PriorityHealth

2022
Evidence of Coverage

PriorityMedicare Select℠ (PPO)
offered by Priority Health

January 1, 2022 – December 31, 2022

OMB Approval 0938-1051 (Expires: February 29, 2024)
H4875_110011502205_C CMS-accepted 09272021

Your Medicare Health Benefits and Services and Prescription Drug Coverage as a Member of PriorityMedicare Select (PPO)

This booklet gives you the details about your Medicare health care and prescription drug coverage from January 1 – December 31, 2022. 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.**

Additional resources
This information is available in a different format, including Braille and large print.

Benefits, premium, deductible, and/or copayments/coinsurance may change on January 1, 2023.

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

Please contact our Customer Service at 888.389.6648 for additional information. (TTY users should call 711). We're available 8 a.m. to 8 p.m., seven days a week.

Coverage under this Plan qualifies as Qualifying Health Coverage (QHC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at *irs.gov/Affordable-Care-Act/Individuals-and-Families* for more information.

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

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

Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 888.389.6648. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 888.389.6648. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电888.389.6648。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 888.389.6648。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 888.389.6648. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 888.389.6648. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 888.389.6648 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 888.389.6648. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 888.389.6648번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобывоспользоваться услугами переводчика, позвоните нам по телефону 888.389.6648. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول بمساعدتك. هذه على مترجم فوري، ليس عليك سوى الاتصال بنا على 8466-.983.888.1 سيقوم شخص ما يتحدث العربية خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 888.389.6648 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 888.389.6648. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 888.389.6648. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 888.389.6648. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 888.389.6648. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、888. 389. 6648にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサービスです。

2022 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 Select**, which is a Medicare PPO**

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 Select.

There are different types of Medicare health plans. **Priority**Medicare Select is a Medicare Advantage PPO Plan (PPO stands for Preferred Provider Organization). Like all Medicare health plans, this Medicare PPO is approved by Medicare and run by a private company.

Coverage under this Plan qualifies as Qualifying Health Coverage (QHC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at: *www.irs.gov/affordable-care-act/individuals-and-families* for more information.

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 Select.

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 Select 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 Select between January 1, 2022 and December 31, 2022.

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 Select after December 31, 2022. We can also choose to stop offering the plan, or to offer it in a different service area, after December 31, 2022.

Medicare must approve our plan each year

Medicare (the Centers for Medicare & Medicaid Services) must approve **Priority**Medicare Select 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 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.

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, home infusion therapy, 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 Select

Although Medicare is a Federal program, **Priority**Medicare Select is available only to 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. The service area is described below.

Our service area includes all 68 counties in Michigan's Lower Peninsula:

Michigan Counties		
Alcona	Allegan	Alpena
Antrim	Arenac	Barry
Bay	Benzie	Berrien
Branch	Calhoun	Cass
Charlevoix	Cheboygan	Clare
Clinton	Crawford	Eaton
Emmet	Genesee	Gladwin
Grand Traverse	Gratiot	Hillsdale
Huron	Ingham	Ionia
Iosco	Isabella	Jackson
Kalamazoo	Kalkaska	Kent
Lake	Lapeer	Leelanau
Lenawee	Livingston	Macomb
Manistee	Mason	Mecosta
Midland	Missaukee	Monroe
Montcalm	Montmorency	Muskegon
Newaygo	Oakland	Oceana
Ogemaw	Osceola	Oscoda
Otsego	Ottawa	Presque Isle
Roscommon	Saginaw	St. Clair
St. Joseph	Sanilac	Shiawassee
Tuscola	Van Buren	Washtenaw
Wayne	Wexford	

If you plan to move out of the service area, please contact Customer Service (phone numbers are printed on the back cover of this booklet). When you move, you will 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 permanent and/or 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.

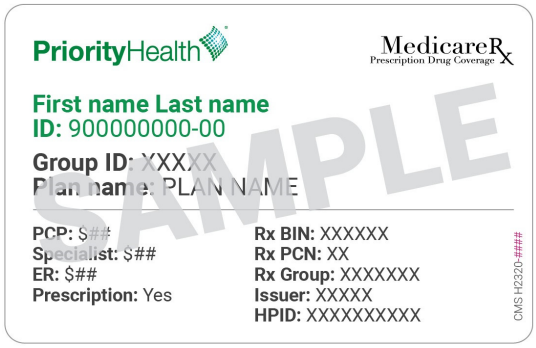
Section 2.4 U.S. citizen or lawful presence

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:



Do NOT use your red, white, and blue Medicare card for covered medical services while you are a member of this plan. If you use your Medicare card instead of your **Priority**Medicare Select membership card, you may have to pay the full cost of medical services yourself. Keep your Medicare card in a safe place. You may be asked to show it if you need hospital services, hospice services, or participate in routine research studies.

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 Select 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

The *Provider/Pharmacy Directory* lists our network providers and 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 *prioritymedicare.com*.

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

As a member of our plan, you can choose to receive care from out-of-network providers. Our plan will cover services from either in-network or out-of-network providers, as long as the services are covered benefits and medically necessary. However, if you use an out-of-network provider, your share of the costs for your covered services may be higher. See Chapter 3 (*Using the plan's coverage for your medical services*) for more specific information.

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 call Customer Service for more information about our network providers, including their qualifications. You can also see the *Provider/Pharmacy Directory* at *prioritymedicare.com*, 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 *prioritymedicare.com*. You may also call Customer Service for updated pharmacy information or to ask us to mail you a *Provider/Pharmacy Directory*. **Please review the 2022 *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 *prioritymedicare.com*, 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 Select. 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 Select Drug List.

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

We will provide you a copy of the Drug List. To get the most complete and current information about which drugs are covered, you can visit the plan's website (*prioritymedicare.com*) 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, others on your behalf, and we have spent on your Part D prescription drugs and the total amount paid for each of your Part D prescription drugs during each month the Part D benefit is used. The Part D EOB provides more information about the drugs you take, such as increases in price and other drugs with lower cost sharing that may be available. You should consult with your prescriber about these lower cost options. 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.

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

You can also call Express Scripts at 800.758.4574 or go online to *express-scripts.com/easyeob* and log in to your account to access your Part D Explanation of Benefits.

SECTION 4 Your monthly premium for **Priority**Medicare Select

Section 4.1 How much is your plan premium?

As a member of our plan, you pay a monthly plan premium. The table below shows the monthly plan premium amount for each region we serve. 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). Note: Your service area includes all the counties listed below. For details on what to expect when you move outside the service area or from one region to another, refer to Chapter 10, Section 2.3.

Region	County	Premium
Region 1	Allegan Barry, Kent, Lenawee, Ottawa	$159.00
Region 2	Berrien, Calhoun, Cass, Ionia, Isabella, Kalamazoo, Mason, Midland, Missaukee, Montcalm, Muskegon, Newaygo, Oceana, Osceola, Otsego, St. Clair, Van Buren, Wexford	$149.00
Region 3	Alcona, Antrim, Benzie, Charlevoix, Clare, Crawford, Grand Traverse, Hillsdale, Lake, Lapeer, Leelanau, Manistee, Mecosta, Monroe	$208.00
Region 4	Alpena, Cheboygan, Eaton, Emmet, Gladwin, Gratiot, Iosco, Jackson, Kalkaska, Montmorency, Oscoda, Presque Isle, Roscommon, St. Joseph, Sanilac, Shiawassee	$225.00
Region 5	Arenac, Bay, Branch, Clinton, Genesee, Huron, Ingham, Livingston, Macomb, Oakland, Ogemaw, Saginaw, Tuscola, Washtenaw, Wayne	$214.00

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 and our email address for Customer Service are printed on the back cover of this booklet.)

In some situations, your plan premium could be more

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

- If you signed up for extra benefits, also called "optional supplemental benefits", then you pay an additional premium each month for these extra benefits. If you have any questions about your plan premiums, please call or email Customer Service (phone numbers and our email address are printed on the back cover of this booklet).

Optional supplemental benefit	Monthly premium
Enhanced Dental and Vision Package	$29.00

- 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.
    - If you are required to pay the Part D late enrollment penalty, the cost of the late enrollment penalty depends on how long you went without Part D or other creditable prescription drug coverage. 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.
- Some members may be required to pay an extra charge, known as the Part D Income Related Monthly Adjustment Amount, also known as IRMAA, because, 2 years ago, they had a modified adjusted gross income, above a certain amount, on their IRS tax return. Members subject to an IRMAA will have to pay the standard premium amount and this extra charge, which will be added to their premium. Chapter 1, Section 6 explains the IRMAA in further detail.

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 late enrollment penalty.

The 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 cost of the late enrollment penalty depends on how long you went without Part D or other 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 Select, we will advise you on 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.

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 2022, this average premium amount is $33.37.
- 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 $33.37, which equals $4.6718. This rounds to $4.70. 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, even if you change plans.
- 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 2022* 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 first letter you receive stating you have to pay a late enrollment penalty. If you were paying a penalty before joining our plan, you may not have another chance to request a review of that 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?

If your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium.

If you have to pay an extra amount, Social Security, not your Medicare plan, will send you a letter telling you what that extra amount will be and how to pay it. 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. For

more information on the extra amount you may have to pay based on your income, visit *www.medicare.gov/part-d/costs/premiums/drug-plan-premiums.html*.

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 by law 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 have both Medicare Part A and Medicare Part B. Some plan members (those who aren't eligible for premium-free Part A) pay a premium for Medicare Part A. 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 a.m. to 6 p.m., Monday through Friday. TTY users should call 1-855-386-9643. For additional information please go to *MyAdvocateHelps.com*.

If your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium.

- **If you 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.**
- 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 *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 the *Medicare & You 2022* handbook gives information about the Medicare premiums in the section called "2022 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 the *Medicare & You 2022* handbook 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 the *Medicare & You 2022* handbook from the Medicare website (*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 We have several options for you to pay your monthly plan premium and/or optional supplemental benefits premium

We have 5 convenient payment options available for you to pay your monthly plan premium. You likely selected a payment option on your enrollment form, but if you did not, you will receive a monthly invoice by mail. If you would like to change your payment method, you can do so at any time.

If you decide to change the way you pay your monthly plan premium to Social Security Deduction (SSA), please go to *www.priorityhealth.com/medicare/once-you-enroll/plan-administration/pay-your-premium/ssa-deduction*. It could take up to three months to take effect. While we are processing your request for this payment change, you are responsible for making sure that your monthly plan premium is paid on time. You will receive a mailed invoice until SSA officially accepts the SSA deduction request. At that time, you will receive a letter confirming this change.

Option 1: Automatic withdrawal from your bank account

You can elect to have your monthly plan premium automatically withdrawn from your bank account on the first day of each month. This draft will deduct your full balance due at the time of the draft. Your payment is always automatically applied to the oldest outstanding balance first. If you pay more than the monthly amount due in addition to your automatic payment, it will appear as a credit on the next bill, and your automatic draft will only pull what is due as of the first business day of the month. Payments received by the due date will be reflected on the next invoice. Please go to *www.priorityhealth.com/eftmedicare* or call Customer Service at 888.389.6648 to set up your automatic withdrawal. You can submit an automatic bill pay form online (*www.priorityhealth.com/medicare/once-you-enroll/planadministration/pay-your-premium*) or print a paper form, fill it out, and mail it to us.

If your bank account does not have sufficient funds to cover your plan's premium payment, Priority Health reserves the right to charge a non-sufficient funds (NSF) fee up to the amount allowed by the state of Michigan, which is $25. Note: if you have two or more NSFs within a

three month period, we will stop withdrawing your monthly plan premium automatically and send you a monthly invoice by mail.

Option 2: Social Security Deduction (SSA)

You can have your monthly plan premium deducted from your monthly Social Security Administration (SSA) check. This will protect you from any risk of potentially being disenrolled from your optional supplemental benefits plan and/or your Medical and Prescription coverage. To set up deduction from your Social Security check, you can enroll online at *www.priorityhealth.com/ssamedicare* or call Customer Service at 888.389.6648, and we'll forward the information to the Centers for Medicare and Medicaid Services (CMS). It could take up to three months before the Social Security Administration (SSA) begins deducting your premiums.

- Depending on the date you enroll, you may need to pay your first few months' premiums by personal check or money order. In that case, we'll mail you an invoice.
- The first time SSA deducts your premium from your Social Security check, they will deduct at most three months' premiums, depending on how long it takes the Social Security Administration (SSA) to begin deducting your premiums.
- If for any reason your request is not accepted or is delayed longer than three months, Medicare will stop your request. In that case, Priority Health will notify you and bill you directly for your premium(s).

Option 3: Check or Money Order

You can pay for your monthly plan premium by check or money order. You will receive a monthly bill which must be paid by the FIRST of each month. To pay by mail, enclose your check or money order, payable to Priority Health, in the return envelope provided with the bottom half of your invoice. If you have misplaced your return envelope, please mail payment to 3915 Momentum Place, Chicago, IL 60689-5339. If you're close to one of our walk-in centers, you can pay in person. Visit *prioritymedicare.com* and click on "Contact us" for walk-in center locations and hours of operation. If your bank account does not have sufficient funds to cover your plan's premium payment, Priority Health reserves the right to charge a non-sufficient funds (NSF) fee up to the amount allowed by the state of Michigan, which is $25.

Option 4: Check by Phone

You can pay your monthly plan premium by phone from your bank account. Please call Customer Service at 888.389.6648 and have both your routing and account number available. The payment may take up to five business days to process.

Option 5: Credit Card payment

You can pay your monthly plan premium by credit card. It may take up to 10 business days for the payment to reflect on your Priority Health member account. Please call Customer Service or make a secured credit card payment at *www.priorityhealth.com/medicare/once-you-enroll/plan-administration/pay-your-premium*.

What to do if you are having trouble paying your monthly plan premium

Your monthly plan premium is due in our office by the first day of the month. If we have not received your premium payment by the first day of the month, we may send you a notice telling you that your plan membership will end if we do not receive your premium within 90 days. 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 having trouble paying your premium on time, please contact Customer Service to see if we can direct you to programs that may help you. (Phone numbers for Customer Service are printed on the back cover of this booklet.)

If we end your membership because you did not pay your plan premium, you will have health coverage under Original Medicare.

We do have the right to end your membership with the plan if you do not pay your plan premium. We will notify you, in writing, 60 days before your membership is subject to end. If this happens, then you may not be able to receive Part D coverage until the following year if you enroll in a new plan during the annual enrollment period. During the annual enrollment period, you may either join a stand-alone prescription drug plan or a health plan that also provides drug coverage. (If you go without "creditable" drug coverage for more than 63 days, you may have to pay a Part D late enrollment penalty for as long as you have Part D coverage.)

At the time we end your membership, you may still owe us for premiums you have not paid. We have the right to pursue collection of the premiums you owe. In the future, if you want to enroll again in our plan (or another plan that we offer), you will need to pay the amount you owe before you can enroll.

Because disenrollment is effective the first of the month following the disenrollment request or involuntary termination for nonpayment of premium as required under CMS rules, a premium covers a full month and refunds are not prorated.

If you think we have wrongfully ended your membership, you have a right to ask us to reconsider this decision by making a complaint. Chapter 9, Section 10 of this booklet tells how to make a complaint. If you had an emergency circumstance that was out of your control and it caused you to not be able to pay your plan premium within our grace period, you can ask us to reconsider this decision by calling 888.389.6648, between 8 a.m. and 8 p.m., 7 days a week. TTY users should call 711. You must make your request no later than 60 days after the date your membership ends.

Section 7.2 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. If the monthly plan premium changes for next year we will tell you in September and the change will take effect on January 1.

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, or your email address.
- 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 us know by calling or emailing Customer Service or by mailing a signed written request (phone numbers, our email address, and mailing address are printed on the back cover of this booklet). *Note:* You can easily change your PCP in your member account. Register or log in to your member account at *prioritymedicare.com*, look for the My Primary care section and select Find a new primary physician.

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).

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 1.3 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.

CHAPTER 2

Important phone numbers and resources

Chapter 2. Important phone numbers and resources

SECTION 1 **Priority**Medicare Select **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 Select Customer Service. We will be happy to help you.

Method	Customer Service – Contact Information
CALL	888.389.6648 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	616.942.0995
WRITE	Customer Service Department, MS 1115 Priority Health Medicare 1231 East Beltline Ave, NE Grand Rapids, MI 49525 *MedicareCS@priorityhealth.com*
WEBSITE	*prioritymedicare.com*

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 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	888.647.6152
WRITE	Health Management Department, MS 1255 Priority Health Medicare 1231 East Beltline Ave, NE Grand Rapids, MI 49525
WEBSITE	*prioritymedicare.com*

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 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

Method	Coverage Decisions for Part D Prescription Drugs – Contact Information
WRITE	Medicare Part D, MS 1260 Priority Health Medicare 1231 East Beltline Ave, NE Grand Rapids, MI 49525
WEBSITE	*prioritymedicare.com*

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 – Contact Information
CALL	888.389.6648 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	*prioritymedicare.com*

Method	Appeals for Part D Prescription Drugs – Contact Information
CALL	888.389.6648 Calls to this number are free, 8 a.m. to 8 p.m., 7 days a week.

Method	Appeals for Part D Prescription Drugs – Contact Information
TTY	711 Calls to this number are free, 8 a.m. to 8 p.m., 7 days a week.
FAX	877.974.4411
WRITE	Part D Appeal Coordinator, MS 1260 Priority Health Medicare 1231 East Beltline Ave, NE Grand Rapids, MI 49525
WEBSITE	*prioritymedicare.com*

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 you have a problem 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 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 Select directly to Medicare. To submit an online complaint to Medicare go to *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 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	*prioritymedicare.com*

Method	Payment Requests for Part D Prescription Drugs – Contact Information
CALL	888.389.6648 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

Method	Payment Requests for Part D Prescription Drugs – Contact Information
WRITE	Medicare Part D, MS 1260 Priority Health 1231 E. Beltline NE Grand Rapids, MI 49525
WEBSITE	*prioritymedicare.com*

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.

Method	Medicare – Contact Information
WEBSITE	*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 Select: • **Tell Medicare about your complaint:** You can submit a complaint about **Priority**Medicare Select directly to Medicare. To submit a complaint to Medicare, go to *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 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 TO ACCESS SHIP and OTHER RESOURCES:

- Visit *www.medicare.gov*
- Click on "**Forms, Help, and Resources**" on far right of menu on top
- In the drop down click on "**Phone Numbers & Websites**"
- You now have several options
    - Option #1: You can have a **live chat**
    - Option #2: You can click on any of the "**TOPICS**" in the menu on bottom
    - Option #3: You can select your **STATE** from the dropdown menu and click GO. This will take you to a page with phone numbers and resources specific to your state.

Method	**Michigan Medicare/Medicaid Assistance Program (MMAP) – Contact Information**
CALL	800.803.7174 or dial 211
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 Livanta LLC.

Livanta 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. Livanta is an independent organization. It is not connected with our plan.

You should contact Livanta 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	Livanta LLC (Michigan's Quality Improvement Organization) – Contact Information
CALL	888.524.9900, Monday - Friday 9 a.m. to 5 p.m. local time Weekend/holidays 11 a.m. to 3 p.m. local time
TTY	888.985.8775 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
FAX	855.236.2423
WRITE	Livanta LLC, BFCC-QIO Program 10820 Guilford Road, Suite 202 Annapolis Junction, MD 20701-1105
WEBSITE	*www.livanta.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. 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	*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	517.241.3911 Monday-Friday, 8 a.m. to 5 p.m.
TTY	844.578.6563 Hearing impaired callers may contact the Michigan Relay Center at 711 and ask for the number above.
WRITE	Michigan Department of Health and Human Services 333 S. Grand Ave. P.O. Box 30195 Lansing, Michigan 48909
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.

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.); or
- Change Healthcare at 1-866-783-0896, between 9 a.m. to 6 p.m., Monday through Friday. TTY users should call 1-855-386-9643. 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 documentation 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 70% discount provided by manufacturers excludes any dispensing fee for costs in the gap. Members pay 25% 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 (5%) 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 75% of the price for generic drugs and you pay the remaining 25% of the price. For generic drugs, the amount paid by the plan (75%) 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.

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. If you press "0," you may speak with an RRB representative from 9:00 am to 3:30 pm, Monday, Tuesday, Thursday, and Friday, and from 9:00 am to 12:00 pm on Wednesday. If you press "1", you may access the automated RRB HelpLine and recorded information 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.

Method	Railroad Retirement Board – Contact Information
WEBSITE	*rrb.gov/*

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

If you (or your spouse) get benefits from your (or your spouse's) employer or retiree group as part of this plan, you may call the employer/union benefits administrator or Customer Service if you have any questions. You can ask about your (or your spouse's) employer or retiree health benefits, premiums, or the enrollment period. (Phone numbers for Customer Service are printed on the back cover of this booklet.) You may also call 1-800-MEDICARE (1-800-633-4227; TTY: 1-877-486-2048) with questions related to your Medicare coverage under this plan. 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.
- **"In-network providers"** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have a contract 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.
- **"Out-of-network providers"** are doctors and other health care professionals, medical groups, hospitals, and other health care facilities that do not have a contract agreement with us. See Section 2.4 (*How to get care from out-of-network providers*) in this chapter to learn about getting care from out-of-network providers in Michigan and also those outside of Michigan.
- **"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 Select must cover all services covered by Original Medicare and must follow Original Medicare's coverage rules.

PriorityMedicare Select 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 receive your care from a provider who is eligible to provide services under Original Medicare.** As a member of our plan, you can receive your care from either a network provider or an out-of-network provider (for more about this, see Section 2 in this chapter).
    - The providers in our network are listed in the *Provider/Pharmacy Directory*.
    - If you use an out-of-network provider, your share of the costs for your covered services may be higher.
    - 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 you go to a provider who is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive. Check with your provider before receiving services to confirm that they are eligible to participate in Medicare.

SECTION 2 Using network and out-of-network providers to get your medical care

Section 2.1 You may 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 Select, you may 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 *prioritymedicare.com*. 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 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 in our plan or you will pay more for covered services.

To change your PCP, please contact Customer Service or make your PCP change online through your member account at *prioritymedicare.com*. You will find a list of PCPs to choose from on our website at *prioritymedicare.com*. 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, COVID-19 vaccinations, 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 get services on your own. If you prefer, you may ask your PCP for his or her recommendation. Remember that when you use in-network providers, you will pay less. When you use out-of-network providers, you could pay a higher cost share for same service. Prior authorization requirements apply for some services obtained in-network. See Chapter 4 for details.

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 let you know when something is not covered. Providers should tell you verbally when Medicare does not cover the 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 that your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider to manage your care.

If your specialist, hospital, or clinic leaves the plan, you should contact one of the following to find a new provider:

- Primary Care Provider (PCP) to see if they can make a recommendation,
- Go to *prioritymedicare.com* 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 pre-service organization determination 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.

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. Our plan will cover services from either in-network or out-of-network providers, as long as the services are covered benefits and are medically necessary. **If you use an out-of-network provider in the state of Michigan, the costs for your covered services may be higher.** Your plan offers out-of-state travel coverage, so you can see a Medicare participating provider within the U.S. and its territories, and your cost will be the same as if you were using an in-network provider. See Chapter 4, Section 2.3 (*Getting care using our plan's out-of-state travel benefit*) for details.

Here are other important things to know:

- Except for emergency care, we cannot pay a provider who does not participate in Medicare. If you receive care from a provider who does not participate in Medicare, you will be responsible for the full cost of the services you receive. Check with your provider before receiving services to confirm that they participate in Medicare.
- As part of the out-of-state travel benefit, if you receive services from Medicare-participating providers while traveling **outside the state of Michigan** (within the U.S. and its territories), you will pay the same as if you were using in-network providers. We also partner with MultiPlan, a network of Medicare providers, to make it even easier for you to get care from providers in other states. See Chapter 4, Section 2.3 *(Getting care using our plan's out-of-state travel benefit)* for details.
- You don't need to get a referral or prior authorization when you get care from out-of-network providers in the state of Michigan or when using providers with the out-of-state travel benefit. However, before getting services we encourage you to ask for a pre-visit coverage decision to confirm that the services you are getting are covered and are

medically necessary. (See Chapter 9, Section 4 for information about asking for coverage decisions.) This is important because:

- Without a pre-visit coverage decision, 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 make an appeal.

- It is best to ask an out-of-network provider or a provider you are using with the out-of-state travel benefit to bill the plan first. But, if you have already paid for the covered services or if they ask you to pay upfront and then seek reimbursement from us, we will reimburse you for our share of the cost for covered services. 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 us to pay our share of a bill you have received for covered 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 services, or dialysis, you will not have to pay a higher cost-sharing amount. This applies whether you are in or out of the State of Michigan. See Section 3 for more information about these situations.

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 of 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 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 benefit. The out-of-network 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 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, the amount of cost sharing that you pay will depend on whether you get the care from network providers or out-of-network providers. If you get the care from network providers, your share of the costs will usually be lower than if you get the care from out-of-network providers.

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 or inaccessible. 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?

In most situations, if you are in the plan's service area and you use an out-of-network provider, you will pay a higher share of the costs for your care.

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 <u>outside</u> 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: *prioritymedicare.com* 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 Select covers all medical services that are medically necessary, these services 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 plan rules were not followed.

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 visiting the Medicare website to read or download the publication "Medicare and Clinical Research Studies." (The publication is available at: *www.medicare.gov/Pubs/pdf/02226-Medicare-and-Clinical-Research-Studies.pdf*.) 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 Receiving Care From a Religious Non-Medical Health Care Institution

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 your 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 DME own the equipment after paying copayments for the item for 13 months. As a member of **Priority**Medicare Select, 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 at no additional cost to you. 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.

SECTION 8 Rules for Oxygen Equipment, Supplies, and Maintenance

Section 8.1 What oxygen benefits are you entitled to?

If you qualify for Medicare oxygen equipment coverage, then for as long as you are enrolled, **Priority**Medicare Select will cover:

- Rental of oxygen equipment
- Delivery of oxygen and oxygen contents
- Tubing and related oxygen accessories for the delivery of oxygen and oxygen contents
- Maintenance and repairs of oxygen equipment

If you leave **Priority**Medicare Select or no longer medically require oxygen equipment, then the oxygen equipment must be returned to the owner.

Section 8.2 What is your cost sharing? Will it change after 36 months?

Your cost sharing for Medicare oxygen equipment coverage is the cost you pay for durable medical equipment, every month.

Your cost sharing will not change after being enrolled for 36 months in **Priority**Medicare Select.

If prior to enrolling in **Priority**Medicare Select you had made 36 months of rental payment for oxygen equipment coverage, your cost sharing in **Priority**Medicare Select is the cost you pay for durable medical equipment.

Section 8.3 What happens if you leave your plan and return to Original Medicare?

If you return to Original Medicare, then you start a new 36-month cycle which renews every five years. For example, if you had paid rentals for oxygen equipment for 36 months prior to joining **Priority**Medicare Select, join **Priority**Medicare Select for 12 months, and then return to Original Medicare, you will pay full cost sharing for oxygen equipment coverage.

Similarly, if you made payments for 36 months while enrolled in **Priority**Medicare Select and then return to Original Medicare, you will pay full cost sharing for oxygen equipment coverage.

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 Select. 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.

- 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 the most you will pay for covered medical services?

Under our plan, there are two different limits on what you have to pay out-of-pocket for covered medical services:

- Your **in-network maximum out-of-pocket amount** is $3,500. This is the most you pay during the calendar year for covered plan services received from in-network providers. The amounts you pay for copayments and coinsurance for covered services from in-network providers count toward this in-network maximum out-of-pocket amount. (The amounts you pay for plan premiums, and for your Part D prescription drugs, and services from out-of-network providers 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 have paid $3,500 for covered plan services from in-network providers, you will not have any out-of-pocket costs for the rest of the year when you see our in-network providers. However, you must continue to pay your plan

premium and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

- Your **combined maximum out-of-pocket amount** is $3,500. This is the most you pay during the calendar year for covered plan services received from both in-network and out-of-network providers. The amounts you pay for copayments-and coinsurance for covered services count toward this combined 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 combined maximum out-of-pocket amount. In addition, amounts you pay for some services do not count toward your combined maximum out-of-pocket amount. These services are marked with an asterisk in the Medical Benefits Chart.) If you have paid $3,500 for covered services, you will have 100% coverage and will not have any out-of-pocket costs for the rest of the year for covered plan services. However, you must continue to pay your plan premium and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Section 1.3 Our plan does not allow providers to "balance bill" you

As a member of **Priority**Medicare Select, an important protection for you is that 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. You will generally have higher copays when you obtain care from out-of-network providers.
- 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 obtain 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 obtain 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.
    - If you obtain covered services from an out-of-network provider who does not participate with Medicare, then you pay the coinsurance amount multiplied by the Medicare payment rate for non-participating providers.
- 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 Select 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.
- Some of the services listed in the Medical Benefits Chart are covered *only* if your doctor or other network 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 the checkmark symbol and 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
Blepharoplasty	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)

PRIOR AUTHORIZATION REFERENCE CHART	
Prior authorization is required for the following:	Look for this service in the Medical Benefits Chart below for details:
Cosmetic and reconstructive surgery	Outpatient hospital Outpatient surgery
Dental services (Medicare-covered)	Outpatient hospital Outpatient surgery Physician/practitioner services (specialist)
Durable medical equipment (DME) item(s) that cost more than $1,000	Durable medical equipment (DME)
Durable medical equipment (DME) rentals	Durable medical equipment (DME)
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
Home health services	Home health agency care
Home infusion therapy	Home infusion therapy
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
Nuclear cardiology studies	Outpatient diagnostic tests/therapeutic services
Orthopedic office visits for spinal conditions	Physician/practitioner services
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)

PRIOR AUTHORIZATION REFERENCE CHART	
Prior authorization is required for the following:	Look for this service in the Medical Benefits Chart below for details:
Parenteral/enteral feedings	Prosthetic devices
Partial hospitalization	Partial hospitalization
Positron Emission Tomography (PET) scan	Outpatient diagnostic tests/therapeutic services
Prosthetics and orthotics item(s) that cost more than $1,000	Prosthetic devices
Radical prostatectomy	Outpatient hospital Outpatient surgery
Radiofrequency catheter ablation for back pain	Outpatient hospital Outpatient surgery
Radiosurgery	Outpatient hospital Outpatient surgery
Skilled nursing facility admissions	Skilled nursing facility (SNF) care
Sleep studies (except in-home)	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)
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)

- While you don't need approval in advance for out-of-network services, you or your doctor can ask us to make a coverage decision in advance.
- 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:

- For benefits where your cost sharing is a coinsurance percentage, the amount you pay depends on what type of provider you receive the services from:

  - 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.
  - 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.

- 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 2022* handbook. View it online at *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 cost share 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 2022, 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 and beyond what Original Medicare covers.

✓ You will see this check mark when a benefit requires a prior authorization.

* You will see an asterisk on services that do not apply to your maximum out-of-pocket amount, in-network or combined, and will be referred to as "combined" throughout the Medical Benefits Chart.

Medical Benefits Chart

Important: If you receive services outside of the benefit described, an additional cost share may apply.		
Services that are covered for you	**What you must pay when you get these services**	
	In-network:	**Out-of-network:**
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.	There is no copayment for members eligible for this preventive screening.	Members eligible for this preventive screening pay 30%.
Acupuncture for chronic low back pain **Medicare-covered services include:** Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: • Lasting 12 weeks or longer; • nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious, etc. disease); • not associated with surgery; and • not associated with pregnancy. An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing.	$20 for each Medicare-covered visit. $20 for each non-Medicare covered acupuncture visit, up to 6 visits each year.	

Use the out-of-state travel benefit anywhere in the U.S. when outside the state of Michigan and pay the same as when you're in-network. See Chapter 4, Section 2.3 for more information.

Important: If you receive services outside of the benefit described, an additional cost share may apply.		
Services that are covered for you	**What you must pay when you get these services**	
	In-network:	**Out-of-network:**
Acupuncture for chronic low back pain *(continued)* Provider Requirements: Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act) may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa)(5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have: • a masters or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, • a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e. Puerto Rico) of the United States, or District of Columbia. Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27.		
Non-Medicare covered routine acupuncture services: Routine acupuncture services (limited to 6 visits whether done in- or out-of-network) for other conditions, such as; headaches, anxiety, sleep issues, osteoarthritis, chemotherapy side effects and respiratory disorders.		

Use the out-of-state travel benefit anywhere in the U.S. when outside the state of Michigan and pay the same as when you're in-network. See Chapter 4, Section 2.3 for more information.

Important: If you receive services outside of the benefit described, an additional cost share may apply.		
Services that are covered for you	**What you must pay when you get these services**	
	In-network:	**Out-of-network:**
Allergy shots and serum You are covered for allergy shots and Medicare-covered Part B serum (antigen) when medically necessary. A specialist copayment/coinsurance may apply, see "Physician/Practitioner services, including doctor's office visits." **Note:** For Medicare-covered allergy testing, see "Outpatient diagnostic tests and therapeutic services and supplies."	20% for each Medicare-covered Part B drug obtained in a provider's office.	20% for each Medicare-covered Part B drug obtained in a provider's office.
Ambulance services • Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only 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. We cover ambulance services not resulting in a transport to a facility if you are stabilized at your home or other location. This service is not covered outside of the U.S. and its territories.	**In- and out-of-service area:** $200 for each one-way Medicare-covered ambulance transport. $200 for each non-Medicare covered ambulance stabilization when there is no transport. Out-of-network cost sharing will apply toward your combined out-of-pocket maximum.	

Use the out-of-state travel benefit anywhere in the U.S. when outside the state of Michigan and pay the same as when you're in-network. See Chapter 4, Section 2.3 for more information.

Important: If you receive services outside of the benefit described, an additional cost share may apply.		
Services that are covered for you	**What you must pay when you get these services**	
	In-network:	**Out-of-network:**
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. ✓ *Prior authorization may apply, see page 64 for more information.*		
Annual preventive physical exam Because you are a member of this plan, if the purpose of the appointment is your scheduled annual exam, you will not be charged for the office visit no matter how much is discussed. This is an opportunity for you and your physician to talk about any concerns or questions you may have. 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.	$0 for an annual preventive physical exam.	30% for an annual preventive physical exam.

Important: If you receive services outside of the benefit described, an additional cost share may apply.		
Services that are covered for you	**What you must pay when you get these services**	
	In-network:	**Out-of-network:**
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. Like the annual preventive physical exam, you will not be charged for the office visit no matter how much is discussed with your physician. 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**: 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.	There is no copayment for the annual wellness visit.	30% for the annual wellness visit.
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.	There is no copayment for Medicare-covered bone mass measurement.	30% for Medicare-covered bone mass measurement.

Important: If you receive services outside of the benefit described, an additional cost share may apply.		
Services that are covered for you	**What you must pay when you get these services**	
	In-network:	**Out-of-network:**
BrainHQ BrainHQ is a gym for the mind, with dozens of online brain exercises that have been shown in studies to sharpen cognitive abilities (attention, brain speed, memory, people skills, navigation, and intelligence). You can use BrainHQ on your own schedule through any computer, tablet, or smart phone with an internet connection. To learn more and get started go to *priority.brainhq.com.*	$0 for BrainHQ.	
Breast cancer screening (mammograms) Covered services include: • One baseline mammogram for women between the ages of 35 and 39 • One screening mammogram every 12 months for women age 40 and older • Clinical breast exams for women once every 24 months A **breast cancer screening mammogram** (2D or 3D) is done 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, 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 have a screening mammogram or a diagnostic mammogram. See "Outpatient diagnostic tests and therapeutic services and supplies."	There is no copayment for covered screening mammograms.	30% for covered screening mammograms.

Use the out-of-state travel benefit anywhere in the U.S. when outside the state of Michigan and pay the same as when you're in-network. See Chapter 4, Section 2.3 for more information.

Important: If you receive services outside of the benefit described, an additional cost share may apply.		
Services that are covered for you	**What you must pay when you get these services**	
	In-network:	**Out-of-network:**
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.	$15 for each Medicare-covered cardiac rehabilitation service and intensive cardiac rehabilitation service.	30% for each Medicare-covered cardiac rehabilitation service and intensive cardiac rehabilitation service.
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 healthy.	There is no copayment for the intensive behavioral therapy cardiovascular disease preventive benefit.	30% for the intensive behavioral therapy cardiovascular disease preventive benefit.
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).	There is no copayment for cardiovascular disease testing that is covered once every 5 years.	30% for cardiovascular disease testing that is covered once every 5 years.
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	There is no copayment for Medicare-covered preventive Pap and pelvic exams.	30% for Medicare-covered preventive Pap and pelvic exams.

Important: If you receive services outside of the benefit described, an additional cost share may apply.		
Services that are covered for you	**What you must pay when you get these services**	
	In-network:	**Out-of-network:**
Cervical and vaginal cancer screening ***(continued)*** • Human Papillomavirus (HPV) tests (as part of a PAP test) once every 5 years if you are aged 30-65 years and asymptomatic.		
Chiropractic services Covered services include: • We cover only manual manipulation of the spine to correct subluxation	$20 for each Medicare-covered visit.	30% for each Medicare-covered visit.
Colorectal cancer screening *Note: A screening can become diagnostic in the same visit and when this happens you will pay a cost share for those services. This is explained at the end of this benefit.* 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	There is no copayment for a Medicare-covered colorectal cancer screening exam.	30% for a Medicare-covered colorectal cancer screening exam.

Important: If you receive services outside of the benefit described, an additional cost share may apply.		
Services that are covered for you	**What you must pay when you get these services**	
	In-network:	**Out-of-network:**
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. A **screening colonoscopy** is a procedure to find colon polyps, cancer, or other colorectal related conditions in individuals with no signs or symptoms. A screening colonoscopy can become a diagnostic colonoscopy during the procedure itself. 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.), because you've had a previous colonoscopy that resulted in removal of polyps, or other colorectal related conditions. If your physician orders a diagnostic colonoscopy see "Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers" or "Outpatient diagnostic tests and therapeutic services and supplies" for cost share.		

Important: If you receive services outside of the benefit described, an additional cost share may apply.		
Services that are covered for you	**What you must pay when you get these services**	
	In-network:	**Out-of-network:**
Dental services **Medicare-covered dental services:** 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. Non-routine dental care (Medicare-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)	$0 for Medicare-covered surgical procedures performed by a physician/practitioner in a provider's office. $40 for each Medicare-covered visit with a specialist. $200 for each Medicare-covered ambulatory surgical center or outpatient hospital facility visit.	30% for all Medicare-covered dental services.
Non-Medicare covered dental services:* In-network (participating) dentists are those in Delta Dental's Medicare Advantage PPO and Medicare Advantage Premier network. All other dentists are considered out-of-network (nonparticipating) dentists. If the Dentist you select is not a Delta Dental Medicare Advantage Participating Dentist, you will still be covered, but you may have to pay more. You can find participating dentists by calling 800.330.2732 (TTY users should call 711), Monday through Friday 9 a.m. to 8 p.m. or search online at *deltadentalmi.com/Find-a-Dentist*. When accessing Delta Dental's online Dentist Directory you must select the link labeled Delta Dental Medicare Advantage PPO and Delta Dental Medicare Advantage Premier.	$0 for two preventive exams.* $0 for two cleanings (regular or periodontal maintenance).* $0 for one set (up to 4 films in a single visit) of bitewing x-rays.* $0 for one brush biopsy.* $0 for radiographs (full-mouth, periapical or panoramic x-rays) once every two years.* These dental services do not apply to your combined out-of-pocket maximum.	

Use the out-of-state travel benefit anywhere in the U.S. when outside the state of Michigan and pay the same as when you're in-network. See Chapter 4, Section 2.3 for more information.

Important: If you receive services outside of the benefit described, an additional cost share may apply.		
Services that are covered for you	**What you must pay when you get these services**	
	In-network:	**Out-of-network:**
Dental services *(continued)* For additional details about your non-Medicare covered dental benefits, go to the back of this document and locate the Appendix. If you want additional dental coverage than what's included in your medical plan, see Chapter 4, Section 2.2 *Extra "optional supplemental" benefits you can buy* for an additional premium.		
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/or referrals.	There is no copayment for an annual depression screening visit.	30% for an annual depression screening visit.
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.	There is no copayment for the Medicare-covered diabetes screening tests.	30% for the Medicare-covered diabetes screening tests.

Important: If you receive services outside of the benefit described, an additional cost share may apply.		
Services that are covered for you	**What you must pay when you get these services**	
	In-network:	**Out-of-network:**
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 calendar 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 (for example; insulin pumps and continuous glucose monitors (CGM)) see "Durable medical equipment and related supplies."	$0 for Medicare-covered diabetes self-management training $0 for diabetic services and supplies. Diabetic test strips are limited to JJHCS and Bayer products when dispensed by a retail pharmacy or mail-order pharmacy. $0 for all other diabetic test strips when obtained through a DME supplier.	30% for Medicare-covered diabetes self-management training and diabetic services and supplies. Diabetic test strips are limited to JJHCS and Bayer products when dispensed by a retail pharmacy or mail-order pharmacy. 30% for all other diabetic test strips when obtained through a DME supplier.

Important: If you receive services outside of the benefit described, an additional cost share may apply.		
Services that are covered for you	**What you must pay when you get these services**	
	In-network:	**Out-of-network:**
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 supplies, 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 *prioritymedicare.com*. 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 page 64 for more information.*	20% for Medicare-covered equipment and supplies.	30% for Medicare-covered equipment and supplies.

Use the out-of-state travel benefit anywhere in the U.S. when outside the state of Michigan and pay the same as when you're in-network. See Chapter 4, Section 2.3 for more information.

Important: If you receive services outside of the benefit described, an additional cost share may apply.		
Services that are covered for you	**What you must pay when you get these services**	
	In-network:	**Out-of-network:**
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. 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. For information on observation, see "Outpatient hospital observation". You have emergency care coverage in the United States and worldwide. **Note:** If you get Part D Medicare-covered self-administered drugs in an emergency room setting, they may be covered under your prescription drug benefit on this plan. See Chapter 6, Section 8.1, for more information on what happens when you get a Part D drug in a medical setting.	**In- and out-of-service area:** $90 for each Medicare-covered emergency room visit. Out-of-network cost sharing will apply toward your combined out-of-pocket maximum. You do not pay this amount if you are admitted to the hospital within 24 hours for the same condition.	

Important: If you receive services outside of the benefit described, an additional cost share may apply.		
Services that are covered for you	**What you must pay when you get these services**	
	In-network:	**Out-of-network:**
Enhanced disease management Care management is available to provide education, care coordination and support for all health conditions, with a particular emphasis on the management of chronic conditions. Care management is focused on assisting members in maximizing their health outcomes and functional capabilities as well as improving their quality of life.	$0 for 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 conditions requiring special diets. Support for stress, anxiety, and depression is also available. We offer these programs to enrich the health and lifestyles of our members. • BrainHQ • Enhanced disease management • Fitness (SilverSneakers®) • Health education • In-home safety assessment • Nutritional education • Post-discharge in-home medication reconciliation • Telemonitoring For more information, please refer to the individual program listed in this medical benefits chart.	$0 for these services.	

Use the out-of-state travel benefit anywhere in the U.S. when outside the state of Michigan and pay the same as when you're in-network. See Chapter 4, Section 2.3 for more information.

Important: If you receive services outside of the benefit described, an additional cost share may apply.		
Services that are covered for you	**What you must pay when you get these services**	
	In-network:	**Out-of-network:**
Health education Health education includes: • Access to **myStrength** for online emotional support during challenging times. Sign up for an account that includes interactive activities, coping tools and other resources, including inspirational community support at *priorityhealth.com/mystrength*. • ThinkHealth – your online resource for tips on healthy living, information on health care trends and health insurance education, go to *thinkhealth.priorityhealth.com*. • Communications to help you understand your plan benefits and get the care you need. • Programs to help you prevent and/or manage your condition(s). • 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.	$0 for 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.	$15 for each Medicare-covered diagnostic hearing exam with a primary care provider. $40 for each Medicare-covered diagnostic hearing exam with a specialist.	30% for each Medicare-covered diagnostic hearing exam.

Use the out-of-state travel benefit anywhere in the U.S. when outside the state of Michigan and pay the same as when you're in-network. See Chapter 4, Section 2.3 for more information.

Important: If you receive services outside of the benefit described, an additional cost share may apply.		
Services that are covered for you	**What you must pay when you get these services**	
	In-network:	**Out-of-network:**
Hearing services *(continued)* **Non-Medicare covered routine hearing services:*** One hearing exam and hearing aids (one per ear per year) from top hearing aid manufacturers. Hearing aid purchase includes: • Provider visits within first year of hearing aid purchase (first visit is for the fitting and adjustment, any additional visits for any adjustments to the programming which might need to be made) • 60-day trial period • 3-year extended warranty • 80 batteries per aid for non-rechargeable models To access your benefits, you must contact TruHearing first to schedule an appointment with a TruHearing provider. Just call 833.714.5356 from 8 a.m. to 8 p.m. Monday through Friday. For additional details about your TruHearing benefits, go to the back of this document and locate the Appendix.	**Covered services with a TruHearing provider:** $0 for one routine hearing exam every year*. Hearing aids – *you pay the following:* $295 per hearing aid for Basic Aids* $695 per hearing aid for Standard Aids* $1,095 per hearing aid for Advanced Aids* $1,495 per hearing aid for Premium Aids* These hearing services do not apply to your combined out-of-pocket maximum. **Services with a non-TruHearing provider:** Not covered	

Important: If you receive services outside of the benefit described, an additional cost share may apply.		
Services that are covered for you	**What you must pay when you get these services**	
	In-network:	**Out-of-network:**
Hepatitis C screening Medicare covers a screening test one time if you meet one or more of these conditions and if ordered by your doctor: • High risk because you use or have used illicit injection drugs. • Received a blood transfusion before 1992. • Born between 1945-1965. If you're at high risk, Medicare covers yearly screenings.	There is no copayment for members eligible for Medicare-covered preventive Hepatitis C screening.	Members eligible for Medicare-covered preventive Hepatitis C screening pay 30%.
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	There is no copayment for members eligible for Medicare-covered preventive HIV screening.	Members eligible for Medicare-covered preventive HIV screening pay 30%.
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.	$0 for each Medicare-covered service.	$0 for each Medicare-covered service.

Use the out-of-state travel benefit anywhere in the U.S. when outside the state of Michigan and pay the same as when you're in-network. See Chapter 4, Section 2.3 for more information.

Important: If you receive services outside of the benefit described, an additional cost share may apply.		
Services that are covered for you	**What you must pay when you get these services**	
	In-network:	**Out-of-network:**
Home health agency care *(continued)* Covered services include, but are not limited to: • 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 (including supplies customarily used in small quantities during the course of home health care) **Note:** Medical supplies ordered by a physician such as DME equipment are not covered under the home health benefit. See "Durable medical equipment and related supplies" for details. ✓ *Prior authorization may apply, see page 64 for more information*.		

Important: If you receive services outside of the benefit described, an additional cost share may apply.		
Services that are covered for you	**What you must pay when you get these services**	
	In-network:	**Out-of-network:**
Home infusion therapy Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to an individual at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Covered services include, but are not limited to: • Professional services, including nursing services, furnished in accordance with the plan of care • Patient training and education not otherwise covered under the durable medical equipment benefit • Remote monitoring • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier This benefit includes supplies/services associated with home infusion drugs. Only drugs listed in the formulary with the "HI" designation are covered under this home infusion therapy benefit. Cost share will apply for all other drugs administered in the home setting, see "Medicare Part B prescription drugs." ✓ *Prior authorization may apply, see page 64 for more information.*	$0 for home infusion supplies, services and drugs.	$0 for home infusion supplies, services and drugs.

Important: If you receive services outside of the benefit described, an additional cost share may apply.		
Services that are covered for you	**What you must pay when you get these services**	
	In-network:	**Out-of-network:**
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 <u>For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis:</u> 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. <u>For services that are covered by Medicare Part A or B and are not related to your terminal prognosis:</u> 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:	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 Select.	
	\$0 for the initial Medicare-covered hospice consultation.	30% for the initial Medicare-covered hospice consultation.

Important: If you receive services outside of the benefit described, an additional cost share may apply.		
Services that are covered for you	**What you must pay when you get these services**	
	In-network:	**Out-of-network:**
Hospice care ***(continued)*** • 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 plan cost sharing for out-of-network services For services that are covered by **Priority**Medicare Select but are not covered by Medicare Part A or B: **Priority**Medicare Select 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*). **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.		

Important: If you receive services outside of the benefit described, an additional cost share may apply.		
Services that are covered for you	**What you must pay when you get these services**	
	In-network:	**Out-of-network:**
Immunizations Covered Medicare Part B services include: • Pneumonia vaccine (2 per lifetime) • Flu shots, each flu season in the fall and winter, with additional flu shots if medically necessary • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B • COVID-19 vaccine • Other vaccines if you are at risk and they meet Medicare Part B coverage rules (see "Medicare Part B prescription drugs" for cost share) We also cover some vaccines under our Part D prescription drug benefit. Vaccines covered under our Part D prescription drug benefit should be obtained, if possible, at a vaccine network pharmacy, which are indicated with a "v" in the *Provider/Pharmacy Directory*. Your Part D cost sharing will apply. Examples of routine vaccines covered under our Part D benefit include shingles vaccine (Zoster/Zostavax) and Tetanus (Td/Tdap). When a Part D Medicare-covered immunization is received in a provider's office or outpatient setting you will pay the cost of the immunization and administration to the provider. We will reimburse you as described in Chapter 6, Section 8.1.	There is no copayment for the pneumonia, influenza, Hepatitis B, and COVID-19 vaccines.	

Important: If you receive services outside of the benefit described, an additional cost share may apply.		
Services that are covered for you	**What you must pay when you get these services**	
	In-network:	**Out-of-network:**
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 hazards throughout your home.	$0 for these services.	
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. There is no limit to the number of days covered by the plan. Your inpatient hospital cost sharing will apply each time you are admitted. This includes when transferring from one facility to another or within the same facility between levels of care. Covered services include but are not limited to: • Semi-private room (or a private room if medically necessary) • Meals including special diets	For each Medicare-covered hospital admission/stay you pay: $200 per day, days 1-6. $0 for additional hospital days.	For each Medicare-covered hospital admission/stay, you pay 30% per stay.

Use the out-of-state travel benefit anywhere in the U.S. when outside the state of Michigan and pay the same as when you're in-network. See Chapter 4, Section 2.3 for more information.

Important: If you receive services outside of the benefit described, an additional cost share may apply.		
Services that are covered for you	**What you must pay when you get these services**	
	In-network:	**Out-of-network:**
Inpatient hospital care *(continued)* • Physician services • Regular nursing services • 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 - including storage and administration. Coverage of whole blood and packed red cells (as well as other components of blood). 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.		

Important: If you receive services outside of the benefit described, an additional cost share may apply.		
Services that are covered for you	**What you must pay when you get these services**	
	In-network:	**Out-of-network:**
Inpatient hospital care *(continued)* 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 Select 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. Look in Chapter 12, *Definitions of important words*, "Transplant travel coverage" for details on reimbursement. **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. 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 *www.medicare.gov/Pubs/pdf/11435-Are-You-an-Inpatient-or-Outpatient.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.		

Important: If you receive services outside of the benefit described, an additional cost share may apply.		
Services that are covered for you	**What you must pay when you get these services**	
	In-network:	**Out-of-network:**
Inpatient hospital care *(continued)* 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. ✓ *Prior authorization may apply, see page 64 for more information*.		
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. Call our Behavioral Health department at 800.673.8043 with questions. ✓ *Prior authorization may apply, see page 64 for more information*.	For each Medicare-covered hospital admission/stay you pay: $200 per day, days 1-6. $0 for additional hospital days.	For each Medicare-covered hospital admission/stay, you pay 30% per stay.

Important: If you receive services outside of the benefit described, an additional cost share may apply.		
Services that are covered for you	**What you must pay when you get these services**	
	In-network:	**Out-of-network:**
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 page 64 for more information.*	\$0 for Medicare-covered services received from the inpatient facility. \$0 for Medicare-covered prosthetic devices and supplies received from the 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.	30% for Medicare-covered services received from the inpatient facility. 30% for all Medicare-covered prosthetic devices and supplies and Medicare-covered DME received from an outpatient provider.

Use the out-of-state travel benefit anywhere in the U.S. when outside the state of Michigan and pay the same as when you're in-network. See Chapter 4, Section 2.3 for more information.

Important: If you receive services outside of the benefit described, an additional cost share may apply.		
Services that are covered for you	**What you must pay when you get these services**	
	In-network:	**Out-of-network:**
Meal benefit Mom's Meals offers fully-prepared, nutritious home-delivered meals created by chefs and registered dietitians. These meals are tailored to support your nutritional needs and are delivered to your home. Mom's Meals offers a variety of condition-specific menus: • Cancer support • Diabetes friendly • General wellness • Gluten free • Heart-friendly • Lower sodium • Puréed • Renal-friendly • Vegetarian Upon discharge from an inpatient hospital, psychiatric hospital or Skilled Nursing Facility (SNF) Mom's Meals will reach out via telephone on behalf of Priority Health Medicare. If you choose to accept these meals you will be sent 28 meals in two weekly shipments of 14. The meals, along with heating instructions and nutritional information, are delivered directly to you in a box that may weigh up to 25 pounds. Once in your refrigerator, the meals will last for up to two weeks (this box has handles which will assist you in getting it inside)	$0 for 28 home-delivered meals, up to four times per year, following an inpatient hospital, psychiatric hospital or Skilled Nursing Facility (SNF) discharge.	

Important: If you receive services outside of the benefit described, an additional cost share may apply.		
Services that are covered for you	**What you must pay when you get these services**	
	In-network:	**Out-of-network:**
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 calendar year.	There is no copayment for members eligible for Medicare-covered medical nutrition therapy services.	Members eligible for Medicare-covered medical nutrition therapy services pay 30%.
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.	There is no copayment for the MDPP benefit.	30% for the MDPP benefit.

Important: If you receive services outside of the benefit described, an additional cost share may apply.		
Services that are covered for you	**What you must pay when you get these services**	
	In-network:	**Out-of-network:**
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 outpatient, or ambulatory surgical center services. **Note:** For approved infused drugs in the home refer to **Home Infusion Therapy** 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)	**Part B chemotherapy/radiation** 20% for each Medicare-covered Part B drug. **Part B drugs obtained in a provider's office or outpatient setting** 20% for each Medicare-covered Part B drug. **Part B drugs obtained at a pharmacy/mail-order** 20% for each Medicare-covered Part B drug.	

Use the out-of-state travel benefit anywhere in the U.S. when outside the state of Michigan and pay the same as when you're in-network. See Chapter 4, Section 2.3 for more information.

Important: If you receive services outside of the benefit described, an additional cost share may apply.		
Services that are covered for you	**What you must pay when you get these services**	
	In-network:	**Out-of-network:**
Medicare Part B prescription drugs ***(continued)*** • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases We also cover some vaccines under our Part B and Part D prescription drug benefit. See the List of Covered Drugs for information on how a Part B versus a Part D drug may be covered in a retail or mail-order pharmacy. Part B versus Part D drugs are noted with "B/D" in the "Notes" column on the Covered Drug List. 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. Step therapy may be required for Part B drugs. ✓ *Prior authorization may apply, see page 64 for more information.*		
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."	$0 for these services.	

Use the out-of-state travel benefit anywhere in the U.S. when outside the state of Michigan and pay the same as when you're in-network. See Chapter 4, Section 2.3 for more information.

Important: If you receive services outside of the benefit described, an additional cost share may apply.		
Services that are covered for you	**What you must pay when you get these services**	
	In-network:	**Out-of-network:**
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.	There is no copayment for preventive obesity screening and therapy.	30% for preventive obesity screening and therapy.
Opioid treatment program services Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services: • U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications. • Dispensing and administration of MAT medications (if applicable) • Substance use counseling • Individual and group therapy • Toxicology testing • Intake activities • Periodic assessments Please see **"Virtual care"** in this medical benefits chart for information on what services are covered.	$20 for Medicare-covered opioid treatment services.	30% for Medicare-covered opioid treatment services.

Important: If you receive services outside of the benefit described, an additional cost share may apply.		
Services that are covered for you	**What you must pay when you get these services**	
	In-network:	**Out-of-network:**
Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but are not limited to: • X-rays • Surgical supplies, such as dressings • Splints, casts and other devices used to reduce fractures and dislocations • Laboratory tests • Pathology • 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. • Blood - including storage and administration. Coverage of whole blood and packed red cells (as well as other components of blood). ★ 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 page 64 for more information.*	**X-rays** $30 per day, per provider, for Medicare-covered x-ray services. **Diagnostic radiology** $75 per day, per provider, for Medicare-covered diagnostic radiology services. **Medical supplies** $0 for Medicare-covered surgical supplies, splints, casts and other devices. **Radiation therapy** $25 per day, per provider, for Medicare-covered, radiation therapy services. **Labs** $20 per day, per provider, for Medicare-covered lab services. $0 per day, per provider, for Medicare-covered anticoagulant lab services. **Pathology** $20 per day, per provider, for Medicare-covered pathology services.	**X-rays** 30% per day, per provider, for Medicare-covered x-ray services. **Diagnostic radiology** 30% per day, per provider, for Medicare-covered diagnostic radiology services. **Medical supplies** $0 for Medicare-covered surgical supplies, splints, casts and other devices. **Radiation therapy** 30% per day, per provider, for Medicare-covered, radiation therapy services. **Labs** 30% per day, per provider, for Medicare-covered lab services. $0 per day, per provider, for Medicare-covered anticoagulant lab services. **Pathology** 30% per day, per provider, for Medicare-covered pathology services.

Important: If you receive services outside of the benefit described, an additional cost share may apply.		
Services that are covered for you	**What you must pay when you get these services**	
	In-network:	**Out-of-network:**
Outpatient diagnostic tests and therapeutic services and supplies *(continued)*	**Diagnostic procedures and tests** $20 per day, per provider, for diagnostic procedures and tests. **Blood** $0 for blood.	**Diagnostic procedures and tests** 30% per day, per provider, for diagnostic procedures and tests. **Blood** $0 for blood.
Outpatient hospital observation Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **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." If you are not sure if you are an outpatient, you should ask the hospital staff. 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	$90 for each Medicare-covered observation visit, including all services received.	

Use the out-of-state travel benefit anywhere in the U.S. when outside the state of Michigan and pay the same as when you're in-network. See Chapter 4, Section 2.3 for more information.

Important: If you receive services outside of the benefit described, an additional cost share may apply.		
Services that are covered for you	**What you must pay when you get these services**	
	In-network:	**Out-of-network:**
Outpatient hospital observation *(continued)* on the Web at *www.medicare.gov/Pubs/pdf/11435-Are-You-an-Inpatient-or-Outpatient.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. See Chapter 6, Section 8.1, for more information on what happens when you get a Part D drug in a medical setting.		
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	\$200 for each Medicare-covered outpatient hospital facility visit. You may receive other services while in an outpatient hospital facility. The cost share for those services can be found in this Medical Benefits Chart.	30% for each Medicare-covered outpatient hospital facility visit. You may receive other services while in an outpatient hospital facility. The cost share for those services can be found in this Medical Benefits Chart.

Use the out-of-state travel benefit anywhere in the U.S. when outside the state of Michigan and pay the same as when you're in-network. See Chapter 4, Section 2.3 for more information.

Important: If you receive services outside of the benefit described, an additional cost share may apply.		
Services that are covered for you	**What you must pay when you get these services**	
	In-network:	**Out-of-network:**
Outpatient hospital services *(continued)*		
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 "observation." If you are not sure if you are an outpatient or under observation, you should ask the hospital staff. For information on services provided in a rural health clinic, see *"Rural Health Clinic"* within this Medical Benefits Chart. 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 *www.medicare.gov/Pubs/pdf/11435-Are-You-an-Inpatient-or-Outpatient.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. 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 page 64 for more information*.		

Use the out-of-state travel benefit anywhere in the U.S. when outside the state of Michigan and pay the same as when you're in-network. See Chapter 4, Section 2.3 for more information.

Important: If you receive services outside of the benefit described, an additional cost share may apply.		
Services that are covered for you	**What you must pay when you get these services**	
	In-network:	**Out-of-network:**
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. See Chapter 6, Section 8.1, for more information on what happens when you get a Part D drug in a medical setting. Please see **"Virtual care"** in this medical benefits chart for information on what services are covered.	$20 for each Medicare-covered individual visit. $20 for each Medicare-covered group visit.	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).	$30 per day for Medicare-covered physical therapy services. $30 per day for Medicare-covered occupational therapy services. $30 per day for Medicare-covered speech language therapy services.	30% per day for Medicare-covered physical therapy services. 30% per day for Medicare-covered occupational therapy services. 30% per day for Medicare-covered speech language therapy services.

Important: If you receive services outside of the benefit described, an additional cost share may apply.		
Services that are covered for you	**What you must pay when you get these services**	
	In-network:	**Out-of-network:**
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. See Chapter 6, Section 8.1, for more information on what happens when you get a Part D drug in a medical setting.	$20 for each Medicare-covered individual visit. $20 for each Medicare-covered group visit.	30% for each Medicare-covered individual and group visit.
Outpatient surgery ***including services provided at hospital outpatient facilities and ambulatory surgical centers*** 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. **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. See Chapter 6, Section 8.1, for more information on what happens when you get a Part D drug in a medical setting.	$200 for each Medicare-covered ambulatory surgical center visit. $200 for each Medicare-covered outpatient hospital facility visit. You may receive other services while in an outpatient hospital facility or ambulatory surgical center. The cost share for those services can be found in this Medical Benefits Chart.	30% for each Medicare-covered ambulatory surgical center visit. 30% for each Medicare-covered outpatient hospital facility visit. You may receive other services while in an outpatient hospital facility or ambulatory surgical center. The cost share for those services can be found in this Medical Benefits Chart.

Important: If you receive services outside of the benefit described, an additional cost share may apply.		
Services that are covered for you	**What you must pay when you get these services**	
	In-network:	**Out-of-network:**
Outpatient surgery ***including services provided at hospital outpatient facilities and ambulatory surgical centers (continued)*** 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. ✓ *Prior authorization may apply, see page 64 for more information.*		
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. Call our Behavioral Health department at 800.673.8043 with questions. ✓ *Prior authorization may apply, see page 64 for more information.*	$55 per day for Medicare-covered partial hospitalization services.	40% for Medicare-covered partial hospitalization services.

Important: If you receive services outside of the benefit described, an additional cost share may apply.		
Services that are covered for you	**What you must pay when you get these services**	
	In-network:	**Out-of-network:**
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 • If you're living with a long-term illness and want to talk to a physician about getting relief from the symptoms and physical and mental stress, visit a palliative care physician. • Basic hearing and balance exams performed by your PCP or specialist, if your doctor orders it to see if you need medical treatment. • Second opinion prior to surgery Please see **"Virtual care"** in this medical benefits chart for information on what services are covered. **Note:** To determine if your provider is a PCP or a Specialist, see Chapter 3, Section 2.1. 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.	\$15 for each Medicare-covered visit with a PCP. \$0 for each palliative care physician office visit. \$40 for each Medicare-covered visit with a specialist. \$0 for surgical procedures performed by a physician/practitioner in a provider's office. \$50 for each urgently needed Medicare-covered visit in a physician's office after hours.	30% for each Medicare-covered visit with a PCP, palliative care physician, or specialist. 30% for surgical procedures performed by a physician/practitioner in a provider's office. \$50 for each urgently needed Medicare-covered visit in a physician's office after hours.

Use the out-of-state travel benefit anywhere in the U.S. when outside the state of Michigan and pay the same as when you're in-network. See Chapter 4, Section 2.3 for more information.

Important: If you receive services outside of the benefit described, an additional cost share may apply.		
Services that are covered for you	**What you must pay when you get these services**	
	In-network:	**Out-of-network:**
Physician/Practitioner services, including doctor's office visits *(continued)* ✓ *Prior authorization may apply, see page 64 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 certain medical conditions affecting the lower limbs, such as diabetes with compromised circulation.	\$40 for each Medicare-covered visit. \$0 for nail debridement & callous removal, for members with specific medical conditions.	30% for each Medicare-covered visit. 30% for nail debridement & callous removal, for members with specific medical conditions.
Post-discharge in-home medication reconciliation Immediately following a hospital or SNF inpatient stay, a qualified health care provider, in cooperation with your physician, will review/reconcile a complete medication regimen. 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.	\$0 for these services.	

Important: If you receive services outside of the benefit described, an additional cost share may apply.		
Services that are covered for you	**What you must pay when you get these services**	
	In-network:	**Out-of-network:**
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."	There is no copayment for an annual PSA test.	30% for an annual PSA test.
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 page 64 for more information.*	$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.	30% for Medicare-covered prosthetic devices and supplies.

Important: If you receive services outside of the benefit described, an additional cost share may apply.		
Services that are covered for you	**What you must pay when you get these services**	
	In-network:	**Out-of-network:**
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.	$15 for each Medicare-covered pulmonary rehabilitation service.	30% for each Medicare-covered pulmonary rehabilitation service.
Rural Health Clinic Rural health clinics are located in rural, underserved areas where there are physician shortages. Covered services must meet state and federal requirements by offering primary and preventive care services. The following lab tests are provided at rural health clinics, see *"Outpatient diagnostic tests and therapeutic services and supplies"* for cost share, within this Medical Benefits Chart: • Stick or tablet chemical urine exam or both • Hemoglobin or hematocrit • Blood sugar • Occult blood stool specimens exam • Pregnancy tests • Primary culturing to send to a certified laboratory	$15 for each rural health clinic visit.	30% for each rural health clinic visit.
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.	There is no copayment for the Medicare-covered screening and counseling to reduce alcohol misuse.	30% for the Medicare-covered screening and counseling to reduce alcohol misuse.

Important: If you receive services outside of the benefit described, an additional cost share may apply.		
Services that are covered for you	**What you must pay when you get these services**	
	In-network:	**Out-of-network:**
Screening and counseling to reduce alcohol misuse *(continued)* 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.		
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 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.	There is no copayment for the Medicare-covered counseling and shared decision making visit or for the LDCT.	30% for the Medicare-covered counseling and shared decision making visit or for the LDCT.

Important: If you receive services outside of the benefit described, an additional cost share may apply.		
Services that are covered for you	**What you must pay when you get these services**	
	In-network:	**Out-of-network:**
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.	There is no copayment for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.	30% for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.
Services to treat kidney disease 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)	$0 for Medicare-covered kidney disease education services. 20% for each Medicare-covered renal dialysis service with an in-network provider or when you are outside of the plan's service area.	30% for Medicare-covered kidney disease education services. 30% for each Medicare-covered renal dialysis service with an out-of-network provider when you are in the plan's service area.

Use the out-of-state travel benefit anywhere in the U.S. when outside the state of Michigan and pay the same as when you're in-network. See Chapter 4, Section 2.3 for more information.

Important: If you receive services outside of the benefit described, an additional cost share may apply.		
Services that are covered for you	**What you must pay when you get these services**	
	In-network:	**Out-of-network:**
Services to treat kidney disease *(continued)* • 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."		
SilverSneakers® (Fitness) SilverSneakers can help you live a healthier, more active life through fitness and social connection. You are covered for a fitness benefit through SilverSneakers at participating locations. You have access to instructors who lead specially designed group exercise classes. At participating locations nationwide, you can take classes plus use exercise equipment and other amenities. Additionally, SilverSneakers FLEX® gives you options to get active outside of traditional gyms (like recreation centers, malls and parks). SilverSneakers also connects you to a support network and virtual resources through SilverSneakers LIVE, SilverSneakers On-Demand™ and our mobile app, SilverSneakers GO™.	$0 for SilverSneakers® comprehensive fitness program.	

Important: If you receive services outside of the benefit described, an additional cost share may apply.		
Services that are covered for you	**What you must pay when you get these services**	
	In-network:	**Out-of-network:**
SilverSneakers® (Fitness) ***(continued)*** All you need to get started is your personal SilverSneakers ID number. Go to *SilverSneakers.com* to learn more about your benefit or call 1-888-423-4632 (TTY: 711) Monday through Friday, 8 a.m. to 8 p.m. ET. **Always talk with your doctor before starting an exercise program.**		
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.") Covered up to 100 days per benefit period (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	For Medicare-covered services for each benefit period† you pay: $0 per day for days 1-20. $188 per day for days 21-100.	For Medicare-covered services for each benefit period†, you pay 30% for each stay.

Important: If you receive services outside of the benefit described, an additional cost share may apply.		
Services that are covered for you	**What you must pay when you get these services**	
	In-network:	**Out-of-network:**
Skilled nursing facility (SNF) care ***(continued)*** • Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors.) • Blood - including storage and administration. Coverage of whole blood and packed red cells (as well as other components of blood).  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.		

 Use the out-of-state travel benefit anywhere in the U.S. when outside the state of Michigan and pay the same as when you're in-network. See Chapter 4, Section 2.3 for more information.

Important: If you receive services outside of the benefit described, an additional cost share may apply.		
Services that are covered for you	**What you must pay when you get these services**	
	In-network:	**Out-of-network:**
Skilled nursing facility (SNF) care *(continued)* †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. ✓ *Prior authorization may apply, see page 64 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 inpatient or outpatient cost sharing. Each counseling attempt includes up to four face-to-face visits.	There is no copayment for the Medicare-covered smoking and tobacco use cessation preventive benefits.	30% for the Medicare-covered smoking and tobacco use cessation preventive benefits.

Important: If you receive services outside of the benefit described, an additional cost share may apply.		
Services that are covered for you	**What you must pay when you get these services**	
	In-network:	**Out-of-network:**
Supervised Exercise Therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD). Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.	$15 for each Medicare-covered SET visit.	30% for each Medicare-covered SET visit.

Important: If you receive services outside of the benefit described, an additional cost share may apply.		
Services that are covered for you	**What you must pay when you get these services**	
	In-network:	**Out-of-network:**
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.	$0 for these services.	
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. **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. See Chapter 6, Section 8.1, for more information on what happens when you get a Part D drug in a medical setting.	**In- and out-of-service area:** $50 for each Medicare-covered urgent care provider visit. Out-of-network cost sharing will apply toward your combined out-of-pocket maximum. You do not pay this amount if you are admitted to the hospital within 24 hours for the same condition.	

Important: If you receive services outside of the benefit described, an additional cost share may apply.		
Services that are covered for you	**What you must pay when you get these services**	
	In-network:	**Out-of-network:**

Virtual care
(also referred to as telehealth services, virtual check-ins or eVisits)
 	
Members have the option to receive health care services in places like your home from the following providers:
• Primary care providers (PCPs)
• Specialists
• Behavioral health providers
 	
Covered telehealth services include virtual visits, evaluations, communication via telephone, or video (computer, smart phone, tablet, online patient portal). Ask one of our network providers if they can do virtual visits.
 	
• Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home.
• Telehealth services to diagnose, evaluate, or treat symptoms of a stroke regardless of your location
• Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location
• Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if**:
  • You're not a new patient **and**
  • The check-in isn't related to an office visit in the past 7 days **and**
  • The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment
	$0 for virtual visits.	Not covered.

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Important: If you receive services outside of the benefit described, an additional cost share may apply.		
Services that are covered for you	**What you must pay when you get these services**	
	In-network:	**Out-of-network:**

Virtual care
(also referred to as telehealth services, virtual check-ins or eVisits) ***(continued)***
• Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours **if**:
  • You're not a new patient **and**
  • The evaluation isn't related to an office visit in the past 7 days **and**
  • The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment
• Consultation your doctor has with other doctors by phone, internet, or electronic health record		

Vision care **Medicare-covered vision care:** • 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.	**Medicare-covered vision care:** $0 for annual glaucoma screenings. $0 for Medicare-covered eyewear after cataract surgery. $0 for annual diabetic retinopathy screening. $40 for each Medicare-covered exam to diagnose and treat diseases or conditions of the eye.	**Medicare-covered vision care:** 30% for annual glaucoma screenings, Medicare-covered eyeglasses or contact lenses after cataract surgery, annual diabetic retinopathy screening, and each Medicare-covered exam to diagnose and treat diseases or conditions of the eye.

Use the out-of-state travel benefit anywhere in the U.S. when outside the state of Michigan and pay the same as when you're in-network. See Chapter 4, Section 2.3 for more information.

Important: If you receive services outside of the benefit described, an additional cost share may apply.		
Services that are covered for you	**What you must pay when you get these services**	
	In-network:	**Out-of-network:**
Vision care *(continued)* For people with diabetes, screening for diabetic retinopathy is covered once per year. If your visit involves other services you will not be charged for the office visit. • 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.		
Non-Medicare covered routine vision care:* • You have access to these benefits yearly, you may choose to use an in-network EyeMed "Select" provider OR use a non-EyeMed "Select" provider and seek reimbursement. • Call 844.366.5127 to locate a provider, Monday through Friday from 8 a.m. to 8 p.m. or visit *eyemed.com* and select "Find an eye doctor" then choose the "Select" network to search for an in-network provider. • For additional details about your EyeMed benefits, go to the back of this document and locate the Appendix.	**Covered services with an EyeMed "Select" provider:** $0 for one non-Medicare covered routine vision exam, including dilation and refraction as necessary.* $0 for one non-Medicare covered retinal imaging.* $100 allowance for non-Medicare covered eyewear.* These vision services do not apply to your combined out-of-pocket maximum. **Services with a non-EyeMed "Select" provider:** Up to $50 reimbursement for one non-Medicare covered routine vision exam, including dilation and refraction as necessary.* Up to $20 reimbursement for one non-Medicare covered retinal imaging.* Up to $100 reimbursement for non-Medicare covered eyewear.*	

Use the out-of-state travel benefit anywhere in the U.S. when outside the state of Michigan and pay the same as when you're in-network. See Chapter 4, Section 2.3 for more information.

Important: If you receive services outside of the benefit described, an additional cost share may apply.		
Services that are covered for you	**What you must pay when you get these services**	
	In-network:	**Out-of-network:**
Vision care *(continued)* For additional vision coverage, see Chapter 4, Section 2.2 *Extra "optional supplemental" benefits you can buy* for an additional premium.		
"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 (such as a one-time EKG/ECG screening). **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.	There is no copayment for the "Welcome to Medicare" preventive visit.	30% for the "Welcome to Medicare" preventive visit.
Worldwide assistance program* Our plan offers you emergency travel assistance services that can be used during your emergency and urgently needed care benefits. The following emergency travel assistance services are available through Assist America: • The travel assistance services are available worldwide, while traveling domestically or internationally, when you are traveling more than 100 miles from home or in another country for up to 90 consecutive days.	$0 for services furnished through Assist America.* You will still pay for benefits covered by Priority Health Medicare, such as emergent/urgent care or prescription drugs.	

Use the out-of-state travel benefit anywhere in the U.S. when outside the state of Michigan and pay the same as when you're in-network. See Chapter 4, Section 2.3 for more information.

Important: If you receive services outside of the benefit described, an additional cost share may apply.		
Services that are covered for you	**What you must pay when you get these services**	
	In-network:	**Out-of-network:**
Worldwide assistance program* ***(continued)*** • Worldwide emergency medical travel assistance services are accessible 24 hours a day, 365 days a year. • Assistance with emergency care and hospital admission when traveling more than 100 miles from home or in a foreign country. • Emergency evacuation or transportation services are available to the nearest facility capable of providing proper care, if care is not locally available. • Round-trip transportation for a family member or friend to be with you, if you are expected to be hospitalized for more than seven days while traveling alone. • Help replacing forgotten or lost prescription (additional costs may apply for the prescription drugs). • In case of death, provide for the return of your mortal remains to your legal residence. Contact Assist America: within the U.S. by calling 1-800-872-1414, outside the U.S. using +1-609-986-1234, or by downloading the free Assist America Mobile App for Android and iPhone. The Assist America reference number for Priority Health Medicare members is 01-AA-PHP-12123M. **Note:** No claims for reimbursement will be accepted.		

Use the out-of-state travel benefit anywhere in the U.S. when outside the state of Michigan and pay the same as when you're in-network. See Chapter 4, Section 2.3 for more information.

Section 2.2 Extra "optional supplemental" benefits you can buy

Our plan offers some extra benefits that are not covered by Original Medicare and not included in your benefits package as a plan member. These extra benefits are called "**Optional Supplemental Benefits."** If you want these optional supplemental benefits, you must sign up for them and you will have to pay an additional premium for them. The optional supplemental benefits described in the Appendix located at the back of this document are subject to the same appeals process as any other benefits. **Priority**Medicare Select offers optional supplemental dental and vision benefits, called the enhanced dental and vision package.

For more information about the dental and vision benefits you would receive if purchasing the Enhanced dental and vision package, please go to the back of this document and look for the Appendix.

How much will I pay?
The premium amount for the enhanced dental and vision package in 2022 will be:

$29.00/month

How do I enroll?
If you did not elect to add the enhanced dental and vision package on the enrollment form when you enrolled in **Priority**Medicare Select, you will need to complete a separate enhanced dental and vision enrollment form. You can enroll by calling 877.333.3013 from 8 a.m. to 8 p.m., seven days a week (TTY users should call 711); or going online to download the enrollment form or enroll online at *priorityhealth.com/enrolldv*. If you'd like to request an informational packet that includes the enhanced dental and vision package enrollment form and summary of benefits please call 888.389.6648, from 8 a.m. to 8 p.m., seven days a week. TTY users should call 711.

When can I enroll?
The enhanced dental and vision package is offered to all Medicare beneficiaries enrolling into the **Priority**Medicare Select plan at the time of enrollment or up to two months after your **Priority**Medicare Select plan's effective date. For example, if your **Priority**Medicare Select plan's effective date is January 1, you can enroll in the enhanced dental and vision package through the end of February. Your effective date is the first of the month following receipt of your completed and signed enrollment form. Once you are enrolled in the enhanced dental and vision package, you remain continuously enrolled in this plan.

How/when do I pay?
The way you choose to pay your Medicare Advantage premium will automatically be the same method that's used to pay your monthly premium for the enhanced dental and vision package, which can be by check or money order, through electronic funds transfer (EFT) or through a deduction from your Social Security check.

If we have not received your premium payment by the date it is due, we will notify you in writing, 60 days before your membership in the enhanced dental and vision package is subject to

end. For more information about how to pay your premium or what to do if you are having trouble paying your plan premium see Chapter 1, Section 4.

What if I sign up & decide I want to disenroll?
You may voluntarily disenroll from the enhanced dental and vision package in writing at Priority Health, MS 1175, 1231 E. Beltline NE, Grand Rapids, MI 49525 or email to *PH-MedicareEnrollment@priorityhealth.com*. For your convenience, you can find a disenrollment form on *priorityhealth.com* and click on **Already a Member**. Your disenrollment will be effective on the first day of the month following receipt of your completed and signed disenrollment request. Benefits will cease on the last day of the month in which you are enrolled. You do not need to pay any monthly premiums after your termination date unless you have a past balance due. If you paid a complete annual premium, you are entitled to a pro-rated refund for the remaining portion of the year. You will be refunded within 30 calendar days of receipt of your disenrollment. If coverage is terminated during the calendar year, you may not re-enroll until the next annual election or special election period.

Section 2.3 Getting care using our plan's out-of-state travel benefit

Your plan includes an out-of-state travel benefit. This is a supplemental benefit we provide. It allows you to receive all plan covered services at in-network cost sharing anywhere in the United States and its territories when you're outside the state of Michigan. You will pay out-of-network cost sharing if you seek services with a provider who is not in our network within the state of Michigan. We encourage you to call Customer Service so we can assist you in finding a Medicare-participating provider and to help arrange services.

We've partnered with MultiPlan to make accessing Medicare-participating providers even easier. To find a Medicare-participating provider or a MultiPlan Medicare provider, call Customer Service or go online to *prioritymedicare.com* and search Find a Doctor.

When seeking services provided by TruHearing, Mom's Meals, Assist America, BrainHQ, and SilverSneakers®, you will need to use their network, which is available nationwide.

When seeking dental services, please note:

- In-network benefits apply when using dentists in the Delta Dental Medicare Advantage PPO and Delta Dental Medicare Advantage Premier network in Michigan, Ohio, and Indiana.
- When using your out-of-state travel benefit (outside of Michigan, Ohio and Indiana) access Delta Dental PPO or Premier providers and pay in-network costs. To find a provider go to *www.providers4you.com/medicareadvantagetraveler* or call 800.330.2732 (TTY users should call 711), Monday through Friday 8 a.m. to 8 p.m.
- Out-of-network benefits apply when using any other dentist who is not excluded from treating Medicare members.

You will remain enrolled in our plan when outside of the service area for up to 12 months as long as your residency remains in the service area. If you have not returned to the plan's service area within 12 months, you will be disenrolled from the plan.

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	Not covered under any condition	When covered
Acupuncture		Routine acupuncture services covered under your plan are described in Chapter 4, Section 2.1 of the Medical Benefits Chart.
Adaptive equipment - see Chapter 12, *Definitions of important words* for adaptive equipment	X	

Service not covered by Medicare	Not covered under any condition	When covered
Ambulance - mileage for ambulance transport beyond nearest facility or to/from facility preferred by member and/or family		May be covered under your Worldwide assistance program. See Chapter 4 Section 2.1, Medical Benefits Chart.
Assistive listening devices -including but not limited to telephone amplifiers and alerting devices	X	
Bathroom safety devices – including but not limited to lifts, raised toilet seats, bidet toilet seats, transfer benches, walk-in bathtub, grab bars, and parallel bars	X	
Beds – mattresses, oscillating, bed baths (home type), boards, lifter (elevator), lounges (power or manual)	X	
Blood Glucose Analyzers - reflectance colorimeter	X	
Blood pressure cuff (i.e. pulse tachometer)	X	
Chiropractic care - maintenance care, x-ray, labs, and any other service done within the office other than what is explained in Chapter 4, Section 2.1 of the Medical Benefits Chart.	X	
Cosmetic surgery or procedures		Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member. Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
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	X	

Service not covered by Medicare	Not covered under any condition	When covered
Cruise ship services		Medicare may cover medically necessary health care services you get on a cruise ship in these situations: The doctor is allowed under certain laws to provide medical services on the cruise ship. The ship is in a U.S. port or no more than 6 hours away from a U.S. port when you get the services, regardless of whether it's an emergency. Medicare doesn't cover health care services you get when the ship is more than 6 hours away from a U.S. port.
Custodial care – see Chapter 12, *Definitions of important words* for custodial care	X	
Dental services		Dental care required to treat illness or injury may be covered as inpatient or outpatient care. Priority Health will determine if you meet Medicare's medically necessary criteria. Routine dental services covered under your medical plan are described in Chapter 4, Section 2.1 of the Medical Benefits Chart. If you purchase the enhanced dental and vision package, which is an optional supplemental benefit for an extra premium, additional dental services are covered, see Chapter 4, Section 2.2 for details.

Service not covered by Medicare	Not covered under any condition	When covered
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.	X	
Drugs (Part D under your prescription drug benefit) - purchased from or obtained while in another country including those obtained on a cruise ship that are considered self-administered. These are considered non-FDA approved.	X	
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.		You may be eligible for reimbursement under your prescription drug coverage
Emergency Communication Systems - such as Personal Emergency Response System (PERS), medical alert devices, in-home telephone alert systems	X	
Experimental medical and surgical procedures, equipment and medications. Experimental procedures and items are those items and procedures determined by our plan and Original Medicare to not be generally accepted by the medical community.		May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan. (See Chapter 3, Section 5 for more information on clinical research studies.)
FDA - services not approved by the federal Food and Drug Administration.	X	
Fees - charged by your immediate relatives or members of your household.	X	

Service not covered by Medicare	Not covered under any condition	When covered
Foot – routine care *Discuss foot care with your physician to find out if covered or call customer service for more information.*		Some limited coverage provided according to Medicare guidelines (e.g., if you have diabetes).
Full-time nursing care in your home	X	
Gender reassignment - surgery and gender reassignment hormones		If determined by Priority Health to meet medical necessity criteria
Hearing (routine/non-Medicare covered) - hearing aid exams, hearing aids or evaluations including the fitting and checking of hearing aids		Routine hearing services covered under your medical plan are described in Chapter 4, Section 2.1 of the Medical Benefits Chart.
Homemaker services - including household assistance, light housekeeping or light meal preparation	X	
Incontinent - pads or supplies	X	
Knee walker	X	
Lab tests - not medically necessary under Medicare coverage criteria. *Discuss labs with your physician to find out if covered or call customer service for more information.*	X	
Lift Chair – chair/recliner portion is not covered		The lifting mechanism of a lift chair may be covered if determined by Priority Health to meet medical necessity criteria.
Long-term care - see Chapter 12, *Definitions of important words*, for long-term care	X	
Massage therapy - performed by a massage therapist	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	X	

Service not covered by Medicare	Not covered under any condition	When covered
Naturopathic / Homeopathic services (uses natural or alternative treatments).	X	
Personal items - in your room at a hospital or skilled nursing facility, including but not limited to a telephone or television	X	
Physical exams and other services - required by third parties such as 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.	X	
Private duty nurses	X	
Private room - when semi-private rooms are available	X	
Precluded providers - services from providers who appear on the CMS Preclusion List. See Chapter 12, *Definitions of important words*, for CMS Preclusion List.	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	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.	X	
Reversal of sterilization procedures and or non-prescription contraceptive supplies.	X	
Smart devices - (smart phones and the cost of the applications, tablets, personal computers, etc.)	X	

Service not covered by Medicare	Not covered under any condition	When covered
Structural modifications - including but not limited to ramps, doorways, elevators and stairway elevators	X	
Support hose	X	
Surgical leggings	X	
Temporomandibular Joint Syndrome (TMJ)	X	
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.	X	
VA - services provided to veterans in Veterans Affairs (VA) facilities	X	
Vision (routine/non-Medicare covered) - eye exam, eyewear, refraction, retinal imaging, and fitting of eyewear.		Routine vision services covered under your medical plan are described in Chapter 4, Section 2.1 of the Medical Benefits Chart. If you purchase the enhanced dental and vision package, which is an optional supplemental benefit for an extra premium, additional vision services are covered, see Chapter 4, Section 2.2 for details.
Vision (services) – Radial keratotomy and keratoplasty to treat refractive defects, laser astigmatism correction, LASIK or LASEK surgery and other low vision aids. Nonconventional intraocular lenses (IOLs) following cataract surgery (for example a presbyopia-correcting IOL)	X	
War related - items or services needed whether due or related to injuries caused by war or an act of war are not covered.	X	

Service not covered by Medicare	Not covered under any condition	When covered
Weight loss - treatment, including but not limited to non-Medicare covered weight loss programs and meal programs	X	
Wigs	X	

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 will send 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 Select 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 and Part C, 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 both retail and mail-order pharmacies that offer standard cost sharing and both retail and mail-order 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 (*prioritymedicare.com*), 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 calling Customer Service (phone numbers are printed on the back of this booklet). 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. Or if the pharmacy you have been using stays within the network but is no longer offering preferred cost sharing, you may want to switch to a different pharmacy. 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 *prioritymedicare.com*.

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 long-term care 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.

Our pharmacy network includes mail-order pharmacies that offer standard cost sharing and mail-order pharmacies that offer preferred cost sharing. Preferred cost sharing for mail-order is limited to our preferred mail-order pharmacy, Express Scripts, but you may choose any network mail-order pharmacy to receive your covered prescription drugs. Your cost sharing may be less at Express Scripts.

To get order forms and information about filling your prescriptions by mail call Customer Service or visit our website at *prioritymedicare.com*. 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 calling the Customer Service number on the back of your card.

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 calling the Customer Service number on the back of your card.

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 us by calling the Customer Service number on the back of your card.

Refills on mail-order prescriptions. For refills of your drugs, you have the option to sign up for an automatic refill program. Under this program we will start to process your next refill automatically when our records show you should be close to running out of your drug. The pharmacy will contact you prior to shipping each refill to make sure you are in need of more medication, and you can cancel scheduled refills if you have enough of your medication or if your medication has changed. If you choose not to use our auto refill program, please contact your pharmacy 14 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.

To opt out of our program that automatically prepares mail-order refills, please contact us by calling the Customer Service number on the back of your card.

So the 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 preferred mail-order 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. Some of these retail pharmacies (which may offer preferred cost sharing) may agree to accept a lower cost-sharing amount for 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 references, such as the American Hospital Formulary Service Drug Information and the DRUGDEX Information System.

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 about this, see Section 7.1 in this chapter).
- In other cases, we have decided not to include a particular drug on our Drug List.

Section 3.2 There are 5 "cost-sharing tiers" for drugs on the Drug List

Every drug on the plan's Drug List is in one of 5 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 (*prioritymedicare.com*). 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 may 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 usually 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 (*prioritymedicare.com*).

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 5

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 must 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 calendar**

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 year if you were in the plan last year**. The total supply will be for a maximum of a 31-day supply. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of a 31-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 temporary supply situation.

- Per CMS regulations, **Priority**Medicare Select 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 specialty tier are not eligible for this type of exception. We do not lower the cost-sharing amount for drugs in this tier.

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.**

We must follow Medicare requirements before we change the plan's Drug List.

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

Information on changes to drug coverage

When changes to the Drug List occur during the year, we post information on our website about those changes. We will update our online Drug List on a regularly scheduled basis to include any changes that have occurred after the last update. Below we point out the times that you would get direct notice if changes are made to a drug that you are then taking. You can also call Customer Service for more information (phone numbers are printed on the back cover of this booklet).

Do changes to your drug coverage affect you right away?

Changes that can affect you this year: In the below cases, you will be affected by the coverage changes during the current year:

- **A new generic drug replaces a brand name drug on the Drug List (or we change the cost-sharing tier or add new restrictions to the brand name drug or both)**
    - We may immediately remove a brand name drug on our Drug List if we are replacing it with a newly approved generic version of the same drug that will appear on the same or lower cost-sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the

brand name drug on our Drug List, but immediately move it to a higher cost-sharing tier or add new restrictions or both.

- We may not tell you in advance before we make that change—even if you are currently taking the brand name drug.
- You or your prescriber can ask us 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)*).
- If you are taking the brand name drug at the time we make the change, we will provide you with information about the specific change(s) we made. This will also include information on the steps you may take to request an exception to cover the brand name drug. You may not get this notice before we make the change.

- **Unsafe drugs and other drugs on the Drug List that are withdrawn from the market**
  - Once in a while, a drug may be suddenly withdrawn because it has been found to be unsafe or removed from the market for another reason. If this happens, we will immediately remove the drug from the Drug List. If you are taking that drug, we will let you know of this change right away.
  - Your prescriber will also know about this change, and can work with you to find another drug for your condition.
- **Other changes to drugs on the Drug List**
  - We may make other changes once the year has started that affect drugs you are taking. For instance, we might add a generic drug that is not new to the market to replace a brand name drug or change the cost-sharing tier or add new restrictions to the brand name drug or both. We also might make changes based on FDA boxed warnings or new clinical guidelines recognized by Medicare. We must give you at least 30 days' advance notice of the change or give you notice of the change and a 30-day refill of the drug you are taking at a network pharmacy.
  - After you receive notice of the change, you should be working with your prescriber to switch to a different drug that we cover.
  - Or you or your prescriber can ask us to make an exception and continue to cover the 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)*).

Changes to drugs on the Drug List that will not affect people currently taking the drug: For changes to the Drug List that are not described above, if you are currently taking the drug, the following types of changes 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.

If any of these changes happen for a drug you are taking (but not because of a market withdrawal, a generic drug replacing a brand name drug, or other change noted in the sections above), 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. You will not get direct notice this year about changes that do not affect you. However, on January 1 of the next year, the changes will affect you, and it is important to check the Drug List in the new benefit year for any changes to drugs.

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 references, such as the American Hospital Formulary Service Drug Information and the DRUGDEX Information System. If the use is not supported by any of these references, 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.
- 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.

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 facility (LTC) (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 a 31-day supply, or less if your prescription is written for fewer days. (Please note that the long-term care 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 **that group's benefits administrator.** He or she can help you determine how your current prescription drug coverage will work with our plan.

In general, if you are currently employed, the prescription drug coverage you get from us will be *secondary* to your employer or retiree group coverage. That means your group coverage would pay first.

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 calendar 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 employer or retiree group plan, you can get a copy from the employer or retiree group's benefits administrator or the employer or union.

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 antianxiety 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
- Unsafe amounts of opioid pain medications

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

Section 10.2 Drug Management Program (DMP) to help members safely use their opioid medications

We have a program that can help make sure our members safely use their prescription opioid medications, and other medications that are frequently abused. This program is called a Drug Management Program (DMP). If you use opioid medications that you get from several doctors or pharmacies, or if you had a recent opioid overdose, we may talk to your doctors to make sure your use of opioid medications is appropriate and medically necessary. Working with your doctors, if we decide your use of prescription opioid or benzodiazepine medications is not safe, we may limit how you can get those medications. The limitations may be:

- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain pharmacy(ies)
- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain doctor(s)
- Limiting the amount of opioid or benzodiazepine medications we will cover for you

If we think that one or more of these limitations should apply to you, we will send you a letter in advance. The letter will have information explaining the limitations we think should apply to you. You will also have an opportunity to tell us which doctors or pharmacies you prefer to use, and about any other information you think is important for us to know. After you've had the opportunity to respond, if we decide to limit your coverage for these medications, we will send you another letter confirming the limitation. If you think we made a mistake or you disagree with our determination that you are at-risk for prescription drug misuse or with the limitation, you and your prescriber have the right to ask us for an appeal. If you choose to appeal, we will review your case and give you a decision. If we continue to deny any part of your request related to the limitations that apply to your access to medications, we will automatically send your case to an independent reviewer outside of our plan. See Chapter 9 for information about how to ask for an appeal.

The DMP may not apply to you if you have certain medical conditions, such as cancer or sickle cell disease, you are receiving hospice, palliative, or end-of-life care, or live in a long-term care facility.

Section 10.3 Medication Therapy Management (MTM) program to help members manage their medications

We have a program that can help our members with complex health needs.

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 and have high drug costs, or are in a DMP to help members use their opioids safely 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. In addition, members in the MTM program will receive information on the safe disposal of prescription medications that are controlled substances.

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 will send 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 5 "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 *prioritymedicare.com*. 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 two 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 Select members?

As shown in the table below, there are "drug payment stages" for your prescription drug coverage under **Priority**Medicare Select. 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 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. (Details are in Section 4 of this chapter.)	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 $4,430. (Details are in Section 5 of this chapter.)	During this stage, you pay 25% of the price for brand name drugs **(**plus a portion of the dispensing fee) and 25% of the price for generic drugs. You stay in this stage until your year-to-date **"out-of-pocket costs"** (your payments) reach a total of $7,050. 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 calendar year (through December 31, 2022). (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 summary 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 summary 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. The Part D EOB provides more information about the drugs you take, such as increases in price and other drugs with lower cost sharing that may be

available. You should consult with your prescriber about these lower cost options. The Part D EOB 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 drugs costs, what the plan paid, and what you and others on your behalf paid.
- **Totals for the year since January 1.** This is called "year-to-date" information. It shows you the total drug costs and total payments for your drugs since the year began.
- **Drug price information.** This information will display the total drug price, and any percentage change from first fill for each prescription claim of the same quantity.
- **Available lower cost alternative prescriptions.** This will include information about other drugs with lower cost sharing for each prescription claim that may be available.

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 the *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 Select

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

There is no deductible for **Priority**Medicare Select. 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 5 cost-sharing tiers

Every drug on the plan's Drug List is in one of 5 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
- A network mail-order pharmacy that offers standard cost sharing
- The plan's preferred mail-order pharmacy, Express Scripts, that offers preferred cost sharing

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:

Tier	**Standard and preferred retail cost sharing (in-network)** (up to a 30-day supply)	**Standard and preferred (Express Scripts) 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*)	**Standard:** $6 **Preferred:** $1	**Standard:** $6 **Preferred:** $1	$6	$6
Cost-Sharing Tier 2 (*generic drugs*)	**Standard:** $12 **Preferred:** $7	**Standard:** $12 **Preferred:** $7	$12	$12
Cost-Sharing Tier 3 (*preferred brand drugs*)	**Standard:** $42 **Preferred:** $37	**Standard:** $42 **Preferred:** $37	$42	$42
Cost-Sharing Tier 4 (*non-preferred drugs*)	**Standard:** 50% **Preferred:** 45%	**Standard:** 50% **Preferred:** 45%	50%	50%
Cost-Sharing Tier 5 (*specialty drugs*)	**Standard:** 33% **Preferred:** 33%	**Standard:** 33% **Preferred:** 33%	33%	33%

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 you 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 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 and preferred retail cost sharing (in-network) (up to a 90-day supply)	Standard and preferred (Express Scripts) mail-order cost sharing (up to a 90-day supply)
Cost-Sharing Tier 1 (*preferred generic drugs*)	**Standard:** $18 **Preferred:** $3	**Standard:** $18 **Preferred:** $0
Cost-Sharing Tier 2 (*generic drugs*)	**Standard:** $36 **Preferred:** $21	**Standard:** $36 **Preferred:** $0
Cost-Sharing Tier 3 (*preferred brand drugs*)	**Standard:** $126 **Preferred:** $111	**Standard:** $126 **Preferred:** $92.50
Cost-Sharing Tier 4 (*non-preferred drugs*)	**Standard:** 50% **Preferred:** 45%	**Standard:** 50% **Preferred:** 45%
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.

Section 5.5 You stay in the Initial Coverage Stage until your total drug costs for the year reach $4,430

You stay in the Initial Coverage Stage until the total amount for the prescription drugs you have filled and refilled reaches the **$4,430 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 2022, the amount that plan paid during the Initial Coverage Stage also counts toward your total drug costs.)

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 for your drugs during the year. Many people do not reach the $4,430 limit in a year.

We will let you know if you reach this $4,430 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 receive a discount on brand name drugs and pay no more than 25% of the costs for generic drugs

Section 6.1 You stay in the Coverage Gap Stage until your out-of-pocket costs reach $7,050

When you are in the Coverage Gap Stage, the Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs. You pay 25% of the negotiated price and a portion of the dispensing fee for brand name drugs. 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 moves you through the coverage gap.

You also receive some coverage for generic drugs. You pay no more than 25% of the cost for generic drugs and the plan pays the rest. For generic drugs, the amount paid by the plan (75%) does not count toward your out-of-pocket costs. Only the amount you pay counts and moves you through the coverage gap.

You continue paying the discounted price for brand name drugs and no more than 25% of the costs of generic drugs until your yearly out-of-pocket payments reach a maximum amount that Medicare has set. In 2022, that amount is $7,050.

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 $7,050, 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 calendar 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 $7,050 in out-of-pocket costs within the calendar 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 allowed to include</u>** 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 Part D 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) summary 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 $7,050 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 $7,050 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.

During this stage, the plan will pay most of the cost for your drugs.

- **Your share** of the cost for a covered drug will be either coinsurance or a copayment, whichever is the *larger* amount:
  - – *either* – coinsurance of 5% of the cost of the drug
  - – *or* – $3.95 for a generic drug or a drug that is treated like a generic and $9.85 for all other drugs.
- **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. Remember you are responsible for all of the costs for any vaccine administration fees during the Coverage Gap Stage of your benefit.

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 medical care from a provider who is not in our plan's network

When you received care 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. (Your share of the cost may be higher for an out-of-network provider than for a network provider.) 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 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 1.3.
- 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 (*prioritymedicare.com*) 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 paid receipts to us at this address:

Attn: Priority Health Claims
Priority Health
PO 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 E. Beltline 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. You may also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights. Contact information is included in this Evidence of Coverage or you may contact Customer Service for additional information.

Section 1.2 We must ensure that you get timely access to your covered services and drugs

You have the right to choose a provider in the plan's network. 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 and still pay the in-network cost-sharing amount.

As a plan member, you have the right to get appointments and covered services from your 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 1.3 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 health care 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 Chapter 11, Section 7, *Legal Notices*, for our complete privacy policy.

Section 1.4 We must give you information about the plan, its network of providers, and your covered services

As a member of **Priority**Medicare Select, 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 Star 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 *prioritymedicare.com*.
- **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 1.5 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).
- **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 & Regulatory Affairs, Bureau of Community and Health Systems - Health Facility Complaints, P.O. Box 30664, Lansing, MI 48909. Phone: 800.882.6006. Fax: 517.335.7167. Email: *BCHS-Complaints@michigan.gov*.

Section 1.6 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 1.7 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 our 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 1.8 You have the right to make recommendations about the **Priority**Medicare Select 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 1.9 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 our 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.
- You can contact **Medicare**.
    - You can visit the Medicare website to read or download the publication "Medicare Rights & Protections." (The publication is available at: *www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.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 tell us.** Please call Customer Service to let us know (phone numbers are printed on the back cover of this booklet).
    - 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.)
- **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 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. Some plan members must pay a premium for Medicare Part A. 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 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).
    - **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 cooperate 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)

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,” or “at-risk” 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 (*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. In limited circumstances a request for a coverage decision will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

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. In limited circumstances a request for a coverage decision will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

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 Review Organization that is not connected to us. (In some situations, your case will be automatically sent to the Independent Review Organization for a Level 2 Appeal. 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).
- You **can get free help** from your State Health Insurance Assistance Program (see Section 2 of this chapter).
- **Your doctor can make a request for you.**
    - For medical care or Part B prescription drugs, 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 *www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf* or on our website at *prioritymedicare.com*.) 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 State Health Insurance Assistance Program (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. The term "medical care" includes medical items and services as well as Medicare Part B prescription drugs. In some cases, different rules apply to a request for a Part B prescription drug. In those

cases, we will explain how the rules for Part B prescription drugs are different from the rules for medical items and services.

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 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 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 Comprehensive Outpatient Rehabilitation Facility (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:
To find out whether we will cover the medical care you want.	You can ask us to make a coverage decision for you. Go to the next section of this chapter, **Section 5.2**.
If 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.
If you want to ask us to pay you back for medical care 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 **for a medical item or service**. If your request is for a **Medicare Part B prescription drug, we will give you an answer within 72 hours** after we receive your request.

- **However,** for a request **for a medical item or service 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. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- 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 if your request is for a medical item or service. If your request is for a Medicare Part B prescription drug, we will answer within 24 hours.**
  - **However,** for a request **for a medical item or service 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. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
  - 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 ask for 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.)

Step 2: 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 on a request for a medical item or service, we will give you our answer **within 72 hours**. If your request is for a Medicare Part B prescription drug, we will answer **within 24 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. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
  - 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), or 24 hours if your request is for a Part B prescription drug, you have the right to appeal. Section 5.3 below tells how to make an appeal.
- **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 on a request for a medical item or service, we will give you our answer **within 14 calendar days of receiving your request.** If your request is for a Medicare Part B prescription drug, we will give you an answer **within 72 hours** of receiving your request.
    - For a request for a medical item or service, 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. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
    - 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), or 72 hours if your request is for a Part B prescription drug, you have the right to appeal. Section 5.3 below tells how to make an 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.

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 or Part D prescription drugs.*
- **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 or Part D prescription drugs*).
    - 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 *www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf* or on our website at *prioritymedicare.com*.) 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 or Part D prescription drugs*).
- **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, explain the reason your appeal is late when you make your appeal. 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 that 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 your request is for a medical item or service. If we decide to take extra days to make the decision, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
  - 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 Review 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 automatically send 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 on a request for a medical item or service **within 30 calendar days** after we receive your appeal if your appeal is about coverage for services you have not yet received. If your request is for a Medicare Part B prescription drug you have not yet received, we will give you our answer **within 7 calendar days** after we receive your appeal. 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 your request is for a medical item or service. If we decide to take extra days to make the decision, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
    - 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 applicable deadline above (or by the end of the extended time period if we took extra days on your request for a medical item or service), 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 authorize or provide the coverage we have agreed to provide within 30 calendar days if your request is for a medical item or service, or **within 7 calendar days** if your request is for a Medicare Part B prescription drug.
- **If our answer is no to part or all of what you requested**, we will automatically send your appeal to the Independent Review Organization for a Level 2 Appeal.

<u>Step 3:</u> 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 your request is for a medical item or service and the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The Independent Review Organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

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. If your request is for a medical item or service, the review organization must give you an answer to your Level 2 Appeal **within 30 calendar days** of when it receives your appeal. If your request is for a Medicare Part B prescription drug, the review organization must give you an answer to your Level 2 Appeal **within 7 calendar days** of when it receives your appeal.
- However, if your request is for a medical item or service and the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The Independent Review Organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

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 a request for a medical item or service,** 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 we receive the decision from the review organization for expedited requests.
- **If the review organization says yes to part or all of a request for a Medicare Part B prescription drug,** we must authorize or provide the Part B prescription drug under dispute within **72 hours** after we receive the decision from the review organization for **standard requests** or within **24 hours** from the date we receive 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 get after your Level 2 Appeal.
- The Level 3 Appeal is handled by an Administrative Law Judge or attorney adjudicator. 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, the pharmacy will give you 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?

If you are in this situation:	This is what you can do:
If 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.	You can ask us to make an exception. (This is a type of coverage decision.) Start with **Section 6.2** of this chapter.

If you are in this situation:	This is what you can do:
If 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.	You can ask us for a coverage decision. Skip ahead to **Section 6.4** of this chapter.
If you want to ask us to pay you back for a drug you have already received and paid for.	You can ask us to pay you back. (This is a type of coverage decision.) Skip ahead to **Section 6.4** of this chapter.
If 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 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. 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 5 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."**

   - If our drug list contains alternative drug(s) for treating your medical condition that are in a lower cost-sharing tier than your drug, you can ask us to cover your drug at the cost-sharing amount that applies to the alternative drug(s). This would lower your share of the cost for the drug.
     - If the drug you're taking is a brand name drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains brand name alternatives for treating your condition.

- If the drug you're taking is a generic drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains either brand or generic alternatives for treating your condition.

- You cannot ask us to change the cost-sharing tier for any drug in 5 specialty tier.
- If we approve your request for a tiering exception and there is more than one lower cost-sharing tier with alternative drugs you can't take, you will usually pay the lowest amount.

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 or are likely to cause an adverse reaction or other harm.

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 asking 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.

If your health requires it, ask us to give you a "fast coverage decision"

Legal Terms
A "fast coverage decision" is called an **"expedited coverage determination."**

- 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 ask for 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 Review 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 you can 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 Review 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 you can 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 Review 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 you can appeal.

<u>Step 3:</u> 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 medical care or 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 us when you are making an appeal about your medical care or 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 medical care or 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.

If your health requires it, ask for a "fast appeal"

Legal Terms
A "fast appeal" is also called an **"expedited redetermination."**

- 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 you can 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 for a drug you have not received yet. 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 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**
  - 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 you can appeal our decision.
- If you are requesting that we pay you back 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 give you a decision within 14 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 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 30 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 you can 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 it is for a drug you have not received yet. If you are requesting that we pay you back for a drug you have already bought, the review organization must give you an answer to your level 2 appeal **within 14 calendar days** after it receives your request.
- **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 or attorney adjudicator. 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 your right to 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 will be asked to sign the written notice to show that you received it and understand your rights.**
   - You or someone who is acting on your behalf will be asked to 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 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 the notice online at *www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices*.

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 midnight the day of your discharge.** (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, and you still wish to appeal, you must make an 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**."

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 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 *www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices*.

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 stay 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.
- 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 an Administrative Law Judge or attorney adjudicator.

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 an Administrative Law Judge or attorney adjudicator.
- 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, whichever comes first.) 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 or Part D prescription drugs*.
- **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

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 an Administrative Law Judge or attorney adjudicator.

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."**

2. **You will be asked to sign the written notice to show that you received it.**
   - You or someone who is acting on your behalf will be asked to 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).

During a Level 1 Appeal, 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 by noon of the day before the effective date on the Notice of Medicare Non-Coverage.
- If you miss the deadline for contacting the Quality Improvement Organization, and you still wish to file an appeal, you must make an 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 informed 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 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 an Administrative Law Judge or attorney adjudicator.

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 an Administrative Law Judge or attorney adjudicator.
- 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 or Part D prescription drugs*.
- **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

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 an Administrative Law Judge or attorney adjudicator.
- 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 Appeal Levels 3, 4 and 5 for Medical Service Requests

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 (called an Administrative Law Judge) or an attorney adjudicator who works for the Federal government** will review your appeal and give you an answer.

- **If the Administrative Law Judge or attorney adjudicator 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 Administrative Law Judge's or attorney adjudicator'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 or attorney adjudicator 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 or attorney adjudicator 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 Medicare **Appeals Council** (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 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 the value of the item or medical service meets the required dollar value.
    - If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the 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 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 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 appeals process.

Section 9.2 Appeal Levels 3, 4 and 5 for Part D Drug Requests

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 (called an Administrative Law Judge) or an attorney adjudicator who works for the Federal government** will review your appeal and give you an answer.

- **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 or attorney adjudicator 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 Medicare **Appeals Council** (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 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 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 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 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?
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?

Complaint	Example
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 coverage 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 attempt to resolve concerns during the first point of contact. If this is not possible, then we will attempt to do so within 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 need 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. Expedited grievances will be responded to verbally within 24 hours of receipt at Priority Health Medicare.

  If upon review of your request we see that delaying our decision will not seriously harm you medically, we will not accept the request. We will handle your request according to standard 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.
- For expedited grievances, we respond orally within 24 hours if the grievance is received orally. If the grievance is received in a written format, we will respond orally AND in writing within 24 hours. We are required by CMS to respond to all written grievances in writing.
- **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 within 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 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 Select directly to Medicare. To submit a complaint to Medicare, go to *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 Select 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.
  - There are only certain times during the year, or certain situations, when you may voluntarily end your membership in the plan. 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 and prescription drugs through our plan until your membership ends.

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 Medicare Advantage Open Enrollment Period. In certain situations, you may also be eligible to leave the plan at other times of the year.

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 Open Enrollment 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 for 63 or more days in a row, you may have 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 Open Enrollment Period

You have the opportunity to make *one* change to your health coverage during the annual **Medicare Advantage Open Enrollment Period.**

- **When is the annual Medicare Advantage Open Enrollment Period?** This happens every year from January 1 to March 31.
- **What type of plan can you switch to during the annual Medicare Advantage Open Enrollment Period?** During this time, you can:
  - Switch to another Medicare Advantage Plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
  - Disenroll from our plan and obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time.
- **When will your membership end?** Your membership will end on the first day of the month after you enroll in a different Medicare Advantage plan or 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 Select 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 may be 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 (*www.medicare.gov*):
    - Usually, when you have moved outside the plan's service area (see Chapter 1, Section 2.3 for a list of the counties and premiums). Note: If you move within the service area, you will not be eligible for a Special Enrollment Period but your premium may change.
    - 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).
    - **Note:** If you're in a drug management program, you may not be able to change plans. Chapter 5, Section 10 tells you more about drug management programs.
- **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 have 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 and our email address are printed on the back cover of this booklet).
- You can find the information in the ***Medicare & You 2022*** handbook.
  - Everyone with Medicare receives a copy of the *Medicare & You 2022* handbook 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 (*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, you must ask to be disenrolled from our plan. There are three ways you can ask to be disenrolled:

- You can complete a disenrollment form.
  - You can obtain a disenrollment form by visiting our website (*www.priorityhealth.com/medicare/once-you-enroll/plan-administration/disenroll*) or contacting Customer Service. (Phone numbers are printed on the back cover of this booklet).

  - For us to process the request: you must be eligible to disenroll, select a disenrollment reason on the form, sign the form, and date the form.

- You can make a request in writing to us.
  - For us to process the request: you must be eligible to disenroll, include your intent to disenroll, include a reason for disenrollment, include a signature, and include a date.
- 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.

Your disenrollment form or written request can be:

  - Emailed to *ph-MedicareEnrollment@priorityhealth.com*.
  - Or, mailed to 1231 E. Beltline NE, MS 1175, Grand Rapids, MI 49525.

Contact Customer Service if you need more information on how to do this (phone numbers are printed on the back cover of this booklet).

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 have 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 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 Select 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 Select when your new plan's coverage begins.

If you would like to switch from our plan to:	This is what you should do:
• 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 for 63 days or more in a row, you may have to pay a late enrollment penalty if you join a Medicare drug plan later. See Chapter 1, Section 5 for more information about the late enrollment penalty.	• **Send us a completed disenrollment form or a written request to disenroll and include a reason for disenrollment, a signature, and the current date.** For us to process the request, you must be eligible to disenroll. You can email your request to, *ph-MedicareEnrollment@priorityhealth.com* or, mail it to 1231 E. Beltline NE, MS 1175, Grand Rapids, MI 49525. Contact Customer Service if you need more information on how to do this (phone numbers are printed on the back cover of this booklet). • 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 not be disenrolled from **Priority**Medicare Select until we receive a valid form or written request.
• Original Medicare and add a Medicare supplement plan (or "Medigap plan") 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 for 63 days or more in a row, 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.	• **Send us a completed disenrollment form or a written request to disenroll and include your reason for disenrollment, a signature, and the current date.** For us to process a disenrollment request, you must be eligible to disenroll. You can email your request to *ph-MedicareEnrollment@priorityhealth.com* or, mail it to 1231 E. Beltline NE, MS 1175, Grand Rapids, MI 49525. Contact Customer Service if you need more information on how to do this (phone numbers are printed on the back cover of this booklet). • You will not be disenrolled from **Priority**Medicare Select until we receive a valid form or 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 Select, 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 Select must end your membership in the plan in certain situations

Section 5.1 When must we end your membership in the plan?

PriorityMedicare Select **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 12 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 we receive a notification from Medicare that you have moved out of our service area, we will attempt to contact you to verify if the notification from Medicare is correct.
    - If we are unable to reach you for 12 months from the date of the notification from Medicare, you may be disenrolled from our plan.

  - If we are able to reach you, and you have verified that you have moved outside of our service area, you will be disenrolled from our plan beginning the 1st of the month following the date you verified the change with us.
  - If you are disenrolled due to being out of our service area you will have a special enrollment period for 60 days to enroll into a new plan.
  - Go to Chapter 4, Section 2.3 for information on getting care when you are away from the service area through our plan's visitor/traveler benefit.
- 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 Priority Health Medicare premium, we reserve the right to end your membership in your Priority Health Medicare plan.
  - We must give you advance notice in writing that you have not paid your premium.
  - This written notice sent 60 days prior to the date your membership will end serves to tell you of our intent to end your membership.
  - If you do not pay your premium by the date stated in your advance notice of involuntary termination of membership, we may disenroll you as of that date.
  - If this happens you will go back to Original Medicare for your medical coverage but you will not be able to pick up a Part D prescription drug plan until the Annual Election Period (AEP) or if you qualify for a Special Election Period (SEP).
- If you do not pay the Optional Supplemental plan premium, we reserve the right to end your membership in your Optional Supplemental plan. This means your membership in the optional plan will end but you will remain a member of your Priority Health Medicare plan.

- We must give you advance notice in writing that you have not paid your premium.
- This written notice sent 60 days prior to the date your Optional Supplemental plan will end serves to tell you of our intent to terminate benefits.
- If you do not pay your premium by the date stated in your advance notice of involuntary termination of your Optional Supplemental plan, we will disenroll you.
- We will not be able to reinstate your benefits until the following plan year or special election period (SEP).
- All claims incurred after your supplemental benefits are terminated will be your responsibility.

- 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 our 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 Select 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 also 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 nondiscrimination

Our plan must obey laws that protect you from discrimination or unfair treatment. **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 within the service area. 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.

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.

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. to 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 *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 *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 8466.983.888 (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）。

.ܚܝ ܒܠܘܟ ܕܡܨܠܒܠܘܟ ܝܠܦܬܐ ܕܡܫܘܕܥܢܘܬܐ ܠܠܫܢܐ ܡܓܢܢܐܝܬ ،ܙܘܗܪܐ :ܐܝܢ ܐܢܬܘܢ ܟܐ ܡܗܡܙܡܝܬܘܢ ܠܫܢܐ ܐܬܘܪܝܐ
888.389.6648 (TTY: 711)ܡܢܘܢ ܥܠ ܡܢܝܢܐ

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 Select, 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 home-owners 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 (PHI) 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 PHI 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 PHI. 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 PHI.

Use and disclosure of your health information

The sections below describe the ways Priority Health uses and discloses your health information without your authorization. Your health information is not shared with anyone who does not have a "need to know" to perform one of the tasks below.

Treatment. Priority Health may use or disclose your health information to professionals who are treating you and 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 with medical care.

Payment. Priority Health may use your health information or disclose it to third parties to collect premiums, establish eligibility 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 or disclose your health information 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 to decide whether we will give you coverage and the price of that coverage.

Please note that we do not destroy personal information about you when you terminate your coverage with us. It may be necessary to use and disclose this information for the purposes described above even after your coverage terminates, although policies and procedures will remain in place to protect against inappropriate use or disclosure.

To you and your personal representative. We may disclose your PHI to you or to your personal representatives (someone who has the legal right to act on your behalf).

To others involved in your care. We may, under certain circumstances, disclose to a member of your family, a relative, a close friend or any other person you identify, the PHI directly relevant to that person's involvement in your health care or payment for health care. For example, we may discuss a claim decision with you in the presence of a friend or a relative, unless you object.

If you are not able to tell us your preference, for example if you are unconscious, we share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

This notice also applies to the Priority Health Organized Health Care Arrangement (OHCA) between Priority Health and Spectrum Health. Priority Health will share PHI with Spectrum Health for treatment, payment and health care operations purposes. Priority Health reserves the right to change participation in its OCHA by any individual or organization.

Other permitted or required uses and disclosures without your written authorization.

Priority Health is allowed or required to share your information in other ways - usually in ways that contribute to the public good, such as public health and research. Priority Health may also use or disclose your health information:

- When required by law.
- For law enforcement purposes.
- When necessary for judicial or administrative (i.e., court) proceedings
- For compliance with workers' compensation requirements, as authorized by applicable law
- For various government functions, such as disclosures to health oversight agencies for activities authorized by law, 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).
- 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 matters of Public Interest
- Reporting adult abuse, neglect or domestic violence.
- To prevent a serious threat to an individual or a community's health and safety. Reporting to organ procurement and tissue donation organizations.
- For public health and safety activities, including disease control and vital statistic reporting, child abuse reporting, and Food and Drug Administration oversight.
- 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.
- From time to time, we engage third parties called Business Associates to provide various services for us. Whenever an arrangement with such a third party involves the use or disclosure of your PHI, we will have a written contract with that third party designed to

protect the privacy of your PHI. For example, we may share your information with business associates who process claims or conduct disease management programs on our behalf.

Disclosures to health plan sponsors

(This section of the Notice of Privacy Practices applies 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 PHI to the sponsor for the sponsor's administration of the group health plan.

Other uses of health information - by authorization only

Priority Health may not use or disclose your PHI without your written authorization, except as described in this notice. You may give us written authorization to use your PHI 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. 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 also must obtain your written authorization to sell information about you to a third party or, in most circumstances, to use or disclose your PHI to send you communications about products and services. We do not need your written authorization, however, to send you communications about treatment alternatives, treatment reminders, health related products or services, as long as the products or services are associated with your coverage or are offered by us.

We will never sell your PHI or use or disclose it for marketing purposes without your written authorization.

We must receive your written authorization to disclose psychotherapy notes, except for certain treatment, payment or health care operations activities.

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

Health Insurance Portability and Accountability Act (HIPAA) 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.

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 as long as we maintain them. 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 receive a copy of your health information, contact Priority Health's Compliance department.

Right to correct your health and claims record. 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 and include a reason to support the change.

Right to know an accounting of disclosures. You have the right to request an "accounting of disclosures," which is a list of the disclosures we made regarding your health information for 6 years prior to the date of your request, except the following types of disclosures:

- To carry out treatment, payment or health care operations.
- To you or your personal representative.
- For which you have given your written permission (authorization).
- For national security or intelligence purposes.
- To correctional institutions or to law enforcement, as described in this notice.
- As part of a limited data set (a collection of information that does not directly identify you).

Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within 12 months will be free. We may charge you for the costs of providing additional lists. We will notify you of the cost and you can choose to withdraw or modify your request at that time before any fees are incurred.

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. 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. For example, you might want us to send health information (e.g., Explanation of Benefits (EOB) and other claim information) to a different address. 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 claim s. To request confidential communications, you must make your request in writing to Priority Health's Compliance department.

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. Otherwise, you may also print a copy of this Notice from our website at ***priorityhealth.com***.

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 Privacy department. You will not be retaliated against for filing a complaint.

Our Responsibilities

We are required by law to maintain the privacy and security of your PHI.

We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.

We must follow the duties and privacy practices described in this notice and give you a copy of it.

We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

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 this notice will be effective for all PHI that we maintain, including PHI regardless of when it was created or received. 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. The new notice will also be available upon request and posted on our website.

Contact information

If you have questions about how your medical information may be used and disclosed and how to get access to this information, please contact Priority Health's Privacy Department below.

For any other questions or concerns, please contact Priority Health's Compliance Department below.

Priority Health Compliance Department:
Priority Health Compliance Department
1231 East Beltline NE
Grand Rapids Ml 49525
616.942.0954
800.942.0954

Priority Health Privacy Department:
Priority Health
Chief Privacy Officer
100 Michigan Street NE
Grand Rapids, Ml 49503
616.486.4113

This Notice is effective: September 1, 2019

Notice of Nondiscrimination

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.

- Free aids and services are available to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Information written in other formats
- Free language services are available to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services:

- Medicare members: Contact Priority Health Medicare customer service at 888.389.6648 (TTY users call 711), 8 a.m. - 8 p.m., 7 days a week
- All other plans: Call the number on the back of your member ID card or 800.942.0954

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 by:

Mail: Priority Health Compliance Department
Attention: Civil Rights Coordinator
1237 East Beltline Ave NE
Grand Rapids, Ml 49525-4507
Toll free: 866.807.1937 (TTY users should call 711)
Fax: 67 6.975.8850
Email: *PH-compliance@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
- By mail at U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20207
- By phone at 800.368.1019

Complaint forms are available at the U.S. Department of Health and Human Services (HHS) website.

Contact us

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia en su idioma. Consulte al número de Servicio al Cliente que está en la parte de atrás de su tarjeta de identificación de miembro. (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888.983.8466 (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。請撥打會員卡背面的客服電話 (TTY: 711）。

ﺧﺪﻣﺎﺕ ﻛﻤﻚ ﺯﺑﺎﻧﻲ ﺑﻪ ﺻﻮﺭﺕ ﺭﺍﻳﮕﺎﻥ ﺩﺭ ﺩﺳﺘﺮﺱ ﺷﻤﺎ ﻗﺮﺍﺭ ﺩﺍﺭﺩ. ﺑﻪ ﺷﻤﺎﺭﻩ ﺧﺪﻣﺎﺕ ﻣﺸﺘﺮﻳﺎﻥ ﻛﻪ ﺩﺭ ﭘﺸﺖ ﻛﺎﺭﺕ ﻋﻀﻮﻳﺖ ﺷﻤﺎ ﻗﺮﺍﺭ ﺩﺍﺭﺩ ﺗﻤﺎﺱ ﺑﮕﻴﺮﻳﺪ. (TTY:711) 1.888.389.6648

CHÚ Ý: Nếu quý vị nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Xin hãy gọi tới số điện thoại của bộ phận dịch vụ khách hàng có ở mặt sau thẻ ID thành viên của quý vị. (TTY: 711).

KUJDES: Nëse flisni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Ju lutem kontaktoni qendrën e shërbimit për klient në pjesën e pasme të ID kartës tuaj të anëtaresimit (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 멤버쉽 ID카드의 뒷면에 있는 고객 서비스 번호로 전화해 주십시오. (TTY: 711)

লক্ষ্য করুনঃ আপনন বাাংলায় কথা বলতে পারতল আপনার জনয ননঃখরচায় ভাষা সহায়ো সসবা সুলভ রতয়তে। অনুগ্রহ কতর আপনার সদসযপদ আইনি কাতিে র সপেতন থাকা গ্রাহক সসবা নম্বতর কল করুন। (TTY: 711)

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer telefonicznej obsługi klienta wskazany na odwrocie Twojej legitymacji członkowskiej (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienste zur Verfügung. Bitte rufen Sie die Kundendienstnummer auf der Rückseite Ihrer Mitgliedskarte an. (TTY: 711).

ATTENZIONE: se parla italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero sul retro della tessera identificativa di membro. (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。メンバーシップIDカードの 裏面にあるお客様サービスセンターの番号までお電話にてご連絡ください。(TTY: 711).

ВНИМАНИЕ! Если Вы говорите на русском языке, то Вам доступны услуги бесплатной языковой поддержки. Пожалуйста, позвоните в службу поддержки клиентов по номеру, указанному на обратной стороне Вашей идентификационной карточки участника (телетайп (TTY: 711).

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Molimo nazovite broj službe za korisnike na pozadini vaše članske iskaznice (TTY: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog,mga serbisyo ng tulong sa wika, ng libre, ay available para sa iyo. Pakitawan ang numero ng customer service sa likod ng iyong ID card ng pagiging miyembro. (TTY: 711).

The term "Priority Health" refers to four corporations: Priority Health Choice Inc. (a Michigan non-profit corporation), "Priority Health" (a Michigan non-profit corporation), "Priority Health Insurance Company" (a Michigan corporation) and "Priority Health Managed Benefits, Inc." (a Michigan corporation).

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CHAPTER 12

Definitions of important words

Chapter 12. Definitions of important words

Adaptive equipment – Items used to assist with completing activities of daily living (ADLs). Bathing, dressing, grooming, toileting and feeding are self-care activities. Examples of adaptive equipment include but are not limited to bathroom grab bars, bath seats, elevators, grabbers, and personal emergency systems.

Admission – A hospital or inpatient facility admission involves being admitted by a physician 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.

Allowed Amount – The maximum amount the plan will pay providers for covered services or supplies.

Ambulatory Surgical Center – An Ambulatory Surgical Center (ASC) is an entity that 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.

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 and your plan will be effective January 1st of the following year.

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.

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, 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 1.3 for more information about balance billing.

Benefit Period –The way that both our plan and Original Medicare measures your use of 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 $7,050 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.

CMS Preclusion List – A list maintained by CMS of individuals or entities that are currently revoked from the Medicare program, or that have engaged in behavior which CMS determines is detrimental to the best interests of the Medicare program. Medicare Advantage plans are prohibited from paying individuals or entities that appear on this list.

Coinsurance – An amount you may be required to pay as your share of the cost for services or prescription drugs. Coinsurance is usually a percentage (for example, 20%).

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.

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.

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 5 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.

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.

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 find or monitor a disease or other condition. It is done in order to explain symptoms identified by your physician. A diagnostic test is not the same as a screening. And, sometimes a screening can turn diagnostic during the screening procedure.

Discharge – A discharge happens when you are released from an inpatient hospital, skilled nursing facility, observation stay, or other hospital setting to go home or go to a higher or lower level of care. This includes when you are physically discharged from the hospital to another facility or a unit within the same facility. See **Transfer** for more 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. Medicare requires that your equipment and supplies be received from a Medicare-participating provider. Contracted Priority Health Medicare DME providers are Medicare-participating providers.

Elective surgery – A surgery that is a planned, non-emergent surgical procedure.

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.

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 decision 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.

Fixed Wing Air Transportation – This service is furnished when your medical condition is such that transport by ground ambulance, is not appropriate. Generally, transport by fixed wing air ambulance (not transport by a helicopter) may be necessary because your condition requires rapid transport to a treatment facility. 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.

Formulary ("Drug List" or "List of Covered Drugs") – A list of prescription drugs covered by the plan and approved by Medicare. 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.

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 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."**

Income Related Monthly Adjustment Amount (IRMAA) –If your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your Part B premium. 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 $4,430.

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.

In-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 "**in-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 in-network providers based on the agreements it has with the providers or if the providers agree to provide you with plan-covered services. In-network providers may also be referred to as "plan providers."

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, such as a nursing home, and services not medically related.

Low Income Subsidy (LIS) – See "Extra Help."

Maximum Allowable Charge – The highest amount of money you can be charged for a covered service by doctors and other health care supplies who don't accept assessment. This relates to the limiting charge, which is 15% over Medicare's approved amount.

Maximum Out-of-Pocket Amount – The most that you pay out-of-pocket during the calendar 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. You will see an asterisk (*) in the Chapter 4 medical benefits chart on services, such as your supplemental benefits, that do not apply to your in-network 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 deemed necessary by Medicare.

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 Open Enrollment Period – A set time each year when members in a Medicare Advantage plan can cancel their plan enrollment and switch to another Medicare Advantage plan, or obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time. The Medicare Advantage Open Enrollment Period is from January 1 until March 31, and is also available for a 3-month period after an individual is first eligible for Medicare.

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 Advantage health plan that is offered in their area.

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.

Observation (or "Observation stay") – An observation stay is an outpatient hospital stay in which you receive medically necessary Medicare-covered services. 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. The provider should issue you a Medicare Outpatient Observation Notice (MOON). See also **"Hospital Inpatient Stay"** and **"Outpatient."**

Optional Supplemental Benefits – Non-Medicare covered benefits that can be purchased for an additional premium and are not automatically included in your Priority Health Medicare plan. If you choose to have optional supplemental benefits, you will have to pay an additional premium. You must enroll in optional supplemental benefits in order to get them. See Chapter 4, Section 2.2 (*Extra "optional supplemental" benefits you can buy*).

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 – "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. An out-of-network provider does not have a contract agreement with us. 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 Hospital Facility – An outpatient hospital facility is an area of a hospital or a standalone 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."

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.

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 (LEP) – 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 after you are first eligible to join a Part D plan. 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.

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 – Payments made to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Prescription Drug Benefit Manager – A third-party administrator of prescription drug programs handling processing and paying 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.

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.

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.

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.

Rehabilitation Services – These services include physical therapy, speech and language therapy, and occupational therapy.

Rural health clinic (RHC) – A clinic that is located in a rural, medically under-served area in the United States. An outpatient clinic is different than an RHC.

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 – 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.

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.

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.

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.

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.

Transfer – A transfer happens when you are moved from an inpatient hospital, skilled nursing facility, observation stay, or another level of care within the same facility or moved to a different facility. When you are transferred, you are being discharged. See also **Discharge** for further information.

Transplant Travel Coverage – We will cover reimbursement for reasonable transportation (personal car, rental car, bus or air) up to a combined maximum total of $60 per day, not to exceed 5 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 $80 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.

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.

APPENDIX

Mandatory Vision, Dental and Hearing Benefits

(included in your Medicare Advantage plan
for no additional monthly premium)

and

Optional Enhanced Dental and Vision Package

(not included in your Medicare Advantage plan, you must enroll
& pay an extra monthly premium for this additional coverage)

Thank you for being a Priority Health Medicare member.

Your **Priority**Medicare Select plan includes vision, dental and hearing coverage at no additional cost in premium to you. These are extra benefits that are not covered by Medicare, but that Priority Health includes in your plan and therefore are referred to as "Mandatory."

If you are enrolled in our Optional Enhanced Dental and Vision package, you pay an additional monthly premium of $29.00 for added dental and vision coverage, above and beyond what is included in your **Priority**Medicare Select.

If you are not enrolled in our Optional Enhanced Dental and Vision package and would like further details on cost, how to enroll and when you may enroll, please see Chapter 4, Section 2.2 Extra "optional supplemental" benefits.

This document contains details on what's covered, what's not, how to access your benefits, and so much more. For benefit, provider or network questions, call toll-free Monday – Friday 8 a.m. to 8 p.m. (TTY 711):

- **EyeMed**[SM] at 844.366.5127
- **Delta Dental**® at 800.330.2732
- **TruHearing**® at 833.714.5356

For assistance on Saturday or Sunday, please contact Priority Health Medicare at 888.389.6648, from 8 a.m. to 8 p.m. (TTY 711). Or, visit *prioritymedicare.com* and select **Already a member**.

DENTAL INFORMATION
(Mandatory & Optional)

Your dental program is administered by Delta Dental Plan of Michigan, Inc., a nonprofit dental care corporation doing business as Delta Dental of Michigan. Good oral health is a vital part of good general health, and your Delta Dental program is designed to promote regular dental visits. We encourage you to take advantage of this program by calling your Dentist today for an appointment.

If you have any questions about this program, please call our Customer Service department at (800) 330-2732 (TTY 711), access Priority Health's website at *priorityhealth.com* or write us at:

SEND WRITTEN INQUIRIES TO:
DELTA DENTAL
P.O. BOX 9230
FARMINGTON HILLS, MI
48333-9230

You can easily verify your own benefit, claims and eligibility information online 24 hours a day, seven days a week by visiting www.*DeltaDentalMI.com* and selecting the link for our Member Portal. The Member Portal will also allow you to print claim forms, select paperless Explanation of Benefits statements (EOBs), search our Dentist directories, and read oral health tips.

WHAT DO I NEED WHEN I GO TO THE DENTIST?

All you need is your Priority Health Medicare member ID card. You must use your Member ID number to register for the Member Portal or to identify yourself as a Delta Dental Medicare Advantage enrollee when you visit your dentist(s) or call customer service.

WHY SELECT A DELTA DENTAL MEDICARE ADVANTAGE PARTICIPATING DENTIST?

When selecting a Dentist, your out-of-pocket costs are likely to be less if you go to a Delta Dental Medicare Advantage Participating Dentist. Medicare Advantage Participating Dentists agree to accept payment according to the applicable Delta Dental Medicare Advantage Participating Dentist Agreement and, in most cases, this results in a reduction of their fees. Additionally, when receiving treatment from a Delta Dental Medicare Advantage Participating Dentist, your out-of-pocket costs may be further reduced if you go to a Delta Dental Medicare Advantage PPO Dentist.

If the Dentist you select is not a Delta Dental Medicare Advantage Participating Dentist, you will still be covered, but you may have to pay more.

FINDING A DELTA DENTAL MEDICARE ADVANTAGE PARTICIPATING DENTIST

In-network (participating) dentists are those in Michigan, Indiana and Ohio who are in Delta Dental's Medicare Advantage PPO or Medicare Advantage Premier network. All other dentists are considered out-of-network (nonparticipating) providers. There are three ways to find Delta Dental Medicare Advantage participating dentists near you:

1. Call your dentist's office and ask if they participate with the Delta Dental Medicare Advantage PPO or Delta Dental Medicare Advantage Premier network.

2. Call our DASI (Delta Dental's Automated Service Inquiry) system at (800) 330-2732. You may exit the automated system to speak with a Customer Service associate at any time during our normal business hours, Monday through Friday from 8 a.m. to 8 p.m. Eastern Time. For assistance on Saturday or Sunday, call Priority Health Medicare at 888.389.6648 (TTY 711), from 8 a.m. – 8 p.m.

3. Check our online dentist directory at *www.deltadentalmi.com/Find-a-Dentist*. When accessing Delta Dental's online Dentist Directory, you must select the link labeled Medicare Advantage PPO and Medicare Advantage Premier.

HOW PAYMENT IS MADE TO DELTA DENTAL MEDICARE ADVANTAGE PARTICIPATING AND NON-PARTICIPATING DENTISTS

If your dentist participates with Medicare Advantage, Delta Dental will base payment on the maximum approved fee for covered services. Medicare Advantage Participating Dentists will fill out and submit your dental claims for you to Delta Dental. Delta Dental will send payment directly to the Medicare Advantage participating dentist and you will be responsible for any applicable cost share, which your dentist will collect from you.

If your dentist does not participate with Delta Dental, the payment will be based on the fee for what we cover with non-participating dentists. The dental staff may submit your claim to Delta Dental for payment or they may require you to pay for your visit and submit the receipt and claim form to Delta Dental for reimbursement yourself, to the address below. Your Dentist should use the most recent American Dental Association ("ADA") approved claim form. Delta Dental will send payments to you for covered services, unless otherwise required by law or contract, and you will be responsible for making full payment to the dentist. You will be responsible for any difference between Delta Dental's payment and the dentist's submitted amount, in addition to any copayment.

MAIL CLAIMS ONLY TO:
DELTA DENTAL
P.O. BOX 9298
FARMINGTON HILLS, MI
48333-9298

For covered services provided by a dentist that has affirmatively opted out of Medicare, Delta Dental will not reimburse you or the dentist. You will be responsible for the total cost of the services rendered.

COORDINATION OF BENEFITS

The Coordination of Benefits ("COB") provision applies when a person has health care coverage under more than one plan. "Plan" is defined below.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans does not exceed 100 percent of the total allowable expense.

Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

1. Plan includes: group and non-group insurance contracts, medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.
2. Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; or coverage under other federal governmental plans that do not permit coordination.

Each contract for coverage under (1) or (2) above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

This Plan, for purposes of this section, means the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other Plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

Order of Benefit Determination Rules determine whether This Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan.

When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that the total benefits paid by all Plans do not exceed the submitted amount. In no event will This Plan's payments exceed the maximum approved fee.

Order of Benefits Determination Rules
When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

1. This Plan will pay primary over any Medicaid or Retiree Plan that you may have.
2. This Plan will pay secondary to any employer sponsored, automobile, group, or individual Plan you may have, except for those listed in (1) above.
3. If This Plan is the Primary Plan, it will pay its benefits according to its terms of coverage and without regard to the benefits under any other Plan.
4. Except as provided in the following paragraph, a Plan that does not contain a COB provision is always primary unless otherwise required by law.
   Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder, shall be secondary regardless of whether or not it contains a COB provision.
5. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

Effect on the Benefits of This Plan
When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total submitted amount. In determining the amount to be paid, This Plan will calculate the benefits it would have paid in the absence of other health care coverage (maximum approved fee) and apply that the remaining amount that you owe to the dentist following the Primary Plan's payment. The amount paid by This Plan will not exceed the maximum approved fee.

Right of Recovery
If the amount of the payments made by Delta Dental is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid, or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Coordination Disputes
If you believe that we have not paid a claim properly, you should first attempt to resolve the problem by contacting us. You or your Dentist should contact Delta Dental's Customer Service department and ask them to check the claim to make sure it was processed correctly. You may do this by calling the toll-free number, (800) 330-2732, and speaking to a telephone advisor. You may also mail your inquiry to the Customer Service Department at PO Box 9230, Farmington Hills, Michigan, 48333-9230. You may also follow the Grievance and Appeals Procedure below.

GRIEVANCE AND APPEAL PROCEDURES

What to do if you have a problem or concern
This section explains two types of processes for handling problems and concerns:

- For problems related to benefits or coverage, you need to use the process for making appeals.

- For problems other than those related to benefits or coverage, you need to use the process for making grievances.

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 following is a brief description of each procedure. For a full description of these procedures, you should follow the process described in your Priority Health plan coverage documents or call the Customer Service number on the back of your member ID card.

You should contact us right away. An appeal or grievance must be made within 60 calendar days after you had the problem you want to appeal or complain about.

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 make an appeal, we review the coverage decision we have made to check to see if we were following all of the rules properly.

Delta Dental will notify you or your authorized representative if you receive an Adverse Benefit Determination after your claim is filed.

If you receive notice of an Adverse Benefit Determination, and if you think that Delta Dental incorrectly denied all or part of your claim, you can appeal. You can send your dispute to:

Priority Health
Grievance & Appeals, MS1150
1231 East Beltline Ave, NE
Grand Rapids, MI 49525
or
Fax: (616) 975-8827

Please include a copy of your Explanation of Benefits and describe the problem. Be sure to include your name, your telephone number, the date, and any other information about your claim that you would like considered.

Filing a Grievance
The Grievance 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. This type of complaint does not involve coverage or payment disputes. The following explains how to use the process for filing a grievance.

Usually, calling Priority Health is the first step. If there is anything else you need to do, Priority Health will let you know. Call the Customer Service number on the back of your member ID card.

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 Priority Health. If you put your complaint in writing, we will respond to your complaint in writing. You can send your complaint to:

Priority Health
Grievance & Appeals, MS1150
1231 East Beltline Ave, NE
Grand Rapids, MI 49525
or
Fax: (616) 975-8827

Please include your name, your telephone number, the date, and any other information about your claim that you would like considered.

DENTAL DEFINITIONS

Adverse Benefit Determination - Any denial, reduction or termination of the benefits for which you filed a claim. Or a failure to provide or to make payment (in whole or in part) of the benefits you sought, including any such determination based on eligibility, application of any utilization review criteria, or a determination that the item or service for which benefits are otherwise provided was experimental or investigational, or was not medically necessary or appropriate.

Allowed Amount - The amount permitted under the Medicare Advantage Dentist Fee Schedule which Delta Dental will base its payment for a Covered Service.

Completion Dates - The date that treatment is complete. Some procedures may require more than one appointment before they can be completed. Treatment is complete on the date of the final procedure that completes treatment.

Delta Dental - Delta Dental Plan of Michigan, Inc., provides dental benefits. Delta Dental is not an insurance company. Delta Dental Plan of Michigan, Inc., has been delegated by Priority Health to provide dental benefits for This Plan.

Dentist - A person licensed to practice dentistry in the state or jurisdiction in which dental services are performed.

- **Delta Dental Medicare Advantage PPO Dentist -** a Dentist located in Michigan, Indiana or Ohio who has signed an agreement with Delta Dental for This Plan that is part of Delta Dental's Medicare Advantage PPO Network.
- **Delta Dental Medicare Advantage Premier Dentist -** a Dentist located in Michigan, Indiana or Ohio who has signed an agreement with Delta Dental for This Plan that is part of Delta Dental's Medicare Advantage Premier Network.

- **Nonparticipating Dentist** – a Dentist who has not signed an agreement with Delta Dental to become part of the Delta Dental Medicare Advantage Premier or Delta Dental Medicare Advantage PPO Network or is located in a state other than Michigan, Indiana or Ohio. Services received from dentists who do NOT participate in Delta Dental's Medicare Advantage Network will be processed as services received from a Nonparticipating Dentist and your out-of-pocket costs may be higher.

IMPORTANT: If you receive services from a dentist that DOES NOT participate in Delta Dental's Medicare Advantage Network YOU WILL BE RESPONSIBLE for the difference between Delta Dental's payment to you and the amount charged by the Nonparticipating Dentist.

Delta Dental Medicare Advantage PPO and Delta Dental Medicare Advantage Premier Dentists are sometimes collectively referred to as "Medicare Advantage Participating Dentists."

Maximum Approved Fee - The maximum fee that Delta Dental approves for a given procedure in a given region and/or specialty, under normal circumstances, based upon applicable Medicare Advantage Participating Dentist schedules and internal procedures.

Maximum Payment - The maximum dollar amount Delta Dental will pay in any Benefit Year or lifetime for Covered Services. (See the Summary of Dental Plan Benefits.)

Nonparticipating Dentist Fee - The most Delta Dental will pay Nonparticipating Dentists for a Covered Service.

Post-Service Claims - Claims for Benefits that are not conditioned on your seeking advance approval, certification, or authorization to receive the full amount for any Covered Services. In other words, Post-Service Claims arise when you receive the dental service or treatment before you file a claim for Benefits.

Pre-Service Organization Determination - A determination that is made prior to receiving dental services based on your benefits and coverage. This decision will determine whether a dental service will be covered and will provide information on how much you may have to pay for this service. This is a request submitted by you or your Dentist.

Processing Policies - Delta Dental's policies and guidelines used for Pre-Service Organization Determination and payment of claims. The Processing Policies may be amended from time to time.

Submitted Amount - The amount a Dentist bills to Delta Dental for a specific treatment or service. A Delta Dental Medicare Advantage Participating Dentist cannot charge you for the difference between this amount and the amount Delta Dental approves for the treatment.

<u>MANDATORY</u> DENTAL COVERAGE DETAILS
(#1179-2000, 2100)

This section provides information about the **<u>dental coverage that is included in your Priority Health Medicare Advantage plan</u>.** The chart below is a summary of covered services with cost and frequency, followed by a more detailed chart of the covered services including procedure codes, and then exclusions and limitations.

Your dental plan does not have a deductible, so you start paying for the cost of the service right away. Also, there is no waiting period, which means there isn't a time span which must be met before we begin covering your dental benefits.

Summary of Covered Services	**If you see a Participating Delta Dental Medicare Advantage PPO or Medicare Advantage Premier (in-network) Dentist you pay**	**If you see a Nonparticipating (out-of-network) Dentist you pay**	**Frequency**
Diagnostic and Preventive Services – oral exams and cleanings which include periodontal maintenance cleanings	$0	$0	Two per calendar year
Bitewing Radiographs – one set (up to 4 films in a single visit) of bitewing X-rays	$0	$0	One set per calendar year
All other radiographs – Full-mouth series, periapical or panoramic X-rays	$0	$0	Payable once every 24 month period
Brush biopsy – to detect oral cancer	$0	$0	One per calendar year

The copay amounts listed above are applicable for services from both in-network (participating) providers and out-of-network (non-participating) providers. If the Dentist you select is not a Delta Dental Medicare Advantage Participating Dentist, you will still be covered, but you may have to pay more. See the above sections; "*Why Select A Delta Dental Medicare Advantage Participating Dentist?*" and "*How payment is made to Delta Dental Medicare Advantage Participating and non-participating dentists*" for details.

Procedure codes covered under MANDATORY dental

Listed below are the dental procedures and codes covered by your **Mandatory** dental plan. If a procedure is not on this list, it is not a standard covered benefit under your plan. Standard benefit limitations are listed where applicable in the Benefit Limitations column and also in the Limitations for Mandatory Dental section below. Some services share frequencies.

Code	Description	In-network dentists you pay	Out-of-network dentists you pay	Benefit Limitations
D0100-D0999 Diagnostic				
D0120	periodic oral evaluation - established patient	$0	$0	Twice per calendar year (including examinations by a specialist)
D0140	limited oral evaluation - problem focused	$0	$0	As needed for diagnosis of emergency condition
D0150	comprehensive oral evaluation - new or established patient	$0	$0	Once per 36 months
D0160	detailed and extensive oral evaluation - problem focused, by report	$0	$0	Once per 36 months
D0180	comprehensive periodontal evaluation - new or established patient	$0	$0	Once per calendar year
D0190	screening of a patient	$0	$0	Once per calendar year
D0210	intra-oral - complete series	$0	$0	Once per 2 year period
D0220*, D0230, D0240,	intraoral - periapical first image	$0	$0	Covered service

Code	Description	In-network dentists you pay	Out-of-network dentists you pay	Benefit Limitations
D0250*	extra-oral - 2D projection radiographic image created using a stationary radiation source, and detector	$0	$0	Covered service
D0270, D0272, D0273, D0274, D0277	bitewing - single image	$0	$0	Once per calendar year
D0330	panoramic image	$0	$0	Once per 2 year period
D1000-D1999 Preventive				
D1110	prophylaxis - adult	$0	$0	Twice per calendar year
D4000-D4999 Periodontics				
D4910*	periodontal maintenance	$0	$0	Included in the cleaning frequency of twice per calendar year
D7000-D7999 Oral and Maxillofacial Surgery				
D7288*	brush biopsy - transepithelial sample collection	$0	$0	Covered service

*Please note, procedures in the following code ranges may require diagnostic information such as radiographs or patient treatment records for claims processing and final payment determinations: D0220-D0250; D4000-D4999 Periodontics; D7288 Oral and Maxillofacial Surgery.

Exclusions for <u>MANDATORY</u> dental

Delta Dental will make no payment for the following services or supplies, unless otherwise specified in the mandatory covered services chart or procedure codes list above. All charges for the same will be your responsibility (though your payment obligation may be satisfied by insurance or some other arrangement for which you are eligible):

1. Services or supplies, as determined by Delta Dental, for correction of congenital or developmental malformations.
2. Cosmetic surgery or dentistry for aesthetic reasons, as determined by Delta Dental.
3. Services started or appliances started before a person became eligible under This Plan. This exclusion does not apply to orthodontic treatment in progress (if a covered service).
4. Prescription drugs (except intramuscular injectable antibiotics), premedication, medicaments/ solutions, and relative analgesia.
5. General anesthesia and intravenous sedation for (a) surgical procedures, unless medically necessary, or (b) restorative dentistry.
6. Charges for hospitalization, laboratory tests, and histopathological examinations.
7. Charges for failure to keep a scheduled visit with the dentist.
8. Services or supplies, as determined by Delta Dental, for which no valid dental need can be demonstrated.
9. Services or supplies, as determined by Delta Dental that are investigational in nature, including services or supplies required to treat complications from investigational procedures.
10. Services or supplies, as determined by Delta Dental, which are specialized techniques.
11. Treatment by other than a Dentist, except for services performed by a licensed dental hygienist or other dental professional, as determined by Delta Dental, under the scope of his or her license as permitted by applicable state law.
12. Services or supplies for which the patient is not legally obligated to pay, or for which no charge would be made in the absence of Delta Dental coverage.
13. Services or supplies received due to an act of war, declared or undeclared.
14. Services or supplies covered under a hospital, surgical/medical, (including Medicare Advantage), or prescription drug program.
15. Services or supplies that are not within the categories of Benefits selected by your Medicare Advantage Organization and that are not covered under the terms of this certificate.
16. Fluoride rinses, self-applied fluorides, or desensitizing medicaments.
17. Interim caries arresting medicament.
18. Preventive control programs (including oral hygiene instruction, caries susceptibility tests, dietary control, tobacco counseling, home care medicaments, etc.).
19. Preventive fluoride treatments.
20. Sealants.
21. Space maintainers.
22. Lost, missing, or stolen appliances of any type and replacement or repair of orthodontic appliances or space maintainers.
23. Cosmetic dentistry, including repairs to facings posterior to the second bicuspid position.
24. Veneers.

25. Prefabricated crowns used as final restorations on permanent teeth.
26. Appliances, surgical procedures, and restorations for increasing vertical dimension; for altering, restoring, or maintaining occlusion; for replacing tooth structure loss resulting from attrition, abrasion, abfraction, or erosion; or for periodontal splinting. If orthodontic services are covered services, this exclusion will not apply to orthodontic services as limited by the terms and conditions of the contract between Delta Dental and your Medicare Advantage organization.
27. Implant/abutment supported interim fixed denture for edentulous arch.
28. Paste-type root canal fillings on permanent teeth.
29. Replacement, repair, relines, or adjustments of occlusal guards.
30. Chemical curettage.
31. Major restorative services.
32. Prosthodontic services.
33. Implants and related services.
34. Services associated with overdentures.
35. Metal bases on removable prostheses.
36. The replacement of teeth beyond the normal complement of teeth.
37. Personalization or characterization of any service or appliance.
38. Temporary crowns used for temporization during crown or bridge fabrication.
39. Posterior bridges in conjunction with partial dentures in the same arch.
40. Precision attachments and stress breakers.
41. Biological materials to aid in soft and osseous tissue regeneration when submitted on the same day as soft tissue grafting, guided tissue regeneration and periodontal or implant bone grafting.
42. Bone replacement grafts and specialized implant surgical techniques, including radiographic/surgical implant index.
43. Appliances, restorations, or services for the diagnosis or treatment of disturbances of the temporomandibular joint (TMJ).
44. Orthodontic services.
45. Periodontal services other than periodontal maintenance.
46. Prosthodontic relines and repairs.
47. All extractions and oral surgery.
48. Diagnostic photographs and cephalometric films, unless done for orthodontics and orthodontics are a Covered Service.
49. Myofunctional therapy.
50. Mounted case analyses.
51. Any and all taxes applicable to the services.
52. Processing policies may otherwise exclude payment by Delta Dental for services or supplies.

Delta Dental will make no payment for the following services or supplies. Medicare Advantage Participating Dentists may not charge Members for these services or supplies. All charges from Nonparticipating Dentists for the following are your responsibility:

1. Services or supplies, as determined by Delta

Dental, which are not provided in accordance with generally accepted standards of dental practice.

2. The completion of forms or submission of claims.
3. Consultations, patient screening, or patient assessment when performed in conjunction with examinations or evaluations.
4. Local anesthesia.
5. Acid etching, cement bases, cavity liners, and bases or temporary fillings.
6. Infection control.
7. Temporary, interim, or provisional crowns.
8. Gingivectomy as an aid to the placement of a restoration.
9. The correction of occlusion, when performed with prosthetics and restorations involving occlusal surfaces.
10. Diagnostic casts, when performed in conjunction with restorative or prosthodontic procedures.
11. Palliative treatment, when any other service is provided on the same date except X-rays and tests necessary to diagnose the emergency condition.
12. Post-operative X-rays, when done following any completed service or procedure.
13. Periodontal charting.
14. Pins and preformed posts, when done with core buildups.
15. Any substructure when done for inlays, onlays, and veneers.
16. A pulp cap, when done with a sedative filling or any other restoration. A sedative or temporary filling, when done with pulpal debridement for the relief of acute pain prior to conventional root canal therapy or another endodontic procedure. The opening and drainage of a tooth or palliative treatment, when done by the same dentist or dental office on the same day as completed root canal treatment.
17. A pulpotomy on a permanent tooth, except on a tooth with an open apex.
18. A therapeutic apical closure on a permanent tooth, except on a tooth where the root is not fully formed.
19. Retreatment of a root canal by the same Dentist or dental office within two years of the original root canal treatment.
20. A prophylaxis or full mouth debridement, when done on the same day as periodontal maintenance or scaling and root planing.
21. Scaling in the presence of gingival inflammation when done on the same day as periodontal maintenance.
22. Prophylaxis, scaling in the presence of gingival inflammation, or periodontal maintenance when done within 30 days of three or four quadrants of scaling and root planing or other periodontal treatment.
23. Full mouth debridement when done within 30 days of scaling and root planing.

24. Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces without flap entry and closure, when performed within 12 months of implant restorations, provisional implant crowns and implant or abutment supported interim dentures.
25. Full mouth debridement, when done on the same day as the delivery of a partial denture.
26. An occlusal adjustment, when performed on the same day as the delivery of an occlusal guard.
27. Reline, rebase, or any adjustment or repair within six months of the delivery of a partial denture.
28. Tissue conditioning, when performed on the same day as the delivery of a denture or the reline or rebase of a denture.
29. Periapical and/or bitewing X-rays, when done within a clinically unreasonable period of time of performing panoramic and/or full mouth X-rays, as determined solely by Delta Dental.
30. Charges or fees for overhead, internet/video connections, software, hardware or other equipment necessary to deliver services, including but not limited to teledentistry services.
31. Processing policies may otherwise exclude payment by Delta Dental for services or supplies.

Limitations for <u>MANDATORY</u> dental

The benefits for the following services or supplies are limited as follows, unless otherwise specified in the mandatory covered services chart or procedure codes list above. All charges for services or supplies that exceed these limitations will be your responsibility. All time limitations are measured from the applicable prior dates of services in our records with any Delta Dental Plan or any dental plan:

1. Bitewing X-rays (up to 4 films in a single visit) are payable once per calendar year. Full mouth series X-rays (which include bitewing X-rays), panoramic or periapical X-rays are payable once per 2 year period.
2. Any combination of teeth cleanings (prophylaxes (routine adult cleanings) and periodontal maintenance) are payable twice per calendar year.
3. Oral examinations and evaluations are payable twice per calendar year, regardless of the dentist's specialty.
4. Brush biopsy is payable once per calendar year.
5. Delta Dental's obligation for payment of benefits ends on the last day of coverage. This date is usually the first of the month following receipt of a valid, written request to dis-enroll that was accepted by our plan during a valid Medicare election period. However, Delta Dental will make payment for covered services provided on or before the last day of coverage, as long as Delta Dental receives a claim for those services within one year of the date of service.

6. When services in progress are interrupted Delta Dental will not issue payment for any incomplete services; however, Delta Dental will calculate the maximum approved fee that the dentist may charge you for such incomplete services, and those charges will be your responsibility. In the event the interrupted services are completed later by a dentist, Delta Dental will review the Claim to determine the amount of payment, if any, to the dentist in accordance with Delta Dental's policies at the time services are completed.
7. Optional treatment: If you select a more expensive service than is customarily provided, Delta Dental may make an allowance for certain services based on the fee for the customarily provided service. You are responsible for the difference in cost. In all cases, Delta Dental will make the final determination regarding optional treatment and any available allowance.
8. Maximum payment: all benefits available under this plan are subject to the maximum payment limitations set forth in your Summary of Dental Plan Benefits.
9. Processing policies may otherwise limit Delta Dental's payment for services or supplies.

Delta Dental will make no payment for services or supplies that exceed the following limitations. All charges are your responsibility. However, Medicare Advantage participating dentists may not charge members for these services or supplies when performed by the same dentist or dental office. All time limitations are measured from the applicable prior dates of services in our records with any Delta Dental Plan:

1. Services or supplies, as determined by Delta Dental, which are not provided in accordance with generally accepted standards of dental practice.
2. Processing policies may limit Delta Dental's payment for services or supplies.

OPTIONAL ENHANCED DENTAL BENEFITS

(#1179-3000)

This section provides information about the additional dental coverage that is part of the Optional Enhanced Dental and Vision package. **If you are enrolled in this package, you will pay an additional $29.00 each month.** The chart below is a summary of covered services with cost and frequency, followed by a more detailed chart of the covered services including procedure codes, and then exclusions and limitations.

As a member of **Priority**Medicare Select, you have dental benefits already included in your Medicare Advantage plan, these optional enhanced dental benefits provide you with additional coverage. See the "Summary of Mandatory Dental" section in this appendix.

Your dental plan does not have a deductible, so you start paying for the cost of the service right away. Also, there is no waiting period, which means there isn't a time span which must be met before we begin covering your dental benefits.

Your dental plan will cover $2,500 of the allowable cost of covered services. Fluoride will not apply to the maximum.

Summary of Covered Services	**If you see a Participating Delta Dental Medicare Advantage PPO or Medicare Advantage Premier (in-network) Dentist you pay**	**If you see a Nonparticipating (out-of-network) Dentist you pay**	**Frequency**
Diagnostic services – emergency treatment of dental pain	$0	$0	No limit
Preventive services – fluoride	$0	$0	Once per calendar year
Minor restorative services – fillings and crown repair	$0	$0	No Limit
Endodontic services – root canals	50%	50%	Once every 24 months, per tooth.

Summary of Covered Services	If you see a Participating Delta Dental Medicare Advantage PPO or Medicare Advantage Premier (in-network) Dentist you pay	If you see a Nonparticipating (out-of-network) Dentist you pay	Frequency
Major restorative services – crowns, onlays and associated substructures	50%	50%	Once every 60 months, per tooth.
Simple extractions – non-surgical removal of teeth	50%	50%	Once per lifetime, per tooth.
Oral surgery – surgical extractions and other dental surgery	50%	50%	Extractions are covered once per tooth per lifetime
Anesthesia	$0	$0	Payable in conjunction with Covered Services when medically necessary
Relines & repairs – to bridges and dentures	50%	50%	Once every 36 months, per appliance.
Implant Services – and the restorations	50%	50%	Once every 60 months per tooth.
Other basic services – certain films, tests	50%	50%	Once per visit

The copay amounts listed above are applicable for services from both in-network (participating) providers and out-of-network (non-participating) providers. If the Dentist you select is not a Delta Dental Medicare Advantage Participating Dentist, you will still be covered, but you may have to pay more. See the above sections; "*Why Select A Delta Dental Medicare Advantage*

Participating Dentist?" and "*How payment is made to Delta Dental Medicare Advantage Participating and non-participating dentists*" for details.

Procedure codes covered under <u>OPTIONAL</u> dental

Listed below are the dental procedures and codes covered by your **Optional** dental plan. If a procedure is not on this list, it is not a standard covered benefit under your plan. Standard benefit limitations are listed where applicable in the Benefit Limitations column and also in the Limitations for Optional Dental section below. Some services share frequencies.

Code	Description	In-network dentists you pay	Out-of-network dentists you pay	Benefit Limitations
D1000-D1999 Preventive				
D1206, D1208	Topical application of fluoride	$0	$0	Once per calendar year
D2000-D2999 Restorative				
D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394	amalgam and composite resin	$0	$0	Covered service
D2410, D2420, D2430	gold foil - one surface	Optional	Optional	Plan will pay only the applicable amount that it would have paid for an amalgam restoration (D2140, D2150, D2160)

Code	Description	In-network dentists you pay	Out-of-network dentists you pay	Benefit Limitations
D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652	inlay - any material	Optional	Optional	Plan will pay only the applicable amount that it would have paid for an amalgam restoration (D2140, D2150, D2160, D2161)
D2542, D2543, D2544	onlay - metallic -	50%	50%	Once per 5 year period
D2642, D2643, D2644, D2662, D2663, D2664	onlay - porcelain/ceramic or resin-based	50% / Optional	50% / Optional	Once per 5 year period; Optional service on molar teeth. Plan will pay only the applicable amount that it would have paid for a metallic onlay (D2542, D2543, D2544,)
D2710*, D2712*, D2720*, D2721*, D2722*, D2740*, D2750*, D2751*, D2752*, D2753*, D2783*	crown - resin-based composite or porcelain/ceramic	50% / Optional	50% / Optional	Once per 5 year period; Optional service on molar teeth. Plan will pay only the applicable amount that it would have paid for a full metal crown (D2791)
D2780*, D2781*, D2782*	crown - 3/4 cast	50%	50%	Once per 5 year period

Code	Description	In-network dentists you pay	Out-of-network dentists you pay	Benefit Limitations
D2790*, D2791*, D2792*, D2794*	crown - full cast	50% / Optional	50% / Optional	Once per 5 year period
D2910*	re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$0	$0	Covered service
D2915*	re-cement or re-bond indirectly fabricated or prefabricated post and core	$0	$0	Covered service
D2920*	re-cement or re-bond crown	$0	$0	Covered service
D2921*	reattachment of tooth fragment, incisal edge or cusp	$0	$0	Covered service
D2929*, D2930*, D2931*, D2932*, D2933*, D2934*	prefabricated crown	50%	50%	Covered service
D2940	protective restoration	$0	$0	Once per tooth per lifetime and considered to be part of the fee when done in conjunction with a definitive restoration, indirect pulp cap or endodontic treatment (including pulpotomy)

Code	Description	In-network dentists you pay	Out-of-network dentists you pay	Benefit Limitations
D2941	interim therapeutic restoration - primary dentition	$0	$0	Once per primary tooth
D2950*	core buildup, including any pins when required	50%	50%	Once per 5 year period
D2951*	pin retention - per tooth, in addition to restoration	$0	$0	Once per tooth per lifetime
D2952*, D2954*	post and core in addition to crown	50%	50%	Once per 5 year period
D2955*	post removal	50%	50%	Covered service
D2971*	additional procedures to construct new crown under existing partial denture framework	50%	50%	Covered service
D2980*, D2981*, D2982*, D2983*	repair necessitated by restorative material failure	$0	$0	Covered service
D2999*	unspecified restorative procedure, by report	$0	$0	Benefit determined by consultant review
D3000-D3999 Endodontics				
D3220*	therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	50%	50%	Covered service

Code	Description	In-network dentists you pay	Out-of-network dentists you pay	Benefit Limitations
D3221*	pulpal debridment, primary or permanent teeth	50%	50%	Covered service
D3222*	partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	50%	50%	Once per tooth per lifetime; additional benefit will require review
D3230*, D3240*	pulpal therapy (resorbable filling) - any tooth (excluding final restoration)	50%	50%	Covered service
D3310*, D3320*, D3330*	endodontic therapy (excluding final restoration)	50%	50%	Covered service
D3332*	incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	50%	50%	Covered service
D3333*	internal root repair of perforation defects	50%	50%	Covered service
D3346*, D3347*, D3348*	retreatment of previous root canal therapy	50%	50%	Covered service
D3351*, D3352*, D3353*	apexification/recalcification (apical closure/calcific repair of perforations, root resorption, root canal, pulp space, disinfection etc.)	50%	50%	Covered service

Code	Description	In-network dentists you pay	Out-of-network dentists you pay	Benefit Limitations
D3410*, D3421*, D3425*, D3426*	apicoectomy	50%	50%	Covered service
D3430*	retrograde filling - per root	50%	50%	Covered service
D3450*	root amputation - per root	50%	50%	Covered service
D3471*, D3472*, D3473*	surgical repair of root resorption	50%	50%	Covered service
D3501*, D3502*, D3503*	surgical exposure of root surface without apicoectomy or repair of root resorption	50%	50%	Covered Service
D3920*	hemisection (including any root removal), not including root canal therapy	50%	50%	Covered service
D3999*	unspecified endodontic procedure, by report	50%	50%	Benefit determined by consultant review
D5000-D5999 Prosthodontics (Removable)				
D5410*, D5411*, D5421*, D5422*	adjust complete/partial denture	50%	50%	Covered service
D5511*, D5512*, D5611*, D5612*, D5621*, D5622*, D5630*	repair broken complete or partial denture	50%	50%	Covered service

Code	Description	In-network dentists you pay	Out-of-network dentists you pay	Benefit Limitations
D5512*	repair broken complete denture base, maxillary	50%	50%	Covered service
D5640*	replace broken teeth - per tooth	50%	50%	Covered service
D5650*	add tooth to existing partial denture	50%	50%	Covered service
D5660*	add clasp to existing partial denture - per tooth	50%	50%	Covered service
D5670*, D5671*	replace all teeth and acrylic on cast metal framework	50%	50%	Covered service
D5710, D5711, D5720, D5721	rebase complete or partial denture	50%	50%	Once per 36 month period
D5730, D5731, D5740, D5741, D5750, D5751, D5760, D5761	reline complete or partial denture	50%	50%	Once per 36 month period
D5850, D5851	tissue conditioning,	50%	50%	Twice per 36 month period
D6000-D6199 Implant Services				
D6010*	surgical placement of implant body; endosteal implant	50%	50%	Once per 5 year period

Code	Description	In-network dentists you pay	Out-of-network dentists you pay	Benefit Limitations
D6013*	surgical placement of mini implant	50%	50%	Once per 5 year period
D6056*	prefabricated abutment - includes modification and placement	50%	50%	Once per 5 year period
D6057*	custom abutment - includes placement	50%	50%	Once per 5 year period
D6065*, D6066*, D6067*, D6082*, D6083*, D6084*, D6086*, D6087*, D6088*	implant supported crown, any material	50%	50%	Once per 5 year period
D6080*	implant maintenance procedures - when prostheses are removed and reinserted, including cleansing of prostheses and abutments	50%	50%	Once per 5 year period

Code	Description	In-network dentists you pay	Out-of-network dentists you pay	Benefit Limitations
D6081*	scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure	50%	50%	Once per 5 year period
D6090*	repair implant supported prosthesis, by report	50%	50%	Covered service
D6092*, D6093*	recement implant/abutment supported crown or fixed partial denture	50%	50%	Covered service
D6094*, D6097*	abutment supported crown	50%	50%	Covered service
D6095*	repair implant abutment, by report	50%	50%	Covered service
D6096*	remove broken implant retaining screw	50%	50%	1 per 5 year period
D6100*	implant removal, by report	50%	50%	Once per tooth per lifetime
D6101*	debridement of a peri-implant defect and surface cleaning of exposed implant surfaces, including flap entry and closure	50%	50%	Covered service

Code	Description	In-network dentists you pay	Out-of-network dentists you pay	Benefit Limitations
D6102*	debridement and osseous contouring of a peri-implant defect; includes surface cleaning of exposed implant surfaces and flap entry and closure	50%	50%	Covered service
D6103*	bone graft for repair of peri-implant defect - does not include flap entry and closure	50%	50%	Covered service
D6104*	bone graft at time of implant placement	50%	50%	Covered service
D6190*	radiographic/surgical implant index, by report	50%	50%	Covered service
D6199*	unspecified implant procedure, by report	50%	50%	Benefit determined by consultant review
D6200-D6999 Prosthodontics (Fixed)				
D6930*	re-cement or re-bond fixed partial denture	50%	50%	Covered service
D6980*	fixed partial denture repair, necessitated by restorative material failure	50%	50%	Covered service
D7000-D7999 Oral and Maxillofacial Surgery				
D7111*	extraction, coronal remnants - primary tooth	50%	50%	Once per tooth per lifetime

Code	Description	In-network dentists you pay	Out-of-network dentists you pay	Benefit Limitations
D7140*	extraction, erupted tooth or exposed root (elevation and or forceps removal)	50%	50%	Once per tooth per lifetime
D7210*	extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap, if indicated	50%	50%	Once per tooth per lifetime
D7220*, D7230*, D7240*	removal of impacted tooth	50%	50%	Once per tooth per lifetime
D7241*	removal of impacted tooth - completely bony, with unusual surgical complications	50%	50%	Once per tooth per lifetime
D7250*	removal of residual tooth roots (cutting procedure)	50%	50%	Once per tooth per lifetime
D7251*	coronectomy - intentional partial tooth removal	50%	50%	Once per tooth per lifetime
D7270*	tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	50%	50%	Covered service
D7280*	exposure of an unerupted tooth	50%	50%	Once per tooth per lifetime

Code	Description	In-network dentists you pay	Out-of-network dentists you pay	Benefit Limitations
D7282	mobilization of erupted or malpositioned tooth to aid eruption	50%	50%	Once per tooth per lifetime
D7283*	placement of device to facilitate eruption of impacted tooth	50%	50%	Covered service
D7286	biopsy of oral tissue - soft	50%	50%	Subject to services it is performed in conjunction with. Predetermination is strongly recommended
D7290*	surgical repositioning of teeth	50%	50%	Covered service
D7291*	transseptal fiberotomy/supra crestal fiberotomy, by report	50%	50%	Covered service
D7292*	placement of temporary anchorage device (screw retained plate) requiring flap; includes device removal	50%	50%	Covered service
D7293*	placement of temporary anchorage device requiring flap; includes device removal	50%	50%	Covered service

Code	Description	In-network dentists you pay	Out-of-network dentists you pay	Benefit Limitations
D7294*	placement of temporary anchorage device without flap; includes device removal	50%	50%	Covered service
D7295*	harvest of bone for use in autogenous grafting procedure	50%	50%	Covered service
D7310*, D7311*	alveoloplasty in conjunction with extractions - per quadrant	50%	50%	Covered service
D7320*, D7321*	alveoloplasty not in conjunction with extractions	50%	50%	Covered service
D7510*	incision and drainage of abscess - intraoral soft tissue	50%	50%	Covered service
D7511*	incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	50%	50%	Covered service
D7910*	suture of recent small wounds up to 5 cm	50%	50%	Covered service
D7921*	collection and application of autologous blood concentrate product	50%	50%	Covered service

Code	Description	In-network dentists you pay	Out-of-network dentists you pay	Benefit Limitations
D7950*	osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla - autogenous or nonautogenous, by report	50%	50%	Covered service
D7951*	sinus augmentation with bone or bone substitutes via a lateral open approach	50%	50%	Covered service
D7952*	sinus augmentation via a vertical approach	50%	50%	Covered service
D7953*	bone replacement graft for ridge preservation - per site	50%	50%	Covered service
D7955*	repair of maxillofacial soft and/or hard tissue defect	50%	50%	Covered service
D7970*	excision of hyperplastic tissue - per arch	50%	50%	Covered service
D7971*	excision of pericoronal gingiva	50%	50%	Covered service
D7996*	implant-mandible for augmentation purposes (excluding alveolar ridge), by report	50%	50%	Covered service

Code	Description	In-network dentists you pay	Out-of-network dentists you pay	Benefit Limitations
D7999*	unspecified oral surgery procedure, by report	50%	50%	Benefit determined by consultant review
D9000-D9999 Adjunctive General Services				
D9110	palliative (emergency) treatment of dental pain - minor procedure	$0	$0	As needed for diagnosis of emergency condition
D9222, D9223	deep sedation/general anesthesia	$0	$0	Paid in conjunction with qualifying services
D9239, D9243	intravenous moderate (conscious) sedation/analgesia	$0	$0	Paid in conjunction with qualifying services

Exclusions for <u>OPTIONAL</u> Dental

Delta Dental will make no payment for the following services or supplies, unless otherwise specified in the optional covered services chart or procedure codes list above. All charges for the same will be your responsibility (though your payment obligation may be satisfied by insurance or some other arrangement for which you are eligible):

1. Services or supplies, as determined by Delta Dental, for correction of congenital or developmental malformations.
2. Cosmetic surgery or dentistry for aesthetic reasons, as determined by Delta Dental.
3. Services started or appliances started before a person became eligible under This Plan. This exclusion does not apply to orthodontic treatment in progress (if a Covered Service).
4. Prescription drugs (except intramuscular injectable antibiotics), premedication, medicaments/ solutions, and relative analgesia.
5. General anesthesia and intravenous sedation for (a) surgical procedures, unless medically necessary, or (b) restorative dentistry.
6. Charges for hospitalization, laboratory tests, and histopathological examinations.
7. Charges for failure to keep a scheduled visit with the Dentist.
8. Services or supplies, as determined by Delta Dental, for which no valid dental need can be demonstrated.

9. Services or supplies, as determined by Delta Dental that are investigational in nature, including services or supplies required to treat complications from investigational procedures.
10. Services or supplies, as determined by Delta Dental, which are specialized techniques.
11. Treatment by other than a Dentist, except for services performed by a licensed dental hygienist or other dental professional, as determined by Delta Dental, under the scope of his or her license as permitted by applicable state law.
12. Services or supplies for which the patient is not legally obligated to pay, or for which no charge would be made in the absence of Delta Dental coverage.
13. Services or supplies received due to an act of war, declared or undeclared.
14. Services or supplies covered under a hospital, surgical/medical, (including Medicare Advantage), or prescription drug program.
15. Services or supplies that are not within the categories of Benefits selected by your Medicare Advantage Organization and that are not covered under the terms of this Certificate.
16. Fluoride rinses, self-applied fluorides, or desensitizing medicaments.
17. Interim caries arresting medicament.
18. Preventive control programs (including oral hygiene instruction, caries susceptibility tests, dietary control, tobacco counseling, home care medicaments, etc.).
19. Sealants.
20. Space maintainers.
21. Lost, missing, or stolen appliances of any type and replacement or repair of orthodontic appliances or space maintainers.
22. Cosmetic dentistry, including repairs to facings posterior to the second bicuspid position.
23. Veneers.
24. Prefabricated crowns used as final restorations on permanent teeth.
25. Appliances, surgical procedures, and restorations for increasing vertical dimension; for altering, restoring, or maintaining occlusion; for replacing tooth structure loss resulting from attrition, abrasion, abfraction, or erosion; or for periodontal splinting. If Orthodontic Services are Covered Services, this exclusion will not apply to Orthodontic Services as limited by the terms and conditions of the contract between Delta Dental and your Medicare Advantage Organization.
26. Implant/abutment supported interim fixed denture for edentulous arch.
27. Paste-type root canal fillings on permanent teeth.
28. Replacement, repair, relines, or adjustments of occlusal guards.
29. Chemical curettage.
30. Prosthodontic Services.

31. Services associated with overdentures.
32. Metal bases on removable prostheses.
33. The replacement of teeth beyond the normal complement of teeth.
34. Personalization or characterization of any service or appliance.
35. Temporary crowns used for temporization during crown or bridge fabrication.
36. Posterior bridges in conjunction with partial dentures in the same arch.
37. Precision attachments and stress breakers.
38. Biologic materials to aid in soft and osseous tissue regeneration when submitted on the same day as soft tissue grafting, guided tissue regeneration and periodontal or implant bone grafting.
39. Appliances, restorations, or services for the diagnosis or treatment of disturbances of the temporomandibular joint (TMJ).
40. Orthodontic Services other than Periodontal Maintenance.
41. Diagnostic photographs and cephalometric films, unless done for orthodontics and orthodontics are a Covered Service.
42. Myofunctional therapy.
43. Mounted case analyses.
44. Any and all taxes applicable to the services.
45. Processing policies may otherwise exclude payment by Delta Dental for services or supplies.

Delta Dental will make no payment for the following services or supplies. Medicare Advantage Participating Dentists may not charge Members for these services or supplies. All charges from Nonparticipating Dentists for the following are your responsibility:

1. Services or supplies, as determined by Delta Dental, which are not provided in accordance with generally accepted standards of dental practice.
2. The completion of forms or submission of claims.
3. Consultations, patient screening, or patient assessment when performed in conjunction with examinations or evaluations.
4. Local anesthesia unless performed in conjunction with Covered Services when medically necessary.
5. Acid etching, cement bases, cavity liners, and bases or temporary fillings.
6. Infection control.
7. Temporary, interim, or provisional crowns.
8. Gingivectomy as an aid to the placement of a restoration.
9. The correction of occlusion, when performed with prosthetics and restorations involving occlusal surfaces.
10. Diagnostic casts, when performed in conjunction with restorative or prosthodontic procedures.
11. Palliative treatment, when any other service is provided on the same date except X-rays and tests necessary to diagnose the emergency condition.

12. Post-operative X-rays, when done following any completed service or procedure.
13. Periodontal charting.
14. Pins and preformed posts, when done with core buildups.
15. Any substructure when done for inlays, onlays, and veneers.
16. A pulp cap, when done with a sedative filling or any other restoration. A sedative or temporary filling, when done with pulpal debridement for the relief of acute pain prior to conventional root canal therapy or another endodontic procedure. The opening and drainage of a tooth or palliative treatment, when done by the same Dentist or dental office on the same day as completed root canal treatment.
17. A pulpotomy on a permanent tooth, except on a tooth with an open apex.
18. A therapeutic apical closure on a permanent tooth, except on a tooth where the root is not fully formed.
19. Retreatment of a root canal by the same Dentist or dental office within two years of the original root canal treatment.
20. A prophylaxis or full mouth debridement, when done on the same day as periodontal maintenance or scaling and root planing.
21. Scaling in the presence of gingival inflammation when done on the same day as periodontal maintenance.
22. Prophylaxis, scaling in the presence of gingival inflammation, or periodontal maintenance when done within 30 days of three or four quadrants of scaling and root planing or other periodontal treatment.
23. Full mouth debridement when done within 30 days of scaling and root planing.
24. Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces without flap entry and closure, when performed within 12 months of implant restorations, provisional implant crowns and implant or abutment supported interim dentures.
25. Full mouth debridement, when done on the same day as the delivery of a partial denture.
26. An occlusal adjustment, when performed on the same day as the delivery of an occlusal guard.
27. Reline, rebase, or any adjustment or repair within six months of the delivery of a partial denture.
28. Tissue conditioning, when performed on the same day as the delivery of a denture or the reline or rebase of a denture.
29. Periapical and/or bitewing X-rays, when done within a clinically unreasonable period

of time of performing panoramic and/or full mouth X-rays, as determined solely by Delta Dental.

30. Charges or fees for overhead, internet/video connections, software, hardware or other equipment necessary to deliver services, including but not limited to teledentistry services.
31. Processing policies may otherwise exclude payment by Delta Dental for services or supplies.

Limitations for <u>OPTIONAL</u> Dental

The benefits for the following services or supplies are limited as follows, unless otherwise specified in the optional covered services chart or procedure codes list above. All charges for services or supplies that exceed these limitations will be your responsibility. All time limitations are measured from the applicable prior dates of services in our records with any Delta Dental Plan or any dental plan:

1. Fluoride treatments are payable once per calendar year.
2. Cast restorations (including jackets, crowns and onlays) and associated substructures) are payable once in any five-year period.
3. Crowns or onlays are payable only for extensive loss of tooth structure due to caries (decay) or fracture (lost or mobile tooth structure).
4. Individual crowns over implants are payable at the prosthodontic benefit level.
5. Substructures, porcelain, porcelain substrate, and cast restorations are not payable for people under age 12.
6. Pulp vitality tests are payable once per visit for the diagnosis of emergency conditions.
7. A reline or the complete replacement of denture base material is payable once in any three-year period per appliance.
8. Implants and/or the restorations are payable once per tooth per five-year period.
9. Delta Dental's obligation for payment of Benefits ends on the last day of coverage. This date is usually the first of the month following receipt of a valid, written request to disenroll that was accepted by our plan during a valid Medicare election period. However, Delta Dental will make payment for Covered Services provided on or before the last day of coverage, as long as Delta Dental receives a claim for those services within one year of the date of service.
10. When services in progress are interrupted Delta Dental will not issue payment for any incomplete services; however, Delta Dental will calculate the

Maximum Approved Fee that the dentist may charge you for such incomplete services, and those charges will be your responsibility. In the event the interrupted services are completed later by a Dentist, Delta Dental will review the Claim to determine the amount of payment, if any, to the Dentist in accordance with Delta Dental's policies at the time services are completed.

11. Optional treatment: If you select a more expensive service than is customarily provided, Delta Dental may make an allowance for certain services based on the fee for the customarily provided service. You are responsible for the difference in cost. In all cases, Delta Dental will make the final determination regarding optional treatment and any available allowance.

For example:

a. Resin, porcelain fused to metal, and porcelain crowns, bridge retainers, or pontics on posterior teeth – Delta Dental will pay only the amount that it would pay for a full metal crown.

b. Inlays, regardless of the material used – Delta Dental will pay only the amount that it would pay for an amalgam or composite resin restoration.

c. Gold foil restorations – Delta Dental will pay only the amount that it would pay for an amalgam or composite restoration.

d. Posterior stainless steel crowns with esthetic facings, veneers or coatings – Delta Dental will pay only the amount that it would pay for a conventional stainless steel crown.

12. Maximum Payment: All Benefits available under This Plan are subject to the Maximum Payment limitations set forth in your Summary of Dental Plan Benefits.

13. Processing policies may otherwise limit payment by Delta Dental for services or supplies.

Delta Dental will make no payment for services or supplies that exceed the following limitations. All charges are your responsibility. However, Medicare Advantage Participating Dentists may not charge Members for these services or supplies when performed by the same Dentist or dental office. All time limitations are measured from the applicable prior dates of services in our records with any Delta Dental Plan:

1. Amalgam and composite resin restorations are payable once in any two-year period, regardless of the number or combination of restorations placed on a surface.

2. Core buildups and other substructures are payable only when needed to retain a crown on a tooth with excessive breakdown due to caries (decay) and/or fractures.
3. Recementation of a crown, onlay, inlay, space maintainer, or bridge within six months of the seating date.
4. Retention pins are payable once in any two-year period. Only one substructure per tooth is a Covered Service.
5. The allowance for a denture repair (including reline or rebase) will not exceed half the fee for a new denture.
6. Services or supplies, as determined by Delta Dental, which are not provided in accordance with generally accepted standards of dental practice.
7. Processing Policies may limit Delta Dental's payment for services or supplies.

VISION INFORMATION
(Mandatory & Optional)

Your routine vision benefits are administered by our partner, EyeMed[SM].

If you have any questions about your routine vison coverage, contact EyeMed's Customer Service Department at 844.366.5127, Monday through Friday 8 a.m. to 8 p.m. EST (TTY 711). For assistance on Saturday or Sunday, call Priority Health Medicare at 888.389.6648 (TTY 711), from 8 a.m. to 8 p.m. EST.

WHAT DO I NEED WHEN I GO TO MY ROUTINE VISION PROVIDER?

When making an appointment identify yourself as a Priority Health Medicare member with EyeMed coverage and provide your name and member ID, located on your Priority Health member ID card. Confirm the provider is a provider in EyeMed's "Select" network. While your ID card is not necessary to receive services, it is helpful to present your Priority Health member ID card to identify your membership.

WHY CHOOSE AN EYEMED "SELECT" PROVIDER?

EyeMed "Select" providers will file your claim on your behalf saving you the hassle of having to pay upfront and seek reimbursement. Plus, these providers may offer additional discounts.

FINDING AN EYEMED "SELECT" PROVIDER?

To find an in-network provider (providers in EyeMed's "Select" network), go to *priorityhealth.com* and use the "Find a Doctor" tool or call the EyeMed Customer Service Department at 844.366.5127, Monday through Friday 8 a.m. to 8 p.m. EST (TTY 711).

You have access to thousands of independent and retail providers, including these national retailers: LensCrafters®, Target® Optical, and most Pearle Vision® locations. Plus, you can use your contact lens benefit at *ContactsDirect.com* or *LensCraftersContacts.com*. Other online in-network providers for frames and lenses include*: glasses.com, Ray-Ban.com, TargetOptical.com* and *LensCrafters.com*. Your contacts, frames or lenses will be delivered directly to your home.

HOW PAYMENT IS MADE TO EYEMED "SELECT" NETWORK PROVIDERS

When you receive services in-network with an EyeMed "Select" provider, the provider will file your claim. You will have to pay the cost of any services or eyewear that exceeds any benefit allowances and/or discounts. You will also owe state tax, if applicable, and the cost of any non-covered expense.

HOW TO SEEK REIMBURSEMENT WHEN YOU USE A NON-EYEMED "SELECT" NETWORK PROVIDER

If you use a non-EyeMed "Select" provider (out-of-network provider) you will be responsible for paying the cost of any expense out-of-pocket. You are eligible to submit for reimbursement for covered services, see the covered services chart below for reimbursement amounts.

To seek reimbursement, please submit an EyeMed out-of-network claim form or required claim information with an itemized receipt with your name included to receive reimbursement. The claim form is available online at *prioritymedicare.com* as well as in the EyeMed member portal at *member.eyemedvisioncare.com.* On the claim form select "Access Form", enter a valid email address, and select "Send me a claim form link". You should receive an email from noreply@processmyclaim.com with the claim form link shortly after (if not received, check spam folder).

You can also request an out-of-network claim form be mailed to you by calling the EyeMed Customer Service Department at 844.366.5127, Monday through Friday 8 a.m. to 8 p.m. EST (TTY users should call 711).

You can submit your out-of-network claim form or required claim information by mail, email or fax:

- **Mail:** First American Administrators, Inc. Attn: OON Claims, P.O. Box 8504, Mason, OH 45040-7111
- **EyeMed Email:** OONClaims@eyemed.com
- **Fax:** 866.293.7373

Once the required out-of-network claim information is received, it takes on average up to 15 business days for processing, payment comes in check form.

GRIEVANCE AND APPEAL PROCEDURES

See Chapter 9 *"What to do if you have a problem or complaint"* of this Evidence of Coverage document for details.

SUMMARY OF MANDATORY VISION

The Summary of Mandatory vision provides information about the **routine vision coverage that is included in your Priority Health Medicare Advantage plan.** The chart below includes your covered services, cost and frequency, followed by additional savings & discounts available to you and exclusions.

Your routine vision does not have a deductible that needs to be met. Also, there is no waiting period, which means there isn't a time span which must be met before we begin covering your routine vision benefits.

<table>
<tr><th>Covered Services</th><th>EyeMed "Select" Network Provider Benefits[1]</th><th>Non- EyeMed "Select" Network Provider Benefits[4]</th><th>Frequency</th></tr>
<tr><td>Routine exam including refraction with dilation as necessary</td><td>$0 copay</td><td>Up to $50 reimbursement</td><td rowspan="6">Once per calendar year.</td></tr>
<tr><td>Retinal imaging</td><td>$0 copay</td><td>Up to $20 reimbursement</td></tr>
<tr><td rowspan="4">Frames, lens and lens options benefits package (combined)

Or

Contact lenses

(For prescription contact lenses for only one eye, the Plan will pay on-half of the amount payable for contact lenses for both eyes)</td><td>Frames, lens and lens options package (combined):

$100 allowance[2]; or</td><td>Frames, lens and lens options package (combined):

Up to $100 reimbursement[2]; or</td></tr>
<tr><td>Conventional contact lenses:

$100 allowance[2]; or</td><td>Conventional contact lenses:

$100 reimbursement[2]; or</td></tr>
<tr><td>Disposable contact lenses:

$100 allowance[2]; or</td><td>Disposable contact lenses:

Up to $100 reimbursement[2]; or</td></tr>
<tr><td>Medically necessary contact lenses[3]: $0 copay</td><td>Medically necessary contact lenses[3]:

Up to $210 reimbursement</td></tr>
</table>

[1] You must use an EyeMed "Select" Network provider when using in-network benefits.

[2] Plan allows members to file multiple materials (eyeglasses or contacts) until the allowance is used in full. Plan allowance cannot be combined with in-store promotions.

[3] Coverage for medically necessary contact lenses is provided when one of the following conditions exists; Anisometropia of 3D in meridian powers, High Ametropia (exceeding –10D or +10D in meridian powers), Keratoconus (where the member's vision is not correctable to 20/25 in either or both eyes using standard spectacle lenses), vision improvement for Members whose vision can be corrected two lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses. The benefit may not be expanded for other eye conditions even if you or your providers deem contact lenses necessary for other eye conditions or visual improvement.

(4) You may choose to use benefits in-network with an EyeMed "Select" provider OR see a Non-EyeMed "Select" network provider (out-of-network provider) and seek reimbursement. Allowances/benefits or reimbursement are offered once per year per benefit. In-network and out-of-network benefit cannot be combined.

Additional Discounts for <u>MANDATORY</u> Vision

Once your in-network allowances are exhausted you may receive the following discounts from an EyeMed provider during your benefit period:

- 20% off balance over $100 for frame, lens and lens options package
- 15% off balance over $100 for conventional contact lenses
- Additional Pairs Benefit: 40% off complete pair eyeglasses purchases (including prescription sunglasses) once the funded benefit has been used.

These in-network provider discounts may not be combined with any other discounts or promotional offers. Discounts do not apply to EyeMed "Select" Provider's professional services, disposable contact lenses or certain brand name vision materials in which the manufacturer imposes a no-discount practice or policy. Discounts on services may not be available at all EyeMed "Select" Providers.

Savings on Laser Vision Correction

EyeMed, in connection with the U.S. Laser Network, owned and operated by LCA Vision, offers benefits to you for LASIK and PRK. You receive a discount when using an in-network in the U.S. Laser Network. The U.S. Laser Network offers many locations nationwide. For additional information or to locate an in-network provider, visit *www.eyemedlasik.com* or call 877.5LASER6.

Discount:

- 15% off retail price, or
- 5% off promotional price

After you have located a U.S. Laser Network provider, contact the provider and confirm the provider is in-network, identify yourself as a Priority Health Medicare member with EyeMed vision coverage and schedule a consultation to determine if you are a good candidate for laser vision correction. If you are a good candidate and schedule treatment, you must call the U.S. Laser Network again at 877.5LASER6 to activate the discount.

At the time treatment is scheduled, you will be responsible for an initial refundable deposit to the U.S. Laser Network. Upon receipt of the deposit, and prior to treatment, the U.S. Laser Network will issue an authorization number to your provider. Once you receive treatment, the deposit will be deducted from the total cost of the treatment. On the day of treatment, you must pay or arrange to pay the remaining balance of the fee. Should you decide against the treatment, the deposit will be refunded.

SUMMARY OF OPTIONAL ENHANCED VISION

This section provides information about the additional vision coverage that is part of the Optional Enhanced Dental and Vision package. **If you are enrolled in this package, you will pay an additional $29.00 each month.** The chart below includes your covered services, cost and frequency, followed by additional savings & discounts available to you and exclusions.

Your vision coverage does not have a deductible that needs to be met. Also, there is no waiting period, which means there isn't a time span which must be met before we begin covering your vision benefits.

As a member of **Priority**Medicare Select, you have vision benefits already included in your Medicare Advantage plan, these optional enhanced dental benefits provide you with additional coverage. See the "Summary of Mandatory Vision" section in this appendix.

In addition to the vision coverage included in your medical plan, your enhanced package includes an additional $150 allowance for eyewear each year.

<table>
<tr><th>Covered Services</th><th>EyeMed "Select" Network Provider Benefits(1)</th><th>Non- EyeMed "Select" Network Provider Benefits(3)</th><th>Frequency</th></tr>
<tr><td rowspan="3">Frames, lens and lens options benefits package (combined)

Or

Contact lenses

(For prescription contact lenses for only one eye, the Plan will pay on-half of the amount payable for contact lenses for both eyes)</td><td>Frames, lens and lens options package (combined):

$250 allowance(2); or</td><td>Frames, lens and lens options package (combined):

Up to $250 reimbursement(2); or</td><td rowspan="3">Once per calendar year.</td></tr>
<tr><td>Conventional contact lenses:

$250 allowance(2); or</td><td>Conventional contact lenses:

$250 reimbursement(2); or</td></tr>
<tr><td>Disposable contact lenses:

$250 allowance(2)</td><td>Disposable contact lenses:

Up to $250 reimbursement(2)</td></tr>
</table>

(1) You must use an EyeMed "Select" Network provider when using in-network benefits.
(2) Plan allows members to file multiple materials (eyeglasses or contacts) until the allowance is used in full. Plan allowance cannot be combined with in-store promotions.
(3) You may choose to use benefits in-network with an EyeMed "Select" provider OR see a Non-EyeMed "Select" network provider (out-of-network provider) and seek reimbursement.

Allowances/benefits or reimbursement are offered once per year per benefit. In-network and out-of-network benefit cannot be combined.

Additional Discounts for <u>OPTIONAL</u> Vision

Once your in-network allowances are exhausted you may receive the following discounts from an EyeMed provider during your benefit period:

- 20% off balance over $250 for frame, lens and lens options package
- 15% off balance over $250 for conventional contact lenses
- Additional Pairs Benefit: 40% off complete pair eyeglasses purchases (including prescription sunglasses) once the funded benefit has been used.

These in-network provider discounts may not be combined with any other discounts or promotional offers. Discounts do not apply to EyeMed "Select" Provider's professional services, disposable contact lenses or certain brand name vision materials in which the manufacturer imposes a no-discount practice or policy. Discounts on services may not be available at all EyeMed "Select" Providers.

Savings on Laser Vision Correction

EyeMed, in connection with the U.S. Laser Network, owned and operated by LCA Vision, offers benefits to you for LASIK and PRK. You receive a discount when using an in-network in the U.S. Laser Network. The U.S. Laser Network offers many locations nationwide. For additional information or to locate an in-network provider, visit *www.eyemedlasik.com* or call 877.5LASER6.

Discount:

- 15% off retail price, or
- 5% off promotional price

After you have located a U.S. Laser Network provider, contact the provider and confirm the provider is in-network, identify yourself as a Priority Health Medicare member with EyeMed vision coverage and schedule a consultation to determine if you are a good candidate for laser vision correction. If you are a good candidate and schedule treatment, you must call the U.S. Laser Network again at 877.5LASER6 to activate the discount.
At the time treatment is scheduled, you will be responsible for an initial refundable deposit to the U.S. Laser Network. Upon receipt of the deposit, and prior to treatment, the U.S. Laser Network will issue an authorization number to your provider. Once you receive treatment, the deposit will be deducted from the total cost of the treatment. On the day of treatment, you must pay or arrange to pay the remaining balance of the fee. Should you decide against the treatment, the deposit will be refunded

Exclusions for <u>MANDATORY AND OPTIONAL</u> Vision
EyeMed will make no payment for the following services or supplies. All charges for these will be your responsibility

1. Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses.
2. Medical and/or surgical treatment of the eye, eyes or supporting structures. These are covered under your medical plan.
3. Any eye or vision examination, or any corrective or safety eyewear required by an Employer as a condition of employment.
4. Safety eyewear of any kind, for any purpose.
5. Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof.
6. Plano (non-prescription) lenses and/or contact lenses.
7. Non-prescription sunglasses.
8. Two pair of glasses in lieu of bifocals.
9. Services rendered after the date an Eligible Person ceases to be Covered under the Certificate, except when Vision Materials ordered before Coverage ended are delivered, and the services rendered to the Eligible Person are within 31 days from the date of such order.
10. Services or materials provided by any other group benefit plan providing vision care.
11. Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available.
12. Glasses or contacts post cataract surgery. These are covered under your medical plan.
13. Refraction when done on its own. It must be performed during an eye exam to be covered.
14. Conventional or disposable contact lens fitting.

HEARING INFORMATION

(Mandatory)

As a Priority Health Medicare member your plan includes routine hearing coverage through our partnership with TruHearing™, who administers these benefits.

If you have any questions about your coverage, contact TruHearing at 833.714.5356, Monday through Friday from 8 a.m. to 8 p.m., TTY users should call 711. For assistance on Saturday or Sunday, call Priority Health Medicare at 888.389.6648 (TTY users should call 711), from 8 a.m. to 8 p.m. Or write TruHearing at:

TruHearing, Inc.
12936 Frontrunner Blvd #100
Draper, UT 84020

DO I HAVE TO USE A TRUHEARING NETWORK PROVIDER?

Yes, you must use a TruHearing Network Provider for services to be covered.

FINDING A TRUHEARING NETWORK PROVIDER

Call TruHearing at 833.714.5356.

DO I HAVE TO CALL TRUHEARING <u>BEFORE</u> I SEE A TRUHEARING NETWORK PROVIDER?

Yes. To access your benefits, you must call TruHearing at 833.714.5356 to schedule an appointment with a TruHearing Network Provider. A TruHearing consultant will verify your coverage and help you to set up a hearing exam with an in-network hearing provider. If hearing loss is discovered, your audiologist or hearing instrument specialist will help you choose the appropriate hearing aids for your hearing loss.

If you receive services from a TruHearing Network Provider without first calling to TruHearing to access your benefits, you will pay for the full cost of any services received. You will NOT be reimbursed.

WHAT IF I USE A NON-TRUHEARING NETWORK PROVIDER?

If you choose to receive services from a Non-TruHearing Network Provider, **<u>you will pay for the full cost of any services received. You will NOT be reimbursed</u>**. Services and supplies from Non-TruHearing Providers are not covered under this plan.

HOW PAYMENT IS MADE TO TRUHEARING NETWORK PROVIDERS

TruHearing works with their network providers to make payments. You are responsible for paying any applicable cost-share that is not covered in the current described covered services chart below. You are also responsible for paying for any charges above the maximum benefit available under this plan for provider services, supplies or hearing aids.

GRIEVANCE AND APPEAL PROCEDURES

See Chapter 9 *"What to do if you have a problem or complaint"* of this Evidence of Coverage document for details.

SUMMARY OF MANDATORY HEARING

The Summary of Mandatory hearing provides information about the **routine hearing coverage that is included in your Priority Health Medicare Advantage plan.** The chart below includes your covered services, cost, and frequency, followed by what's included with your hearing aid purchase and any exclusions that apply.

Your routine hearing does not have a deductible that needs to be met. Also, there is no waiting period, which means there isn't a time span which must be met before we begin covering your routine hearing benefits.

Covered Services	TruHearing Network Provider Benefits[1]	Frequency
Hearing exam (routine)	$0 copay	One every calendar year
Hearing aids through TruHearing at four levels of technology from 6 hearing aid manufacturers; available in over 100 models and a variety of styles and colors. To access your benefits, call TruHearing at 833.714.5356 8:00 a.m. to 8:00 p.m. Monday through Friday to schedule an appointment.	Basic aid: $295 copay for one hearing aid per ear Standard aid: $695 copay for one hearing aid per ear Advanced aid: $1,095 copay for one hearing aid per ear Premium aid: $1,495 copay for one hearing aid per ear	Up to two hearing aids every calendar year (one per ear, per year).

- Basic aids: Moderately-featured devices that offer exceptional customer value.
- Standard aids: Devices with good hearing performance that include features such as wind and noise reduction (or similar).
- Advanced aids: Advanced devices equipped to handle challenging listening environments.
- Premium aids: Full-featured devices that offer top-of-the-line hearing in all listening environments.

Hearing aid purchases include:

- Provider visits within first year of hearing aid purchase
- 3-year warranty for loss and damage
- 60-day risk-free trial
- 80 batteries per aid

Exclusions for <u>MANDATORY</u> hearing

- Any hearing aids other than those listed in the benefits chart above
- Earmolds
- Hearing aid accessories
- Additional hearing aid batteries
- Additional provider visits
- Replacement warranty costs

PriorityMedicare Select **Customer Service**

Method	Customer Service – Contact Information
CALL	888.389.6648 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	616.942.0995
WRITE	Customer Service, MS 1115, Priority Health Medicare, 1231 East Beltline NE, Grand Rapids, MI 49525 *MedicareCS@priorityhealth.com*
WEBSITE	*prioritymedicare.com*

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 or dial 211
WRITE	MMAP 6105 St. Joseph, Suite 204 Lansing, MI 48917-4850
WEBSITE	*mmapinc.org*

PRA Disclosure Statement *According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1051. If you have comments or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.*

PriorityMedicare Select's pharmacy network includes limited lower-cost, preferred pharmacies in Michigan. The lower costs advertised in our plan materials for these pharmacies may not be available at the pharmacy you use. For up-to-date information about our network pharmacies, including whether there are any lower-cost preferred pharmacies in your area, please call 888.389.6648, TTY users should call 711, or consult the online pharmacy directory at *prioritymedicare.com*.