Priority Health

2024
Evidence of Coverage

PriorityMedicare Key℠ (HMO-POS)
offered by Priority Health

January 1, 2024–December 31, 2024
Regions 1 and 2

OMB Approval 0938-1051 (Expires: February 29, 2024)
H2320_110011502405_C

Your Medicare Health Benefits and Services and Prescription Drug Coverage as a Member of PriorityMedicare Key (HMO-POS)

This booklet gives you the details about your Medicare health care and prescription drug coverage from January 1–December 31, 2024. 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, 2025.

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. For more information, please visit the Internal Revenue Service (IRS) website at ***irs.gov/Affordable-Care-Act/Individuals-and-Families***

About PriorityMedicare Key
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 Key, 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 Key.)

Evidence of Coverage:

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

This document gives you the details about your Medicare health care and prescription drug coverage from January 1 – December 31, 2024. **This is an important legal document. Please keep it in a safe place.**

For questions about this document, please contact Customer Service at 888.389.6648 for additional information. (TTY users should call 711). Hours are 7 days a week, 8 a.m. to 8 p.m. This call is free.

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

This information is available in a different format, including braille, large print, and audio format.

Benefits, premiums, deductibles, and/or copayments/coinsurance may change on January 1, 2025.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary. We will notify affected enrollees about changes at least 30 days in advance.

This document explains your benefits and rights. Use this document to understand about:

- Your plan premium and cost sharing;
- Your medical and prescription drug benefits;
- How to file a complaint if you are not satisfied with a service or treatment;
- How to contact us if you need further assistance; and,
- Other protections required by Medicare law.

OMB Approval 0938-1051 (Expires: February 29, 2024)

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 ðể trả lời các câu hỏi về chýõng sức khỏe và chýõng trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 888.389.6648 sẽ có nhân viên nói tiếng Việt giúp ðỡ 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. Чтобы воспользоваться 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 على مترجم فوري، ليس عليك سوى الاتصال بنا على 8466.983.888. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 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.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 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。

2024 Evidence of Coverage

Table of Contents

CHAPTER 1:
Getting started as a member

SECTION 1 Introduction

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

You are covered by Medicare, and you have chosen to get your Medicare health care and your prescription drug coverage through our plan, **Priority**Medicare Key. We are required to cover all Part A and Part B services. However, cost sharing and provider access in this plan differ from Original Medicare.

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

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* document about?

This *Evidence of Coverage* document tells you how to get your medical care and prescription drugs. It explains your rights and responsibilities, what is covered, what you pay as a member of the plan, and how to file a complaint if you are not satisfied with a decision or treatment.

The words *coverage* and *covered services* refer to the medical care and services and the prescription drugs available to you as a member of **Priority**Medicare Key.

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* document.

If you are confused, concerned, or just have a question, please contact Customer Service.

Section 1.3 Legal information about the *Evidence of Coverage*

This *Evidence of Coverage* is part of our contract with you about how **Priority**Medicare Key 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 Key between January 1, 2024 and December 31, 2024.

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 Key after December 31, 2024. We can also choose to stop offering the plan in your service area, after December 31, 2024.

Medicare (the Centers for Medicare & Medicaid Services) must approve **Priority**Medicare Key each year. You can continue each year 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
- -- *and* -- you live in our geographic service area (Section 2.2 below describes our service area). Incarcerated individuals are not considered living in the geographic service area even if they are physically located in it.
- -- *and* -- you are a United States citizen or are lawfully present in the United States

Section 2.2 Here is the plan service area for **Priority**Medicare Key

PriorityMedicare Key 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

Michigan Counties		
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, you cannot remain a member of this plan. Please contact Customer Service to see if we have a plan in your new area. 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 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.

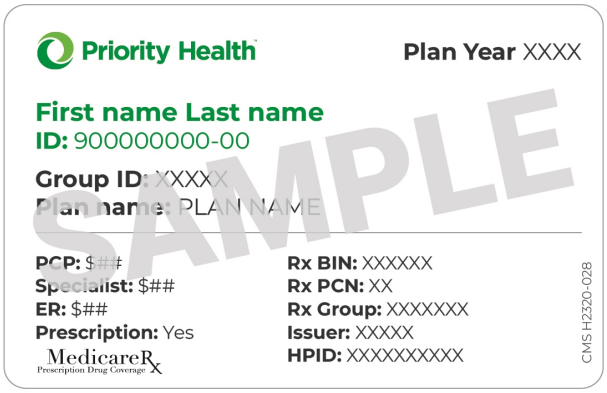
Section 2.3 U.S. Citizen or Lawful Presence

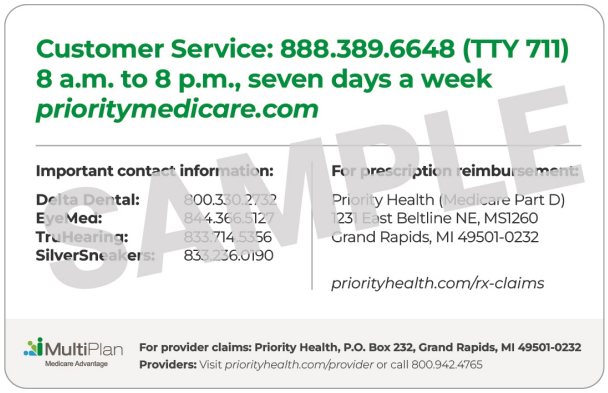
A member of a Medicare health plan must be a U.S. citizen or lawfully present in the United States. Medicare (the Centers for Medicare & Medicaid Services) will notify Priority Health Medicare if you are not eligible to remain a member on this basis. Priority Health Medicare must disenroll you if you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

SECTION 3 Important membership materials you will receive

Section 3.1 Your plan membership card

While you are a member of our plan, you must use your membership card whenever you get 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 Key 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 Medicare approved clinical research studies also called clinical trials.

If your plan membership card is damaged, lost, or stolen, call Customer Service right away and we will send you a new card.

Section 3.2 Provider/Pharmacy Directory

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

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.

You will only pay your Point-of-Service (POS) or "out-of-network" benefit if you see a provider in the lower peninsula of Michigan that does not participate with our plan. When traveling outside of the lower peninsula of Michigan but within the United States and its territories, you can use the Priority Health Travel Pass. For more information, see Chapter 4, Section 2.3 to learn how you can receive care.

The most recent list of providers and suppliers is available on our website at *priorityhealth.com/key24*.

If you don't have your copy of the *Provider/Pharmacy Directory*, you can request a copy (electronically or in hardcopy form) from Customer Service. Requests for hard copy Provider Directories will be mailed to you within three business days.

The pharmacy directory lists our network pharmacies. **Network pharmacies** are all of the pharmacies that have agreed to fill covered prescriptions for our plan members. You can use the *Pharmacy Directory* to find the network pharmacy you want to use. See Chapter 5, Section 2.5 for information on when you can use pharmacies that are not in the plan's 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. You can also see the *Provider/Pharmacy Directory* at *priorityhealth.com/key24*, 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 Key. 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 Key "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." The "Drug List" we provide you includes information for the covered drugs that are most commonly used by our members. However, we cover additional drugs that are not included in the provided "Drug List." If one of your drugs is not listed in the "Drug List," you should visit our website or contact Customer Service to find out if we cover it. To get the most complete and current information about which drugs are covered, you can visit the plan's website (*priorityhealth.com/key24*) or call Customer Service.

SECTION 4 Your monthly costs for **Priority**Medicare Key

Your costs may include the following:

- Plan Premium (Section 4.1)
- Monthly Medicare Part B Premium (Section 4.2)
- Optional Supplemental Benefit Premium (Section 4.3)
- Part D Late Enrollment Penalty (Section 4.4)
- Income Related Monthly Adjusted Amount (Section 4.5)

Section 4.1 Plan premium

You do not pay a separate monthly plan premium for **Priority**Medicare Key.

Section 4.2 Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums

You must continue paying your Medicare premiums to remain a member of the plan. This includes your premium for Part B. It may also include a premium for Part A which affects members who aren't eligible for premium free Part A.

- To learn more or determine if you qualify for assistance paying your Part B premium, you can contact Change Healthcare at 1.866.783.7047, between 9 am to 6 pm, Monday through Friday. TTY users should call 1.877.644.3244. Priority Health works with MyAdvocate Change Healthcare to help members identify and apply for programs that they may qualify for. For additional information please go to *MyAdvocateHelps.com*.

- An additional source for members to see if they qualify for extra help from Medicare may be found by calling Priority Health at 888.389.6648.

Section 4.3 Optional Supplemental Benefit Premium

If you signed up for extra benefits, also called *optional supplemental benefits*, then you pay an additional premium each month for these extra benefits. See Chapter 4, Section 2.2 for details.

Optional supplemental benefit	**Monthly premium**
Enhanced Dental and Vision Package	$33.00

Section 4.4 Part D Late Enrollment Penalty

Some members are required to pay a Part D **late enrollment penalty**. The Part D late enrollment penalty is an additional premium that must be paid for Part D coverage 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.

When you first enroll in **Priority**Medicare Key, we let you know the amount of the penalty.

If you do not pay your Part D late enrollment penalty, you could lose your prescription drug benefits.

You **will not** have to pay it if:

- You receive "Extra Help" from Medicare to pay for your prescription drugs.
- You have gone less than 63 days in a row without creditable coverage.
- You have had creditable drug coverage through another source such as a former employer, union, TRICARE, or 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.

    - **Note:** Any notice must state that you had creditable prescription drug coverage that is expected to pay as much as Medicare's standard prescription drug plan pays.

        - **Note:** The following are *not* creditable prescription drug coverage: prescription drug discount cards, free clinics, and drug discount websites.

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

- If you went 63 days or more without Part D or other creditable prescription drug coverage after you were first eligible to enroll in Part D, the plan will count the number of full months that you did not have coverage. The penalty is 1% for every month that you did not 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 2024, this average premium amount is $34.70.
- 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 $34.70, which equals $4.858. This rounds to $4.90. This amount would be added **to the monthly premium for someone with a Part D late enrollment penalty**.

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

- First, **the penalty may change each year** because the average monthly premium can change each year.
- 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.

If you disagree about your Part D late enrollment penalty, you or your representative can ask for a review. 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. However, 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.

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 4.5 Income Related Monthly Adjustment Amount

Some members may be required to pay an extra charge, known as the Part D Income Related Monthly Adjustment Amount, also known as IRMAA. The extra charge is figured out using your modified adjusted gross income as reported on your IRS tax return from 2 years ago. If this amount is above a certain amount, you'll pay the standard premium amount and the additional IRMAA. For more information on the extra amount you may have to pay based on your income, visit *https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans.*

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. 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. If you do not pay the extra amount, you will be disenrolled from the plan and lose prescription drug coverage.**

If you disagree about paying an extra amount, 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 5 More information about your monthly premium

Section 5.1 If you pay a Part D late enrollment penalty or have our optional supplemental benefits, we have several options for you to pay your monthly premium

We have 5 convenient payment options available for you to pay your monthly premium.

Option 1: Automatic withdrawal from your bank account

You can elect to have your monthly 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 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 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 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 your bank account does not have sufficient funds to cover your 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 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 premium by setting up a one-time credit card payment, or by setting up recurring credit card payments by going to *www.priorityhealth.com/medicare/once-you-enroll/plan-administration/pay-your-premium* or by calling Customer Service at 888.389.6648. Credit card payments may take up to 10 business days for the payment to reflect on your Priority Health member account.

Changing the way you pay your Part D late enrollment penalty. If you decide to change the option by which you pay your monthly Part D late enrollment penalty 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 Part D late enrollment penalty 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. 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.

What to do if you are having trouble paying your monthly Part D late enrollment penalty

Your monthly Part D late enrollment penalty is due in our office by the first of the month. If we have not received your premium payment by the first of the month, we may send you a notice

telling you that your Optional Supplemental Benefits and/or Medical and Prescription coverage 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 at 888.389.6648 to see if we can direct you to programs that may help you.

If you have the Optional Supplemental Benefit package and have no other premium (such as a Part D Late Enrollment Penalty) we may terminate only the Optional Supplemental Benefit. You would remain enrolled in the Medical and Prescription portion of your plan. You would be eligible to re-enroll into the Optional Supplemental Benefit package during your next qualifying election period, which would typically be during the Annual Enrollment Period (AEP) which is from October 15-December 7 of each year. Elections made during this period would take effect on January 1st of the following calendar year.

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 can make a complaint (also called a grievance); see Chapter 9 for how to file 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 Part D late enrollment penalty, if owed, within our grace period, you can make a complaint. For complaints, we will review our decision again. Chapter 9, Section 10 of this document tells how to make a complaint, or you can call us at 888.389.6648 between 8 a.m. to 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 5.2 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, you may be able to stop paying a late enrollment penalty, if owed, or need to start paying a late enrollment penalty. This could happen if you become eligible for the "Extra Help" program or if you lose your eligibility for the "Extra Help" program during the year:

- If you currently pay the Part D late enrollment penalty and become eligible for "Extra Help" during the year, you would be able to stop paying your penalty.
- If you lose "Extra Help", you may be subject to the late enrollment penalty if you go 63 days or more in a row without Part D or other creditable prescription drug coverage.

You can find out more about the "Extra Help" program in Chapter 2, Section 7.

SECTION 6 Keeping your plan membership record up to date

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 address, your phone number
- Changes in any other health insurance coverage you have (such as from your employer, your spouse or domestic partner'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. (**Note:** You are not required to tell your plan about the clinical research studies, you intend to participate in, but we encourage you to do so.)

If any of this information changes, please let us know by calling Customer Service or by mailing a signed written request. *Note:* You can easily change your PCP in your member account. Register or log in to your member account at *priorityhealth.com/key24*, go to "My Plan" and select "My Plan & Spending" and "find a new Primary physician" under current listed PCP.

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.

SECTION 7 How other insurance works with our plan

Other insurance

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. This is called **Coordination of Benefits**.

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 Customer Service. 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.

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. If you have other insurance, tell your doctor, hospital, and pharmacy.

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 or domestic partner 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.

CHAPTER 2:
Important phone numbers and resources

SECTION 1 **Priority**Medicare Key **contacts** (how to contact us, including how to reach Customer Service)

How to contact our plan's Customer Service

For assistance with claims, billing, or member card questions, please call or write to **Priority**Medicare Key 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	*priorityhealth.com/key24*

How to contact us when you are asking for a coverage decision or appeal 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 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 asking for coverage decisions or appeals 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	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	*priorityhealth.com/key24*

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
WRITE	Medicare Part D, MS 1260 Priority Health Medicare 1231 East Beltline Ave, NE Grand Rapids, MI 49525
WEBSITE	*priorityhealth.com/key24*

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	*priorityhealth.com/key24*

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.
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	*priorityhealth.com/key24*

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 pharmacies, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. 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	Medical: 616.975.8827 Part D: 877.974.4411
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 Key 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

If you have received a bill or paid for services (such as a provider bill) that you think we should pay for, you may need to ask us for reimbursement or to pay the provider bill. 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	616.942.0995
WRITE	Customer Service Department, MS 1115 Priority Health Medicare 1231 East Beltline Ave, NE Grand Rapids, MI 49525
WEBSITE	*priorityhealth.com/key24*

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
WRITE	Medicare Part D, MS 1260 Priority Health Medicare 1231 East Beltline Ave, NE Grand Rapids, MI 49525
WEBSITE	*priorityhealth.com/key24*

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

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

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

Method	Medicare – Contact Information
CALL	1-800-MEDICARE, or 1-800-633-4227 Calls to this number are free. 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WEBSITE	*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 documents 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.

Method	Medicare – Contact Information
WEBSITE (continued)	You can also use the website to tell Medicare about any complaints you have about **Priority**Medicare Key: • **Tell Medicare about your complaint:** You can submit a complaint about **Priority**Medicare Key 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 and review the information with 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 an independent (not connected with any insurance company or health plan) 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 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 with Medicare questions or problems and help you understand your Medicare plan choices and answer questions about switching plans.

METHOD TO ACCESS SHIP and OTHER RESOURCES:

- Visit *https://www.shiphelp.org* (Click on SHIP LOCATOR in middle of page)
- Select your **STATE** from the list. 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

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 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	833.868.4059

Method	Livanta LLC (Michigan's Quality Improvement Organization) – Contact Information
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 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 8:00 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 8:00 am to 7:00 pm, Monday through Friday.
WEBSITE	*www.ssa.gov*

SECTION 6 Medicaid

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.

The programs offered through Medicaid help people with Medicare pay their Medicare costs, such as their Medicare premiums. These **Medicare Savings Programs** include:

- **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	517.241.3740, 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

The Medicare.gov website (*https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/costs-in-the-coverage-gap/5-ways-to-get-help-with-prescription-costs*) provides

information on how to lower your prescription drug costs. For people with limited incomes, there are also other programs to assist, described below.

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.

If you automatically qualify for "Extra Help" Medicare will mail you a letter. You will not have to apply. If you do not automatically qualify 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 8 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 1.866.783.7047, between 9 am to 6 pm, Monday through Friday. TTY users should call 1.877.644.3244. Priority Health works with MyAdvocate Change Healthcare to help members identify and apply for programs that they may qualify for. For additional information please go to *MyAdvocateHelps.com*.
- An additional source for members to see if they qualify for extra help from Medicare may be found by calling Priority Health at 888.389.6648.

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 a process for 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 the payment directly to the state. Please contact Customer Service if you have questions.

What if you have coverage from a State Pharmaceutical Assistance Program (SPAP)?

Many states and the U.S. Virgin Islands offer help paying for prescriptions, drug plan premiums and/or other drug costs. If you are enrolled in a State Pharmaceutical Assistance Program (SPAP), or any other program that provides coverage for Part D drugs (other than "Extra Help"), you still get the 70% discount on covered brand name drugs. Also, the plan pays 5% of the costs of brand drugs in the coverage gap. The 70% discount and the 5% paid by the plan are both applied to the price of the drug before any SPAP or other coverage.

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 on the ADAP formulary 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 change plans, please notify your local ADAP enrollment worker so you can continue to receive assistance.

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

State Pharmaceutical Assistance Programs

Many states have State Pharmaceutical Assistance Programs that help some people pay for prescription drugs based on financial need, age, medical condition, or disabilities. Each state has different rules to provide drug coverage to its members.

In , the State Pharmaceutical Assistance Program is Michigan Drug Assistance Program (MIDAP).

Method	Michigan Drug Assistance Program (MIDAP) – Contact Information
CALL	888.826.6566 Monday-Friday, 9 a.m. to 5 p.m.
WRITE	Michigan Department of Health and Human Services P.O. Box 30727 Lansing, MI 48909
WEBSITE	https://www.ncsl.org/health/state-pharmaceutical-assistance-programs

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 receive your Medicare through the Railroad Retirement Board, it is important that you let them know if you move or change your mailing address. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

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.
WEBSITE	*rrb.gov/*

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

If you (or your spouse or domestic partner) get benefits from your (or your spouse or domestic partner'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 or domestic partner's) employer or retiree health benefits, premiums, or the enrollment period. (Phone numbers for Customer Service are printed on the back cover of this document.) 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 or domestic partner'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 for your medical services

SECTION 1 Things to know about getting your medical care 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, equipment, prescription drugs, 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 In-network providers and covered services?

- **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.
- **Covered services** include all the medical care, health care services, supplies, equipment, and Prescription Drugs that are covered by our plan. Your covered services for medical care are listed in the benefits chart in Chapter 4. Your covered services for prescription drugs are discussed in Chapter 5.

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

As a Medicare health plan, **Priority**Medicare Key must cover all services covered by Original Medicare and must follow Original Medicare's coverage rules.

PriorityMedicare Key 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 document).
- **The care you receive is considered medically necessary**. Medically necessary means that the services, supplies, equipment, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- **You have a network primary care provider (a PCP) who is providing and overseeing your care.** As a member of our plan, you must choose a network PCP (for more information about this, see Section 2.1 in this chapter).

  - Your network PCP may recommend other providers in the plan's network, such as specialists, hospitals, skilled nursing facilities, or home health care agencies. This is called giving you a referral. For more information about this, see Section 2.3 of this chapter.
  - Referrals from your PCP are not required.
- **You can receive your care from in-network and out-of-network providers, however you will typically pay less if you use an in-network provider** (for more information about this, see Section 2 in this chapter). When you receive care from an in-network provider you will be covered under your in-network benefit (HMO). When you receive care from an out-of-network provider you will be covered under your out-of-network benefit (POS). *Here are three exceptions:*
  - The plan covers emergency care or urgently needed services that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed services means, see Section 3 in this chapter.
  - If you need medical care that Medicare requires our plan to cover but there are no specialists in our network that provide this care, you can get this care from an out-of-network provider at the same cost sharing you normally pay in-network. **Prior authorization needs to be obtained from Priority Health Medicare before seeking care.** In this situation, you will pay the same as you would pay if you got the care from an in-network provider. For information about getting approval to see an out-of-network doctor, see Section 2.4 in this chapter.
  - The plan covers kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area or when your provider for this service is temporarily unavailable or inaccessible. The cost sharing you pay the plan for dialysis can never exceed the cost sharing in Original Medicare. If you are outside the plan's service area and obtain the dialysis from a provider that is outside the plan's network, your cost sharing cannot exceed the cost sharing you pay in-network. However, if your usual in-network provider for dialysis is temporarily unavailable and you choose to obtain services inside the service area from a provider outside the plan's network the cost sharing for the dialysis may be higher.

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

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

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

When you become a member of **Priority**Medicare Key, your first step is to choose a primary care provider (PCP). Your PCP may be a family practitioner, a general practitioner, an internal medicine physician, an obstetrician/gynecologist, a nurse practitioner and/or a physician assistant working in a primary care setting who meets state requirements and is trained to give you basic

medical care in a primary care setting. Your PCP is your partner in helping you stay healthy and will help you learn how to take control of your health. Because he or she knows your health history, you can get the care you need, when you need it.

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

A PCP can be searched through the Find-a-Doctor tool at *priorityhealth.com/key24* and then updated through your member portal.

Changing your PCP

You may change your PCP for any reason, at any time. Also, it's possible that your PCP might leave our plan's network of providers and you would have to find a new PCP. To change your PCP, please contact Customer Service or make your PCP change online through your member account at *priorityhealth.com/key24*. You will find a list of PCPs to choose from on our website at *priorityhealth.com/key24*. If you need a hard copy of our list of PCPs, or if you need help choosing a PCP, please contact Customer Service. When you make a request to change your PCP, we will make the change immediately.

Section 2.2 What kinds of medical care can you get without a referral 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 are covered services that are not emergency services, provided when the network providers are temporarily unavailable or inaccessible or when the enrollee is out of the service area. For example, you need immediate care during the weekend. Services must be immediately needed and medically necessary.
- 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

at 888.389.6648 before you leave the service area so we can help arrange for you to have maintenance dialysis while you are away.

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

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

- Oncologists care for patients with cancer.
- Cardiologists care for patients with heart conditions.
- Orthopedists care for patients with certain bone, joint, or muscle conditions.
- You may ask your PCP to recommend specialists and other network providers or you may search them out on your own. If you are uncertain as to whether the provider participates with our plan, call Customer Service (phone numbers are on the back of this document) or go to *priorityhealth.com/key24* and use our Find a Doctor tool. Remember that when you use in-network providers, you will pay less. When you use out-of-network providers, you will pay a deductible and you could pay a higher cost share for the same service.

  Prior authorization requirements may apply for some services whether obtained in-network or out-of-network. See Chapter 4, Section 2.1, for details about the services that require prior authorization. Prior authorization decisions are made by Priority Health Medicare and other delegated entities. To obtain prior authorization, you or your provider should contact Priority Health Medicare. You may contact Customer Service at 888.389.6648 to learn more about prior authorization requirements and how to ask for prior authorization of a service.

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

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

We may make changes to the hospitals, doctors, and specialists (providers) that are part of your plan during the year. If your doctor or specialist leaves 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 notify you that your provider is leaving our plan so that you have time to select a new provider.
    - If your primary care or behavioral health provider leaves our plan, we will notify you if you have seen that provider within the past three years.

  - If any of your other providers leave our plan, we will notify you if you are assigned to the provider, currently receive care from them, or have seen them within the past three months.

- We will assist you in selecting a new qualified in-network provider that you may access for continued care.
- If you are currently undergoing medical treatment or therapies with your current provider, you have the right to request, and we will work with you to ensure, that the medically necessary treatment or therapies you are receiving continues.
- We will provide you with information about the different enrollment periods available to you and options you may have for changing plans.
- We will arrange for any medically necessary covered benefit outside of our provider network, but at in-network cost sharing, when an in-network provider or benefit is unavailable or inadequate to meet your medical needs.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider to manage your care.
- 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 a quality of care complaint to the QIO, a quality of care grievance to the plan, or both. Please see Chapter 9.

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

As a member of our plan, you can choose to receive care from out-of-network providers. However, please note providers that do not contract with us are under no obligation to treat you, except in emergency situations. 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. Your plan offers The Priority Health Travel Pass, so you can see Medicare participating providers outside the lower peninsula of Michigan (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 Priority Health Travel Pass*) for details.

Here are some 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 Priority Health Travel Pass, if you receive services from Medicare-participating providers while traveling outside the lower peninsula 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 Priority Health Travel Pass)* for details.

- When you receive services from a provider who does not participate with Priority Health Medicare in the lower peninsula of Michigan, you will pay the out-of-network cost sharing as defined in Chapter 4, Section 2.1.
- You don't need a referral if you are seeking care from out-of-network providers in the lower peninsula of Michigan or when using providers with the Priority Health Travel Pass. However, before getting services we encourage you to confirm that the services you are getting are covered and are medically necessary. This is important because:
    - If we later determine that the services are not covered or were not medically necessary, we may deny coverage and you will be responsible for the entire cost. If we say we will not cover your services, you have the right to appeal our decision not to cover your care. See Chapter 9 (What to do if you have a problem or complaint) to learn how to appeal.
- It is best to ask an out-of-network provider in the lower peninsula of Michigan or a provider you are using with the Priority Health Travel Pass 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 they send you a bill that you think we should pay, you can send it to us for payment. See Chapter 7 (*Asking the plan to pay its share of a bill you have received for medical services or drugs*) for information about what to do if you receive a bill or if you need to ask for reimbursement.
- If you are using an out-of-network provider whether you are in or out of the lower peninsula of Michigan for ambulance, emergency care, or urgently needed care you will not have to pay a higher cost-sharing amount. See Section 3 for more information about these situations.

It is important to know what Medicare will or will not cover. Be sure to ask your provider if a service is covered.

SECTION 3 How to get 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 your loss of life (and, if you are a pregnant woman, loss of an unborn child), loss of a limb or function of a limb, or loss of or serious impairment to a bodily function. 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. You do not need to use a network doctor. You may get covered emergency medical care whenever you need it, anywhere in the United States or worldwide emergency/urgent coverage, and from any provider with an appropriate state license even if they are not part of our network.
- **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?

Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. We also cover medical services during the emergency.

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 doctors will continue to treat you until your doctors contact us and make plans for additional care. Your follow-up care will be covered by our plan. Your in-network benefit would apply for medically necessary acute follow-up care after an emergency or urgent care event if the care cannot be delayed without adverse medical effects. Your out-of-network (or POS) benefit would apply for acute follow-up care after an emergency or urgent care event if the care can be delayed without adverse medical effects and you are physically or reasonably able to return to the service area to receive care from contracted providers. If you are physically or reasonably able to return to the service area but choose to remain outside the service area after the event, the care you receive will be under your out-of-network (or POS) benefit. The out-of-network (or POS) benefit applies for treatment or follow-up care for a chronic or existing condition. See Chapter 4 (*Medicare benefits chart what is covered and what you pay*) for details on your POS (out-of-network) cost share.

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.

What if it wasn’t a medical emergency?

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

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

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

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

What are urgently needed services?

An urgently needed service is a non-emergency situation requiring immediate medical care but given your circumstances, it is not possible or not reasonable to obtain these services from a network provider. The plan must cover urgently needed services provided out of network. Some examples of urgently needed services are i) a severe sore throat that occurs over the weekend or ii) an unforeseen flare-up of a known condition when you are temporarily outside the service area.

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.

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

Section 3.3 Getting care during a disaster

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

Please visit the following website: *priorityhealth.com/key24* for information on how to obtain needed care during a disaster.

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 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 plan cost-sharing 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 Key covers all medically necessary services as listed in the Medical Benefits Chart in Chapter 4 of this document. If you receive services not covered by our plan or services obtained out-of-network and were not authorized, you are responsible for paying the full cost of services.

For covered services that have a benefit limitation, you also 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.

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. Certain clinical research studies are approved by Medicare. Clinical research studies approved by Medicare typically request volunteers to participate in the study.

Once Medicare approves the study, and you express interest, 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. If you tell us that you are in a qualified clinical trial, then you are only responsible for the in-network cost sharing for the services in that trial. If you paid more, for example, if you already paid the Original Medicare cost-sharing amount, we

will reimburse the difference between what you paid and the in-network cost sharing. However, you will need to provide documentation to show us how much you paid. 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 any Medicare-approved clinical research study, you do *not* need to tell us or 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. Please note that this does not include benefits for which our plan is responsible that include, as a component, a clinical trial or registry to assess the benefit. These include certain benefits specified under national coverage determinations (NCDs) and investigational device exemption (IDE) studies trials and may be subject to prior authorization and other plan rules.

Although you do not need to get our plan's permission to be in a clinical research study, covered for Medicare Advantage enrollees by Original Medicare, we encourage you to notify us in advance when you choose to participate in Medicare-qualified clinical trials.

Our plan also covers some clinical research studies. For these studies, we will have to approve your participation. Participation in the clinical research study is also voluntary.

If you participate in a study that Medicare or our plan has *not* approved, *you will be responsible for paying all costs for your participation in the study*.

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

Once you join a Medicare-approved clinical research study, Original Medicare covers the 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.

After Medicare has paid its share of the cost for these services, our plan will pay the difference between the cost sharing in Original Medicare and your in-network 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. However, you are required to submit documentation showing how much cost sharing you paid. Please see Chapter 7 for more information for submitting requests for payments.

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 you would pay the $20 copay required under Original Medicare. You would then notify your plan that you received a qualified clinical trial service and submit documentation such as a provider bill to the plan. The plan would then directly pay you $10. Therefore, your net payment is $10, the same amount you would pay under our plan's benefits. Please note that in order to receive payment from your plan, you must submit documentation to your plan such as a provider bill.

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 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 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. This benefit is provided only for Part A inpatient services (non-medical health care services).

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.
    - You must get approval in advance from our plan before you are admitted to the facility, or your stay will not be covered.

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

SECTION 7 Rules for ownership of durable medical equipment

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

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

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. As a member of **Priority**Medicare Key, however, you may acquire ownership of certain rented durable medical equipment items while a member of our plan after 13 consecutive payments. Call Customer Service for more information.

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. The payments made while enrolled in your plan do not count.

Example 1: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. The payments you made in Original Medicare do not count.

Example 2: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. You were in our plan but did not obtain ownership while in our plan. You then go back to Original Medicare. You will have to make 13 consecutive new payments to own the item once you join Original Medicare again. All previous payments (whether to our plan or to Original Medicare) do not count.

Section 7.2 Rules for oxygen equipment, supplies, and maintenance

What oxygen benefits are you entitled to?

If you qualify for Medicare oxygen equipment coverage **Priority**Medicare Key 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 Key or no longer medically require oxygen equipment, then the oxygen equipment must be returned.

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

Original Medicare requires an oxygen supplier to provide you services for five years. During the first 36 months you rent the equipment. The remaining 24 months the supplier provides the equipment and maintenance (you are still responsible for the copayment for oxygen). After five years you may choose to stay with the same company or go to another company. At this point, the five-year cycle begins again, even if you remain with the same company, requiring you to pay copayments for the first 36 months. If you join or leave our plan, the five-year cycle starts over.

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 provides 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 Key. Later in this chapter, you can find information about medical services that are not covered or may explain 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.

- **Deductible** is the amount you must pay for medical services before our plan begins to pay its share. (Section 1.2 tells you more about your plan deductible.)
- **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.

Section 1.2 What is your plan deductible?

Your out-of-network (POS) deductible is $1,500. This is the amount you have to pay out-of-pocket before we will pay our share for your covered out-of-network (POS) medical services.

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

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

- Out-of-network Abridge
- Out-of-network BrainHQ
- Out-of-network SilverSneakers
- Out-of-network Worldwide Assistance Program
- Out-of-network Mom's Meals
- Out-of-network Medicare-covered & routine non-Medicare covered acupuncture services
- Out-of-network ambulance services
- Out-of-network emergency room services
- Out-of-network Medicare-covered immunizations
- Out-of-network routine non-Medicare covered dental services
- Out-of-network routine non-Medicare covered hearing services
- Out-of-network outpatient hospital observation
- Out-of-network routine non-Medicare covered vision services
- Out-of-network urgently needed services
- Out-of-network Part B insulin furnished through an item of durable medical equipment

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

Because you are enrolled in a Medicare Advantage Plan, there is a limit on the total amount you have to pay out-of-pocket each year for in-network medical services that are covered by our plan. This limit is called the maximum out-of-pocket (MOOP) amount for medical services. For calendar year 2024 this amount is $5,000.

The amounts you pay for copayments and coinsurance for in-network covered services count toward this maximum out-of-pocket amount. (The amounts you pay for your Part D late enrollment penalty, if any, and for your Part D prescription drugs do not count toward your maximum out-of-pocket amount.) In addition, amounts you pay for some services do not count toward your maximum out-of-pocket amount. These services are marked with an asterisk in the Medical Benefits Chart. If you reach the maximum out-of-pocket amount of $5,000, you will not have to pay any out-of-pocket costs for the rest of the year for in-network covered services. However, you must continue to pay the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Section 1.4 Our plan does not allow providers to balance bill you

As a member of **Priority**Medicare Key, an important protection for you is that, after you meet any deductibles, you only have to pay your cost-sharing amount when you get services covered by our plan. Providers may not add additional separate charges, called **balance billing**. This protection applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don't pay certain provider charges.

Here is how this protection works.

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

SECTION 2 Use the *Medical Benefits Chart* to find out what is covered 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 Key covers and what you pay out-of-pocket for each service. Part D prescription drug coverage is in Chapter 5. 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, equipment, and Part B prescription drugs) *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 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)
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 affirming – surgery and hormone therapy	Outpatient hospital Outpatient surgery
Genetic testing	Outpatient diagnostic tests/therapeutic services
Home health services	Home health agency care
Home infusion services	Home infusion services
Implanted cardiac devices	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:
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
Nuclear cardiology studies	Outpatient diagnostic tests/therapeutic 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)
Parenteral/enteral feedings	Prosthetic devices
Partial hospitalization and Intensive outpatient services	Partial hospitalization and Intensive outpatient services
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
Radiation oncology procedures (such as but not limited to, intensity-modulated radiation therapy (IMRT), neutron beam radiotherapy (NBRT), proton beam radiotherapy (PBRT), stereotactic radiosurgery (SRS), stereotactic body radiation therapy (SBRT)	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)

PRIOR AUTHORIZATION REFERENCE CHART	
Prior authorization is required for the following:	Look for this service in the Medical Benefits Chart below for details:
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)

Other important things to know about our coverage:

- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay *more* in our plan than you would in Original Medicare. For others, you pay *less.* (If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You 2024* 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.
- If Medicare adds coverage for any new services during 2024, either Medicare or our plan will cover those services.

Important Benefit Information for Enrollees with Chronic Conditions

- To qualify for Special Supplemental Benefits for the Chronically Ill (SSBCI) you must be diagnosed with one or more of the following chronic conditions (s), be at high risk for hospitalization or other adverse health outcomes, and require intensive care coordination.

    - Chronic alcohol and other drug dependence
    - Autoimmune disorders limited to: Polyarteritis nodosa, Polymyalgia rheumatica, Polymyositis, Rheumatoid arthritis, and Systemic lupus erythematosus
    - Cancer, excluding pre-cancer conditions or in-situ status

- Cardiovascular disorders limited to: Cardiac arrhythmias, Coronary artery disease, Peripheral vascular disease, and Chronic venous thromboembolic disorder
- Chronic heart failure
- Dementia
- Diabetes mellitus
- End-stage liver disease
- End-stage renal disease (ESRD) requiring dialysis
- Severe hematologic disorders limited to: Aplastic anemia, Hemophilia, Immune thrombocytopenic purpura, Myelodysplatic syndrome, Sickle-cell disease (excluding sickle-cell trait), and Chronic venous thromboembolic disorder
- HIV/AIDS
- Chronic lung disorders limited to: Asthma, Chronic bronchitis, Emphysema, Pulmonary fibrosis, and Pulmonary hypertension
- Chronic and disabling mental health conditions limited to: Bipolar disorders, Major depressive disorders, Paranoid disorder, Schizophrenia, and Schizoaffective disorder
- Neurologic disorders limited to: Amyotrophic lateral sclerosis (ALS), Epilepsy, Extensive paralysis (i.e., hemiplegia, quadriplegia, paraplegia, monoplegia), Huntington's disease, Multiple sclerosis, Parkinson's disease, Polyneuropathy, Spinal stenosis, and Stroke-related neurologic deficit
- Stroke
- Obesity

Chronic conditions may be identified based on information from claims data from your providers, your Health Risk Assessment or from the Special Supplemental Benefits for the Chronically Ill online assessment.

- Please contact us to find out exactly which benefits you may be eligible for.

 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 in-network maximum out-of-pocket amount.

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**	
	HMO (in-network):	**POS (out-of-network):**
Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk, once per lifetime. The plan would cover additional screenings, 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 50%. Deductible does apply.
Abridge* Abridge is a smartphone-based application that securely records medical conversations during patient appointments. Once the recording is complete the Abridge app will transcribe the conversation and pull out any key information (prescription refills, follow up appointments, etc.). The app also allows members to share the transcripts with caregivers/family as they wish. To start using Abridge, download the app by going to *abridgeapp.com/priority* on your mobile device or tablet. Contact Abridge for more information at *prioritysupport@abridge.com*.	$0 for Abridge services.* Deductible does not apply.	

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**	
	HMO (in-network):	**POS (out-of-network):**
Acupuncture for chronic low back pain **Medicare-covered services include:** Up to 12 services 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 disease, etc.); • 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. 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.	$20 for each Medicare-covered service. $20 for each non-Medicare covered acupuncture visit, up to 6 visits each year.	$20 for each Medicare-covered service. $20 for each non-Medicare covered acupuncture visit, up to 6 visits each year. Deductible does not apply.

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**	
	HMO (in-network):	**POS (out-of-network):**
Acupuncture for chronic low back pain ***(continued)*** 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 visits:** Routine acupuncture visits (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 Priority Health Travel Pass when in the upper peninsula of Michigan and across the U.S. 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**	
	HMO (in-network):	**POS (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."	Up to 20% for each Medicare-covered Part B drug obtained in a provider's office.	Up to 20% for each Medicare-covered Part B drug obtained in a provider's office. Deductible does apply.
Ambulance services Covered ambulance services, whether for an emergency or non-emergency situation, include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by the plan. If the covered ambulance services are not for an emergency situation, it should be 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.	**In- and out-of-service area:** $270 for each one-way Medicare-covered ambulance transport. $270 for each non-Medicare covered ambulance stabilization when there is no transport. Out-of-network cost sharing will apply toward your in-network out-of-pocket maximum. Deductible does not apply.	

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**	
	HMO (in-network):	**POS (out-of-network):**
Ambulance services (*continued*) 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. 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 54 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.	50% for an annual preventive physical exam. Deductible does apply.

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**	
	HMO (in-network):	**POS (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 calendar year. 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.	50% for the annual wellness visit. Deductible does apply.
Bone mass measurement For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	There is no copayment for Medicare-covered bone mass measurement.	50% for Medicare-covered bone mass measurement. Deductible does apply.

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**	
	HMO (in-network):	**POS (out-of-network):**
BrainHQ* BrainHQ(™) is an online, evidence-based brain health program to address your overall brain health. Your brain is at the core of just about everything you do, so training your brain can improve so many things in your life. BrainHQ has dozens of exercises that have been proven in over 100 scientific publications to help people think faster, focus better, and remember more. As an online headquarters for working out your brain, you can work out your memory, attention, brain speed, people skills, intelligence and navigation. Just as our bodies require care and exercise over the course of life, so do our brains—especially as we age. BrainHQ adjusts to meet the needs of your unique brain over time; providing the best exercises at the right pace that your brain needs to be at its sharpest.	$0 for BrainHQ.* Deductible does not apply.	

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**	
	HMO (in-network):	**POS (out-of-network):**
BrainHQ* *(continued)* You can use BrainHQ on almost any computer or mobile device, so you can take it on the go. It takes less than five minutes to do each BrainHQ level, so you can use it in tiny bites or long blocks, depending on your schedule. You can set up personal training goals and have BrainHQ send you training reminders when you want them. BrainHQ members receive personal, one-on-one assistance getting started, access to a monthly brain health newsletter, and invitations to BrainHQ Academy - a live webinar series on current topics related to brain health. Members can register for BrainHQ at *priority.brainhq.com* or by calling 877.573.9059.		
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 aged 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.	There is no copayment for covered screening mammograms.	50% for covered screening mammograms. Deductible does apply.

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**	
	HMO (in-network):	**POS (out-of-network):**
Breast cancer screening (mammograms) ***(continued)*** 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."		
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.	$20 for each Medicare-covered cardiac rehabilitation service and intensive cardiac rehabilitation service.	50% for each Medicare-covered cardiac rehabilitation service and intensive cardiac rehabilitation service. Deductible does apply.
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	There is no copayment for the intensive behavioral therapy cardiovascular disease preventive benefit.	50% for the intensive behavioral therapy cardiovascular disease preventive benefit. Deductible does apply.

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**	
	HMO (in-network):	**POS (out-of-network):**
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.	50% for cardiovascular disease testing that is covered once every 5 years. Deductible does apply.
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 • Human Papillomavirus (HPV) tests (as part of a Pap test) once every 5 years if you are aged 30-65 years and asymptomatic.	There is no copayment for Medicare-covered preventive Pap and pelvic exams.	50% for Medicare-covered preventive Pap and pelvic exams. Deductible does apply.
Chiropractic services Medicare-covered services include manual manipulation of the spine to correct subluxation. Office visits and x-rays related to a Medicare-covered service are not covered. Non-Medicare covered routine visits can be used for conditions including, but not limited to, back pain, neck pain and headaches. Limited to 12 non-Medicare covered routine visits and one non-Medicare covered x-ray per year when done in-network	$20 for each Medicare-covered service. $20 for each non-Medicare covered routine visit, up to 12 each year. $35 for non-Medicare covered x-ray services performed once per year by a chiropractor (you would pay this in addition to your visit).	50% for each Medicare-covered service. Non-Medicare covered routine visits and x-rays performed by a chiropractor are not covered out-of-network. Deductible does apply.

Use the Priority Health Travel Pass when in the upper peninsula of Michigan and across the U.S. 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**	
	HMO (in-network):	**POS (out-of-network):**
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.* The following screening tests are covered: • Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who are not at high risk for colorectal cancer, and once every 24 months for high risk patients after a previous screening colonoscopy or barium enema. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient received a screening colonoscopy. Once every 48 months for high risk patients from the last flexible sigmoidoscopy or barium enema. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years.	There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam, excluding barium enemas, for which coinsurance applies. If your doctor finds and removes a polyp or other tissue during the colonoscopy or flexible sigmoidoscopy, the screening exam becomes a diagnostic exam.	50% for a Medicare-covered colorectal cancer screening exam. 50% for a Medicare-covered barium enema. Deductible does apply.

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**	
	HMO (in-network):	**POS (out-of-network):**
Colorectal cancer screening *(continued)* • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Barium Enema as an alternative to colonoscopy for patients at high risk and 24 months since the last screening barium enema or the last screening colonoscopy. • Barium Enema as an alternative to flexible sigmoidoscopy for patients not at high risk and 45 years or older. Once at least 48 months following the last screening barium enema or screening flexible sigmoidoscopy. • Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test returns a positive result.		

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**	
	HMO (in-network):	**POS (out-of-network):**
Colorectal cancer screening *(continued)* **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, if that occurs 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. 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**	
	HMO (in-network):	**POS (out-of-network):**
Dental services **Medicare-covered dental services:** In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. However, Medicare currently pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a beneficiary's primary medical condition. Some examples include reconstruction of the jaw following fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams preceding kidney transplantation. In addition, we cover:	$0 for Medicare-covered surgical procedures performed by a physician/practitioner in a provider's office. $45 for each Medicare-covered visit with a specialist. $290 for each Medicare-covered ambulatory surgical center or outpatient hospital facility visit.	50% for all Medicare-covered dental services. Deductible does apply.
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 per year.* $0 for two cleanings (regular or periodontal maintenance) per year.* $0 for one set (up to 4 films in a single visit) of bitewing x-rays per year.* $0 for periapical radiographs as needed.* $0 for one brush biopsy per year.* $0 for radiographs (full-mouth or panoramic x-rays) once every 24 months.* $0 for simple extractions, once per tooth per lifetime.* $0 for crown repairs, once per tooth every 12 months.* $0 for fillings, once per tooth, every 24 months.*	

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**	
	HMO (in-network):	**POS (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.	$0 for anesthesia when used during qualifying dental procedures.* $2,500 per year maximum coverage amount for non-Medicare Covered Comprehensive dental services. Preventive services, including periodontal maintenance cleanings do not roll up to the maximum. Deductible does not apply.	
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.	50% for an annual depression screening visit. Deductible does apply.
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.	There is no copayment for the Medicare-covered diabetes screening tests.	50% for the Medicare-covered diabetes screening tests. Deductible does apply.

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**	
	HMO (in-network):	**POS (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.	50% 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. 50% for all other diabetic test strips when obtained through a DME supplier. Deductible does apply.

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**	
	HMO (in-network):	**POS (out-of-network):**
Durable medical equipment (DME) and related supplies (For a definition of durable medical equipment, see Chapter 12 as well as Chapter 3, Section 7 of this document.) Covered items include, but are not limited to: wheelchairs, walkers, crutches, powered mattress systems, hospital beds ordered by a provider for use in the home, infusion pumps, pneumatic compression devices, speech generating devices, oxygen equipment, nebulizers, wound pump, wound care supplies, diabetic supplies, insulin pumps, continuous glucose monitors (CGM), enteral pump, enteral feedings and enteral supplies. We cover all medically necessary DME covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you. Our *Provider/Pharmacy Directory* includes DME suppliers. The most recent list of suppliers is available on our website at *priorityhealth.com/key24*.	20% for Medicare-covered equipment and supplies. 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. You will continue to be charged a cost share for oxygen; but not the machine rental. If prior to enrolling in **Priority**Medicare Key you had made 36 months of rental payment for oxygen equipment coverage, your cost sharing in **Priority**Medicare Key is the cost you pay for durable medical equipment.	30% for Medicare-covered equipment and supplies. 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. You will continue to be charged a cost share for oxygen; but not the machine rental. If prior to enrolling in **Priority**Medicare Key you had made 36 months of rental payment for oxygen equipment coverage, your cost sharing in **Priority**Medicare Key is the cost you pay for durable medical equipment. Deductible does apply.

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**	
	HMO (in-network):	**POS (out-of-network):**
Durable medical equipment (DME) and related supplies (*continued*) 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. Please see Chapter 3, Section 7.2 for additional details around oxygen equipment. ✓ *Prior authorization may apply, see page 54 for more information*.		
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition.	**In- and out-of-service area:** $120 for each Medicare-covered emergency room visit. Out-of-network cost sharing will apply toward your in-network out-of-pocket maximum. You do not pay this amount if you are admitted to the hospital within 24 hours for the same condition. Deductible does not apply.	

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**	
	HMO (in-network):	**POS (out-of-network):**
Emergency care (*continued*) 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 (and, if you are a pregnant woman, loss of an unborn child), 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, for more information on what happens when you get a Part D drug in a medical setting.		

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**	
	HMO (in-network):	**POS (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.	Not covered
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. • Abridge* • 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.	Not covered

Use the Priority Health Travel Pass when in the upper peninsula of Michigan and across the U.S. 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**	
	HMO (in-network):	**POS (out-of-network):**
Health education* Health education includes: • Access to Teladoc Health Mental Health (previously myStrength) for online emotional support during challenging times. Sign up for an account that includes interactive activities, coping tools and other resources, including practice skills and inspirational community support at *priorityhealth.com/mentalhealth*. • 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 hub with information and tools tailored to your specific health and wellbeing needs – physical, mental, and financial. You can achieve your health goals with a fun and engaging experience that delivers powerful resources, right at your fingertips.	$0 for these services.*	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**	
	HMO (in-network):	**POS (out-of-network):**
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. **Non-Medicare covered routine hearing services:*** Up to two hearing aids from the applicable TruHearing Catalog every year (limit 1 hearing aid per ear). You must see a TruHearing provider to use this benefit. Call 1.833.714.5356 to schedule an appointment (for TTY, dial 711). Hearing aid purchase includes: • First year of follow-up provider visits • 60-day trial period • 3-year extended warranty • 80 batteries per aid for non-rechargeable models	$0 for each Medicare-covered diagnostic hearing exam with a primary care provider. $45 for each Medicare-covered diagnostic hearing exam with a specialist.	50% for each Medicare-covered diagnostic hearing exam. Deductible does apply.

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**	
	HMO (in-network):	**POS (out-of-network):**
Hearing services *(continued)* Benefit does not include or cover any of the following: • Over-the-counter (OTC) hearing aids • Ear molds • Hearing aid accessories • Additional provider visits • Additional batteries; batteries when a rechargeable hearing aid is purchased • Hearing aids that are not in the applicable catalog • Costs associated with loss & damage warranty claims To access your benefits, you must contact TruHearing first to schedule an appointment with a TruHearing provider. Just call 833.714.5356 from 8a.m. to 8p.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* Deductible does not apply. **Services with a non-TruHearing provider:** Not covered	
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 50%. Deductible does apply.

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**	
	HMO (in-network):	**POS (out-of-network):**
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 50%. Deductible does apply.

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**	
	HMO (in-network):	**POS (out-of-network):**
Home health agency care Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but are not limited to: • 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 54 for more information*.	$0 for each Medicare-covered service.	$0 for each Medicare-covered service. Deductible does apply.

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**	
	HMO (in-network):	**POS (out-of-network):**
Home infusion services Home infusion services 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 services 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 54 for more information.*	\$0 for home infusion supplies, services and drugs.	\$0 for home infusion supplies, services and drugs. Deductible does apply.

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**	
	HMO (in-network):	**POS (out-of-network):**
Hospice care 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. You may receive care from any Medicare-certified hospice program. Your plan is obligated to help you find Medicare-certified hospice programs in the plan's service area, including those the MA organization owns, controls, or has a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • Drugs for symptom control and pain relief • Short-term respite care • Home care When you are admitted to hospice you have the right to remain in your plan; if you chose to remain in your plan you must continue to pay plan premiums. For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis: Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A and Part B services related to your terminal prognosis.	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 Key.	
	\$0 for an initial Medicare-covered hospice consultation.	50% for an initial Medicare-covered hospice consultation. Deductible does apply.

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**	
	HMO (in-network):	**POS (out-of-network):**
Hospice care (*continued)* While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for. You will be billed Original Medicare cost sharing. For services that are covered by Medicare Part A or B and are not related to your terminal prognosis: If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network and follow plan rules (such as if there is a requirement to obtain prior authorization). • If you obtain the covered services from a network provider or a provider outside the lower peninsula of Michigan but within the U.S. and its territories, and follow plan rules for obtaining service, 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		

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**	
	HMO (in-network):	**POS (out-of-network):**
Hospice care (*continued)* For services that are covered by **Priority**Medicare Key but are not covered by Medicare Part A or B: **Priority**Medicare Key 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: If these drugs are unrelated to your terminal hospice condition you pay cost sharing. If they are related to your terminal hospice condition, then you pay Original Medicare cost sharing. 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 initial hospice consultation services 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**	
	HMO (in-network):	**POS (out-of-network):**
Immunizations Covered Medicare Part B services include: • Pneumonia vaccine (2 per lifetime) • Flu shots, once 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 may apply; however, we do cover certain vaccines (defined by Medicare) under our Part D prescription drug benefit at no cost to you. Examples of routine vaccines covered under our Part D benefit include shingles vaccine (Zoster/Shingrix) 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.	There is no copayment for the pneumonia, influenza, Hepatitis B, and COVID-19 vaccines. Deductible does not apply.	

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**	
	HMO (in-network):	**POS (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 home hazards throughout your home.	$0 for these services.	Not covered
Inpatient hospital care Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day. 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 • Physician services • Regular nursing services • Costs of special care units (such as intensive care or coronary care units)	For each Medicare-covered hospital admission/stay you pay: $320 per day, days 1-7. $0 for additional hospital days.	For each Medicare-covered hospital admission/stay, you pay 50% per stay. Deductible does apply.

Use the Priority Health Travel Pass when in the upper peninsula of Michigan and across the U.S. 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**	
	HMO (in-network):	**POS (out-of-network):**
Inpatient hospital care (*continued*) • 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. 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 Key provides transplant services at a location outside the pattern of care for transplants in your community		

Use the Priority Health Travel Pass when in the upper peninsula of Michigan and across the U.S. 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**	
	HMO (in-network):	**POS (out-of-network):**
Inpatient hospital care (*continued*) and you choose 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 *https://www.medicare.gov/sites/default/files/2021-10/11435-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. 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.		

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**	
	HMO (in-network):	**POS (out-of-network):**
Inpatient hospital care (*continued*) ✓ *Prior authorization may apply, see page 54 for more information.*		
Inpatient services in a psychiatric hospital 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 54 for more information.*	For each Medicare-covered hospital admission/stay you pay: $275 per day, days 1-6. $0 for additional hospital days.	For each Medicare-covered hospital admission/stay, you pay 50% per stay. Deductible does apply.
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	$0 for Medicare-covered services received from the inpatient facility. $0 for Medicare-covered prosthetic devices and supplies received from the inpatient facility or an outpatient provider when implanted as part of a surgery. 20% for all other Medicare-covered prosthetic devices and supplies and Medicare-covered DME received from an outpatient provider.	50% for Medicare-covered services received from the inpatient facility. 30% for Medicare-covered prosthetic devices and supplies received from an inpatient facility and Medicare-covered prosthetic devices and supplies and DME received from an outpatient provider. Deductible does apply.

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**	
	HMO (in-network):	**POS (out-of-network):**
Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay *(continued)* • 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 54 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**	
	HMO (in-network):	**POS (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 50%. Deductible does apply.
Medicare Diabetes Prevention Program (MDPP) MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	There is no copayment for the MDPP benefit.	50% for the MDPP benefit. Deductible does apply.

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**	
	HMO (in-network):	**POS (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 Services** in this *Medical Benefits Chart.* • Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) • Other 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	**Part B chemotherapy/radiation** Up to 20% for each Medicare-covered Part B drug. **Part B drugs obtained in a provider's office or outpatient setting** Up to 20% for each Medicare-covered Part B drug. **Part B drugs obtained at a pharmacy/mail-order** Up to 20% for each Medicare-covered Part B drug. There may be a fee for the administration of the Part B medication. Insulin administered through an item of durable medical equipment (such as insulin pumps or continuous glucose monitors (CGM)) will be capped at $35. You will pay 20% up to a $35 copayment and will never pay more than $35 for a one-month supply.	**Part B chemotherapy/radiation** Up to 20% for each Medicare-covered Part B drug. **Part B drugs obtained in a provider's office or outpatient setting** Up to 20% for each Medicare-covered Part B drug. **Part B drugs obtained at a pharmacy/mail-order** Up to 20% for each Medicare-covered Part B drug. There may be a fee for the administration of the Part B medication. Deductible does apply. Insulin administered through an item of durable medical equipment (such as insulin pumps or continuous glucose monitors (CGM)) will be capped at $35. You will pay 20% up to a $35 copayment and will never pay more than $35 for a one-month supply whether your deductible has been met or not.

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**	
	HMO (in-network):	**POS (out-of-network):**
Medicare Part B prescription drugs ***(continued)*** 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®, Darbepoetin Alfa, or Retacrit®) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases The following link will take you to a list of Part B Drugs that may be subject to Step Therapy: *priorityhealth.com/DrugInfo*. Click on Medicare Part B prior authorization criteria. 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. ✓ *Prior authorization may apply, see page 54 for more information*.		


Use the Priority Health Travel Pass when in the upper peninsula of Michigan and across the U.S. 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**	
	HMO (in-network):	**POS (out-of-network):**
Mom's Meals* 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). Must be initiated within 30 days from date of discharge.	$0 for 28 home-delivered meals, up to four times per year, following an inpatient hospital, psychiatric hospital or Skilled Nursing Facility (SNF) discharge.* Deductible does not apply.	

Use the Priority Health Travel Pass when in the upper peninsula of Michigan and across the U.S. 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**	
	HMO (in-network):	**POS (out-of-network):**
Nutrition education General nutrition education includes up to both individual and group classes or counseling sessions**.** These may occur in-home or in an outpatient setting and are provided by a Registered Dietician. For people with diabetes, renal (kidney) disease or after a kidney transplant, see "Medical Nutrition Therapy."	$0 for these services.	Not covered
Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	There is no copayment for preventive obesity screening and therapy.	50% for preventive obesity screening and therapy. Deductible does apply.
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	$20 for Medicare-covered opioid treatment services.	50% for Medicare-covered opioid treatment services. Deductible does apply.

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**	
	HMO (in-network):	**POS (out-of-network):**
Opioid treatment program services ***(continued)*** • Toxicology testing • Intake activities • Periodic assessments Please see "**Virtual care**" in this medical benefits chart for information on what virtual opioid treatment services are covered.		
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. • Other outpatient diagnostic tests (for example; allergy testing, genetic testing, sleep studies) • Diagnostic radiology services (for example; MRI, CT) • Blood - including storage and administration. Coverage of whole blood and packed red cells (as well as other components of blood).	**X-rays and ultrasounds** $35 per day, per provider, for Medicare-covered x-ray and ultrasound services. **Diagnostic radiology** $160 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.	**X-rays and ultrasounds** 50% per day, per provider, for Medicare-covered x-ray and ultrasound services. **Diagnostic radiology** 50% 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** 50% per day, per provider, for Medicare-covered, radiation 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**	
	HMO (in-network):	**POS (out-of-network):**
Outpatient diagnostic tests and therapeutic services and supplies *(continued)* Coverage begins with the first pint of blood that you need. ✓ *Prior authorization may apply, see page 54 for more information.*	**Labs** $10 per day, per provider, for Medicare-covered lab services. $0 per day, per provider, for Medicare-covered anticoagulant lab services. **Pathology** $10 per day, per provider, for Medicare-covered pathology services. **Diagnostic procedures and tests** $10 per day, per provider, for diagnostic procedures and tests. **Blood** $0 for blood.	**Labs** 50% per day, per provider, for Medicare-covered lab services. $0 per day, per provider, for Medicare-covered anticoagulant lab services. **Pathology** 50% per day, per provider, for Medicare-covered pathology services. **Diagnostic procedures and tests** 50% per day, per provider, for diagnostic procedures and tests. **Blood** $0 for blood. Deductible does apply.
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.	$120 for each Medicare-covered observation visit, including all services received.	$120 for each Medicare-covered observation visit, including all services received. Deductible does not apply.

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**	
	HMO (in-network):	**POS (out-of-network):**
Outpatient hospital observation *(continued)* 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 on the Web at *https://www.medicare.gov/sites/default/files/2021-10/11435-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, for more information on what happens when you get a Part D drug in a medical setting.		

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**	
	HMO (in-network):	**POS (out-of-network):**
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 • Wound care services **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.	$290 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.	50% 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. Deductible does apply.

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**	
	HMO (in-network):	**POS (out-of-network):**
Outpatient hospital services *(continued)* You can also find more information in a Medicare fact sheet called *Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!* This fact sheet is available on the Web at *https://www.medicare.gov/sites/default/files/2021-10/11435-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, for more information on what happens when you get a Part D drug in a medical setting. ✓ *Prior authorization may apply, see page 54 for more information*.		
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, licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), nurse practitioner (NP), physician assistant (PA), or other Medicare-qualified mental health care professional as allowed under applicable state laws.	$20 for each Medicare-covered individual visit. $20 for each Medicare-covered group visit.	50% for each Medicare-covered individual and group visit. Deductible does apply.

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**	
	HMO (in-network):	**POS (out-of-network):**
Outpatient mental health care *(continued)* **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, 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.		
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.	50% per day for Medicare-covered physical therapy services. 50% per day for Medicare-covered occupational therapy services. 50% per day for Medicare-covered speech language therapy services. Deductible does apply.
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).	$20 for each Medicare-covered individual visit. $20 for each Medicare-covered group visit.	50% for each Medicare-covered individual and group visit. Deductible does apply.

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**	
	HMO (in-network):	**POS (out-of-network):**
Outpatient substance abuse services ***(continued)*** **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, for more information on what happens when you get a Part D drug in a medical setting.		
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, for more information on what happens when you get a Part D drug in a medical setting.	$290 for each Medicare-covered ambulatory surgical center visit. $290 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.	50% for each Medicare-covered ambulatory surgical center visit. 50% 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. Deductible does apply.

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**	
	HMO (in-network):	**POS (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 54 for more information.*		
OTC Plus* Your plan offers a benefit allowance to use towards over-the-counter (non-prescription) medication and health related items. Members with certain chronic conditions who meet eligibility criteria can also use this allowance in-store to purchase healthy food and produce such as; vegetables, fruit, meats, milk and more.	You have a $100 allowance per quarter to use on OTC items. If eligible, this allowance can be used on healthy food and produce.* Deductible does not apply.	

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**	
	HMO (in-network):	**POS (out-of-network):**
OTC Plus* ***(continued)*** For details on eligibility requirements see Chapter 4, Section 2.1 of this document. Examples of covered over-the-counter items include: • Toothpaste • Eye drops • Nasal spray • Vitamins • Cough drops • Pain relievers • Allergy medication • Antacids • First aid items There are four ways you can use your Priority Health Medicare OTC Plus card to buy health items: 1. **Shop in-store** for OTC or food items at Meijer, Kroger, Family Dollar, CVS, Walgreens, Walmart and other participating store locations near you. 2. **Order your OTC items online.** View and purchase products online anytime at *PriorityHealth.com/OTC*.		

Use the Priority Health Travel Pass when in the upper peninsula of Michigan and across the U.S. 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**	
	HMO (in-network):	**POS (out-of-network):**
OTC Plus* ***(continued)***		
3. **Call for OTC delivery.** Call 800.688.1838 (TTY 711) Monday through Friday 8 a.m. to 11 p.m. or Saturday and Sunday 8 a.m. to 8 p.m. EST to place an order after reviewing the items in your OTC catalog. Have your product names, OTC benefit card number, and shipping information available. 4. **OTC mail order**. Use your OTC mail order delivery form (included in catalog packet) to place an order via mail. Your unused OTC Plus allowance does not rollover. Funds expire at the end of each quarter on March 31st, June 30th, September 30th, and December 31st. For more program details, or to place an order, visit *PriorityHealth.com/OTC*, visit the OTC-Anywhere mobile app or call 800.688.1838 (TTY 711).		

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**	
	HMO (in-network):	**POS (out-of-network):**
Partial hospitalization services and Intensive outpatient 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. Intensive outpatient service is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a Federally qualified health center, or a rural health clinic that is more intense than the care received in your doctor's or therapist's office but less intense than partial hospitalization. Call our Behavioral Health department at 800.673.8043 with questions. ✓ *Prior authorization may apply, see page 54 for more information*.	$55 per day for Medicare-covered partial hospitalization services and intensive outpatient services.	40% for Medicare-covered partial hospitalization services and intensive outpatient services. Deductible does apply.

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**	
	HMO (in-network):	**POS (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	$0 for each Medicare-covered visit with a PCP. $0 for each palliative care physician office visit. $45 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.	50% for each Medicare-covered visit with a PCP, palliative care physician, or specialist. 50% 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. Deductible may apply.

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**	
	HMO (in-network):	**POS (out-of-network):**
Physician/Practitioner services, including doctor's office visits *(continued)* Please see **"Virtual care"** in this medical benefits chart for information on what virtual physician/practitioner visits are covered. **Note:** To determine if your provider is a PCP or a Specialist, see Chapter 3, Section 2.1 (You must choose a Primary Care Provider (PCP) to provide and oversee your medical care). Pre-surgical education is recommended for new elective implantable cardioverter defibrillators (ICD's) with or without biventricular pacing, total hip replacement, total knee replacement, and spinal surgeries. The education is an interactive, online program that will help you understand your procedure, the risks and complications, and what you can do before and after surgery to ensure the best results. ✓ *Prior authorization may apply, see page 54 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**	
	HMO (in-network):	**POS (out-of-network):**
Podiatry services Medicare-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 visits and 6 callous removal visits per plan year) for members with certain medical conditions affecting the lower limbs, such as diabetes with compromised circulation.	$45 for each visit. $0 for nail debridement visits & callous removal visits, for members with specific conditions affecting the lower limbs.	50% for each Medicare-covered visit. 50% for nail debridement visits & callous removal visits, for members with specific medical conditions affecting the lower limbs. Deductible does apply.
Post-discharge in-home medication reconciliation Immediately following a medical or behavioral hospitalization or SNF inpatient stay, a qualified health care provider, in cooperation with your physician, will review/reconcile a complete medication regimen. 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.	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**	
	HMO (in-network):	**POS (out-of-network):**
Prostate cancer screening exams For men aged 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.	50% for an annual PSA test. Deductible does apply.
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 54 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. Deductible does apply.

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**	
	HMO (in-network):	**POS (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.	50% for each Medicare-covered pulmonary rehabilitation service. Deductible does apply.
Rural Health Clinic Rural health clinics are located in non-urbanized areas. These clinics offer outpatient primary care and preventive health services to people in medically underserved or shortage areas. 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	$0 for each rural health clinic visit.	50% for each rural health clinic visit. Deductible does apply.
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.	50% for the Medicare-covered screening and counseling to reduce alcohol misuse. Deductible does apply.

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**	
	HMO (in-network):	**POS (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 50 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 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 members 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.	50% for the Medicare-covered counseling and shared decision-making visit or for the LDCT. Deductible does apply.

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**	
	HMO (in-network):	**POS (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 two 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.	50% for the Medicare-covered screening for STIs and counseling for STIs preventive benefit. Deductible does apply.
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, or when your provider for this service is temporarily unavailable or inaccessible)	$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.	50% for Medicare-covered kidney disease education services. 50% for each Medicare-covered renal dialysis service with an out-of-network provider when you are in the plan's service area. Deductible does apply.

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**	
	HMO (in-network):	**POS (out-of-network):**
Services to treat kidney disease *(continued)* • Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section, **Medicare Part B prescription drugs.**		

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**	
	HMO (in-network):	**POS (out-of-network):**
SilverSneakers® Membership (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 online and at participating locations.1 You have access to a nationwide network of participating locations where you can take classes2 and use exercise equipment and other amenities. Enroll in as many locations as you like, at any time. You also have access to instructors who lead specially designed group exercise classes in-person and online, seven days a week. Additionally, SilverSneakers Community gives you options to get active outside of traditional gyms at recreation centers, parks and other neighborhood locations. SilverSneakers also connects you to a support network and online resources through SilverSneakers LIVE classes, SilverSneakers On-Demand videos and the SilverSneakers GO mobile app. Activate your free online account at *SilverSneakers.com* to view your SilverSneakers Member ID number, and all program features available to you at no additional cost. For additional questions, go to *SilverSneakers.com* or call 1.888.423.4632 (TTY: 711) Monday through Friday, 8 a.m. to 8 p.m. ET.	$0 for SilverSneakers® comprehensive fitness program.* Deductible does not apply.	

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**	
	HMO (in-network):	**POS (out-of-network):**
SilverSneakers® (Fitness)* ***(continued)*** **Always talk with your doctor before starting an exercise program.** 1. Participating locations ("PL") are not owned or operated by Tivity Health, Inc. or its affiliates. Use of PL facilities and amenities is limited to terms and conditions of PL basic membership. Facilities and amenities vary by PL. 2. Membership includes SilverSneakers instructor-led group fitness classes. Some locations offer members additional classes. Classes vary by location. SilverSneakers is a registered trademark of Tivity Health, Inc. © 2023 Tivity Health, Inc. All rights reserved.		
Skilled nursing facility (SNF) care (For a definition of skilled nursing facility care, see Chapter 12 of this document. 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)+.	For Medicare-covered services for each benefit period+ you pay: $0 per day for days 1-20. $203 per day for days 21-100.	For Medicare-covered services for each benefit period+, you pay 50% for each stay. Deductible does apply.

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**	
	HMO (in-network):	**POS (out-of-network):**
Skilled nursing facility (SNF) care ***(continued)*** **No prior hospital stay is required.** Covered services include but are not limited to: • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs administered to you as part of your plan of care (this includes substances that 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		

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**	
	HMO (in-network):	**POS (out-of-network):**
Skilled nursing facility (SNF) care ***(continued)*** 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 or domestic partner is living at the time you leave the hospital. +A benefit period starts the day you go into a skilled nursing facility. The benefit period ends when you go for 60 days in a row without skilled nursing care. If you go into a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have. ✓ *Prior authorization may apply, see page 54 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.	There is no copayment for the Medicare-covered smoking and tobacco use cessation preventive benefits.	50% for the Medicare-covered smoking and tobacco use cessation preventive benefits. Deductible does apply.

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**	
	HMO (in-network):	**POS (out-of-network):**
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) ***(continued)*** If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period, however, you will pay the applicable cost sharing. Each counseling attempt includes up to four face-to-face visits.		
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	$20 for each Medicare-covered SET visit.	50% for each Medicare-covered SET visit. Deductible does apply.

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**	
	HMO (in-network):	**POS (out-of-network):**
Supervised Exercise Therapy (SET) ***(continued)*** 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.		
Telemonitoring services Telemonitoring or other remote monitoring services for heart failure, uncontrolled diabetes, chronic obstructive pulmonary disease (COPD), cardiovascular conditions and hypertension. Includes specially adapted equipment, telecommunications, and technology to monitor health conditions across a distance.	$0 for these services.	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**	
	HMO (in-network):	**POS (out-of-network):**
Urgently needed services Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care but given your circumstances, it is not possible, or it is unreasonable, to obtain services from network providers. If it is unreasonable given your circumstances to immediately obtain the medical care from a network provider, then your plan will cover the urgently needed services from a provider out-of-network. Services must be immediately needed and medically necessary. Examples of urgently needed services that the plan must cover out of network occur if: You are temporarily outside the service area of the plan and require medically needed immediate services for an unforeseen condition but it is not a medical emergency; or it is unreasonable given your circumstances to immediately obtain the medical care from a network provider. 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, 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 in-network out-of-pocket maximum. You do not pay this amount if you are admitted to the hospital within 24 hours for the same condition. Deductible does not apply.	

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**	
	HMO (in-network):	**POS (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 • Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if:	$0 for virtual visits.	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**	
	HMO (in-network):	**POS (out-of-network):**
Virtual care *(also referred to as telehealth services, virtual check-ins or eVisits)* ***(continued)*** ○ You have an in-person visit within 6 months prior to your first telehealth visit ○ You have an in-person visit every 12 months while receiving these telehealth services ○ Exceptions can be made to the above for certain circumstances • Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers • 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 • 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		

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**	
	HMO (in-network):	**POS (out-of-network):**
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. 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.	**Medicare-covered vision care:** $0 for annual glaucoma screenings. $0 for Medicare-covered eyewear after cataract surgery. $45 for each Medicare-covered exam to diagnose and treat diseases or conditions of the eye. $0 for annual diabetic retinopathy screening.	**Medicare-covered vision care:** 50% 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. Deductible does apply.

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**	
	HMO (in-network):	**POS (out-of-network):**
Vision care *(continued)* • 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.	**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.* **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.* Deductible does not apply.	

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**	
	HMO (in-network):	**POS (out-of-network):**
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. For additional vision coverage, see Chapter 4, Section 2.2 *Extra "optional supplemental" benefits you can buy* for an additional premium.		

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**	
	HMO (in-network):	**POS (out-of-network):**
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.	50% for the *Welcome to Medicare* preventive visit. Deductible does apply.
Worldwide assistance program* Assist America offers you travel assistance services for both medical and non-medical emergencies while traveling internationally or domestically while 100 miles away from home for less than 90 consecutive days. Services are available 24/7/365. • Assist America's Operations Center is staffed by trained, multilingual assistance personnel who can provide immediate recommendations for any emergency situation. • Emergency evacuation or transportation services are available to the nearest facility capable of providing proper care, if care is not locally available.	$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. Deductible does not apply.	

Use the Priority Health Travel Pass when in the upper peninsula of Michigan and across the U.S. 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**	
	HMO (in-network):	**POS (out-of-network):**
Worldwide assistance program* ***(continued)*** • Assist America will arrange and pay for a loved one to join a member who is traveling alone and is expected to be hospitalized for more than seven days. • When a prescription is lost or left behind, Assist America works with the prescribing physician and a local pharmacy to replace the member's medicine. • In the event that a member passes away while traveling, Assist America will arrange and pay for the required documents, preparation of remains and transport to bring the mortal remains to a funeral home near the member's place of residence. Contact Assist America: within the US by calling 1.800.872.1414, outside the US by calling +1.609.986.1234, or by downloading the free Assist America mobile app. 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 Priority Health Travel Pass when in the upper peninsula of Michigan and across the U.S. 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. 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 Key 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 2024 will be:

$33.00/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 Key, 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 Key plan at the time of enrollment or up to two months after your **Priority**Medicare Key plan's effective date. For example, if your **Priority**Medicare Key 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 Part D late enrollment penalty 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 Part D late enrollment penalty 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 Priority Health Travel Pass

Your plan includes the Priority Health Travel Pass. 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 lower peninsula 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 lower peninsula of Michigan. We encourage you to call Customer Service at 888.389.6648 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 at 888.389.6648 or go online to *prioritymedicare.com* and search Find a Doctor.

When using the following benefits, you must use the nationwide network of participating providers/locations defined by each: Abridge, Assist America, BrainHQ, Mom's Meals, OTC Plus, SilverSneakers®, and TruHearing.

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.

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 except under the specific conditions listed 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. The only exception is if the service is appealed and decided 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 document.)

Services 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		May be covered under your OTC Plus allowance. See Chapter 4, Section 2.1, Medical Benefits Chart.
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.

Services not covered by Medicare	Not covered under any condition	When covered
Assistive listening devices -including but not limited to telephone amplifiers and alerting devices	**Not covered under any condition**	
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		May be covered under your OTC Plus allowance. See Chapter 4, Section 2.1, Medical Benefits Chart.
Beds – mattresses, oscillating, bed baths (home type), boards, lifter (elevator), lounges (power or manual)	**Not covered under any condition**	
Blood Glucose Analyzers - reflectance colorimeter	**Not covered under any condition**	
Blood pressure cuff (i.e. pulse tachometer)		May be covered under your OTC Plus allowance. See Chapter 4, Section 2.1, Medical Benefits Chart.
Chiropractic care - maintenance care, x-ray, labs, and any other service done within the office		Routine chiropractic services covered under your plan are described in Chapter 4, Section 2.1 of the Medical Benefits Chart.
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.

Services not covered by Medicare	**Not covered under any condition**	**When covered**
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	**Not covered under any condition**	
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	**Not covered under any condition**	

Services not covered by Medicare	Not covered under any condition	When covered
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 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.
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.	**Not covered under any condition**	
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.	**Not covered under any condition**	
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		Members who are part of the enhanced disease management program may be eligible for an emergency communication system.

Services not covered by Medicare	Not covered under any condition	When covered
Experimental medical and surgical procedures, equipment, and medications. Experimental procedures and items are those items and procedures determined by 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.	**Not covered under any condition**	
Fees - charged by your immediate relatives or members of your household.	**Not covered under any condition**	
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	**Not covered under any condition**	
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	**Not covered under any condition**	
Incontinent - pads or supplies		May be covered under your OTC Plus allowance. See Chapter 4, Section 2.1, Medical Benefits Chart.

Services not covered by Medicare	**Not covered under any condition**	**When covered**
Knee walker	**Not covered under any condition**	
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.*	**Not covered under any condition**	
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	**Not covered under any condition**	
Massage therapy - performed by a massage therapist	**Not covered under any condition**	

Services not covered by Medicare	Not covered under any condition	When covered
Medical necessity - services considered not reasonable and medically necessary, according to the standards of Original Medicare, see Chapter 9, about obtaining a coverage decision	**Not covered under any condition**	
Naturopathic / Homeopathic services (uses natural or alternative treatments).	**Not covered under any condition**	
Orthopedic shoes or supportive devices for the feet		May be covered under your OTC Plus allowance and/or under your diabetes self-management training, diabetic services, and supplies benefit for people who have severe diabetic foot disease. See Chapter 4, Section 2.1, Medical Benefits Chart.
Personal items - in your room at a hospital or skilled nursing facility, including but not limited to a telephone or television	**Not covered under any condition**	
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.	**Not covered under any condition**	
Precluded providers - services from providers who appear on the CMS Preclusion List. See Chapter 12, *Definitions of important words,* for CMS Preclusion List.	**Not covered under any condition**	
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	**Not covered under any condition**	

Services not covered by Medicare	Not covered under any condition	When covered
Private duty nurses	**Not covered under any condition**	
Private room - when semi-private rooms are available	**Not covered under any condition**	
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.	**Not covered under any condition**	
Reversal of sterilization procedures and or non-prescription contraceptive supplies.	**Not covered under any condition**	
Smart devices - (smart phones and the cost of the applications, tablets, personal computers, etc.)	**Not covered under any condition**	
Structural modifications - including but not limited to ramps, doorways, elevators and stairway elevators	**Not covered under any condition**	
Support hose		May be covered under your OTC Plus allowance. See Chapter 4, Section 2.1, Medical Benefits Chart.
Surgical leggings		May be covered under your OTC Plus allowance. See Chapter 4, Section 2.1, Medical Benefits Chart.
Temporomandibular Joint Syndrome (TMJ)	**Not covered under any condition**	

Services not covered by Medicare	Not covered under any condition	When covered
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.	**Not covered under any condition**	
VA - services provided to veterans in Veterans Affairs (VA) facilities	**Not covered under any condition**	
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)	**Not covered under any condition**	
War related - items or services needed whether due or related to injuries caused by war or an act of war are not covered.	**Not covered under any condition**	
Weight loss - treatment, including but not limited to non-Medicare covered weight loss programs and meal programs	**Not covered under any condition**	
Wigs	**Not covered under any condition**	

CHAPTER 5:
Using the plan's coverage for Part D prescription drugs

SECTION 1 Introduction

This chapter **explains rules for using your coverage for Part D drugs**. Please see Chapter 4 for Medicare Part B drug benefits and hospice drug benefits.

Section 1.1 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 you a prescription which must be valid under applicable state law.
- Your prescriber must not be on Medicare's Exclusion or Preclusion Lists.
- 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 references. (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 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 on the plan's "Drug List."

Section 2.2 Network pharmacies

How do you find a network pharmacy in your area?

To find a network pharmacy, you can look in your *Provider/Pharmacy Directory*, visit our website (*priorityhealth.com/key24*), and/or call Customer Service.

You may go to any of our network pharmacies. Some of our network pharmacies provide preferred cost sharing, which may be lower than the cost sharing at a pharmacy that offers standard cost sharing. The *Provider/Pharmacy Directory* will tell you which of the network pharmacies offer preferred cost sharing. Contact us to find out more about how your out-of-pocket costs could vary for different drugs.

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 network or preferred pharmacy, if available. To find another pharmacy in your area, you can get help from Customer Service or use the *Provider/Pharmacy Directory*. You can also find information on our website at *priorityhealth.com/key24*.

What if you need a specialized pharmacy?

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

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care (LTC) facility. Usually, a LTC facility (such as a nursing home) has its own pharmacy. If you 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.

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 *priorityhealth.com/key24*. 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 be delivered 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 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 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. It is important that you respond each time you are contacted by the pharmacy, to let them know whether to ship, delay, or cancel the new prescription.

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 need 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 but still want the mail-order pharmacy to send you your prescription, please contact your pharmacy 14 days before your current prescription will run out. This will ensure your 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.

If you receive a refill automatically by mail that you do not want, you may be eligible for a refund.

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.)

1. **Some retail pharmacies** in our network allow you to get a long-term supply of maintenance drugs (which may offer preferred cost sharing) at a lower cost-sharing amount. 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.
2. You may also receive maintenance drugs through our mail-order program. Please see Section 2.3 for more information.

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. **Please check first with Customer Service** to see if there is a network pharmacy nearby. You will most likely 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.

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 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.

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 cost share) at the time you fill your prescription. You can ask us to reimburse you for our share of the cost. (Chapter 7, Section 2 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 meets Medicare's requirements and has been approved by Medicare.

The drugs on the "Drug List" are only those covered under Medicare Part D.

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 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 brand name drugs, generic drugs, and biosimilars.

A brand name drug is a prescription drug that is sold under a trademarked name owned by the drug manufacturer. Brand name drugs that are more complex than typical drugs (for example, drugs that are based on a protein) are called biological products. On the "Drug List," when we refer to drugs, this could mean a drug or a biological product.

A generic drug is a prescription drug that has the same active ingredients as the brand name drug. Since biological products are more complex than typical drugs, instead of having a generic form, they have alternatives that are called biosimilars. Generally, generics and biosimilars work just as well as the brand name drug or biological product and usually cost less. There are generic

drug substitutes available for many brand name drugs. There are biosimilar alternatives for some biological products.

What is *not* on the "Drug List"?

The plan does not cover all prescription drugs.

- In some cases, the law does not allow any Medicare plan to cover certain types of drugs (for more information about this, see Section 7.1 in this chapter).
- In other cases, we have decided not to include a particular drug on the "Drug List." In some cases, you may be able to obtain a drug that is not on the "Drug List." For more information, please see Chapter 9.

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 four ways to find out:

1. Check the most recent "Drug List" we provided electronically. (Please note: The "Drug List" we provide includes information for the covered drugs that are most commonly used by our members. However, we cover additional drugs that are not included in the provided "Drug List." If one of your drugs is not listed in the "Drug List," you should visit our website or contact Customer Service to find out if we cover it.)

2. Visit the plan's website (*priorityhealth.com/key24*). 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.
4. Use the plan's "Real-Time Benefit Tool" (*https://member.priorityhealth.com/login* or by calling Customer Service). With this tool you can search for drugs on the "Drug List" to see an estimate of what you will pay and if there are alternative drugs on the "Drug List" that could treat the same condition.

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 encourage you and your provider to use drugs in the most effective ways. To find out if any of these restrictions apply to a drug you take or want to take, check the "Drug List."

If 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.

Please note that sometimes a drug may appear more than once on our "Drug List." This is because the same drugs can differ based on the strength, amount, or form of the drug prescribed by your health care provider, and different restrictions or cost sharing may apply to the different versions of the drug (for instance, 10 mg versus 100 mg; one per day versus two per day; tablet versus liquid).

Section 4.2 What kinds of restrictions?

The sections below tell you more about the types of restrictions we use for certain drugs.

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. 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.)

Restricting brand name drugs or original biological products when a generic or interchangeable biosimilar version is available

Generally, a **generic** drug or interchangeable biosimilar works the same as a brand name drug or original biological product and usually costs less. **In most cases, when a generic or**

interchangeable biosimilar version of a brand name drug or original biological product is available, our network pharmacies will provide you the generic or interchangeable biosimilar version instead of the brand name drug or original biological product. However, if your provider has told us the medical reason that neither the generic drug, interchangeable biosimilar, nor other covered drugs that treat the same condition will work for you, then we may cover the brand name drug or original biological product. (Your share of the cost may be greater for the brand name drug or original biological product than for the generic drug or interchangeable biosimilar.)

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**. This is put in place to ensure medication safety and help 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 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 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

There are situations where there is a prescription drug you are 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.

- 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.
- There are things you can do if your drug is not covered in the way that you'd like it to be covered. 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 options:

- You may be able to get a temporary supply of the drug.
- 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 provide a temporary supply of a drug that you are already taking. This temporary supply gives you time to talk with your provider about the change in coverage and decide what to do.

To be eligible for a temporary supply, the drug you have been taking **must no longer be on the plan's "Drug List"** OR **is now restricted in some way**.

- **If you are a new member,** we will cover a temporary supply of your drug during the first **90 days** of your membership in the plan.
- **If you were in the plan last year,** we will cover a temporary supply of your drug during the first 90 days of the calendar year.
- This temporary supply will be for a maximum of a 30-day supply or a 31-day supply if you reside in a long-term care (LTC) facility. 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 or a 31-day supply if you reside in a long-term care (LTC) facility. The prescription must be filled at a network pharmacy. (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 facility and need a supply right away:**

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

- Per CMS regulations, **Priority**Medicare Key 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.

For questions about a temporary supply, call Customer Service.

During the time when you are using a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. You have two options:

1) You can change to another drug

Talk with your provider about whether there is a different drug covered by the plan that may 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.

2) You can ask for an exception

You and your provider can ask the plan to make an exception and cover the drug in the way you would like it 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. 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 tell you about any change prior to the new 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 you 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, talk to your provider. There may be a different drug in a lower cost-sharing tier that might work just as well for you. 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.

You can ask for an exception

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 Tier 5 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 can make some changes to the "Drug List." For example, the plan might:

- **Add or remove drugs from the "Drug List."**
- **Move a drug to a higher or lower cost-sharing tier**.
- **Add or remove a restriction on coverage for a drug.**
- **Replace a brand name drug with a generic version of the drug.**
- Replace an original biological product with an interchangeable biosimilar version of the biological product.

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, we post information on our website about those changes. We also update our online "Drug List" on a regularly scheduled basis. Below we point out the times that you would get direct notice if changes are made to a drug that you are taking.

Changes to your drug coverage that affect you during the current plan 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. The generic drug will appear on the same or lower cost-sharing tier and with the same or fewer restrictions. 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 when the new generic is added.
    - We may not tell you in advance before we make that change—even if you are currently taking the brand name drug. 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). 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.
    - 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.

- **Unsafe drugs and other drugs on the "Drug List" that are withdrawn from the market**
    - Sometimes a drug may be deemed unsafe or taken off the market for another reason. If this happens, we may immediately remove the drug from the "Drug List." If you are taking that drug, we will tell you 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 example, we might add a generic drug that is not new to the market to replace a brand name drug on the "Drug List" 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.
    - For these changes, 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 work with your prescriber to switch to a different drug that we cover or to satisfy any new restrictions on the drug you are taking.

- 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.

Changes to the "Drug List" that do not affect you during this plan year

We may make certain changes to the "Drug List" that are not described above. In these cases, the change will not apply to you if you are taking the drug when the change is made; however, these changes will likely affect you starting January 1 of the next plan year if you stay in the same plan.

In general, changes that will not affect you during the current plan year are:

- We move your drug into a higher cost-sharing tier.
- We put a new restriction on the use of your drug.
- We remove your drug from the "Drug List."

If any of these changes happen for a drug you are taking (except for 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 restrictions to your use of the drug.

We will not tell you about these types of changes directly during the current plan year. You will need to check the "Drug List" for the next plan year (when the list is available during the open enrollment period) to see if there are any changes to the drugs you are taking that will impact you during the next plan year.

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. If you appeal and the requested drug is found not to be excluded under Part D, we will pay for or cover it. (For information about appealing a decision, go to Chapter 9.)

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 or 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.
    - 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.

In addition, by law, the following categories of drugs are not covered by Medicare drug plans:

- Non-prescription drugs (also called over-the-counter drugs)
- Drugs used to promote fertility
- Drugs used for the relief of cough or cold symptoms
- Drugs used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs used for the treatment of sexual or erectile dysfunction
- Drugs 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 are receiving "Extra Help" to pay for your prescriptions, the "Extra Help" program will not pay for the drugs not normally covered. However, if you have drug coverage through Medicaid, 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 Filling a prescription

Section 8.1 Provide your membership information

To fill your prescription, provide your plan membership information, which can be found on your membership card, at the network pharmacy you choose. The network pharmacy will automatically bill the plan for *our* share of your 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 information with you?

If you don't have your plan membership information with you when you fill your prescription, you or the pharmacy can call the plan to get the necessary information. or you can ask the pharmacy to look up your plan enrollment 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 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 prescription drugs as long as the drugs meet all of our rules for coverage described in this Chapter.

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

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

Check your *Provider/Pharmacy Directory* to find out if your LTC facility's pharmacy or the one that it uses is part of our network. If it isn't, or if you need more information or assistance, please contact Customer Service. 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.

What if you're a resident in a long-term care (LTC) facility and need a drug that is not on our "Drug List" or is restricted in some way?

Please refer to Section 5.2 about a temporary or emergency supply.

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

If you currently have other prescription drug coverage through your (or your spouse or domestic partner's) employer or retiree group, 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 have employee or retiree group coverage, the drug coverage you get from us will be *secondary* to your 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.

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 this notice about creditable coverage because you may need it 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 the creditable coverage notice, request a copy from your employer or retiree plan's benefits administrator or the employer or union.

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

Hospice and our plan do not cover the same drug at the same time. If you are enrolled in Medicare hospice and require certain drugs (e.g., anti-nausea drugs, laxatives, pain medication or anti-anxiety drugs) that are 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 these drugs that should be covered by our plan, ask your hospice provider or prescriber to provide notification before your prescription is filled.

In the event you either revoke your hospice election or are discharged from hospice, our plan should cover your drugs as explained in this document. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, bring documentation to the pharmacy to verify your revocation or discharge.

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.

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 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 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 helps make sure members safely use prescription opioids and other frequently abused medications. 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 may not be safe, we may limit how you can get those medications. If we place you in our DMP, 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 plan on limiting how you may get these medications or how much you can get, we will send you a letter in advance. The letter will tell you if we will limit coverage of these drugs for you, or if you'll be required to get the prescriptions for these drugs only from a specific doctor or pharmacy. You will 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 decision or with the limitation, you and your prescriber have the right to appeal. If you appeal, we will review your case and give you a new 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.

You will not be placed in our DMP if you have certain medical conditions, such as active cancer-related pain 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. Our program is called a Medication Therapy Management (MTM) program. This program is voluntary and free. A team of pharmacists and doctors developed the program for us to help make sure that our members get the most benefit from the drugs they take.

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. If you qualify for the program, a pharmacist or other health professional will give you a comprehensive review of all your medications. During the review, you can talk about 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 which has a recommended to-do list that includes steps you should take to get the best results from your medications. You'll also get a medication list that will include all the medications you're taking, how much you take, and when 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 talk to your doctor about your recommended to-do list and medication list. Bring the summary with you to your visit or anytime you talk with your doctors, pharmacists, and other health care providers. Also, keep your medication list up to date and 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. If you have any questions about this program, please contact Customer Service.

CHAPTER 6:
What you pay for your Part D prescription drugs

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.

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 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, you need to know what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Chapter 5, Sections 1 through 4 explain these rules. When you use the plan's "Real-Time Benefit Tool" to look up drug coverage (see Chapter 5, Section 3.3), the cost shown is provided in "real time" meaning the cost you see in the tool reflects a moment in time to provide an estimate of the out-of-pocket costs you are expected to pay. You can also obtain information provided by the "Real-Time Benefit Tool" by calling Customer Service.

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

There are different types of out-of-pocket costs for Part D drugs. The amount that you pay for a drug is called **cost sharing** and there are two ways you may be asked to pay.

- **Copayment** is a fixed amount you pay each time you fill a prescription.
- **Coinsurance** is a percentage of the total cost you pay each time you fill a prescription.

Section 1.3 How Medicare calculates your out-of-pocket costs

Medicare has rules about what counts and what does *not* count toward your out-of-pocket costs. Here are the rules we must follow to keep track of your out-of-pocket costs.

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

<u>Your out-of-pocket costs 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):

- 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* in your out-of-pocket costs 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, by a State Pharmaceutical Assistance Program that is qualified by Medicare, or by the Indian Health Service. Payments made by Medicare's "Extra Help" Program are also included.
- Some payments made by the Medicare Coverage Gap Discount Program are included in your out-of-pocket costs. 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 $8,000 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

Your out-of-pocket costs **do not include** any of these types of payments:

- Drugs you buy outside the United States and its territories.
- Drugs that are not covered by our plan.
- Drugs you get at an out-of-network pharmacy that do not meet the plan's requirements for out-of-network coverage.
- Non-Part D drugs, including prescription drugs covered by Part A or Part B and other drugs excluded from coverage by Medicare.
- Payments you make toward prescription drugs not normally covered in a Medicare Prescription Drug Plan.

- Payments made by the plan for your brand or generic drugs while in the Coverage Gap.
- Payments for your drugs that are made by group health plans including employer health plans.
- Payments for your drugs that are made by certain insurance plans and government-funded health programs such as TRICARE and the Veterans Affairs.
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Workers' Compensation).

Reminder: If any other organization such as the ones listed above pays part or all of your out-of-pocket costs for drugs, you are required to tell our plan by calling Customer Service.

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

- **We will help you**. The Part D Explanation of Benefits (EOB) report you receive includes the current amount of your out-of-pocket costs. When this amount reaches $8,000, 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 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 Key members?

There are four **drug payment stages** for your prescription drug coverage under **Priority**Medicare Key. How much you pay depends on what stage you are in when you get a prescription filled or refilled. Details of each stage are in Sections 4 through 7 of this chapter. The stages are:

Stage 1: Yearly Deductible Stage

Stage 2: Initial Coverage Stage

Stage 3: Coverage Gap Stage

Stage 4: Catastrophic Coverage Stage

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 Costs**.
- 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.

If you have had one or more prescriptions filled through the plan during the previous month, we will send you a Part D EOB. 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 drug 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 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 information about increases in price from first fill for each prescription claim of the same quantity.
- **Available lower cost alternative prescriptions.** This will include information about other available drugs with lower cost sharing for each prescription claim.

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 every time you get a prescription filled.** This helps us make sure we know about the prescriptions you are filling and what you are paying.
- **Make sure we have the information we need.** There are times you may pay for the entire cost of a prescription drug. In these cases, 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, give us copies of your receipts. Here are examples of when you should give us copies of your drug receipts:

- 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.
- 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.

- **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. For example, payments made by a State Pharmaceutical Assistance Program, an AIDS drug assistance program (ADAP), the Indian Health Service, and most charities count toward your out-of-pocket costs. 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 EOB look it over to be sure the information is complete and correct. If you think something is missing or you have any questions, please call us at Customer Service. Be sure to keep these reports.

SECTION 4 There is no deductible for **Priority**Medicare Key

There is no deductible for **Priority**Medicare Key. 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. You pay $35 per month supply of each covered insulin product on this tier.
- **Tier 4 – Non-preferred drug.** This tier includes non-preferred brand drugs and some high-cost generic drugs. You pay $35 per month supply of each covered insulin product on this tier.
- **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. You pay $35 per month supply of each covered insulin product on this tier.

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. Costs may be less at pharmacies that offer preferred cost sharing.
- A network retail pharmacy that offers preferred cost sharing.
- A pharmacy that is not in the plan's network. We cover prescriptions filled at out-of-network pharmacies in only limited situations. Please see Chapter 5, Section 2.5 to find out when we will cover a prescription filled at an out-of-network pharmacy.
- 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 and the plan's *Provider/Pharmacy Directory.*

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.

As shown in the table below, the amount of the copayment or coinsurance depends on the cost-sharing tier.

Sometimes the cost of the drug is lower than your copayment. In these cases, you pay the lower price for the drug instead of the copayment.

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

Tier	**Preferred and standard retail cost sharing (in-network)** (up to a 30-day supply)	**Preferred (Express Scripts) and standard 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*)	**Preferred:** $4 **Standard:** $10	**Preferred:** $4 **Standard:** $10	$10	$10
Cost-Sharing Tier 2 (*generic drugs*)	**Preferred:** $15 **Standard:** $20	**Preferred:** $15 **Standard:** $20	$20	$20
Cost-Sharing Tier 3 (*preferred brand drugs*)	**Preferred:** $42 **Standard:** $47	**Preferred:** $42 **Standard:** $47	$47	$47
Cost-Sharing Tier 4 (*non-preferred drugs*)	**Preferred:** 45% **Standard:** 50%	**Preferred:** 45% **Standard:** 50%	50%	50%

Tier	**Preferred and standard retail cost sharing (in-network)** (up to a 30-day supply)	**Preferred (Express Scripts) and standard 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 5 (*specialty drugs*)	**Preferred:** 33% **Standard:** 33%	**Preferred:** 33% **Standard:** 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.

You won't pay more than $35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier.

Please see Section 8 of this chapter for more information on Part D vaccines cost sharing for Part D vaccines.

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

Typically, the amount you pay for a prescription drug covers a full month's supply. There may be times when you or your doctor would like you to have less than a month's supply of a drug (for example, when you are trying a medication for the first time). You can also ask your doctor to prescribe, and your pharmacist to dispense, less than a full month's supply of your drugs, if this will help you better plan refill dates for different prescriptions.

If you receive less than a full month's supply of certain drugs, you will not have to pay for the full month's supply.

- If you are responsible for coinsurance, you pay a percentage of the total cost of the drug. Since the coinsurance is based on the total cost of the drug, your cost will be lower since the total cost for the drug will be lower.
- If you are responsible for a copayment for the drug, you will only pay for the number of days of the drug that you receive instead of a whole month. 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.

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). A long-term supply is up to a 90-day supply.

The table below shows what you pay when you get a long-term supply of a drug.

- Sometimes the cost of the drug is lower than your copayment. In these cases, you pay the lower price for the drug instead of the copayment.

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

Tier	**Preferred and standard retail cost sharing (in-network)** (up to a 90-day supply)	**Preferred (Express Scripts) and standard mail-order cost sharing** (up to a 90-day supply)
Cost-Sharing Tier 1 (*preferred generic drugs*)	**Preferred:** $0 **Standard:** $30	**Preferred:** $0 **Standard:** $30
Cost-Sharing Tier 2 (*generic drugs*)	**Preferred:** $45 **Standard:** $60	**Preferred:** $0 **Standard:** $60
Cost-Sharing Tier 3 (*preferred brand drugs*)	**Preferred:** $126 **Standard:** $141	**Preferred:** $105 **Standard:** $141
Cost-Sharing Tier 4 (*non-preferred drugs*)	**Preferred:** 45% **Standard:** 50%	**Preferred:** 45% **Standard:** 50%
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.

You won't pay more than $70 for up to a two-month supply or $105 for up to a three-month supply of each covered insulin product regardless of the cost-sharing tier.

Section 5.5 You stay in the Initial Coverage Stage until your total drug costs for the year reach $5,030

You stay in the Initial Coverage Stage until the total amount for the prescription drugs you have filled reaches the **$5,030 limit for the Initial Coverage Stage**.

The Part D EOB that you receive will help you keep track of how much you, the plan, and any third parties have spent on your behalf during the year. Many people do not reach the $5,030 limit in a year.

We will let you know if you reach this amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Coverage Gap Stage. See Section 1.3 on how Medicare calculates your out-of-pocket costs.

SECTION 6 Costs in the Coverage Gap Stage

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 move 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. Only the amount you pay counts and moves you through the coverage gap.

You continue paying these costs until your yearly out-of-pocket payments reach a maximum amount that Medicare has set. Once you reach this amount $8,000, you leave the Coverage Gap Stage and move to the Catastrophic Coverage Stage.

Medicare has rules about what counts and what does *not* count toward your out-of-pocket costs (Section 1.3).

Coverage Gap Stage coinsurance requirements do not apply to Part D covered insulin products and most adult Part D vaccines, including shingles, tetanus, and travel vaccines.

You won’t pay more than $35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier.

Please see Section 8 of this chapter for more information on Part D vaccines and cost sharing for Part D vaccines.

SECTION 7 During the Catastrophic Coverage Stage, the plan pays the full cost for your covered Part D drugs

You enter the Catastrophic Coverage Stage when your out-of-pocket costs have reached the $8,000 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.

- During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.

SECTION 8 Part D Vaccines. What you pay for depends on how and where you get them

Important Message About What You Pay for Vaccines – Some vaccines are considered medical benefits. Other vaccines are considered Part D drugs. You can find these vaccines listed in the plan's "Drug List". Our plan covers most adult Part D vaccines at no cost to you. Refer to your plan's "Drug List" or contact Customer Service for coverage and cost-sharing details about specific vaccines.

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

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

Your costs for a Part D vaccination depend on three things:

1. **Whether the vaccine is recommended for adults by an organization called the Advisory Committee on Immunization Practices (ACIP).**
    - Most adult Part D vaccinations are recommended by ACIP and cost you nothing.
2. **Where you get the vaccine.**
    - The vaccine itself may be dispensed by a pharmacy or provided by the doctor's office.
3. **Who gives you the vaccine.**
    - A pharmacist or another provider may give the vaccine in the pharmacy. Alternatively, a provider may give it in the doctor's office.

What you pay at the time you get the Part D vaccination can vary depending on the circumstances and what **drug payment stage** you are in.

- Sometimes when you get a vaccination, you have to pay for the entire cost for both the vaccine itself and the cost for the provider to give you the vaccine. You can ask our plan to pay you back for our share of the cost. For adult Part D vaccines, this means you will be reimbursed the entire cost you paid.
- Other times, when you get a vaccination, you will pay only your share of the cost under your Part D benefit. For most adult Part D vaccines, you will pay nothing.

Below are three examples of ways you might get a Part D vaccine.

Situation 1: You get the Part D vaccination at the network pharmacy. (Whether you have this choice depends on where you live. Some states do not allow pharmacies to give certain vaccines.)

- For most adult Part D vaccines, you will pay nothing.
- For other Part D vaccines, you will pay the pharmacy your copayment or coinsurance for the vaccine itself which includes 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 vaccine, you may have to pay for the entire cost of the vaccine itself and the cost for the provider to give it to you.
- You can then ask our plan to pay our share of the cost by using the procedures that are described in Chapter 7.
- For most adult Part D vaccines, you will be reimbursed the full amount you paid. For other Part D vaccines, you will be reimbursed the amount you paid less any copayment or coinsurance for the vaccine (including administration)*, and* less any difference between the amount the doctor charges and what we normally pay. (If you get "Extra Help," we will reimburse you for this difference.)

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

- For most adult Part D vaccines, you will pay nothing for the vaccine itself.
- For other Part D vaccines, you will pay the pharmacy your copayment or coinsurance for the vaccine itself.
- When your doctor gives you the vaccine, you may have to 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.
- For most adult Part D vaccines, you will be reimbursed the full amount you paid. For other Part D vaccines, you will be reimbursed the amount you paid less any coinsurance for the vaccine administration, and less any difference between the amount the doctor charges and what we normally pay. (If you get "Extra Help," we will reimburse you for this difference.).

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 document (*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.)

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

Sometimes when you get medical care or a prescription drug, you may need to pay the full cost. Other times, you may find that you have paid more than you expected under the coverage rules of the plan. In these cases, 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 be deadlines that you must meet to get paid back. Please see Section 2 of this chapter.

There may also be times when you get a bill from a provider for the full cost of medical care you have received or possibly for more than your share of cost sharing as discussed in the document. First try to resolve the bill with the provider. If that does not work, send the 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. If we decide not to pay it, we will notify the provider. You should never pay more than plan-allowed cost sharing. If this provider is contracted, you still have the right to treatment.

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

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

Outside the service area, you can receive emergency or urgently needed services from any provider, whether or not the provider is a part of our network. In these cases,

- You are only responsible for paying your share of the cost for emergency or urgently needed services. Emergency providers are legally required to provide emergency care. If you pay the entire amount yourself at the time you receive the care, 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.
- 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 covered services. 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.
- 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. (This 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 such as receipts and bills for us to handle the reimbursement.

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

If you go to an out-of-network pharmacy, 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.

Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost. Remember that we only cover out-of-network pharmacies in limited circumstances. See Chapter 5, Section 2.5 for a discussion of these circumstances.

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 "Drug List" 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 document 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

You may request us to pay you back by sending us a request in writing. If you send a request in writing, send 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. For Medical claims, **you must submit your claim to us within one year** of the date you received the service, item, or drug. For Part D Pharmacy claims, **you must submit your claim to us within three years** of the date you received the drug.

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

- You don't have to use the form, but it will help us process the information faster.
- Either download a copy of the form from our website (*priorityhealth.com/key24*) or call Customer Service and ask for a Claim Reimbursement Form to be mailed or emailed to you.

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

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, 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.
- 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. We will send you a letter explaining the reasons why we are not sending the payment and your right 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 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. The appeals process is a formal process with detailed procedures and important deadlines. For the details on how to make this appeal, go to Chapter 9 of this document.

CHAPTER 8:
Your rights and responsibilities

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

Section 1.1 We must provide information in a way that works for you and consistent with your cultural sensitivities (in languages other than English, in braille, in large print, as an audio file, or other alternate formats, etc.)

Your plan is required to ensure that all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all enrollees, including those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds. Examples of how a plan may meet these accessibility requirements include, but are not limited to: provision of translator services, interpreter services, teletypewriters, or TTY (text telephone or teletypewriter phone) connection.

Our plan has free interpreter services available to answer questions from non-English speaking members. We are required to provide information about the plan's benefits in a format that is accessible and appropriate to you. To get information in another language, large print, or other alternate format at no cost to you, please call Customer Service at 888.389.6648.

Our plan is required to give female enrollees the option of direct access to a women's health specialist within the network for women's routine and preventive health care services.

If providers in the plan's network for a specialty are not available, it is the plan's responsibility to locate specialty providers outside the network who will provide you with the necessary care. In this case, you will only pay in-network cost sharing. If you find yourself in a situation where there are no specialists in the plan's network that cover a service you need, call the plan for information on where to go to obtain this service at in-network cost sharing.

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, seeing a women's health specialists or finding a network specialist, 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 at 1-800-368-1019 or TTY 1-800-537-7697.

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

You have the right to choose a primary care provider (PCP) in the plan's network to provide and arrange for your covered services. You also have the right to go to a women's health specialist (such as a gynecologist) without a referral. We do not require you to get referrals to go to in-network providers.

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

If you think that you are not getting your medical care or Part D drugs within a reasonable amount of time, Chapter 9 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.
- You have rights related to your 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.
- Except for the circumstances noted below, if we intend to 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 or someone you have given legal power to make decisions for you first.*
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
    - 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; typically, this requires that information that uniquely identifies you not be shared.

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 by the plan, and to get a copy of your records. We are allowed to charge you a fee for making copies. You also have the right to ask us

to make additions or corrections to your medical records. If you ask us to do this, we will work with your healthcare provider to decide whether the changes should be made.

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

If you have questions or concerns about the privacy of your personal health information, please call Customer Service.

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 Key, you have the right to get several kinds of information from us.

If you want any of the following kinds of information, please call Customer Service:

- **Information about our plan**. This includes, for example, information about the plan's financial condition.
- **Information about our network providers and pharmacies.** You have the right to get information about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
- **Information about your coverage and the rules you must follow when using your coverage.** Chapters 3 and 4 provide information regarding medical services. Chapters 5 and 6 provide information about Part D prescription drug coverage.
- **Information about why something is not covered and what you can do about it.** Chapter 9 provides information on asking for a written explanation on why a medical service or Part D drug is not covered or if your coverage is restricted. Chapter 9 also provides information on asking us to change a decision, also called an appeal.

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. 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.** 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.

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.
- Please note - verification of a plan holder's inability to make decisions on their own behalf may be required in order to enact non-plan holder decision making ability.

The legal documents that you can use to give your directions in advance of 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.** You can get an advance directive 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.

- **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 who can make decisions for you if you can't. You may want to give copies to close friends or family members. 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**.

- The hospital 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, concerns, or complaints and need to request coverage, or make an appeal, Chapter 9 of this document tells what you can do. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we are required to treat you fairly**.

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, sexual orientation, 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 Customer Service**.
- You can **call the SHIP**. For details, 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 1-877-486-2048).

Section 1.8 You have the right to make recommendations about the **Priority**Medicare Key **rights and responsibility policy**

You have the right to make recommendations about our member rights and responsibilities policy. Contact Customer Service.

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 Customer Service**.
- You can **call the SHIP**. For details, 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 1-877-486-2048).

SECTION 2 You have some responsibilities as a member of the plan

Things you need to do as a member of the plan are listed below. If you have any questions, please call Customer Service.

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this *Evidence of Coverage* 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.

  - Chapters 5 and 6 give the details about your Part D prescription drug coverage.
- **If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **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 get the best care, tell your doctors and other health providers about your health problems. 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 and get an answer you can understand.
- **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 continue to pay a premium for your 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.
  - 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 continue to pay the extra amount directly to the government to remain a member of the plan.
- **If you move *within* our plan service area, we need to know** so we can keep your membership record up to date and know how to contact you.
- **If you move *outside* of our plan service area, you cannot remain a member of our plan.**
- If you move, it is also important to tell Social Security (or the Railroad Retirement Board).
- **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.

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 problems, you need to use the **process for coverage decisions and appeals**.
- For other problems, you need to use the **process for making complaints;** also called grievances.

Both of these processes have been approved by Medicare. Each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

The guide in Section 3 will help you identify the right process to use and what you should do.

Section 1.2 What about the legal terms?

There are 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 make things easier, this chapter:

- Uses 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. Knowing which terms to use will help you communicate more accurately to 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 Where to get more information and personalized assistance

We are always available to help you. Even if you have a complaint about our treatment of you, we are obligated to honor your right to complain. Therefore, you should always reach out to

Customer Service for help. But in some situations, you may also want help or guidance from someone who is not connected with us. Below are two entities that can assist you.

State Health Insurance Assistance Program (SHIP)

Each state has a government program with trained counselors. 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 and website URLs in Chapter 2, Section 3 of this document.

Medicare

You can also contact Medicare to get help. To contact 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 also visit the Medicare website (*www.medicare.gov*).

SECTION 3 To deal with your problem, which process should you use?

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.

Is your problem or concern about your benefits or coverage?

This includes problems about whether medical care (medical items, services and/or Part B prescription drugs) are covered or not, the way they are covered, and problems related to payment for medical care.

Yes.

Go on to the next section of this chapter, **Section 4, A guide to the basics of coverage decisions and appeals.**

No.

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

Coverage decisions and appeals deal with problems related to your benefits and coverage for your medical care (services, items and Part B prescription drugs, including payment). To keep things simple, we generally refer to medical items, services and Medicare Part B prescription drugs as **medical care**. You use the coverage decision and appeals process for issues such as whether something is covered or not and the way in which something is covered.

Asking for coverage decisions prior to receiving benefits

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical care. For example, if your plan network doctor refers you to a medical specialist not inside the network, this referral is considered a favorable coverage decision unless either your network doctor can show that you received a standard denial notice for this medical specialist, or the Evidence of Coverage makes it clear that the referred service is never covered under any condition. 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 care 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 the medical care 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, whether before or after a benefit is received, and you are not satisfied, you can **appeal** the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made. Under certain circumstances, which we discuss later, you can request an expedited or **fast appeal** of a coverage decision. Your appeal is handled by different reviewers than those who made the original decision.

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 properly following the rules. When we have completed the review, we give you our decision.

In limited circumstances a request for a Level 1 appeal 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 Level 1 appeal, 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 for medical care, your appeal will automatically go on to a Level 2 appeal conducted by an independent review organization that is not connected to us.

- You do not need to do anything to start a Level 2 appeal. Medicare rules require we automatically send your appeal for medical care to Level 2 if we do not fully agree with your Level 1 appeal.
- See **Section 5.4** of this chapter for more information about Level 2 appeals.
- For Part D drug appeals, if we say no to all or part of your appeal, you will need to ask for a Level 2 appeal. Part D appeals are discussed further in Section 6 of this chapter.

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 9 in this chapter explains the Level 3, 4, and 5 appeals processes).

Section 4.2 How to get help when you are asking for a coverage decision or making an appeal

Here are resources if you decide to ask for any kind of coverage decision or appeal a decision:

- You **can call us at Customer Service**.
- You **can get free help** from your State Health Insurance Assistance Program.
- **Your doctor can make a request for you.** If your doctor helps with an appeal past Level 2, they will need to be appointed as your representative. Please call Customer Service 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*.)
    - 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.
    - For Part D prescription drugs, your doctor or other prescriber can request a coverage decision or a Level 1 appeal on your behalf. If your Level 1 appeal is denied your doctor or prescriber can request a Level 2 appeal.
- **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.
    - If you want a friend, relative, or other person to be your representative, call Customer Service 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*.) 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.
    - 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.
- **You also have the right to hire a lawyer.** 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 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 you are being discharged 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 only to these services:* 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. You can also get help or information from government organizations such as your SHIP.

SECTION 5 Your medical care: How to ask for a coverage decision or make an appeal of a coverage decision

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. These benefits are described in Chapter 4 of this document: *Medical Benefits Chart (what is covered and what you pay*). 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 is covered by our plan. **Ask for a coverage decision. Section 5.2.**

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. **Ask for a coverage decision. Section 5.2.**

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. **Make an appeal. Section 5.3.**

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. **Send us the bill. Section 5.5.**

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. **Make an appeal. Section 5.3.**

   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 Sections 7 and 8 of this Chapter. Special rules apply to these types of care.

Section 5.2 Step-by-step: How to ask for a coverage decision

Legal Terms
When a coverage decision involves your medical care, it is called an **organization determination.** A fast coverage decision is called an **expedited determination.**

<u>Step 1:</u> Decide if you need a standard coverage decision or a fast coverage decision.

A standard coverage decision is usually made within 14 days or 72 hours for Part B drugs. A fast coverage decision is generally made within 72 hours, for medical services, or 24 hours for Part B drugs. In order to get a fast coverage decision, you must meet two requirements:

- You may *only ask* for coverage for medical items and/or services (not requests for payment for items and/or services 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 do not approve a fast coverage decision, we will send you a letter that:

- Explains that we will use the standard deadlines.
- Explains if your doctor asks for the fast coverage decision, we will automatically give you a fast coverage decision.
- Explains that you can file a fast complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you requested.

Step 2: Ask our plan to make a coverage decision or fast coverage decision.

- 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. Chapter 2 has contact information.

Step 3: We consider your request for medical care coverage and give you our answer.

For standard coverage decisions we use the standard deadlines.

This 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,** if you ask for more time, or if we need more information that may benefit you **we can take up to 14 more days** if your request is for a medical item or service. If we 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. We will give you an answer to your complaint as soon as we make the decision. (The process for making a complaint is different from the process for coverage decisions and appeals. See Section 10 of this chapter for information on complaints.)

For Fast Coverage decisions we use an expedited timeframe

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,** if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more days**. If we 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. (See Section 10 of this chapter for information on complaints.) We will call you as soon as we make the decision.

- **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 4: If we say no to your request for coverage for medical care, you can appeal.

- If we say no, you have the right to ask us to reconsider this decision by making an appeal. This means asking again to get the medical care coverage you want. If you make an appeal, it means you are going on to Level 1 of the appeals process.

Section 5.3 Step-by-step: How to make a Level 1 appeal

Legal Terms
An appeal to the plan about a medical care coverage decision is called a plan **reconsideration.** A fast appeal is also called an **expedited reconsideration.**

Step 1: Decide if you need a standard appeal or a fast appeal.

A standard appeal is usually made within 30 days or 7 days for Part B drugs. A fast appeal is generally made within 72 hours.

- 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. If your doctor tells us that your health requires a fast appeal, we will give you a fast appeal.
- The requirements for getting a fast appeal are the same as those for getting a fast coverage decision in Section 5.2 of this chapter.

Step 2: Ask our plan for an appeal or a Fast appeal

- **If you are asking for a standard appeal, submit your standard appeal in writing.** Chapter 2 has contact information.
- **If you are asking for a fast appeal, make your appeal in writing or call us.** Chapter 2 has contact information.
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer on the 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 may include 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. You and your doctor may add more information to support your appeal.**

Step 3: We consider your appeal and we give you our answer.

- When our plan is reviewing your appeal, we take a careful look at all of the information. We check to see if we were following all the rules when we said no to your request.
- We will gather more information if needed possibly contacting you or your doctor.

Deadlines for a fast appeal

- For fast appeals, 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.
  - However, if you ask for more time, or if we need 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 take extra days, we will tell you in writing. We can't take extra time 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. Section 5.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will send you our decision in writing and automatically forward your appeal to the independent review organization for a Level 2 appeal. The independent review organization will notify you in writing when it receives your appeal.

Deadlines for a standard appeal

- For standard appeals, we must give you our answer **within 30 calendar days** after we receive your appeal. 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 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 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. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (See Section 10 of this chapter for information on complaints.)
  - If we do not give you an answer by the deadline (or by the end of the extended time period), we will send your request to a Level 2 appeal, where an independent

review organization will review the appeal. Section 5.4 explains the Level 2 appeal process.

- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage 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 plan says no to part or all of your appeal,** we will automatically send your appeal to the independent review organization for a Level 2 appeal.

Section 5.4 Step-by-step: How a Level 2 appeal is done

Legal Term
The formal name for the independent review organization is the **Independent Review Entity.** It is sometimes called the **IRE.**

The **independent review organization is an independent organization hired by Medicare**. It is not connected with us and is not a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

Step 1: The independent review organization reviews your appeal.

- 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**.
- 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

- For the fast appeal, 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

- For the standard appeal 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. For expedited requests, we have 72 hours from the date we receive the decision from the review organization.
- **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 within **72 hours** after we receive the decision from the review organization for **standard requests.** For **expedited requests** we have **24 hours** from the date we receive the decision from the review organization.
- **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** or **turning down your appeal**.). In this case, the independent review organization will send you a letter:
  - Explaining its decision.
  - Notifying you of the right to a Level 3 appeal if the dollar value of the medical care coverage meets a certain minimum. The written notice you get from the independent review organization will tell you the dollar amount you must meet to continue the appeals process.
  - Telling you how to file a Level 3 appeal.

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 you want to go to a Level 3 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 explains the Level 3, 4, and 5 appeals processes.

Section 5.5 What if you are asking us to pay you for our share of a bill you have received for medical care?

Chapter 7 describes when 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 asking for reimbursement, you are asking for a coverage decision. To make this decision, we will check to see if the medical care you paid for is covered. We will also check to see if you followed all the rules for using your coverage for medical care.

- **If we say yes to your request**: If the medical care is covered and you followed all the rules, we will send you the payment for our share of the cost within 60 calendar days after we receive your request. If you haven't paid for the medical care, we will send the payment directly to the provider.
- **If we say no to your request:** 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 medical care and the reasons why.

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. For appeals concerning reimbursement, please note:

- 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, you are not allowed to ask for a fast appeal.
- If the independent review organization decides we should pay, we must send you or the provider the payment 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

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 include coverage for many prescription drugs. To be covered, the drug must be used for a medically accepted indication. (See Chapter 5 for more information about a medically accepted indication.) For details about Part D drugs, rules, restrictions, and costs please see Chapters 5 and 6. **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. We also use the term "Drug List" instead of *List of Covered Drugs* or *Formulary*.

- If you do not know if a drug is covered or if you meet the rules, you can ask us. Some drugs require that you get approval from us before we will cover it.
- 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.

Part D coverage decisions and appeals

Legal Term
An initial coverage decision about your Part D drugs is called a **coverage determination.**

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs. This section tells what you can do if you are in any of the following situations:

- Asking to cover a Part D drug that is not on the plan's *List of Covered Drugs*. **Ask for an exception. Section 6.2**
- Asking to waive a restriction on the plan's coverage for a drug (such as limits on the amount of the drug you can get). **Ask for an exception. Section 6.2**
- Asking to pay a lower cost-sharing amount for a covered drug on a higher cost-sharing tier. **Ask for an exception. Section 6.2**
- Asking to get pre-approval for a drug. **Ask for a coverage decision. Section 6.4**
- Pay for a prescription drug you already bought. **Ask us to pay you back. Section 6.4**

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.

Section 6.2 What is an exception?

Legal Terms
Asking for coverage of a drug that is not on the "Drug List" is sometimes called asking for a **formulary exception.** Asking for removal of a restriction on coverage for a drug is sometimes called asking for a **formulary exception.** Asking to pay a lower price for a covered non-preferred drug is sometimes called asking for a **tiering 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.

For us to consider your exception request, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. 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 "Drug List."** If we agree to cover a drug not on the "Drug List," you will need to pay the cost-sharing amount that applies to drugs in tier 4 for non-preferred drugs. You cannot ask for an exception to the cost-sharing amount we require you to pay for the drug.
2. **Removing a restriction for a covered drug**. Chapter 5 describes the extra rules or restrictions that apply to certain drugs on our "Drug List." 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.
    - 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).
    - 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 generic alternatives for treating your condition.

- You cannot ask us to change the cost-sharing tier for any drug in tier 5 specialty drugs tier.
- If we approve your tiering exception request 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, you can ask for another review by making an appeal.

Section 6.4 Step-by-step: How to ask for a coverage decision, including an exception

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

Step 1: Decide if you need a standard coverage decision or a fast coverage decision.

Standard coverage decisions are made within **72 hours** after we receive your doctor's statement. **Fast coverage decisions** are made within **24 hours** after we receive your doctor's statement.

If your health requires it, ask us to give you a fast coverage decision. **To get a fast coverage decision, you must meet two requirements:**

- You must be asking for a drug you have not yet received. (You cannot ask for fast coverage decision to be paid back for a drug you have already bought.)
- 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 give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor or prescriber's support, we will decide whether your health requires that we give you a fast coverage decision.** If we do not approve a fast coverage decision, we will send you a letter that:
    - Explains that we will use the standard deadlines.
    - Explains if your doctor or other prescriber asks for the fast coverage decision, we will automatically give you a fast coverage decision.
    - Tells you 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. We will answer your complaint within 24 hours of receipt.

Step 2: Request a standard coverage decision or a fast coverage decision.

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 can also access the coverage decision process through our website. We must accept any written request, including a request submitted on the *CMS Model Coverage Determination Request* form. Chapter 2 has contact information. To assist us in processing your request, please be sure to include your name, contact information, and information identifying which denied claim is being appealed.

You, your doctor (or other prescriber), or your representative can do this. You can also have a lawyer act on your behalf. Section 4 of this chapter tells how you can give written permission to someone else to act as your representative.

- **If you are requesting an exception, provide the supporting statement** which is the medical reasons for the exception. 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.

Step 3: We consider your request and give you our answer.

Deadlines for a fast coverage decision

- We must generally give you our answer **within 24 hours** after we receive your request.
    - For exceptions, we will give you our answer within 24 hours after we receive your doctor's supporting statement. 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 to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **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

- We must generally give you our answer **within 72 hours** after we receive your request.
    - For exceptions, we will give you our answer within 72 hours after we receive your doctor's supporting statement. 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.
- **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 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 to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **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.

Step 4: If we say no to your coverage request, you can make an appeal.

- If we say no, you have the right to ask us to reconsider this decision by making an appeal. This means asking again to get the drug coverage you want. If you make an appeal, it means you are going to Level 1 of the appeals process.

Section 6.5 Step-by-step: How to make a Level 1 appeal

Legal Terms
An appeal to the plan about a Part D drug coverage decision is called a plan **redetermination.** A fast appeal is also called an **expedited redetermination.**

Step 1: Decide if you need a standard appeal or a fast appeal.

A standard appeal is usually made within 7 days. A fast appeal is generally made within 72 hours. If your health requires it, ask for a fast appeal.

- If you are appealing a decision we made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a fast appeal.
- The requirements for getting a fast appeal are the same as those for getting a fast coverage decision in Section 6.4 of this chapter.

Step 2: You, your representative, doctor, or other prescriber must contact us and make your Level 1 appeal. If your health requires a quick response, you must ask for a fast appeal.

- **For standard appeals, submit a written request**. Chapter 2 has contact information.
- **For fast appeals either submit your appeal in writing or call us at** 888.389.6648. Chapter 2 has contact information.
- **We must accept any written request,** including a request submitted on the *CMS Model Coverage Determination Request Form*, which is available on our website. Please be sure to include your name, contact information, and information regarding your claim to assist us in processing your request.
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer on the 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 may include 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 and your doctor may add more information to support your appeal.

Step 3: 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

- For fast appeals, 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.
    - 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. Section 6.6 explains the Level 2 appeal 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 for a drug you have not yet received

- For standard appeals, we must give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so.
    - If 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. Section 6.6 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested**, we must provide the coverage as quickly as your health requires, but no later than **7 calendar days** after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a standard appeal 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 to Level 2 of the appeals process, where it will be reviewed by an independent review organization.

- **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.

Step 4: If we say no to your appeal, you decide if you want to continue with the appeals process and make *another* appeal.

- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process.

Section 6.6 Step-by-step: How to make a Level 2 appeal

Legal Term
The formal name for the independent review organization is the **Independent Review Entity.** It is sometimes called the **IRE.**

The independent review organization is an independent organization hired by Medicare. It is not connected with us and is not a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

Step 1: 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. If, however, we did not complete our review within the applicable timeframe, or make an unfavorable decision regarding **at-risk** determination under our drug management program, we will automatically forward your claim to the IRE.
- 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**.
- You have a right to give the independent review organization additional information to support your appeal.

Step 2: The independent review organization reviews your appeal.

Reviewers at the independent review organization will take a careful look at all of the information related to your appeal.

Deadlines for fast appeal

- If your health requires it, ask the independent review organization for a fast appeal.
- If the organization agrees to give you a fast appeal, the organization must give you an answer to your Level 2 appeal **within 72 hours** after it receives your appeal request.

Deadlines for standard appeal

- For standard appeals, 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 yet received. 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.

Step 3: The independent review organization gives you their answer.

For fast appeals:

- **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.

For standard appeals:

- **If the independent review organization says yes to part or all of your 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 says yes to part or all of your 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 **part or all of** your appeal, it means they agree with our decision not to approve your request (or part of your request). (This is called **upholding the decision**. It is also called **turning down your appeal**.). In this case, the independent review organization will send you a letter:

- Explaining its decision.
- Notifying you of the right to a Level 3 appeal if the dollar value of the drug coverage you are requesting meets a certain minimum. 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.
- Telling you the dollar value that must be in dispute to continue with the appeals process.

Step 4: 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 you want to go on to a Level 3 appeal the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- 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 you are being discharged 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.

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 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 is decided, your doctor or the hospital staff will tell you.
- 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.

Section 7.1 During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights

Within two days of being admitted to the hospital, 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. If you do not get the notice from someone at the hospital (for example, a caseworker or nurse), ask any hospital employee for it. If you need help, please call Customer Service or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

1. **Read this notice carefully and ask questions if you don't understand it.** It tells you:

- 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.
- Where to report any concerns you have about the quality of your hospital care.
- Your right to **request an immediate review** of the decision to discharge you if you think you are being discharged from the hospital too soon. This 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.

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.
   - Signing the notice shows *only* that you have received the information about your rights. The notice does not give your discharge date. Signing the notice **does *not* mean** you are agreeing on a discharge date.

3. **Keep your copy** of the notice handy so you will have the information about making an appeal (or reporting a concern about quality of care) if you need it.
   - If you sign the notice more than two days before your discharge date, 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 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.**
- **Meet the deadlines.**
- **Ask for help if you need it**. If you have questions or need help at any time, please call Customer Service. Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance.

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.

The **Quality Improvement Organization** is a group of doctors and other health care professionals paid by the Federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare. These experts are not part of our plan.

Step 1: Contact the Quality Improvement Organization for your state and ask for an immediate review of your hospital discharge. You must act quickly.

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.

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.**
    - **If you meet this deadline**, you may stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision 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.

Once you request an immediate review of your hospital discharge the Quality Improvement Organization will contact us. By noon of the day after we are contacted, we will give you a **Detailed Notice of Discharge**. This notice 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.

You can get a sample of the **Detailed Notice of Discharge** by calling Customer Service 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 2: The Quality Improvement Organization conducts an independent review of your case.

- Health professionals at the Quality Improvement Organization (*the reviewers*) 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 told us of your appeal, you will get a written notice from us that gives your planned discharge date. This notice also 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.

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*, **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.

What happens if the answer is no?

- If the review organization says *no*, 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 said *no* to 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

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at their decision 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.

Step 1: 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 Level 2 appeal, the 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. This is called upholding the decision.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process.

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 you want to go to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.

- 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 7.4 What if you miss the deadline for making your Level 1 appeal to change your hospital discharge date?

Legal Term
A fast review (or fast appeal) is also called an **expedited appeal**.

You can appeal to us instead

As explained above, you must act quickly to start your Level 1 appeal of your hospital discharge date. If you miss the deadline for contacting the Quality Improvement 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

Step 1: Contact us and ask for a fast review.

- **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. Chapter 2 has contact information.

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 see if the decision about when you should leave the hospital was fair and followed all the rules.

Step 3: We give you our decision within 72 hours after you ask for a fast review.

- **If we say yes to your appeal,** it means we have agreed with you that you still need to be in the hospital after the discharge date. We will keep providing your covered inpatient hospital services for as long as they are 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 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 appeal, your case will *automatically* be sent on to the next level of the appeals process.

Step-by-Step: Level 2 *Alternate* appeal Process

Legal Term
The formal name for the independent review organization is the **Independent Review Entity.** It is sometimes called the **IRE.**

The independent review organization is an independent organization hired by Medicare. It is not connected with our plan and is not a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

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. 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.

- 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 pay you back for our share of the costs of hospital care you 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 that your planned hospital discharge date was medically appropriate.
    - The written notice you get from the independent review organization will tell how to start a Level 3 appeal with the review process, 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 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 only about three services:* Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services

When you are getting covered **home health services, skilled nursing care, or rehabilitation care (Comprehensive Outpatient Rehabilitation Facility)**, you have the right to keep getting your services for that type of care for as long as the care is needed to diagnose and treat your illness or injury.

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

Legal Term
Notice of Medicare Non-Coverage. It tells you 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.

1. **You receive a notice in writing** at least two days before our plan is going to stop covering your care. The notice tells you:
   - The date when we will stop covering the care for you.

- How to request a fast track appeal to request us to keep covering your care for a longer period of time.

2. **You, or someone who is acting on your behalf, will be asked to sign the written notice to show that you received it.** 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's decision to stop 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.**
- **Meet the deadlines.**
- **Ask for help if you need it**. If you have questions or need help at any time, please call Customer Service. Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It decides if the end date for your care is medically appropriate.

The **Quality Improvement Organization** is a group of doctors and other health care experts paid by the Federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing plan decisions about when it's time to stop covering certain kinds of medical care. These experts are not part of our plan.

<u>Step 1:</u> Make your Level 1 appeal: contact the Quality Improvement Organization and ask for a *fast-track appeal*. You must act quickly.

How can you contact this organization?

- The written notice you received (*Notice of Medicare Non-Coverage*) 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.

Act quickly:

- 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.

Legal Term
Detailed Explanation of Non-Coverage. Notice that provides details on reasons for ending coverage.

What happens during this review?

- Health professionals at the Quality Improvement Organization ("the reviewers") 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 tell us of your appeal, you will get the **Detailed Explanation of Non-Coverage** from us that explains in detail our reasons for ending our coverage for your services.

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?

- 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). There may be limitations on your covered services.

What happens if the reviewers say no?

- If the reviewers say *no*, then **your coverage will end on the date we have told you.**
- 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.

- 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 a Level 2 appeal.

Section 8.4 Step-by-step: How to make a Level 2 appeal to have our plan cover your care for a longer time

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at the decision 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.

Step 1: 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?

- **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 made to your Level 1 appeal.
- 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 you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.

- 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 8.5 What if you miss the deadline for making your Level 1 appeal?

You can appeal to us instead

As explained above, 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

Legal Term
A fast review (or fast appeal) is also called an **expedited appeal**.

Step 1: Contact us and ask for a fast review.

- **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. Chapter 2 has contact information.

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.

Step 3: We give you our decision within 72 hours after you ask for a fast review.

- **If we say yes to your 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 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.

Step 4: If we say *no* to your fast appeal, your case will *automatically* go on to the next level of the appeals process.

Legal Term
The formal name for the independent review organization is the **Independent Review Entity.** It is sometimes called the **IRE.**

Step-by-Step: Level 2 Alternate appeal Process

During the Level 2 appeal, the **independent review organization** reviews the decision we made to your fast appeal. This organization decides whether the decision should be changed. **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.

Step 1: We 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. 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.

- 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 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 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 go on to a Level 3 appeal.

Step 3: If the independent review organization says no to 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 you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- A Level 3 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. The written response you receive to your Level 2 appeal will explain how to make 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	**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.** Unlike a decision at a Level 2 appeal, we have the right to appeal a Level 3 decision that is favorable to you. If we decide to appeal, it will go to a Level 4 appeal.
    - If we decide *not* to appeal, we must authorize or provide you with the medical care 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 medical care 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. The notice you get will tell you what to do for a Level 4 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.** Unlike a decision at Level 2, we have the right to appeal a Level 4 decision that is favorable to you. We will decide whether to appeal this decision to Level 5.
  - If we decide *not* to appeal the decision, we must authorize or provide you with the medical 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 may 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 and how to continue with a Level 5 appeal.

Level 5 appeal A judge at the **Federal District Court** will review your appeal.

- A judge will review all of the information and decide *yes* or *no* to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

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 **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**. We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge or attorney adjudicator **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. The notice you get will tell you what to do for a Level 4 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**. 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 may 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 will tell you whether the rules allow you to go on to a Level 5 appeal. It 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.

- A judge will review all of the information and decide *yes* or *no* to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

MAKING COMPLAINTS

SECTION 10 How to make a complaint about quality of care, waiting times, customer service, or other concerns

Section 10.1 What kinds of problems are handled by the complaint process?

The complaint process is *only* used for certain types of problems. This includes problems related to quality of care, waiting times, and the customer service. Here are examples of the kinds of problems handled by the complaint process.

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	• Did someone not respect your right to privacy or share confidential information?
Disrespect, poor customer service, or other negative behaviors	• Has someone been rude or disrespectful to you? • Are you unhappy with our Customer Service? • 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 or exam room, or getting a prescription.
Cleanliness	• Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
Information you get from us	• Did we fail to give you a required notice? • Is our written information hard to understand?

Complaint	Example
Timeliness (These types of complaints are all related to the timeliness of our actions related to coverage decisions and appeals)	If you have asked for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can make a complaint about our slowness. Here are examples: • You asked us for a fast coverage decision or a fast appeal, and we have said no; you can make a complaint. • You believe we are not meeting the deadlines for coverage decisions or appeals; you can make a complaint. • You believe we are not meeting deadlines for covering or reimbursing you for certain medical items or services or drugs that were approved; you can make a complaint. • You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.

Section 10.2 How to make a complaint

Legal Terms

- A **Complaint** is also called a **grievance.**
- **Making a complaint** is also called **filing a grievance.**
- **Using the process for complaints** is also called **using the process for filing a grievance.**
- A **fast complaint** is also called an **expedited 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.
- **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.
- All grievances must be submitted within 60 calendar days of the event or incident. Any grievance outside this time frame cannot be accepted.

- For standard grievances, 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. We are required by CMS to respond to all written grievances in writing.
- You may request an expedited grievance whenever we extend the time frame to make an organization or coverage determination, extend the time frame to make a decision for a reconsideration or redetermination, deny your request for an expedited appeal, or deny your request for an expedited organization determination. If you wish to file an expedited grievance you may contact Customer Service at 888.389.6648. For expedited grievances, we respond verbally within 24 hours if the grievance is received orally. If the expedited grievance is received in a written format, we will respond verbally within 24 hours AND in writing within three (3) calendar days after the verbal notification. Please note, if upon review of your expedited grievance 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 timeframes.
- The **deadline** for making a complaint is 60 calendar days from the time you had the problem you want to complain about.

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.
- **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 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**.
- **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 include our reasons in our response to you.

Section 10.4 You can also make complaints about quality of care to the Quality Improvement Organization

When your complaint is about *quality of care*, you also have two extra options:

- **You can make your complaint directly to the Quality Improvement Organization**. 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. Chapter 2 has contact information.

Or

- **You can make your complaint to both the Quality Improvement Organization and us at the same time**.

Section 10.5 You can also tell Medicare about your complaint

You can submit a complaint about **Priority**Medicare Key directly to Medicare. To submit a complaint to Medicare, go to *www.medicare.gov/MedicareComplaintForm/home.aspx*. You may also 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

SECTION 1 Introduction to ending your membership in our plan

Ending your membership in **Priority**Medicare Key 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. Sections 2 and 3 provide information on ending your membership voluntarily.
- There are also limited situations where 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, our plan must continue to provide your medical care and prescription drugs and you will continue to pay your cost share until your membership ends.

SECTION 2 When can you end your membership in our plan?

Section 2.1 You can end your membership during the Annual Enrollment Period

You can end your membership in our plan during the **Annual Enrollment Period** (also known as the **Annual Open Enrollment Period**). During this time, review your health and drug coverage and decide about coverage for the upcoming year.

- **The Annual Enrollment Period** is from **October 15 to December 7**.
- **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, with or without prescription drug coverage.
    - Original Medicare *with* a separate Medicare prescription drug plan.
    - Original Medicare *without* a separate Medicare prescription drug plan.
        - If you choose this option, 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.
- **Your membership will end in our plan** 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**.

- **The annual Medicare Advantage Open Enrollment Period** is from January 1 to March 31.
- **During the annual Medicare Advantage Open Enrollment Period** you can:
  - Switch to another Medicare Advantage Plan with or without prescription drug coverage.
  - 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.
- **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 Key may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period**.

You may be eligible to end your membership during a Special Enrollment Period if any of the following situations apply to you. These are just examples, for the full list you can contact the plan, call Medicare, or visit the Medicare website (*www.medicare.gov*):

- When you have moved outside the plan's service area (see Chapter 1, Section 2.3 for a list of the counties). Note: If you move within the service area, you will not be eligible for a Special Enrollment Period.
- If you have Michigan Medicaid program.
- 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.

The enrollment time periods vary depending on your situation.

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. You can choose:

- Another Medicare health plan with or without prescription drug coverage.
- Original Medicare *with* a separate Medicare prescription drug plan.
- – *or* – Original Medicare *without* a separate Medicare prescription drug plan.

  Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

Your membership will usually end on the first day of the month after your request to change your plan is received.

- **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.

Section 2.4 Where can you get more information about when you can end your membership?

If you have any questions about ending your membership you can:

- **Call Customer Service.**
- Find the information in the ***Medicare & You 2024*** handbook.
- Contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

SECTION 3 How do you end your membership in our plan?

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 Key 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 Key when your new plan's coverage begins.
• Original Medicare *without* a separate Medicare prescription drug plan.	• **Send us a written request to disenroll.** Contact Customer Service if you need more information on how to do this. • You can also contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048. • You will be disenrolled from **Priority**Medicare Key when your coverage in Original Medicare begins.

SECTION 4 Until your membership ends, you must keep getting your medical items, services and drugs through our plan

Until your membership ends, and your new Medicare coverage begins, you must continue to get your medical services, items and prescription drugs through our plan.

- **Continue to use our network providers to receive medical care.**
- **Continue to use our network pharmacies or mail order to get your prescriptions filled**.
- **If you are hospitalized on the day that your membership ends, your hospital stay will be covered by our plan until you are discharged** (even if you are discharged after your new health coverage begins).

SECTION 5 **Priority**Medicare Key **must end your membership in the plan in certain situations**

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

PriorityMedicare Key **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, call Customer Service to find out if the place you are moving or traveling to is in our plan's area.
- If you become incarcerated (go to prison).
- If you are no longer a United States citizen or lawfully present in the United States.
- If you lie 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 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 as of that date.

- We will not be able to reinstate your benefits until the following plan year.
- 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 call Customer Service.

Section 5.2 We cannot ask you to leave our plan for any health-related reason

PriorityMedicare Key is not allowed to ask you to leave our plan for any health-related reason.

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, call Medicare at 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. (TTY 1-877-486-2048).

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.

CHAPTER 11:
Legal notices

SECTION 1 Notice about governing law

The principal law that applies to this *Evidence of Coverage* 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. This may affect your rights and responsibilities even if the laws are not included or explained in this document.

SECTION 2 Notice about nondiscrimination

We don't discriminate based on race, ethnicity, national origin, color, religion, sex, gender, age, sexual orientation, 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. You can also review information from the Department of Health and Human Services' Office for Civil Rights at *https://www.hhs.gov/ocr/index.html*.

If you have a disability and need help with access to care, please call us at Customer Service. 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*.

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 Key, as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any State laws.

SECTION 4 Notice about coordinating benefits with Third Party Payers

Section 4.1 Recovery Rights

As explained in Chapter 1, Section 7 (“How other insurance works with our plan”), we coordinate benefits with third party payers under rules established by Medicare. We incorporate those Medicare rules into this Evidence of Coverage (see “More Information,” below) to the extent permitted by law. Third-party payers include (but are not limited to) other health plan coverage, liability insurance (such as automobile liability or homeowners insurance), underinsured/uninsured motorist coverage, “Med-Pay” coverage, workers’ compensation plans or insurance, no-fault insurance, self-funded entities that provide such coverage, and any other entity or person who would be a primary payer under the Medicare Secondary Payer provisions. Under the Medicare rules, we have rights to recover amounts we pay for services for which third-party payers are responsible, including amounts third-party payers pay to you.

Section 4.2 Subrogation and Reimbursement

Our recovery rights include a right to subrogation (which means that we can stand in your shoes and sue a third party directly for amounts we pay for services provided to you as a result of an illness or injury) and a right of reimbursement (which means that we have a right to be reimbursed out of any recoveries you will receive or have received from third parties for amounts we pay for services provided to you as a result of an illness or injury). We are entitled to the subrogation and reimbursement rights that Medicare has under the Medicare Secondary Payer provision, to the extent permitted by law. The Social Security Act preempts State laws and State requirements that might otherwise interfere with these rights. Our recovery rights are not limited by stipulations in settlement agreements unless we are a party to the agreement. When we act as a provider of medical services, our recovery will be based on the reasonable value of the benefits provided.

Section 4.3 Lien on Proceeds

We will have a lien on the proceeds of any judgment, settlement, or other reward or recovery you receive from a third party payer to the extent of any payment we made for health care services provided to you that are related to the proceeds. Our lien will be the first priority claim on the proceeds. You must hold the proceeds in trust for us. Transfer of the proceeds to a third party does not defeat our recovery rights if the proceeds were or are intended for your benefit.

Section 4.4 Notice of Possible Third-Party Payer

You must provide us notice as soon as practicable, but in any event within thirty (30) days, of filing a claim with or a legal action against a person or entity that may be a third-party payer with respect to services provided to you as a result of an illness or injury. Your notice must be in writing and explain the basis for the claim. Send your notice to:

Priority Health
Medicare Advantage Subrogation Unit, MS 2205
1231 East Beltline NE
Grand Rapids, Michigan 49525

Section 4.5 Cooperation

You are required, when requested, to acknowledge our recovery rights in writing. Our recovery rights, however, are not dependent upon your acknowledgement. You must tell us as soon as practicable, in writing, about any situation that might involve our rights under this section. You must cooperate with us to help protect our rights under this section. Neither you, nor anyone acting for you, may do anything to harm our rights under this section. We may recover from you expenses we incur because of your failure to cooperate in enforcing our rights under this section.

Section 4.6 More Information

This Section 4 contains a summary of our rights under the Medicare Secondary Payer provisions. We incorporate the Medicare Secondary Payer provisions into this Evidence of Coverage to the extent permitted by law. For more information, see the Medicare Secondary Payer provisions in § 1862(b) of the Social Security Act (42 C.F.R. § 1395y(b)) and 42 C.F.R. Part 411, subparts B – H.

Section 4.7 Definition

For purposes of this Section 4, "you" means you, your estate, your guardian, or any other person acting on your behalf.

SECTION 5 Notice about Evidence of Coverage - Terms are Binding

By enrolling in our plan and accepting benefits under this Evidence of Coverage, you agree to the terms of this Evidence of Coverage, including the terms of this Chapter 11.

SECTION 6 Notice about Coverage Decisions and Appeal Rights

If you would like to contest any coverage decision we make concerning your benefits, including any coverage decision involving the rules for coordinating benefits, you must follow the procedures in Chapter 9, "What to do if you have a problem or complaint (coverage decisions, appeals, complaints)."

SECTION 7 Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our commitment to you

Priority Health understands the importance of handling protected health information (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 Corewell Health. Priority Health will share PHI with Corewell 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 claims. 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

CHAPTER 12:
Definitions of important words

Adaptive equipment – Items which can assist with completing activities of daily living (ADL's) if your specific needs meet medical necessity and is prescribed by your doctor. Examples include shower chairs, transfer boards, and wheelchairs.

Admission – When you are admitted at a hospital, you could be transferred within the same facility to receive a different type of service (for example, acute rehab). When this occurs, you will be responsible for a new cost-share for the new service that you receive. 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 – The time period of October 15 until December 7 of each year when members can change their health or drug plans or switch to Original Medicare.

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.

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 1.4 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. 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.

Biological Product – A prescription drug that is made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and cannot be copied exactly, so alternative forms are called biosimilars. Biosimilars generally work just as well, and are as safe, as the original biological products.

Biosimilar – A prescription drug that is considered to be very similar, but not identical, to the original biological product. Biosimilars generally work just as well, and are as safe, as the original biological product; however, biosimilars generally require a new prescription to substitute for the original biological product. Interchangeable biosimilars have met additional requirements that allow them to be substituted for the original biological product at the pharmacy without a new prescription, subject to state laws.

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 that begins when you (or other qualified parties on your behalf) have spent $8,000 for Part D covered drugs during the covered year. During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that administers Medicare.

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, expressed as a percentage (for example 20%) as your share of the cost for services or prescription drugs after you pay any deductibles.

Complaint - The formal name for making a complaint is **filing a grievance**. The complaint process is used *only* for certain types of problems. This includes problems related to quality of care, waiting times, and the customer service you receive. It also includes complaints if your plan does not follow the time periods in the appeal process.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, 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 (for example $10), rather than a percentage.

Cost Sharing – Cost sharing refers to amounts that a member has to pay when services or drugs are received. 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.

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 document.

Covered Drugs – The term we use to mean all of the prescription drugs covered by our plan.

Covered Services – The 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, home, or other facility setting when you do not need skilled medical care or skilled nursing care. Custodial care, provided by people who do not have professional skills or training, includes 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.

Deductible – The amount you must pay for health care or prescriptions before our plan pays.

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 termination of your coverage from or by our plan.

Dispensing Fee – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription such as the pharmacist's time to prepare and package the prescription.

"Drug List" – See Formulary.

Dual Eligible Special Needs Plans (D-SNP) – D-SNPs enroll individuals who are entitled to both Medicare (title XVIII of the Social Security Act) and medical assistance from a state plan under Medicaid (title XIX). States cover some Medicare costs, depending on the state and the individual's eligibility.

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 (and, if you are a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb, or loss of or serious impairment to a bodily function. 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) provided 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 our 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 our plan requires you to try another drug before receiving the drug you are requesting, or if our plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

"Extra Help" – A Medicare or a State 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.

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 our plan, providers, or pharmacies, including a complaint concerning the quality of your care. This does not involve coverage or payment disputes.

Home Health Aide – A person who provides services that do not 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).

Hospice – A benefit that provides special treatment for a member who has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less. 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.

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 $5,030.

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. 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 can help coordinate care for members. 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 suppliers who don't participate with Medicare. 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 services. Amounts you pay for your 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.

Medicaid (or Medical Assistance) – A joint Federal and state program that helps with medical costs for some people with low incomes and limited resources. State Medicaid programs vary, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medically Accepted Indication – A use of a drug that is either approved by the Food and Drug Administration or supported by certain reference books.

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).

Medicare Advantage Open Enrollment Period – The time period from January 1 until March 31 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 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 i) HMO, ii) PPO, a iii) Private Fee-for-Service (PFFS) plan, or a iv) Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP). 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**.

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.

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans, must cover all of the services that are covered by Medicare Part A and B. The term Medicare-Covered Services does not include the extra benefits, such as vision, dental or hearing, that a Medicare Advantage plan may offer.

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, Special Needs 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 pharmacy that contracts with our plan where members of our plan can get their prescription drug benefits. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Network Provider – Provider is the general term 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. **Network providers** 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. Network providers are also called **plan providers**.

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. 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 – A decision our plan makes 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 document. 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 does not have a contract with our plan to coordinate or provide covered drugs to members of our plan. Most drugs you get from out-of-network pharmacies are not covered by our plan unless certain conditions apply.

Out-of-Network Provider or Out-of-Network Facility – A provider or facility that does not have a contract with our plan to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that are not employed, owned, or operated by our plan. Using out-of-network providers or facilities is explained in this document 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 services and supports (LTSS) for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible. 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.

Part D Drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. Certain categories of drugs have been excluded as covered Part D drugs by Congress. Certain categories of Part D drugs must be covered by every plan. 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.

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 that handles processing and paying prescription drug claims.

Primary Care Provider (PCP) – The doctor or other provider you see first for most health problems. In many Medicare health plans, you must see your primary care provider before you see any other health care provider.

Prior Authorization – Approval in advance to get services or certain drugs. Covered services that need prior authorization are marked in the Benefits Chart in Chapter 4. Covered drugs that need prior authorization are marked in the formulary.

Prosthetics and Orthotics – Medical devices including, 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.

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.

Real-Time Benefit Tool – A portal or computer application in which enrollees can look up complete, accurate, timely, clinically appropriate, enrollee-specific formulary and benefit information. This includes cost sharing amounts, alternative formulary medications that may be used for the same health condition as a given drug, and coverage restrictions (Prior Authorization, Step Therapy, Quantity Limits) that apply to alternative medications.

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 non-urbanized area. These clinics offer outpatient primary care and preventive health services to people in medically underserved or shortage areas. 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 you must live to join a particular health plan. 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 must 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 care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Special Enrollment Period (SEP) – 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 – Covered services that are not emergency services, provided when the network providers are temporarily unavailable or inaccessible or when the enrollee is out of the service area. For example, you need immediate care during the weekend. Services must be immediately needed and medically necessary.

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 Key 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 $33.00 for added dental and vision coverage, above and beyond what is included in your **Priority**Medicare Key.

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**.

(Mandatory & Optional)

Delta Dental Medicare Advantage™ Dental Plan

Welcome!

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.

This Member Handbook which describes the specific benefits of your Delta Dental program, how to use them and your Covered Code List. If you have any questions about this program, please call our Customer Service department at 800.330.2732 (TTY Users call 711).

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.

We look forward to serving you!

Medicare Advantage Supplemental Dental Plan
Priority Health Medicare - Mandatory
Group Number - 3514
Subgroup Number - 2000

Benefit Year: January 1 through December 31

Maximum Payment: $2,500 on all services, except diagnostic, prophylaxes, X-rays, brush biopsy, and periodontal maintenance

Deductible: None

A complete listing of covered dental services begins on the next page.

***Services received from dentists who do NOT participate in the Delta Dental Medicare Advantage PPO and Premier Network will result in your out of pocket costs being 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 and the amount charged by the Nonparticipating dentist.

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.

Appeal

The procedures that deal with the review of adverse initial determination for payment of services.

Benefit Year

The calendar year.

Benefits

Payment for the Covered Services that have been selected under This Plan.

Claim

A request for payment for a Covered Service. Claims are not conditioned upon your seeking advance approval, certification, or authorization to receive payment for any 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:

- For dentures and partial dentures, on the delivery dates;
- For crowns and bridgework, on the permanent cementation date;
- For root canals and periodontal treatment, on the date of the final procedure that completes treatment.

Coinsurance

The percentage of the charge, if any, that you must pay for Covered Services.

Copayment

A fixed amount of money that you must pay for Covered Services, if any.

Covered Code List

The unique list of the ADA dental codes that are covered services under This Plan. These codes are subject to the terms of this Member Handbook.

Covered Services

The unique dental services selected for coverage as described in this Member Handbook.

Deductible

The amount a person must pay toward Covered Services before Delta Dental begins paying for those services under this Member Handbook. If applicable, the deductible that applies to you is listed at the beginning of this Member Handbook.

Delta Dental

Delta Dental Plan of Michigan, Inc. is a nonprofit dental care corporation doing business as Delta Dental of Michigan. Delta Dental is not an insurance company. Delta Dental of Michigan, Inc. has been delegated by your Health Plan to provide dental benefits for This Plan.

Dental Emergency

A Dental Emergency is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child; Serious impairment to bodily functions; or Serious dysfunction of any bodily organ or part.

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.
- **Out-of-Country Dentist** – a Dentist whose office is located outside the United States and its territories. These dentists are nonparticipating because Out-of-Country Dentists are not eligible to sign participating agreements with Delta Dental.
- **IMPORTANT: If you receive services from a dentist that <u>DOES NOT</u> participate in Delta Dental's Medicare Advantage Network <u>YOU WILL BE RESPONSIBLE</u> for the difference between Delta Dental's payment and the amount charged by the Nonparticipating dentist.**

Grievance

An expression of dissatisfaction (other than a coverage determination) with any aspect of the operations, activities or behavior of Delta Dental, your MAO or a Dentist that has provided dental services under This Plan.

Inquiry

A verbal or written request for information that does not involve a grievance, coverage or appeals process, such as a routine question about a benefit.

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.

Medicare Advantage Dentist Fee Schedule

The maximum fee allowed per procedure for services rendered by a Delta Dental Medicare Advantage Dentist as determined by Delta Dental.

Member

A person with coverage under This Plan.

Member Handbook

Delta Dental will provide Benefits as described in this Member Handbook. Any changes in this Member Handbook will be based on changes to the contract between Delta Dental and your Medicare Advantage Organization (MAO).

Nonparticipating Dentist Fee

The maximum fee allowed per procedure for services rendered by a Nonparticipating Dentist as determined by Delta Dental.

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.

Pre-Treatment Estimate

An estimate of cost for a planned treatment. Pre-treatment estimates are not required before treatment.

Processing Policies

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

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.

This Plan

The dental coverage established for Eligible Persons pursuant to this Member Handbook.

Selecting a Dentist

To receive benefits under This Plan you must receive services from a Delta Dental Medicare Advantage Dentist. **Services received from dentists who do NOT participate in the Delta Dental Medicare Advantage PPO and Premier Network will result in your out of pocket costs being higher.**

To verify that a Dentist is a Medicare Advantage Participating Dentist, you can use Delta Dental's online Dentist Directory at *http://deltadentalmi.com/Find-a-Dentist* or call 800. 330.2732 (TTY Users call 711). **When accessing Delta Dental's online Dentist Directory you must select the link labeled Medicare Advantage PPO and Medicare Advantage Premier.**

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 and the amount charged by the Nonparticipating dentist.

Accessing Your Benefits

To utilize your dental benefits, follow these steps:

1. Please read this Member Handbook carefully so you are familiar with your benefits, payment methods, and terms of This Plan.
2. Make an appointment with your Dentist and tell him or her that you have dental benefits with Delta Dental's Medicare Advantage Dental Plan. If your Dentist is not familiar with This Plan or has any questions, have him or her contact Delta Dental by calling the toll-free number at 800.330.2732 or, by writing to Delta Dental:

Attention: Customer Service,
P.O. Box 9230
Farmington Hills, Michigan 48333-9230

3. After you receive your dental treatment, you or the dental office staff will file a claim form, completing the information portion with:
   a. Your full name and address
   b. Your Member ID number
   c. Your date of birth

Notice of Claim Forms

Your Dentist should submit your dental claims form using the most recent American Dental Association ("ADA") approved claim form. Medicare Advantage Participating Dentists will fill out and submit your dental claims for you.

Mail claims and completed information requests to:

Delta Dental
PO Box 9298
Farmington Hills, Michigan 48333-9298

Pre-Service Organization Determinations

Your Dentist can submit a request for a coverage decision to determine whether you qualify for a dental service that may be covered under This Plan through the Dental Office Toolkit® (DOT). You can also request a coverage decision to determine whether you qualify for a dental service that may be covered under This Plan by calling the Customer Service department toll-free at 800.330.2732 or in writing at:

Delta Dental
PO Box 9230
Farmington Hills, Michigan 48333-9230

For a standard pre-service coverage decision, Delta Dental will provide an answer within 14 calendar days after receiving your request. To file a fast coverage decision the standard deadlines must potentially cause serious harm to your health or hurt your ability to function. If Delta Dental approves the fast request, an answer will be provided within 72 hours. For both standard and fast requests, Delta Dental may take up to 14 additional calendar days under certain circumstances. If additional time is taken, Delta Dental will notify you in writing and explain the reasons for the extension.

If Delta Dental does not approve your standard or fast coverage request, you have the right to file an appeal. Please see the Appeal section for more information. Availability of dental benefits at the time your request is completed is dependent on several factors. These factors include, but are not limited to, medical necessity, your continued eligibility for benefits, your available annual or lifetime Maximum Payments, any coordination of benefits, the status of your Dentist, This Plan's limitations and any other provisions, together with any additional information or changes to your dental treatment. To determine whether a service may be covered under This Plan, please review the benefits included in this document.

Written Notice of Claim and Time of Payment

All claims for Benefits must be filed with Delta Dental within one year of the date the services were completed. Once a claim for payment is filed, Delta Dental will decide it within 30 days of receiving it. If there is not enough information to decide your claim, Delta Dental will notify you or your Dentist within 30 days. The notice will

(a) describe the information needed,

(b) explain why it is needed,

(c) request an extension of time in which to decide the claim, and

(d) inform you or your Dentist that the information must be received within 60 days or your claim will be denied. You will receive a copy of any notice sent to your Dentist.

Once Delta Dental receives the requested information, it will decide your claim and send you notice of that decision. If you or your Dentist does not supply the requested information, Delta Dental will have no choice but to deny your claim. Once Delta Dental decides your claim, it will notify you within five days.

Authorized Representative

You may also appoint an authorized representative to deal with Priority Health on your behalf with respect to any benefit claim you file or any review of a denied claim you wish to pursue (see the Grievance and Appeals Procedure section). You should call Priority Health's Customer Service department, toll-free, at (888) 389.6648, or write them at:

Priority Health
Grievance & Appeals, MS1150
1231 East Beltline Ave, NE
Grand Rapids, MI 49525

To request a form to designate the person you wish to appoint as your representative or you may use the CMS Appointment of Representative Form (Form CMS-1696). While in some circumstances your Dentist is treated as your authorized representative, generally Delta Dental only recognizes the person whom you have authorized on the last dated form filed with Priority Health. Once you have appointed an authorized representative, Priority Health will communicate directly with your representative and will not inform you of the status of your claim. You will have to get that information from your representative. If you have not designated a representative, Priority Health will communicate directly with you.

How Payment is Made

If your Dentist is a Medicare Advantage Participating Dentist, Delta Dental will base payment on the Maximum Approved Fee for Covered Services.

Delta Dental will send payment directly to the Medicare Advantage Participating Dentists and you will be responsible for any applicable Coinsurance, Copayments or Deductibles.

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 and the amount charged by the Nonparticipating dentist.

Exclusion and Limitations

Exclusions

Delta Dental will make no payment for the following services or supplies, unless otherwise specified in this Member Handbook. 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).

NOTE: Not all Plans cover the services that may be noted below. Please reference the Covered Code List for the services your Plan covers.

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.
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, histopathological examinations and miscellaneous tests.
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 under the supervision of a licensed Dentist. Treatment rendered by any other licensed dental professional may be covered only as solely determined by the MAO and/or Delta Dental.
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 or terrorism.
14. Services or supplies covered under a hospital, surgical/medical or prescription drug program.
15. Services or supplies that are not within the categories of Benefits selected by the MAO and that are not covered under the terms of this Member Handbook.

16. Fluoride rinses, self-applied fluorides, or desensitizing medicaments.
17. Caries preventive medicament.
18. Preventive control programs (including oral hygiene instruction, caries susceptibility tests, dietary control, tobacco counseling, home care medicaments, etc.).
19. Lost, missing, or stolen appliances of any type.
20. Cosmetic dentistry, including repairs to facings posterior to the second bicuspid position.
21. Prefabricated crowns used as final restorations on permanent teeth.
22. 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.
23. Implant/abutment supported interim fixed denture for edentulous arch.
24. Soft occlusal guard appliances.
25. Paste-type root canal fillings on permanent teeth.
26. Replacement, repair, relines or adjustments of occlusal guards.
27. Chemical curettage.
28. Services associated with overdentures.
29. Metal bases on removable prostheses.
30. The replacement of teeth beyond the normal complement of teeth.
31. Personalization or characterization of any service or appliance.
32. Temporary crowns used for temporization during crown or bridge fabrication.
33. Posterior bridges in conjunction with partial dentures in the same arch, sharing at least one posterior edentulous space in common.
34. Precision abutments, attachments and stress breakers.
35. Biologic materials to aid in soft and osseous tissue regeneration when submitted on the same day as tooth extraction, periradicular surgery, soft tissue grafting, guided tissue regeneration and periodontal or implant bone grafting.
36. Bone replacement grafts and specialized implant surgical techniques, including radiographic/surgical implant index.
37. Appliances, restorations, or services for the diagnosis or treatment of disturbances of the temporomandibular joint (TMJ).
38. Diagnostic photographs and cephalometric films.
39. Myofunctional therapy.
40. Mounted case analyses.
41. Molecular, antigen or antibody testing for a public health related pathogen.
42. Vaccinations.
43. Bone replacement grafts when performed in conjunction with a hemisection.
44. Fabrication, adjustment or repair of sleep apnea appliances.
45. Any and all taxes applicable to the services.
46. 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.

NOTE: Not all Plans cover the services that may be noted below. Please reference the Covered Code List for the services your Plan covers.

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 for crowns, onlays, or inlays.
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 in the presence of gingival inflammation.
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 services without flap entry and closure, when performed within 12 months of implant restorations, provisional implant crowns and implant or abutment supported interim dentures.
25. Scaling and debridement in the presence of inflammation or mucositis of a single implant, when done on the same day as a prophylaxis, scaling in the presence of gingival inflammation, periodontal maintenance, full mouth debridement, periodontal scaling and root planing, periodontal surgery or debridement of a peri-implant defect.
26. Full mouth debridement, when done on the same day as comprehensive evaluation.
27. An occlusal adjustment, when performed on the same day as the delivery of an occlusal guard.
28. Reline, rebase, or any adjustment or repair within six months of the delivery of a denture.
29. Adjustments, temporary relines, or tissue conditioning within three months of delivery of an immediate denture.
30. Tissue conditioning, when performed on the same day as the delivery of a denture or the reline or rebase of a denture.
31. 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.
32. Charges or fees for overhead, internet/video connections, software, hardware or other equipment necessary to deliver services, including but not limited to teledentistry services.
33. Capture only images which are not associated with any interpretation or reporting.
34. Frenulectomy when performed on the same day as any other surgical procedure(s) in the same surgical area by the same dentist or dental office.
35. Implant removal when performed within three (3) months of an implant/mini-implant on the same tooth by the same dentist or dental office.
36. Scaling and root planing when performed on the same day as surgical root repair or exposures.
37. Surgical repair or exposure of root when performed on the same day as endodontic or periodontal surgical procedures.
38. Intraorifice barriers.
39. Excision of benign lesions when performed in the same area and on the same day as another surgical procedure by the same dentist or dental office.
40. Processing policies may otherwise exclude payment by Delta Dental for services or supplies.

Limitations

The Benefits for the following services or supplies are limited as follows, unless otherwise specified in this Member Handbook. In addition to limitations listed in the Covered Code List, 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 or, at the request of your Medicare Advantage Organization, any dental plan.

NOTE: Not all Plans cover the services that may be noted below. Please reference the Covered Code List for the services your Plan covers.

1. Crowns or onlays are payable only for extensive loss of tooth structure, 50% loss of tooth structure or greater, due to caries (decay) or fracture (lost or mobile tooth structure).
2. Individual crowns over implants are payable at the prosthodontic benefit level.
3. Delta Dental's obligation for payment of Benefits ends on the last day of coverage. 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.
4. 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.
5. Care terminated due to the death of a Member will be paid to the limit of Delta Dental's liability for the services completed or in progress.
6. Optional treatment: If you select a more expensive service that 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 different in cost. In all cases, Delta Dental will make the final determination regarding optional treatment and any available allowance.

   Listed below are services for which Delta Dental will provide an allowance for optional treatment. **Remember, you are responsible for the difference in cost for any optional treatment.**

   a. Overdentures – Delta Dental will pay only the amount that it would pay for a conventional denture, if covered.
   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, if covered.
   c. All-porcelain/ceramic bridges – Delta Dental will pay only the amount that it would pay for a conventional fixed bridge, if covered.
   d. Implant/abutment supported complete or partial dentures – Delta Dental will pay only the amount that it would pay for a conventional denture, if covered.

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

f. 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, if covered.

7. Maximum Payment:

    a. All Benefits available under This Plan are subject to the Maximum Payment limitations set forth in this Member Handbook.

8. If a Deductible amount is stated in this Member Handbook, Delta Dental will not pay for any services or supplies, in whole or in part, to which the Deductible applies until the Deductible amount is met.

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 or, at the request of your Medicare Advantage Organization, any dental plan.

NOTE: Not all Plans cover the services that may be noted below. Please reference the Covered Code List for the services your Plan covers.

1. 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.
2. Retention pins are payable once in any two-year period. Only one substructure per tooth is a Covered Service.
3. Services or supplies, as determined by Delta Dental, which are not provided in accordance with generally accepted standards of dental practice.
4. Scaling and debridement in the presence of inflammation or mucositis of a single implant is payable once per tooth in any 24-month period when performed by the same office.
5. Processing Policies may limit Delta Dental's payment for services or supplies.

Coordination of Benefits

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.

Definitions

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, retiree, or individual plan that you may have.
2. This Plan will pay secondary to any employer sponsored, automobile or group 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:

Delta Dental
PO Box 9230
Farmington Hills, Michigan 48333-9230

You may also follow the Grievance and Appeals Procedure below.

Grievance and Appeals Procedures

If we make an Adverse Benefit Determination, you will receive a Notice of Denial of Coverage. You or your authorized representative, should seek a review as soon as possible, but you must file your request for review within **60 days** of the date that you received that Notice of Denial of Coverage. Priority Health may give you more time if you have a good reason for missing the deadline.

There are two types of appeals.

Standard Appeal – We will give you a written decision on a standard appeal within 30 days after we get your appeal for a Pre-Service Organization Determination. Our decision might take longer if you ask for an extension, or if we need more information about your case. We will tell you if we are taking extra time and will explain why more time is needed. If your appeal is for payment of a service you have already received, we will give you a written decision within 60 days.

Fast Appeal – We will give you a decision on a fast appeal within 72 hours after we get your appeal. You can ask for a fast appeal if you or your doctor believe your health could be seriously harmed by waiting up to 30 Days for a decision. You cannot request a fast appeal if you are asking us to pay you back for a service you have already received.

Send appeals to the following:

Priority Health
Grievance & Appeals, MS1150
1231 Ease Beltline Ave, NE
Grand Rapids, MI 49525

Fax: 616.975.8826
Phone: 888.389.6648
TTY: 711

Please include your name and address, the Member ID, the explanation of benefits, the reason why you believe your claim was wrongly denied, and any other information you believe supports your claim. Indicate in your letter that you are requesting a formal appeal (Standard/Fast Appeal) of your claim. You also have the right to review any documents related to your appeal. If you would like a record of your request and proof that Priority Health received it, mail your request certified mail, return receipt requested.

If you want someone else to act for you, you can name a relative, friend, attorney, dentist or someone else to act as your representative. You can do this by following the authorized representative section above. Both you and the person you want to act for you must sign and date a statement confirming this is what you want. You will need to mail or fax the statement to Priority Health.

The Dental Director or any person reviewing your claim will not be the same as, nor subordinate to, the person(s) who initially decided your claim. The reviewer will grant no deference to the prior decision about your claim. The reviewer will assess the information, including any additional information that you have provided, as if he or she were deciding the claim for the first time. The reviewer's decision will take into account all comments, documents, records and other information relating to your claim even if the information was not available when your claim was initially decided.

The notice of any adverse determination regarding your appeal will

(a) inform you of the specific reason(s) for the denial,

(b) list the pertinent Plan provision(s) on which the denial is based,

(c) contain a description of any additional information or material that is needed to decide the claim and an explanation of why such information is needed,

(d) reference any internal rule, guideline, or protocol that was relied on in making the decision on review.

Adverse appeals will be automatically submitted to the CMS's contracted independent review entity within 60 calendar days from the date Priority Health received the member's first level appeal. The Appeals Staff will concurrently notify the member that the appeal is being forwarded to CMS's independent review entity.

If you have a complaint or dispute, other than a Notice of Denial of Coverage, expressing dissatisfaction with the manner in which Priority Health or a dentist has provided dental services, you can contact Priority Health at the address listed above in this section or call customer service at 888.389.6648 within 60 days of the event. You will receive a response to your grievance within 30 days of receipt.

Termination of Coverage

Your Delta Dental coverage may automatically terminate:

- When your Health Plan advises Delta Dental to terminate your coverage.
- On the first day of the month for which your Health Plan has failed to pay Delta Dental.
- For fraud or misrepresentation in the submission of any claim.
- For any other reason stated in the contract between Delta Dental and your Health Plan.

Delta Dental will not continue eligibility for any person covered under This Plan beyond the termination date requested by your Health Plan. A person whose eligibility is terminated may not continue coverage under this Member Handbook.

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 your 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.

General Conditions

Subrogation and Right of Reimbursement

If Delta Dental provides Benefits under This Plan and you have a right to recover damages from another, Delta Dental is subrogated to that right.

To the extent that This Plan provides or pays Benefits for Covered Services, Delta Dental is subrogated to any right you or your Eligible Dependent has to recover from another, his or her insurer, or under his or her "Medical Payments" coverage or any "Uninsured Motorist," "Underinsured Motorist," or other similar coverage provisions. You or your legal representative must do whatever is necessary to enable Delta Dental to exercise its rights and do nothing to prejudice them.

If you recover damages from any party or through any coverage named above, you must reimburse Delta Dental from that recovery to the extent of payments made under This Plan.

Obtaining and Releasing Information

While you are an Eligible Person, you agree to provide Delta Dental with any information it needs to process your claims and administer your Benefits. This includes allowing Delta Dental access to your dental records.

Dentist-Patient Relationship

Eligible Persons are free to choose any Dentist. Each Dentist maintains the dentist-patient relationship and is solely responsible to the patient for dental advice and treatment and any resulting liability.

Loss of Eligibility During Treatment

If an Eligible Person loses eligibility while receiving dental treatment, only Covered Services received while that person was covered under This Plan will be payable.

Certain services begun before the loss of eligibility may be covered if they are completed within 60 days from the date of termination. In those cases, Delta Dental evaluates those services in progress to determine what portion may be paid by Delta Dental. The difference between Delta Dental's payment and the total fee for those services is your responsibility.

Late Claims Submission

Delta Dental will make no payment for services or supplies if a claim for such has not been received by Delta Dental within one year following the date the services or supplies were completed.

Change of Member Handbook or Contract

No agent has the authority to change any provisions in this Member Handbook or the provisions of the contract on which it is based. No changes to this Member Handbook or the underlying contract are valid unless Delta Dental approves them in writing.

Actions

No action on a legal claim arising out of or related to this Member Handbook will be brought within 60 days after notice of the legal claim has been given to Delta Dental, unless prohibited by applicable state law. In addition, no action can be brought more than three years after the legal claim first arose or after expiration of the applicable statute of limitations, if longer. Any person seeking to do so will be deemed to have waived his or her right to bring suit on such legal claim. Except as set forth above, this provision does not preclude you from seeking a judicial decision or pursuing other available legal remedies.

Right of Recovery Due to Fraud

If Delta Dental pays for services that were sought or received under fraudulent, false, or misleading pretenses or circumstances, pays a claim that contains false or misrepresented information, or pays a claim that is determined to be fraudulent due to your acts or acts of your Eligible Dependents, it may recover that payment from you or your Eligible Dependents. You and your Eligible Dependents authorize Delta Dental to recover any payment determined to be based on false, fraudulent, misleading, or misrepresented information by deducting that amount from any payments properly due to you or your Eligible Dependents. Delta Dental will provide an explanation of the payment recovery at the time the deduction is made.

Governing Law

This Member Handbook and the underlying group contract will be governed by and interpreted under the Centers for Medicare and Medicaid Services (CMS)

Legally Mandated Benefits

If any applicable law requires broader coverage or more favorable treatment for you or your Eligible Dependents than is provided by this Member Handbook, that law shall control over the language of this Member Handbook.

Sanctioned and/or Precluded Providers

If you choose to receive services from a Nonparticipating dentist, be sure to ask the dentist if they are excluded from the Medicare program. Delta Dental is unable to make payment to either you or your dentist for any services received from a provider that has been excluded from Medicare.

Any person intending to deceive an insurer, who knowingly submits an application or files a claim containing a false or misleading statement, is guilty of insurance fraud.

Insurance fraud significantly increases the cost of health care. If you are aware of any false information submitted to Delta Dental, please call our toll-free hotline. We only accept anti-fraud calls at this number.

ANTI-FRAUD TOLL-FREE HOTLINE:
800.524.0147

MANDATORY DENTAL COVERAGE DETAILS
(#3514-2000, 2100)

This section provides information about the **dental coverage that is included in your Priority Health Medicare Advantage Key plan.** 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.

$2,500 per year maximum coverage amount for non-Medicare Covered Comprehensive dental services. Preventive services, including periodontal maintenance cleanings do not roll up to the maximum.

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 or panoramic X-rays	$0	$0*	Payable once every 24 month period
Brush Biopsy – to detect oral cancer	$0	$0*	One per calendar year
Minor Restorative Services – fillings and crown repair	$0	$0	Crown repairs - once per tooth every 12 months Fillings - once per tooth every 24 months

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
Simple Extractions – non-surgical removal of teeth	$0	$0	Once per lifetime, per tooth
Anesthesia	$0	$0*	Payable in conjunction with Covered Services when medically necessary

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.

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

This section provides a list of dental procedures covered by your plan. **If a procedure is not on this list, it is not a covered benefit under your plan.** Benefit limitations under these programs are listed where applicable in the Benefit Limitations column. Some services share frequencies. Additional information on the frequency limitations can be found in this Delta Dental Member Handbook.

*Please note, certain procedures may require review or diagnostic information such as radiographs or patient treatment records for claims processing and final payment determinations. **If further clarification regarding your coverage and benefits is needed, please ask your dentist for a Pre-Service Organization Determination (PSOD).**

- PSOD's expire at the end of the benefit year. Once a new benefit year begins, it is recommended another request for a PSOD is submitted to determine whether the service is covered under the current benefit plan.

It may be necessary for codes listed to be changed to comply with State, Federal, and American Dental Association (ADA) regulations. The ADA codes are subject to annual updates which may not be reflected in the list provided.

Services for which Delta Dental will provide an allowance for optional treatment is indicated within the Frequency and Limitations column of the Covered Code List. Remember, you are responsible for the difference in cost for any optional treatment.

Code	Description	Plan pay for Delta Dental Medicare Advantage Dentist	Plan pay for Nonparticipating (out-of-network) Dentist	Frequency
D0100-D0999 Diagnostic				
D0120	periodic oral evaluation - established patient	100%	100%	Twice per calendar year (including examinations by a specialist)
D0140	limited oral evaluation - problem focused	100%	100%	As needed for diagnosis of emergency condition
D0150	comprehensive oral evaluation - new or established patient	100%	100%	Once per 36 months
D0160	detailed and extensive oral evaluation - problem focused, by report	100%	100%	Once per 36 months

Code	Description	Plan pay for Delta Dental Medicare Advantage Dentist	Plan pay for Nonparticipating (out-of-network) Dentist	Frequency
D0180	comprehensive periodontal evaluation - new or established patient	100%	100%	Once per calendar year
D0190	screening of a patient	100%	100%	Once per calendar year
D0210	intraoral - complete series	100%	100%	Once per 2 year period
D0220*. D0230*, D0240*, D0250*	intraoral/extra-oral - periapical image, occlusal image	100%	100%	Covered service
D0270, D0272, D0273, D0274, D0277	bitewing x-rays	100%	100%	Once per calendar year
D0330	panoramic image	100%	100%	Once per 2 year period
Diagnostic Notes: • Bitewing X-rays are covered once per calendar year, except in years when you get the full-mouth or panoramic X-ray. • Some exam procedures share frequencies.				
D1000-D1999 Preventive				
D1110	prophylaxis - adult	100%	100%	Twice per calendar year
Preventive Notes: • Any combination of teeth cleanings (prophylaxes and periodontal cleanings) are payable twice per calendar year. • Prophylaxis is only payable on natural teeth.				

Code	Description	Plan pay for Delta Dental Medicare Advantage Dentist	Plan pay for Nonparticipating (out-of-network) Dentist	Frequency
D2000-D2999 Restorative				
D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394	amalgam and composite resin	100%	100%	Covered service
D2910*	re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	100%	100%	Covered service
D2915*	re-cement or re-bond indirectly fabricated or prefabricated post and core	100%	100%	Covered service
D2920*	re-cement or re-bond crown	100%	100%	Covered service
D2921*	reattachment of tooth fragment, incisal edge or cusp	100%	100%	Covered service

Code	Description	Plan pay for Delta Dental Medicare Advantage Dentist	Plan pay for Nonparticipating (out-of-network) Dentist	Frequency
D2940	protective restoration	100%	100%	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)
D2941	interim therapeutic restoration - primary dentition	100%	100%	Once per primary tooth
D2951*	pin retention - per tooth, in addition to restoration	100%	100%	Once per tooth per lifetime
D2980*, D2981*, D2982*, D2983*	repair necessitated by restorative material failure	100%	100%	Covered service
D2999*	unspecified restorative procedure, by report	100%	100%	Benefit determined by consultant review

Code	Description	Plan pay for Delta Dental Medicare Advantage Dentist	Plan pay for Nonparticipating (out-of-network) Dentist	Frequency
Restorative Notes: • Subsequent minor restorations would not be a benefit within that five-year period on crowns or onlays. • Crowns or onlays are payable only for extensive loss of tooth structure due to caries (decay) or fracture (lost or mobile tooth structure). Our standard for extensive loss of tooth structure is 50% tooth loss. • Participating dentists may not charge members for recementation of a crown, onlay, inlay, or bridge within 6 months of the seating date. • When implants are NOT covered, crowns over implants are not covered. • Crowns on bridges are NOT covered if bridges are NOT covered. • Amalgam and composite resin restorations are payable once in any two-year period by the same dentist, same tooth and same surface, regardless of the number or combination of restorations placed on a surface.				
D4000-D4999 Periodontics				
D4910*	periodontal maintenance	100%	100%	Including in the cleaning frequency of twice per calendar year
D7000-D7999 Oral and Maxillofacial Surgery				
D7111*	extraction, coronal remnants - primary tooth	100%	100%	Once per tooth per lifetime
D7140*	extraction, erupted tooth or exposed root (elevation and or forceps removal)	100%	100%	Once per tooth per lifetime
D7288	Brush biopsy – transepithelial sample collection	100%	100%	Covered Service
D9000-D9999 Adjunctive General Services				
D9222*, D9223*	deep sedation/general anesthesia	100%	100%	Paid in conjunction with qualifying services

Code	Description	Plan pay for Delta Dental Medicare Advantage Dentist	Plan pay for Nonparticipating (out-of-network) Dentist	Frequency
D9239*, D9243*	intravenous moderate (conscious) sedation/analgesia	100%	100%	Paid in conjunction with qualifying services

*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 Diagnostic; D2910–D2999 Restorative; D4000-D4999 Periodontics; D7111-D7140 Oral and Maxillofacial Surgery.

Delta Dental Medicare Advantage™ Dental Plan

Welcome!

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.

This Member Handbook which describes the specific benefits of your Delta Dental program, how to use them and your Covered Code List. If you have any questions about this program, please call our Customer Service department at 800.330.2732 (TTY Users call 711).

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.

We look forward to serving you!

Medicare Advantage Supplemental Dental Plan
Priority Health Medicare – Optional Supplemental
Group Number - 3514
Subgroup Number - 3000

Benefit Year: January 1 through December 31

Maximum Payment: $2,500 on all services covered by the selected Optional Supplemental plan. Covered services included with your Priority Health Medicare Advantage Plan have a separate $2,500 maximum. Diagnostic, prophylaxes, X-rays, brush biopsy, and periodontal maintenance do not apply to either maximum.

Deductible: None

A complete listing of covered dental services begins on the next page.

***Services received from dentists who do NOT participate in the Delta Dental Medicare Advantage PPO and Premier Network will result in your out of pocket costs being 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 and the amount charged by the Nonparticipating dentist.

OPTIONAL ENHANCED DENTAL BENEFITS

(#3514-3000)

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 $33.00 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 Key, 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.

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
Fluoride	$0	$0*	Once per calendar year
Endodontic services – root canals	50%	50%*	Once every 24 months, per tooth.
Major restorative services – crowns, onlays and associated substructures	50%	50%*	Once every 60 months, per tooth.

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
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
Prosthodontics - dentures, denture relines/ repairs and bridge repairs	50%	50%*	Once every 36 months, per appliance.
Implant Services	50%	50%*	Once every 60 months per tooth.

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

This section provides a list of dental procedures covered by your plan. **If a procedure is not on this list, it is not a covered benefit under your plan.** Benefit limitations under these programs are listed where applicable in the Benefit Limitations column. Some services share frequencies. Additional information on the frequency limitations can be found in this Delta Dental Member Handbook.

*Please note, certain procedures may require review or diagnostic information such as radiographs or patient treatment records for claims processing and final payment determinations. **If further clarification regarding your coverage and benefits is needed, please ask your dentist for a Pre-Service Organization Determination (PSOD).**

- PSOD's expire at the end of the benefit year. Once a new benefit year begins, it is recommended another request for a PSOD is submitted to determine whether the service is covered under the current benefit plan.

It may be necessary for codes listed to be changed to comply with State, Federal, and American Dental Association (ADA) regulations. The ADA codes are subject to annual updates which may not be reflected in the list provided.

Services for which Delta Dental will provide an allowance for optional treatment is indicated within the Frequency and Limitations column of the Covered Code List. Remember, you are responsible for the difference in cost for any optional treatment.

Code	Description	Plan pay for Delta Dental Medicare Advantage Dentist	Plan pay for Nonparticipating (out-of-network) Dentist	Frequency
D0100-D0999 Diagnostic				
D0120	periodic oral evaluation - established patient	100%	100%	Twice per calendar year (including examinations by a specialist)
D0140	limited oral evaluation - problem focused	100%	100%	As needed for diagnosis of emergency condition
D0150	comprehensive oral evaluation - new or established patient	100%	100%	Once per 36 months

Code	Description	Plan pay for Delta Dental Medicare Advantage Dentist	Plan pay for Nonparticipating (out-of-network) Dentist	Frequency
D0160	detailed and extensive oral evaluation - problem focused, by report	100%	100%	Once per 36 months
D0180	comprehensive periodontal evaluation - new or established patient	100%	100%	Once per calendar year
D0190	screening of a patient	100%	100%	Once per calendar year
D0210	intraoral - complete series	100%	100%	Once per 2 year period
D0220*. D0230*, D0240*, D0250*	intraoral/extra-oral - periapical image, occlusal image	100%	100%	Covered service
D0270, D0272, D0273, D0274, D0277	bitewing x-rays	100%	100%	Once per calendar year
D0330	panoramic image	100%	100%	Once per 2 year period
Diagnostic Notes: • Bitewing X-rays are covered once per calendar year, except in years when you get the full-mouth or panoramic X-ray. • Some exam procedures share frequencies.				
D1000-D1999 Preventive				
D1110	prophylaxis - adult	100%	100%	Twice per calendar year
D1206, D1208	topical application of fluoride	100%	100%	Once per calendar year
Preventive Notes: • Any combination of teeth cleanings (prophylaxes and periodontal cleanings) are payable twice per calendar year. • Prophylaxis is only payable on natural teeth.				

Code	Description	Plan pay for Delta Dental Medicare Advantage Dentist	Plan pay for Nonparticipating (out-of-network) Dentist	Frequency
D2000-D2999 Restorative				
D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394	amalgam and composite resin	100%	100%	Covered service
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%	50%	Once per 5 year period;
D2710*, D2712*, D2720*, D2721*, D2722*, D2740*, D2750*, D2751*, D2752*, D2753*,	crown - resin-based composite or porcelain ceramic	50%	50%	Once per 5 year period;
D2780*, D2781*, D2782*	crown - 3/4 cast	50%	50%	Once per 5 year period
D2783*	crown - 3/4 porcelain/ceramic	50%	50%/	Once per 5 year period;
D2790*, D2791*, D2792*, D2794*	crown - full cast	50%	50%	Once per 5 year period
D2910*	re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	100%	100%	Covered service

Code	Description	Plan pay for Delta Dental Medicare Advantage Dentist	Plan pay for Nonparticipating (out-of-network) Dentist	Frequency
D2915*	re-cement or re-bond indirectly fabricated or prefabricated post and core	100%	100%	Covered service
D2920*	re-cement or re-bond crown	100%	100%	Covered service
D2921*	reattachment of tooth fragment, incisal edge or cusp	100%	100%	Covered service
D2928*, D2929*, D2930*, D2931*, D2932*, D2933*, D2934*	prefabricated crown	50%	50%	Covered service
D2940	protective restoration	100%	100%	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)
D2941	interim therapeutic restoration - primary dentition	100%	100%	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	100%	100%	Once per tooth per lifetime
D2952*, D2954*	post and core in addition to crown	50%	50%	Once per 5 year period

Code	Description	Plan pay for Delta Dental Medicare Advantage Dentist	Plan pay for Nonparticipating (out-of-network) Dentist	Frequency
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	100%	100%	Covered service
D2999*	unspecified restorative procedure, by report	100%	100%	Benefit determined by consultant review
Restorative Notes: • Subsequent minor restorations would not be a benefit within that five-year period on crowns or onlays. • Crowns or onlays are payable only for extensive loss of tooth structure due to caries (decay) or fracture (lost or mobile tooth structure). Our standard for extensive loss of tooth structure is 50% tooth loss. • Participating dentists may not charge members for recementation of a crown, onlay, inlay, or bridge within 6 months of the seating date. • When implants are NOT covered, crowns over implants are not covered. • Crowns on bridges are NOT covered if bridges are NOT covered. • Amalgam and composite resin restorations are payable once in any two-year period by the same dentist, same tooth and same surface, regardless of the number or combination of restorations placed on a surface.				
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	Plan pay for Delta Dental Medicare Advantage Dentist	Plan pay for Nonparticipating (out-of-network) Dentist	Frequency
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, pulp space disinfection, etc.)	50%	50%	Covered service
D3410*, D3421*, D3425*, D3426*	apicoectomy	50%	50%	Covered service
D3430*	retrograde filling - per root	50%	50%	Covered service

Code	Description	Plan pay for Delta Dental Medicare Advantage Dentist	Plan pay for Nonparticipating (out-of-network) Dentist	Frequency
D3450*	root amputation - per root	50%	50%	Covered service
D3471, D3472, D3473, D3501, D3502, D3503		50%	50%	
D3920*	hemisection (including any root removal), not including root canal therapy	50%	50%	Covered service
D3921	Decoronation or submergence of an erupted tooth	50%	50%	Benefit determined by consultant review
D3999	unspecified endodontic procedure, by report	50%	50%	Benefit determined by consultant review
D4000-D4999 Periodontics				
D4910*	Periodontal maintenance	100%	100%	Including in the cleaning frequency of twice per calendar year
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	Plan pay for Delta Dental Medicare Advantage Dentist	Plan pay for Nonparticipating (out-of-network) Dentist	Frequency
D5520*	replace missing or broken teeth - complete denture (each tooth)	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
D5820, D5821	interim partial denture	50%	50%	Payable for the replacement of permanent anterior teeth during the healing period
D5850, D5851	tissue conditioning	50%	50%	Twice per 36 month period

Code	Description	Plan pay for Delta Dental Medicare Advantage Dentist	Plan pay for Nonparticipating (out-of-network) Dentist	Frequency
Prosthodontics (Removable) Notes: • One complete upper denture and one complete lower denture, and any implant used to support a denture, are payable once in any five-year period. • A removable partial denture, endosteal implant (other than to support a denture), or fixed bridge is payable once in any five-year period unless the loss of additional teeth requires the construction of a new appliance. • The allowance for a denture repair (including reline or rebase) will not exceed half the fee for a new denture.				
D6000-D6199 Implant Services				
D6010*	surgical placement of implant body; endosteal implant	50%	50%	Once per 5 year period
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
D6058*	abutment supported porcelain/ceramic crown	50%	50%	Once per 5 year period
D6059*	abutment supported porcelain fused to metal crown (high noble metal)	50%	50%	Once per 5 year period
D6060*	abutment supported porcelain fused to metal crown (predominantly base metal)	50%	50%	Once per 5 year period
D6061*	abutment supported porcelain fused to metal crown (noble metal)	50%	50%	Once per 5 year period
D6062*	abutment supported cast metal crown (high noble metal)	50%	50%	Once per 5 year period

Code	Description	Plan pay for Delta Dental Medicare Advantage Dentist	Plan pay for Nonparticipating (out-of-network) Dentist	Frequency
D6063*	abutment supported cast metal crown (predominantly base metal)	50%	50%	Once per 5 year period
D6064*	abutment supported cast metal crown (noble metal)	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
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
D6094*, D6097	abutment supported crown	50%	50%	Covered service

Code	Description	Plan pay for Delta Dental Medicare Advantage Dentist	Plan pay for Nonparticipating (out-of-network) Dentist	Frequency
D6095*	repair implant abutment, by report	50%	50%	Covered service
D6096*	remove broken implant retaining screw	50%	50%	Once 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
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
Implant Services Notes: • Participating dentists may not charge members for the recementation or rebonding of partial dentures within 6 months of the seating date.				

Code	Description	Plan pay for Delta Dental Medicare Advantage Dentist	Plan pay for Nonparticipating (out-of-network) Dentist	Frequency
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	100%	100%	Once per tooth per lifetime
D7140*	extraction, erupted tooth or exposed root (elevation and or forceps removal)	100%	100%	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

Code	Description	Plan pay for Delta Dental Medicare Advantage Dentist	Plan pay for Nonparticipating (out-of-network) Dentist	Frequency
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
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.
D7288	Brush biopsy – transepithelial sample collection	100%	100%	Covered Service
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

Code	Description	Plan pay for Delta Dental Medicare Advantage Dentist	Plan pay for Nonparticipating (out-of-network) Dentist	Frequency
D7293*	placement of temporary anchorage device requiring flap; includes device removal	50%	50%	Covered service
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 per quadrant	50%	70%	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	Plan pay for Delta Dental Medicare Advantage Dentist	Plan pay for Nonparticipating (out-of-network) Dentist	Frequency
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
D7999*	unspecified oral surgery procedure, by report	50%	50%	Benefit determined by consultant review

Code	Description	Plan pay for Delta Dental Medicare Advantage Dentist	Plan pay for Nonparticipating (out-of-network) Dentist	Frequency
D9000-D9999 Adjunctive General Services				
D9110	palliative (emergency) treatment of dental pain – minor procedure	100%	100%	As needed for diagnosis of emergency condition
D9222*, D9223*	deep sedation/general anesthesia	100%	100%	Paid in conjunction with qualifying services
D9239*, D9243*	intravenous moderate (conscious) sedation/analgesia	100%	100%	Paid in conjunction with qualifying services

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 *www.lenscrafters.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.

Covered Services	EyeMed "Select" Network Provider Benefits[1]	Non- EyeMed "Select" Network Provider Benefits[4]	Frequency
Routine exam including refraction with dilation as necessary	$0 copay	Up to $50 reimbursement	Once per calendar year.
Retinal imaging	$0 copay	Up to $20 reimbursement	
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)	Frames, lens and lens options package (combined): $100 allowance[2]; or	Frames, lens and lens options package (combined): Up to $100 reimbursement[2]; or	
	Conventional contact lenses: $100 allowance[2]; or	Conventional contact lenses: $100 reimbursement[2]; or	
	Disposable contact lenses: $100 allowance[2]; or	Disposable contact lenses: Up to $100 reimbursement[2]; or	
	Medically necessary contact lenses[3]: $0 copay	Medically necessary contact lenses[3]: Up to $210 reimbursement	

[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 $33.00 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 Key, you have vision benefits already included in your Medicare Advantage plan, these optional enhanced vision 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

No benefits will be paid for services or materials connected with or charges arising from:

1. Medical or surgical treatment, services or supplies for the treatment of the eye, eyes or supporting structures;

2. Refraction, when not provided as part of a Comprehensive Eye Examination;
3. 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;
4. Orthoptic or vision training, subnormal vision aids and any associated supplemental testing;
5. Aniseikonic lenses;
6. Any Vision Examination or any corrective Vision Materials required by a Policyholder as a condition of employment;
7. Safety eyewear;
8. Solutions, cleaning products or frame cases;
9. Non-prescription sunglasses;
10. Plano (non-prescription) lenses;
11. Plano (non-prescription) contact lenses;
12. Two pair of glasses in lieu of bifocals;
13. Electronic vision devices;
14. Services rendered after the date an Insured Person ceases to be Covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order;
15. Services or materials provided by any other group benefit plan providing vision care;
16. Lost or broken lenses, frames, glasses, or contact lenses that are replaced before the next Benefit Frequency when Vision Materials would next become available;

HEARING INFORMATION

(Mandatory)

As a Priority Health Medicare Key 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 BEFORE 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, **you will pay for the full cost of any services received. You will NOT be reimbursed**. 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 225 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 per hearing aid Standard aid: $695 copay per hearing aid Advanced aid: $1,095 copay per hearing aid Premium aid: $1,495 copay per hearing aid	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 Key **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 Department, MS 1115 Priority Health Medicare 1231 East Beltline Ave, NE Grand Rapids, MI 49525 *MedicareCS@priorityhealth.com*
WEBSITE	*priorityhealth.com/key24*

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 W St. Joseph Hwy, Suite 204 Lansing, MI 48917-4850
WEBSITE	*mmapinc.org*

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