Priority Health

2025 Certificate of Coverage

PriorityMedicare[SM] D-SNP (HMO)
Offered by Priority Health

January 1, 2025-December 31, 2025

OMB Approval 0938-1051 (Expires: August 31, 2026)
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Thank you for being a Priority Health Medicare D-SNP member.

Your **Priority**Medicare D-SNP 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."

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 833.714.5355

For assistance on Saturday or Sunday, please contact Priority Health Medicare at 833.939.0983, from 8 a.m. to 8 p.m. (TTY 711). Or, visit *priorityhealth.com/dsnp25* and select **Already a member**.

(Mandatory)

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 833.939.0983 (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, you **MUST** see an EyeMed "Select" provider to access these benefits. 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 *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. Services and supplies from Non-EyeMed "Select: Providers are not covered under this plan. You must see a provider in EyeMed's "Select" Network.

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 D-SNP 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]	Frequency
Routine exam including refraction with dilation as necessary	$0 copay	Once per calendar year.
Retinal imaging	$0 copay	
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): $200 allowance[2]; or	
	Conventional contact lenses: $200 allowance[2]; or	
	Disposable contact lenses: $200 allowance[2]; or	
	Medically necessary contact lenses[3]: $0 copay	

[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.

Additional Discounts

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 $200 for frame, lens and lens options package
- 15% off balance over $200 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 MANDATORY 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. Lost or broken lenses, frames, glasses, or contact lenses that are replaced before the next Benefit Frequency when Vision Materials would next become available.

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 includes your Covered Code List describes the specific benefits of your Delta Dental program and how to use them. 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 DSNP Group
Number - 9509 Subgroup
Number - 4000

***Services received from dentists who do NOT participate in the Delta Dental Medicare Advantage PPO 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 PPO Network YOU WILL BE RESPONSIBLE for the full cost of those services and Delta Dental will make no payment.
Benefit Year – January 1 through December 31

Maximum Payment: $1,500 on all services.

Deductible: None.

This section provides information about the **dental coverage that is included in your Priority Health Medicare Advantage D-SNP 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.
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 $1,500 of the allowable cost of covered services.

Covered Services	If you see a Participating Delta Dental Medicare Advantage PPO 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	100% of the cost of the service*	Two per calendar year (oral exams and cleanings) Four per calendar year (periodontal maintenance cleanings)
Fluoride	$0	100% of the cost of the service*	Once per calendar year
Brush Biopsy – to detect oral cancer	$0	100% of the cost of the service*	Covered Service
Bitewing Radiographs – one set (up to 4 films in a single visit) of bitewing X-rays	$0	100% of the cost of the service*	One set per calendar year

Covered Services	If you see a Participating Delta Dental Medicare Advantage PPO Dentist you pay*	If you see a Nonparticipating (out-of-network) Dentist you pay*	Frequency
All Other Radiographs – full mouth series, periapical or panoramic x-rays	$0	100% of the cost of the service*	Once every 2 years

*Services received from dentists who do NOT participate in Delta Dental's Medicare Advantage PPO Network are Not covered benefits.

IMPORTANT: If you receive services from a dentist that DOES NOT participate in Delta Dental's Medicare Advantage PPO Network, YOU WILL BE RESPONSIBLE for the full cost of those services and no payment will be made by Delta Dental. In-network (participating) dentists are those in Michigan, Indiana and Ohio who are in Delta Dental's Medicare Advantage PPO network. All other dentists are considered out-of-network (nonparticipating) providers.

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 Frequency column. Some services share frequencies. Additional information on the exclusions and limitations can be found within 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.

ADA Dental Code	Dental Procedure 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%	0%	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%	0%	Once per 36 months
D0160	detailed and extensive oral evaluation - problem focused, by report	100%	0%	Once per 36 months
D0180	comprehensive periodontal evaluation - new or established patient	100%	0%	Once per calendar year
D0190	screening of a patient	100%	0%	Once per calendar year
D0220*, D0230*, D0240*, D0250*	intraoral - periapical image, occlusal image	100%	0%	Covered service
D0210	intraoral – complete series	100%	0%	Once per two-calendar years

D0270, D0272, D0273, D0274, D0277	bitewing x-rays	100%	0%	Once per calendar year
D0330	panoramic image	100%	0%	Once per two-calendar years
D0364, D0365, D0366, D0367	Cone beam CT capture and interpretation with limited field of view – less than one whole jaw	100%	0%	Covered service
D0419	assessment of salivary flow, by measurement	100%	0%	Once per three-year period
D0460	pulp vitality tests	100%	0%	Payable per visit not per tooth for the diagnosis of emergency conditions
Diagnostic Notes: • Bitewing X-rays are covered, except in years when you get the full-mouth or panoramic x-ray. • Oral examinations and evaluations (not including limited problem focused evaluations or patient screenings) share frequencies. • A full mouth X-ray and panoramic X-ray share frequencies.				
D1000-D1999 Preventive				
D1110	prophylaxis - adult	100%	0%	Twice per calendar year
D1206, D1208	topical application of fluoride	100%	0%	Once per calendar year
Preventive Notes: • Teeth cleanings (prophylaxes and periodontal cleanings) share frequencies. • Prophylaxis is payable on natural teeth and implants.				
D4000-D4999 Periodontics				
D4910*	periodontal maintenance	100%	0%	Limited to two per calendar year and will be reduced by the number of routine cleanings received during the same calendar year
Periodontic Notes: • Periodontal cleanings are limited to two per calendar year and will be reduced by the number of routine cleanings received during the same calendar year so that the total number of cleanings will not exceed two in a calendar year.				
D7000-D7999 Oral and Maxillofacial Surgery				
D7288*	Brush biopsy – transepithelial sample collection	100%	0%	Covered Service

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 seeing 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 Plan 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 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 full cost of those services and Delta Dental will make no payment.**

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 PPO Dentist Fee Schedule

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

Medicare Advantage Premier Dentist Schedule

The maximum fee allowed per procedure for services rendered by a Delta Dental Medicare Advantage Premier 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, Pre-Treatment Estimates 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 Members pursuant to this Member Handbook.

Teledentistry

The delivery of dental services through the use of synchronous, real-time communication and the delivery of services of a dental hygienist or expanded function dental auxiliary pursuant to a dentist's authorization.

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 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 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.**

IMPORTANT: If you receive services from a dentist that DOES NOT participate in Delta Dental's Medicare Advantage PPO Network YOU WILL BE RESPONSIBLE for the full cost of those services and Delta Dental will make no payment.

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, MI 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, MI 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:

Attention: Customer Service
P.O. Box 9230
Farmington Hills, MI 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 Priority Health 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.

Exclusion and Limitations

If you receive services from a dentist that DOES NOT participate in Delta Dental's Medicare Advantage PPO Network YOU WILL BE RESPONSIBLE for the full cost of those services and Delta Dental will make no payment.

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):

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 procedures or techniques.
11. Treatment by other than a Dentist, except for services performed by a licensed dental hygienist or other dental professional, as determined by Delta Dental under the scope of his or her license as permitted by applicable state law.
12. Services or supplies for which the patient is not legally obligated to pay, or for which no charge would be made in the absence of Delta Dental coverage.
13. Services or supplies received due to an act of war, declared or undeclared 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 covered under the terms of this Member Handbook.
16. Fluoride rinses, self-applied fluorides, or desensitizing medicaments.
17. Interim caries arresting medicament.
18. Preventive control programs (including oral hygiene instruction, caries susceptibility tests, dietary control, tobacco counseling, immunization 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. Veneers.
22. Prefabricated crowns used as final restorations on permanent teeth.
23. 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.
24. Paste-type root canal fillings on permanent teeth.
25. Replacement, repair, relines or adjustments of occlusal guards.
26. Chemical curettage.
27. Services associated with overdentures.
28. Implant/abutment supported interim fixed denture for edentulous arch.
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, implants, ridge augmentation, ridge preservation/extraction sites, apicoectomy sites, hemisections, and periodontal or implant bone grafting.

36. Bone replacement grafts and specialized implant surgical techniques, including radiographic/surgical implant index.
37. Indexing for osteotomy using dynamic robotic assisted or dynamic navigation.
38. Appliances, restorations, or services for the diagnosis or treatment of disturbances of the temporomandibular joint (TMJ).
39. Diagnostic photographs and cephalometric films.
40. 3-D scans and images, and printings of such scans or images.
41. Myofunctional therapy.
42. Mounted case analyses.
43. Molecular, antigen or antibody testing for a public health related pathogen.
44. Vaccinations.
45. Bone replacement grafts when performed in conjunction with a hemisection.
46. Fabrication, adjustment, reline or repair of sleep apnea appliances.
47. The administration of a home sleep apnea test, or screening for sleep apnea related breathing disorders.
48. Fabrication, delivery, or titration of oral appliance therapy (OAT) morning repositioning device.
49. Fabrication and placement of a custom removable clear plastic temporary aesthetic appliance.
50. Removal of non-resorbable barrier.
51. Intraoral tomosynthesis images.
52. Any and all taxes applicable to the services.
53. Processing policies may otherwise exclude payment by Delta Dental for services or supplies.

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

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

15. Any substructure when done for inlays, onlays, and veneers.
16. Excavation of a tooth resulting in the determination of non-restorability.
17. 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.
18. A pulpotomy on a permanent tooth, except on a tooth with an open apex.
19. A therapeutic apical closure on a permanent tooth, except on a tooth where the root is not fully formed.
20. Retreatment of a root canal by the same Dentist or dental office within two years of the original root canal treatment.
21. A prophylaxis or full mouth debridement, when done on the same day as periodontal maintenance or scaling in the presence of gingival inflammation.
22. Scaling in the presence of gingival inflammation when done on the same day as periodontal maintenance.
23. 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.
24. Full mouth debridement when done within 30 days of scaling and root planing.
25. 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.
26. 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.
27. Full mouth debridement, when done on the same day as comprehensive periodontal evaluation.
28. Interim caries arresting medicament is not payable when done on the same day as the application of hydroxyapatite regeneration medicament when performed on the same tooth.
29. Application of hydroxyapatite regeneration medicament is not payable on the same day as a restoration or a fixed partial denture retainer when performed by the same dentist or dental office.
30. An occlusal adjustment, when performed on the same day as the delivery of an occlusal guard.
31. Reline, rebase, or any adjustment or repair within six months of the delivery of a partial denture.
32. Reline or any adjustment or repair to a sleep apnea appliance within six (6)-months of the delivery.
33. Tissue conditioning, when performed on the same day as the delivery of a denture or the reline or rebase of a denture.
34. Adjustments, temporary relines, or tissue conditioning within three months of delivery of an immediate denture.
35. Periapical and/or bitewing X-rays, when done within a clinically unreasonable period of time of performing full mouth X-rays, as determined solely by Delta Dental.

36. Charges or fees for overhead, internet/video connections, software, hardware or other equipment necessary to deliver services, including but not limited to teledentistry services.

37. Capture only images which are not associated with any interpretation or reporting.

38. 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.

39. Surgical removal of implant body when performed within three (3) months of an implant/mini-implant on the same tooth by the same dentist or dental office.

40. Non-surgical implant removal when performed within six(6)-months of an implant/mini-implant on the same tooth by the same dentist or dental office.

41. Accessing and retorquing loose implant screw is not payable when performed on the same day as implant maintenance and repair procedures on an implant supported prosthesis by the same dentist or dental office.

42. Scaling and root planing when performed on the same day as surgical root repair or exposures.

43. Surgical repair or exposure of root when performed on the same day as endodontic or periodontal surgical procedures.

44. Intraorifice barriers.

45. Removal of non-resorbable barrier when performed by the same dentist who placed the barrier.

46. Excision of benign or malignant lesions or salivary glands when performed in the same area and on the same day as another surgical procedure by the same dentist or dental office.

47. 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. 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 actual date (i.e. to the day) of the applicable prior dates of services in our records or, at the request of your Medicare Advantage Organization, any dental plan:

1. 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.

2. 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.

3. 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.

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

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

    c. Implant/abutment supported complete or partial dentures – Delta Dental will pay only the amount that it would pay for a conventional denture.

    d. Foil restorations – Delta Dental will pay only the amount that it would pay for an amalgam or composite restoration.

    e. 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.

5. 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.

6. Retention pins are payable once in any two-year period. Only one substructure per tooth is a Covered Service.

7. Processing policies may otherwise exclude payment by Delta Dental for services or supplies.

Coordination of Benefits

Coordination of Benefits ("COB") applies to This Plan 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 defined by Centers for Medicare & Medicaid Services (CMS).

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:

Attention: Customer Service
P.O. Box 9230
Farmington Hills, MI 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 East Beltline Ave, NE
Grand Rapids, MI 49525

Fax: (616) 975-8826
Phone: (833) 939-0983
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 (833) 939-0983 within 60 days of the event. Priority Health will respond in writing to all Grievances 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

Assignment

Services and Benefits are for the personal benefit of Members and cannot be transferred or assigned, other than to pay Participating Dentists directly.

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 enrolled in This Plan, you agree to provide Delta Dental with any information it needs to process Claims and administer Benefits for you. This includes allowing Delta Dental access to your dental records.

Dentist-Patient Relationship

Members are free to choose any Dentist. Each Dentist is solely responsible for the treatment and/or dental advice provided to the Member and Delta Dental does not have any liability resulting therefrom.

Loss of Eligibility During Treatment

If a Member 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. In the event that a Participating Provider submits a Claim more than one year from the date of service, Delta Dental will deny that portion of the Claim that Delta Dental would have paid if the Claim had been timely submitted, and such denied portion of the Claim will not be chargeable to the Member. However, you will remain responsible for any applicable Deductible and/or Copayment and/or Coinsurance. In the event that a Nonparticipating Provider submits a Claim more than one year from the date of service, Delta Dental will Deny the Claim and you may be responsible for the full amount.

Change of Member Handbook or Contract

No changes to this Member Handbook or the underlying contract are valid unless Delta Dental approves them in writing.

Actions

You cannot bring an action on a legal claim arising out of or related to this Member Handbook unless you have provided at least 60 days' written notice to Delta Dental, unless prohibited by applicable state law. In addition, you cannot bring an action more than three years after the legal claim first arose or after expiration of the applicable statute of limitations, whichever is shorter. 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, it may recover that payment from you. Delta Dental may 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. 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 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)

As a Priority Health Medicare D-SNP 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 833.714.5355, 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 833.939.0983 (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 833.714.5355.

DO I HAVE TO CALL TRUHEARING BEFORE I SEE A TRUHEARING NETWORK PROVIDER?

Yes. To access your benefits, you must call TruHearing at 833.714.5355 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 D-SNP 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 limited to Advanced hearing aids, available in various styles and colors. To access your benefits, call TruHearing at 833.714.5355 8:00 a.m. to 8:00 p.m. Monday through Friday to schedule an appointment.	Advanced aid: $0 copay per hearing aid	Up to two TruHearing Advanced hearing aids every calendar year (one per every two years).

- Advanced aids: Advanced devices equipped to handle challenging 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
- Earmolds (for applicable hearing aid styles)

Exclusions for <u>MANDATORY</u> hearing

- Any hearing aids other than those listed in the benefits chart above
- Over-the-counter (OTC) hearing aids
- Hearing aid accessories
- Costs associated with optional rechargeability
- Warranty claim fees
- Additional hearing aid batteries
- Hearing aid batteries (beyond the 80 free batteries per non-rechargeable aid purchased)
- Additional provider visits.

prioritymedicare.com

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