Priority Health

2026

Member Handbook

PriorityMedicare® Dual Premier (HMO D-SNP) offered by Priority Health

January 1, 2026 – December 31, 2026

OMB Approval 0938-1051 (Expires: August 31, 2026)
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PriorityMedicare Dual Premier® (HMO-DSNP) *Member Handbook*

OMB Approval 0938-1444 (Expires: June 30, 2026)

January 1, 2026 – December 31, 2026

Your Health and Drug Coverage under PriorityMedicare Dual Premier

Member Handbook Introduction

This *Member Handbook, otherwise known as the Evidence of Coverage,* tells you about your coverage under our plan through December 31, 2026. It explains health care services, behavioral health (mental health and substance use disorder) services, drug coverage, and long-term services and supports, as needed. Key terms and their definitions appear in alphabetical order in **Chapter 12** of this *Member Handbook*.

This is an important legal document. Keep it in a safe place.

When this *Member Handbook* says "we", "us", "our", or "our plan", it means **Priority**Medicare Dual Premier.

You can get this document for free in other formats, such as large print, braille, and/or audio by calling Customer Care at the number at the bottom of this page. The call is free.

Our plan can also give you your important plan materials in languages other than English and in formats such as large print, braille, or audio. To get your important plan materials in one of these alternative formats, you can submit a request using any of the following methods:

- Contact our Customer Care team by calling 833.939.0983 (TTY: 711). From Oct. 1–Mar. 31, we're available seven days a week from 8 a.m.–8 p.m. ET. From Apr. 1– Sept. 30, we're available Mon.– Fri. from 8 a.m.–8 p.m. and Sat. 8 a.m.-Noon ET.
- Create and log in to your member account at *member.priorityhealth.com* to send us a secure message.
- Send a written request to:
  Priority Health
  1231 East Beltline Ave. NE
  Grand Rapids, MI 49525

Upon receiving your request, unless you indicate this is a one-time need, we will continue to send future mailings and communications in the preferred language and/or format. If at any time you would like to update or change your preferred preferences, you can use any of the above contact methods.

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

We offer free language assistance services and auxiliary aids and services.

Albanian (Shqip) - VINI RE: Nëse flisni shqip, shërbime falas të ndihmës së gjuhës janë në dispozicion për ju. Ndihma të përshtatshme dhe shërbime shtesë për të siguruar informacion në formate të përdorshme janë gjithashtu në dispozicion falas. Telefononi 800.942.0954 (TTY: 711) ose bisedoni me ofruesin tuaj të shërbimit.

Arabic (العربية) - تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 800.942.0954 (TTY: 711) أو تحدث إلى مقدم الخدمة.

Assyrian (ܐܬܘܪܝܐ) - ܡܙܗܪܢܘܬܐ: ܐܢ ܐܢܬ ܗܘܬ ܡܡܠܠ ܐܬܘܪܝܐ، ܫܡܫܬܘܬܐ ܕܠܫܢܐ ܒܡܓܢܐ ܕܐܝܬܠܟ ܘܡܘܬܪܐ ܠܡܘܬܒܘܬܐ ܒܠܫܢܐ. ܐܝܟܢܐ ܡܬܡܨܝܢ ܘܡܫܬܘܬܐ ܕܠܟܠ ܒܣܘܪܐ ܕܐܬܘܪܝܐ ܡܘܬܒܐ ܐܦ ܐܢܐ ܐܢܬ ܒܠܫܢܐ. ܩܪܝ 800.942.0954 (TTY: 711) ܘܡܠܠ ܠܗ ܡܫܡܫܢܐ ܕܝܠܟ.

Bengali (বাংলা) - মনোযোগ দিন: যদি আপনি বাংলা বলেন তাহলে আপনার জন্য বিনামূল্যে ভাষা সহায়তা পরিষেবাদি উপলব্ধ রয়েছে। অ্যাক্সেসযোগ্য ফরম্যাটে তথ্য প্রদানের জন্য উপযুক্ত সহায়ক সহযোগিতা এবং পরিষেবাদিও বিনামূল্যে উপলব্ধ রয়েছে। 800.942.0954 (TTY: 711) নম্বরে কল করুন অথবা আপনার প্রদানকারীর সাথে কথা বলুন।

Bosnian/Croatian (Bosanski/Hrvatski) - PAŽNJA: Ako govorite bosanski/hrvatski, dostupne su vam besplatne jezičke usluge. Odgovarajuća pomagala i usluge za pružanje informacija u pristupačnim formatima takođe se pružaju besplatno. Pozovite 800.942.0954 (TTY: 711) ili kontaktirajte svog pružatelja usluga.

Brazilian Portuguese (Português do Brasil) - ATENÇÃO: Se você fala português do Brasil, serviços gratuitos de assistência linguística estão disponíveis para você. Auxílios e serviços auxiliares apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 800.942.0954 (TTY: 711) ou fale com seu provedor.

Chinese – Simplified (中文) - 注意：如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 800.942.0954 (TTY: 711) 或咨询您的服务提供商。

English - ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 800.942.0954 (TTY: 711) or speak to your provider.

French (Français) - ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 800.942.0954 (TTY: 711) ou parlez à votre fournisseur.

German (Deutsch) - ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 800.942.0954 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.

Haitian Creole (Kreyòl Ayisyen) - ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd aladispozisyon w gratis pou lang ou pale a. Èd ak sèvis siplemantè apwopriye pou bay enfòmasyon nan fòma aksesib yo disponib gratis tou. Rele nan 800.942.0954 (TTY: 711) oswa pale avèk founisè w la.

Hindi (हिंदी) - ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 800.942.0954 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।

Italian (Italiano) - ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l'800.942.0954 (TTY: 711) o parla con il tuo fornitore.

Japanese (日本語) - 注：日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル（誰もが利用できるよう配慮された）な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。800.942.0954 (TTY: 711) までお電話ください。または、ご利用の事業者にご相談ください。

Korean (한국어) - 주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 800.942.0954 (TTY: 711) 번으로 전화하거나 서비스 제공업체에 문의하십시오.

Polish (Polski) - UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 800.942.0954 (TTY: 711) lub porozmawiaj ze swoim dostawcą.

Russian (Русский) - ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 800.942.0954 (TTY: 711) или обратитесь к своему поставщику услуг.

Serbian (Srpski) - ПАЖЊА: Ако говорите језиком који није енглески, доступне су вам услуге бесплатне помоћи у вези језика. Одговарајућа помоћна средства и услуге ради пружања информација у приступачном формату су такође доступни без накнаде. Позовите 800.942.0954 (TTY: 711) или разговарајте са пружаоцем услуга.

Spanish (Español) - ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 800.942.0954 (TTY: 711) o hable con su proveedor.

Tagalog - PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 800.942.0954 (TTY: 711) o makipag-usap sa iyong provider.

Urdu (اردو) - توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کے لیے زبان کی مفت مدد کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں 800.942.0954 (TTY: 711) پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔

Vietnamese (Tiếng Việt) - LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 800.942.0954 (TTY: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

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Disclaimers

- Benefits and/or copayments may change on January 1, 2027.
- Our covered drugs, pharmacy network, and/or provider network may change at any time. You'll get a notice about any changes that may affect you at least 30 days in advance.
- **Priority**Medicare Dual Premier is a health plan that contracts with both Medicare and Michigan Medicaid to provide benefits of both programs to member. Enrollment depends on contract renewal.

Chapter 1: Getting started as a member

Introduction

This chapter includes information about **Priority**Medicare Dual Premier, a health plan that contracts with both Medicare and Michigan Medicaid to provide all of your Medicare and Michigan Medicaid services, and your membership in it. It also tells you what to expect and what other information you'll get from us. Key terms and their definitions appear in alphabetical order in the last chapter of this *Member Handbook*.

Table of Contents

A. Welcome to our plan

PriorityMedicare Dual Premier provides Medicare and Michigan Medicaid services to individuals who are eligible for both programs. Our plan includes doctors, hospitals, pharmacies, providers of long-term services and supports, behavioral health providers, and other providers. We also have care managers and care teams to help you manage your providers and services. They all work together to provide the care you need. **Priority**Medicare Dual Premier's parent company is Corewell Health.

B. Information about Medicare and Michigan Medicaid

B1. Medicare

Medicare is the federal health insurance program for:

- people 65 years of age or over,
- some people under age 65 with certain disabilities, **and**
- people with end-stage renal disease (kidney failure).

B2. Michigan Medicaid

Michigan Medicaid is the name of Michigan's Medicaid program. Michigan Medicaid is run by the state and is paid for by the state and the federal government. Michigan Medicaid helps people with limited incomes and resources pay for Long-Term Services and Supports (LTSS) and medical costs. It covers extra services and drugs not covered by Medicare.

Each state decides:

- what counts as income and resources,
- who is eligible,
- what services are covered, **and**
- the cost for services.

States can decide how to run their programs, as long as they follow the federal rules.

Medicare and the state of Michigan approved our plan. You can get Medicare and Michigan Medicaid services through our plan as long as:

- we choose to offer the plan, **and**
- Medicare and the state of Michigan allow us to continue to offer this plan.

Even if our plan stops operating in the future, your eligibility for Medicare and Michigan Medicaid services isn't affected.

C. Advantages of our plan

You'll now get all your covered Medicare and Michigan Medicaid services from our plan, including drugs. **You don't pay extra to join this health plan.**

We help make your Medicare and Medicaid benefits work better together and work better for you. Some of the advantages include:

- You can work with us for **most** of your health care needs.
- You have a care team that you help put together. Your care team may include yourself, your caregiver, doctors, nurses, counselors, or other health professionals.
- You have access to a care manager. This is a person who works with you, with our plan, and with your care team to help make a care plan.
- You're able to direct your own care with help from your care team and care manager.
- Your care team and care manager work with you to make a care plan designed to meet **your** health needs. The care team helps coordinate the services you need. For example, this means that your care team makes sure:
    - Your doctors know about all the medicines you take so they can make sure you're taking the right medicines and can reduce any side effects that you may have from the medicines.
    - Your test results are shared with all of your doctors and other providers, as appropriate.

D. Our plan's service area

Our service area includes these counties in Michigan: Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, Macomb, St. Joseph, Van Buren, and Wayne.

Only people who live in our service area can join our plan.

You can't stay in our plan if you move outside of our service area. Refer to **Chapter 8** of this *Member Handbook* for more information about the effects of moving out of our service area.

E. What makes you eligible to be a plan member

You're eligible for our plan as long as you:

- live in our service area (incarcerated individuals aren't considered living in the service area even if they're physically located in it), **and**
- have both Medicare Part A and Medicare Part B, **and**
- are a United States citizen or are lawfully present in the United States, **and**
- are currently eligible for Michigan Medicaid, **and**
- are age 21 or older at the time of enrollment including individuals age 21 and older served by the Children's Specialized Health Care Services (CSHCS) program.
- are receiving full Medicaid benefits (this includes individuals who are eligible for Medicaid through expanded financial eligibility limits under a 1915(c) waiver or who reside in a Nursing Facility, including those who have a monthly Patient Pay Amount).

If you lose eligibility but can be expected to regain it within 3 months, then you're still eligible for our plan.

Call Customer Care for more information.

F. What to expect when you first join our health plan

When you first join our plan, you get a health risk assessment (HRA) within 90 days before or after your enrollment effective date. We must complete an HRA for you. This

HRA is the basis for developing your care plan. The HRA includes questions to identify your medical, behavioral health, and functional needs.

We reach out to you to complete the HRA. We can complete the HRA by an in-person visit, telephone call, or electronically.

We'll send you more information about this HRA.

PriorityMedicare Dual Premier must maintain your current providers and services you're receiving at the time of Enrollment. This includes drugs and providers which aren't part of our network. How long you'll continue to receive these services depends on what services you're receiving and why you're getting them. Only after we've completed your HRA will we consider any changes to the services you're getting at the time you enroll.

G. Your care team and care plan

G1. Care team

A care team can help you keep getting the care you need. A care team may include your doctor, a care manager, or other health person that you choose.

A care manager is a person trained to help you manage the care you need. You get a care manager when you enroll in our plan. This person also refers you to other community resources that our plan may not provide and will work with your care team to help coordinate your care. Call us at the numbers at the bottom of the page for more information about your care manager and care team.

G2. Care plan

Your care team works with you to make a care plan. A care plan tells you and your doctors what services you need and how to get them. It includes your medical, behavioral health, and LTSS or other services. The care plan will focus on your goals taking into account your concerns, wants, needs and strengths. It'll include a summary of your health status and your plan for addressing your concerns. You'll be asked to sign your care plan after it's satisfactory to you.

Your care plan includes:

- your health care goals,
- a timeline for getting the services you need,
- your cultural values and the communication needs and preferences,

- your preferences for care, services, and supports,
- your prioritized list of concerns, goals and objectives, and strengths,
- specific providers, supports and services including amount, scope, and duration,
- a summary of your health status,
- the plan for addressing your concerns or goals and measures for achieving them,
- the person(s) responsible for helping you achieve your goals,
- due dates for the interventions and Reassessment, **and**
- a plan to address health related social needs such as food or housing security.

Your care team meets with you after your HRA. They ask you about services you need. They also tell you about services you may want to think about getting. Your care plan is created based on your needs and goals. Your care team works with you to update your care plan at least every year.

H. Your monthly costs for PriorityMedicare Dual Premier

You do not pay a separate monthly premium for this plan.

If you do lose your Low-Income Subsidy (LIS) and/or Medicaid, you may owe a premium. You will be sent an invoice if this occurs. Your costs may include the following:

- Plan premium (**Section H1**)
- Monthly Medicare Part B Premium (**Section H2**)

In some situations, your plan premium could be less.

There are programs to help people with limited resources pay for their drugs. These include “Extra Help”. The “Extra Help” program helps people with limited resources pay for their drugs. Learn more about this program in **Chapter 2, Section H2**. If you qualify, enrolling in the program might lower your monthly plan premium.

If you *already* get help from one of these programs, **the information about premiums in this *Member Handbook* does not apply to you.** We sent you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also known as the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug coverage. If you don't have this insert, please call Customer Care at the number at the bottom of this page and ask for the "LIS Rider".

H1. Plan premium

Our plan has no premium.

H2. Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums

As explained in **Section E** above to be eligible for our plan, you must maintain your eligibility for Medicaid as well as have both Medicare Part A and Medicare Part B. For most **Priority**Medicare Dual Premier *members*, Medicaid pays for your Medicare Part A premium (if you don't qualify for it automatically) and Part B premium.

If Medicaid isn't paying your Medicare premiums for you, you must continue to pay your Medicare premiums to stay a member of our plan. This includes your premium for Medicare Part B. You may also pay a premium for Medicare Part A if you aren't eligible for premium-free Medicare Part A. **In addition, please contact Customer Care or your care manager and inform them of this change.**

H3. Medicare Prescription Payment Amount

If you're participating in the Medicare Prescription Payment Plan, you'll get a bill from your plan for your drugs (instead of paying the pharmacy). Your monthly bill is based on what you owe for any prescriptions you get, plus your previous month's balance, divided by the number of months left in the year.

Chapter 2 tells more about the Medicare Prescription Payment Plan. If you disagree with the amount billed as part of this payment option, you can follow the steps in **Chapter 9** to make a complaint or appeal.

I. This *Member Handbook*

This *Member Handbook* is part of our contract with you. This means that we must follow all rules in this document. If you think we've done something that goes against these rules, you may be able to appeal our decision. For information about appeals, refer to **Chapter 9** of this *Member Handbook* or call 1-800-MEDICARE (1-800-633-4227).

You can ask for a *Member Handbook* by calling Customer Care at the numbers at the bottom of the page. You can also refer to the *Member Handbook* found on our website priorityhealth.com/dual26.

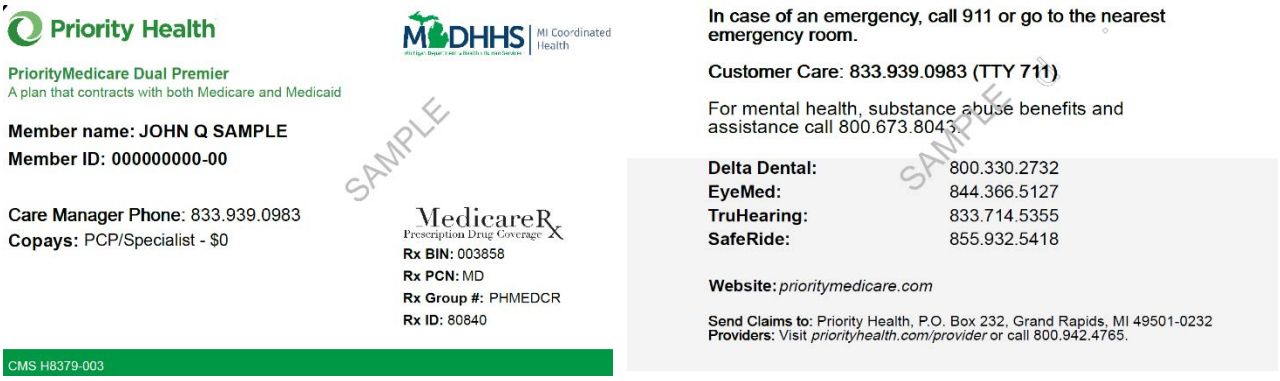
The contract is in effect for the months you're enrolled in our plan between January 1, 2026, and December 31, 2026.

J. Other important information you get from us

Other important information we provide to you includes your Member ID Card, information about how to access a *Provider and Pharmacy Directory*, a List of Durable Medical Equipment (DME), and information about how to access a *List of Covered Drugs,* also known as a *Drug List* or *Formulary*.

J1. Your Member ID Card

Under our plan, you have one card for your Medicare and Michigan Medicaid services, including LTSS, certain behavioral health services, and prescriptions. You show this card when you get any services or prescriptions. Here is a sample Member ID Card:



If your Member ID Card is damaged, lost, or stolen, call Customer Care at the number at the bottom of the page right away. We'll send you a new card.

As long as you're a member of our plan, you don't need to use your red, white, and blue Medicare card or your Michigan Medicaid card to get most services. Keep those cards in a safe place in case you need them later. If you show your Medicare card instead of your Member ID Card, the provider may bill Medicare instead of our plan, and you may get a bill. You may be asked to show your Medicare card if you need hospital services, hospice services, or participate in Medicare-approved clinical research studies (also

called clinical trials). Refer to **Chapter 7** of this *Member Handbook* to find out what to do if you get a bill from a provider.

J2. *Provider and Pharmacy Directory*

The *Provider and Pharmacy Directory* lists the providers and pharmacies in our plan's network. While you're a member of our plan, you must use network providers to get covered services.

You can ask for a *Provider and Pharmacy Directory* (electronically or in hard copy form) by calling Customer Care at the numbers at the bottom of the page. Requests for hard copy Provider and Pharmacy Directories will be mailed to you within three business days. You can also refer to the *Provider and Pharmacy Directory* at priorityhealth.com/dual26.

During the first 90 days after you enroll with PriorityMedicare Dual Premier, you can see any provider you've seen within the previous twelve (12) months, even if the provider isn't in our network.

Definition of network providers

- Our network providers include:
    - doctors, nurses, and other health care professionals that you can use as a member of our plan;
    - clinics, hospitals, nursing facilities, and other places that provide health services in our plan; **and**
    - LTSS, behavioral health services, home health agencies, durable medical equipment (DME) suppliers, dentists and others who provide goods and services that you get through Medicare or Medicaid.

Network providers agree to accept payment from our plan for covered services as payment in full.

Definition of network pharmacies

- Network pharmacies are pharmacies that agree to fill prescriptions for our plan members. Use the *Provider and Pharmacy Directory* to find the network pharmacy you want to use.

- Except during an emergency, you must fill your prescriptions at one of our network pharmacies if you want our plan to [insert if applicable: help you] pay for them.

Call Customer Care at the numbers at the bottom of the page for more information. Both Customer Care and our website can give you the most up-to-date information about changes in our network pharmacies and providers.

J3. *List of Covered Drugs*

Our plan has a *List of Covered Drugs*. We call it the *Drug List* for short. It tells you which drugs our plan covers. The drugs on this list are selected by our plan with the help of doctors and pharmacists. The *Drug List* must meet Medicare's requirements. Drugs with negotiated prices under the Medicare Drug Price Negotiation Program will be included on your *Drug List* unless they have been removed and replaced as described in **Chapter 5, Section B.** Medicare approved the PriorityMedicare Dual Premier *Drug List.*

The *Drug List* also tells you if there are any rules or restrictions on any drugs, such as a limit on the amount you can get. Refer to **Chapter 5** of this *Member Handbook* for more information.

Each year, we send you information about how to access the *Drug List*, but some changes may occur during the year. To get the most up-to-date information about which drugs are covered, call your Care manager or Customer Care or visit our website at the address at the bottom of the page. The *Drug List* will include a section that lists all Medicaid drugs covered in our plan. This information will also be found at our website or by calling your Care manager or Customer Care.

J4. The *Explanation of Benefits*

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

The EOB tells you the total amount you, or others on your behalf, spent on your Medicare Part D drugs and the total amount we paid for each of your Medicare Part D drugs during the month. This EOB isn't a bill. The EOB has more information about the drugs you take such as increases in price and other drugs with lower cost-sharing that may be available. You can talk to your prescriber about these lower cost options. **Chapter 6** of this *Member Handbook* gives more information about the EOB and how it helps you track your drug coverage.

You can also ask for an EOB. To get a copy, contact Customer Care at the numbers at the bottom of the page.

K. Keeping your membership record up to date

You can keep your membership record up to date by telling us when your information changes.

We need this information to make sure that we have your correct information in our records. The doctors, hospitals, pharmacists, and other providers in our plan's network use your membership record to know what services and drugs are covered and your cost-sharing amounts. Because of this, it's very important to help us keep your information up to date.

Tell us right away about the following:

- changes to your name, address, or phone number;
- changes to any other health insurance coverage, such as from your employer, your spouse's employer, or your domestic partner's employer, or workers' compensation;
- any liability claims, such as claims from an automobile accident;
- admission to a nursing facility or hospital;
- care from a hospital or emergency room;
- changes in your caregiver (or anyone responsible for you); **and**
- you participate in a clinical research study. (**Note:** You're not required to tell us about a clinical research study you intend to participate in, but we encourage you to do so.)

If any information changes, call Customer Care at the numbers at the bottom of the page.

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.

K1. Privacy of personal health information (PHI)

Information in your membership record may include personal health information (PHI). Federal and state laws require that we keep your PHI private. We protect your PHI. For more details about how we protect your PHI, refer to **Chapter 8** of this *Member Handbook*

Chapter 2: Important phone numbers and resources

Introduction

This chapter gives you contact information for important resources that can help you answer your questions about our plan and your health care benefits. You can also use this chapter to get information about how to contact your care manager and others to advocate on your behalf. Key terms and their definitions appear in alphabetical order in the last chapter of this *Member Handbook*.

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A. Customer Care

CALL	833.939.0983. This call is free. Oct. 1–Mar. 31, we're available seven days a week from 8 a.m.–8 p.m. ET. From Apr. 1–Sept. 30, we're available Mon.–Fri. from 8 a.m.–8 p.m. and Sat. 8 a.m.–noon ET. We have free interpreter services for people who don't speak English.
TTY	TTY 711. This call is free. Oct. 1–Mar. 31, we're available seven days a week from 8 a.m.–8 p.m. ET. From Apr. 1–Sept. 30, we're available Mon.–Fri. from 8 a.m.–8 p.m. and Sat. 8 a.m.–noon ET.
FAX	616.942.0995
WRITE	Customer Care Department, MS 1115 Priority Health Medicare 1231 East Beltline Ave. NE Grand Rapids, MI 49525
EMAIL	*MedicareCS@priorityhealth*.com
WEBSITE	priorityhealth.com/dual26

Contact Customer Care to get help with:

- Questions about the plan
- Questions about claims or billing
- Coverage decisions about your health care
    - A coverage decision about your health care is a decision about:
        - Your benefits and covered services **or**
        - The amount we pay for your health services.

  - Call us if you have questions about a coverage decision about your health care.
  - To learn more about coverage decisions, refer to **Chapter 9** of this *Member Handbook*.

- Appeals about your health care
  - An appeal is a formal way of asking us to review a decision we made about your coverage and asking us to change it if you think we made a mistake or disagree with the decision.
  - To learn more about making an appeal, refer to **Chapter 9** of this *Member Handbook* or contact Customer Care.

- Complaints about your health care
  - You can make a complaint about us or any provider (including a non-network or network provider). A network provider is a provider who works with our plan. You can also make a complaint to us or to the Quality Improvement Organization (QIO) about the quality of the care you received (refer to **Section D**).
  - You can call us and explain your complaint at 833.939.0983.
  - If your complaint is about a coverage decision about your health care, you can make an appeal (refer to the section above).
  - You can send a complaint about our plan to Medicare. You can use an online form at www.medicare.gov/my/medicare-complaint. Or you can call 1-800-MEDICARE (1-800-633-4227) to ask for help.
  - You can contact the MICH Ombudsman to help you with your complaint. The MICH Ombudsman can be reached at 1-800-746-6456 or www.mhlo.org.
  - To learn more about making a complaint about your health care, refer to **Chapter 9** of this *Member Handbook*.

- Coverage decisions about your drugs
  - A coverage decision about your drugs is a decision about:
    - your benefits and covered drugs **or**

  - the amount we pay for your drugs.
  - This applies to your Medicare Part D drugs and medications covered by Michigan Medicaid.
  - For more on coverage decisions about your drugs, refer to **Chapter 9** of this *Member Handbook*.
- Appeals about your drugs
  - An appeal is a way to ask us to change a coverage decision.
  - For more on making an appeal about your drugs, refer to **Chapter 9** of this *Member Handbook*.
- Complaints about your drugs
  - You can make a complaint about us or any pharmacy. This includes a complaint about your drugs.
  - If your complaint is about a coverage decision about your drugs, you can make an appeal. (Refer to the section above.)
  - You can send a complaint about our plan to Medicare. You can use an online form at www.medicare.gov/my/medicare-complaint. Or you can call 1-800-MEDICARE (1-800-633-4227) to ask for help.
  - For more on making a complaint about your drugs, refer to **Chapter 9** of this *Member Handbook*.
- Payment for health care or drugs you already paid for
  - For more on how to ask us to pay you back, or to pay a bill you got, refer to **Chapter 7** of this *Member Handbook*.
  - If you ask us to pay a bill and we deny any part of your request, you can appeal our decision. Refer to **Chapter 9** of this *Member Handbook*.

B. Your Care Manager

Care Managers are available to all Dual Premier members. Care Managers are available to assist in coordinating your healthcare services, managing care across the network of care, and linking to appropriate service providers. Members wanting to change to a different Care Manager may contact Customer Care at the number below.

CALL	833.939.0983. This call is free. From 10/1–3/31, we're available seven days a week from 8 a.m.–8 p.m. ET. From 4/1–9/30, we're available Mon. – Fri. from 8 a.m.– 8 p.m. and Sat. 8 a.m.–noon ET We have free interpreter services for people who don't speak English.
TTY	TTY 711. This call is free. This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it. From 10/1–3/31, we're available seven days a week from 8 a.m.–8 p.m. ET. From 4/1–9/30, we're available Mon. – Fri. from 8 a.m.– 8 p.m. and Sat. 8 a.m.–noon ET
FAX	616.942.0995
WRITE	Customer Service Department, MS 1115 Priority Health Medicare 1231 East Beltline Ave. NE Grand Rapids, MI 49525
EMAIL	*MedicareCS@priorityhealth.com*
WEBSITE	priorityhealth.com/dual26

Contact your care manager to get help with:

- Questions about your health care

- Questions about getting behavioral health (mental health and substance use disorder) services
- Questions about transportation
- If your provider or Care Manager thinks you may be eligible for Long-Term Care or additional supports and services such as respite care, personal care services, or home health aide services to keep you in your home, your Care Manager can assist you in applying for LTSS. Refer to **Chapter 3** of this *Member Handbook*
- Sometimes you can get help with your daily health care and living needs. You might be able to get these services:
    - Personal care services such as bathing and dressing
    - Support for everyday tasks such as laundry, shopping, and non-medical transportation
    - Home delivered meals
    - Adult day program
    - Skilled nursing care

C. Michigan Medicare/Medicaid Assistance Program

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state that offers free help, information, and answers to your Medicare questions. In Michigan, the SHIP is called Michigan Medicare/Medicaid Assistance Program (MMAP).

CALL	Beneficiary Help Line 1-800-642-3195 8:00 am – 7:00 pm Monday through Friday (except holidays)
TTY	711 This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
WRITE	MI Options 6105 St Joe Hwy # 204 Lansing, MI 48917
WEBSITE	www.michigan.gov/MDHHSMIOptions

Contact MI Options for help with:

- Questions about Medicare
- MI Options counselors can answer your questions about changing to a new plan and help you:
    - understand your rights,
    - understand your plan choices,
    - answer questions about switching plans,
    - make complaints about your health care or treatment, **and**
    - straighten out problems with your bills.

D. Quality Improvement Organization (QIO)

Our state has an organization called Commence Health for quality improvement. This is a group of doctors and other health care professionals who help improve the quality of care for people with Medicare. Commence Health is an independent organization. It's not connected with our plan.

CALL	1-888-524-9900 This call is free.
TTY	Dial 711.This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
WRITE	BFCC-QIO Program Commence Health PO Box 2687 Virginia Beach, VA 23450
WEBSITE	www.livantaqio.com

Contact Commence Health for help with:

- Questions about your health care rights
- Making a complaint about the care you got if you:
    - have a problem with the quality of care such as getting the wrong medication, unnecessary tests or procedures, or a misdiagnosis,
    - think your hospital stay is ending too soon, **or**
    - think your home health care, skilled nursing facility care, or comprehensive outpatient rehabilitation facility (CORF) services are ending too soon.

E. Medicare

Medicare is the federal health insurance program for people 65 years of age or over, 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, or CMS. This agency contracts with Medicare Advantage organizations including our plan.

CALL	1-800-MEDICARE (1-800-633-4227) Calls to this number are free, 24 hours a day, 7 days a week.
TTY	1-877-486-2048. This call is free. This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
CHAT LIVE	Chat live at www.Medicare.gov/talk-to-someone
WRITE	Write to Medicare at PO Box 1270, Lawrence, KS 66044

WEBSITE	www.medicare.gov • Get information about the Medicare health and drug plans in your area, including what they cost and what services they provide. • Find Medicare-participating doctors or other health care providers and suppliers. • Find out what Medicare covers, including preventative services (like screenings, shots, or vaccines, and yearly "wellness" visits). • Get Medicare appeals information and forms. • Get information about the quality of care provided by plans, nursing homes, hospitals, doctors, home health agencies, dialysis facilities, hospice centers, inpatient rehabilitation facilities, and long-term care hospitals. • Look up helpful websites and phone numbers. To submit a complaint to Medicare, go to www.medicare.gov/my/medicare-complaint. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

F. Michigan Medicaid

Michigan Medicaid helps with medical and long-term services and supports costs for people with limited incomes and resources.

You're enrolled in Medicare and in Medicaid. If you have questions about the help you get from Medicaid, call Beneficiary Help Line: 1-800-642-3195 or go to www.michigan.gov/mdhhs/assistance-programs/medicaid/portalhome/beneficiaries/support.

Contact Type	
CALL	Beneficiary Help Line 800.642.3195 8:00 am – 7:00 pm Monday through Friday (except holidays)
TTY	866.501.5656 This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
WRITE	400 S. Pine St. 5th Floor Lansing, MI 48933
EMAIL	beneficiarysupport@michigan.gov
WEBSITE	www.michigan.gov/mdhhs/assistance-programs/medicaid/portalhome/beneficiaries/support

G. MI Community, Home, and Health Ombudsman

The MI Community, Home, and Health Ombudsman (MI CHHO) works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do. The MI CHHO also helps you with service or billing problems. They aren't connected with our plan or with any insurance company or health plan. Their services are free.

CALL	888.746.6456
TTY	711 This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
WRITE	15851 S. US 27, Suite 73 Lansing, MI 48906
EMAIL	MI-CHHO@meji.org
WEBSITE	meji.org

H. Michigan Long Term Care Ombudsman Program (MLTCOP)

The MLTCOP helps people get information about nursing homes and resolve problems between nursing homes and residents or their families.

The Michigan Long Term Care Ombudsman Program (MLTCOP) isn't connected with our plan or any insurance company or health plan.

CALL	517-827-8040
TTY	711 This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
WRITE	MLTCOP - MEJI 15851 S. US 27, Suite 73 Lansing. MI 48906
EMAIL	MLTCOP@meji.org
WEBSITE	mltcop.org/

I. Programs to Help People Pay for Drugs

The Medicare website (www.medicare.gov/basics/costs/help/drug-costs) provides information on how to lower your drug costs. For people with limited incomes, there are also other programs to assist, as described below.

I1. Extra Help from Medicare

Because you're eligible for Medicaid, you qualify for and are getting "Extra Help" from Medicare to pay for your drug plan costs. You don't need to do anything to get this "Extra Help."

Contact Type	
CALL	1-800-MEDICARE (1-800-633-4227) Calls to this number are free, 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This call is free. This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
WEBSITE	www.medicare.gov

If you think you're paying an incorrect amount for your prescription at a pharmacy, our plan has a process to help get evidence of your correct copayment amount. If you already have evidence of the right amount, we can help you share this evidence with 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 get the evidence showing the right copayment level, we'll update our system so you can pay the right copayment amount when you get your next prescription. If you overpay your copayment, we'll pay you back either by check or a future copayment credit. If the pharmacy didn't collect your copayment and you owe them a debt, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Please contact Customer Care if you have questions.

J. Social Security

Social Security determines Medicare eligibility and handles Medicare enrollment.

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

CALL	800.772.1213 Calls to this number are free. Available 8:00 am to 7:00 pm, Monday through Friday. You can use their automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	800.325.0778 This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it. Calls to this number are free. Available 8:00 am to 7:00 pm, Monday through Friday.
WEBSITE	www.ssa.gov

K. Railroad Retirement Board (RRB)

The RRB is an independent Federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you get Medicare through the RRB, let them know if you move or change your mailing address. For questions about your benefits from the RRB, contact the agency.

CALL	1-877-772-5772 Calls to this number are free. Press "0" to speak with a RRB representative from 9 a.m. to 3 p.m., Monday through Friday, except federal holidays. Press "1" to access the automated RRB Help Line and get recorded information 24 hours a day, including weekends and holidays.
TTY	1-312-751-4701 This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it. Calls to this number aren't free.
WEBSITE	*www.rrb.gov*

L. Other resources

LOCAL AREA AGENCY AND AREA SERVICED	CALL	WEBSITE
Area Agency on Aging IIIA (3A) *Kalamazoo County*	269.373.5147	Kalcounty.com/hcs/aaa/
CareWell Services Southwest (3B) *Barry and Calhoun Counties*	269.966.2450 800.626.6719 (outside of Calhoun County)	Carewellservices.org
Branch – St. Joseph AAA (3C) *Branch and St. Joseph Counties*	517.278.2538	BHSJ.org/AAA
Region IV Area Agency on Aging (4) *Berrien and Cass Counties*	296.983.0177	AreaAgencyonAging.org
AgeWays (Formerly Area Agency on Aging 1B) *Macomb County*	248.357.2255	Ageways.org/
The Senior Alliance,Inc. (1C) Wayne County	734.722.2830	AAA1C.org

Chapter 3: Using our plan's coverage for your health care and other covered services

Introduction

This chapter has specific terms and rules you need to know to get health care and other covered services with our plan. It also tells you about your care manager, how to get care from different kinds of providers and under certain special circumstances (including from out-of-network providers or pharmacies), what to do if you're billed directly for services we cover, and the rules for owning Durable Medical Equipment (DME). Key terms and their definitions appear in alphabetical order in the last chapter of this *Member Handbook*.

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A. Information about services and providers

Services are health care, long-term services and supports (LTSS), supplies, behavioral health services, prescription and over-the-counter drugs, equipment and other services. **Covered services** are any of these services that our plan pays for. Covered health care, behavioral health, and LTSS are in **Chapter 4** of this *Member Handbook*. Your covered services for prescription and over-the-counter drugs are in **Chapter 5** of this *Member Handbook*.

Providers are doctors, nurses, and other people who give you services and care and are licensed by the state. Providers also include hospitals, home health agencies, clinics, and other places that give you health care services, behavioral health services, medical equipment, and certain LTSS.

Network providers are providers who work with our plan. These providers agree to accept our payment as full payment. We arranged for these providers to deliver covered services to you. Network providers bill us directly for care they give you. When you use a network provider, you usually pay nothing for covered services.

B. Rules for getting services our plan covers

Our plan covers all services covered by Medicare and Michigan Medicaid. This includes behavioral health and LTSS.

Our plan will generally pay for health care services, covered behavioral health services, and LTSS you get when you follow our rules. To be covered by our plan:

- The care you get must be included in our Medical Benefits Chart in **Chapter 4** of this *Member Handbook*.
- The care must be **medically necessary**. By medically necessary, we mean you need services to prevent, diagnose, or treat your condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing facility. It also means the services, supplies, or drugs meet accepted standards of medical practice. Services and supplies are deemed medically/clinically necessary when required to diagnose, care for or treat physical or mental conditions. Examples include:
    - Decisions about covered medical benefits, including hospitalizations and emergency care.

- Decisions about care or services that could be considered either covered or non-covered, depending on the circumstances, including requests for care that may be considered experimental.
- Decisions about dental procedures that are covered under the enrollee's medical benefits.

- For medical services, you must have a network **primary care provider (PCP)** providing and overseeing your care. As a plan member, you must choose a network provider to be your PCP (for more information, go to **Section D1** of this chapter).
  - In most cases, your network PCP must give you approval before you can use a provider that isn't your PCP or use other providers in our plan's network. This is called a **referral**. If you don't get approval, we may not cover the services.
  - You don't need referrals from your PCP for emergency care or urgently needed care or to use a woman's health provider. You can get other kinds of care without having a referral from your PCP (for more information, go to **Section D1** in this chapter).
- **You must get your care from network providers** for more information, go to **Section D** in this chapter**.** Usually, we won't cover care from a provider who doesn't work with our health plan. This means that you'll have to pay the provider in full for services you get. Here are some cases when this rule doesn't apply:
  - We cover emergency or urgently needed care from an out-of-network provider (for more information, go to **Section I** in this chapter).
  - If you need care that our plan covers and our network providers can't give it to you, you can get care from an out-of-network provider. If the standard of care for your condition is not available from a Participating Provider, your PCP may ask Priority Health for authorization to refer you to a non-participating provider. If you do not receive authorization from Priority Health prior to seeking covered services from a non-participating provider, or if we determine the medically appropriate treatment for your condition is available from a participating provider, you will be responsible for the full cost. In this situation, we cover the care as if you got it from

a network provider **or** at no cost to you. For information about getting approval to use an out-of-network provider, go to **Section D4** in this chapter.

- We cover kidney dialysis services when you're outside our plan's service area for a short time or when your provider is temporarily unavailable or not accessible. If you're outside our plan's service area and get dialysis from a provider outside the plan's network, your cost-sharing can't be higher than the cost-sharing you pay in-network. However, if your usual in-network provider for dialysis is temporarily unavailable and you choose to get services inside our service area from an out-of-network provider, your cost-sharing for the dialysis may be higher. If possible, call Customer Care at the number at the bottom of the page before you leave the service area so we can help arrange for you to have maintenance dialysis while you're away.

C. Your care manager

C1. What a care manager is

Your Care Manager will help establish priorities and to link all of your doctors, pharmacies, behavioral health care and long-term care supports and services through your health plan. The Care Manager will help make sure that your doctors and other providers work together to meet your needs and honor your choices. The Care Manager connects you to supports and services that you need to be healthy and to live where you wish. This person will assist with your care plan, answer your questions, help get appointments and services, arrange transportation, and more.

C2. How you can contact your care manager

You can contact your care manager by calling the number included on your welcome to Care Management letter or Customer Care at 833.939.0983.

C3. How you can change your care manager

You can request to change your care manager at any time by contacting Priority Health Customer Care at 833.939.0983.

D. Care from providers

D1. Care from a primary care provider (PCP)

You must choose a PCP to provide and manage your care.

Definition of a PCP and what a PCP does do for you

Your PCP is the health care provider or doctor who takes care of all your health needs.

The role of a PCP in

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

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

When a clinic can be your PCP (RHC/FQHC)

You can also get medical care from these types of medical providers: Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHCs), Indian Health Care Providers (IHCPs) You must choose a specific provider to be your PCP. **Priority**Medicare Dual Premier cannot list a clinic name. You can choose a provider from an in-network rural health clinic (RHC) or a federally qualified health center (FQHC) to be your PCP.

Your choice of PCP

You can use our Provider Directory to find doctors and specialists that are in our network. The Provider Directory lists addresses, office hours, languages spoken, and information about accessibility. It is located at priorityhealth.com/dual26. You

can view or print the provider directory from the website. You can also request a copy of our provider directory, free of charge by calling 833.939.0983. Remember, provider information changes often. Visit our website for the most up-to-date information. Call Customer Care if you need help finding a doctor. You can look in the *Provider and Pharmacy Directory* or ask Customer Care to find out if the PCP you want makes referrals to that specialist or uses that hospital.

Option to change your PCP

You can change your PCP for any reason, at any time. It's also possible that your PCP may leave our plan's network. If your PCP leaves our network, we can help you find a new PCP in our network.

To change your PCP, please contact Customer Care or make your PCP change online through your member account at priorityhealth.com/dual26. You'll find a list of PCPs to choose from on our website at priorityhealth.com/dual26. If you need a hard copy of our list of PCPs, or if you need help choosing a PCP, please contact Customer Care. When you make a request to change your PCP, we'll make the change immediately.

When a provider is termed with Priority Health, members are reassigned to a new provider. We will do our best to reassign within the same office if possible and if not, they will be reassigned to a new provider within a 30-mile radius of the member's home. Members will be notified of their assigned provider change by mailed letter.

D2. Care from specialists and other network providers

A specialist is a doctor who provides health care for a specific disease or part of the body. There are many kinds of specialists, such as:

- Oncologists care for patients with cancer.
- Cardiologists care for patients with heart problems.
- Certified nurse midwives for patients who are pregnant.
- Orthopedists care for patients with bone, joint, or muscle problems.

How to access specialists and other network providers

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 Care at 833.939.0983 or go to priorityhealth.com/dsnp26 and use our Find a Doctor tool. If we do not have a doctor or specialist in our provider network in your area, or if we do not have a

provider that can see you timely, we will get you the care you need from a provider outside our network. We will only cover services by an out of network provider if we are unable to provide a necessary and covered service in our network and if you have approval before your appointment. We will coordinate payment with the out of network provider. We will also ensure that the cost to you is no greater than it would be if the service was provided in network.

Prior authorization requirements may apply for some services. See Chapter 4, for details about the services that require prior authorization. Prior authorization decisions are made by **Priority**Medicare Dual Premier and other delegated entities. To obtain prior authorization, your provider should contact **Priority**Medicare Dual Premier. You may contact Customer Care to learn more about prior authorization requirements and how to ask for prior authorization of a service.

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

D3. When a provider leaves our plan

A network provider you use may leave our plan. If one of your providers leaves our plan, you have these rights and protections that are summarized below:

- Even if our network of providers change during the year, we must give you uninterrupted access to qualified providers.
- We'll 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'll notify you if you visited that provider within the past three years.
    - If any of your other providers leave our plan, we'll notify you if you're assigned to the provider, currently get care from them, or visited them within the past three months.
- We help you select a new qualified in-network provider to continue managing your health care needs.
- If you're currently undergoing medical treatment or therapies with your current provider, you have the right to ask to continue getting medically necessary treatment or therapies. We'll work with you so you can continue to get care.

- We'll give you information about available enrollment periods and options you may have for changing plans.
- If we can't find a qualified network specialist accessible to you, we must arrange an out-of-network specialist to provide your care when an in-network provider or benefit is unavailable or inadequate to meet your medical needs. Prior authorization is required for out-of-network referrals and specialists.
- If you find out one of your providers is leaving our plan, contact us. We can help you choose a new provider to manage your care.
- If you think we haven't replaced your previous provider with a qualified provider or that we aren't managing your care well, you have the right to file a quality-of-care complaint to the Quality Improvement Organization (QIO), a quality of care grievance, or both. (Refer to **Chapter 9** for more information.)

D4. Out-of-network providers

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

- The plan covers ambulance, emergency or urgently needed care from out-of-network providers. You do not need prior approval from the plan for out-of-network emergency care, even if you are in the service area. If you are experiencing an emergency, go to the nearest hospital. You also do not need prior approval for out-of-network urgent care services if you are out of the service area or not near an in-network facility.
- The plan covers kidney dialysis services when you are outside the plan's service area for a short time. You can get these services at a Medicare/Medicaid-certified dialysis facility.
- If you need care that our in-network providers cannot give to you, you can get the care from an out-of-network provider. In most situations you must receive prior approval from the plan before receiving care from out-of-network providers. Either you or your provider can make the request. In this situation, if you receive prior approval from the plan, we will cover the care as if you received it from an in-network provider. To learn about getting approval to see an out-of-network provider, please contact Customer Care.

If you use an out-of-network provider, the provider must be eligible to participate in Medicare and/or Michigan Medicaid.

- We can't pay a provider who isn't eligible to participate in Medicare and/or Michigan Medicaid.
- If you use a provider who isn't eligible to participate in Medicare, you must pay the full cost of the services you get.
- Providers must tell you if they aren't eligible to participate in Medicare.

E. Long-term services and supports (LTSS)

Long-Term Supports and Services (LTSS) are services that help elderly people and people with disabilities meet their daily needs for help and improve the quality of their lives. Examples of LTSS include help with bathing, dressing, and other basic activities of daily life and self-care, as well as support for everyday tasks such as laundry, shopping, and transportation. LTSS are provided over an extended period, usually in homes and communities, but also in nursing homes and other facilities. If you think you need help with daily needs, please call your Care Manager to determine what services you qualify for.

F. Behavioral health (mental health and substance use disorder) services

All Medicaid and Medicare behavioral health services are covered by your plan. All existing Medicare and Medicaid behavioral health services will continue to be provided for people currently receiving care and who enroll in MICH. Certain behavioral health services covered by Medicaid are managed by Michigan Pre-paid Inpatient Health Plans (PIHPs), organizations that the Michigan Department of Health and Human Services contracts with to administer Medicaid covered behavioral health benefits. All Medicaid covered Behavioral Health services not managed by the PIHPs and all behavioral health services covered by Medicare will be managed by us. If you have questions about behavioral health, contact your Care Manager.

Priority Health remains committed to your mental well-being. Navigating the behavioral health system can be tough. We have a team of behavioral health specialists who can talk to you about your health coverage, treatment options, and find in-network specialists. They can even help you determine whether outpatient care or inpatient care will best meet your needs. Just call the number on the back of your member ID card or 800.673.8043 (TTY: 711). Crisis support is available 24 hours a day, seven days a week.

G. How to get self-directed care

Your care manager can help you get self-directed care if you qualify for self- directed care. Self-directed care is an option available if you qualify for LTSS and allows you to design and exercise control over your life. It includes managing a fixed amount of dollars to cover your authorized supports and services through an individualized budget. If you choose, you can also have control over the hiring and management of providers.

G1. What self-directed care is

You have the option to self-direct your services if you qualify. You would control a budget and have the right to hire and manage personal care workers and other providers.

G2. Who can get self-directed care (for example, if it's limited to waiver populations)

Your care manager will work with you to determine whether you qualify for self-directed services.

G3. How to get help in employing personal care providers (if applicable)

Talk to your care manager if you think you need services that can be self-directed.

H. Transportation services

Your benefit provides options for transportation. We provide transportation free of charge for doctor's visits, lab visits, non-emergency hospital services, prescription pick-up, dental services, ongoing services (dialysis, therapy, substance use disorder services), and other covered services, whether those services are provided by Priority Medicare or through MDHHS directly. In some cases, we may provide bus tokens or if you have your own vehicle or someone else to drive you, you can request mileage reimbursement.

Please call SafeRide at 1-833-944-0535 for more information and to schedule a ride. Please call three days before an appointment so we can make sure we have someone available to transport you. You can request same-day transportation for an urgent non-emergency appointment. You can also schedule 30 days in advance and arrange transportation for the entire month. Have this information ready when you call:

- Your name, Member ID number and date of birth
- The address and phone number of where you will be picked up
- The address and phone number of where you are going
- Your appointment date and time
- The name of your provider

Members with any special needs (wheelchair accommodations, oxygen resources, etc.) will want to schedule transportation as early as possible in order to meet your needs with the appropriate vendor. If you are receiving services through the local Community Mental Health Services Program (CMHSP) agency, there may be some transportation services that you will continue to receive through the local CMHSP agency. Contact your local CMHSP agency for questions about this benefit.

We may be able to help you get to your medical appointments and, if you qualify, may be able to help with transportation for other things. If you need help with transportation, talk to your care manager.

I. Covered services in a medical emergency, when urgently needed, or during a disaster

I1. Care in a medical emergency

A medical emergency is a medical condition with symptoms such as illness, severe pain, serious injury, or a medical condition that's quickly getting worse. The condition is so serious that, if it doesn't get immediate medical attention, you or anyone with an average knowledge of health and medicine could expect it to result in:

- serious risk to your life and, if you're pregnant, loss of an unborn child; **or**
- loss of or serious harm to bodily functions; **or**
- loss of a limb or function of a limb; **or**
- In the case of a pregnant woman in active labor, when:
- There isn't enough time to safely transfer you to another hospital before delivery.
    - A transfer to another hospital may pose a threat to your health or safety or to that of your unborn child.

If you have a medical emergency:

- **Get help as fast as possible.** Call 911 or use the nearest emergency room or hospital. Call for an ambulance if you need it. You **don't** need approval or a referral from your PCP. You don't need to use a network provider. You can get covered emergency medical care whenever you need it, anywhere in the U.S. or its territories or worldwide, from any

provider with an appropriate state license even if they're not part of our network.

- **As soon as possible, tell your care manager about your emergency.** Your care manager will follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. However, you won't pay for emergency services if you delay telling us. Call us at 833.939.0983 (TTY 711) from 10/1-3/31, we're available seven days a week from 8 a.m. to 8 p.m., ET. From 4/1/-9/30, we're available Monday – Fri. from 8 a.m. to 8 p.m. and Sat. 8. a.m.- noon ET.

Covered services in 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. To learn more, refer to the Benefits Chart in **Chapter 4** of this *Member Handbook*.

The providers who give you emergency care decide when your condition is stable and the medical emergency is over. They'll continue to treat you and will contact us to make plans if you need follow-up care to get better.

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.

Our plan covers your follow-up care. If you get your emergency care from out-of-network providers, we'll try to get network providers to take over your care as soon as possible.

Getting emergency care if it wasn't an emergency

Sometimes it can be hard to know if you have a medical or behavioral health emergency. You may go in for emergency care and the doctor says it wasn't really an emergency. As long as you reasonably thought your health was in serious danger, we cover your care.

However, after the doctor says it wasn't an emergency, we cover your additional care only if:

- You use a network provider **or**

- The additional care you get is considered “urgently needed care” and you follow the rules for getting it. Refer to the next section.

I2. Urgently needed care

Urgently needed care is care you get for a situation that isn’t an emergency but needs care right away. For example, you might have a flare-up of an existing condition or an unforeseen illness or injury.

Urgently needed care in our plan’s service area

In most cases, we cover urgently needed care only if:

- You get this care from a network provider **and**
- You follow the rules described in this chapter.

If it isn’t possible or reasonable to get to a network provider, given your time, place or circumstances we cover urgently needed care you get from an out-of-network provider.

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

Urgently needed care outside our plan’s service area

When you’re outside our plan’s service area, you may not be able to get care from a network provider. In that case, our plan covers urgently needed care you get from any provider. However, medically necessary routine provider visits, such as annual checkups, aren’t considered urgently needed even if you’re outside our plan’s service area or our plan network is temporarily unavailable.

Our plan covers emergency and urgently needed care worldwide. You are also covered for emergency and urgently needed care anywhere in the United States.

I3. 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’re still entitled to care from our plan.

Visit our website for information on how to get care you need during a declared disaster: priorityhealth.com/dual26.

During a declared disaster, if you can't use a network provider, you can get care from out-of-network providers at no cost to you. If you can't use a network pharmacy during a declared disaster, you can fill your drugs at an out-of-network pharmacy. Refer to **Chapter 5** of this *Member Handbook* for more information.

J. What if you're billed directly for covered services

If a provider sends you a bill instead of sending it to our plan, you should ask us to pay the bill. If you paid for your covered services or if you got a bill for covered medical services, refer to **Chapter 7** of this *Member Handbook* to find out what to do.

You shouldn't pay the bill yourself. If you do, we may not be able to pay you back.

J1. What to do if our plan doesn't cover services

Our plan covers all services:

- that are determined medically necessary, **and**
- that are listed in our plan's Benefits Chart (refer to **Chapter 4** of this *Member Handbook*), **and**
- that you get by following plan rules.

If you get services that our plan doesn't cover, **you pay the full cost yourself**.

If you want to know if we pay for any medical service or care, you have the right to ask us. You also have the right to ask for this in writing. If we say we won't pay for your services, you have the right to appeal our decision.

Chapter 9 of this *Member Handbook* explains what to do if you want us to cover a medical service or item. It also tells you how to appeal our coverage decision. Call Customer Care to learn more about your appeal rights.

We pay for some services up to a certain limit. If you go over the limit, you pay the full cost to get more of that type of service. Refer to **Chapter 4** for specific benefit limits. Call Customer Care to find out what the benefit limits are and how much of your benefits you've used.

K. Coverage of health care services in a clinical research study

K1. Definition of a clinical research study

A clinical research study (also called a clinical trial) is a way doctors test new types of health care or drugs. A clinical research study approved by Medicare typically asks for volunteers to be in the study. When you're in a clinical research study, you can stay enrolled in our plan and continue to get the rest of your care (care that's not related to the study) through our plan.

If you want to take part in any Medicare-approved clinical research study, you **don't** need to tell us or get approval from us or your primary care provider. Providers that give you care as part of the study **don't** need to be network providers. This doesn't apply to covered benefits that require a clinical trial or registry to assess the benefit, including certain benefits requiring coverage with evidence development (NCDs-CED) and investigational device exemption (IDE) studies. These benefits may also be subject to prior authorization and other plan rules.

We encourage you to tell us before you take part in a clinical research study.

If you plan to be in a clinical research study, covered for enrollees by Original Medicare, we encourage you or your care manager to contact Customer Care to let us know you'll take part in a clinical trial.

K2. Payment for services when you're in a clinical research study

If you volunteer for a clinical research study that Medicare approves, you pay nothing for the services covered under the study. Medicare pays for services covered under the study as well as routine costs associated with your care. Once you join a Medicare-approved clinical research study, you're covered for most services and items you get as part of the study. This includes:

- 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 that's part of the research study
- treatment of any side effects and complications of the new care

If you volunteer for a Medicare approved clinical research study, we pay any costs that Medicare doesn't that our plan approves. If you're part of a study that Medicare **hasn't** approved, you pay any costs associated with being in the study. There will be no coverage provided by Medicare or Priority Health.

K3. More about clinical research studies

You can learn more about joining a clinical research study by reading "Medicare & Clinical Research Studies" on the Medicare website (www.medicare.gov/sites/default/files/2019-09/02226-medicare-and-clinical-research-studies.pdf).You can also call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

L. How your health care services are covered in a religious non-medical health care institution

L1. Definition of a religious non-medical health care institution

A religious non-medical health care institution is a place that provides care you would normally get in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against your religious beliefs, we cover care in a religious non-medical health care institution.

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

L2. 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're against getting medical treatment that's "non-excepted."

- "Non-excepted" medical treatment is any care or treatment that's **voluntary and not required** by any federal, state, or local law.
- "Excepted" medical treatment is any care or treatment that's **not voluntary and 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 only covers non-religious aspects of care.
- If you get services from this institution provided to you in a facility:
    - You must have a medical condition that would allow you to get covered services for inpatient hospital care or skilled nursing facility care.

- – *and* -You must get approval from us before you're admitted to the facility, or your stay **won't** be covered.

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

M. Durable medical equipment (DME)

M1. DME as a member of 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.

You always own some DME items, such as prosthetics.

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 Dual Premier however, you may acquire ownership of certain rented durable medical equipment items while a member of our plan after 13 consecutive payments. Call Customer Care for more information.

M2. DME ownership if you switch to Original Medicare

In the Original Medicare program, people who rent certain types of DME own it after 13 months. In a Medicare Advantage (MA) plan, the plan can set the number of months people must rent certain types of DME before they own it.

You'll have to make 13 payments in a row under Original Medicare, or you'll have to make the number of payments in a row set by the MA plan, to own the DME item if:

- you didn't become the owner of the DME item while you were in our plan, **and**
- you leave our plan and get your Medicare benefits outside of any health plan in the Original Medicare program or an MA plan.

If you made payments for the DME item under Original Medicare or an MA plan before you joined our plan, **those Original Medicare or MA plan payments don't count toward the payments you need to make after leaving our plan**.

- You'll have to make 13 new payments in a row under Original Medicare or a number of new payments in a row set by the MA plan to own the DME item.
- There are no exceptions to this when you return to Original Medicare or an MA plan

M3. Oxygen equipment benefits as a member of our plan

If you qualify for oxygen equipment covered by Medicare we cover:

- rental of oxygen equipment
- delivery of oxygen and oxygen contents
- tubing and related accessories for the delivery of oxygen and oxygen contents
- maintenance and repairs of oxygen equipment

Oxygen equipment must be returned when it's no longer medically necessary for you or if you leave our plan.

M4. Oxygen equipment when you switch to Original Medicare or another Medicare Advantage (MA) plan

When oxygen equipment is medically necessary and **you leave our plan and switch to Original Medicare**, you rent it from a supplier for 36 months. Your monthly rental payments cover the oxygen equipment and the supplies and services listed above.

If oxygen equipment is medically necessary **after you rent it for 36 months**, your supplier must provide:

- oxygen equipment, supplies, and services for another 24 months
- oxygen equipment and supplies for up to 5 years if medically necessary

If oxygen equipment is still medically necessary **at the end of the 5-year period**:

- Your supplier no longer has to provide it, and you may choose to get replacement equipment from any supplier.
- A new 5-year period begins.
- You rent from a supplier for 36 months.

- Your supplier then provides the oxygen equipment, supplies, and services for another 24 months.
- A new cycle begins every 5 years as long as oxygen equipment is medically necessary.

When oxygen equipment is medically necessary and **you leave our plan and switch to another MA plan**, the plan will cover at least what Original Medicare covers. You can ask your new MA plan what oxygen equipment and supplies it covers and what your costs will be.

Chapter 4: Benefits chart

Introduction

This chapter tells you about the services our plan covers and any restrictions or limits on those services.It also tells you about benefits not covered under our plan. Key terms and their definitions appear in alphabetical order in the last chapter of this *Member Handbook*.

Table of Contents

A. Your covered services

This chapter tells you about services our plan covers.You can also learn about services that aren't covered. Information about drug benefits is in **Chapter 5** of this *Member Handbook*. This chapter also explains limits on some services.

Because you get help from Michigan Medicaid you pay nothing for your covered services as long as you follow our plan's rules. Refer to **Chapter 3** of this *Member Handbook* for details about our plan's rules.

If you need help understanding what services are covered, call your care manager and/or Customer Care at 833.838.0983.

B. Rules against providers charging you for services

We don't allow our providers to bill you for in network covered services. We pay our providers directly, and we protect you from any charges. This is true even if we pay the provider less than the provider charges for a service.

You should never get a bill from a provider for covered services. If you do, refer to **Chapter 7** of this *Member Handbook* or call Customer Care.

C. About our plan's Benefits Chart

The Benefits Chart tells you the services our plan pays for. It lists covered services in alphabetical order and explains them.

We pay for the services listed in the Benefits Chart when the following rules are met. You **don't** pay anything for the services listed in the Benefits Chart, as long as you meet the requirements described below.

- We provide covered Medicare and Michigan Medicaid covered services according to the rules set by Medicare and Michigan Medicaid.
- The services including medical care, behavioral health and substance use services, long-term services and supports, supplies, equipment, and drugs must be "medically necessary." Medically necessary describes services, supplies, or drugs you need to prevent, diagnose, or treat a medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing facility.
- For new enrollees, for the first 90 days we may not require you to get approval in advance for any active course of treatment, even if the course of treatment was for a service that began with an out-of-network provider.
- You get your care form a network provider. A network provider is a provider who works with us. In most cases, care you get from an out-of-network provider won't be covered unless it's an emergency or urgently needed care or unless your plan or a network provider gave you a referral. **Chapter 3** of this *Member Handbook* has more information about using network and out-of-network providers.
- You have a primary care provider (PCP) or a care team providing and managing you care. Your 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 a referral. **Chapter 3** of this

Member Handbook has more information about getting a referral when you **don't** need one.

- We cover some services in the Benefits Chart only if your doctor or other network provider gets our approval first. This is called prior authorization (PA). We mark covered services in the Benefits Chart that need PA with a footnote. If your plan provides approval of a PA request for a course of treatment, the approval must be valid for as long as medically reasonable and necessary to avoid disruptions in care based on coverage criteriea, your medical history and the treating provider's recommendations.

Important Benefit Information for Members with Certain Chronic Conditions.

If you have any of the chronic condition(s) listed below and meet certain medical criteria, you may be eligible for additional benefits.

- Chronic alcohol and other drug dependence
- Autoimmune disorders limited to: Polyarteritis nodosa, Polymyalgia rheumatica, Polymyositis, Dermatomyositis, Rheumatoid arthritis, Systemic lupus erythematosus, and scleroderma
- Cancer
- Cardiovascular disorders limited to: Cardiac arrhythmias, Coronary artery disease, Peripheral vascular disease
- Chronic gastrointestinal disease: chronic liver disease, non-alcoholic fatty liver disease (NAFLD), Hepatitis B Hepatitis C, Pancreatitis, Irritable bowel syndrome, inflammatory bowel disease
- Chronic kidney disease (CKD): CKD requiring dialysis/End-stage renal disease (ESRD) (SDRD), CKD not requiring dialysis
- Dementia
- Diabetes mellitus, pre-diabetes (fasting glucose: 100-125 mg/dl or Hgb A1C: 5.7-6.4
- Post-organ transplantation care
- Severe hematologic disorders limited to: Aplastic anemia, Hemophilia, Immune thrombocytopenic purpura, Myelodysplastic syndrome, Sickle-cell disease (excluding sickle-cell trait), and Chronic venous thromboembolic disorder
- HIV/AIDS
- Conditions that may cause similar function challenges and require similar services: spinal cord injury, paralysis, limb loss, stroke, arthritis, chronic

conditions that impair vision, hearing (deafness), taste, touch and smell, conditions that require continued therapy, services in order for individuals to maintain or retain functioning

- 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, post-traumatic stress disorder (PTSD), eating disorders and anxiety disorders
- Neurologic disorders limited to: Amyotrophic lateral sclerosis (ALS), cerebral palsy, 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, chronic fatigue syndrome, spinal cord injuries, traumatic brain injury
- Stroke
- Overweight, obesity and metabolic syndrome
- Conditions that may cause cognitive impairment: Alzheimer's disease, intellectual and developmental disabilities, traumatic brain injury, disabling mental illness associated with cognitive impairment, mild cognitive impairment.
- Chronic Hypertension
- Osteoporosis
- Chronic back pain

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 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.
- Refer to the "Help with certain chronic conditions" row in the Benefits Chart for more information. Contact Customer Care for additional informaiton.

All preventive services are free. This apple shows the preventive services in the Benefits Chart

This star is next to benefits that our plan offers above what Original Medicare and Michigan Medicaid cover.

D. Our plan's Benefits Chart

Covered Service		What you pay
	Abdominal aortic aneurysm screening We pay for a one-time ultrasound screening for people at risk. Our plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	$0

Covered Service		What you pay
	Acupuncture We pay for up to 12 acupuncture visits in 90 days if you have chronic low back pain, defined as: • lasting 12 weeks or longer; • not specific (having no systemic cause that can be identified, such as not associated with metastatic, inflammatory, or infectious disease); • not associated with surgery; **and** • not associated with pregnancy. In addition, we pay for an additional eight sessions of acupuncture for chronic low back pain if you show improvement. You may not get more than 20 acupuncture treatments for chronic low back pain each year. Acupuncture treatments must be stopped if you don't get better or if you get worse. Provider Requirements: Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act)) may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa) (5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have: **This benefit continues on the next page.**	

	Covered Service	What you pay
	Acupuncture (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 master's 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.	$0 for each Medicare-covered acupuncture services.
☆	**Non-Medicare covered routine acupuncture** Routine acupuncture visits (up to 6 visits) for other conditions, such as; headaches, anxiety, sleep issues, osteoarthritis, chemotherapy side effects and respiratory disorders.	$0 copay for each non-Medicare-covered routine acupuncture visits, up to 6 visits each year.

Covered Service		What you pay
	Adaptive medical equipment and supplies The plan covers devices, controls, or appliances that enable you to increase your ability to perform activities of daily living or to perceive, control, or communicate with the environment in which you live. Services might include: • shower chairs/benches • lift chairs • raised toilet seats • reachers • jar openers • transfer seats • bath lifts/room lifts • swivel discs • bath aids such as long handle scrubbers • telephone aids • automated/telephone or watches that assist with medication reminders • button hooks or zipper pulls • modified eating utensils • modified oral hygiene aids • modified grooming tools • heating pads • sharps containers • exercise items and other therapy items • voice output blood pressure monitor • nutritional supplements such as: Ensure	$0

	Covered Service	What you pay
	Alcohol misuse screening and counseling We pay for one alcohol-misuse screening for adults who misuse alcohol but aren't alcohol dependent. This includes pregnant women. If you screen positive for alcohol misuse, you can get up to four brief, face-to-face counseling sessions each year (if you're able and alert during counseling) with a qualified primary care provider (PCP) or practitioner in a primary care setting.	$0
	Allergy shots and serum You are covered for allergy shots and Medicare-covered Part B serum (antigen) when medically necessary. **Note:** For Medicare-covered allergy testing, see "Outpatient diagnostic tests and therapeutic services and supplies."	$0

	Covered Service	What you pay
	Ambulance services Covered ambulance services, whether for an emergency or non-emergency situation, include ground and air (airplane and helicopter), and ambulance services. The ambulance will take you to the nearest place that can give you care. Your condition must be serious enough that other ways of getting to a place of care could risk your health or life. Ambulance services for other cases (non-emergent) must be approved by us. In cases that aren't emergencies, we may pay for an ambulance. Your condition must be serious enough that other ways of getting to a place of care could risk your life or health. 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.*	$0
	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 exam includes measurement of height, weight, body mass index, blood pressure, visual acuity screening and other routine measurements.	$0

Covered Service	What you pay
Annual wellness visit You can get an annual checkup. This is to make or update a prevention plan based on your current risk factors. We pay for this once every calendar year. **Note:** Your first annual wellness visit can't take place within 12 months of your **Welcome to Medicare** visit. However, you don't need to have had a **Wecome to Medicare** visit to get annual wellness visits after you've had Part B for 12 months. Like the annual preventive physical exam, you will not be charged for the office visit no matter how much is discussed with your physician.	$0
Bone mass measurement We pay for certain procedures for members who qualify (usually, someone at risk of losing bone mass or at risk of osteoporosis). These procedures identify bone mass, find bone loss, or find out bone quality. We pay for the services once every 24 months, or more often if medically necessary. We also pay for a doctor to look at and comment on the results.	$0
Breast cancer screening (mammograms) We pay for the following services: • one baseline mammogram between the ages of 35 and 39 • one screening mammogram every 12 months for women aged 40 and over • clinical breast exams once every 24 months	$0

	Covered Service	What you pay
	Cardiac (heart) rehabilitation services We pay for cardiac rehabilitation services such as exercise, education, and counseling. Members must meet certain conditions and have a doctor's order. We also cover intensive cardiac rehabilitation programs, which are more intense than cardiac rehabilitation programs.	$0
	**Cardiovascular (heart) disease risk reduction visit (therapy for heart disease)** We pay for one visit a year, or more if medically necessary, with your primary care provider (PCP) to help lower your risk for heart disease. During the visit, your doctor may: • discuss aspirin use, • check your blood pressure, **and/or** • give you tips to make sure you're eating well.	$0
	**Cardiovascular (heart) disease screening tests** We pay for blood tests to check for cardiovascular disease once every five years (60 months). These blood tests also check for defects due to high risk of heart disease.	$0

Covered Service		What you pay
	Caregiver support services Caregiver support services provided by Carallel®. There is no cost to you to use this benefit. Caregiver support services are available to all Priority Health members and their families. Carallel's Care Advocates provide support and research on topics like health insurance, emotional support, stress management, housing and transportation, and guidance on financial matters and legal concerns. Carallel offers online tools and resources that provide personalized support tailored to your unique situation. Sign up for Carallel's caregiver support services by calling 1-877-715-7872, 8 a.m. to 7 p.m. ET, Monday through Friday. TTY users call 711. Sign up online at http://app.carallel.com/priorityhealth	$0
	Cervical and vaginal cancer screening We pay for the following services: • for all women: Pap tests and pelvic exams once every 24 months • for women who are at high risk of cervical or vaginal cancer: one Pap test every 12 months • For women who have had an abnormal Pap test within the last three years and are of childbearing age: 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.	$0

	Covered Service	What you pay
	Chiropractic services We pay for the following services: • adjustments of the spine to correct alignment	$0
	Non-Medicare Covered Chiropractic services Non-Medicare covered routine visits can be used for conditions including but not limited to, back pain, neck pain, and headaches.	$0 for each non-Medicare/Medicaid covered routine visit, up to 24 each year. $0 for one non Medicare/Medicaid covered routine x-ray services performed by a chiropractor once per plan year.

	Covered Service	What you pay
	Chronic pain management and treatment services Covered monthly services for people living with chronic pain (persistent or recurring pain lasting longer than 3 months). Services may include pain assessment, medication management, and care coordination and planning.	$0 per day per provider for pain assessments performed at a PCP office $0 per day per provider for pain assessments performed at a specialist office $0 per day per provider for physical/occupational therapy $0 for medication management, care coordination and planning performed one time per month.
	CogniFit® Train your brain with more than games. • Get online brain training mode just for you to help improve your memory and focus. • Set reminders and track progress to help you reach your goals. To sign up for CogniFit® please visit *youronepass.com*. Visit the One Pass (Fitness) benefit for more information on how to get started.	$0

Covered Service		What you pay
	**Colorectal cancer screening** We pay for the following services: • Colonscopy 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 aren't at high risk for colorectal cancer, and once every 24 months for high risk patients after a previous screening colonoscopy or barium enema. **This benefit is continued on the next page**	$0

Covered Service	What you pay
Colorectal cancer screening (continued) • Computed tomography colonography for patients 45 years and older who aren't at high risk of colorectal cancer and is covered when at least 59 months have passed following the month in which the last screening computed tomography colonography was performed or 47 months have passed following the month in which the last screening flexible sigmoidoscopy or screening colonoscopy was performed. For patients at high risk for colorectal cancer, payment may be made for a screening computed tomography colonography performed after at least 23 months have passed following the month in which the last screening computed tomography colonography or the last screening colonsocopy was performed. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient got 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. • Blood-based Biomarker Tests for pateints 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. **This benefit is continued on the next page**	

	Covered Service	What you pay
	Colorectal cancer screening (continued) • 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 resturns a positive result.	
	Community Health Worker (CHW) Services CHWs are non-licensed public health providers who facilitate access to needed health and social services for members. CHW services focus on preventing disease, disability, and other chronic conditions or their progression, and promoting physical and mental health. CHW services must be recommended by a licensed provider. Conditions that may define a member's eligibility for CHW services include the following: • diagnosis of one or more chronic health conditions including behavioral health; • suspected or documented unmet health-related social needs; or • pregnancy and post-partum.	$0

Covered Service		What you pay
	Dental services **Priority**Medicare Dual Premier will pay for the following services: • examinations and evaluations are covered once every six months • cleaning is a covered benefit once every six months • silver diamine fluoride treatment is covered with a maximum of six applications per lifetime Fluoride Varnish (1 in 6 months for members under the age of 21) • X-rays ○ bitewing x-rays are a covered benefit only once in a 12-month period ○ full mouth or panoramic x-rays are a covered benefit once every five years • fillings • tooth extractions • complete or partial dentures are covered once every five years • sealants are covered once every three years, if criteria are met • indirect restorations (crowns) are covered once every 5 years per tooth, if criteria are met • root canal therapy/re-treatment of previous root canal • comprehensive periodontal evaluation once every 12 months. Note: comprehensive periodontal evaluation is not a covered benefit when billed in conjunction with, or within six months of other oral exams. • scaling in presence of inflammation once every six months • periodontal scaling and root planning (1 in 2 years per quadrant, max of 2 quadrants per day). **This benefit is continued on the next page**	$0

	Covered Service	What you pay
	Dental services (continued) Note: scaling in the presence of inflammation is not covered within 6 months of prophylaxis, scaling and root planing, periodontal maintenance, or debridement procedures • other periodontal maintenance We pay for some dental services when the service is an integral part of specific treatment of a person's primary medical condition. Examples include reconstruction of the jaw after a fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams prior to organ transplantation. *Prior authorization may apply*	
	**Depression screening** We pay for one depression screening each year. The screening must be done in a primary care setting that can give follow-up treatment and/or referrals.	$0

	Covered Service	What you pay
	Diabetes prevention program services Our plan will pay for Medicare Diabetes Prevention Program services and Michigan Diabetes Prevention Program services: **Medicare Diabetes Prevention Program (MDPP)** • Our plan will pay for MDPP services for eligible people. MDPP is designed to help you increase healthy behavior. It provides practical training in: ○ long-term dietary change, and ○ increased physical activity, and ○ ways to maintain weight loss and a healthy lifestyle. **Michigan Diabetes Prevention Program (MiDPP) services** • Our plan will pay for 28 structured health behavior change one-hour sessions provided by a Medicaid-enrolled **This benefit is continued on the next page** • Lifestyle Coach associated with an enrolled MiDPP provider for members who are: ○ overweight or obese as defined by Body Mass Index (BMI) and has one of the following: ○ elevated blood glucose levels according to CDC standards for blood glucose level requirements ○ history of gestational diabetes mellitus (GDM) ○ score at “high risk” on the CDC prediabetes risk test ○ a member with previously diagnosed type 1 or type 2 diabetes or who’s currently pregnant can’t enroll in MiDPP	$0

Covered Service		What you pay
	Diabetes screening We pay for 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 • history of high blood sugar (glucose) Tests may be covered in some other cases, such as if you're overweight and have a family history of diabetes. You may qualify for up to two diabetes screenings every 12 months following the date of your most recent diabetes screening test.	$0

Covered Service	What you pay
Diabetic self-management training, services, and supplies We pay for the following services for all people who have diabetes (whether they use insulin or not): • Supplies to monitor your blood glucose, including the following: ○ a blood glucose monitor ○ blood glucose test strips ○ lancet devices and lancets ○ glucose-control solutions for checking the accuracy of test strips and monitors • For people with diabetes who have severe diabetic foot disease, we pay for the following: ○ one pair of therapeutic custom-molded shoes (including inserts), including the fitting, and two extra pairs of inserts each calendar year, **or** ○ one pair of depth shoes, including the fitting, and three pairs of inserts each year (not including the non-customized removable inserts provided with such shoes) • In some cases, we pay for training to help you manage your diabetes. To find out more, contact Customer Care.	$0

Covered Service		What you pay
	Doula services The plan will pay for different types of doula services, including community-based doulas, prenatal doulas, labor and birth doulas, and postpartum doulas. The plan will pay for twelve total visits during the prenatal and postpartum periods and one visit for attendance at labor and delivery. Additional visits may be requested. **This benefit is continued on the next page** Doula support during the perinatal period may include, but isn't limited to: • prenatal services • labor and delivery services • postpartum services **A recommendation for doula services must come from a licensed healthcare provider.**	$0

Covered Service		What you pay
	Durable medical equipment (DME) and related supplies Refer to **Chapter 12** of this *Member Handbook* for a definition of "Durable medical equipment (DME)." We cover the following items: • wheelchairs • crutches • powered mattress systems • diabetic supplies • hospital beds ordered by a provider for use in the home • intravenous (IV) infusion pumps and pole • speech generating devices • oxygen equipment and supplies • nebulizers • walkers • standard curved handle or quad cane and replacement supplies • cervical traction (over the door) • bone stimulator • dialysis care equipment • Breast pumps; personal use, double electric Other items may be covered. **This benefit is continued on the next page**	$0 for Medicare-covered and Medicaid-covered equipment and supplies Your cost-sharing for Medicare oxygen equipment coverage is $0 every month. If prior to enrolling in **Priority**Medicare Dual Premier you had made 36 months of rental payment for oxygen equipement coverage, your cost-sharing in **Priority**Medicare Dual Premier is $0.

	Covered Service	What you pay
	Durable medical equipment (DME) and related supplies (continued) We pay for all medically necessary DME that Medicare and Medicaid usually pay for. If our supplier in your area doesn't carry a particular brand or maker, you may ask them if they can special order it for you. *Prior authorization may apply.*	

Covered Service		What you pay
	Emergency care Emergency care means services that are: • given by a provider trained to give emergency services, **and** • needed to evaluate or treat a medical emergency. ○ A medical emergency is an illness, injury, severe pain, or medical condition that's quickly getting worse. The condition is so serious that, if it doesn't get immediate medical attention, anyone with an average knowledge of health and medicine could expect it to result in: serious risk to your life or to that of your unborn child; **or** serious harm to bodily functions; **or** • loss of a limb, or loss of function of a limb. • In the case of a pregnant woman in active labor, when: ○ There isn't enough time to safely transfer you to another hospital before delivery. ○ A transfer to another hospital may pose a threat to your health or safety or to that of your unborn child. 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 7, Section A, for more information on what happens when you get a Part D drug in a medical setting.	$0 If you get emergency care at an out-of-network hospital and need inpatient care after your emergency is stabilized, you must move to a network hospital for your care to continue to be paid for. You can stay in the out-of-network hospital for your inpatient care only if our plan approves your stay.

Covered Service		What you pay
	Enhanced disease management services Our care management assists members in finding community resources and programs to achieve maximum physical or mental functioning when identified with the following as needing enhanced disease management: • Chronic conditions who are identified as needing enhanced disease management • Hospitalization for a complication of a condition or disease and are identified as having moderate to high risk for readmission • Discharge from an inpatient psychiatric setting for a Behavioral Health condition • High opioid utilization patterns • Chronic kidney disease • Advanced stages of a chronic disease state. (CHF, COPD, Oncology, Diabetes, CKD)	$0
	Family planning services The law lets you choose any provider – whether a network provider or out-of-network provider – for certain family planning services. This means any doctor, clinic, hospital, pharmacy or family planning office. We pay for the following services: • family planning exam and medical treatment • family planning lab and diagnostic tests • family planning methods (IUC/IUD, implants, injections, birth control pills, patch, or ring) • family planning supplies with prescription (condom, sponge, foam, film, diaphragm, cap) **This benefit is continued on the next page**	$0

Covered Service		What you pay
	Family planning services (continued) • counseling and diagnosis of infertility and related services • counseling, testing, and treatment for sexually transmitted infections (STIs) • counseling and testing for HIV and AIDS, and other HIV-related conditions • permanent contraception (You must be age 21 or over to choose this method of family planning. You must sign a federal sterilization consent form at least 30 days, but not more than 180 days before the date of surgery.) • genetic counseling We also pay for some other family planning services. However, you must use a provider in our provider network for the following services: • treatment for medical conditions of infertility (This service doesn't include artificial ways to become pregnant.) • treatment for AIDS and other HIV-related conditions • genetic testing	

Covered Service		What you pay
	Group prenatal care services The plan will pay for group prenatal care services if you have a low-risk pregnancy that doesn't require individual monitoring. You'll be educated in health topics such as childbirth preparation, nutrition and exercise, stress management, breastfeeding, parenting, and contraception. Group sessions are facilitated by a trained healthcare provider and include others in similar stages of pregnancy. The plan may cover up to 12 total in-person group sessions per pregnancy in addition to the required individual professional maternity visit, if: • The group session is in addition to but doesn't replace the individual prenatal physical assessment visit. • The group session is at least 60 minutes. (90 to 120 minutes • The time spent in the group session is documented. One of the 12 group sessions may relate to the postpartum professional visit.	$0

Covered Service		What you pay
	**Health and wellness education programs** These programs are focused on health conditions such as COPD, CHF, diabetes, and kidney disease. Physical and mental/behavioral support is available to ensure members are connected with the appropriate programs/benefit offerings: • Enhanced disease management • Fitness (One Pass®) • Health education • In-home safety assessment • Nutritional education • Personal Emergency Response System (PERS) • Post-discharge in-home medication reconciliation • Telemonitoring For more information, please refer to the individual program listed in this medical benefits chart.	$0

Covered Service		What you pay
	Health Education Health education includes: • Access to Teledoc Health Mental Health 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

	Covered Service	What you pay
	Hearing services We pay for hearing and balance tests done by your provider. These tests tell you whether you need medical treatment. They're covered as outpatient care when you get them from a physician, audiologist, or other qualified provider.	$0 for each Medicare/Medicaid covered hearing exams.

Covered Service	What you pay
Routine Hearing Services We pay for up to two hearing aids (one per ear every three years). Benefit is limited to TruHearing-branded Advanced Aids, which come in various styles and colors. You must see a TruHearing provider to use this benefit. Call 1-833-714-5355 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 • Ear molds Benefit does not include or cover any of the following: • Over-the-counter (OTC) hearing aids • Hearing aid accessories • Additional provider visits • Additional batteries • Hearing aids that are not TruHearing-branded Advanced Aids • Costs associated with loss & damage warranty claims Costs associated with excluded items are the responsibility of the member and not covered by the plan.	$0 for one routine hearing exam every year. $0 per hearing aid for Advanced Aids, one per ear, every three years.
Help with certain chronic conditions In order to use your PriorityFlex card towards healthy food and produce, meal delivery, pest control services, select utilities, household supplies and personal care items on your PriorityFlex card you must be eligible for Special Supplemental Benefits for the Chronically Ill (SSBCI).	See PriorityFlex for allowance.

Covered Service		What you pay
	Help with certain chronic conditions (continued) To qualify for 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. Qualifying Conditions: • Chronic alcohol and other drug dependence • Autoimmune disorders limited to: Polyarteritis nodosa, Polymyalgia rheumatica, Polymyositis, Dermatomyositis, Rheumatoid arthritis, Systemic lupus erythematosus, and sclerdoma • Cancer • Cardiovascular disorders limited to: Cardiac arrhythmias, Coronary artery disease, Peripheral vascular disease • Chronic gastrointestinal disease: chronic liver disease, non-alcoholic fatty liver disease (NAFLD), Hepatitis B Hepatitis C, Pancreatitis, Irritable bowel syndrome, inflammatory bowel disease • Chronic kidney disease (CKD): CKD requiring dialysis/End-stage renal disease (ESRD) (SDRD), CKD not requiring dialysis • Dementia • Diabetes mellitus, pre-diabetes (fasting glucose: 100-125 mg/dl or Hgb A1C: 5.7-6.4 **This benefit is continued on the next page**	

	Covered Service	What you pay
	Help with certain chronic conditions (continued) • Post-organ transplantation care • 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 • Conditions that may cause similar function challenges and require similar services: spinal cord injury, paralysis, limb loss, stroke, arthritis, chronic conditions that impair vision, hearing (deafness), taste, touch and smell, conditions that require continued therapy, services in order for individuals to maintain or retain functioning • 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, post-traumatic stress disorder (PTSD), eating disorders and anxiety disorders **Help with certain chronic conditions (continued)** • Neurologic disorders limited to: Amyotrophic lateral sclerosis (ALS), cerebral palsy, Epilepsy, Extensive paralysis (i.e., hemiplegia, quadriplegia, paraplegia, monoplegia), Huntington's disease, Multiple sclerosis, Parkinson's disease, Polyneuropathy, Spinal stenosis,	

Covered Service		What you pay
	and Stroke-related neurologic deficit, chronic fatigue syndrome, spinal cord injuries, traumatic brain injury • Stroke • Overweight, obesity and metabolic syndrome • Conditions that may cause cognitive impairment: Alzheimer's disease, intellectual and developmental disabilities, traumatic brain injury, disabling mental illness associated with cognitive impairment, mild cognitive impairment. • Chronic Hypertension • Osteoporosis • Chronic back pain To learn if you qualify contact Customer Care or visit priorityhealth.com/dual26.	
	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/Medicaid covers yearly screenings.	$0

	Covered Service	What you pay
🍎	**HIV screening** We pay for one HIV screening exam every 12 months for people who: • ask for an HIV screening test, **or** • are at increased risk for HIV infection. If you're pregnant, we pay for up to three HIV screening tests during a pregnancy.	$0
	Home health agency care Before you can get home health services, a doctor must tell us you need them, and they must be provided by a home health agency. You must be homebound, which means leaving home is a major effort. We pay for the following services, and maybe other services not listed here: • 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 • home health aide when provided with a nursing service **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.	$0

	Covered Service	What you pay
	Home infusion therapy Our plan pays for home infusion therapy, defined as drugs or biological substances administered into a vein or applied under the skin and provided to you at home. The following are needed to perform home infusion: • the drug or biological substance, such as an antiviral or immune globulin; • equipment, such as a pump; **and** • supplies, such as tubing or a catheter. Our plan covers home infusion services that include but aren't limited to: • professional services, including nursing services, provided in accordance with your care plan; • member training and education not already included in the DME benefit; • remote monitoring; **and** • 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. *Prior authorization may apply.*	$0
	Hospice care You have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal illness and are expected to have six months or less to live. You can get	$0 for the initial hospice consultation.

	Covered Service	What you pay
	Hospice Care (continued) care from any hospice program certified by Medicare. Our plan must help you find Medicare-certified hospice programs in the plan's service area, including programs we own, control, or have a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • drugs to treat symptoms and pain • short-term respite care • home care **For hospice services and services covered by Medicare Part A or Medicare Part B that relate to your terminal prognosis are billed to Medicare.** • Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A or B services related to your terminal illness. While you're in the hospice program, your hospice provider will bill Original Medicare for the services Original Medicare pays for. **For services covered by our plan but not covered by Medicare Part A or Medicare Part B:** • Our plan covers services not covered under Medicare Part A or Medicare Part B. We cover the services whether or not they relate to your terminal prognosis. You pay nothing for these services. **For drugs that may be covered by our plan's Medicare Part D benefit:** • Drugs are never covered by both hospice and our plan at the same time. For more information, refer to **Chapter 5** of this *Member Handbook*.	

	Covered Service	What you pay
	Hospice care (continued) **Note:** If you need non-hospice care, call your care manager and/or Customer Care to arrange the services. Non-hospice care is care that **isn't** related to your terminal prognosis. Our plan covers hospice consultation services (one time only) for a terminally ill member who hasn't chosen the hospice benefit.	
	**Immunizations** We pay for the following services: • pneumonia vaccines • flu/influenza shots, once each flu/influenza season in the fall and winter, with additional flu/influenza shots if medically necessary • hepatitis B vaccines if you're at high or intermediate risk of getting hepatitis B • COVID-19 vaccines • other vaccines if you're at risk and they meet Medicare Part B coverage rules We pay for other vaccines that meet the Medicare Part D coverage rules. Refer to **Chapter 6** of this *Member Handbook* to learn more.	$0

Covered Service	What you pay
In-home safety assessment services 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

Covered Service		What you pay
	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're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day. There is no limit to the number of days covered by the plan. We pay for the following services and other medically necessary services not listed here: • semi-private room (or a private room if medically necessary) • meals, including special diets • regular nursing services • costs of special care units, such as intensive care or coronary care units • drugs and medications • lab tests • X-rays and other radiology services • needed surgical and medical supplies • appliances, such as wheelchairs • operating and recovery room services • physical, occupational, and speech therapy • inpatient substance abuse services • in some cases, the following types of transplants: corneal, kidney, kidney/pancreas, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral **This benefit is continued on the next page**	$0 You must get approval from our plan to get inpatient care at an out-of-network hospital after your emergency is stabilized.

Inpatient hospital care (continued)

If you need a transplant, a Medicare-approved transplant center will review your case and decide if you're a candidate for a transplant. Transplant providers may be local or outside of the service area. If local transplant providers are willing to accept the Medicare rate, then you can get your transplant services locally or outside the pattern of care for your community. If our plan provides transplant services outside the pattern of care for our community and you choose to get your transplant there, we arrange or pay for lodging and travel costs for you and one other person. 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.

- blood, including storage and administration

  Coverage begins with the first pint of blood that you need.

Covered Service		What you pay
	• physician services **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." If you're not sure if you're an inpatient or an outpatient, ask the hospital staff. Get more information in the Medicare fact sheet *Medicare Hospital Benefits*. This fact sheet is available at Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. *Prior authorization may apply.*	

	Covered Service	What you pay
	Inpatient services in a psychiatric hospital Medicaid Specialty Behavioral Health Services are provided by regional Pre-paid Inpatient Health Plans (PIHPs) or Community Mental Health Services Providers (CMHSPs). This includes inpatient services in psychiatric hospitals. • If you live in Wayne County, the plan will refer you to the Detroit Wayne Integrated Health Network for this service. • If you live in Macomb County, the plan will refer you to the Macomb County Community Mental Health for this service. • If you live in Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, Van Buren counties, the plan will refer you to the Southwest Michigan Behavioral Health for this service. Refer to **Section E2** in this chapter for more information. We pay for other mental health care services not covered by PIHPs that require a hospital stay.There is a 190-day lifetime limit for inpatient services in a psychiatric hospital.The 190pday limit doesn't 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*.	$0

	Covered Service	What you pay
	Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay If you've used up your inpatient benefits or if the inpatient stay isn't reasonable and necessary, we won't cover your inpatient stay. In some cases, we'll cover certain services you get while you're in the hospital or the skilled nursing facility (SNF). Covered services include, but aren't limited to: • Physician services • Diagnostic tests (like lab tests) • X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings • Splints, casts, and other devices used to reduce fractures and dislocations • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy, speech therapy, and occupational therapy *Prior authorization may apply.*	$0

	Covered Service	What you pay
	Kidney disease services and supplies We pay for the following services: • Kidney disease education services to teach kidney care and help you make good decisions about your care. You must have stage IV chronic kidney disease, and your doctor must refer you. We cover up to six sessions of kidney disease education services. • Outpatient dialysis treatments, including dialysis treatments when temporarily out of the service area, as explained in **Chapter 3** of this *Member Handbook*, or when your provider for this service is temporarily unavailable or inaccessible. • Inpatient dialysis treatments if you're admitted as an inpatient to a hospital for special care • Self-dialysis training, including training for you and anyone helping you with your home dialysis treatments • Home dialysis equipment and supplies • Certain home support services, such as necessary visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and to check your dialysis equipment and water supply. Medicare Part B pays for some drugs for dialysis. For information, refer to "Medicare Part B drugs" in this chart.	$0

Covered Service		What you pay
🍎	**Lung cancer screening with low dose computed tomography (LDCT)** Our plan pays for lung cancer screening every 12 months if you: • are aged 50-77, **and** • have a counseling and shared decision-making visit with your doctor or other qualified provider, **and** • have smoked at least 1 pack a day for 20 years with no signs or symptoms of lung cancer or smoke now or have quit within the last 15 years After the first screening, our plan pays for another screening each year with a written order from your doctor or other qualified provider. If a provider elects to provide a lung cancer screening counseling and shared decision-making visit for lung cancer screenings, the visit must meet the Medicare criteria for such visits.	$0

Covered Service		What you pay
	Maternal Infant Health Program (MIHP) MIHP is a home visiting program for women and infants to promote healthy pregnancies, positive birth outcomes, and healthy infant growth and development. MIHP covered services include: • Prenatal teaching • Childbirth education classes • Nutritional support, education, and counseling • Breasfeeding or formula feeding support • Help with personal problems that may complicate your pregnancy • Newborn baby assessments • Referrals to community resources and help finding baby cribs, car seats, clothing, etc. • Support to stop smoking • Help with substance abuse • Personal care or home help services	$0

Covered Service		What you pay
🍎	**Medical nutrition therapy** This benefit is for people with diabetes or kidney disease without dialysis. It's also for after a kidney transplant when ordered by your doctor. We pay for three hours of one-on-one counseling services during the first year you get medical nutrition therapy services under Medicare. We may approve additional services if medically necessary. We pay for two hours of one-on-one counseling services each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a doctor's order. A doctor must prescribe these services and renew the] each year if you need treatment in the next calendar year. We may approve additional services if medically necessary.	$0

	Covered Service	What you pay
	Medicare Part B drugs These drugs are covered under Part B of Medicare. Our plan pays for the following drugs: • drugs you don't usually give yourself and are injected or infused while you get doctor, hospital outpatient, or ambulatory surgery center services • 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 our plan authorized • the Alzheimer's drug Leqembi® (generic lecanemab) which is given intravenously (IV) • clotting factors you give yourself by injection if you have hemophilia • transplant/immunosuppressive drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs. Medicare Part D covers immunosuppressive drugs if Part B doesn't cover them • osteoporosis drugs that are injected. We pay for these drugs if you're homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and can't inject the drug yourself **This benefit is continued on the next page**	$0

Covered Service		What you pay
	Medicare Part B drugs (continued) • some antigens: Medicare covers antigens if a doctor prepares them and a properly instructed person (who could be you, the patient) gives them under appropriate supervision • certain oral anti-cancer drugs: Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug). As new oral cancer drugs become available, Part B may cover them. If Part B doesn't cover them, Part D does • oral anti-nausea drugs: Medicare covers oral anti-nausea drugs you use as part of an anti-cancer chemotherapeutic regimen if they're administered before, at, or within 48 hours of chemotherapy or are used as a full therapeutic replacement for an intravenous anti-nausea drug • certain oral End-Stage Renal Disease (ESRD) drugs covered under Medicare Part B • calcimimetic and phosphate binder medications under the ESRD payment system, including the intravenous medication Parsabiv®, and the oral medication Sensipar • certain drugs for home dialysis, including heparin, the antidote for heparin (when medically necessary) and topical anesthetics • erythropoiesis-stimulating agents: Medicare covers erythropoietin by injection if you have ESRD or you need this drug to treat anemia related to certain other conditions (such as Epogen®, Procrit®, Retacrit®, Epoetin Alfa, Aranesp®, Darbepoetin Alfa®, Mircera®, or Methoxy polyethylene glycol-epotin beta) **This benefit is continued on the next page**	

Covered Service		What you pay
	Medicare Part B drugs (continued) • IV immune globulin for the home treatment of primary immune deficiency diseases • parenteral and enteral nutrition (IV and tube feeding) This 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 Medicare Part B and most adult vaccines under our Medicare Part D drug benefit. **Chapter 5** of this *Member Handbook* explains our drug benefit. It explains rules you must follow to have prescriptions covered. **Chapter 6** of this *Member Handbook* explains what you pay for your drugs through our plan. *Prior authorization may apply.*	

	Covered Service	What you pay
	Non-emergency medical transportation Your Medicaid benefit provides options for transportation. We provide transportation free of charge for doctor's visits, lab visits, non-emergency hospital services, prescription pick-up, dental services, and other Medicaid covered services, whether those services are provided by your Medicaid health plan or through MDHHS directly. In some cases, we may provide bus tokens or if you have your own vehicle or someone else to drive you, you can request mileage reimbursement. Please call SafeRide at 1-833-944-0535 for more information and to schedule a ride. Please call 3 days before an appointment so we can make sure we have someone available to transport you. You can request same-day transportation for an urgent non-emergency appointment. Have this information ready when you call: • Your name, Member ID number and date of birth • The address and phone number of where you will be picked up • The address and phone number of where you are going • Your appointment date and time • The name of your provider Members with any special needs (wheelchair accommodations, oxygen resources, etc.) will want to schedule transportation as early as possible in order to meet your needs with the appropriate vendor.	$0

	Covered Service	What you pay
	Nursing facility care A nursing facility (NF) is a place that provides care for people who can't get care at home but who don't need to be in a hospital. Services that we pay for include, but aren't limited to, the following: • semiprivate room (or a private room if medically necessary) • meals, including special diets • nursing services • physical therapy, occupational therapy, and speech therapy • respiratory therapy • drugs given 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 • medical and surgical supplies usually given by nursing facilities • lab tests usually given by nursing facilities • X-rays and other radiology services usually given by nursing facilities • use of appliances, such as wheelchairs usually given by nursing facilities **This benefit is continued on the next page**	When your income exceeds an allowable amount, you must contribute toward the cost of your nursing facility care. The allowable amount is based on each person's situation and is determined when a person applies for assistance with paying a nursing facility. This contribution, known as the Patient Pay Amount (PPA), is required if you live in a nursing facility. However, you might not end up having to pay each month. Patient pay responsibility doesn't apply to Medicare-covered days in a nursing facility.

Covered Service		What you pay
	Nursing facility care (continued) • physician/practitioner services • durable medical equipment • dental services, including dentures • vision benefits • hearing exams • chiropractic care • podiatry services You usually get your care from network facilities. However, you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our plan's amounts for payment: • a nursing facility or continuing care retirement community where you were living right before you went to the hospital (as long as it provides nursing facility care). • a nursing facility where your spouse or domestic partner is living at the time you leave the hospital. • the nursing home where you were living when you enrolled in **Priority**Medicare Dual Premier This service is intended to be long term custodial care and doesn't overlap with skilled nursing facility care. You must meet Michigan Medicaid Nursing Facility Level of Care standards to get this service.	

Covered Service		What you pay
	Nutrition Education A dietitian who will work to prevent and treat illness and promote a healthy lifestyle by recommending healthy eating habits and will address a person's overall health through diet and nutrition. A nutritionist will provide a total of 12 individual or group sessions individual nutrition assessments, counseling, and education by phone or in person, which would include: • Provide nutrition education materials to promote prevention, disease management, and healthy living • Apply appropriate behavioral and adult learning theories to develop, present, and educate members, providers, and staff on nutrition topics • Work closely with care management, pharmacy, and other medical support staff to assist with member care planning • Participate as a member of ICT as needed • Maintain knowledge of the latest advances and research on various health/nutrition topics • Act as a resource for Priority Health providers, health networks and community partners For people with diabetes, renal (kidney) disease or after a kidney transplant, see "Medical Nutrition Therapy."	$0

Covered Service		What you pay
	**Obesity screening and therapy to keep weight down** If you have a body mass index of 30 or more, we pay for counseling to help you lose weight. You must get the counseling in a primary care setting. That way, it can be managed with your full prevention plan. Talk to your primary care provider to find out more.	$0

	Covered Service	What you pay
	One Pass® (Fitness) Discover the joy of whole-body health. At One Pass, we're on a mission to make fitness engaging for everyone. One Pass can help you reach your fitness goals, while finding new passions along the way. Find a routine that's right for you whether you work out at home or at the gym. One Pass includes: • Access to the largest network of gyms and fitness locations. • Live, digital fitness classes and on-demand workouts. • CogniFit® brain-training made just for you to improve your memory and focus. • Home fitness kit (1 per plan year) **How to get started** Getting started with One Pass is simple: 1. Go to *YourOnePass.com* 2. Click "Get started" and follow prompts. 3. Get your One Pass member code on the dashboard page. 4. Click "Fitness" and then "Find Gyms" to search for fitness locations near you. 5. Bring your One Pass member code with you to any participating location, and the staff will set up your membership for all future visits.	$0

	Covered Service	What you pay
	Opioid treatment program (OTP) services Our plan pays for the following services to treat opioid use disorder (OUD) through an OTP which includes the following services: • intake activities • periodic assessments • medications approved by the FDA and, if applicable, managing and giving you these medications • substance use counseling • individual and group therapy • testing for drugs or chemicals in your body (toxicology testing)	$0

	Covered Service	What you pay
	Outpatient diagnostic tests and therapeutic services and supplies We pay for the following services and other medically necessary services not listed here: • X-rays and ultrasounds • radiation (radium and isotope) therapy, including technician materials and supplies • surgical supplies, such as dressings • splints, casts, and other devices used for fractures and dislocations • lab tests • blood, including storage and administration Coverage begins with the first pint of blood that you need • diagnostic non-laboratory tests such as CT scans, MRIs, EKGs, and PET scans when your doctor or other health care provider orders them to treat a medical condition • other outpatient diagnostic tests (for example: allergy testing, genetic testing and sleep studies) *Prior authorization may apply.*	$0

	Covered Service	What you pay
	Outpatient hospital observation We pay for outpatient hospital observation services to determine if you need to be admitted as an inpatient or can be discharged. The services must meet Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another person authorized by state law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **Note:** Unles the provider has written an order to admit you as an inpatient to the hospital, you're an outpatient. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you aren't sure if you're an outpatient, ask hospital staff. Get more information in the Medicare fact sheet *Medicare Hospital Benefits.* This fact sheet is available at Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf	$0 for all services received.

	Covered Service	What you pay
	Outpatient hospital services We pay for medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury, such as: • Services in an emergency department or outpatient clinic, such as outpatient surgery or observation services ○ Observation services help your doctor know if you need to be admitted to the hospital as “inpatient.” ○ Sometimes you can be in the hospital overnight and still be “outpatient.” ○ You can get more information about being inpatient or outpatient in this fact sheet: es.medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf. • Labs 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 needed without it • X-rays and other radiology services billed by the hospital • Medical supplies, such as splints and casts • Preventive screenings and services listed throughout the Benefits Chart • Some drugs that you can’t give yourself • Wound care *Prior authorization may apply.*	$0

	Outpatient mental health care We pay for mental health services provided by: • a state-licensed psychiatrist or doctor • a clinical psychologist • a clinical social worker • a clinical nurse specialist • a licensed professional counselor (LPC) • a licensed marriage and family therapist (LMFT) • a nurse practitioner (NP) • a physician assistant (PA) • any other Medicare-qualified mental health care professional as allowed under applicable state laws Medicaid Specialty Behavioral Health Services are provided by regional Pre-paid Inpatient Health Plans (PIHPs) or Community Mental Health Services Providers (CMHSPs). This includes outpatient mental health care. • If you live in Wayne County, the plan will refer you to the Detroit Wayne Integrated Health Network for this service. • If you live in Macomb County, the plan will refer you to the Macomb County Community Mental Health for this service. • If you live in Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, Van Buren counties, the plan will refer you to the Southwest Michigan Behavioral Health for this service. Refer to **Section E2** in this chapter for more information. *Prior authorization may apply.*	$0

	Covered Service	What you pay
	Outpatient mental health care (continued) The plan will pay for the following services, and maybe other services not listed here if they're Medicare or Medicaid benefits but aren't covered by the PIHP: • clinic services • day treatment • psychosocial rehab services	
	Outpatient rehabilitation services We pay for physical therapy, occupational therapy, and speech therapy. You can get outpatient rehabilitation services from hospital outpatient departments, independent therapist offices, comprehensive outpatient rehabilitation facilities (CORFs), and other facilities.	$0

	Covered Service	What you pay
	Outpatient substance use disorder services Medicaid Specialty Behavioral Health Services are provided by regional Pre-paid Inpatient Health Plans (PIHPs) or Community Mental Health Services Providers (CMHSPs). This includes outpatient substance use disorder services. • If you live in Wayne County, the plan will refer you to the Detroit Wayne Integrated Health Network for this service. • If you live in Macomb County, the plan will refer you to the Macomb County Community Mental Health for this service. • If you live in Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, Van Buren counties, the plan will refer you to the Southwest Michigan Behavioral Health for this service. Refer to **Section E2** in this chapter for more information. *Prior authorization may apply.*	$0
	Outpatient surgery We pay for outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers. **Note:** If you're having surgery in a hospital facility, you should check with your provider about whether you'll be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you're an outpatient. Even if you stay in the hospital overnight, you might still be considered an outpatient.	$0

	Partial hospitalization services and intensive outpatient services **Partial hospitalization** is a structured program of active psychiatric treatment. It's offered as a hospital outpatient service or by a community mental health centerthat's more intense than the care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office. It can help keep you from having to stay in the hospital. **Intensive outpatient service** is a structured program of active behavioral (mental) health therapy treatment provided as a hospital outpatient service, a community mental health center, a federally qualified health center, or a rural health clinic that's more intense than care you get in your doctor's, therapist's, LMFT, or licensed professional counselor's office but less intense than partial hospitalization. This plan will pay for Medicaid Specialty Behavioral Health Services (which includes partial hospitalization services). Medicaid Specialty Behavioral Health Services are provided by regional Pre-paid Inpatient Health Plans (PIHPs) or Community Mental Health Services Providers (CMHSPs) • If you live in Wayne County, the plan will refer you to the Detroit Wayne Integrated Health Network for this service. • If you live in Macomb County, the plan will refer you to the Macomb County Community Mental Health for this service. • If you live in Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, Van Buren counties, the plan will refer you to the Southwest Michigan Behavioral Health for this service.	$0

	Covered Service	What you pay
	Refer to **Section E2** in this chapter for more information. Prior authorization may apply.	
	Personal care services The plan will pay for hands-on assistance to help you remain in your home for as long as possible. Services include assistance with activities of daily living (ADLs), which are tasks like bathing, eating, dressing, and toileting. This service can include instrumental activities of daily living (IADLs) but only when there's also a need for an ADL. IADLs include things like shopping, laundry, meal preparation, medication reminders, and taking you to your appointments.	$0
	**Personal Emergency Response System** The plan covers an electronic in-home device that secures help in an emergency. You may also wear a portable "help" button to allow for mobility. The system is connected to your phone and programmed to signal a response center once a "help" button is activated. This benefit package includes in-home or Mobile GPS equipment, installation support, onboarding welcome call, 24/7 monitoring, and Customer Care that include social care. Please contact your Care Manager at 833.939.0983 to take advantage of this benefit or to receive more information.	$0

	Covered Service	What you pay
	Physician/provider services, including doctor's office visits We pay for the following services: • medically necessary health care or surgery services given in places such as: • physician's office • certified ambulatory surgical center • hospital outpatient department • consultation, diagnosis, and treatment by a specialist • basic hearing and balance exams given by your : primary care provider ***or*** specialist, if your doctor orders them to find out whether you need treatment • Certain telehealth services, including virtual visits, evaluations, communication via telephone or video (computer, smart phone, tablet, online patient portal with: o primary care providers (PCP), o specialists o behavioral health providers **This benefit is continued on the next page**	$0

Covered Service		What you pay
	Physician/provider services, including doctor's office visits (continued) ○ You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth. • Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner, for members in certain rural areas or other places approved by Medicare • telehealth services for monthly end-stage renal disease (ESRD) related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or at home • telehealth services to diagnose, evaluate, or treat symptoms of a stroke • telehealth services for members with a substance use disorder or co-occurring mental health disorder **This benefit is continued on the next page**	

Covered Service		What you pay
	Physician/provider services, including doctor's office visits (continued) • telehealth services for diagnosis, evaluation, and treatment of mental health disorders if: ○ 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 **This benefit is continued on the next page**	

	Covered Service	What you pay
	Physician/provider services, including doctor's office visits (continued) • Consultation your doctor has with other doctors by phone, the Internet, or electronic health record if you're not a new patient • Second opinionbefore surgery *Prior authorization may apply.*	
	Podiatry services We pay for the following services: • diagnosis and medical or surgical treatment of injuries and diseases of the foot (such as hammer toe or heel spurs) • routine foot care for members with conditions affecting the legs, such as diabetes	$0 for each visit $0 for nail debridement and callous removal, for members with specific conditions affecting the lower limbs.
☆	**Non-Medicare/Medicaid covered routine podiatry services:** You may self-refer 6 routine visits/services each year, such as nail debridement or callous removal, whether or not you have a medical condition affecting your lower limbs.	$0 for up to 6 visits/services for routine podiatry

Covered Service		What you pay
	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
	Pre-exposure prophylaxis (PrEP) for HIV prevention If you don't have HIV, but your doctor or other health care practitioner determines you're at an increased risk for HIV, we cover pre-exposure prophylaxis (PrEP) medication and related services. If you qualify, covered services include: • FDA-approved oral or injectable PrEP medication. If you're getting an injectable drug, we also cover the fee for injecting the drug. • Up to 8 individual counseling sessions (including HIV risk assessment, HIV risk reduction, and medication adherence) every 12 months. • Up to 8 HIV screenings every 12 months. • A one-time hepatitis B virus screening.	$0

Covered Service	What you pay
PriorityFlex There are three ways you can use your PriorityFlex card to buy over-the-counter (OTC) items, home and bathroom safety device and modifications and if SSBCI eligible, personal care supplies and household items:: 1. **Order Online.** View and purchase products online anytime at *PriorityHealth.com/shopOTC* or by downloading the Priority Health OTC app. 2. **Shop in-store.** Shop at Meijer, Kroger, CVS, Walgreens, Walmart and other participating stores near you. You can search for participating store locations online anytime at *PriorityHealth.com/shopOTC* or by downloading the Priority Health OTC app and using the Find A Store tool. 3. **Call for delivery.** Call 833.415.4380 (TTY 711) Monday through Friday 8 a.m. to 8 p.m. and Saturday 8 a.m. to 12 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. If eligible for SSBCI, you may use your card to shop for healthy food and produce at participating retail locations which can be found at *PriorityHealth.com/OTC* or by downloading the Priority Health OTC app and using the Find A Store tool. If eligible for SSBCI, meal delivery and pest control services can be purchased by going to *PriorityHealth.com/shopOTC* or by using the Priority Health OTC mobile app. Pest control services will be scheduled with a verified service provider in your area. **This benefit continues on the next page**	$96 (Barry County) and $70 (all other counties) per month to use on OTC, home and bathroom safety devices and modifications. If SSBCI eligible, you may also use your allowance towards healthy food and produce, meal delivery, pest control services, select utilities, personal care items and household supplies. Allowance does not rollover.

	Covered Service	What you pay
	PriorityFlex (continued) If you eligible for SSBCI, you may use your card to pay for utility bills (phone, internet, gas, electric, septic, trash, water, sewer) you can pay as you would with any other MasterCard. For a list of participating service providers visit *PriorityHealth.com/OTC*. Please note, when making a payment for your utility provider using your PriorityFlex benefit it is important to only submit a payment for the amount available on your card. You can check your card balance at anytime online at *PriorityHealth.com/shopOTC* or by downloading the Priority Health OTC app. You may be required to pay your remaining utility bill balance with an alternative personal form of payment. Your unused PriorityFlex allowance does not rollover. Allowances expire at the end of each month. For more information on SSBCI eligibilty go to the “Help with Certain Chronic Conditions” benefit. **NOTE:** In the event you had to pay out-of-pocket to purchase any eligible PriorityFlex benefit items reimbursement is available to you. Log into your priority health account at *PriorityHealth.com/shopOTC* or through the Priority Health OTC app and complete the reimbursement form found under Make A Reimbursement. To be eligible for reimbursement, the item purchased must be an eligible item purchased at a participating location and you have available funds in your PriorityFlex balance. All reimbursements must be submitted within 90 days of purchase date and include a picture of the receipt.	

	Covered Service	What you pay
	Prostate cancer screening exams For men aged 50 and over,] we pay for the following services once every 12 months: • a digital rectal exam • a prostate specific antigen (PSA) test	$0
	Prosthetic and orthotic devices and related supplies Prosthetic devices replace all or part of a body part or function. These include but aren't limited to: • testing, fitting, or training in the use of prosthetic and orthotic devices • colostomy bags and supplies related to colostomy care • pacemakers • braces • prosthetic shoes • artificial arms and legs • breast prostheses (including a surgical brassiere after a mastectomy) We pay for some supplies related to prosthetic and orthotic devices. We also pay to repair or replace prosthetic and orthotic devices. We offer some coverage after cataract removal or cataract surgery. Refer to "Vision care" later in this chart for details. *Prior authorization may apply.*	$0

Covered Service		What you pay
	Pulmonary rehabilitation services We pay for pulmonary rehabilitation programs for members who have moderate to very severe chronic obstructive pulmonary disease (COPD). You must have order for pulmonary rehabilitation from the doctor or provider treating the COPD.	$0
	Respite You may get respite care services on a short-term, intermittent basis to relieve your family or other primary caregiver(s) from daily stress and care demands during times when they're providing unpaid care. Relief needs of hourly or shift staff workers should be accommodated by staffing substitutions, plan adjustments, or location changes and not by respite care. Respite isn't intended to be provided on a continuous, long-term basis where it's a part of daily services that would enable an unpaid caregiver to work elsewhere full time. Respite is limited to 14 overnight stays per 365 days unless **Priority**Medicare Dual Premier approves additional time.	$0

	Covered Service	What you pay
	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: • 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
	**Screening for Hepatitis C Virus infection** We cover one Hepatitis C screening if your primary care doctor or other qualified health care provider orders one and you meet one of these conditions: • You're at high risk because you use or have used illicit injection drugs. • You had a blood transfusion before 1992. • You were born between 1945-1965. If you were born between 1945-1965 and aren't considered high risk, we pay for a screening once. If you're at high risk (for example, you've continued to use illicit injection drugs since your previous negative Hepatitis C screening test), we cover yearly screenings.	$0

Covered Service		What you pay
	Sexually transmitted infections (STIs) screening and counseling We pay for screenings for chlamydia, gonorrhea, syphilis, and hepatitis B. These screenings are covered for pregnant women and for some people who are at increased risk for an STI. A primary care provider must order the tests. We cover these tests once every 12 months or at certain times during pregnancy. We also pay for up to two face-to-face, high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. Each session can be 20 to 30 minutes long. We pay for these counseling sessions as a preventive service only if given by a primary care provider. The sessions must be in a primary care setting, such as a doctor's office.	$0

Covered Service		What you pay
	Skilled nursing facility (SNF) care For a definition of skilled nursing facility care, go to **Chapter 12.** No prior hospital stay is required. We pay for the following services, and maybe other services not listed here: • a semi-private room, or a private room if it is medically necessary • meals, including special diets • skilled nursing services • physical therapy, occupational therapy, and speech therapy • drugs you get as part of your plan of care, including substances that are naturally in the body, such as blood-clotting factors • blood, including storage and administration Coverage begins with the first pint of blood that you need. • medical and surgical supplies given by SNFs • lab tests given by SNFs • X-rays and other radiology services given by nursing facilities • appliances, such as wheelchairs, usually given by nursing facilities • physician/provider services You usually get SNF care from network facilities. Under certain conditions you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our plan's amounts for payment:	$0

	Covered Service	What you pay
	• a nursing facility or continuing care retirement community where you lived before you went to the hospital (as long as it provides nursing facility care) • a nursing facility where your spouse or domestic partner lives at the time you leave the hospital *Prior authorization may apply.*	
	Stipend for maintenance costs of a service animal The plan will pay up to $20 per month for maintenance costs of a service animal if: • you're receiving personal care services, and • you're certified as disabled due to a specific condition defined by the Americans with Disabilities Act, such as arthritis, blindness, cerebral palsy, polio, multiple sclerosis, deafness, stroke or spinal cord injury, and • the service animal is trained to meet your specific needs relative to your disability. • your service plan must document that the service animal will be used primarily to meet your personal care needs.	$0

Covered Service		What you pay
	**Smoking and tobacco use cessation** If you use tobacco, don't have signs or symptoms of tobacco-related disease, and want or need to quit: • We pay for two quit attempts in a 12-month period as a preventive service. This service is free for you. Each quit attempt includes up to four face-to-face counseling visits. If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: • We pay for two counseling quit attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits.	$0

	Covered Service	What you pay
	Supervised exercise therapy (SET) We pay for SET for members with symptomatic peripheral artery disease (PAD). Our plan pays for: • up to 36 sessions during a 12-week period if all SET requirements are met • an additional 36 sessions over time if deemed medically necessary by a health care provider The SET program must be: • 30 to 60-minute sessions of a therapeutic exercise-training program for PAD in members with leg cramping due to poor blood flow (claudication) • in a hospital outpatient setting or in a physician's office • delivered by qualified personnel who make sure benefit exceeds harm and who are trained in exercise therapy for PAD • under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist trained in both basic and advanced life support techniques	$0
	Targeted Case Management (TCM) Services The plan will pay for TCM services for members who have a chronic or complex physical or behavioral health care needs and was a recent inmate or was involuntarily residing in a prison or county jail. TCM services assist members in gaining access to appropriate medical, educational, social, and/or other services. TCM services include assessments, planning, linkage, advocacy, care coordination, referral, monitoring, and follow- up activities (e.g., education and supports).	$0

Covered Service		What you pay
☆	**Telemonitoring services** We developed telemonitoring services to complement our disease management program and to target those chronic conditions prevalent in our most vulnerable population. Priority Health's telemonitoring services are available to members diagnosed with heart failure, uncontrolled diabetes, chronic obstructive pulmonary dysfunction (COPD), cardiovascular conditions, and hypertension. We provide members with specially adapted equipment, telecommunications, and technology to monitor health conditions across a distance.	$0
☆	**Urgently needed care** Urgently needed care is care given to treat: • a non-emergency that requires immediate medical care, **or** • an unforeseeen illness, **or** • an injury, **or** • a condition that needs care right away. If you require urgently needed care, you should first try to get it from a network provider. However, you can use out-of-network providers when you can't get to a network provider beause given your time, place, or circumstances, it's not possible, or it's unreasonable to get this service from network providers (for example, when you're outside the plan's service area and you require medically needed immediate services for an unseen condition but it's not a medical emergency). You have coverage for urgently needed services in the United States and worldwide.	$0

Covered Service	What you pay
Vision care Routine eye examinations are covered once per year, including dilation and refraction as necessary with an EyeMed Provider. The plan will provide an annual allowance to use towards eyewear, in addition the plan will pay for an initial pair of eye glasses. Replacement glasses are offered once every year. The plan will pay for contact lenses for people with certain conditions. The plan will pay for basic and essential low vision aids (such as telescopes, microscopes, and certain other low vision aids). We pay for outpatient doctor services for the diagnosis and treatment of diseases and injuries of the eye. For example, treatment for age-related macular degeneration. For people at high risk of glaucoma, we pay for 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 50 and over • Hispanic Americans who are 65 and over For people with diabetes, we pay for screening for diabetic retinopathy once per year. We pay for one pair of glasses or contact lenses after each cataract surgery when the doctor inserts an intraocular lens. If you have two separate cataract surgeries, you must get one pair of glasses after each surgery. You can't get two pairs of glasses after the second surgery, even if you didn't get a pair of glasses after the first surgery.	$0 for each Medicare/ Medicaid covered exam to diagnose and treat diseases or conditions of the eye. $0 for annual glaucoma screenings $0 for annual diabetic retinopathy screening $0 for Medicare/ Medicaid covered eyewear after cataract surgery **Covered services with an EyeMed provider** $0 for one routine exam per year,including dilation and refraction as necessary $200 allowance for non-Medicare/Medicaid covered eyewear 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 "Michigan Medicaid" network to search for a provider

Covered Service		What you pay
	"Welcome to Medicare" preventive visit We cover the one-time "Welcome to Medicare" preventive visit. The visit includes: • a review of your health, • education and counseling about preventive services you need (including screenings and shots), **and** • referrals for other care if you need it. **Note:** We cover the "Welcome to Medicare" preventive visit only during the first 12 months that you have Medicare Part B. When you make your appointment, tell your doctor's office you want to schedule your "Welcome to Medicare" preventive visit.	$0

Home and Community-Based Services (HCBS) Waiver that our plan pays for		What you pay
	Adult day program The plan covers structured day activities at a program of direct care and supervision if you qualify. This service: • provides personal attention, and promotes social, physical and emotional well-being	$0

Home and Community-Based Services (HCBS) Waiver that our plan pays for		What you pay
	Assistive technology The plan covers technology items used to increase, maintain, or improve functioning and promote independence if you qualify. Some examples of services include: • van lifts • hand controls • computerized voice system • communication boards • voice activated door locks • power door mechanisms • specialized alarm or intercom • assistive dialing device	$0
	Chore services The plan covers services needed to maintain your home in a clean, sanitary, and safe environment if you qualify. Examples of services include: • heavy household chores (washing floors, windows, and walls) • tacking loose rugs and tiles • moving heavy items of furniture • mowing, raking, and cleaning hazardous debris such as fallen branches and trees The plan may cover materials and disposable supplies used to complete chore tasks.	$0

Home and Community-Based Services (HCBS) Waiver that our plan pays for		What you pay
	Environmental modifications The plan covers modifications to your home if you qualify. The modifications must be designed to ensure your health, safety and welfare or make you more independent in your home. Modifications may include: • installing ramps and grab bars • widening of doorways • modifying bathroom facilities • installing specialized electric systems that are necessary to accommodate medical equipment and supplies	$0
	Expanded community living supports To get this service, you must have a need for prompting, cueing, observing, guiding, teaching, and/or reminding to help you complete activities of daily living (ADLs) like eating, bathing, dressing, toileting, other personal hygiene, etc. If you have a need for this service, you can also get assistance with instrumental activities of daily living (IADLs) like laundry, meal preparation, transportation, help with finances, help with medication, shopping, go with you to medical appointments, other household tasks. This may also include prompting, cueing, guiding, teaching, observing, reminding, and/or other support to complete IADLs yourself.	$0

Home and Community-Based Services (HCBS) Waiver that our plan pays for		What you pay
	Fiscal intermediary services The plan will pay for a fiscal intermediary (FI) to assist you to live independently in the community while you control your individual budget and choose the staff to work with you. The FI helps you to manage and distribute funds contained in the individual budget. You use these funds to purchase home and community-based services authorized in your plan of care. You have the authority to hire the caregiver of your choice.	$0
	Home delivered meals The plan covers up to two prepared meals per day brought to your home if you qualify.	$0
	Individual Directed Goods and Services Includes services, equipment or supplies that address a need in the individual plan of services. The item or service would: • Decrease the need for other Medicaid services • Promote inclusion in the community • Increase safety in the home environment	$0
	Non-medical transportation The plan covers transportation services to enable you to access waiver and other community services, activities, and resources, if you qualify.	$0

Home and Community-Based Services (HCBS) Waiver that our plan pays for		What you pay
	Preventive nursing services The plan covers nursing services provided by a registered nurse (RN) or licensed practical nurse (LPN). You must require observation and evaluation of skin integrity, blood sugar levels, prescribed range of motion exercises, or physical status to qualify. You may get other nursing services during the nurse visit to your home. These services aren't provided on a continuous basis.	$0
	Private Duty Nursing (PDN) The plan covers skilled nursing services on an individual and continuous basis, up to a maximum of 16 hours per day, to meet your health needs directly related to a physical disability. PDN includes the provision of nursing assessment, treatment and observation provided by licensed nurse, consistent with physician's orders and in accordance with your plan of care. You must meet certain medical criteria to qualify for this service.	$0

Home and Community-Based Services (HCBS) Waiver that our plan pays for		What you pay
	Respite Care Services You may get respite care services on a short-term, intermittent basis to relieve your family or other primary caregiver(s) from daily stress and care demands during times when they're providing unpaid care. Relief needs of hourly or shift staff workers should be accommodated by staffing substitutions, plan adjustments, or location changes and not by respite care. Respite isn't intended to be provided on a continuous, long-term basis where it's a part of daily services that would enable an unpaid caregiver to work elsewhere full time.	$0
	Vehicle Modifications The plan covers modifications to your primary vehicle to accommodate your needs.	$0

E. Benefits covered outside of our plan

We don't cover the following services, but they're available through Medicare or Michigan Medicaid.

E1. Hospice Care

You have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal illness and are expected to have six months or less to live. You can get care from any hospice program certified by Medicare. The plan must help you find Medicare-certified hospice programs. Your hospice doctor can be a network provider or an out-of-network provider.

Refer to the Benefits Chart in Section D of this chapter for more information about what **Priority**Medicare Dual Premier pays for while you are getting hospice care services.

For hospice services and services covered by Medicare Part A or B that relate to your terminal prognosis:

- The hospice provider will bill Medicare for your services. Medicare will pay for hospice services related to your terminal prognosis. You pay nothing for these services.

For services covered by Medicare Part A or B that are not related to your terminal prognosis:

- The provider will bill Medicare for your services. Medicare will pay for the services covered by Medicare Part A or B. You pay nothing for these services.

For drugs that may be covered by PriorityMedicare Dual Premier's Medicare Part D benefit:

- Drugs are never covered by both hospice and our plan at the same time. For more information, please refer to Chapter 5. You pay nothing for these drugs.

For services covered by Michigan Medicaid:

- The provider will bill **Priority**Medicare Dual Premier for your services. UPHP MI Health Link will pay for the services covered by Michigan Medicaid. You pay nothing for these services.

E2. Services covered by the plan or Prepaid Inpatient Health Plan (PIHP)

The following services are covered by **Priority**Medicare Dual Premier but are also available through the Prepaid Inpatient Health Plan (PIHP) and its provider network.

Inpatient behavioral health care

- The plan will pay for behavioral health care services that require a hospital stay.

Outpatient substance use disorder services

- We'll pay for treatment services that are provided in the outpatient department of a hospital if you, for example, have been discharged from an inpatient stay for the treatment of drug substance abuse or if you require treatment but don't require the level of services provided in the inpatient hospital setting. Refer to coverage for Opioid treatment program (OTP) services in The Benefits Chart in **Section D**.

Partial hospitalization services

- Partial hospitalization is a structured program of active psychiatric treatment. It's offered as hospital outpatient service or by a community

mental health center. It's more intense than the care you get in your doctor's or therapist's office. It can help keep you from having to stay in the hospital.

If you're receiving services through the PIHP, please refer to the separate PIHP *Member Handbook* for more information and work with your Care manager to get services provided through the PIHP.

F.Benefits not covered by our plan, Medicare, or Michigan Medicaid

This section tells you about benefits excluded by our plan. "Excluded" means that we don't pay for these benefits. Medicare and Medicaid don't pay for them either.

The list below describes some services and items not covered by us under any conditions and some excluded by us only in some cases.

We don't pay for excluded medical benefits listed in this section (or anywhere else in this *Member Handbook*) except under specific conditions listed. Even if you get the services at an emergency facility, the plan won't pay for the services. If you think that our plan should pay for a service that isn't covered, you can request an appeal. For information about appeals, refer to **Chapter 9** of this *Member Handbook*.

In addition to any exclusions or limitations described in the Benefits Chart, our plan doesn't cover the following items and services:

- services considered not "reasonable and medically necessary", according Medicare and Michigan Medicaid standards, unless we list these as covered services
- experimental medical and surgical treatments, items, and drugs, unless Medicare, a Medicare-approved clinical research study, or our plan covers them. Refer to **Chapter 3** of this *Member Handbook* for more information on clinical research studies. Experimental treatment and items are those that aren't generally accepted by the medical community.
- surgical treatment for morbid obesity, except when medically necessary and Medicare pays for it
- a private room in a hospital, except when medically necessary
- private duty nurses

- personal items in your room at a hospital or a nursing facility, such as a telephone or television
- full-time nursing care in your home
- fees charged by your immediate relatives or members of your household
- elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary
- cosmetic surgery or other cosmetic work, unless it's needed because of an accidental injury or to improve a part of the body that isn't shaped right. However, we pay for reconstruction of a breast after a mastectomy and for treating the other breast to match it
    - orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease.
    - May be covered under your PriorityFlex 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.
- supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease
- radial keratotomy, LASIK surgery, and other low-vision aids
- reversal of sterilization procedures and non-prescription contraceptive supplies
- naturopath services (the use of natural or alternative treatments)
- services provided to veterans in Veterans Affairs (VA) facilities

Chapter 5: Getting your outpatient drug plan

Introduction

This chapter explains rules for getting your outpatient drugs. These are drugs that your provider orders for you that you get from a pharmacy or by mail-order. They include drugs covered under Medicare Part D and Michigan Medicaid. **Chapter 6** of this *Member Handbook* tells you what you pay for these drugs. Key terms and their definitions appear in alphabetical order in the last chapter of this *Member Handbook*.

We also cover the following drugs, although they're not discussed in this chapter:

- **Drugs covered by Medicare Part A.** These generally include drugs given to you while you're in a hospital or nursing facility.
- **Drugs covered by Medicare Part B.** These include some chemotherapy drugs, some drug injections given to you during an office visit with a doctor or other provider, and drugs you're given at a dialysis clinic. To learn more about what Medicare Part B drugs are covered, refer to the Benefits Chart in **Chapter 4** of this *Member Handbook*.
- In addition to the plan's Medicare Part D and medical benefits coverage, your drugs may be covered by Original Medicare if you're in Medicare hospice. For more information, please refer to **Chapter 5**, **Section D** "If you're in a Medicare-certified hospice program."

Rules for our plan's outpatient drug coverage

We usually cover your drugs as long as you follow the rules in this section.

You must have a provider (doctor, dentist, or other prescriber) write your prescription, which must be valid under applicable state law. This person often is your primary care provider (PCP). It could also be another provider if your PCP has referred you for care.

Your prescriber must **not** be on Medicare's Exclusion or Preclusion Lists. For drugs covered by Medicaid, your prescriber must be approved by the Michigan Department of Health and Human Services (MDHHS).

You generally must use a network pharmacy to fill your prescription (Refer to **Section A1** for more information). Or you can fill your prescription through the plan's mail-order service.

Your prescribed drug must be on our plan's *List of Covered Drugs*. We call it the "*Drug List*" for short. (Refer to **Section B** of this chapter.)

- If it isn't on the *Drug List*, we may be able to cover it by giving you an exception.
- Refer to **Chapter 9**, Section G2 to learn about asking for an exception.

Your drug must be used for a medically accepted indication. This means that use of the drug is either approved by the Food and Drug Administration (FDA) or supported by certain medical references. Your prescriber may be able to help identify medical references to support the requested use of the prescribed drug.

Your drug may require approval from our plan based on certain criteria before we'll cover it. (Refer to **Section C** in this chapter.)

Table of Contents

A. Getting your prescriptions filled

A1. Filling your prescription at a network pharmacy

In most cases, we pay for prescriptions only when filled at any of our network pharmacies. A network pharmacy is a drug store that agrees to fill prescriptions for our plan members. You may use any of our network pharmacies. (Refer to **Section A8** for information about when we cover prescriptions filled at out-of-network pharmacies.)

To find a network pharmacy, refer to the *Provider and Pharmacy Directory*, visit our website or contact Customer Care or your care manager.

A2. Using your Member ID Card when you fill a prescription

To fill your prescription, **show your Member ID Card** at your network pharmacy. The network pharmacy bills us for our share of the cost of your covered drug. You may need to pay the pharmacy a copay when you pick up your prescription.

If you don't have your Member ID Card with you when you fill your prescription, ask the pharmacy to call us to get the necessary information, or you can ask the pharmacy to look up your plan enrollment information.

If the pharmacy can't get the necessary information, you may have to pay the full cost of the prescription when you pick it up. Then you can ask us to pay you back for our share. **If you can't pay for the drug, contact Customer Care right away.** We'll do everything we can to help.

- To ask us to pay you back, refer to **Chapter 7** of this *Member Handbook*.
- If you need help getting a prescription filled, contact your care manager or Customer Care.

A3. What to do if you change your network pharmacy

If you change pharmacies and need a prescription refill, you can either ask to have a new prescription written by a provider *or* ask your pharmacy to transfer the prescription to the new pharmacy if there are any refills left.

If you need help changing your network pharmacy, contact Customer Care or your care manager.

A4. What to do if your pharmacy leaves the network

If the pharmacy you use leaves our plan's network, you need to find a new network pharmacy.

To find a new network pharmacy, refer to the *Provider and Pharmacy Directory*, visit our website, or contact Customer Care or your care manager.

A5. Using a specialized pharmacy

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

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care facility, such as a nursing facility.
    - Usually, long-term care facilities have their own pharmacies. If you're a resident of a long-term care facility, we make sure you can get the drugs you need at the facility's pharmacy.
    - If your long-term care facility's pharmacy isn't in our network or you have difficulty getting your drugs in a long-term care facility, contact Customer Care.
- Pharmacies that serve the Indian Health Service/Tribal/Urban Indian Health Program. Except in emergencies, only Native Americans or Alaska Natives may use these pharmacies.
- Pharmacies that dispense drugs 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 find a specialized pharmacy, refer to the *Provider and Pharmacy Directory*, visit our website, or contact Customer Care or your care manager.

A6. Using mail-order services to get your drugs

For certain kinds of drugs, you can use our plan's network mail-order services. Generally, drugs available through mail-order are drugs that you take on a regular basis for a chronic or long-term medical condition. Drugs **not** available through our plan's mail-order service are marked with "NE" in our *Drug List*.

Our plan's mail-order service allows you to order at least a 35-day supply of the drug and up to a three-month supply, except for drugs on Tier 5, which are limited to a 30-day supply at all of our network pharmacies. A three- month supply has the same copay as a one-month supply.

Filling prescriptions by mail

To get information about filling your prescriptions by mail, visit our website at *priorityhealth.com/dualpremier26*.

Usually, a mail-order prescription arrives within 14 days. If your order does not arrive before you run out of medication, please call Customer Care to get permission to fill a 30-day supply of your prescription from a local network retail pharmacy.

Mail-order processes

Mail-order service has different procedures for new prescriptions it gets from you, new prescriptions it gets directly from your provider's office, and refills on your mail-order prescriptions.

1. New prescriptions the pharmacy gets from you

The pharmacy automatically fills and delivers new prescriptions it gets from you.

2. New prescriptions the pharmacy gets from your provider's office

The pharmacy automatically fills and delivers new prescriptions it gets from health care providers, without checking with you first, if:

- You used mail-order services with our plan in the past, **or**
- You sign up for automatic delivery of all new prescriptions you get directly from health care providers. You may ask for automatic delivery of all new prescriptions now or at any time by calling Customer Care.
- If you get a prescription automatically by mail that you don't want, and you weren't contacted to find out if you wanted it before it shipped, you may be eligible for a refund.
- If you used mail-order in the past and don't want the pharmacy to automatically fill and ship each new prescription, contact us by calling Customer Care.
- If you never used our mail-order delivery and/or decide to stop automatic fills of new prescriptions, the pharmacy contacts you each time it gets a new prescription from a health care provider to find out if you want the medication filled and shipped immediately.
- This gives you an opportunity to make sure the pharmacy is delivering the correct drug (including strength, amount, and form) and, if necessary,

allows you to cancel or delay the order before you're billed, and it's shipped.

- Respond each time the pharmacy contacts you, to let them know what to do with the new prescription and to prevent any delays in shipping.
- To opt out of automatic deliveries of new prescriptions you get directly from your health care provider's office, contact us by calling Customer Care.

3. 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 start to process your next refill automatically when our records show you should be close to running out of your drug.

- The pharmacy contacts you before shipping each refill to make sure you need more medication, and you can cancel scheduled refills if you have enough medication, or your medication has changed.
- If you choose not to use our auto refill program, contact your pharmacy 14 days before your current prescription will run out to make sure your next order is shipped to you in time.
- To opt out of our program that automatically prepares mail-order refills, contact us by calling Customer Care.
- Let the pharmacy know the best ways to contact you so they can reach you to confirm your order before shipping.
- Our plan can also give you your important plan materials in languages other than English and in formats such as large print, braille, or audio. To get your important plan materials in one of these alternative formats, you can submit a request using any of the following methods:
    - Contact our Customer Care team by calling the numbers at the bottom of this page.
    - Create and log in to your member account at *member.priorityhealth.com* to send us a secure message.

A7. Getting a long-term supply of drugs

You can get a long-term supply of maintenance drugs on our plan's *Drug List*. Maintenance drugs are drugs you take on a regular basis, for a chronic or long-term medical condition.

Some network pharmacies allow you to get a long-term supply of maintenance drugs. A 90-day supply has the same copay as a one-month supply. The *Provider and Pharmacy Directory* tells you which pharmacies can give you a long-term supply of maintenance drugs. You can also call your care manager or Customer Care for more information.

You can use our plan's network mail-order services to get a long-term supply of maintenance drugs. Refer to **Section A6, Using mail-order services to get your drugs,** to learn about mail-order services.

A8. Using a pharmacy not in our plan's network

Generally, we pay for drugs filled at an out-of-network pharmacy only when you aren't able to use a network pharmacy. We have network pharmacies outside of our service area where you can get prescriptions filled as a member of our plan. In these cases, check with your care manager or Customer Care first to find out if there's a network pharmacy nearby.

We pay for prescriptions filled at an out-of-network pharmacy in the following cases:

- 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.).

- 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.

A9. Paying you back for a prescription

If you must use an out-of-network pharmacy, you must generally pay the full cost instead of a copay when you get your prescription. You can ask us to pay you back for our share of the cost.

To learn more about this, refer to **Chapter 7** of this *Member Handbook*.

B. Our plan's *Drug List*

We have a *List of Covered Drugs.* We call it the "*Drug List*" for short.

We select the drugs on the *Drug List* with the help of a team of doctors and pharmacists. The *Drug List* also tells you the rules you need to follow to get your drugs.

We generally cover a drug on our plan's *Drug List* when you follow the rules we explain in this chapter.

B1. Drugs on our *Drug List*

Our *Drug List* includes drugs covered under Medicare Part D and some prescription and over-the-counter (OTC) drugs covered under Michigan Medicaid.

Our *Drug List* includes brand name drugs, generic drugs, and biological products (which may include biosimilars).

A brand name drug is a drug sold under a trademarked name owned by the drug manufacturer. Biological products are drugs that are more complex than typical drugs. On our *Drug List*, when we refer to "drugs" this could mean a drug or a biological product.

Generic drugs have the same active ingredients as brand name drugs. Biological products have alternatives called biosimilars. Generally, generic drugs and biosimilars work just as well as brand name or original biological products and usually cost less. There are generic drug substitutes available for many brand name drugs and biosimilar alternatives for some original biological products. Some biosimilars are interchangeable biosimilars and, depending on state law, may be substituted for the original biological product at the pharmacy without needing a new prescription, just like generic drugs can be substituted for brand name drugs.

Refer to **Chapter 12** for definitions of the types of drugs that may be on the *Drug List.*

Our plan also covers certain OTC drugs and products. Some OTC drugs cost less than prescription drugs and work just as well. For more information, call Customer Care.

B2. How to find a drug on our *Drug List*

To find out if a drug you take is on our *Drug List*, you can:

- Visit our plan's website at *priorityhealth.com/dualpremier26.* The *Drug List* on our website is always the most current one.
- Call your care manager or Customer Care to find out if a drug is on our *Drug List* or to ask for a copy of the list.
- Use our "Real Time Benefit Tool" at *priorityhealth.com/dualpremier26* to search for drugs on the *Drug List* to get an estimate of what you'll pay and if there are alternative drugs on the *Drug List* that could treat the same condition. You can also call your care manager or Customer Care.

B3. Drugs not on our *Drug List*

We don't cover all drugs.

- Some drugs aren't on our *Drug List* because the law doesn't allow us to cover those drugs.
- In other cases, we decided not to include a drug on our *Drug List*.
- In some cases, you may be able to get a drug that isn't on our *Drug List.* For more information refer to **Chapter 9.**

Our plan doesn't pay for the kinds of drugs described in this section. These are called **excluded drugs**. If you get a prescription for an excluded drug, you may need to pay for it yourself. If you think we should pay for an excluded drug because of your case, you can make an appeal. Refer to **Chapter 9** of this *Member Handbook* for more information about appeals.

Here are three general rules for excluded drugs:

1. Our plan's outpatient drug coverage (which includes Medicare Part D and Michigan Medicaid drugs) can't pay for a drug that Medicare Part A or Medicare Part B already covers. Our plan covers drugs covered under Medicare Part A or Medicare Part B for free, but these drugs aren't considered part of your outpatient drug benefits.
2. Our plan can't cover a drug purchased outside the United States and its territories.
3. Use of the drug must be approved by the FDA or supported by certain medical references as a treatment for your condition. Your doctor or other

provider may prescribe a certain drug to treat your condition, even though it wasn't approved to treat the condition. This is called "off-label use." Our plan usually doesn't cover drugs prescribed for off-label use.

Also, by law, Medicare or Michigan Medicaid can't cover the types of drugs listed below.

- 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 select vitamins used for prenatal care, End Stage Renal Disease (ESRD), and fluoride preparations
- Drugs used for the treatment of sexual or erectile dysfunction
- Drugs used for the treatment of anorexia or weight gain
- Outpatient drugs made by a company that says you must have tests or services done only by them

B4. *Drug List* cost-sharing tiers

Every drug on our *Drug List* is in one of five tiers. A tier is a group of drugs of generally the same type (for example, brand name, generic, or OTC drugs). In general, the higher the cost-sharing tier, the higher your cost for the drug.

- **MC – Medicaid-covered.** This is the lowest tier and includes drugs and OTCs covered by Michigan Medicaid
- **Tier 1 – Preferred generic drugs.** This tier includes preferred generic drugs.
- **Tier 2 – Generic drugs.** This tier includes generic drugs.
- **Tier 3 – Preferred brand drugs.** This tier includes preferred brand drugs and some generic drugs.
- **Tier 4 – Non-preferred drugs.** This tier includes non-preferred brand drugs and some high-cost generic drugs.
- **Tier 5 – Specialty drugs.** This is the highest tier and includes specialty drugs, which are limited to a 30-day supply per prescription or refill.

To find out which cost-sharing tier your drug is in, look for the drug on our *Drug List*. **Chapter 6** of this *Member Handbook* tells the amount you pay for drugs in each tier.

C. Limits on some drugs

For certain drugs, special rules limit how and when our plan covers them. Generally, our rules encourage you to get a drug that works for your medical condition and is safe and effective. When a safe, lower-cost drug works just as well as a higher-cost drug, we expect your provider to prescribe the lower-cost drug.

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

If there's a special rule for your drug, it usually means that you or your provider must take extra steps for us to cover the drug. For example, your provider may have to tell us your diagnosis or provide results of blood tests first. If you or your provider thinks our rule shouldn't apply to your situation, ask us to use the coverage decision process to make an exception. We may or may not agree to let you use the drug without taking extra steps.

To learn more about asking for exceptions, refer to **Chapter 9** of this *Member Handbook*.

1. **Limiting use of a brand name drug or original biological product when respectively, 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, if there's a generic or interchangeable biosimilar version of a brand name drug or original biological product available, our network pharmacies give you respectively, the generic or interchangeable biosimilar version.

- We usually don't pay for the brand name drug or original biological product when there's an available generic version.
- However, if your provider told us the medical reason that the generic drug or interchangeable biosimilar won't work for you, or other covered drugs that treat the same condition won't work for you, then we may cover the brand name drug.
- Your copay may be greater for the brand name drug or original biological product than for the generic drug or interchangeable biosimilar.

2. **Getting plan approval in advance**

For some drugs, you or your prescriber must get approval from our plan before you fill your prescription. This is called prior authorization. This is put in place to ensure medication safety and help guide appropriate use of certain drugs. If you don't get approval, we may not cover the drug. Call Customer Care at the number at the bottom of the page or on our website at *priorityhealth.com/medicare/drug-requirements* more information about prior authorization.

3. Trying a different drug first

In general, we want you to try lower-cost drugs that are as effective before we cover drugs that cost more. For example, if Drug A and Drug B treat the same medical condition, and Drug A costs less than Drug B, we may require you to try Drug A first.

If Drug A doesn't work for you, then we cover Drug B. This is called step therapy. Call Customer Care at the number at the bottom of the page or on our website at *priorityhealth.com/medicare/drug-requirements* for more information about step therapy.

4. Quantity limits

For some drugs, we limit the amount of the drug you can have. This is called a quantity limit. For example, if it's normally considered safe to take only one pill per day for a certain drug, we might limit how much of a drug you can get each time you fill your prescription.

To find out if any of the rules above apply to a drug you take or want to take, check our *Drug List*. For the most up-to-date information, call Customer Care or check our website at priorityhealth.com/dual26. If you disagree with our coverage decision based on any of the above reasons you may request an appeal. Please refer to **Chapter 9** of this *Member Handbook.*

D. Reasons your drug might not be covered

We try to make your drug coverage work well for you, but sometimes a drug may not be covered in the way that you like. For example:

- Our plan doesn't cover the drug you want to take. The drug may not be on our *Drug List*. We may cover a generic version of the drug but not the brand name version you want to take. A drug may be new, and we haven't reviewed it for safety and effectiveness yet.

- Our plan covers the drug, but there are special rules or limits on coverage. As explained in the section above, Limits on some drugs, some drugs our plan covers have rules that limit their use. In some cases, you or your prescriber may want to ask us for an exception.
- The drug is covered, but in a cost-sharing tier that makes your cost more expensive than you think it should be.

There are things you can do if we don't cover a drug the way you want us to cover it.

D1. Getting a temporary supply

In some cases, we can give you a temporary supply of a drug when the drug isn't on our *Drug List* or is limited in some way. This gives you time to talk with your provider about getting a different drug or to ask us to cover the drug.

To get a temporary supply of a drug, you must meet the two rules below:

1. The drug you've been taking:
    - is no longer on our *Drug List* **or**
    - was never on our *Drug List* **or**
    - is now limited in some way.
2. You must be in one of these situations:
    - You're new to our plan.
        - We cover a temporary supply of your drug **during the first 90 days of your membership in our plan.**
        - This temporary supply is for up to 30 days.
        - If your prescription is written for fewer days, we allow multiple refills to provide up to a maximum of 30 days of medication. You must fill the prescription at a network pharmacy.
        - Long-term care pharmacies may provide your drug in small amounts at a time to prevent waste.
    - You've been in our plan for more than 90 days, live in a long-term care facility, and need a supply right away.

- We cover one 31-day supply, or less if your prescription is written for fewer days. This is in addition to the temporary supply above.
- We provide members experiencing a level of care change with a temporary supply of at least 30 days of medication unless the prescription is written for fewer days.

D2. Asking for a temporary supply

To ask for a temporary supply of a drug, call Customer Care.

When you get a temporary supply of a drug, talk with your provider as soon as possible to decide what to do when your supply runs out. Here are your choices:

- Change to another drug.

  Our plan may cover a different drug that works for you. Call Customer Care to ask for a list of drugs we cover that treat the same medical condition. The list can help your provider find a covered drug that may work for you.

OR

- Ask for an exception.

  You and your provider can ask us to make an exception. For example, you can ask us to cover a drug that isn't on our *Drug List* or ask us to cover the drug without limits. If your provider says you have a good medical reason for an exception, they can help you ask for one.

D3. Asking for an exception

If a drug you take will be taken off our *Drug List* or limited in some way next year, we allow you to ask for an exception before next year.

- We tell you about any change in the coverage for your drug for next year. Ask us to make an exception and cover the drug for next year the way you would like.
- We answer your request for an exception within 72 hours after we get your request (or your prescriber's supporting statement).
- If we approve your request, we'll authorize coverage for the drug before the change takes effect.

To learn more about asking for an exception, refer to **Chapter 9** of this *Member Handbook*.

If you need help asking for an exception, contact your Care Manager or Customer Care.

E. Coverage changes for your drugs

Most changes in drug coverage happen on January 1, but we may add or remove drugs on our *Drug List* during the year. We may also change our rules about drugs. For example, we may:

- Decide to require or not require prior approval (PA) for a drug (permission from us before you can get a drug).
- Add or change the amount of a drug you can get (quantity limits).
- Add or change step therapy restrictions on a drug (you must try one drug before we cover another drug).
- Replace an original biological product with an interchangeable biosimilar version of the biological product.

We must follow Medicare requirements before we change our plan's *Drug List.* For more information on these drug rules, refer to **Section C**.

If you take a drug that we covered at the **beginning** of the year, we generally won't remove or change coverage of that drug **during the rest of the year** unless:

- a new, cheaper drug comes on the market that works as well as a drug on our *Drug List* now, **or**
- we learn that a drug isn't safe, **or**
- a drug is removed from the market.

What happens if coverage changes for a drug you're taking?

To get more information on what happens when our *Drug List* changes, you can always:

- Check our current *Drug List* online at priorityhealth.com/dual26 **or**
- Call Customer Care at the number at the bottom of the page to check our current *Drug List*.

Changes we may make to the *Drug List* that affect you during the current plan year

Some changes to the *Drug List* will happen immediately. For example:

- A new generic drug becomes available. Sometimes, a new generic drug or biosimilar comes on the market that works as well as a brand name drug or original biological product on the *Drug List* now. When that happens, we may remove the brand name drug and add the new generic drug, but your cost for the new drug will stay the same or will be lower.

  When we add the new generic drug, we may also decide to keep the brand name drug on the list but change its coverage rules or limits.

  - We may not tell you before we make this change, but we'll send you information about the specific change we made once it happens.
  - You or your provider can ask for an "exception" from these changes. We'll send you a notice with the steps you can take to ask for an exception. Please refer to **Chapter 9** of this handbook for more information on exceptions.

Removing unsafe drugs and other drugs that are taken off the market. Sometimes a drug may be found unsafe or taken off the market for another reason. If this happens, we may immediately take it off our *Drug List*. If you're taking the drug, we'll send you a notice after we make the change. If we make this type of change to any of the drugs you are taking, talk with your prescriber about the options that would work best for you, including changing to a different drug to treat your condition.

We may make other changes that affect the drugs you take. We tell you in advance about these other changes to our *Drug List*. These changes might happen if:

- The FDA provides new guidance or there are new clinical guidelines about a drug.

When these changes happen, we:

- Tell you at least 30 days before we make the change to our Drug List or

- Let you know and give you a 30-day supply of the drug after you ask for a refill.

This gives you time to talk to your doctor or other prescriber. They can help you decide:

- If there's a similar drug on our *Drug List* you can take instead **or**
- If you should ask for an exception from these changes to continue covering the drug or the version of the drug you've been taking. To learn more about asking for exceptions, refer to **Chapter 9** of this *Member Handbook*.

Changes to the *Drug List* that don't affect you during this plan year

We may make changes to drugs you take that aren't described above and don't affect you now. For such changes, if you're taking a drug we covered at the **beginning** of the year, we generally don't remove or change coverage of that drug **during the rest of the year**.

For example, if we remove a drug you're taking, increase what you pay for the drug, or limit its use, then the change doesn't affect your use of the drug or what you pay for the drug for the rest of the year.

If any of these changes happen for a drug you're taking (except for the changes noted in the section above), the change won't affect your use until January 1 of the next year.

We won't tell you about these types of changes directly during the current year. You'll 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 that will impact you during the next plan year.

F. Drug coverage in special cases

F1. In a hospital or a skilled nursing facility for a stay that our plan covers

If you're admitted to a hospital or skilled nursing facility for a stay our plan covers, we generally cover the cost of your drugs during your stay. You won't pay a copay. Once you leave the hospital or skilled nursing facility, we cover your drugs as long as the drugs meet all of our coverage rules.

To learn more about drug coverage and what you pay, refer to **Chapter 6** of this *Member Handbook*.

F2. In a long-term care facility

Usually, a long-term care facility, such as a nursing facility, has its own pharmacy or a pharmacy that supplies drugs for all of their residents. If you live in a long-term care facility, you may get your drugs through the facility's pharmacy if it's part of our network.

Check your *Provider and Pharmacy Directory* to find out if your long-term care facility's pharmacy is part of our network. If it isn't or if you need more information, contact Customer Care.

F3. In a Medicare-certified hospice program

Drugs are never covered by both hospice and our plan at the same time.

- You may be enrolled in a Medicare hospice and require certain drugs (e.g., pain, anti-nausea drugs, laxative, or anti-anxiety drugs) that your hospice doesn't cover because it isn't related to your terminal prognosis and conditions. In that case, our plan must get notification from the prescriber or your hospice provider that the drug is unrelated before we can cover the drug.
- To prevent delays in getting any unrelated drugs that our plan should cover, you can ask your hospice provider or prescriber to make sure we have the notification that the drug is unrelated before you ask a pharmacy to fill your prescription.

If you leave hospice, our plan covers all of your drugs. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, take documentation to the pharmacy to verify that you left hospice.

Refer to earlier parts of this chapter that tell about drugs our plan covers. Refer to **Chapter 4** of this *Member Handbook* for more information about the hospice benefit.

G. Programs on drug safety and managing drugs

G1. Programs to help you use drugs safely

Each time you fill a prescription, we look for possible problems, such as drug errors or drugs that:

- may not be needed because you take another similar drug that does the same thing
- may not be safe for your age or gender

- could harm you if you take them at the same time
- have ingredients that you are or may be allergic to
- may be an error in the amount (dosage)
- have unsafe amounts of opioid pain medications

If we find a possible problem in your use of drugs, we work with your provider to correct the problem.

G2. Programs to help you manage your drugs

Our plan has a program to help members with complex health needs. In such cases, you may be eligible to get services, at no cost to you, through a medication therapy management (MTM) program. This program is voluntary and free. This program helps you and your provider make sure that your medications are working to improve your health. If you qualify for the program, a pharmacist or other health professional will give you a comprehensive review of all of your medications and talk with you about:

- how to get the most benefit from the drugs you take
- any concerns you have, like medication costs and drug reactions
- how best to take your medications
- any questions or problems you have about your prescription and over-the-counter medication

Then, they'll give you:

- A written summary of this discussion. The summary has a medication action plan that recommends what you can do for the best use of your medications.
- A personal medication list that includes all medications you take, how much you take, and when and why you take them.
- Information about safe disposal of prescription medications that are controlled substances.

It's a good idea to talk to your prescriber about your action plan and medication list.

- Take your action plan and medication list to your visit or anytime you talk with your doctors, pharmacists, and other health care providers.

- Take your medication list with you if you go to the hospital or emergency room.

MTM programs are voluntary and free to members who qualify. If we have a program that fits your needs, we enroll you in the program and send you information. If you don't want to be in the program, let us know, and we'll take you out of it.

If you have questions about these programs, contact Customer Care or your care manager.

G3. Drug management program (DMP) to help members safely use 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 prescribers or pharmacies or if you had a recent opioid overdose, we may talk to your prescriber to make sure your use of opioid medications is appropriate and medically necessary. Working with your prescriber, 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 include:

- Requiring you to get all 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 prescriber(s)
- Limiting the amount of opioid or benzodiazepine medications we'll cover for you

If we plan on limiting how you get these medications or how much you can get, we'll send you a letter in advance. The letter will tell you if we'll limit coverage of these drugs for you, or if you'll be required to get the prescriptions for these drugs only from a specific provider or pharmacy.

You'll have a chance to tell us which prescribers or pharmacies you prefer to use and any 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'll send you another letter that confirms the limitations.

If you think we made a mistake, you disagree with our decision or the limitation, you and your prescriber can make an appeal. If you appeal, we'll review your case and give you a new decision. If we continue to deny any part of your appeal related to limitations that apply to your access to medications, we'll automatically send your case to an Independent Review Organization (IRO). (To learn more about appeals and the IRO, refer to **Chapter 9** of this *Member Handbook*.)

The DMP may not apply to you if you:

- have certain medical conditions, such as cancer or sickle cell disease,
- are getting hospice, palliative, or end-of-life care, **or**
- live in a long-term care facility.

Chapter 6: What you pay for your Medicare and Michigan Medicaid drugs

Introduction

This chapter tells what you pay for your outpatient drugs. By "drugs," we mean:

- Medicare Part D drugs, **and**
- Drugs and items covered under Medicaid

Because you're eligible for Michigan Medicaid, you get Extra Help from Medicare to help pay for your Medicare Part D drugs. We sent you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also known as the "Low Income Subsidy Rider" or the LIS Rider"), which tells you about your drug coverage. If you don't have this insert, please call Customer Care and ask for the "LIS Rider."

> **Extra Help** is a Medicare program that helps people with limited incomes and resources reduce Medicare Part D drug costs, such as premiums, deductibles, and copays. Extra Help is also called the "Low-Income Subsidy," or "LIS."

Other key terms and their definitions appear in alphabetical order in the last chapter of this *Member Handbook*.

To learn more about drugs, you can look in these places:

- Our *List of Covered Drugs*.
    - We call this the *Drug List*. It tells you:
        - Which drugs we pay for
        - Which of the five tiers each drug is in
        - If there are any limits on the drugs
    - If you need a copy of our *Drug List*, call Customer Care. You can also find the most current copy of our *Drug List* on our website at priorityhealth.com/dual26.

- **Chapter 5** of this *Member Handbook*.
    - It tells how to get your outpatient drugs through our plan.
    - It includes rules you need to follow. It also tells which types of drugs our plan doesn't cover.
    - When you use the plan's "Real Time Benefit Tool" to look up drug coverage (refer to **Chapter 5, Section B2**), the cost shown is an estimate of the out-of-pocket costs you're expected to pay. You can call your care manager or Customer Care for more information.
- Our *Provider and Pharmacy Directory*.
    - In most cases, you must use a network pharmacy to get your covered drugs. Network pharmacies are pharmacies that agree to work with us.
    - The *Provider and Pharmacy Directory* lists our network pharmacies. Refer to **Chapter 5** of this *Member Handbook* more information about network pharmacies.

Table of Contents

A. The *Explanation of Benefits* (EOB)

Our plan keeps track of your drug costs and the payments you make when you get prescriptions at the pharmacy. We track two types of costs:

- Your **out-of-pocket costs**. This is the amount of money you, or others on your behalf, pay for your prescriptions. This includes what you paid when you get a covered Part D drug, any payments for your drugs made by family or friends, any payments made for your drugs by Extra Help from Medicare, employer or union health plans, Indian Health Service, AIDS drug assistance programs, charities, and most State Pharmaceutical Assistance Programs (SPAPs).
- Your **total drug costs**. This is the total of all payments made for your covered Part D drugs. It includes what our plan paid, and what other programs or organizations paid for your covered Part D drugs.

When you get drugs through our plan, we send you a summary called the *Explanation of Benefits*. We call it the EOB for short. The EOB isn't a bill. The EOB has more information about the drugs you take such as increases in price and other drugs with lower cost sharing that may be available. You can talk to your prescriber about these lower cost options. The EOB includes:

- **Information for the month**. The summary tells what drugs you got for the previous month. It shows the total drug costs, what we paid, and what you and others paid for you.
- **Totals for the year since January 1.** This shows the total drug costs and total payments for your drugs since the year began.
- **Drug price information**. This is the total price of the drug and changes in the drug price since the first fill for each prescription claim of the same quantity.
- **Lower cost alternatives**. When applicable, information about other available drugs with lower cost sharing for each prescription.

We offer coverage of drugs not covered under Medicare.

- Payments made for these drugs don't count towards your total out-of-pocket costs.

- To find out which drugs our plan covers, refer to our *Drug List*. In addition to the drugs covered under Medicare, some prescription and over-the-counter drugs are covered under Michigan Medicaid. These drugs are included in the *Drug List*.

B. How to keep track of your drug costs

To keep track of your drug costs and the payments you make, we use records we get from you and from your pharmacy. Here is how you can help us:

1. **Use your Member ID Card.**

   Show your Member ID Card every time you get a prescription filled. This helps us know what prescriptions you fill and what you pay.

2. **Make sure we have the information we need.**

   Give us copies of receipts for covered drugs that you paid for. You can ask us to pay you back for our share of the cost of the drug.

   - Here are examples of when you should give us copies of your receipts:

   - When you buy a covered drug at a network pharmacy at a special price or use a discount card that isn't part of our plan's benefit
   - When you pay a copay for drugs that you get under a drug maker's patient assistance program
   - When you buy covered drugs at an out-of-network pharmacy
   - When you pay the full price for a covered drug under special circumstances

   For more information about asking us to pay you back for our share of the cost of a drug, refer to **Chapter 7** of this *Member Handbook*.

3. **Send us information about payments others make for you.**

   Payments made by certain other people 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. This can help you qualify for catastrophic coverage. When

you reach the Catastrophic Coverage Stage, our plan pays all of the costs of your Medicare Part D drugs for the rest of the year.

4. **Check the EOBs we send you.**

   When you get an EOB in the mail, make sure it's complete and correct.

   - **Do you recognize the name of each pharmacy?** Check the dates. Did you get drugs that day?
   - **Did you get the drugs listed?** Do they match those listed on your receipts? Do the drugs match what your doctor prescribed?

What if you find mistakes on this summary?

If something is confusing or doesn't seem right on this EOB, please call us at **Priority**Medicare Dual Premier Customer Care. You can also find answers to many questions on our website: priorityhealth.com/dual26.

What about possible fraud?

If this summary shows drugs you're not taking or anything else that seems suspicious to you, please contact us.

- Call us at **Priority**Medicare Dual Premier Customer Care.
- Or call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call these numbers for free.
- In Michigan, you can report fraud by calling toll free at 855-MI-FRAUD (643-7283) Monday - Friday, 8:00 am to 5:00 pm. You can also submit an online complaint at www.michigan.gov/mdhhs/doing-business/providers/providers/billingreimbursement/report-medicaid-fraud-and-abuse and you may find information on our website at www.michigan.gov/mdhhs/inside-mdhhs/office-of-inspector-general/contact-us, or you can write to the inspector general at Office of Inspector General
  PO Box 30062 Lansing, MI 48909.

If you think something is wrong or missing, or if you have any questions, call your care manager or Customer Care. Your EOB may be available electronically by visiting *express-scripts.com.* Keep these EOBs. They're an important record of your drug expenses.

C. Drug Payment Stages for Medicare Part D drugs

There are three payment stages for your Medicare Part D drug coverage under our plan. How much you pay for each prescription depends on which stage you're in when you get a prescription filled or refilled. These are the three stages:

Stage 1: Deductible Stage	**Stage 2: Initial Coverage Stage**	**Stage 3: Catastrophic Coverage Stage**
During this stage, you pay the full cost of drugs until you've reached the yearly deductible. You begin this stage when you fill your first prescription of the year. If you qualify for Extra Help, this stage does not apply to you.	During this stage, we pay part of the costs of your drugs, and you pay your share. Your share is called the copay.	During this stage, we pay all of the costs of your drugs through 12/31/2026. You begin this stage when you've paid a certain amount of out-of-pocket costs.

D. Stage 1: The Deductible Stage

Because most of our members get Extra Help with their prescription drug costs, the Deductible Stage doesn't apply to most members. If you get Extra Help, this payment stage doesn't apply to you.

Look at the separate insert (the LIS Rider) for information about your deductible amount.

If you don't get Extra Help, the Deductible Stage is the first payment stage for your drug coverage. The deductible doesn't apply to covered insulin products and most adult Part D vaccines, including shingles, tetanus, and travel vaccines. You'll pay a yearly deductible of $615 on Tier 3-5 drugs. You must pay the full cost of your Tier 3-5 drugs

until you reach our plan's deductible amount. For all other drugs, you won't have to pay any deductible. The full cost is usually lower than the normal full price of the drug since our plan negotiated lower costs for most drugs at network pharmacies. The full cost cannot exceed the maximum fair price plus dispensing fees for drugs with negotiated prices under the Medicare Drug Price Negotiation Program. Once you pay $615 for your Tier 3 - 5 drugs, you leave the Deductible Stage and move on to the Initial Coverage Stage.

E. Stage 2: The Initial Coverage Stage

During the Initial Coverage Stage, we pay a share of the cost of your covered drugs, and you pay your share. Your share is called the copay. The copay depends on the cost-sharing tier the drug is in and where you get it.

Cost-sharing tiers are groups of drugs with the same copay. Every drug on our plan's *Drug List* is in one of five cost-sharing tiers. In general, the higher the tier number, the higher the copay. To find the cost-sharing tiers for your drugs, refer to our *Drug List*.

- Tier 1, Tier 2 (these are generic drugs covered by Medicare Part D) and Medicaid-Covered (MC) drugs have the lowest copay. The copay is $0.
- Tier 3, Tier 4, and Tier 5 drugs have the highest cost share. These are mostly brand name and specialty drugs. The cost share is from $0 – 25% of the cost of the drug, depending on your income. Tier 5 (specialty) drugs are limited to a 30-day supply per fill.

E1. Your pharmacy choices

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

- A network retail pharmacy **or**
- An out-of-network pharmacy.
- In limited cases, we cover prescriptions filled at out-of-network pharmacies. Refer to **Chapter 5** of this *Member Handbook* to find out when we do that.
- Our plan's mail-order pharmacies.

To learn more about these choices, refer to **Chapter 5** of this *Member Handbook* and to our *Provider and Pharmacy Directory*.

E2. Getting a long-term supply of a drug

For some drugs, you can get a long-term supply (also called an “extended supply”) when you fill your prescription. A long-term supply is up to a three-month supply. It costs you the same as a one-month supply.

For details on where and how to get a long-term supply of a drug, refer to **Chapter 5** of this Member Handbook or our plan’s *Provider and Pharmacy Directory*.

E3. What you pay

During the Initial Coverage Stage, you may pay a copay each time you fill a prescription. If your covered drug costs less than the copay, you pay the lower price.

Contact Customer Care to find out how much your copay is for any covered drug.

Your share of the cost when you get a one-month or long-term supply of a covered drug from:

	A network pharmacy A one-month or up to a 30-day supply	**Our plan’s mail-order service** A -three-month or up to a 90 -day supply	**A network long-term care pharmacy** Up to a 31day supply	**An out-of-network pharmacy** Up to a 30-day supply. Coverage is limited to certain cases. Refer to **Chapter 5** of this *Member Handbook* for details.
Cost-sharing **Medicaid-Covered (MC) Drugs and OTCs**	$0 copay	$0 copay	$0 copay	$0 copay

	A network pharmacy A one-month or up to a 30-day supply	**Our plan's mail-order service** A -three-month or up to a 90 -day supply	**A network long-term care pharmacy** Up to a 31day supply	**An out-of-network pharmacy** Up to a 30-day supply. Coverage is limited to certain cases. Refer to **Chapter 5** of this *Member Handbook* for details.
Cost-sharing Tier 1 (preferred generic drugs)	$0 copay	$0 copay	$0 copay	$0 copay
Cost-sharing Tier 2 (generic drugs)	$0 copay	$0 copay	$0 copay	$0 copay

	A network pharmacy A one-month or up to a 30-day supply	**Our plan's mail-order service** A -three-month or up to a 90 -day supply	**A network long-term care pharmacy** Up to a 31day supply	**An out-of-network pharmacy** Up to a 30-day supply. Coverage is limited to certain cases. Refer to **Chapter 5** of this *Member Handbook* for details.
Cost-sharing Tier 3 (preferred brand drugs)	$0 - $12.65 copay (Cost share can vary based on the level of Extra Help you get.) 25% of the cost of the drug (if you don't get Extra Help)	$0 - $12.65 copay (Cost share can vary based on the level of Extra Help you get.) 25% of the cost of the drug (if you don't get Extra Help)	$0 - $12.65 copay (Cost share can vary based on the level of Extra Help you get.) 25% of the cost of the drug (if you don't get Extra Help)	$0 - $12.65 copay (Cost share can vary based on the level of Extra Help you get.) 25% of the cost of the drug (if you don't get Extra Help)

	A network pharmacy A one-month or up to a 30-day supply	**Our plan's mail-order service** A -three-month or up to a 90 -day supply	**A network long-term care pharmacy** Up to a 31day supply	**An out-of-network pharmacy** Up to a 30-day supply. Coverage is limited to certain cases. Refer to **Chapter 5** of this *Member Handbook* for details.
Cost-sharing Tier 4 (non-preferred drugs)	$0 - $12.65 copay (Cost share can vary based on the level of Extra Help you get.) 25% of the cost of the drug (if you don't get Extra Help)	$0 - $12.65 copay (Cost share can vary based on the level of Extra Help you get.) 25% of the cost of the drug (if you don't get Extra Help)	$0 - $12.65 copay (Cost share can vary based on the level of Extra Help you get.) 25% of the cost of the drug (if you don't get Extra Help)	$0 - $12.65 copay (Cost share can vary based on the level of Extra Help you get.) 25% of the cost of the drug (if you don't get Extra Help)

	A network pharmacy A one-month or up to a 30-day supply	**Our plan's mail-order service** A -three-month or up to a 90 -day supply	**A network long-term care pharmacy** Up to a 31day supply	**An out-of-network pharmacy** Up to a 30-day supply. Coverage is limited to certain cases. Refer to **Chapter 5** of this *Member Handbook* for details.
Cost-sharing Tier 5 (specialty drugs) **Drugs in this tier are limited to a 30-day supply per fill.**	$0 - $12.65 copay (Cost share can vary based on the level of Extra Help you get.) 25% of the cost of the drug (if you don't get Extra Help)	$0 - $12.65 copay (Cost share can vary based on the level of Extra Help you get.) 25% of the cost of the drug (if you don't get Extra Help)	$0 - $12.65 copay (Cost share can vary based on the level of Extra Help you get.) 25% of the cost of the drug (if you don't get Extra Help)	$0 - $12.65 copay (Cost share can vary based on the level of Extra Help you get.) 25% of the cost of the drug (if you don't get Extra Help)

For information about which pharmacies can give you long-term supplies, refer to our *Provider and Pharmacy Directory*.

E4. End of the Initial Coverage Stage

The Initial Coverage Stage ends when your total out-of-pocket costs reach $2,100. At that point, the Catastrophic Coverage Stage begins. We cover all your drug costs from then until the end of the year.

Your EOB helps you keep track of how much you've paid for your drugs during the year. We let you know if you reach the $2,100 limit. Many people don't reach it in a year.

F. Stage 3: The Catastrophic Coverage Stage

When you reach the out-of-pocket limit of $2,100 for your drugs, the Catastrophic Coverage stage begins. You stay in the Catastrophic Coverage stage until the end of the calendar year. During this stage, you pay nothing for your Part D covered drugs.

G. Your drug costs if your doctor prescribes less than a full month's supply

Usually, you pay a copay to cover a full month's supply of a covered drug. However, your doctor can prescribe less than a month's supply of drugs.

- There may be times when you want to ask your doctor about prescribing less than a month's supply of a drug (for example, when you're trying a drug for the first time).
- If your doctor agrees, you don't pay for the full month's supply for certain drugs.

When you get less than a month's supply of a drug, the amount you pay is based on the number of days of the drug that you get. We 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 get.

- Here's an example: Let's say the copay for your drug for a full month's supply (a 30-day supply) is $1.35. This means that the amount you pay for your drug is less than $0.05 per day. If you get a 7 days' supply of the drug, your payment is less than $.05 per day multiplied by 7 days, for a total payment less than $0.35.
- Daily cost-sharing allows you to make sure a drug works for you before you pay for an entire month's supply.
- You can also ask your provider to prescribe less than a full month's supply of a drug to help you:
    - Better plan when to refill your drugs,
    - Coordinate refills with other drugs you take, **and**

- Take fewer trips to the pharmacy.

H. What you pay for Part D vaccines

Important message about what you pay for vaccines: Some vaccines are considered medical benefits and are covered under Medicare Part B. Other vaccines are considered Medicare Part D drugs. You can find these vaccines listed in our *Drug List*. Our plan covers most adult Medicare Part D vaccines at no cost to you. Refer to your plan's *Drug List* or contact Customer Care for coverage and cost sharing details about specific vaccines.

There are two parts to our coverage of Medicare Part D vaccines:

1. The first part is for the cost of the vaccine itself.
2. The second part is for the cost of giving you the vaccine. For example, sometimes you may get the vaccine as a shot given to you by your doctor.

H1. What you need to know before you get a vaccine

We recommend that you call your care manager or Customer Care if you plan to get a vaccine.

- We can tell you about how our plan covers your vaccine and explain your share of the cost.
- We can tell you how to keep your costs down by using network pharmacies and providers. Network pharmacies and providers agree to work with our plan. A network provider works with us to ensure that you have no upfront costs for a Medicare Part D vaccine.

H2. What you pay for a vaccine covered by Medicare Part D

What you pay for a vaccine depends on the type of vaccine (what you're being vaccinated for).

- Some vaccines are considered health benefits rather than drugs. These vaccines are covered at no cost to you. To learn about coverage of these vaccines, refer to the Benefits Chart in **Chapter 4** of this *Member Handbook*.
- Other vaccines are considered Medicare Part D drugs. You can find these vaccines on our plan's *Drug List*. You may have to pay a copay for Medicare Part D vaccines. If the vaccine is recommended for adults

by an organization called the **Advisory Committee on Immunization Practices (ACIP)** then the vaccine will cost you nothing.

Here are three common ways you might get a Medicare Part D vaccine.

1. You get the Medicare Part D vaccine and your shot at a network pharmacy.
    - For most adult Part D vaccines, you'll pay nothing.
    - For other Part D vaccines, you pay a copay for the vaccine.
2. You get the Medicare Part D vaccine at your doctor's office, and your doctor gives you the shot.
    - You pay a copay to the doctor for the vaccine.
    - Our plan pays for the cost of giving you the shot.
    - The doctor's office should call our plan in this situation so we can make sure they know you only have to pay a copay for the vaccine.
3. You get the Medicare Part D vaccine medication at a pharmacy, and you take it to your doctor's office to get the shot.
    - For most adult Part D vaccines, you'll pay nothing for the vaccine itself.
    - For other Part D vaccines, you pay a copay for the vaccine.
    - Our plan pays for the cost of giving you the shot.

Chapter 7: Asking us to pay our share of a bill you got for covered services or drugs

Introduction

This chapter tells you how and when to send us a bill to ask for payment. It also tells you how to make an appeal if you don't agree with a coverage decision. Key terms and their definitions appear in alphabetical order in the last chapter of this *Member Handbook*.

Table of Contents

A. Asking us to pay for your services or drugs

Our network providers must bill the plan for your covered services and drugs after you get them. A network provider is a provider who works with the health plan.

We don't allow **Priority**Medicare Dual Premier providers to bill you for these services or drugs. We pay our providers directly, and we protect you from any charges.

If you get a bill for the full cost of health care or drugs, don't pay the bill and send the bill to us. To send us a bill, refer to Chapter 7, Section B

- If we cover the services or drugs, we'll pay the provider directly.
- If we cover the services or drugs and you already paid more than your share of the cost, it's your right to be paid back.
    - If you paid for services covered by Medicare, we'll pay you back.
    - If you paid for services covered by Michigan Medicaid we can't pay you back, but the provider will. Customer Care or your care manager can help you contact the provider's office. Refer to the bottom of the page for the Customer Care phone number.
- If we don't cover the services or drugs, we'll tell you.

Contact your care manager or Customer Care if you have any questions. If you don't know what you should've paid, or if you get a bill and you don't know what to do about it, we can help. You can also call if you want to tell us information about a request for payment you already sent to us.

Examples of times when you may need to ask us to pay you back or to pay a bill you got include:

1. **When you get emergency or urgently needed health care from an out-of-network provider**

   Ask the provider to bill us.

   - If you pay the full amount when you get the care, ask us to pay you back for our share of the cost. Send us the bill and proof of any payment you made.
   - You may get a bill from the provider asking for payment that you think you don't owe. Send us the bill and proof of any payment you made.

- If the provider should be paid, we'll pay the provider directly.
- If you already paid more than your share of the cost for the Medicare service, we'll figure out how much you owed and pay you back for our share of the cost.

2. When a network provider sends you a bill

Network providers must always bill us. It's important to show your Member ID Card when you get any services or prescriptions. But sometimes they make mistakes and ask you to pay for your services or more than your share of the costs. **Call your Care Manager or Customer Care** at the number at the bottom of this page **if you get any bills.**

- Because we pay the entire cost for your services, you aren't responsible for paying any costs. Providers shouldn't bill you anything for these services.
- Whenever you get a bill from a network provider, send us the bill. We'll contact the provider directly and take care of the problem.
- If you already paid a bill from a network provider for Medicare-covered services, send us the bill and proof of any payment you made. We'll pay you back for your covered services.

3. If you're retroactively enrolled in our plan

Sometimes your enrollment in the plan can be retroactive. (This means that the first day of your enrollment has passed. It may have even been last year.)

- If you were enrolled retroactively and you paid a bill after the enrollment date, you can ask us to pay you back.
- Send us the bill and proof of any payment you made.

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

If you use an out-of-network pharmacy, you pay the full cost of your prescription.

- In only a few cases, we'll cover prescriptions filled at out-of-network pharmacies. Send us a copy of your receipt when you ask us to pay you back for our share of the cost.
- Refer to **Chapter 5** of this *Member Handbook* to learn more about out-of-network pharmacies.

- We may not pay you back the difference between what you paid for the drug at the out-of-network pharmacy and the amount that we'd pay at an in-network pharmacy.

5. When you pay the full Medicare Part D prescription cost because you don't have your Member ID Card with you

If you don't have your Member ID Card with you, you can ask the pharmacy to call us or look up your plan enrollment information.

- If the pharmacy can't get the information right away, you may have to pay the full prescription cost yourself or return to the pharmacy with your Member ID Card.
- Send us a copy of your receipt when you ask us to pay you back for our share of the cost.
- We may not pay you back the full cost you paid if the cash price you paid is higher than our negotiated price for the prescription.

6. When you pay the full Medicare Part D prescription cost for a drug that's not covered

You may pay the full prescription cost because the drug isn't covered.

- The drug may not be on our *List of Covered Drugs* (*Drug List*) on our website, or it may have a requirement or restriction that you don't know about or don't think applies to you. If you decide to get the drug, you may need to pay the full cost.
    - If you don't pay for the drug but think we should cover it, you can ask for a coverage decision (refer to **Chapter 9** of this *Member Handbook*).
    - If you and your doctor or other prescriber think you need the drug right away, (within 24 hours), you can ask for a fast coverage decision (refer to **Chapter 9** of this *Member Handbook*).
- Send us a copy of your receipt when you ask us to pay you back. In some cases, we may need to get more information from your doctor or other prescriber to pay you back for our share of the cost of the drug. We may not pay you back the full cost you paid if the price you paid is higher than our negotiated price for the prescription.

When you send us a request for payment, we review it and decide whether the service or drug should be covered. This is called making a "coverage decision." If we decide the service or drug should be covered, we pay for our share of the cost of it.

If we deny your request for payment, you can appeal our decision. To learn how to make an appeal, refer to **Chapter 9** of this *Member Handbook*.

B. Sending us a request for payment

Send us your bill and proof of any payment you made for Medicare services [*Insert if allowed:* or call us]. Proof of payment can be a copy of the check you wrote or a receipt from the provider. **It's a good idea to make a copy of your bill and receipts for your records.** You can ask your care manager for help. You must send your information to us within one year of the date you received the service, item, or drug. For Medicare Part D Pharmacy claims, you must send your information to us within three years of the date you received the drug.

To make sure you give us all the information we need to decide, you can fill out our claim form to ask for payment.

- You aren't required to use the form, but it helps us process the information faster.
- You can get the form on our website (priorityhealth.com/dual26), or you can call Customer Care and ask for the form.

Mail your request for payment together with any bills or receipts to this address:

For medical claims:

ATTN: Priority Health Claims
Priority Health P.O. Box 232
Grand Rapids, MI 49501

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

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

C. Coverage decisions

When we get your request for payment, we make a coverage decision. This means that we decide if our plan covers your service, item, or drug. We also decide the amount of money, if any, you must pay.

- We'll let you know if we need more information from you.
- If we decide that our plan covers the service, item, or drug and you followed all the rules for getting it, we'll pay our share of the cost for it. If you already paid for the service or drug, we'll mail you a check for our share of the cost. If you paid the full cost of a drug, you might not be reimbursed the full amount you paid (for example, if you got a drug at an out-of-network pharmacy or if the cash price you paid is higher than our negotiated price). If you haven't paid, we'll pay the provider directly.

Chapter 3 of this *Member Handbook* explains the rules for getting your services covered. **Chapter 5** of this *Member Handbook* explains the rules for getting your Medicare Part D drugs covered.

- If we decide not to pay for our share of the cost of the service or drug, we'll send you a letter with the reasons. The letter also explains your rights to make an appeal.
- To learn more about coverage decisions, refer to **Chapter 9, Section E.**

D. Appeals

If you think we made a mistake in turning down your request for payment, you can ask us to change our decision. This is called "making an appeal." You can also make an appeal if you don't agree with the amount we pay.

The formal appeals process has detailed procedures and deadlines. To learn more about appeals, refer to **Chapter 9** of this *Member Handbook*:

- To make an appeal about getting paid back for a health care service, refer to **Chapter 9**, **Section F.**
- To make an appeal about getting paid back for a drug, refer to **Chapter 9, Section G.**

Chapter 8: Your rights and responsibilities

Introduction

This chapter includes your rights and responsibilities as a member of our plan. We must honor your rights. Key terms and their definitions appear in alphabetical order in the last chapter of this *Member Handbook*.

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A. Your right to get services and information in a way that meets your needs

We must ensure **all** services, both clinical and non-clinical, are provided to you in a culturally competent and accessible manner including for those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds. We must also tell you about our plan's benefits and your rights in a way that you can understand. We must tell you about your rights each year that you're in our plan.

- To get information in a way that you can understand, call Customer Care. Our plan has free interpreter services available to answer questions in different languages.
- Our plan can also give you materials in languages other than English, including Spanish, and in formats such as large print, braille, or audio. You can make a standing request to get materials, now and in the future, in a language other than English or in an alternative format by calling Customer Care at 833.939.0983. This information will be documented in your file, and you will receive materials in the format you requested. You can make changes to your request at any time.

If you have trouble getting information from our plan because of language problems or a disability and you want to file a complaint, call:

- Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- **You may file a complaint with Michigan Medicaid by doing the following:**
    - Fill out the Beneficiary Complaint Form (BCF) online at *www.michigan.gov/mdhhs/assistance-programs/healthcare/beneficiary-support/msa-0300-online-form.* Submitting online will send an email with your BCF to the Beneficiary Support Unit.
    - Print and complete the Beneficiary Complaint Form (MSA-0300).
    - Follow the instructions on the form and then mail it to the address shown below:

      Michigan Department of Health and Human Services
      Health and Aging Services Administration
      Customer Services Division

PO Box 30479
Lansing, MI 48909-7979

- If you have questions about the Beneficiary Complaint form or this process, call the **Beneficiary HelpLine** at **1-800-642-3195**.

- **The Michigan Office of Recipient Rights** (ORR) is a state agency that investigates allegations of violations of rights established by the Michigan Mental Health Code.
    - You may file by complaint by contacting the MCCMH-ORR at (586) 469-6528. Our business hours are 8:30 am – 5:00 pm, Monday through Friday. You may also leave a message during non-business hours and staff will contact you during normal business hours.
    - You may also fill out a Recipient Rights Complaint form and either mail, fax or e-mail it.
- Office for Civil Rights at 1-800-368-1019. TTY users should call 1-800-537-7697.

B. Our responsibility for your timely access to covered services and drugs

You have rights as a member of our plan.

- You have the right to choose a primary care provider (PCP) in our network. A network provider is a provider who works with us. You can find more information about what types of providers may act as a PCP and how to choose a PCP in **Chapter 3** of this *Member Handbook*.
    - Call your care manager or Customer Care or go to the *Provider and Pharmacy Directory* to learn more about network providers and which doctors are accepting new patients.
- You have the right to a women's health specialist without getting a referral. A referral is approval from your PCP to use a provider that isn't your PCP.
- You have the right to get covered services from network providers within a reasonable amount of time.
    - This includes the right to get timely services from specialists.
    - If you can't get services within a reasonable amount of time, we must pay for out-of-network care.

- You have the right to get emergency services or care that‘s urgently needed without prior approval (PA).
- You have the right to get your prescriptions filled at any of our network pharmacies without long delays.
- You have the right to know when you can use an out-of-network provider. To learn about out-of-network providers, refer to **Chapter 3** of this *Member Handbook*.

Chapter 9 of this *Member Handbook* tells what you can do if you think you aren’t getting your services or drugs within a reasonable amount of time. It also tells what you can do if we denied coverage for your services or drugs and you don’t agree with our decision.

C. Our responsibility to protect your personal health information (PHI)

We protect your PHI as required by federal and state laws.

Your PHI includes the personal information you gave us when you enrolled in our plan. It also includes your medical records and other medical and health information.

You have rights when it comes to your information and controlling how your PHI is used. We give you a written notice that tells about these rights and explains how we protect the privacy of your PHI. The notice is called the “Notice of Privacy Practice.”

C1. How we protect your PHI

We make sure that no unauthorized people look at or change your records.

Except for the cases noted below, we don’t give your PHI to anyone not providing your care or paying for your care. If we do, we must get written permission from you first. You, or someone legally authorized to make decisions for you, can give written permission.

Sometimes we don’t need to get your written permission first. These exceptions are allowed or required by law:

- We must release PHI to government agencies checking on our plan’s quality of care.
- We must release PHI by court order.
- We must give Medicare your PHI including information about your Medicare Part D drugs. If Medicare releases your PHI for research or

other uses, they do it according to federal laws. Michigan Medicaid may disclose your information without your permission for purposes of treatment, payment, health care operations or when required by law to do so.

C2. Your right to look at your medical records

- You have the right to look at your medical records and to get a copy of your records.
- You have the right to ask us to update or correct your medical records. If you ask us to do this, we work with your health care provider to decide if changes should be made.
- You have the right to know if and how we share your PHI with others for any purposes that aren't routine.

If you have questions or concerns about the privacy of your PHI, call Customer Care.

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 and Priority Health Choice, Inc. (known as "Priority Health") understands the importance of handling protected health information (PHI) with care. We are committed to protecting the privacy of our members' PHI in every setting. State and federal laws require us to make sure your PHI is kept private.

When you enroll with Priority Health or use services provided by a Priority Health plan, your PHI may be released to Priority Health and by Priority Health. Your PHI is shared and used to arrange and oversee your medical care, pay your medical claims and assist in health care operations.

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 legal rights under these laws with respect to the use or sharing of your PHI. Priority Health is required by law to follow the terms of the Notice of Privacy Practices currently

in effect. We are also required to notify those affected following a breach of unsecured PHI.

The use or sharing of your PHI

The sections below describe the ways Priority Health uses or shares your PHI without your written authorization. Your PHI 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 share your PHI to those who are treating you to arrange and oversee your medical care. For example, we may share information about your prescription drugs to your provider to better understand how to give you medical care.

Payment. Priority Health may use your PHI or share it to third parties to collect premiums, establish eligibility or pay for your medical care. For example, we may use your PHI when we receive a claim for payment. Your claim tells us what services you received and may include a diagnosis. We may also share your PHI to another health plan company if you are covered under more than one health plan.

Health care operations. Priority Health may use or share your PHI 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 PHI, along with other Priority Health members' PHI, may be used by Priority Health's staff to review the quality of care given by health care providers. Priority Health may also use or share your PHI for underwriting, enrollment and other activities related to creating, renewing or replacing a health plan. Priority Health may not, however, use or share genetic information to decide whether we will give you coverage and the price of that coverage.

Please note that we do not destroy your PHI when you end your coverage with us. It may be necessary to use or share your PHI for the purposes described above even after your coverage ends. Privacy policies and procedures will remain in place to protect against incorrect use or sharing of your PHI.

To you and your personal representative. We may share your PHI to you or your personal representative, who is someone that has the legal right to act on your behalf.

To others involved in your care. We may, in certain cases, share your PHI to a member of your family, a relative, a close friend or any other person you identify if they

are involved 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, we will share your PHI if we believe it is in your best interest. For example, we may share your PHI when you are unconscious. We may also share your PHI when needed to reduce a serious threat to health or safety.

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

Other use or sharing of your PHI without your written authorization

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

- When required by law.
    - For law enforcement purposes.
    - When necessary for judicial or administrative proceedings, such as court proceedings.
    - For compliance with workers' compensation requirements, as authorized by applicable law.
    - For various government functions, such as 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, such as 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 (FDA) oversight.
    - For research purposes, as long as applicable research privacy standards are met.
    - To make a collection of de-identified information, which is PHI that cannot be traced back to you
- From time to time, we engage with third parties, called business associates, to provide various services for us. Whenever a third party involves the use or sharing 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 PHI with business associates who process claims or conduct disease management programs on our behalf.

The use or sharing of your PHI with group health plan sponsors

This section of the Notice of Privacy Practices applies only to group health plans.

Priority Health may share your PHI with the sponsor of your group health plan, usually your employer, about whether you are enrolled or disenrolled in the group health plan. Priority Health may also share summary health information with the sponsor, which is a summary of the amount, type and history of claims paid under the sponsor's group health plan with most identifying information, such as your name, age and address, except for zip code, removed. The sponsor may use this information to obtain premium bids for health plan coverage or to decide whether to modify, amend or end the plan. If the sponsor of your group health plan takes appropriate steps to comply with federal privacy regulations, Priority Health may also share your PHI with the sponsor for the sponsor's administration of the group health plan.

Other use or sharing of your PHI by written authorization only

Priority Health may not use or share your PHI without your written authorization, except as described in this Notice. You may give us written authorization to use your PHI or to share it with anyone for any purpose. If you give us written authorization, you may take back (revoke) the written authorization at any time by notifying Priority Health's Compliance department in writing. If you revoke your written authorization, we will no longer use or share your PHI for the reasons covered by your written authorization, but it will not affect any use or sharing of your PHI permitted by the written authorization while it was in effect. We also must obtain your written authorization to sell your PHI to a third party or, in most cases, to use or share 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 and 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 share it for marketing purposes without your written authorization.

We must receive your written authorization to share 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 or revoke written authorization to use or share your PHI if you are not able to. Court documents may be required to verify this authority.

Potential impact of other applicable laws

The 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.

Our policies and procedures

We have policies and procedures in place that protect the privacy of your PHI.

- Every employee receives training when they are hired and on an annual basis.
- Every employee must acknowledge that they understand they are required to keep member's PHI private. They also learn about the actions the company will take if the privacy policies are not followed.
- Priority Health has strict control of access to electronic and paper information specific to members. Only those users authorized with a password have access to electronic information. Paper information is stored in secure locations. Access is only given to those who need it to manage care for members or for administrative purposes.

Your legal rights regarding your PHI

You have the following legal rights:

Legal right to inspect and copy. You have the legal right to look at and get a copy of your PHI that may be used to make decisions about your care and payment for your care as long as we maintain them. There are limited cases in which we may deny your request to inspect and copy these records. If you are denied access to your PHI, you may request that the denial be reviewed. If you request a copy of your PHI, we may charge a fee for the cost of copying, mailing and other costs regarding your request.

To inspect and copy your PHI, contact Priority Health's Compliance department.

Legal right to correct your health and claims record. You have the legal right to request that Priority Health amend any of your PHI 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 PHI, you must write to Priority Health's Compliance department and include a reason to support the change.

Legal right to know an accounting of disclosures. You have the legal right to request an accounting of disclosures, which is a list of times we shared your PHI for 6 years prior to the date of your request. The accounting of disclosures will not include times when PHI was shared:

- To carry out treatment, payment or health care operations.
- To you or your personal representative.
- To anyone you have given written 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, which is a collection of your PHI that does not directly identify you.

Your request should indicate in what way you want the list, such as 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 we charge you any fees.

Legal right to request restrictions. You have the legal right to request a limit on your PHI that we use or share. 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 your PHI 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 PHI you want to limit.
- Whether you want to limit our use, sharing or both.
- To whom you want the limits to apply.

Priority Health will notify you, either in writing or by phone, when we receive your request and of any restrictions to which we agree.

Legal right to request confidential communications. You may request that Priority Health communicate with you through other ways or a different location. For example, you might want us to send your PHI, such as 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 other ways or a different location could endanger you. Priority Health will accommodate your request if it is reasonable, specifies the other ways or different 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.

Legal right to a paper copy of this Notice. You have the legal right to a paper copy of Priority Health's current Notice of Privacy Practices 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 broken, you may file a complaint with Priority Health and/or the Office for Civil Rights (OCR) at the U.S. Department of Health and Human Services (HHS). 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

Priority Health has the following 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 PHI.
- 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 PHI 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 changes to our Notice of Privacy Practices 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 PHI may be used and shared and how to get access to this information, please contact Priority Health's Privacy department.

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

Priority Health Compliance department:

Priority Health Compliance department

1231 East Beltline NE

Grand Rapids, MI 49525

616.942.0954

800.942.0954

Priority Health Privacy department:

Priority Health

Chief Privacy Officer

100 Michigan Street NE

Grand Rapids, MI 49503

616.486.4113

This Notice is effective: September 1, 2019

D. Our responsibility to give you information

As a member of our plan, you have the right to get information from us about our plan, our network providers, and your covered services.

If you don't speak English, we have interpreter services to answer questions you have about our plan. To get an interpreter, call Customer Care. This is a free service to you. We can also give you materials in languages other than English including Spanish. We can also give you information in large print, braille, or audio.

If you want information about any of the following, call Customer Care:

- How to choose or change plans
- Our plan, including:
    - financial information
    - how plan members have rated us
    - the number of appeals made by members
    - how to leave our plan
- Our network providers and our network pharmacies, including:
    - how to choose or change primary care providers
    - qualifications of our network providers and pharmacies
    - how we pay providers in our network
- Covered services and drugs, including:
    - services (refer to **Chapters 3 and 4** of this *Member Handbook*) and drugs (refer to **Chapters 5 and 6** of this *Member Handbook*) covered by our plan
    - limits to your coverage and drugs
    - rules you must follow to get covered services and drugs

- Why something isn't covered and what you can do about it (refer to **Chapter 9** of this *Member Handbook*), including asking us to:
    - put in writing why something isn't covered
    - change a decision we made
    - pay for a bill you got

E. Inability of network providers to bill you directly

Doctors, hospitals, and other providers in our network can't make you pay for covered services. They also can't balance bill or charge you if we pay less than the amount the provider charged. To learn what to do if a network provider tries to charge you for covered services, refer to **Chapter 7** of this *Member Handbook*.

F. Your right to leave our plan

No one can make you stay in our plan if you don't want to.

- You have the right to get most of your health care services through Original Medicare or another Medicare Advantage (MA) plan.
- You can get your Medicare Part D drug benefits from a drug plan or from another MA plan.
- Refer to **Chapter 10** of this *Member Handbook:*
    - For more information about when you can join a new MA or drug benefit plan.
    - For information about how you'll get your Michigan Medicaid benefits if you leave our plan.

G. Your right to make decisions about your health care

You have the right to full information from your doctors and other health care providers to help you make decisions about your health care.

G1. Your right to know your treatment choices and make decisions

Your providers must explain your condition and your treatment choices in a way that you can understand. You have the right to:

- **Know your choices.** You have the right to be told about all treatment options regardless of cost or benefit coverage.
- **Know the risks.** You have the right to be told about any risks involved. We must tell you in advance if any service or treatment is part of a research experiment. You have the right to refuse experimental treatments.
- **Get a second opinion.** You have the right to use another doctor before deciding on treatment.
- **Say no.** You have the right to refuse any treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to. You have the right to stop taking a prescribed drug. If you refuse treatment or stop taking a prescribed drug, we won't drop you from our plan. However, if you refuse treatment or stop taking a drug, you accept full responsibility for what happens to you.
- **Ask us to explain why a provider denied care.** You have the right to get an explanation from us if a provider denied care that you think you should get.
- **Ask us to cover a service or drug that we denied or usually don't cover.** This is called a coverage decision. **Chapter 9** of this *Member Handbook* tells how to ask us for a coverage decision.

G2. Your right to say what you want to happen if you can't make health care decisions for yourself

In Michigan, you can create a legal document called a **Durable Power of Attorney for Health Care (DPOA-HC)**. This document allows you to name a **patient advocate** who can make medical decisions for you if you become incapacitated and can't make your own decisions. The DPOA-HC may include an "Advance Directive" as described below. Sometimes people are unable to make health care decisions for themselves. Before that happens to you, you can:

- Fill out a written form **giving someone the right to make health care decisions for you** if you ever become unable to make decisions for yourself.
- **Give your doctors written instructions** about how to handle your health care if you become unable to make decisions for yourself, including care you **don't** want.

The legal document you use to give your directions is called an "advance directive." There are different types of advance directives and different names for them. Examples are a living will and a power of attorney for health care.

You aren't required to have an advance directive, but you can. Here's what to do if you want to use an advance directive:

- **Get the form.** You can get the form from your doctor, a lawyer, a social worker, or some office supply stores. Pharmacies and provider offices often have the forms. You can find a free form online and download it. *https://www.priorityhealth.com/medicare/once-you-enroll/plan-administration/advance-directives*.
- **Fill out the form and sign it.** The form is a legal document. Consider having a lawyer or someone else you trust, such as a family member or your PCP, help you complete it.
- **Give copies of the form to people who need to know.** Give a copy of the form to your doctor. You should also give a copy to the person you name to 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're being hospitalized and you have a signed advance directive, **take a copy of it to the hospital**.
    - The hospital will ask if you have a signed advance directive form and if you have it with you.
    - If you don't have a signed advance directive form, the hospital has forms and will ask if you want to sign one.

You have the right to:

- Have your advance directive placed in your medical records.
- Change or cancel your advance directive at any time.

By law, no one can deny you care or discriminate against you based on whether you signed an advance directive. Call Customer Care for more information.

G3. What to do if your instructions aren't followed

If you signed an advance directive and you think a doctor or hospital didn't follow the instructions in it, you can make a complaint with the Michigan Department of Licensing and Regulatory Affairs, Bureau of Community and Health Systems, P.O. Box 30664, Lansing, MI 48909. Phone: 800.882.6006. Fax: 517.335.7167. Email: BCHS-Complaints@michigan.gov.

H. Your right to make complaints and ask us to reconsider our decisions

Chapter 9 of this *Member Handbook* tells you what you can do if you have any problems or concerns about your covered services or care. For example, you can ask us to make a coverage decision, make an appeal to change a coverage decision, or make a complaint.

You have the right to get information about appeals and complaints that other plan members have filed against us. Call Customer Care to get this information.

H1. What to do about unfair treatment or to get more information about your rights

If you think we treated you unfairly – and it **isn't** about discrimination for reasons listed in **Chapter 11** of this *Member Handbook* – or you want more information about your rights, you can call:

- Customer Care.
- The Michigan Medicare/Medicaid Assistance Program (MMAP) at 800.803.7174. For more details about Michigan Medicare/Medicaid Assistance Program (MMAP), refer to **Chapter 2**.
- The MICH Ombudsperson Program at 1-888-746-6456. For more details about this program, refer to **Chapter 2** of this *Member Handbook*.

Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. (You can also read or download "Medicare Rights & Protections," found on the Medicare website at www.medicare.gov/publications/11534-medicare-rights-and-protections.pdf.)

Medicaid Customer Help - MSA/MDHHS at 1-800-642-3195. For Michigan calls only, call 1-800-642-3195.

I. Your responsibilities as a plan member

As a plan member, you have a responsibility to do the things that are listed below. If you have any questions, call Customer Care.

- **Read this *Member Handbook*** to learn what our plan covers and the rules to follow to get covered services and drugs. For details about your:
    - Covered services, refer to **Chapters 3 and 4** of this *Member Handbook*. Those chapters tell you what's covered, what isn't covered, what rules you need to follow, and what you pay.
    - Covered drugs, refer to **Chapters 5 and 6** of this *Member Handbook*.
    - **Tell us about any other health or drug coverage** you have. We must make sure you use all of your coverage options when you get health care. Call Customer Care if you have other coverage.
- **Tell your doctor and other health care providers** that you're a member of our plan. Show your Member ID Card when you get services or drugs.
- **Help your doctors** and other health care providers give you the best care.
    - Give them information they need about you and your health. Learn as much as you can about your health problems. Follow the treatment plans and instructions that you and your providers agree on.
    - Make sure your doctors and other providers know about all the drugs you take. This includes prescription drugs, over-the-counter drugs, vitamins, and supplements.
    - Ask any questions you have. Your doctors and other providers must explain things in a way you can understand. If you ask a question and you don't understand the answer, ask again.
- **Be considerate.** We expect all plan members to respect the rights of others. We also expect you to act with respect in your doctor's office, hospitals, and other provider offices.

- **Pay what you owe.** As a plan member, you're responsible for these payments:
    - Medicare Part A and Medicare Part B premiums. For most **Priority**Medicare Dual Premier members, Medicaid pays for your Medicare Part A premium and for your Medicare Part B premium.
    - For some of your drugs covered by our plan, you must pay your share of the cost when you get the drug. This will be a coinsurance or a copayment/copay (a fixed amount). **Chapter 6** tells what you must pay for your drugs.
    - **If you get any services or drugs that aren't covered by our plan, you must pay the full cost.** (**Note:** If you disagree with our decision to not cover a service or drug, you can make an appeal. Please refer to **Chapter 9** to learn how to make an appeal.)
- **Tell us if you move.** If you plan to move, tell us right away. Call Customer Care.
    - **If you move outside of our service area, you can't stay in our plan.** Only people who live in our service area can be members of this plan. **Chapter 1** of this *Member Handbook* tells about our service area.
    - We can help you find out if you're moving outside our service area. During a special enrollment period, you can switch to Original Medicare or enroll in a Medicare health or drug plan in your new location. We can tell you if we have a plan in your new area. tell you if we have a plan in your new area.
    - Tell Medicare and Michigan Medicaid your new address when you move. Refer to **Chapter 2** of this *Member Handbook* for phone numbers for Medicare and Michigan Medicaid.
    - **If you move and stay in our service area, we still need to know.** We need to keep your membership record up to date and know how to contact you.
    - **If you move, tell Social Security (or the Railroad Retirement Board.)**
- **Call Customer Care for help if you have questions or concerns**

Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Introduction

This chapter has information about your rights. Read this chapter to find out what to do if:

- You have a problem with or complaint about your plan.
- You need a service, item, or medication that your plan said it won't pay for.
- You disagree with a decision your plan made about your care.
- You think your covered services are ending too soon.

This chapter is in different sections to help you easily find what you're looking for. **If you have a problem or concern, read the parts of this chapter that apply to your situation.**

You should get the health care, drugs, long-term supports and services, and other supports and services that your doctor and other providers determine are necessary for your care as a part of your care plan. You should try to work with your providers and **Priority**Medicare Dual Premier first. **If you're still having a problem with your care or our plan, you can call the MICH Ombudsman at 1-888-746-6456.** This chapter explains the different options you have for different problems and complaints, but you can always call the MICH Ombudsman to help guide you through your problem. For additional resources to address your concerns and ways to contact them, refer to **Chapter 2,** sections G-H for more information on ombudsman programs.

Table of Contents

A. What to do if you have a problem or concern

This chapter explains how to handle problems and concerns. The process you use depends on the type of problem you have. Use one process for **coverage decisions and appeals** and another for **making complaints** (also called grievances).

To ensure fairness and promptness, each process has a set of rules, procedures, and deadlines that we and you must follow.

A1. About the legal terms

There are legal terms in this chapter for some rules and deadlines. Many of these terms can be hard to understand, so we use simpler words in place of certain legal terms when we can. We use abbreviations as little as possible.

For example, we say:

- “Making a complaint” instead of “filing a grievance”
- “Coverage decision” instead of “organization determination”, “benefit determination”, “at-risk determination”, or “coverage determination”
- “Fast coverage decision” instead of “expedited determination”
- “Independent Review Organization” (IRO) instead of “Independent Review Entity” (IRE)

Knowing the proper legal terms may help you communicate more clearly, so we provide those too.

B. Where to get help

B1. For more information and help

Sometimes it’s confusing to start or follow the process for dealing with a problem. This can be especially true if you don’t feel well or have limited energy. Other times, you may not have the information you need to take the next step.

Help from the Michigan Medicare/Medicaid Assistance Program

You can call the Michigan Medicare/Medicaid Assistance Program (MMAP). Michigan Medicare/Medicaid Assistance Program (MMAP) counselors can answer your questions and help you understand what to do about your problem. Michigan Medicare/Medicaid Assistance Program (MMAP) isn’t connected with us or with any insurance company or

health plan. Michigan Medicare/Medicaid Assistance Program (MMAP) has trained counselors in every county, and services are free. The Michigan Medicare/Medicaid Assistance Program (MMAP) phone number is 800.803.7174.

Help and information from Medicare

For more information and help, you can contact Medicare. Here are two ways to get help from Medicare:

- Call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.
- Visit the Medicare website (www.medicare.gov).

Help and information from Michigan Medicaid

You can call the Beneficiary Help Line at 1-800-642-3195 from 8:00 AM to 7:00 PM Monday through Friday (except holidays) or email beneficiarysupport@michigan.gov. The Beneficiary Support website can be found at www.michigan.gov/mdhhs/assistance-programs/medicaid/portalhome/beneficiaries/supportht.

C. Understanding Medicare and Michigan Medicaid complaints and appeals in our plan

You have Medicare and Michigan Medicaid. Information in this chapter applies to **all** your Medicare and Michigan Medicaid benefits. This is sometimes called an “integrated process” because it combines, or integrates, Medicare and Michigan Medicaid processes.

Sometimes Medicare and Michigan Medicaid processes can’t be combined. In those situations, you use one process for a Medicare benefit and another process for a Michigan Medicaid benefit. **Section G4** explains these situations.

D. Problems with your benefits

If you have a problem or concern, read the parts of this chapter that apply to your situation. The following chart helps you find the right section of this chapter for problems or complaints.

Is your problem or concern about your benefits or coverage? This includes problems about whether particular medical care (medical items, services, long term supports and services and/or Part B drugs) are covered or not, the way they're covered, and problems about payment for medical care.	
Yes. My problem is about benefits or coverage. Refer to **Section F,** "Coverage decisions and appeals."	**No.** My problem isn't about benefits or coverage. Refer to **Section L**, "How to make a complaint."

E. Coverage decisions and appeals

The process for asking for a coverage decision and making an appeal deals with problems related to your benefits and coverage for your medical care (services, items and Part B drugs, including payment). To keep things simple we generally refer to medical items, services, and Part B drugs as **medical care.**

NOTE: Medicaid specialty behavioral health services are covered by the Prepaid Inpatient Health Plan (PIHP). This includes mental health, intellectual/developmental disability, and substance use disorder services and supports. If the PIHP makes a coverage decision and you don't agree with it, you must appeal to the PIHP. Information about the PIHP in your area is found **Chapter 4** of this *Member Handbook*.

E1. Coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we pay for your medical services or drugs. For example, if your plan network provider refers you to a medical specialist outside of the network, this referral is considered a favorable decision unless either your network provider can show that you received a standard denial notice for this medical specialist, or the referred service is never covered under any condition (refer to **Chapter 4**, **Section H** of this *Member Handbook).*

You or your doctor can also contact us and ask for a coverage decision. You or your doctor may be unsure whether we cover a specific medical service or if we may refuse to provide medical care you think you need. **If you want to know if we'll cover a**

medical service before you get it, you can ask us to make a coverage decision for you.

We make a coverage decision whenever we decide what's covered for you and how much we pay. In some cases, we may decide a service or drug isn't covered or is no longer covered for you by Medicare or Michigan Medicaid. If you disagree with this coverage decision, you can make an appeal.

E2. Appeals

If we make a coverage decision and you aren't satisfied with this decision, you can "appeal" the decision. An appeal is a formal way of asking us to review and change a coverage decision we made.

When you appeal a decision for the first time, this is called a Level 1 Appeal. In this appeal, we review the coverage decision we made to check if we followed all rules properly. Different reviewers than those who made the original unfavorable decision handle your appeal.

When we complete the review, we give you our decision. Under certain circumstances, explained later in this chapter, you can ask for an expedited or "fast coverage decision" or "fast appeal" of a coverage decision.

If we say **No** to part or all of what you asked for, we'll send you a letter. If your problem is about coverage of a Medicare medical care, the letter will tell you that we sent your case to the Independent Review Organization (IRO) for a Level 2 Appeal. If your problem is about coverage of a Medicare Part D or Medicaid service or item, the letter will tell you how to file a Level 2 Appeal yourself. Refer to **Section G4** for more information about Level 2 Appeals. If your problem is about coverage of a service or item covered by both Medicare and Medicaid, the letter will give you information regarding both types of Level 2 Appeals.

If you aren't satisfied with the Level 2 Appeal decision, you may be able to go through additional levels of appeal.

E3. Help with coverage decisions and appeals

You can ask for help from any of the following:

- Call your **Care Manager** at 833.939.0983.
- **Customer Care** at the numbers at the bottom of the page.

- Health Insurance Assistance Program (SHIP) at 800.803.7174 or MDHHS-MIOPTIONS@Michigan.gov. Visit ShipHelp.org for more information.
- Call the **MICH Ombudsman** for free help. The MICH Ombudsman can help you with questions about or problems with the MICH program or our plan. The MICH Ombudsman is an independent program, and is not connected with this plan. The phone number is 1-888-746-6456.
- **Your doctor or other provider**. Your doctor or other provider can ask for a coverage decision or appeal on your behalf.
- **A friend or family member**. You can name another person to act for you as your "representative" and ask for a coverage decision or make an appeal.
- **A lawyer**. You have the right to a lawyer, but **you aren't required to have a lawyer** to ask for a coverage decision or make an appeal.
- Call your own lawyer or get the name of a lawyer from the local bar association or other referral service. Some legal groups will give you free legal services if you qualify.
- **Michigan Long Term Care Ombudsman Program (MLTCOP) -** MLTCOP strives to improve the quality of care and quality of life experienced by residents who live in nursing homes, homes for the aged, and adult foster care homes. MLTCOP includes both the State Ombudsman and staff and a network of local ombudsmen whom the State Ombudsman program trains, designates, and supervises. To contact a local ombudsman in your area, call 866-485-9393 or send us an email mltcop.org/contact.

Fill out the Appointment of Representative form if you want a lawyer or someone else to act as your representative. The form gives someone permission to act for you.

Call Customer Care at the numbers at the bottom of the page and ask for the "Appointment of Representative" form. You can also get the form by visiting www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at *priorityhealth.com/dual26.* **You must give us a copy of the signed form.**

E4. Which section of this chapter can help you

There are four situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. We give details for each one in a separate section of this chapter. Refer to the section that applies:

- **Section F**, “Medical care”
- **Section G**, “Medicare Part D drugs”
- **Section H**, “Asking us to cover a longer hospital stay”
- **Section I**, “Asking us to continue covering certain medical services” (This section only applies to these services: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services.)

If you’re not sure which section to use, call Customer Care at the numbers at the bottom of the page. If you need other help or information, please call the MICH Ombudsman at 888.746.6456.

F. Medical care

This section explains 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 that’s described in **Chapter 4** of this *Member Handbook* in the benefits chart. In some cases, different rules may apply to a Medicare Part B drug. When they do, we explain how rules for Medicare Part B prescription drugs differ from rules for medical services and items.

F1. Using this section

This section explains what you can do in any of the five following situations:

1. You think we cover medical care you need but aren’t getting.

What you can do: You can ask us to make a coverage decision. Refer to **Section F2**.

2. We didn’t approve the medical care your doctor or other health care provider wants to give you, and you think we should.

What you can do: You can appeal our decision. Refer to **Section F3**.

3. You got medical care that you think we cover, but we won't pay.

   What you can do: You can appeal our decision not to pay. Refer to **Section F5**.

4. You got and paid for medical care you thought we cover, and you want us to pay you back.

   What you can do: You can ask us to pay you back. Refer to **Section F5**.

5. We reduced or stopped your coverage for certain medical care, and you think our decision could harm your health.

   What you can do: You can appeal our decision to reduce or stop the medical care. Refer to **Section F4**.

   - If the coverage is for hospital care, home health care, skilled nursing facility care, or CORF services, special rules apply. Refer to **Section I** or **Section J** to find out more.
   - For all other situations involving reducing or stopping your coverage for certain medical care, use this section (**Section F**) as your guide.

F2. Asking for a coverage decision

> When a coverage decision involves your medical care, it's called an **integrated organization determination**.

You, your doctor, or your representative can ask us for a coverage decision by:

- Calling: 833.989.0983 TTY: 711.
- Faxing: 888.647.6152.
- Writing: Priority Health
  Health Management Department
  1231 East Beltline Ave. NE
  MS 1255
  Grand Rapids, MI 49525

Standard coverage decision

When we give you our decision, we use the “standard” deadlines unless we agree to use the “fast” deadlines. A standard coverage decision means we give you an answer about a**:**

- **7 calendar days** after we get your request **for a medical service or item that is subject to our prior authorization rules**.
- **14 calendar days** after we get your request **for all other medical services or items**.
- **72 hours** after we get your request **for a Medicare Part B drug**.

For a medical item or service, we can take up to 14 more calendar days if you ask for more time or if we need more information that may benefit you (such as medical records from out-of-network providers). If we take extra days to make the decision, we’ll tell you in writing. **We can’t take extra days if your request is for a Medicare Part B drug.**

If you think we **shouldn’t** take extra days, you can make a “fast complaint” about our decision to take extra days. When you make a fast complaint, we give you an answer to your complaint within 24 hours. The process for making a complaint is different from the process for coverage decisions and appeals. For more information about making a complaint, including a fast complaint, refer to **Section L**.

Fast coverage decision

> The legal term for fast coverage decision is **expedited determination**.

When you ask us to make a coverage decision about your medical care and your health requires a quick response, ask us to make a “fast coverage decision.” A fast coverage decision means we’ll give you an answer about a:

- **72 hours** after we get your request for a medical service or item.
- **24 hours** after we get your request for a Medicare Part B drug.

For a medical item or service, we can take up to 14 more calendar days if we find information that may benefit you is missing (such as medical records from out-of-network providers) or if you need time to get us information for the review. If we take extra days to make the decision, we’ll tell you in writing. **We can’t take extra time if your request is for a Medicare Part B drug.**

If you think we **shouldn't** take extra days to make the coverage decision, you can make a "fast complaint" about our decision to take extra days. For more information about making a complaint, including a fast complaint, refer to **Section K**. We'll call you as soon as we make the decision.

To get a fast coverage decision, you must meet two requirements:

- You're asking for coverage for medical items and/or services that you **didn't get**. You can't ask for a fast coverage decision about payment for items or services you already got.
- Using the standard deadlines **could cause serious harm to your health** or hurt your ability to function.

We automatically give you a fast coverage decision if your doctor tells us your health requires it. If you ask without your doctor's support, we decide if you get a fast coverage decision.

- If we decide that your health doesn't meet the requirements for a fast coverage decision, we send you a letter that says so and we use the standard deadlines instead. The letter tells you:
  - We automatically give you a fast coverage decision if your doctor asks for it.
  - How you can file a "fast complaint" about our decision to give you a standard coverage decision instead of a fast coverage decision. For more information about making a complaint, including a fast complaint, refer to **Section K**.

If we say No to part or all of your request, we send you a letter explaining the reasons.

- If we say **No**, you have the right to make an appeal. If you think we made a mistake, making an appeal is a formal way of asking us to review our decision and change it.
- If you decide to make an appeal, you'll go on to Level 1 of the appeals process (refer to **Section F3**).

In limited circumstances we may dismiss your request for a coverage decision, 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'll send you a notice explaining why the request was dismissed and how to ask for a review of the dismissal. This review is called an appeal. Appeals are discussed in the next section.

F3. Making a Level 1 Appeal

To start an appeal, you, your doctor, or your representative must contact us.

- Call us at 833.939.0983
- Write to us at:
  PH Appeals Analyst
  1231 East Beltline NE
  MS1150
  Grand Rapids, MI 49525
- Fax: 616.975.8827
- Email: MedicareCS@PriorityHealth.com

Ask for a standard appeal or a fast appeal in writing or by calling us at 833.939.0983.

- If your doctor or other prescriber asks to continue a service or item you're already getting during your appeal, you may need to name them as your representative to act on your behalf.
- If someone other than your doctor makes the appeal for you, include an Appointment of Representative form authorizing this person to represent you. You can get the form by visiting www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at *Priorityhealth.com/dual26.*
- We can accept an appeal request without the form, but we can't begin or complete our review until we get it. If we don't get the form before our deadline for making a decision on your appeal:
  - We dismiss your request, and
  - We send you a written notice explaining your right to ask the IRO to review our decision to dismiss your appeal.

- You must ask for an appeal within 65 calendar days from the date on the letter we sent to tell you our decision.
- If you miss the deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good reasons are things like you had a serious illness or we gave you the wrong information about the deadline. Explain the reason why your appeal is late when you make your appeal.
- You have the right to ask us for a free copy of the information about your appeal. You and your doctor may also give us more information to support your appeal.

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

> The legal term for "fast appeal" is **"expedited reconsideration."**

- If you appeal a decision we made about coverage for care, you and/or your doctor decide if you need a fast appeal.

We automatically give you a fast appeal if your doctor tells us your health requires it. If you ask without your doctor's support, we decide if you get a fast appeal.

- If we decide that your health doesn't meet the requirements for a fast appeal, we send you a letter that says so and we use the standard deadlines instead. The letter tells you:
  - We automatically give you a fast appeal if your doctor asks for it.
  - How you can file a "fast complaint" about our decision to give you a standard appeal instead of a fast appeal. For more information about making a complaint, including a fast complaint, refer to **Section K**.

If we tell you we are stopping or reducing services or items that you already get, you may be able to continue those services or items during your appeal.

- If we decide to change or stop coverage for a service or item that you get, we send you a notice before we take action.
- If you disagree with our decision, you can file a Level 1 Appeal.

- We continue covering the service or item if you ask for a Level 1 Appeal within 10 calendar days of the date on our letter or by the intended effective date of the action, whichever is later.
    - If you meet this deadline, you'll get the service or item with no changes while your Level 1 appeal is pending.
    - You'll also get all other services or items (that aren't the subject of your appeal) with no changes.
    - If you don't appeal before these dates, then your service or item won't be continued while you wait for your appeal decision.

We consider your appeal and give you our answer.

- When we review your appeal, we take another careful look at all information about your request for coverage of medical care.
- We check if we followed all the rules when we said **No** to your request.
- We gather more information if we need it. We may contact you or your doctor to get more information.

There are deadlines for a fast appeal.

- When we use the fast deadlines, we must give you our answer **within 72 hours after we get your appeal**. We'll give you our answer sooner if your health requires it.
- 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 need extra days to make the decision, we tell you in writing.
    - If your request is for a Medicare Part B drug, we can't take extra time to make the decision.
    - If we don't give you an answer within 72 hours or by the end of the extra days we took, we must send your request to Level 2 of the appeals process. An IRO then reviews it. Later in this chapter, Section G4, we tell you about this organization and explain the Level 2 appeals process. If your problem is about coverage of a Medicaid service or item, you can file a Level 2 – Fair Hearing with the state yourself as soon as the time is up. In Michigan Fair

Hearings are held by the Michigan Office of Administrative Hearings and Rules (MOAHR). **If we say Yes to part or all of your request,** we must authorize or provide the coverage we agreed to provide within 72 hours after we get your appeal.

- **If we say No to part or all of your request,** we send your appeal to the IRO for a Level 2 Appeal.

There are deadlines for a standard appeal.

- When we use the standard deadlines, we must give you our answer **within 30 calendar days** after we get your appeal for coverage for services you didn't get.
- If your request is for a Medicare Part B drug you didn't get, we give you our answer **within 7 calendar days** after we get your appeal or sooner if your health requires it.
- 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 need extra days to make the decision, we tell you in writing.
    - If your request is for a Medicare Part B drug, we can't take extra time to make the decision.
    - If you think we **shouldn't** take extra days, you can file a fast complaint about our decision. When you file a fast complaint, we give you an answer within 24 hours. For more information about making complaints, including fast complaints, refer to **Section K.**
    - If we don't give you an answer by the deadline or by the end of the extra days we took, we must send your request to Level 2 of the appeals process. An IRO then reviews it. Later in this chapter, Section G4, we tell you about this organization and explain the Level 2 appeals process. If your problem is about coverage of a Medicaid service or item, you can file a Level 2 – Fair Hearing with the state yourself as soon as the time is up. In Michigan, Fair Hearings *are held by the Michigan Office of Administrative Hearings and Rules (MOAHR)*.

If we say Yes to part or all of your request, we must authorize or provide the coverage we agreed to provide within 30 calendar days, or **within 7 calendar days** if your request is for a Medicare Part B drug, after we get your appeal.

If we say **No** to part or all of your request, **you have additional appeal rights:**

- If we say **No** to part or all of what you asked for, we send you a letter.
- If your problem is about coverage of a Medicare service or item, the letter tells you that we sent your case to the IRO for a Level 2 Appeal.
- If your problem is about coverage of a Michigan Medicaid service or item, the letter tells you how to file a Level 2 Appeal yourself.

F4. Making a Level 2 Appeal

If we say **No** to part or all of your Level 1 Appeal, we send you a letter. This letter tells you if Medicare, Michigan Medicaid , or both programs usually cover the service or item.

- If your problem is about a service or item that Medicare usually covers, we automatically send your case to Level 2 of the appeals process as soon as the Level 1 Appeal is complete.
- If your problem is about a service or item that Medicaid usually covers, you can file a Level 2 Appeal yourself. The letter tells you how to do this. We also include more information later in this chapter and section.
- If your problem is about a service or item that **both Medicare and Michigan Medicaid** may cover, you automatically get a Level 2 Appeal with the IRO. You can also ask for a Fair Hearing with the state.

If you qualified for continuation of benefits when you filed your Level 1 Appeal, your benefits for the service, item, or drug under appeal may also continue during Level 2. Refer to **Section F3** for information about continuing your benefits during Level 1 Appeals.

- If your problem is about a service usually covered only by Medicare, your benefits for that service don’t continue during the Level 2 appeals process with the IRO.
- If your problem is about a service usually covered only by Michigan Medicaid, your benefits for that service continue if you submit a Level 2 Appeal within 10 calendar days after getting our decision letter.

When your problem is about a service or item Medicare usually covers

The IRO reviews your appeal. It's an independent organization hired by Medicare.

> The formal name for the Independent Review Organization (IRO) is the **Independent Review Entity**, sometimes called the **IRE**.

- This organization isn't connected with us and isn't a government agency. Medicare chose the company to be the IRO, and Medicare oversees their work.
- We send information about your appeal (your "case file") to this organization. You have the right to a free copy of your case file.
- You have a right to give the IRO additional information to support your appeal.
- Reviewers at the IRO take a careful look at all information related to your appeal.

If you had a fast appeal at Level 1, you also have a fast appeal at Level 2.

- If you had a fast appeal to us at Level 1, you automatically get a fast appeal at Level 2. The IRO must give you an answer to your Level 2 Appeal **within 72 hours** of getting your appeal.
- If your request is for a medical item or service and the IRO needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The IRO can't take extra time to make a decision if your request is for a Medicare Part B drug.

If you had a standard appeal at Level 1, you also have a standard appeal at Level 2.

- If you had a standard appeal to us at Level 1, you automatically get a standard appeal at Level 2.
- If your request is for a medical item or service, the IRO must give you an answer to your Level 2 Appeal **within 30 calendar days** of getting your appeal.
- If your request is for a Medicare Part B drug, the IRO must give you an answer to your Level 2 Appeal **within 7 calendar days** of getting your appeal.

- If your request is for a medical item or service and the IRO needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The IRO take extra time to make a decision if your request is for a Medicare Part B drug.

The IRO gives you their answer in writing and explains the reasons.

- **If the IRO 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 get the IRO's decision for **standard requests, or**
  - Provide the service **within 72 hours** from the date we get the IRO's decision for **expedited requests**.
- **If the IRO says Yes to part or all of a request for a Medicare Part B drug, we must authorize or provide the Medicare Part B drug under dispute:**
  - **within 72 hours** after we get the IRO's decision for **standard requests, or**
  - **within 24 hours** from the date we get the IRO's decision for **expedited requests.**
  - **If the IRO says No to part or all of your appeal,** it means they agree that we shouldn't approve your request (or part of your request) for coverage for medical care. This is called "upholding the decision" or "turning down your appeal."
    - 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.
    - If your Level 2 Appeal is turned down and you meet the requirements to continue the appeals process, you must decide whether to go on to Level 3 and make a third appeal. The details about how to do this are in the written notice you get after your Level 2 Appeal.

- An Administrative Law Judge (ALJ) or attorney adjudicator handles a Level 3 Appeal. Refer to **Section J** for more information about Level 3, 4, and 5 Appeals.

When your problem is about a service or item Medicaid usually covers, or that's covered by both Medicare and Michigan Medicaid

A Level 2 Appeal for services that Michigan Medicaid usually covers is a Fair Hearing with the state. In Michigan Medicaid a Fair Hearing is called Michigan Office of Administrative Hearings and Rules (MOAHR). You must ask for a Fair Hearing in writing or by phone **within 120 calendar days** of the date we sent the decision letter on your Level 1 Appeal. The letter you get from us tells you where to submit your request for a Fair Hearing.

Complete the **MDHHS-5617** form and send it directly to:

Michigan Office of Administrative Hearings and Rules
Michigan Department of Health and Human Services
P.O. Box 30763
Lansing, MI 48909
Call: 800-648-3397 TTY users call: 711
Fax: 517-763-0146
Email: LARA-MOAHR-DCH@michigan.gov

You, parent, or your legal guardian, must sign the consent to release medical information to the MOAHR (included as part of the State Fair Hearing Form).

After you request a hearing, MOAHR will mail you a Notice of Hearing. This notice will tell you the date, time, and how to join—by phone or video.

A MOAHR Administrative Law Judge (ALJ) will lead the hearing. If you want to attend in person, you must send a letter or fax to MOAHR explaining why. The ALJ will decide if there is a good reason and who must attend in person or by phone, and where the hearing will be.

You'll get a written Decision and Order in the mail within 90 days. If you cancel your request or don't show up, you may get an Order of Dismissal instead.

If the ALJ changes Priority Health's decision, they must follow the new decision within 72 hours or ask a court to review it.

Access to Information

You, your authorized representative, or your doctor of record can request and receive, free of charge, reasonable access to and copies of all documents, records, and other information relevant to your appeal determination.

The Fair Hearing office gives you their decision in writing and explain the reasons.

- If the Fair Hearing office says **Yes** to part or all of a request for a medical item or service**,** we must authorize or provide the service or item **within 72 hours** after we get their decision.
- If the Fair Hearing office says **No** to part or all of your appeal, it means they agree that we shouldn't approve your request (or part of your request) for coverage for medical care. This is called "upholding the decision" or "turning down your appeal."

If the IRO or Fair Hearing office decision is **No** for all or part of your request, you have additional appeal rights.

If your Level 2 Appeal went to the **IRO,** you can appeal again only if the dollar value of the service or item you want meets a certain minimum amount. An ALJ or attorney adjudicator handles a Level 3 Appeal. **The letter you get from the IRO explains additional appeal rights you may have.**

The letter you get from the Fair Hearing office describes the next appeal option.

Refer to **Section J** for more information about your appeal rights after Level 2.

F5. Payment problems

We don't allow our network providers to bill you for covered services and items. This is true even if we pay the provider less than the provider charges for a covered service or item. You're never required to pay the balance of any bill.

If you get a bill for covered services and items, send the bill to us. Don't pay the bill yourself. We'll contact the provider directly and take care of the problem. If you do pay the bill, you can get a refund from our plan if you followed the rules for getting services or item.

For more information, refer to **Chapter 7** of this *Member Handbook*. It describes situations when you may need to ask us to pay you back or pay a bill you got from a provider. It also tells how to send us the paperwork that asks us for payment.

If you ask to be paid back, you're asking for a coverage decision. We'll check if the service or item you paid for is covered and if you followed all the rules for using your coverage.

- If the service or item you paid for is covered and you followed all the rules, we'll send you the payment for the service or item typically within 30 calendar days, but no later than 60 calendar days after we get your request.
- If you haven't paid for the service or item yet, we'll send the payment directly to the provider. When we send the payment, it's the same as saying **Yes** to your request for a coverage decision.
- If the service or item isn't covered or you did not follow all the rules, we'll send you a letter telling you we won't pay for the service or item and explaining why.

If you don't agree with our decision not to pay, **you can make an appeal**. Follow the appeals process described in **Section F3**. When you follow these instructions, note:

- If you make an appeal for us to pay you back, we must give you our answer within 30 calendar days after we get your appeal.

If our answer to your appeal is **No** and **Medicare** usually covers the service or item, we'll send your case to the IRO. We'll send you a letter if this happens.

- If the IRO reverses our decision and says we should pay you, we must send the payment to you or to the provider within 30 calendar days. If the answer to your appeal is **Yes** at any stage of the appeals process after Level 2, we must send the payment to you or to the health care provider within 60 calendar days.
- If the IRO says No to your appeal, it means they agree that we shouldn't approve your request. This is called "upholding the decision" or "turning down your appeal." You'll get a letter explaining additional appeal rights you may have. Refer to Section J for more information about additional levels of appeal.

If our answer to your appeal is **No** and Michigan Medicaid usually covers the service or item, you can file a Level 2 Appeal yourself. Refer to **Section F4** for more information.

G. Medicare Part D drugs

Your benefits as a member of our plan include coverage for many drugs. Most of these are Medicare Part D drugs. There are a few drugs that Medicare Part D doesn't cover that Michigan Medicaid may cover. **This section only applies to Medicare Part D drug appeals.** We'll say "drug" in the rest of this section instead of saying "Medicare Part D drug" every time. For drugs covered only by Medicaid follow the process in **Section E.**

To be covered, the drug must be used for a medically accepted indication. That means the drug is approved by the Food and Drug Administration (FDA) or supported by certain medical references. Refer to **Chapter 5** of this *Member Handbook* for more information about a medically accepted indication.

G1. Medicare Part D coverage decisions and appeals

Here are examples of coverage decisions you ask us to make about your Medicare Part D drugs:

- You ask us to make an exception, including asking us to:
  - cover a Medicare Part D drug that isn't on our plan's *Drug List* or
  - set aside a restriction on our coverage for a drug (such as limits on the amount you can get)
- You ask us if a drug is covered for you (such as when your drug is on our plan's *Drug List* but we must approve it for you before we cover it)

NOTE: If your pharmacy tells you that your prescription can't be filled as written, the pharmacy gives you a written notice explaining how to contact us to ask for a coverage decision.

> An initial coverage decision about your Medicare Part D drugs is called a **"coverage determination."**

- You ask us to pay for a drug you already bought. This is asking for a coverage decision about payment.

If you disagree with a coverage decision we made, you can appeal our decision. This section tells you both how to ask for coverage decisions and how to make an appeal. Use the chart below to help you.

Which of these situations are you in?			
You need a drug that isn't on our *Drug List* or need us to set aside a rule or restriction on a drug we cover.	You want us to cover a drug on our *Drug List*, and you think you meet plan rules or restrictions (such as getting approval in advance) for the drug you need.	You want to ask us to pay you back for a drug you already got and paid for.	We told you that we won't cover or pay for a drug in the way that you want.
You can ask us to make an exception. (This is a type of coverage decision.)	**You can ask us for a coverage decision.**	**You can ask us to pay you back.** (This is a type of coverage decision.)	**You can make an appeal.** (This means you ask us to reconsider.)
Start with **Section G2**, then refer to **Sections G3 and G4**	Refer to **Section G4**	Refer to **Section G4**	Refer to **Section G5**

G2. Medicare Part D exceptions

If we don't cover a drug in the way you would like, you can ask us to make an "exception." If we turn down your request for an exception, you can appeal our decision.

When you ask for an exception, your doctor or other prescriber needs to explain the medical reasons why you need the exception.

> Asking for coverage of a drug not on our *Drug List* or for removal of a restriction on 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.**

Here are some examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. Covering a drug that isn't on our *Drug List*

- If we agree to make an exception and cover a drug that isn't on our *Drug List*, you pay the copay that applies to drugs in Tier 4.
- You can't get an exception to the required copay amount for the drug.

2. Removing a restriction for a covered drug

- Extra rules or restrictions apply to certain drugs on our *Drug List* (refer to **Chapter 5** of this *Member Handbook* for more information).
- Extra rules and restrictions for certain drugs include:
  - Being required to use the generic version of a drug instead of the brand name drug.
  - Getting our approval in advance before we agree to cover the drug for you. This is sometimes called "prior authorization (PA)."
  - Being required to try a different drug first before we agree to cover the drug you ask for. This is sometimes called "step therapy."
  - Quantity limits. For some drugs, there are restrictions on the amount of the drug you can have.
- If we agree to an exception for you and set aside a restriction, you can ask for an exception to the copay amount you're required to pay.

3. **Changing coverage of a drug to a lower cost-sharing tier.** Every drug on our *Drug List* is in one of five cost-sharing tiers. In general, the lower the cost-sharing tier number, the less your required copay amount is.
   - Our *Drug List* often includes more than one drug for treating a specific condition. These are called "alternative" drugs.
   - If an alternative drug for your medical condition is in a lower cost-sharing tier than the drug you take, you can ask us to cover it at the cost-sharing amount for the alternative drug. This would lower your copay amount for the drug.
     - If the drug you take is a biological product, you can ask us to cover it at the cost-sharing amount for the lowest tier for biological product alternatives for your condition.

  - If the drug you take is a brand name drug, you can ask us to cover it at the cost-sharing amount for the lowest tier for brand name alternatives for your condition.
  - If the drug you take is a generic drug, you can ask us to cover it at the cost-sharing amount for the lowest tier for either brand or generic alternatives for your condition.
- You can't ask us to change the cost-sharing tier for any drug in Tier 5 – specialty drugs.
- If we approve your tiering exception request and there's more than one lower cost-sharing tier with alternative drugs you can't take, you usually pay the lowest amount.

G3. Important things to know about asking for an exception

Your doctor or other prescriber must tell us the medical reasons.

Your doctor or other prescriber must give us a statement explaining the medical reasons for asking for an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Our *Drug List* often includes more than one drug for treating a specific condition. These are called "alternative" drugs. If an alternative drug is just as effective as the drug you ask for and wouldn't cause more side effects or other health problems, we generally **don't** approve your exception request. If you ask us for a tiering exception, we generally **don't** approve your exception request unless all 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 say **Yes** to your exception request, the exception usually lasts until the end of the calendar 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 exception request, you can make an appeal. Refer to **Section G5** for information on making an appeal if we say **No**.

The next section tells you how to ask for a coverage decision, including an exception.

G4. Asking for a coverage decision, including an exception

- Ask for the type of coverage decision you want by calling 833.939.0983, writing, or faxing us. You, your representative, or your doctor (or other prescriber) can do this. Please include your name, contact information, and information about the claim.
- You or your doctor (or other prescriber) or someone else acting on your behalf can ask for a coverage decision. You can also have a lawyer act on your behalf.
- Refer to **Section E3** to find out how to name someone as your representative.
- You don't need to give written permission to your doctor or other prescriber to ask for a coverage decision on your behalf.
- If you want to ask us to pay you back for a drug, refer to **Chapter 7** of this *Member Handbook*.
- If you ask for an exception, give us a "supporting statement." The supporting statement includes your doctor or other prescriber's medical reasons for the exception request.
- Your doctor or other prescriber can fax or mail us the supporting statement. They can also tell us by phone and then fax or mail the statement.

If your health requires it, ask us for a "fast coverage decision."

We use the "standard deadlines" unless we agree to use the "fast deadlines."

- A **standard coverage decision** means we give you an answer within 72 hours after we get your doctor's statement.
- A **fast coverage decision** means we give you an answer within 24 hours after we get your doctor's statement.

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

You can get a fast coverage decision if:

- It's for a drug you didn't get. You can't get a fast coverage decision if you're asking us to pay you back for a drug you already bought.

- Your health or ability to function would be seriously harmed if we use the standard deadlines.

If your doctor or other prescriber tells us that your health requires a fast coverage decision, we agree and give it to you. We send you a letter that tells you.

- If you ask for a fast coverage decision without support from your doctor or other prescriber, we decide if you get a fast coverage decision.
- If we decide that your medical condition doesn't meet the requirements for a fast coverage decision, we use the standard deadlines instead.
- We send you a letter that tells you. The letter also tells you how to make a complaint about our decision.
- You can file a fast complaint and get a response within 24 hours. For more information making complaints, including fast complaints, refer to **Section K.**

Deadlines for a fast coverage decision

- If we use the fast deadlines, we must give you our answer within 24 hours after we get your request. If you ask for an exception, we give you our answer within 24 hours after we get your doctor's supporting statement. We give you our answer sooner if your health requires it.
- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an IRO. Refer to **Section G6** for more information about a Level 2 Appeal.
- If we say **Yes** to part or all of your request, we give you the coverage within 24 hours after we get your request or your doctor's supporting statement.
- If we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how you can make an appeal.

Deadlines for a standard coverage decision about a drug you didn't get

- If we use the standard deadlines, we must give you our answer within 72 hours after we get your request. If you ask for an exception, we give you our answer within 72 hours after we get your doctor's supporting statement. We give you our answer sooner if your health requires it.

- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an IRO.
- If we say **Yes** to part or all of your request, we give you the coverage within 72 hours after we get your request or your doctor's supporting statement for an exception.
- If we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how to make an appeal.

Deadlines for a standard coverage decision about a drug you already bought

- We must give you our answer within 14 calendar days after we get your request.
- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an IRO.
- If we say **Yes** to part or all of your request, we pay you back within 14 calendar days.
- **If** we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how to make an appeal.

G5. Making a Level 1 Appeal

> An appeal to our plan about a Medicare Part D drug coverage decision is called a plan **"redetermination".**

- Start your **standard** or **fast appeal** by calling 833.939.0983, writing, or faxing us. You, your representative, or your doctor (or other prescriber) can do this. Please include your name, contact information, and information regarding your appeal.
- You must ask for an appeal **within 65 calendar days** from the date on the letter we sent to tell you our decision.
- If you miss the deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good reasons are things like you had a serious illness or we gave you the wrong information about the deadline. Explain the reason why your appeal is late when you make your appeal.

- You have the right to ask us for a free copy of the information about your appeal. You and your doctor may also give us more information to support your appeal.

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

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

- If you appeal a decision we made about a drug you didn't get, you and your doctor or other prescriber decide if you need a fast appeal.
- Requirements for a fast appeal are the same as those for a fast coverage decision. Refer to **Section G4** for more information.

We consider your appeal and give you our answer.

- We review your appeal and take another careful look at all of the information about your coverage request.
- We check if we followed 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 at Level 1

- If we use the fast deadlines, we must give you our answer **within 72 hours** after we get your appeal.
    - We give you our answer sooner if your health requires it.
    - If we don't give you an answer within 72 hours, we must send your request to Level 2 of the appeals process. Then an IRO reviews it. Refer to **Section G6** for information about the review organization and the Level 2 appeals process.
- If we say **Yes** to part or all of your request, we must provide the coverage we agreed to provide within 72 hours after we get your appeal.
- If we say **No** to part or all of your request, we send you a letter that explains the reasons and tells you how you can make an appeal.

Deadlines for a standard appeal at Level 1

- If we use the standard deadlines, we must give you our answer **within 7 calendar days** after we get your appeal for a drug you didn't get.
- We give you our decision sooner if you didn't get the drug and your health condition requires it. If you believe your health requires it, ask for a fast appeal.
    - If we don't give you a decision within 7 calendar days, we must send your request to Level 2 of the appeals process. Then an IRO reviews it. Refer to **Section G6** for information about the review organization and the Level 2 appeals process.

If we say **Yes** to part or all of your request:

- We must **provide the coverage** we agreed to provide as quickly as your health requires, but **no later than 7 calendar days** after we get your appeal.
- We must **send payment to you** for a drug you bought **within 30 calendar days** after we get your appeal.

If we say **No** to part or all of your request:

- We send you a letter that explains the reasons and tells you how you can make an appeal.
- We must give you our answer about paying you back for a drug you bought **within 14 calendar days** after we get your appeal.
    - If we don't give you a decision within 14 calendar days, we must send your request to Level 2 of the appeals process. Then an IRO reviews it. Refer to **Section G6** for information about the review organization and the Level 2 appeals process.
- If we say **Yes** to part or all of your request, we must pay you within 30 calendar days after we get your request.
- If we say **No** to part or all of your request, we send you a letter that explains the reasons and tells you how you can make an appeal.

G6. Making a Level 2 Appeal

If we say **No** to your Level 1 Appeal, you can accept our decision or make another appeal. If you decide to make another appeal, you use the Level 2 Appeal appeals

process. The **IRO** reviews our decision when we said **No** to your first appeal. This organization decides if we should change our decision.

> The formal name for the "Independent Review Organization" (IRO) is the **"Independent Review Entity",** sometimes called the **"IRE".**

To make a Level 2 Appeal, you, your representative, or your doctor or other prescriber must contact the IRO **in writing** and ask for a review of your case.

- If we say **No** to your Level 1 Appeal, the letter we send you includes **instructions about how to make a Level 2 Appeal** with the IRO. The instructions tell who can make the Level 2 Appeal, what deadlines you must follow, and how to reach the organization.
- When you make an appeal to the IRO, we send the information we have about your appeal to the organization. This information is called your "case file". **You have the right to a free copy of your case file**.
- You have a right to give the IRO additional information to support your appeal.

The IRO reviews your Medicare Part D Level 2 Appeal and gives you an answer in writing. Refer to **Section F4** for more information about the IRO.

Deadlines for a fast appeal at Level 2

If your health requires it, ask the IRO for a fast appeal.

- If they agree to a fast appeal, they must give you an answer **within 72 hours** after getting your appeal request.
- If they say **Yes** to part or all of your request, we must provide the approved drug coverage **within 24 hours** after getting the IRO's decision.

Deadlines for a standard appeal at Level 2

If you have a standard appeal at Level 2, the IRO must give you an answer:

- **within 7 calendar days** after they get your appeal for a drug you didn't get.
- **within 14 calendar days** after getting your appeal for repayment for a drug you bought.

If the IRO says **Yes** to part or all of your request:

- We must provide the approved drug coverage **within 72 hours** after we get the IRO's decision.
- We must pay you back for a drug you bought within 30 calendar days after we get the IRO's decision.
- If the IRO says **No** to your appeal, it means they agree with our decision not to approve your request. This is called "upholding the decision" or "turning down your appeal".

If the IRO says **No** to your Level 2 Appeal, you have the right to a Level 3 Appeal if the dollar value of the drug coverage you ask for meets a minimum dollar value. If the dollar value of the drug coverage you ask for is less than the required minimum, you can't make another appeal. In that case, the Level 2 Appeal decision is final. The IRO sends you a letter that tells you the minimum dollar value needed to continue with a Level 3 Appeal.

If the dollar value of your request meets the requirement, you choose if you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2.
- If the IRO says **No** to your Level 2 Appeal and you meet the requirement to continue the appeals process, you:
    - Decide if you want to make a Level 3 Appeal.
    - Refer to the letter the IRO sent you after your Level 2 Appeal for details about how to make a Level 3 Appeal.

An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

H. Asking us to cover a longer hospital stay

When you're admitted to a hospital, you have the right to get all hospital services that we cover that are necessary to diagnose and treat your illness or injury. For more information about our plan's hospital coverage, refer to **Chapter 4** of this *Member Handbook.*

During your covered hospital stay, your doctor and the hospital staff work with you to prepare for the day when you leave the hospital. They also help arrange for care you may need after you leave.

- The day you leave the hospital is called your “discharge date.”
- Your doctor or the hospital staff will tell you what your discharge date is.

If you think you’re being asked to leave the hospital too soon or you’re concerned about your care after you leave the hospital, you can ask for a longer hospital stay. This section tells you how to ask.

H1. Learning about your Medicare rights

Within two days after you’re admitted to the hospital, someone at the hospital, such as a nurse or caseworker, will give you a written notice called “An Important Message from Medicare about Your Rights.” Everyone with Medicare gets a copy of this notice whenever they’re admitted to a hospital.

If you don’t get the notice, ask any hospital employee for it. If you need help, call Customer Care at the numbers at the bottom of the page. You can also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

- **Read the notice** carefully and ask questions if you don’t understand. The notice tells you about your rights as a hospital patient, including your rights to:
    - Get Medicare-covered services during and after your hospital stay. You have the right to know what these services are, who will pay for them, and where you can get them.
    - Be a part of any decisions about the length of your hospital stay.
    - Know where to report any concerns you have about the quality of your hospital care.
    - Appeal if you think you’re being discharged from the hospital too soon.
- **Sign the notice** to show that you got it and understand your rights.
    - You or someone acting on your behalf can sign the notice.

- Signing the notice **only** shows that you got the information about your rights. Signing **doesn't** mean you agree to a discharge date your doctor or the hospital staff may have told you.

- **Keep your copy** of the signed notice so you have the information if you need it.

If you sign the notice more than two days before the day you leave the hospital, you'll get another copy before you're discharged.

You can look at a copy of the notice in advance if you:

- Call Customer Care at the numbers at the bottom of the page
- Call Medicare at 1-800 MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- Visit www.cms.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

H2. Making a Level 1 Appeal

To ask for us to cover your inpatient hospital services for a longer time, make an appeal. The Quality Improvement Organization (QIO) reviews the Level 1 Appeal to find out if your planned discharge date is medically appropriate for you.

The QIO is a group of doctors and other health care professionals paid by the federal government. These experts check and help improve the quality for people with Medicare. They aren't part of our plan.

In Michigan, the QIO is Livanta. Call them at 1-888-524-9900 (TTY: 1-888-985-8775). Contact information is also in the notice, "An Important Message from Medicare about Your Rights," and in **Chapter 2**.

Call the QIO before you leave the hospital and no later than your planned discharge date.

- **If you call before you leave**, you can stay in the hospital after your planned discharge date without paying for it while you wait for the QIO's decision about your appeal.
- **If you don't call to appeal**, and you decide to stay in the hospital after your planned discharge date, you may pay all costs for hospital care you get after your planned discharge date.

Ask for help if you need it. If you have questions or need help at any time:

- Call Customer Care at the numbers at the bottom of the page.
- Call the Michigan Medicare/Medicaid Assistance Program (MMAP) at 800.803.7174. **Ask for a fast review.** Act quickly and contact the QIO to ask for a fast review of your hospital discharge.

> The legal term for **"fast review"** is **"immediate review"** or **"expedited review."**

What happens during fast review

- Reviewers at the QIO ask you or your representative why you think coverage should continue after the planned discharge date. You aren't required to write a statement, but you may.
- Reviewers look at your medical information, talk with your doctor, and review information that the hospital and our plan gave them.
- By noon of the day after reviewers tell our plan about your appeal, you get a letter with your planned discharge date. The letter also gives reasons why your doctor, the hospital, and we think that's the right discharge date that's medically appropriate for you.

> The legal term for this written explanation is the **"Detailed Notice of Discharge."** You can get a sample by calling Customer Care at the numbers at the bottom of the page or 1-800-MEDICARE (1-800-633-4227). (TTY users should call 1-877-486-2048.) You can also refer to a sample notice online at www.cms.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im

Within one full day after getting all of the information it needs, the QIO give you their answer to your appeal.

If the QIO says **Yes** to your appeal:

- We'll provide your covered inpatient hospital services for as long as the services are medically necessary.

If the QIO says **No** to your appeal:

- They believe your planned discharge date is medically appropriate.

- Our coverage for your inpatient hospital services will end at noon on the day after the QIO gives you their answer to your appeal.
- You may have to pay the full cost of hospital care you get after noon on the day after the QIO gives you their answer to your appeal.
- You can make a Level 2 Appeal if the QIO turns down your Level 1 Appeal **and** you stay in the hospital after your planned discharge date.

H3. Making a Level 2 Appeal

For a Level 2 Appeal, you ask the QIO to take another look at the decision they made on your Level 1 Appeal. Call them at 1-888-524-9900 (TTY: 1-888-985-8775).

You must ask for this review **within 60 calendar days** after the day the QIO 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.

QIO reviewers will:

- Take another careful look at all of the information related to your appeal.
- Tell you their decision about your Level 2 Appeal within 14 calendar days of receipt of your request for a second review.

If the QIO says **Yes** to your appeal:

- We must pay you back for hospital care costs since noon on the day after the date the QIO turned down your Level 1 Appeal.
- We'll provide your covered inpatient hospital services for as long as the services are medically necessary.

If the QIO says **No** to your appeal:

- They agree with their decision about your Level 1 Appeal and won't change it.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.

An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

I. Asking us to continue covering certain medical services

This section is only about three types of services you may be getting:

- home health care services
- skilled nursing care in a skilled nursing facility, **and**
- rehabilitation care as an outpatient at a Medicare-approved CORF. This usually means you're getting treatment for an illness or accident or you're recovering from a major operation.

With any of these three types of services, you have the right to get covered services for as long as the doctor says you need them.

When we decide to stop covering any of these, we must tell you **before** your services end. When your coverage for that service ends, we stop paying for it.

If you think we're ending the coverage of your care too soon, **you can appeal our decision**. This section tells you how to ask for an appeal.

I1. Advance notice before your coverage ends

We send you a written notice that you'll get at least two days before we stop paying for your care. This is called the "Notice of Medicare Non-Coverage." The notice tells you the date when we'll stop covering your care and how to appeal our decision.

You or your representative should sign the notice to show that you got it. Signing the notice **only** shows that you got the information. Signing **doesn't** mean you agree with our decision.

I2. Making a Level 1 Appeal

If you think we're ending coverage of your care too soon, you can appeal our decision. This section tells you about the Level 1 Appeal process and what to do.

- **Meet the deadlines.** The deadlines are important. Understand and follow the deadlines that apply to things you must do. Our plan must follow deadlines too. If you think we're not meeting our deadlines, you can file a complaint. Refer to **Section K** for more information about complaints.
- **Ask for help if you need it.** If you have questions or need help at any time:
    - Call your Care Manager.

- Call Customer Care at the numbers at the bottom of the page.
- Call the Michigan Medicare/Medicaid Assistance Program (MMAP) at 800.803.7174.
- Call the **MICH Ombudsman** for free help. The MICH Ombudsman can help you with questions about or problems with the MICH program or our plan. The MICH Ombudsman is an independent program and is not connected with this plan. The phone number is 1-888-746-6456.
- **Michigan Long Term Care Ombudsman Program (MLTCOP) -** MLTCOP strives to improve the quality of care and quality of life experienced by residents who live in nursing homes, homes for the aged, and adult foster care homes. MLTCOP includes both the State Ombudsman and staff and a network of local ombudsmen whom the State Ombudsman program trains, designates, and supervises. To contact a local ombudsman in your area, call 866-485-9393 or send us an email at mltcop.org/contact.

- **Contact the QIO.**
  - Refer to **Section H2** or refer to **Chapter 2** of this *Member Handbook* for more information about the QIO and how to contact them.
  - Ask them to review your appeal and decide whether to change our plan's decision.
- **Act quickly and ask for a "fast-track appeal.** Ask the QIO if it's medically appropriate for us to end coverage of your medical services.

Your deadline for contacting this organization

- You must contact the QIO to start your appeal by noon of the day before the effective date on the "Notice of Medicare Non-Coverage" we sent you.

The legal term for the written notice is **"Notice of Medicare Non-Coverage".** To get a sample copy, call Customer Care at the numbers at the bottom of the page or call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. Or get a copy online at www.cms.gov/Medicare/Medicare-General-Information/BNI/FFS-Expedited-Determination-Notices.

What happens during a fast-track appeal

- Reviewers at the QIO ask you or your representative why you think coverage should continue. You aren't required to write a statement, but you may.
- Reviewers look at your medical information, talk with your doctor, and review information that our plan gave them.
- Our plan also sends you a written notice that explains our reasons for ending coverage of your services. You get the notice by the end of the day the reviewers inform us of your appeal.

The legal term for the notice explanation is **"Detailed Explanation of Non-Coverage".**

- Reviewers tell you their decision within one full day after getting all the information they need.

If the QIO says **Yes** to your appeal:

- We'll provide your covered services for as long as they're medically necessary.

If the QIO says **No** to your appeal:

- Your coverage ends on the date we told you.
- We stop paying the costs of this care on the date in the notice.
- You pay the full cost of this care yourself if you decide to continue the home health care, skilled nursing facility care, or CORF services after the date your coverage ends
- You decide if you want to continue these services and make a Level 2 Appeal.

I3. Making a Level 2 Appeal

- For a Level 2 Appeal, you ask the QIO to take another look at the decision they made on your Level 1 Appeal. In Michigan, the Quality Improvement Organization is called Livanta. You can reach Livanta at: 1888-524-9900 (TTY: 1-888-985-8775).

You must ask for this review **within 60 calendar days** after the day the QIO said **No** to your Level 1 Appeal. You can ask for this review **only** if you continue care after the date that your coverage for the care ended.

QIO reviewers will:

- Take another careful look at all of the information related to your appeal.
- Tell you their decision about your Level 2 Appeal within 14 calendar days of receipt of your request for a second review.

If the QIO says **Yes** to your appeal:

- We pay you back for the costs of care you got since the date when we said your coverage would end.
- We'll provide coverage for the care for as long as it's medically necessary.

If the QIO says **No** to your appeal:

- They agree with our decision to end your care and won't change it.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.

An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

J. Taking your appeal beyond Level 2

J1. Next steps for Medicare services and items

If you made a Level 1 Appeal and a Level 2 Appeal for Medicare services or items, and both of your appeals were turned down, you may have the right to additional levels of appeal.

If the dollar value of the Medicare service or item you appealed doesn't meet a certain minimum dollar amount, you can't appeal any further. If the dollar value is high enough, you can continue the appeals process. The letter you get from the IRO for your Level 2 Appeal explains who to contact and what to do to ask for a Level 3 Appeal.

Level 3 Appeal

Level 3 of the appeals process is an ALJ hearing. The person who makes the decision is an ALJ or an attorney adjudicator who works for the federal government.

If the ALJ or attorney adjudicator says **Yes** to your appeal**,** we have the right to appeal a Level 3 decision that's favorable to you.

- If we decide **to appeal** the decision, we send you a copy of the Level 4 Appeal request with any accompanying documents. We may wait for the Level 4 Appeal decision before authorizing or providing the service in dispute.
- If we decide **not to appeal** the decision, we must authorize or provide you with the service within 60 calendar days after getting the ALJ or attorney adjudicator's decision.
    - If the ALJ or attorney adjudicator says **No** to your appeal, the appeals process may not be over.
- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, 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.

If you need assistance at any stage of the appeals process, you can contact the MICH Ombudsman. The phone number is 1-888-746-6456.

Level 4 Appeal

The Medicare Appeals Council (Council) reviews your appeal and gives you an answer. The Council is part of the federal government.

If the Council says **Yes** to your Level 4 Appeal or denies our request to review a Level 3 Appeal decision favorable to you, we have the right to appeal to Level 5.

- If we decide **to appeal** the decision, we'll tell you in writing.

- If we decide **not to appeal** the decision, we must authorize or provide you with the service within 60 calendar days after getting the Council's decision.

If the Council says **No** or denies our review request, the appeals process may not be over.

- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you may be able to continue to the next level of the review process. The notice you get will tell you if you can go on to a Level 5 Appeal and what to do.

Level 5 Appeal

- A Federal District Court judge will review your appeal and all of the information and decide **Yes** or **No**. This is the final decision. There are no other appeal levels beyond the Federal District Court.

J2. Additional Michigan Medicaid appeals

If your appeal went to the Michigan Office of Administrative Hearings and Rules (MOAHR) for a Fair Hearing, MOAHR will send you a letter explaining its decision. If you disagree with the MOAHR final decision, you have 30 calendar days from the date of the decision to file a request for rehearing/reconsideration and/or to file an appeal with the Circuit Court. Please call MOAHR at 517-335-2482 for information about requirements you must meet to qualify for a rehearing/reconsideration.

If your appeal went to the Michigan Department of Insurance and Financial Services (DIFS) for an External Review, DIFS will send you a letter explaining the Director's decision. If you disagree with the decision, you have the right to appeal to Circuit Court in the county where you live or the Michigan Court of Claims within 60 calendar days from the date of the decision.

If you need help at any stage of the appeals process, you can contact the MI Health Link Ombudsman. The phone number is 1-888-746-6456.

J3. Appeal Levels 3, 4 and 5 for Medicare Part D Drug Requests

This section may be right for you if you made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals were turned down.

If the value of the drug you appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. The written response you get to your Level 2 Appeal explains who to contact and what to do to ask for a Level 3 Appeal.

Level 3 Appeal

Level 3 of the appeals process is an ALJ hearing. The person who makes the decision is an ALJ or an attorney adjudicator who works for the federal government.

If the ALJ or attorney adjudicator says **Yes** to your appeal**:**

- The appeals process is over.
- We must authorize or provide the approved drug coverage within 72 hours (or 24 hours for an expedited appeal) or make payment no later than 30 calendar days after we get the decision.

If the ALJ or attorney adjudicator says **No** to your appeal, the appeals process may not be over.

- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, 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 Council reviews your appeal and gives you an answer. The Council is part of the federal government.

If the Council says **Yes** to your appeal:

- The appeals process is over.
- We must authorize or provide the approved drug coverage within 72 hours (or 24 hours for an expedited appeal) or make payment no later than 30 calendar days after we get the decision.

If the Council says **No** to your appeal or if the Council denies the review request, the appeals process may not be over.

- If you decide **to accept** the decision that turns down your appeal, the appeals process is over.

- If you decide **not to accept** this decision that turns down your appeal, you may be able to continue to the next level of the review process. The notice you get will tell you if you can go on to a Level 5 Appeal and what to do.

Level 5 Appeal

- A Federal District Court judge will review your appeal and all of the information and decide **Yes** or **No**. This is the final decision. There are no other appeal levels beyond the Federal District Court.

K. How to make a complaint

K1. What kinds of problems should be complaints

The complaint process is used for certain types of problems only, such as problems about quality of care, waiting times, coordination of care, and customer service. Here are examples of the kinds of problems handled by the complaint process.

Complaint	Example
Quality of your medical care	You're unhappy with the quality of care, such as the care you got in the hospital.
Respecting your privacy	You think that someone did not respect your right to privacy or shared confidential information about you.
Disrespect, poor customer service, or other negative behaviors	A health care provider or staff was rude or disrespectful to you. Our staff treated you poorly. You think you're being pushed out of our plan.

Complaint	Example
Accessibility and language assistance	You can't physically access the health care services and facilities in a doctor or provider's office. Your doctor or provider doesn't provide an interpreter for the non-English language you speak (such as American Sign Language or Spanish). Your provider doesn't give you other reasonable accommodations you need and ask for.
Waiting times	You have trouble getting an appointment or wait too long to get it. Doctors, pharmacists, or other health professionals, Customer Care, or other plan staff keep you waiting too long.
Cleanliness	You think the clinic, hospital or doctor's office isn't clean.
Information you get from us	You think we failed to give you a notice or letter that you should have received. You think written information we sent you is too difficult to understand.
Timeliness related to coverage decisions or appeals	You think we don't meet our deadlines for making a coverage decision or answering your appeal. You think that, after getting a coverage or appeal decision in your favor, we don't meet the deadlines for approving or giving you the service or paying you back for certain medical services. You don't think we sent your case to the IRO on time.

There are different kinds of complaints. You can make an internal complaint and/or an external complaint. An internal complaint is filed with and reviewed by our plan. An external complaint is filed with and reviewed by an organization not affiliated with our plan. If you need help making an internal and/or external complaint, you can call MICH Ombudsman at 888.746.6456.

> The legal term for a "complaint" is a **"grievance."**
>
> The legal term for "making a complaint" is **"filing a grievance."**

K2. Internal complaints

To make an internal complaint, call your Care Manager or Customer Care at 833.939.0983. You can make the complaint at any time unless it's about a Medicare Part D drug. If the complaint is about a Medicare Part D drug, you must make it **within 60 calendar** days after you had the problem you want to complain about.

- If there's anything else you need to do, Customer Care will tell you.
- You can also write your complaint and send it to us. If you put your complaint in writing, we'll respond to your complaint in writing.
- You can choose someone you trust—like a friend or family member—to speak for you and send your complaint (called a "grievance"). To do this, you will need to fill out a form called the Appointment of Representative. You can get the form by calling Customer Care or downloading it from the Medicare website (www.cms.gov/Medicare/CMS-Forms/CMSForms/downloads/cms1696.pdf). Both you and the person you choose must sign the form. Then, send us a copy.
    - We can start looking at your grievance without the form, but we cannot finish it until we get the signed form. If we do not get it on time, your grievance may be dismissed. If that happens, we will send you a letter telling you how you or your representative can send it again.
- When we get your grievance, we will send you a letter to let you know we received it.
- For most grievances, we will give you an answer within 30 days. Sometimes we might need up to 14 more days if you ask for more time, or if we need more information and waiting longer is best for you.

- If we take extra time, we will tell you by phone and in writing within 2 days. If you are not happy about the delay, you can send us another grievance.
- You will get a written reply telling you the resolution to your grievance.
- Sometimes the letter will include both the notice that we got your grievance and the final resolution.

> **The legal term** for "fast complaint" is **"expedited grievance."**

If possible, we answer you right away. If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we'll do that.

- We answer most complaints within 30 calendar days. If we don't make a decision within 30 calendar days because we need more information, we notify you in writing. We also provide a status update and estimated time for you to get the answer.
- If you make a complaint because we denied your request for a "fast coverage decision" or a "fast appeal," we automatically give you a "fast complaint" and respond to your complaint within 24 hours.
- If you make a complaint because we took extra time to make a coverage decision or appeal, we automatically give you a "fast complaint" and respond to your complaint within 24 hours.

If we don't agree with some or all of your complaint, we'll tell you and give you our reasons. We respond whether we agree with the complaint or not.

If you need help at any stage of this process, you can contact the MICH Ombudsman. The phone number is 1-888-746-6456.

K3. External complaints

Medicare

You can tell Medicare about your complaint or send it to Medicare. The Medicare Complaint Form is available at: www.medicare.gov/my/medicare-complaint. You don't need to file a complaint with Priority Health Dual Premier before filing a complaint with Medicare.

Medicare takes your complaints seriously and uses this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the health plan isn't addressing your problem, you can also call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. The call is free.

You can tell Michigan Medicaid about your complaint

You can also send your complaint to Michigan Medicaid. You can call the Beneficiary Help Line Monday through Friday from 8:00 AM to 7:00 PM at 1-800-642-3195 (TTY: 1-866-501-5656), or 1-800-975-7630 if calling from an internet-based phone service.

Office for Civil Rights (OCR)

You can make a complaint to the Department of Health and Human Services (HHS) OCR if you think you haven't been treated fairly. For example, you can make a complaint about disability access or language assistance. The phone number for the OCR is 1-800-368-1019. TTY users should call 1-800-537-7697. You can visit www.hhs.gov/ocr for more information.

You may also contact the local OCR office at:

Office for Civil Rights

U.S. Department of Health and Human Services

233 N. Michigan Ave., Suite 240

Chicago, IL 60601

Customer Response Center: (800) 368-1019

Fax: (202) 619-3818

TDD: (800) 537-7697

Email: ocrmail@hhs.gov

- You may also have rights under the Americans with Disability Act (ADA) and under the Michigan Persons with Disabilities Civil Rights Act (PWDCRA), which protects individuals with disabilities from discrimination in employment, housing, public accommodations, services, and education. You can contact the MICH Ombudsman at 1-888-746-6456 for help.

QIO

When your complaint is about quality of care, you have two choices:

- You can make your complaint about the quality of care directly to the QIO.
- You can make your complaint to the QIO and to our plan. If you make a complaint to the QIO, we work with them to resolve your complaint.

The QIO is a group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients. To learn more about the QIO, refer to **Section H2** or refer to **Chapter 2** of this *Member Handbook*. *Member Handbook*.

In Michigan, the QIO is called Livanta. The phone number for Livanta is 1-888-524-9900 (TTY: 1-888-985-8775).

Chapter 10: Ending your membership in our plan

Introduction

This chapter explains how you can end your membership with our plan and your health coverage options after you leave our plan. If you leave our plan, you'll still be in the Medicare and Michigan Medicaid programs as long as you're eligible. Key terms and their definitions appear in alphabetical order in the last chapter of this *Member Handbook*.

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A. When you can end your membership in our plan

Most people with Medicare can end their membership during certain times of the year. Since you have Michigan Medicaid, you have some choices to end your membership with our plan any month of the year.

In addition, you may end your membership in our plan during the following periods each year:

- The **Annual Enrollment Period**, which lasts from October 15 to December 7. If you choose a new plan during this period, your membership in our plan ends on December 31 and your membership in the new plan starts on January 1.
    - The **Medicare Advantage (MA) Open Enrollment Period**, which lasts from January 1 to March 31 and also for new Medicare beneficiaries who are enrolled in a plan, from the month of entitlement to Part A and Part B until the last day of the 3rd month of entitlement. If you choose a new plan during this period, your membership in the new plan starts the first day of the next month.

There may be other situations when you're eligible to make a change to your enrollment. For example, when:

- you move out of our service area,
- your eligibility for Michigan Medicaid or Extra Help changed, **or**
- if you recently moved into, currently are getting care in, or just moved out of a nursing facility or a long-term care hospital.

Your membership ends on the last day of the month that we get your request to change your plan. For example, if we get your request on January 18, your coverage with our plan ends on January 31. Your new coverage begins the first day of the next month (February 1, in this example).

If you leave our plan, you can get information about your:

- Medicare options in the table in **Section C1**
- Medicaid services in **Section C2**

You can get more information about how you can end your membership by calling: Customer Care at the number at the bottom of this page. The number for TTY users is listed too.

- Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- The State Health Insurance Assistance Program (SHIP), Michigan Medicare/Medicaid Assistance Program (MMAP) at 800.803.7174.

B. How to end your membership in our plan

If you decide to end your membership you can enroll in another Medicare plan or switch to Original Medicare. However, if you want to switch from our plan to Original Medicare but you haven't selected a separate Medicare drug plan, you must ask to be disenrolled from our plan. There are two ways you can ask to be disenrolled:

- You can make a request in writing to us. Contact Customer Care at the number at the bottom of this page if you need more information on how to do this.
- Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users (people who have difficulty with hearing or speaking) should call 1-877-486-2048. When you call 1-800-MEDICARE, you can also enroll in another Medicare health or drug plan. More information on getting your Medicare services when you leave our plan is in the chart in Section C1.
- Call the Michigan Medicare/Medicaid Assistance Program (MMAP) at 800.803.7174. **Section C** below includes steps that you can take to enroll in a different plan, which will also end your membership in our plan.

C. How to get Medicare and Michigan Medicaid services separately

You have choices about getting your Medicare and Medicaid services if you choose to leave our plan.

C1. Your Medicare services

You have three options for getting your Medicare services listed below any month of the year. You have an additional option listed below during certain times of the year including the **Annual Enrollment Period** and the **Medicare Advantage Open Enrollment Period** or other situations described in **Section A**. By choosing one of these options, you automatically end your membership in our plan.

1. You can change to: **Another plan that provides your Medicare and most or all of your Medicaid benefits and services in one plan, also known as an integrated dual-eligible special needs plan (D-SNP) or a Program of All-inclusive Care for the Elderly (PACE) plan, if you qualify.**	**Here is what to do:** Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. If you need help or more information: ▪ Call the Michigan Medicare/Medicaid Assistance Program (MMAP) at 800.803.7174. **OR** Enroll in a new integrated D-SNP. You'll automatically be disenrolled from our Medicare plan when your new plan's coverage begins.
2. You can change to: **Original Medicare with a separate Medicare drug plan**	**Here is what to do:** Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. If you need help or more information: ▪ Call the Michigan Medicare/Medicaid Assistance Program (MMAP) at 800.803.7174. **OR** Enroll in a new Medicare drug plan. You'll automatically be disenrolled from our plan when your Original Medicare coverage begins.

3. You can change to: **Original Medicare without a separate Medicare drug plan** **NOTE:** If you switch to Original Medicare and don't enroll in a separate Medicare drug plan, Medicare may enroll you in a drug plan, unless you tell Medicare you don't want to join. You should only drop drug coverage if you have drug coverage from another source, such as an employer or union. If you have questions about whether you need drug coverage, call the Michigan Medicare/Medicaid Assistance Program (MMAP) at 800.803.7174, Monday through Friday from 8:00 a.m. to 5:00 p.m. For more information or to find a local MMAP office in your area, please visit https://mmapinc.org/contact-us/.	**Here is what to do:** Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. If you need help or more information: • Call the Michigan Medicare/Medicaid Assistance Program (MMAP) at 800.803.7174. You'll automatically be disenrolled from our plan when your Original Medicare coverage begins.

4. You can change to:	**Here is what to do:**
Any Medicare health plan during certain times of the year including the Annual **Enrollment Period** and the **Medicare Advantage Open Enrollment Period** or other situations described in **Section A**.	Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. If you need help or more information: ▪ Call the Michigan Medicare/Medicaid Assistance Program (MMAP) at 800.803.7174. **OR** Enroll in a new Medicare plan. You'll automatically be disenrolled from our Medicare plan when your new plan's coverage begins.

C2. Your Michigan Medicaid services

If you leave our plan, you'll get your Michigan Medicaid services through fee-for-service.

Your Michigan Medicaid services include most long-term services and supports and behavioral health care. If you leave our plan you can use any provider that accepts Michigan Medicaid.

Use MI Bridges to update your enrollment information.

D. Your medical items, services and drugs until your membership in our plan ends

If you leave our plan, it may take time before your membership ends and your new Medicare and Medicaid coverage begins. During this time, you keep getting your drugs and health care through our plan until your new plan begins.

- Use our network providers to receive medical care.
- Use our network pharmacies, including through our mail-order pharmacy services, to get your prescriptions filled.

- If you're hospitalized on the day that your membership in PriorityMedicare Dual Premier ends, our plan will cover your hospital stay until you're discharged. This will happen even if your new health coverage begins before you're discharged.

E. Other situations when your membership in our plan ends

These are cases when we must end your membership in our plan:

- If there's a break in your Medicare Part A and Medicare Part B coverage.
- If you no longer qualify for Medicaid. Our plan is for people who qualify for both Medicare and Medicaid.
- If you are no longer eligible for Medicaid. Our plan is for people who are eligible for both Medicare and Medicaid.
- If you move out of our service area.
- If you're away from our service area for more than six months.
    - If you move or take a long trip, call Customer Care to find out if where you're moving or traveling to is in our plan's service area.
- If you go to jail or prison for a criminal offense.
- If you lie about or withhold information about other insurance you have for drugs.
- If you're not a United States citizen or aren't lawfully present in the United States.
    - You must be a United States citizen or lawfully present in the United States to be a member of our plan.
    - The Centers for Medicare & Medicaid Services (CMS) notify us if you're not eligible to remain a member on this basis.
    - We must disenroll you if you don't meet this requirement.
- If you're within this plan, this program allows you to remain enrolled in the HIDE SNP program for up to three (3) months after the loss of Medicaid eligibility. This period of time is referred to as "deeming", which gives you a chance to get your redetermination paperwork sorted out with your caseworker. During this "deeming" period, we'll continue to provide all your Medicare Advantage plan-covered Medicare benefits. If your status isn't

regained at the end of the deeming period, you will be disenrolled. Refer to **Chapter 1, Section E** of this *Member Handbook* for more information. of this *Member Handbook* for more information.

We can make you leave our plan for the following reasons only if we get permission from Medicare and Medicaid first:

- If you intentionally give us incorrect information when you're enrolling in our plan and that information affects your eligibility for our plan.
- If you continuously behave in a way that's disruptive and makes it difficult for us to provide medical care for you and other members of our plan.
- If you let someone else use your Member ID Card to get medical care. (Medicare may ask the Inspector General to investigate your case if we end your membership for this reason.)

F. Rules against asking you to leave our plan for any health-related reason

We can't ask you to leave our plan for any reason related to your health. If you think we're asking you to leave our plan for a health-related reason, **call Medicare** at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

G. Your right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership. You can also refer to **Chapter 9** of this *Member Handbook* for information about how to make a complaint.

H. How to get more information about ending your plan membership

If you have questions or would like more information on ending your membership, you can call Customer Care at the number at the bottom of this page.

Chapter 11: Legal notices

Introduction

This chapter includes legal notices that apply to your membership in our plan. Key terms and their definitions appear in alphabetical order in the last chapter of this *Member Handbook*.

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A. Notice about laws

Many laws apply to this *Member Handbook*. These laws may affect your rights and responsibilities even if the laws aren't included or explained in this *Member Handbook*. The main laws that apply are federal laws about the Medicare and Michigan Medicaid programs. Other federal and state laws may apply too.

B. Notice about nondiscrimination

We don't discriminate or treat you differently because of your race, ethnicity, national origin, color, religion, sex, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. Additionally, we don't discriminate or treat you differently because of your HIV status, marital status, sexual orientation, gender identity or expression, socioeconomic status or source of payment for service, height, weight, veteran status, association or any other protected characteristic based on federal, state or local law.

If you want more information or have concerns about discrimination or unfair treatment:

- Call the Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019. TTY users can call 1-800-537-7697. You can also visit www.hhs.gov/ocr for more information.
- Call your local Office for Civil Rights at 800.482.3604.
- If you have a disability and need help accessing health care services or a provider, call Customer Care. If you have a complaint, such as a problem with wheelchair access, Customer Care can help.

C. Notice about Medicare as a second payer and Michigan Medicaid as a payer of last resort

Sometimes someone else must pay first for the services we provide you. For example, if you're in a car accident or if you're injured at work, insurance or Workers Compensation must pay first.

We have the right and responsibility to collect for covered Medicare services for which Medicare isn't the first payer.

We comply with federal and state laws and regulations relating to the legal liability of third parties for health care services to members. We take all reasonable measures to ensure that Michigan Medicaid is the payer of last resort.

Chapter 12: Definitions of important words

Introduction

This chapter includes key terms used throughout this *Member Handbook* with their definitions. The terms are listed in alphabetical order. If you can't find a term you're looking for or if you need more information than a definition includes, contact Customer Care.

Activities of daily living (ADL): The things people do on a normal day, such as eating, using the toilet, getting dressed, bathing, or brushing teeth.

Administrative law judge: A judge that reviews a level 3 appeal.

AIDS drug assistance program (ADAP): A program that helps eligible individuals living with HIV/AIDS have access to life-saving HIV medications.

Ambulatory surgical center: A facility that provides outpatient surgery to patients who don't need hospital care and who aren't expected to need more than 24 hours of care.

Appeal: A way for you to challenge our action if you think we made a mistake. You can ask us to change a coverage decision by filing an appeal. **Chapter 9** of this *Member Handbook* explains appeals, including how to make an appeal.

Behavioral Health: An all-inclusive term referring to mental health and substance use disorders.

Biological Product: A drug that's made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and can't be copied exactly, so alternative forms are called biosimilars. (See also "Original Biological Product" and "Biosimilar").

Biosimilar: A biological product that's very similar, but not identical, to the original biological product. Biosimilars are as safe and effective as the original biological product. Some biosimilars may be substituted for the original biological product at the pharmacy without needing a new prescription. (Go to "Interchangeable Biosimilar").

Brand name drug: A drug that's made and sold by the company that originally made the drug. Brand name drugs have the same ingredients as the generic versions of the drugs. Generic drugs are usually made and sold by other drug companies and are generally not available until the patent on the brand name drug has ended.

Care Manager: One main person who works with you, with the health plan, and with your care providers to make sure you get the care you need.

Care plan: Refer to "Individualized Care Plan.

Care team: Refer to "Interdisciplinary Care Team."

Catastrophic Coverage stage: The stage in the Medicare Part D drug benefit where our plan pays all costs of your until the end of the year. You begin this stage when you (or other qualified parties on your behalf) have spent $2,100 for Part D covered drugs during the year. You pay nothing.

Centers for Medicare & Medicaid Services (CMS): The federal agency in charge of Medicare. **Chapter 2** of this *Member Handbook* explains how to contact CMS.

Complaint: A written or spoken statement saying that you have a problem or concern about your covered services or care. This includes any concerns about the quality of service, quality of your care, our network providers, or our network pharmacies. The formal name for "making a complaint" is "filing a grievance".

Comprehensive outpatient rehabilitation facility (CORF): A facility that mainly provides rehabilitation services after an illness, accident, or major operation. It provides a variety of services, including physical therapy, social or psychological services, respiratory therapy, occupational therapy, speech therapy, and home environment evaluation services.

Copay: A fixed amount you pay as your share of the cost each time you get certain drugs. For example, you might pay $2 or $5 for a drug.

Cost-sharing: Amounts you have to pay when you get certain drugs. Cost-sharing includes copays.

Cost-sharing tier: A group of drugs with the same copay. Every drug on the *List of Covered Drugs* (also known as the *Drug List*) is in one of five cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.

Coverage decision: A decision about what benefits we cover. This includes decisions about covered drugs and services or the amount we pay for your health services. **Chapter 9** of this *Member Handbook* explains how to ask us for a coverage decision.

Covered drugs: The term we use to mean all of the prescription and over-the-counter (OTC) drugs covered by our plan.

Covered services: The general term we use to mean all the health care, long-term services and supports, supplies, prescription and over-the-counter drugs, equipment, and other services our plan covers.

Cultural competence training: Training that provides additional instruction for our health care providers that helps them better understand your background, values, and beliefs to adapt services to meet your social, cultural, and language needs.

Customer Care: A department in our plan responsible for answering your questions about membership, benefits, grievances, and appeals. Refer to **Chapter 2** of this *Member Handbook* for more information about Customer Care.

Daily cost-sharing rate: A rate that may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you're required to pay a copay. A daily cost-sharing rate is the copay divided by the number of days in a month's supply. Here is an example: Let's say the copay for your drug for a full month's supply (a 30-day supply) is $1.35. This means that the amount you pay for your drug is less than $0.05 per day. If you get a 7-day supply of the drug, your payment is less than $0.05 per day multiplied by 7 days, for a total payment less than $0.35.

Disenrollment: The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Drug management program (DMP): A program that helps make sure members safely use prescription opioids and other frequently abused medications.

Drug tiers: Groups of drugs on our *Drug List*. Generic, brand name, or over-the-counter (OTC) drugs are examples of drug tiers. Every drug on the *Drug List* is in one of five tiers.

Dual eligible special needs plan (D-SNP): Health plan that serves individuals who are eligible for both Medicare and Medicaid. Our plan is a D-SNP.

Durable medical equipment (DME): Certain items your doctor orders for use in your own home. Examples of these items are wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment and supplies, nebulizers, and walkers.

Emergency: A medical emergency when you, or any other person with an average knowledge of health and medicine, believe that you have medical symptoms that need immediate medical attention to prevent death, loss of a body part, or loss of or serious impairment to a bodily function and if you're a pregnant woman, loss of an unborn child. The medical symptoms may be an illness, injury, severe pain, or a medical condition that's quickly getting worse.

Emergency care: Covered services given by a provider trained to give emergency services and needed to treat a medical or behavioral health emergency.

Exception: Permission to get coverage for a drug not normally covered or to use the drug without certain rules and limitations.

Excluded Services: Services that aren't covered by this health plan.

Extra Help: Medicare program that helps people with limited incomes and resources reduce Medicare Part D drug costs, such as premiums, deductibles, and copays. Extra Help is also called the "Low-Income Subsidy", or "LIS".

Generic drug: A drug approved by the FDA to use in place of a brand name drug. A generic drug has the same ingredients as a brand name drug. It's usually cheaper and works just as well as the brand name drug.

Grievance: A complaint you make about us or one of our network providers or pharmacies. This includes a complaint about the quality of your care or the quality of service provided by your health plan.

Health plan: An organization made up of doctors, hospitals, pharmacies, providers of long-term services, and other providers. It also has care managers to help you manage all your providers and services. All of them work together to provide the care you need.

Health risk assessment (HRA): A review of your medical history and current condition. It's used to learn about your health and how it might change in the future.

Home health aide: A person who provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (like bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides don't have a nursing license or provide therapy.

Hospice: A program of care and support to help people who have a terminal prognosis live comfortably. A terminal prognosis means that a person has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less.

- An enrollee who has a terminal prognosis has the right to elect hospice.
- A specially trained team of professionals and caregivers provide care for the whole person, including physical, emotional, social, and spiritual needs.
- We're required to give you a list of hospice providers in your geographic area.

Improper/inappropriate billing: A situation when a provider (such as a doctor or hospital) bills you more than our cost-sharing amount for services. Call Customer Care if you get any bills you don't understand. As a plan member, you only pay our plan's cost-sharing amounts when you get services we cover. We **don't** allow providers to bill you more than this amount.

Independent review organization (IRO): An independent organization hired by Medicare that reviews a level 2 appeal. It isn't connected with us and isn't a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work. The formal name is the Independent Review Entity.

Individualized Care Plan (ICP or Care Plan): A plan for what services you'll get and how you'll get them. Your plan may include medical services, behavioral health services, and long-term services and supports.

Initial coverage stage: The stage before your total Medicare Part D drug expenses reach $2,100. This includes amounts you paid, what our plan paid on your behalf, and the low-income subsidy. You begin in this stage when you fill your first prescription of the year. During this stage, we pay part of the costs of your drugs, and you pay your share.

Inpatient: A term used when you're formally admitted to the hospital for skilled medical services. If you're not formally admitted, you may still be considered an outpatient instead of an inpatient even if you stay overnight.

Interdisciplinary Care Team (ICT or Care team): A care team may include doctors, nurses, counselors, or other health professionals who are there to help you get the care you need. Your care team also helps you make a care plan.

Integrated D-SNP: A dual-eligible special needs plan that covers Medicare and most or all Medicaid services under a single health plan for certain groups of individuals eligible for both Medicare and Medicaid. These individuals are known as full-benefit dually eligible individuals.

Interchangeable Biosimilar: A biosimilar that may be substituted at the pharmacy without needing a new prescription because it meets additional requirements about the potential for automatic substitution. Automatic substitution at the pharmacy is subject to state law.

***List of* Covered *Drugs* (*Drug List*):** A list of prescription and over-the-counter (OTC) drugs we cover. We choose the drugs on this list with the help of doctors and pharmacists. The *Drug List* tells you if there are any rules you need to follow to get your drugs. The *Drug List* is sometimes called a "formulary".

Long-term services and supports (LTSS): Long-term services and supports help improve a long-term medical condition. Most of these services help you stay in your home so you don't have to go to a nursing facility or hospital. LTSS include Community-Based Services and Nursing Facilities (NF).

Low-income subsidy (LIS): Refer to "Extra Help"

Medicaid (or Medical Assistance): A program run by the federal government and the state that helps people with limited incomes and resources pay for long-term services and supports and medical costs.

Medically necessary: This describes services, supplies, or drugs you need to prevent, diagnose, or treat a medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing facility. It also means the services, supplies, or drugs meet accepted standards of medical practice.

Medicare: The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare or a managed care plan (refer to “Health plan”).

Medicare Advantage: A Medicare program, also known as “Medicare Part C” or “MA”, that offers MA plans through private companies. Medicare pays these companies to cover your Medicare benefits.

Medicare Appeals Council (Council): A council that reviews a level 4 appeal. The Council is part of the Federal government.

Medicare-covered services: Services covered by Medicare Part A and Medicare Part B. All Medicare health plans, including our plan, must cover all the services covered by Medicare Part A and Medicare Part B.

Medicare diabetes prevention program (MDPP): A structured health behavior change program that provides training in long-term dietary change, increased physical activity, and strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.

Medicare-Medicaid enrollee: A person who qualifies for Medicare and Medicaid coverage. A Medicare- Medicaid enrollee is also called a “dually eligible individual”.

Medicare Part A: The Medicare program that covers most medically necessary hospital, skilled nursing facility, home health, and hospice care.

Medicare Part B: The Medicare program that covers services (such as lab tests, surgeries, and doctor visits) and supplies (such as wheelchairs and walkers) that are medically necessary to treat a disease or condition. Medicare Part B also covers many preventive and screening services.

Medicare Part C: The Medicare program, also known as “Medicare Advantage” or “MA”, that lets private health insurance companies provide Medicare benefits through an MA Plan.

Medicare Part D: The Medicare drug benefit program. We call this program "Part D" for short. Medicare Part D covers outpatient drugs, vaccines, and some supplies not covered by Medicare Part A or Medicare Part B or Medicaid. Our plan includes Medicare Part D.

Medicare Part D drugs: Drugs covered under Medicare Part D. Congress specifically excludes certain categories of drugs from coverage under Medicare Part D. Medicaid may cover some of these drugs.

Medication Therapy Management (MTM): A Medicare Part D program for complex health needs provided to people who meet certain requirements or are in a Drug Management Program. MTM services usually include a discussion with a pharmacist or health care provider to review medications. Refer to Chapter 5 of this *Member Handbook* for more information.

Member (member of our plan, or plan member): A person with Medicare and Medicaid who qualifies to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS) and the state.

***Member Handbook* and Disclosure Information:** This document, along with your enrollment form and any other attachments, or riders, which explain your coverage, what we must do, your rights, and what you must do as a member of our plan.

Michigan Medicaid: This is the name of Michigan's Medicaid program. Michigan Medicaid is run by the state and is paid for by the state and the federal government. It helps people with limited incomes and resources pay for long-term services and supports and medical costs.

- It covers extra services and some drugs not covered by Medicare.
- Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Network pharmacy: A pharmacy (drug store) that agreed to fill prescriptions for our plan members. We call them "network pharmacies" because they agreed to work with our plan. In most cases, we cover your prescriptions only when filled at one of our network pharmacies.

Network provider: "Provider" is the general term we use for doctors, nurses, and other people who give you services and care. The term also includes hospitals, home health agencies, clinics, and other places that give you health care services, medical equipment, and long-term services and supports.

- They're licensed or certified by Medicare and by the state to provide health care services.
- We call them "network providers" when they agree to work with our health plan, accept our payment, and don't charge members an extra amount.
- While you're a member of our plan, you must use network providers to get covered services. Network providers are also called "plan providers".

Nursing home or facility: A place that provides care for people who can't get their care at home but don't need to be in the hospital.

Ombudsperson: An office in your state that works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do. The ombudsperson's services are free. You can find more information in **Chapters 2 and 9** of this *Member Handbook*.

Organization determination: Our plan makes an organization determination when we, or one of our providers, decide about whether services are covered or how much you pay for covered services. Organization determinations are called "coverage decisions". **Chapter 9** of this *Member Handbook* explains coverage decisions.

Original Biological Product: A biological product that has been approved by the FDA and serves as the comparison for manufacturers making a biosimilar version. It's also called a reference product.

Original Medicare (traditional Medicare or fee-for-service Medicare): The government offers Original Medicare. Under Original Medicare, services are covered by paying doctors, hospitals, and other health care providers amounts that Congress determines.

- You can use any doctor, hospital, or other health care provider that accepts Medicare. Original Medicare has two parts: Medicare Part A (hospital insurance) and Medicare Part B (medical insurance).
- Original Medicare is available everywhere in the United States.
- If you don't want to be in our plan, you can choose Original Medicare.

Out-of-network pharmacy: A pharmacy that hasn't agreed to work with our plan to coordinate or provide covered drugs to members of our plan. Our plan doesn't cover most drugs you get from out-of-network pharmacies unless certain

conditions apply.

Out-of-network provider or Out-of-network facility: A provider or facility that isn't employed, owned, or operated by our plan and isn't under contract to provide covered services to members of our plan. **Chapter 3** of this *Member Handbook* explains out-of-network providers or facilities.

Out-of-pocket costs: The cost- sharing requirement for members to pay for part of the services or drugs they get is also called the "out-of-pocket" cost requirement. Refer to the definition for "cost-sharing" above.

Over-the-counter (OTC) drugs: Over-the-counter drugs are drugs or medicines that a person can buy without a prescription from a health care professional.

Part A: Refer to "Medicare Part A."

Part B: Refer to "Medicare Part B."

Part C: Refer to "Medicare Part C."

Part D: Refer to "Medicare Part D."

Part D drugs: Refer to "Medicare Part D drugs."

Personal health information (also called Protected health information) (PHI): Information about you and your health, such as your name, address, social security number, physician visits, and medical history. Refer to our Notice of Privacy Practices for more information about how we protect, use, and disclose your PHI, as well as your rights with respect to your PHI.

Preventive services: Health care to prevent illness or detect illness at an early stage, when treatment is likely to work best (for example, preventive services include Pap tests, flu shots, and screening mammograms).

Primary care provider (PCP): The doctor or other provider you use first for most health problems. They make sure you get the care you need to stay healthy.

- They also may talk with other doctors and health care providers about your care and refer you to them.
- In many Medicare health plans, you must use your primary care provider before you use any other health care provider.
- Refer to **Chapter 3** of this *Member Handbook* for information about getting

care from primary care providers.

Prior authorization (PA): An approval you must get from us before you can get a specific service or drug or use an out-of-network provider. Our plan may not cover the service or drug if you don't get approval first.

Our plan covers some network medical services only if your doctor or other network provider gets PA from us.

- Covered services that need our plan's PA are marked in **Chapter 4** of this *Member Handbook*.

Our plan covers some drugs only if you get PA from us.

- Covered drugs that need our plan's PA are marked in the *List of Covered Drugs* and the rules are posted on our website.

Program All-Inclusive Care for the Elderly (PACE): A program that covers Medicare and Medicaid benefits together for people age 55 and over who need a higher level of care to live at home.

Prosthetics and Orthotics: Medical devices ordered by your doctor or other health care provider that include, but aren't 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 doctors and other health care experts who help improve the quality of care for people with Medicare. The federal government pays the QIO to check and improve the care given to patients. Refer to **Chapter 2** of this *Member Handbook* for information about the QIO.

Quantity limits: A limit on the amount of a drug you can have. We may limit the amount of the drug that we cover per prescription.

Real Time Benefit Tool: A portal or computer application in which enrollees can look up complete, accurate, timely, clinically appropriate, enrollee-specific covered drugs and benefit information. This includes cost sharing amounts, alternative drugs 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 drugs.

Referral: A referral is your primary care provider's (PCP's) approval to use a provider other than your PCP. If you don't get approval first, we may not cover the services. You don't need a referral to use certain specialists, such as women's health specialists. You can find more information about referrals in **Chapters 3 and 4** of this *Member Handbook*.

Rehabilitation services: Treatment you get to help you recover from an illness, accident or major operation. Refer to **Chapter 4** of this *Member Handbook* to learn more about rehabilitation services.

Service area: A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it's generally the area where you can get routine (non-emergency) services. Only people who live in our service area can enroll in our plan.

Skilled nursing facility (SNF): A nursing facility with the staff and equipment to give skilled nursing care and, in most cases, skilled rehabilitative services and other related health services.

Skilled nursing facility (SNF) care: Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous (IV) injections that a registered nurse or a doctor can give.

Specialist: A doctor who provides health care for a specific disease or part of the body.

State Hearing: If your doctor or other provider asks for a Medicaid service that we won't approve, or we won't continue to pay for a Medicaid service you already have, you can ask for a State Hearing. If the State Hearing is decided in your favor, we must give you the service you asked for.

Step therapy: A coverage rule that requires you to try another drug before we cover the drug you ask for.

Supplemental Security Income (SSI): A monthly benefit Social Security pays to people with limited incomes and resources who are disabled, blind, or age 65 and over. SSI benefits aren't the same as Social Security benefits.

Urgently needed care: Care you get for an unforeseen illness, injury, or condition that isn't an emergency but needs care right away. You can get urgently needed care from out-of-network providers when you can't get to them

because given your time, place, or circumstances, it isn't possible, or it's unreasonable to obtain services from network providers (for example when you're outside our plan's service area and you require medically needed immediate services for an unseen condition, but it isn't a medical emergency).

PriorityMedicare Dual Premier Customer Care

CALL	833.939.0983 Calls to this number are free. Oct. 1–Mar. 31, we're available seven days a week from 8 a.m.–8 p.m. ET. From Apr. 1–Sept. 30, we're available Mon.–Fri. from 8 a.m.–8 p.m. and Sat. 8 a.m.–noon ET. Customer Care also has free language interpreter services available for non-English speakers.
TTY	711 Calls to this number are free. Oct. 1–Mar. 31, we're available seven days a week from 8 a.m.–8 p.m. ET. From Apr. 1–Sept. 30, we're available Mon.–Fri. from 8 a.m.–8 p.m. and Sat. 8 a.m.–noon ET.
FAX	616.942.0995
WRITE	Customer Care Department, MS 1115 Priority Health Medicare 1231 East Beltline Ave. NE Grand Rapids, MI 49525 MedicareCS@priorityhealth.com
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