirements specified by Medicare.

Nutrition Professional – See "Registered Dietitian"

Observation (or "Observation stay") – An observation stay is an outpatient hospital stay in which you receive medically necessary Medicare-covered services while a decision is being made about whether further treatment requires you to be admitted as an inpatient or if you are well enough to be discharged to your home. You may stay more than one day during an observation stay. Observation services may be given in the emergency department or another area of the hospital. See also "**Hospital Inpatient Stay"** and "**Outpatient."**

Occupational Therapy - Therapy based on engagement in meaningful activities of daily life (as self-care skills, education, work, or social interaction) especially to enable or encourage participation in such activities despite impairments or limitations in physical or mental functioning.

Optional Supplemental Benefits – Non-Medicare-covered benefits that can be purchased for an additional premium and are not included in your package of benefits. If you choose to have optional supplemental benefits, you may have to pay an additional premium. You must voluntarily elect Optional Supplemental Benefits in order to get them. See Chapter 4, Section 2.2 (*Extra "optional supplemental" benefits you can buy*).

Opt-out provider – A provider may opt out of Medicare and enter into private contracts with Medicare beneficiaries when specific requirements are met. When a provider opts out, no services provided by him/her are covered by Medicare and no payment can be made to the provider or to the member except for services provided in an emergency/urgent care situation. Providers who opt out from Medicare generally do this for a two year period. See Chapter 4, Section 3.1 for more information about opt out providers.

Organization Determination – The Medicare Advantage plan has made an organization determination when it makes a decision about whether items or services are covered or how much you have to pay for covered items or services. Organization determinations are called "coverage decisions" in this booklet. Chapter 9 explains how to ask us for a coverage decision.

Original Medicare ("Traditional Medicare" or "Fee-for-service" Medicare) – Original Medicare is offered by the government, and not a private health plan like Medicare Advantage Plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Pharmacy – A pharmacy that doesn't have a contract with our plan to coordinate or provide covered drugs to members of our plan. As explained in this Evidence of Coverage, most drugs you get from out-of-network pharmacies are not covered by our plan unless certain conditions apply.

Out-of-Network Provider or Out-of-Network Facility – A provider or facility with which we have not arranged to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that are not employed, owned, or operated by our plan or are not under contract to deliver covered services to you. Using out-of-network providers or facilities is explained in this booklet in Chapter 3.

Out-of-Pocket Costs – See the definition for "cost-sharing" above. A member's cost-sharing requirement to pay for a portion of services or drugs received is also referred to as the member's "out-of-pocket" cost requirement.

Outpatient – Outpatient as used in this EOC means you are receiving medical care or treatment from licensed health care professionals in various medical specialties which does not require you to be admitted as an inpatient to a hospital. See also "**Hospital Inpatient Stay"** and "**Observation."** See **"Ambulatory Surgical Center"** and **"Outpatient Hospital Facility"** for descriptions of different types of facilities where you can get outpatient care.

Outpatient Hospital Facility - An outpatient hospital facility is an area of a hospital or a stand-alone facility focused on providing same-day surgical care, including diagnostic and preventive procedures. An outpatient hospital facility is different than an ambulatory surgical center (ASC). ASCs are a separate identifiable legal entity from any other health care facility, such as a hospital, and outpatient hospital facilities are a legal entity of the hospital. See **"Ambulatory Surgical Center."**

Oxygen equipment and accessories – If you use oxygen, Medicare rules require you to rent oxygen equipment from a Medicare-approved supplier for 36 months. After 36 months, your supplier must continue to provide oxygen equipment and related supplies for an additional 24 months. Your supplier must provide equipment and supplies for up to a total of 5 years, as long as you have a medical need for oxygen. Examples of equipment and accessories are the tubing and/or mouthpiece, Medicare approved containers, maintenance, servicing, and repairs. Oxygen equipment and accessories cannot be purchased.

PACE plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term care (LTC) services for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible, while getting the high-quality care they need. People enrolled in PACE plans receive both their Medicare and Medicaid benefits through the plan.

Parenteral feeding – A way for you to get nutrients intravenously (IV) if you cannot maintain adequate nutrition by enteral feedings alone. Parenteral feedings, also known as parenteral nutrition, does not use the digestive system. That is, it may be given if you are unable to absorb nutrients through your intestinal tract because of vomiting that won't stop, severe diarrhea, or intestinal disease. It may also be given if you are undergoing high-dose chemotherapy or radiation and bone marrow transplantation.

Part A – Original Medicare which is administered directly by the federal government has two parts, Part A and Part B. Medicare Part A covers inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care. It is free if you have worked and paid Social Security taxes for at least 40 calendar quarters (10 years); you will pay a monthly premium if you have worked and paid taxes for less time.

Part B – Original Medicare which is administered directly by the federal government has two parts, Part A and Part B. Medicare Part B covers physician and outpatient services. You pay a monthly premium for this coverage.

Part B Drugs – Drugs that are covered under Medicare Part B. A limited number of outpatient prescription drugs under limited conditions are covered. Generally, drugs covered under Part B are drugs you wouldn't usually give to yourself, like an injection you get at a doctor's office or hospital outpatient setting. Drugs that are self-administered are generally covered under Part D.

Part C – see "Medicare Advantage (MA) Plan."

Part D – The voluntary Medicare Prescription Drug Benefit Program. (For ease of reference, we will refer to the prescription drug benefit program as Part D.)

Part D Drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. (See your formulary for a specific list of covered drugs.) Certain categories of drugs were specifically excluded by Congress from being covered as Part D drugs. Part D drugs are usually self-administered.

Part D Late Enrollment Penalty – An amount added to your monthly premium for Medicare drug coverage if you go without creditable 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 Part D late enrollment penalty.

Pathology – The examination or interpretation of cells or tissue to study and diagnose the characteristics, causes, and effects of disease. A pathologist (doctor) will make these observations in a laboratory setting. You may be charged a cost-share for a pathology lab.

Physician Assistant (PA) - An individual who has graduated from a physician assistant educational program that is accredited by the Accreditation Review Commission on Education for the Physician Assistant, has passed the national certification examination that is administered by the National Commission of Certification of Physician Assistants (NCCPA) and is licensed by the State in which the services are performed to practice as a physician assistant and meets any other requirements specified by Medicare.

Physical Therapy – The treatment of disease, injury, or disability by physical and mechanical means (as massage, regulated exercise, water, light, heat, and electricity).

Point-of-Service (POS) – A benefit offered by Priority Health Medicare that allows you to get covered services by doctors and hospitals outside the plan's network, including those in-state, out-of-state or worldwide, for an additional cost and without a referral. This is also referred to as your out-of-network benefit.

Polyp – A polyp is a projecting mass of overgrown tissue in your body. Virtually all colorectal cancer develops from polyps. See Chapter 4, Section 2.1, *Medical benefits chart*, for more information about your colorectal cancer screening benefit.

Preferred Cost-sharing – Preferred cost-sharing means lower cost-sharing for certain covered Part D drugs at certain network pharmacies.

Preferred Provider Organization (PPO) Plan – A Preferred Provider Organization plan is a Medicare Advantage Plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they are received from network or out-of-network providers. Member cost-sharing will generally be higher when plan benefits are received from out-of-network providers. PPO plans have an

annual limit on your out-of-pocket costs for services received from network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both network (preferred) and out-of-network (non-preferred) providers.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Prescription – A physician's order for the preparation and administration of a drug, service, or device for a member. The ordering physician must participate with Medicare.

Prescription Drug Benefit Manager – A third party administrator of prescription drug programs handling processing and paying of prescription drug claims.

Primary Care Provider (PCP) – Your primary care provider is the doctor or other provider you see first for most health problems. He or she makes sure you get the care you need to keep you healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them. In many Medicare health plans, you must see your primary care provider before you see any other health care provider. See Chapter 3, Section 2.1 for information about Primary Care Providers.

Primary Care Setting – An outpatient non-psychiatric medical setting where care is usually delivered by a family practitioner, a general practitioner, an internal medicine physician, an obstetrician/gynecologist, a nurse practitioner and/or a physician assistant who meets state requirements and is trained to give you basic medical care.

Prior Authorization – Approval in advance to get services or certain drugs that may or may not be on our formulary. Some in-network medical services are covered only if your doctor or other network provider gets "prior authorization" from our plan. Covered services that need prior authorization are marked in the Benefits Chart in Chapter 4. Some drugs are covered only if your doctor or other network provider gets "prior authorization" from us. Covered drugs that need prior authorization are marked in the formulary.

Procedure – Something done to fix a health problem or to learn more about it. For example, surgery, tests, and putting in an IV (intravenous line) are procedures.

Prosthetics and Orthotics – These are medical devices ordered by your doctor or other health care provider. Covered items include, but are not limited to, arm, back and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Provider-Based Billing (also referred to as "Hospital-Based Outpatient Billing") – Provider-based billing (or hospital-based billing) is a national model of practice used by large integrated delivery systems. What this means is that the provider's office is owned and operated by a hospital system, whether it is on the hospital's campus or off-site. Some providers choose to be set up this way, others don't. Providers who are in a system that utilizes provider-based billing submit two bills when seeing patients, one for the professional service rendered and one for the facility.

Qualified Medicare Beneficiary (QMB) Program – QMB Program is a Medicare Savings Program that allows an individual to get help from their state to pay the Medicare premiums. This Program helps pay for Part A premiums, Part B premiums, and deductibles, coinsurance, and copayments. An individual eligible with the QMB Program will need to show their Priority Medicare, Medicaid, &/or QMB card each time they receive care.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients. See Chapter 2, Section 4 for information about how to contact the QIO for your state.

Quantity Limits – A management tool that is designed to limit the use of selected drugs for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

Radiation therapy management – The physicians review of the port films, dosimetry, dose delivery, treatment parameters, treatment setup, care of infected skin, prescribing of necessary medications, fluid and electrolyte management, as well as pain management.

Reconstructive surgery - Surgery to restore form and function in structures (organs or parts) deformed or damaged by disease, congenital anomaly, tumor, trauma, or infection.

Red, White and Blue card - Original Medicare identification card you receive when you're new to Medicare or changing your name or ID number.

Refraction – Refraction is part of an eye or vision exam in which your ophthalmologist or optometrist determines your need for prescription glasses. Your provider refracts your vision using a device that contains hundreds of combinations of lenses to determine any possible refractive errors such as nearsightedness, farsightedness, astigmatism or presbyopia. Refraction is not covered by Medicare. See Chapter 4, Section 3.1 for more information about refractions.

Registered Dietitian – An individual who holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics as accredited by an appropriate national accredited organization recognized for this purpose; has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional and is licensed or certified as a dietitian or nutritional professional by the State in which the services are performed and meets any other requirements specified by Medicare.

Rehabilitation Services – These services include physical therapy, speech and language therapy, and occupational therapy.

Remote access technology – Remote access technology can also be referred to as telehealth. Medical practitioners use electronic forms of communication to evaluate and diagnose patients remotely, prescribe treatment, e-prescribe medications, and quickly detect fluctuations in a patient's medical condition at home, to be able to alter therapy or medications accordingly. This can be done between patient and doctor but does not replace an in-person visit. It allows patients to answer questions that would help the doctor in the process of diagnosing and treating some conditions. Some examples of technologies used are the telephone, videoconferencing, the internet, wireless communications and streaming media.

Residential treatment – Residential treatment means you are required to live in a residential treatment facility in order to receive certain services for and education about a particular condition such as alcohol addictions and eating disorders. Services whose main purpose is to remove you from your environment to prevent the reoccurrence of a condition are not considered medically necessary and are not covered by Medicare.

Retinal imaging – Retinal Imaging is a non-invasive photograph of the structures in the back of the eye that allows providers to document potential signs of many eye conditions such as glaucoma, hypertension, diabetic retinopathy and age-related macular degeneration. Images can be compared year over year to help in the identification of any change in the patient's eyes.

Routine foot care – This includes the cutting or removal of corns and calluses, the trimming, cutting, clipping, or debriding of nails, and other hygienic and preventive maintenance care such as cleaning and soaking of feet, the use of skin creams to maintain skin tone of either ambulatory or bedfast patients and any other service performed in the absence of localized illness, injury or symptoms involving the foot.

Rural health clinic (RHC) – A clinic located in a rural, medically under-served area in the United States that has a separate reimbursement structure from the standard medical office under the Medicare and Medicaid programs. The program was established to address an inadequate supply of physicians serving Medicare beneficiaries and Medicaid recipients in rural areas and to increase the utilization of non-physician practitioners. See **"Clinic"** for the definition of an outpatient clinic which is different than an RHC.

Sanctioned provider – A sanctioned provider is a provider who has been excluded from participation with Medicare or Medicaid for various types of misconduct such as but not limited to conviction of program-related crimes, felony conviction for health care fraud, conviction related to patient abuse and/or neglect, failure to repay health education assistance loans, misdemeanor conviction for controlled substance, license revocation or suspension; and misdemeanor health fraud convictions.

Screening – A screening is a test used to detect early disease or risk factors for disease when you have no signs or symptoms. When you have a sign or symptom and you are diagnosed and treated for a condition, further testing, whether annually or on an on-going basis is considered diagnostic (see "Diagnostic"). NOTE: A screening associated with a Medicare Preventive Services Guideline (for example, diabetes screening, cardiovascular screening, prostate cancer screening, etc.) must be billed according to Medicare preventive services billing rules in order for you to get zero cost-sharing on your in-network benefit level.

Self-administered – The term self-administered refers to the physical process by which a drug enters your body. A self-administered drug is one you would normally take on your own by taking it orally, putting it on your skin (topical), injecting subcutaneously, or inhaling it. It does not refer to whether the process is supervised by a medical professional (for example to observe proper technique or side effects of the drug).

Service – As used in this EOC, a service means a treatment method for receiving medical care that involves the physical treatment of a disorder – this can be a surgery or a non-surgical service. Examples of a service include but are not limited to surgery, chemotherapy, physical therapy, occupation therapy, speech, mental health, etc.

Service Area – A geographic area where a health plan accepts members if it limits membership, as approved by Centers for Medicare & Medicaid Services (CMS), based on where people live. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. The plan may disenroll you if you permanently move out of the plan's service area.

Skilled Nursing Facility (SNF) Care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor. Skilled nursing facilities are sometimes called "SNFs" or "sub-acute rehab.

Sleep apnea – Sleep apnea is a chronic medical condition where you repeatedly stop breathing during sleep. These episodes may last 10 seconds or more and cause oxygen levels in your blood to drop. Sleep apnea may be caused by obstruction of the upper airway passage or by failure of the brain to initiate breath, called central sleep apnea. It can affect other medical conditions such as hypertension, heart failure and diabetes.

Sleep study – A sleep study is a test that records your body functions during sleep such an electrical activity of the brain, eye movement, muscle activity, heart rate, respiratory effort, air flow, and blood oxygen levels. These are used to diagnose sleep apnea and to determine its severity.

Special Enrollment Period – A set time when members can change their health or drug plans or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you are getting "Extra Help" with your prescription drug costs, if you move into a nursing home, or if we violate our contract with you.

Special Needs Plan (SNP)– A special type of Medicare Advantage Plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who reside in a nursing home, or who have certain chronic medical conditions.

Standard Cost-sharing– Standard cost-sharing is cost-sharing other than preferred cost-sharing offered at a network pharmacy.

Stay – The word stay as used in this EOC means the period of time between when you are admitted to a facility until the time you are discharged. A stay may be for observation or for care received while an inpatient at a hospital or skilled nursing facility until you are discharged to your home or admitted to another facility or within the same facility for continuing care. See also **"Hospital Inpatient Stay"** and "**Observation Stay."**

Step Therapy – A utilization tool that requires you to first try another drug to treat your medical condition before we will cover the drug your physician may have initially prescribed.

Subcutaneous – Subcutaneous means under your skin. For example, a subcutaneous injection is an injection in which a needle is inserted just under the skin.

Supplemental Security Income (SSI) – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

Telehealth – Telehealth is the delivery of health-related services and information via telecommunications technologies. See also **"Remote access technologies."**

Telemonitoring – Telemonitoring is the collection and transmission of clinical data between you, from your home, and your health care provider, in his office or facility location through electronic information passing technologies. Telemonitoring services include telemonitoring equipment and telemetry services (i.e. the wireless transmission and reception of measurements for the purpose of monitoring conditions).

Therapy cap limits – Outpatient rehabilitation services therapy cap limits are determined on a plan year basis and apply to certain outpatient provider settings including but not limited to outpatient hospital, critical access hospital settings and home health for certain therapy providers, such as privately practicing therapists and certain home health agencies for those members not under a home health plan of care. For 2017, the physical therapy and speech language pathology services combined limit on incurred services is $1,980. For 2017, the occupational therapy services limit is $1,980. These amounts may change for Medicare in 2018. Both in and out-of-network deductibles and copayments count towards the therapy cap limits. Therapy services may be extended beyond the therapy cap limits if documented by the provider as medically necessary. If extended, there is a limit for physical therapy and speech language services combined which is up to $3,700 and for occupational therapy up to $3,700. When services reach $3,700, additional services need to be reviewed and approved by Priority Health.

Therapeutic radiology – Therapeutic radiology is the treatment of disease (especially cancer) with radiation. It is sometimes referred to as radiation therapy or radiation oncology. It includes physician management.

Tier –Tier is used in this EOC when speaking about your drug costs. Drugs on a formulary are usually grouped into tiers or levels that tell you what you may owe either as a copayment or as coinsurance for drugs that fall into a particular tier.

Transfer – A transfer means you are moved from one hospital, unit or bed within a hospital to a different hospital or to a unit or bed within the same hospital for additional treatment or care once your condition has stabilized or a diagnosis has been established for you. When you are transferred, you are being discharged. See also **Discharge** for further information.

Urgently Needed Services – Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible.

Visit –A visit when used in this EOC is as a meeting with a healthcare professional including but not limited to a physician, nurse practitioner, physician assistant, nurse, clinical social worker, psychologist, physical/occupational therapist, speech pathologist, etc., for the purpose of evaluating, diagnosing, or treating you for a symptom or condition. The visit may also include education about your health. The key components are history taking, examination and medical decision making.

PriorityMedicare (Employer HMO-POS) **Customer Service**

Method	Customer Service – Contact Information
CALL	888.389.6648, option 3 Calls to this number are free, 8 am to 8 pm, 7 days a week. Customer Service also has free language interpreter services available for non-English speakers.
TTY	711 Calls to this number are free, 8 am to 8 pm, 7 days a week.
FAX	616.975.8826
WRITE	Customer Service, MS 1115, Priority Health Medicare, 1231 East Beltline NE, Grand Rapids, MI 49525 *MedicareCS@priorityhealth.com*
WEBSITE	*priorityhealth.com/mpsers*

Michigan Medicare/Medicaid Assistance Program (MMAP)

Michigan Medicare/Medicaid Assistance Program (MMAP) is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

Method	Contact Information
CALL	800.803.7174
WRITE	MMAP, 6105 St. Joseph, Suite 204 Lansing, MI 48917-4850
WEBSITE	*mmapinc.org*

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