Priority Health

2027
Evidence of Coverage

PriorityMedicare® Merit (PPO)
Offered by Priority Health Medicare

January 1, 2027 - December 31, 2027

OMB Approval 0938-1051 (Expires: July 31, 2029)
H4875_110011502706_C

January 1 – December 31, 2027

Evidence of Coverage for 2027:

Your Medicare Health Benefits and Services and Drug Coverage as a Member of **Priority**Medicare Merit (PPO)

This document gives the details of your Medicare health and drug coverage from January 1 – December 31, 2027. **This is an important legal document. Keep it in a safe place.**

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

- Your plan premium and cost sharing
- Your medical and drug benefits
- How to file a complaint if you're not satisfied with a service or treatment
- How to contact us
- Other protections required by Medicare law

For questions about this document, call Customer Care at 888.389.6648. (TTY users call 711). 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. This call is free.

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

This information is available in audio, braille, and large print upon request.

Benefits, premiums, and/or copayments/coinsurance may change on January 1, 2028.

Our formulary, pharmacy network, and/or provider network can change at any time. You'll get notice about any changes that can affect you at least 30 days in advance.

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CHAPTER 1: Get started as a member

SECTION 1 You're a member of **Priority**Medicare Merit (PPO)

Section 1.1 You're enrolled in **Priority**Medicare Merit (PPO), which is a Medicare PPO

You're covered by Medicare, and you chose to get your Medicare health and drug coverage through our plan, **Priority**Medicare Merit (PPO). Our plan covers all Part A and Part B services. However, cost sharing and provider access in this plan are different from Original Medicare.

PriorityMedicare Merit (PPO) is a Medicare Advantage PPO Plan (PPO stands for Preferred Provider Organization). Like all Medicare health plans, this Medicare PPO is approved by Medicare and run by a private company.

Section 1.2 Legal information about the *Evidence of Coverage*

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

The contract is in effect for the months you're enrolled in **Priority**Medicare Merit (PPO) between January 1, 2027, and December 31, 2027.

Medicare allows us to make changes to our plans we offer each calendar year. This means we can change the costs and benefits of **Priority**Medicare Merit (PPO) after December 31, 2027. We can also choose to stop offering our plan in your service area, after December 31, 2027.

Medicare (the Centers for Medicare & Medicaid Services) must approve **Priority**Medicare Merit (PPO) each year. You can continue to get Medicare coverage as a member of our plan as long as we choose to continue offering our plan and Medicare renews approval of our plan.

SECTION 2 Plan eligibility requirements

Section 2.1 Eligibility requirements

You're eligible for membership in our plan as long as you meet all these conditions:

- You have both Medicare Part A and Medicare Part B

- You live in our geographic service area (described in Section 2.2). People who are incarcerated aren't considered to be living in the geographic service area, even if they're physically located in it.
- You're a United States citizen or national, or an eligible noncitizen.

Section 2.2 Plan service area for **Priority**Medicare Merit (PPO)

PriorityMedicare Merit (PPO) is only available to people who live in our plan service area. To stay a member of our plan, you must continue to live in our service area. The service area is described below.

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

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

Michigan Counties		
Roscommon	Saginaw	St. Clair
St. Joseph	Sanilac	Shiawassee
Tuscola	Van Buren	Washtenaw
Wayne	Wexford	

If you move out of our plan's service area, you can't stay a member of this plan. Call Customer Care at 888.389.6648 (TTY users call 711) to see if we have a plan in your new area. When you move, you'll have a Special Enrollment Period to either switch to Original Medicare or enroll in a Medicare health or drug plan in your new location.

If you move or change your mailing address, it's also important to call Social Security. Call Social Security at 1-800-772-1213 (TTY users call 1-800-325-0778).

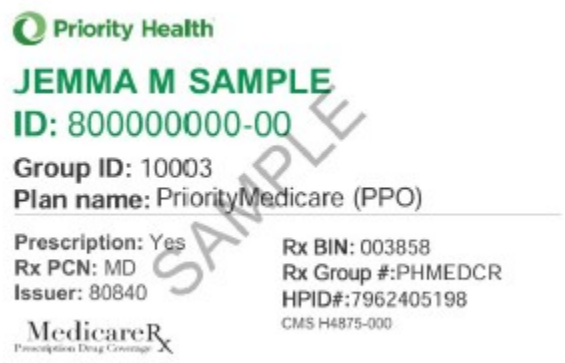
Section 2.3 U.S. citizen or national, or eligible noncitizen

You must be a U.S. citizen or national, or an eligible noncitizen to be a member of a Medicare health plan. Medicare (the Centers for Medicare & Medicaid Services) will notify **Priority**Medicare Merit (PPO) if you're not eligible to stay a member of our plan on this basis. **Priority**Medicare Merit (PPO) must disenroll you if you don't meet this requirement.

SECTION 3 Important membership materials

Section 3.1 Our plan membership card

Use your membership card whenever you get services covered by our plan and for prescription drugs you get at network pharmacies. You should also show the provider your Medicaid card, if you have one. Sample plan membership card:



DON'T use your red, white, and blue Medicare card for covered medical services while you're a member of this plan. If you use your Medicare card instead of your **Priority**Medicare Merit

(PPO) membership card, you may have to pay the full cost of medical services yourself. Keep your Medicare card in a safe place. You may be asked to show it if you need hospital services, hospice services, or participate in Medicare-approved clinical research studies (also called clinical trials).

If our plan membership card is damaged, lost, or stolen, call Customer Care at 888.389.6648 (TTY users call 711) right away and we'll send you a new card.

Section 3.2 Provider/Pharmacy Directory

The *Provider/Pharmacy Directory* available at ***priorityhealth.com/27merit*** lists our current network providers, durable medical equipment suppliers, and network pharmacies.

Network providers are the doctors and other health care professionals, medical groups, durable medical equipment suppliers, hospitals, and other health care facilities that have an agreement with us to accept our payment and any plan cost sharing as payment in full.

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

Network pharmacies are pharmacies that agree to fill covered prescriptions for our plan members. Use the *Provider/Pharmacy Directory* to find the network pharmacy you want to use. Go to Chapter 5, Section 2.4 for information on when you can use pharmacies that aren't in our plan's network.

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

If you don't have a *Provider/Pharmacy Directory*, you can ask for a copy from Customer Care at 888.389.6648 (TTY users call 711). You can also find this information on our website at ***priorityhealth.com/27merit*** or download it from this website. Both Customer Care and the website can give you the most up-to-date information about changes in our network providers.

Section 3.3 Drug List (formulary)

Our plan has a *List of Covered Drugs* (also called the Drug List or formulary). It tells which prescription drugs are covered under the Part D benefit included in **Priority**Medicare Merit (PPO). The drugs on this list are selected by our plan with the help of doctors and pharmacists. The Drug List meets all Medicare requirements. Drugs included in the Medicare Drug Price Negotiation Program will be included on your Drug List unless they have been removed or replaced as described in Chapter 5, Section 6. Medicare approved the **Priority**Medicare Merit (PPO) Drug List.

The Drug List also tells if there are any rules that restrict coverage for a drug.

We'll give you a copy of the Drug List. To get the most complete and current information about which drugs are covered, visit ***priorityhealth.com/27merit*** or call Customer Care at 888.389.6648 (TTY users call 711).

SECTION 4 Summary of Important Costs for 2027

	Your Costs in 2027
Monthly plan premium* * Your premium can be higher than this amount. Go to Section 4.1 for details.	$100 - $163
Maximum out-of-pocket amount This is the most you'll pay out-of-pocket for covered services. (Go to Chapter 4, Section 1 for details.)	**From in-network providers:** $5,000 **From in-network and out-of-network providers combined:** $5,000
Primary care office visits	**In-Network** $0 copay per visit. **Out-of-Network** 30% of the total cost for visits with a PCP.
Specialist office visits	**In-Network** $0 to $45 copay per visit. **Out-of-Network** 30% of the total cost for visits with a specialist.
Inpatient hospital stays Includes various inpatient hospital stays such as acute care, rehabilitation and long-term care. An inpatient hospital stay starts the day you're formally admitted with a doctor's order and ends the day before you're discharged.	**In-Network** For Medicare-covered inpatient hospital stays: $360 copay per day for days 1 - 6. $0 for additional hospital days. **Out-of-Network** For Medicare-covered inpatient hospital stays: 30% of the total cost per stay.

	Your Costs in 2027
Part D drug coverage (Go to Chapter 6 for details, including Yearly Deductible, Initial Coverage, and Catastrophic Coverage Stages.)	**Part D drug coverage deductible** $0 **Copayment/Coinsurance during the Initial Coverage Stage:** **Drug Tier 1:** $2 copay at a preferred network pharmacy or $7 copay at a standard network pharmacy **Drug Tier 2:** $10 copay at a preferred network pharmacy or $15 copay at a standard network pharmacy **Drug Tier 3:** 25% of the total cost at a preferred network pharmacy or 25% of the total cost at a standard network pharmacy You pay no more than $35 per month supply of each covered insulin product on this tier. **Drug Tier 4:** 29% of the total cost at a preferred network pharmacy or 34% of the total cost at a standard network pharmacy You pay no more than $35 per month supply of each covered insulin product on this tier. **Drug Tier 5:** 33% of the total cost at a preferred network pharmacy or 33% of the total cost at a standard network pharmacy You pay no more than $35 per month supply of each covered insulin product on this tier. **Catastrophic Coverage Stage:** During this payment stage, you pay nothing for your covered Part D drugs.

Your costs can include the following:

- Plan Premium (Section 4.1)
- Monthly Medicare Part B Premium (Section 4.2)

- Optional Supplemental Benefit Premium (Section 4.3)
- Part D Late Enrollment Penalty (Section 4.4)
- Income Related Monthly Adjusted Amount (Section 4.5)
- Medicare Prescription Payment Plan Amount (Section 4.6)

Section 4.1 Plan premium

As a member of our plan, you pay a monthly plan premium. The table below shows the monthly plan premium amount for each region we serve.

Note: Your service area includes all the counties listed below. For details on what to expect when you move outside the service area or from one region to another, refer to Chapter 10, Section 2.3.

Region	County	Premium
Region 1:	Allegan, Barry, Kent, Lenawee, Ottawa	$100
Region 2:	Berrien, Calhoun, Cass, Ionia, Isabella, Kalamazoo, Mason, Midland, Missaukee, Montcalm, Muskegon, Newaygo, Oceana, Osceola, Otsego, St. Clair, Van Buren, Wexford	$119
Region 3:	Alcona, Antrim, Benzie, Charlevoix, Clare, Crawford, Grand Traverse, Hillsdale, Lake, Lapeer, Leelanau, Manistee, Mecosta, Monroe	$156
Region 4:	Alpena, Cheboygan, Eaton, Emmet, Gladwin, Gratiot, Iosco, Jackson, Kalkaska, Montmorency, Oscoda, Presque Isle, Roscommon, Sanilac, Shiawasse, St. Joseph	$163
Region 5:	Arenac, Bay, Branch, Clinton, Genesee, Huron, Ingham, Livingston, Macomb, Oakland, Ogemaw, Saginaw, Tuscola, Washtenaw, Wayne	$141

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 and State Pharmaceutical Assistance Programs. Learn more about these programs in Chapter 2, Section 7. If you qualify, enrolling in one of these programs might lower your monthly plan premium.

If you *already* get help from one of these programs, **the information about premiums in this *Evidence of Coverage* may 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, call Customer Care at 888.389.6648 (TTY users call 711) and ask for the *LIS Rider*.

Medicare Part B and Part D premiums differ for people with different incomes. If you have questions about these premiums, check your copy of the *Medicare & You 2027* handbook in the section called *2027 Medicare Costs*. Download a copy from the Medicare website at (Medicare.gov/medicare-and-you) or order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

Section 4.2 Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums

In addition to paying the monthly plan premium, **you must continue paying your Medicare premiums to stay a member of our plan.** This includes your premium for Part B. You may also pay a premium for Part A if you aren't eligible for premium-free Part A.

Section 4.3 Optional Supplemental Benefit Premium

If you signed up for extra benefits, also called *optional supplemental benefits*, you pay an additional premium each month for these extra benefits. Go to Chapter 4, Section 2.1 for details.

Enhanced Dental and Vision Package Option 1: $42 monthly premium.

Enhanced Dental and Vision Package Option 2: $61 monthly premium.

Section 4.4 Part D Late Enrollment Penalty

Some members are required to pay a Part D **late enrollment penalty**. The Part D late enrollment penalty is an additional premium that must be paid for Part D coverage if at any time after your initial enrollment period is over, there was a period of 63 days or more in a row when you didn't have Part D or other creditable prescription drug coverage. Creditable prescription drug coverage is coverage that meets Medicare's minimum standards since it is expected to pay, on average, at least as much as Medicare's standard drug coverage. The cost of the late enrollment penalty depends on how long you went without Part D or other creditable prescription drug coverage. You'll generally have to pay this penalty for as long as you have Part D coverage.

The Part D late enrollment penalty is added to your monthly or quarterly premium. When you first enroll in **Priority**Medicare Merit (PPO), we let you know the amount of the penalty. If you don't pay your Part D late enrollment penalty, you could lose your prescription drug benefits.

You **don't** have to pay the Part D late enrollment penalty if:

- You get Extra Help from Medicare to help pay your drug costs.
- You went less than 63 days in a row without Part D or other creditable coverage.

- You had creditable drug coverage through another source (like a former employer, union, TRICARE, or Veterans Health Administration (VA)). Your insurer or human resources department will tell you each year if your drug coverage is creditable coverage. You may get this information in a letter or in a newsletter from that plan. Keep this information because you may need it if you join a Medicare drug plan later.
  - **Note:** Any letter or notice must state that you had creditable prescription drug coverage that is expected to pay as much as Medicare's standard drug plan pays.
  - **Note:** Prescription drug discount cards, free clinics, and drug discount websites aren't creditable prescription drug coverage.

Medicare determines the amount of the Part D late enrollment penalty. Here's how it works:

- If you went 63 days or more without Part D or other creditable prescription drug coverage after you were first eligible to enroll in Part D, our plan will count the number of full months you didn't have coverage.
- Then Medicare determines the amount of the average monthly plan premium for Medicare drug plans in the nation from the previous year (national base beneficiary premium). For 2027, this average premium amount is $41.33.
- To calculate your monthly penalty, Medicare multiplies the number of uncovered months (penalty percentage) by 1% of the national base beneficiary premium and then rounds that amount to the nearest 10 cents. For example, if you go 14 months without Part D or other creditable coverage, the penalty would be 14% times $41.33, which equals $5.79. This rounds to $5.80. This amount would be added **to the monthly plan premium for someone with a Part D late enrollment penalty**.

Three important things to know about the monthly Part D late enrollment penalty:

- **The penalty may change each year,** because the national base beneficiary premium can change each year.
- **You'll generally continue to pay a penalty** every month for as long as you're enrolled in a plan that has Medicare Part D drug benefits, even if you change plans.
- If you're *under* 65 and enrolled in Medicare, the Part D late enrollment penalty will reset when you turn 65. After age 65, your Part D late enrollment penalty will be based only on the months you don't have coverage after your initial enrollment period for aging into Medicare.

If you disagree about your Part D late enrollment penalty, you or your representative can ask for a reconsideration (appeal) of the penalty. The reconsideration is conducted by an independent review organization that is not connected with us. Generally, you must ask for this reconsideration **within 60 days** from the date on the first letter you get stating you have to pay a late enrollment penalty. However, if you were paying a penalty before you joined our plan, you generally won't have another chance to ask for a reconsideration of that late enrollment penalty.

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

Section 4.5 Income Related Monthly Adjustment Amount

Some members may be required to pay an extra charge, known as the Part D Income Related Monthly Adjustment Amount (IRMAA). The extra charge is calculated using your modified adjusted gross income as reported on your IRS tax return from 2 years ago. If this amount is above a certain amount, you'll pay the standard premium amount and the additional IRMAA. For more information on the extra amount you may have to pay based on your income, visit Medicare.gov/health-drug-plans/part-d/basics/costs.

If you have to pay an extra IRMAA, Social Security, not your Medicare plan, will send you a letter telling you what that extra amount will be. The extra amount will be withheld from your Social Security, Railroad Retirement Board, or Office of Personnel Management benefit check, no matter how you usually pay your plan premium, unless your monthly benefit isn't enough to cover the extra amount owed. If your benefit check isn't enough to cover the extra amount, you'll get a bill from Medicare. **You must pay the extra IRMAA to the government. It can't be paid with your monthly plan premium. If you don't pay the extra IRMAA, you'll be disenrolled from our plan and lose prescription drug coverage.**

If you disagree about paying an extra IRMAA, you can ask Social Security to review the decision. To find out how to do this, call Social Security at 1-800-772-1213 (TTY users call 1-800-325-0778).

Section 4.6 Medicare Prescription Payment Plan Amount

If you're participating in the Medicare Prescription Payment Plan, each month you'll pay your plan premium (if you have one) and you'll get a bill from your health or drug plan for your prescription 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, Section 7 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.

SECTION 5 More information about your monthly plan premium

Section 5.1 How to pay your plan premium

There are four ways you can pay your plan premium.

Option 1: Check or Money Order

You can pay for your monthly premium(s) by check or money order. Payments should be made payable to Priority Health and include your Member ID number in the 'Memo' field. Your Member ID can be found on your invoice or Priority Health Member ID card. To pay by mail, please enclose your payment in the return envelope provided along with the bottom half of your invoice. If you have misplaced your return envelope, please mail payment to 3915 Momentum Place, Chicago, IL 60689-5339. If your bank account does not have sufficient funds to cover your payment, Priority Health reserves the right to charge a non-sufficient funds (NSF) fee up to the amount allowed by the state of Michigan, which is $25.

Option 2: Automatic withdrawal from your bank account

You can elect to have your monthly premium(s) automatically withdrawn from your bank account. The total amount due will be deducted on the first business day of each month. This may include past due premiums. Please note that payment(s) will be applied to the oldest outstanding balance due. If there is a credit made to your account, it will be applied to future premiums due. In this event, your account will only deduct the remaining premium due as of the draft date. Payments received by the due date will be reflected on the next invoice. Please go to ***priorityhealth.com/paymypremium*** or call Customer Care at 888.389.6648 with questions related to setting up your automatic withdrawal.

If your bank account does not have sufficient funds to cover your premium payment, Priority Health reserves the right to charge a non-sufficient funds (NSF) fee up to the amount allowed by the state of Michigan, which is $25. Note: if two or more NSFs occur within a three-month period, we will stop withdrawing your monthly plan premium automatically and send you an invoice by mail each month.

Option 3: Credit Card Payment

You can pay your plan premium(s) by setting up a one-time credit card payment, or by setting up recurring credit card payments online at ***priorityhealth.com/paymypremium*** or by calling Customer Care at 888.389.6648. Please Note: Credit card payments may take up to 10 business days for the payment to reflect on your Priority Health account.

Option 4: Have plan premiums deducted from your monthly Social Security check

You can have your monthly plan premium(s) deducted from your monthly Social Security Administration (SSA) check. This will prevent the risk of being disenrolled from your optional supplemental benefits (OSB) plan and/or your Medical and Prescription coverage for non-payment. To set up deduction from your Social Security check, you can submit a request online at ***priorityhealth.com/paymypremium*** or call Customer Care at 888.389.6648, and we'll forward the information to the Centers for Medicare and Medicaid Services (CMS). It could take multiple months before the Social Security Administration (SSA) begins deducting your premium(s).

- Depending on the date you enroll, you may need to pay your first few months of premium by another method. If this is necessary, we will mail you an invoice. You may send in payment via mail (check or money order) or pay online.
- Your first SSA deduction may show multiple months of premium deducted at once. This can occur if premiums are being paid retroactively back to the requested start date, depending on how long it took SSA to accept your request.
- If for any reason your request for SSA deduction is not accepted, Medicare will stop your request. In that case, Priority Health will notify you and bill you directly for your monthly premium(s).

Changing the way you pay your plan premium. If you decide to change how you pay your plan premium, it can take up to 3 months for your new payment method to take effect. While we process your new payment method, you're still responsible for making sure your plan premium is paid on time. To change your payment method, you will receive a mailed invoice until SSA officially accepts the SSA deduction request. You likely selected a payment option on your enrollment form, but if you didn't, you'll receive a monthly invoice by mail. If you would like to change your payment method, you can do so at any time by visiting ***priorityhealth.com/paymypremium*** or contacting Customer Care at 888.389.6648.

If you have trouble paying your plan premium

Your plan premium is due in our office by the first of the month. If we don't get your payment by the first of the month, we'll send you a notice letting you know our plan membership will end if we don't get your plan premium within 90 days. If you owe a Part D late enrollment penalty, you must pay the penalty to keep your drug coverage.

If you have trouble paying your premium on time, call Customer Care at 888.389.6648 (TTY users call 711) to see if we can direct you to programs that will help with your costs.

If we end your membership because you didn't pay your plan premium, you'll have health coverage under Original Medicare. You may not be able to get Part D drug coverage until the following year if you enroll in a new plan during the Open Enrollment Period. (If you go without creditable drug coverage for more than 63 days, you may have to pay a Part D late enrollment penalty for as long as you have Part D coverage.)

If you think we wrongfully ended your membership, you can make a complaint (also called a grievance). If you had an emergency circumstance out of your control and that made you unable to pay your plan premium within our grace period, you can make a complaint. For complaints, we'll review our decision again. Go to Chapter 9 to learn how to make a complaint or call us at 888.389.6648 between 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. TTY users call 711. You must make your complaint no later than 60 calendar days after the date your membership ends.

Section 5.2 Your monthly plan premium won't change during the year

We're not allowed to change our plan's monthly plan premium amount during the year. If the monthly plan premium changes for next year, we'll tell you in September and the new premium will take effect on January 1.

If you become eligible for Extra Help or lose your eligibility for Extra Help during the year, the part of your plan premium you have to pay may change. If you qualify for Extra Help with your drug coverage costs, Extra Help pays part of your monthly plan premiums. If you lose your eligibility for Extra Help during the year, you'll need to start paying the full monthly plan premium. Find out more about Extra Help in Chapter 2, Section 7.

SECTION 6 Keep your plan membership record up to date

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

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.

If you have any of these changes, let us know:

- Changes to your name, address, or phone number
- Changes in any other health coverage you have (such as from your employer, your spouse or domestic partner's employer, Workers' Compensation, or Medicaid)
- Any liability claims, such as claims from an automobile accident
- If you're admitted to a nursing home
- If you get care in an out-of-area or out-of-network hospital or emergency room
- If your designated responsible party (such as a caregiver) changes
- If you participate in a clinical research study. (**Note:** You're not required to tell our plan about clinical research studies you intend to participate in, but we encourage you to do so.)

If any of this information changes, let us know by calling Customer Care at 888.389.6648 (TTY users call 711).

It's also important to contact Social Security if you move or change your mailing address. Call Social Security at 1-800-772-1213 (TTY users call 1-800-325-0778).

SECTION 7 How other insurance works with our plan

Medicare requires us to collect information about any other medical or drug coverage you have so we can coordinate any other coverage with your benefits under our plan. This is called **Coordination of Benefits**.

Once a year, we'll send you a letter that lists any other medical or drug coverage we know about. Read this information carefully. If it's correct, you don't need to do anything. If the information isn't correct, or if you have other coverage that's not listed, call Customer Care at 888.389.6648 (TTY users call 711). You may need to give our plan member ID number to your other insurers (once you confirm their identity) so your bills are paid correctly and on time.

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

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

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

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

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

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

CHAPTER 2: Phone numbers and resources

SECTION 1 **Priority**Medicare Merit (PPO) contacts

For help with claims, billing, or member card questions, call or write to **Priority**Medicare Merit (PPO) Customer Care. We'll be happy to help you.

Customer Care – Contact Information	
Call	888.389.6648 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	Priority Health Medicare Customer Care Department, MS 1115 1231 East Beltline Ave. NE Grand Rapids MI 49525
Website	***priorityhealth.com/27merit***

How to ask for a coverage decision or appeal about your medical care or Part D drugs

A coverage decision is a decision we make about your benefits and coverage or about the amount we pay for your medical services or Part D drugs. An appeal is a formal way of asking us to review and change a coverage decision. For more information on how to ask for coverage decisions or appeals about your medical care or Part D drugs, go to Chapter 9.

Coverage Decisions for Medical Care – Contact Information	
Call	888.389.6648 Calls to this number are free. Oct. 1 – Mar. 31, we're available seven

Coverage Decisions for Medical Care – Contact Information	
	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	888.647.6152
Write	Priority Health Medicare Health Management Department, MS 1255 1231 East Beltline Ave. NE Grand Rapids MI 49525
Website	***priorityhealth.com/27merit***

Coverage Decisions for Part D Drugs – Contact Information	
Call	888.389.6648 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	877.974.4411
Write	Priority Health Medicare Medicare Part D, MS 1260 1231 East Beltline Ave. NE Grand Rapids MI 49525
Website	***priorityhealth.com/27merit***

Appeals for Medical Care – Contact Information	
Call	888.389.6648 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	616.975.8827
Write	Priority Health Medicare Appeals Coordinator, MS 1150 1231 East Beltline Ave. NE Grand Rapids MI 49525
Website	***priorityhealth.com/27merit***

Appeals for Part D Drugs – Contact Information	
Call	888.389.6648 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	877.974.4411
Write	Priority Health Medicare Part D Appeals Coordinator, MS 1260 1231 East Beltline Ave. NE Grand Rapids MI 49525

Appeals for Part D Drugs – Contact Information	
Website	***priorityhealth.com/27merit***

How to make a complaint about your medical care or Part D drugs

You can make a complaint about us or one of our network providers or pharmacies, including a complaint about the quality of your care. This type of complaint doesn't involve coverage or payment disputes. For more information on how to make a complaint about your medical care or Part D drugs, go to Chapter 9.

Complaints about Medical Care or Part D drugs – Contact Information	
Call	888.389.6648 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	Medical: 616.975.8827 Part D: 877.974.4411
Write	Priority Health Medicare Medicare Grievance Coordinator, MS 1150 1231 East Beltline Ave. NE Grand Rapids MI 49525
Medicare website	To submit a complaint about **Priority**Medicare Merit (PPO) directly to Medicare, go to Medicare.gov/my/medicare-complaint.

How to ask us to pay our share of the cost for medical care or a drug you got

If you got a bill or paid for services (like a provider bill) you think we should pay for, you may need to ask us for reimbursement or to pay the provider bill. Go to Chapter 7 for more information.

If you send us a payment request and we deny any part of your request, you can appeal our decision. Go to Chapter 9 for more information.

Payment Requests for Medical Care – Contact Information	
Call	888.389.6648 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	Priority Health Medicare Customer Care Department, MS 1115 1231 East Beltline Ave. NE Grand Rapids MI 49525
Website	***priorityhealth.com/27merit***

Payment Requests for Part D Drugs – Contact Information	
Call	888.389.6648 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	616.975.8867
Write	Priority Health Medicare Medicare Part D, MS 1260 1231 East Beltline Ave. NE Grand Rapids MI 49525

Payment Requests for Part D Drugs – Contact Information	
Website	***priorityhealth.com/27merit***

SECTION 2 Get help from Medicare

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

The federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (CMS). This agency contracts with Medicare Advantage organizations, including our plan.

Medicare – Contact Information	
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 number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free.
Chat Live	Chat live at Medicare.gov/talk-to-someone.
Write	Write to Medicare at PO Box 1270, Lawrence, KS 66044
Website	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 preventive 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.

Medicare – Contact Information	
	• Look up helpful websites and phone numbers. You can also visit Medicare.gov to tell Medicare about any complaints you have about **Priority**Medicare Merit (PPO). **To submit a complaint to Medicare,** go to Medicare.gov/my/medicare-complaint. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

SECTION 3 State Health Insurance Assistance Program (SHIP)

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 MI Options.

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

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

MI Options – Contact Information	
Call	800.803.7174 8 a.m. to 8 p.m. Monday through Friday
TTY	711 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking.
Write	MI Options PO Box 30676 Lansing, MI 48909
Website	michigan.gov/MDHHSMIOptions

SECTION 4 Quality Improvement Organization (QIO)

A designated Quality Improvement Organization (QIO) serves people with Medicare in each state. For Michigan, the Quality Improvement Organization is called Commence Health.

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

Contact Commence Health in any of these situations:

- You have a complaint about the quality of care you got. Examples of quality-of-care concerns include getting the wrong medication, unnecessary tests or procedures, or a misdiagnosis.
- You think coverage for your hospital stay is ending too soon.
- You think coverage for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services is ending too soon.

Commence Health (Michigan's Quality Improvement Organization) – Contact Information	
Call	888.524.9900 Monday-Friday, 9 a.m. to 5 p.m. local time Weekend/holidays, 10 a.m. to 4 p.m. local time
TTY	711 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking.
Write	Commence Health, BFCC-QIO Program PO Box 2687 Virginia Beach, VA 23450
Website	commencehealthqio.cms.gov

SECTION 5 Social Security

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

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

Social Security – Contact Information	
Call	1-800-772-1213 Calls to this number are free. Available 8 am to 7 pm, Monday through Friday. Use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	1-800-325-0778 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 8 am to 7 pm, Monday through Friday.
Website	SSA.gov

SECTION 6 Medicaid

Medicaid is a joint federal and state government program that helps with medical costs for certain people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid. Medicaid offers programs to help people with Medicare pay their Medicare costs, such as their Medicare premiums. These **Medicare Savings Programs** include:

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other cost sharing (like deductibles, coinsurance, and copayments). (Some people with QMB are also eligible for full Medicaid benefits (QMB+).)
- **Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums. (Some people with SLMB are also eligible for full Medicaid benefits (SLMB+).)
- **Qualifying Individual (QI):** Helps pay Part B premiums.
- **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums.

To find out more about Medicaid and Medicare Savings Programs, contact Michigan Department of Health and Human Services.

Michigan Department of Health and Human Services – Contact Information	
Call	517.241.3740 Monday-Friday, 8 a.m. to 5 p.m.

Michigan Department of Health and Human Services – Contact Information	
TTY	844.578.6563 Hearing impaired callers may contact the Michigan Relay Center at 711 and ask for the number above. This number requires special telephone equipment and is only for people who have difficulties hearing or speaking.
Write	Michigan Department of Health and Human Services 333 S. Grand Ave. P.O. Box 30195 Lansing, Michigan 48909
Website	michigan.gov/mdhhs

SECTION 7 Programs to help people pay for prescription drugs

The Medicare website (Medicare.gov/basics/costs/help/drug-costs) has information on ways to lower your prescription drug costs. The programs below can help people with limited incomes.

Extra Help from Medicare

Medicare and Social Security have a program called Extra Help that can help pay drug costs for people with limited income and resources. If you qualify, you get help paying for your Medicare drug plan's monthly plan premium, yearly deductible, and copayments. Extra Help also counts toward your out-of-pocket costs.

If you automatically qualify for Extra Help, Medicare will mail you a purple letter to let you know. If you don't automatically qualify, you can apply any time. To see if you qualify for getting Extra Help:

- Visit https://secure.ssa.gov/i1020/start to apply online.
- Call Social Security at 1-800-772-1213. TTY users call 1-800-325-0778.

When you apply for Extra Help, you can also start the application process for a Medicare Savings Program (MSP). These state programs provide help with other Medicare costs. Social Security will send information to your state to initiate an MSP application, unless you tell them not to on the Extra Help application.

If you qualify for Extra Help and you think that you're paying an incorrect amount for your prescription at a pharmacy, our plan has a process to help you get evidence of the right 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 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. Call Customer Care at 888.389.6648 (TTY users call 711) if you have questions.

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

Many states offer help paying for prescriptions, drug plan premiums and/or other drug costs. If you're enrolled in a State Pharmaceutical Assistance Program (SPAP), Medicare's Extra Help pays first.

Michigan Drug Assistance Program (MIDAP) – Contact Information	
Call	888.826.6565 Monday-Friday, 9 a.m. to 5 p.m.
Write	Michigan Department of Health and Human Services P.O. Box 30727 Lansing, MI 48909
Website	medicare.gov/plan-compare/#/pharmaceutical-assistance-program/states

What if you have Extra Help and coverage from an AIDS Drug Assistance Program (ADAP)?

The AIDS Drug Assistance Program (ADAP) helps people living with HIV/AIDS access life-saving HIV medications. Medicare Part D drugs that are also on the ADAP formulary qualify for prescription cost-sharing help through the Michigan HIV/AIDS Drug Assistance Program (MIDAP).

Note: To be eligible for the ADAP in your state, people must meet certain criteria, including proof of state residence and HIV status, low income (as defined by the state), and uninsured/under-insured status. If you change plans, notify your local ADAP enrollment worker so you can continue to get help. For information on eligibility criteria, covered drugs, or how to enroll in the program, call 888.826.6565.

State Pharmaceutical Assistance Programs

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

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

Michigan Drug Assistance Program (MIDAP) – Contact Information	
Call	888.826.6565 Monday-Friday, 9 a.m. to 5 p.m.
Write	Michigan Department of Health and Human Services P.O. Box 30727 Lansing, MI 48909
Website	medicare.gov/plan-compare/#/pharmaceutical-assistance-program/states

Medicare Prescription Payment Plan

The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage, and it can help you manage your costs for drugs covered by our plan by spreading them across **the calendar year** (January – December). Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage plan with drug coverage) can use this payment option. **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs. If you're participating in the Medicare Prescription Payment Plan and stay in the same Part D plan, your participation will be automatically renewed for 2027; you do not need to submit a new election request to continue participating in 2027.** To learn more about this

payment option, call Express Scripts at 866.845.1803 (TTY users call 800.716.3231) or visit Medicare.gov.

Medicare Prescription Payment Plan – Contact Information	
Call	866.845.1803 Calls to this number are free. Call hours are 24 hours a day, 7 days a week. Express Scripts 866.845.1803 (TTY users call 800.716.3231) also has free language interpreter services for non-English speakers.
TTY	800.716.3231 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free. Call hours are 24 hours a day, 7 days a week.
Write	Express Scripts Medicare Prescription Payment Plan P.O. Box 2 Saint Louis, MO 63166 This address is only to be used for general inquiries. Additional addresses will be provided for the paper election forms and for the payment process.
Website	***https://express-scripts.com/mppp***

SECTION 8 Railroad Retirement Board (RRB)

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

Railroad Retirement Board (RRB) – Contact Information	
Call	1-877-772-5772 Calls to this number are free. Press "0" to speak with an RRB representative from 9 am to 3:30 pm, Monday, Tuesday, Thursday, and Friday, and from 9 am to 12 pm on Wednesday.

Railroad Retirement Board (RRB) – Contact Information	
	Press “1” to access the automated RRB HelpLine and get recorded information 24 hours a day, including weekends and holidays.
TTY	1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number aren’t free.
Website	https://RRB.gov

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

If you (or your spouse or domestic partner) get benefits from your (or your spouse or domestic partner’s) employer or retiree group as part of this plan, call the employer/union benefits administrator or Customer Care at 888.389.6648 (TTY users call 711) with any questions. You can ask about your (or your spouse or domestic partner’s) employer or retiree health benefits, premiums, or the enrollment period. (Phone numbers for Customer Care are printed on the back cover of this document.) You can call 1-800-MEDICARE (1-800-633-4227) with questions about your Medicare coverage under this plan. TTY users call 1-877-486-2048.

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

CHAPTER 3: Using our plan for your medical services

SECTION 1 How to get medical care as a member of our plan

This chapter explains what you need to know about using our plan to get your medical care covered. For details on what medical care our plan covers and how much you pay when you get care, go to the Medical Benefits Chart in Chapter 4.

Section 1.1 Network providers and covered services

- **Providers** are doctors and other health care professionals licensed by the state to provide medical services and care. The term "providers" also includes hospitals and other health care facilities.
- **Network providers** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and your cost-sharing amount as payment in full. We arranged for these providers to deliver covered services to members in our plan. The providers in our network bill us directly for care they give you. When you see a network provider, you pay only your share of the cost for their services.
- **Covered services** include all the medical care, health care services, supplies, equipment, and prescription drugs that are covered by our plan. Your covered services for medical care are listed in the Medical Benefits Chart in Chapter 4. Your covered services for prescription drugs are discussed in Chapter 5.

Section 1.2 Basic rules for your medical care to be covered by our plan

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

PriorityMedicare Merit (PPO) will generally cover your medical care as long as:

- **The care you get is included in our plan's Medical Benefits Chart** in Chapter 4.
- **The care you get is considered medically necessary**. Medically necessary means that the services, supplies, equipment, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- **You get your care from a provider who's eligible to provide services under Original Medicare.** As a member of our plan, you can get care from either a network provider or an out-of-network provider (go to Section 2 for more information).
    - The providers in our network are listed in the *Provider/Pharmacy Directory* ***priorityhealth.com/27merit***.

- If you use an out-of-network provider, your share of the costs for your covered services may be higher.
- Note: While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare. Except for emergency care, we can't pay a provider who isn't eligible to participate in Medicare. If you go to a provider who isn't eligible to participate in Medicare, you'll be responsible for the full cost of the services you get. Check with your provider before getting services to confirm that they're eligible to participate in Medicare.

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

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

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

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

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

How to choose a PCP

A PCP can be searched through the Find-a-Doctor tool at ***priorityhealth.com/27merit*** and then updated through your member portal.

You'll find a list of PCPs to choose from on our website at ***priorityhealth.com/27merit***. If you need a hard copy of our list of PCPs, or if you need help choosing a PCP, please contact Customer Care.

How to change your PCP

You can change your PCP for any reason, at any time. It's also possible that your PCP might leave our plan's network of providers and you'd need to choose a new PCP or you'll pay more for covered services.

To change your PCP, please contact Customer Care or make your PCP change online through your member account at ***priorityhealth.com/27merit***. When you make a request to change your PCP, we'll make the change immediately.

Section 2.2 Medical care you can get without a PCP referral

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

- Routine women's health care, including breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams
- Flu shots, COVID-19 vaccines, Hepatitis B vaccines, and pneumonia vaccines
- Emergency services from network providers or from out-of-network providers
- Urgently needed plan-covered services are services that require immediate medical attention (but not an emergency) if you're either temporarily outside our plan's service area, or if it's unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you're temporarily outside our plan's service area or when your provider for this service is temporarily unavailable or inaccessible. The cost sharing you pay our plan for dialysis can never exceed the cost sharing in Original Medicare. If you're outside our plan's service area and get dialysis from a provider that is outside our plan's network, your cost sharing can't exceed the cost sharing you pay in-network. However, if your usual in-network provider for dialysis is available and you choose to get services inside the service area from a provider outside our plan's network, the cost sharing for the dialysis may be higher.

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

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

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

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 or go to ***priorityhealth.com/27merit*** and use our Find a Doctor tool.
- Prior authorization requirements apply for some services obtained in-network. You or the rending provider is responsible for obtaining prior authorization when one is required. See Chapter 4, Section 2 for information about which services require prior authorization.
- It is important to know what Medicare will or will not cover. Be sure to ask your provider if a service is covered. Providers should let you know when something is not covered.
- Remember that when you use in-network providers, you will pay less. When you use out-of-network providers, you could pay a higher cost share for the same service.

When a specialist or another network provider leaves our plan

We may make changes to the hospitals, doctors, and specialists (providers) in our plan's network during the year. If your doctor or specialist leaves our plan, you have these rights and protections:

- Even though our network of providers may change during the year, Medicare requires that you have uninterrupted access to qualified doctors and specialists.
- We'll notify you that your provider is leaving our plan so that you have time to choose 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 3 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 3 months.
- We'll help you choose a new qualified in-network provider for continued care.
- If you're 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.
- When an in-network provider or benefit is unavailable or inadequate to meet your medical needs, we'll arrange for any medically necessary covered benefit outside of our provider network at in-network cost sharing.
- If you find out that your doctor or specialist is leaving our plan, contact us so we can help you choose a new provider to manage your care.

- If you believe we haven't furnished you with a qualified provider to replace your previous provider or that your care isn't being appropriately managed, you have the right to file a quality-of-care complaint to the QIO, a quality-of-care grievance to our plan, or both (go to Chapter 9).

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

As a member of our plan, you can choose to get care from out-of-network providers. However, providers that don't contract with us are under no obligation to treat you, except in emergency situations. Our plan will cover services from either network or out-of-network providers, as long as the services are covered benefits and medically necessary. However, **if you use an out-of-network provider, your share of the costs for covered services may be higher.** Here are more important things to know about using out-of-network providers:

- You can get your care from an out-of-network provider; however, in most cases that provider must be eligible to participate in Medicare. Except in certain situations, we cannot pay a provider who has opted out of Medicare or is listed on one of Medicare's exclusion lists. If you get care from a provider who isn't eligible to participate in Medicare, you'll be responsible for the full cost of the services you get. Check with your provider before getting services to confirm that they're eligible to participate in Medicare.
- You don't need a referral or prior authorization when you get care from out-of-network providers. However, before getting services from out-of-network providers, ask for a pre-visit coverage decision to confirm that the services you get are covered and medically necessary (go to Chapter 9, Section 4). This is important because:
    - Without a pre-visit coverage decision, and if our plan later determines that the services aren't covered or weren't medically necessary, our plan may deny coverage and you'll be responsible for the entire cost. If we say we won't cover the services you got, you have the right to appeal our decision not to cover your care (go to Chapter 9).
- It's best to ask an out-of-network provider to bill our plan first. But, if you've already paid for the covered services, we'll reimburse you for our share of the cost for covered services. Or if an out-of-network provider sends you a bill you think we should pay, you can send it to us for payment (go to Chapter 7).
- If you're using an out-of-network provider for emergency care, urgently needed services, or out-of-area dialysis, you may not have to pay a higher cost-sharing amount (go to Section 3).

SECTION 3 How to get services in an emergency, disaster, or urgent need for care

Section 3.1 Get care if you have a medical emergency

A **medical emergency** is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you're a pregnant woman, loss of an unborn child), loss of a limb or function of a limb, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that's quickly getting worse.

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You don't need to get approval or a referral first from your PCP. You don't need to use a network doctor. You can get covered emergency medical care whenever you need it, anywhere in the United States or its territories, as well as worldwide emergency and urgent care coverage, and from any provider with an appropriate state license even if they're not part of our network.
- **As soon as possible, make sure our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. Call us at 888.389.6648 (TTY 711). 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 so we can help.

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.

The doctors giving you emergency care will decide when your condition is stable, and when the medical emergency is over.

After the emergency is over, you're entitled to follow-up care to be sure your condition continues to be stable. Your doctors will continue to treat you until your doctors contact us and make plans for additional care. Your follow-up care will be covered by our plan.

If you get your follow-up care from out-of-network providers, you'll pay the higher out-of-network cost sharing.

What if it wasn't a medical emergency?

Sometimes it can be hard to know if you have a medical emergency. For example, you might go in for emergency care—thinking that your health is in serious danger—and the doctor may

say that it wasn't a medical emergency after all. If it turns out that it wasn't an emergency, as long as you reasonably thought your health was in serious danger, we'll cover your care.

However, after the doctor says it wasn't an emergency, the amount of cost sharing that you pay will depend on whether you get the care from network providers or out-of-network providers. If you get the care from network providers, your share of the costs will usually be lower than if you get the care from out-of-network providers.

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

A service that requires immediate medical attention (but isn't an emergency) is an urgently needed service if you're either temporarily outside our plan's service area, or if it's unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. 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.

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.

Our plan covers worldwide urgently needed services and emergency medical care when you receive the care outside of the United States.

Section 3.3 Get 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 ***priorityhealth.com/27merit*** for information on how to get needed care during a disaster.

If you can't use a network provider during a disaster, our plan will allow you to get care from out-of-network providers at in-network cost sharing. If you can't use a network pharmacy during a disaster, you may be able to fill your prescriptions at an out-of-network pharmacy. Go to Chapter 5, Section 2.4.

SECTION 4 What if you're billed directly for the full cost of covered services?

If you paid more than our plan cost sharing for covered services, or if you get a bill for the full cost of covered medical services, you can ask us to pay our share of the cost of covered services. Go to Chapter 7 for information about what to do.

Section 4.1 If services aren't covered by our plan, you must pay the full cost

PriorityMedicare Merit (PPO) covers all medically necessary services as listed in the Medical Benefits Chart in Chapter 4. If you get services that aren't covered by our plan that are not emergency or urgently needed services, you're responsible for paying the full cost of services.

For covered services that have a benefit limitation, you also pay the full cost of any services you get after you use up your benefit for that type of covered service. Once a benefit limit has been reached any further service beyond the benefit limit won't count toward your out-of-pocket maximum.

SECTION 5 Medical services in a clinical research study

Section 5.1 What is a clinical research study

A clinical research study (also called a *clinical trial*) is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. Certain clinical research studies are approved by Medicare. Clinical research studies approved by Medicare typically ask for volunteers to participate 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 participate in a Medicare-approved study, Original Medicare pays most of the costs for covered services you get as part of the study. If you tell us you're in a qualified clinical trial, you're only responsible for the in-network cost sharing for the services in that trial. If you paid more—for example, if you already paid the Original Medicare cost-sharing amount—we'll reimburse the difference between what you paid and the in-network cost sharing. You'll need to provide documentation to show us how much you paid.

If you want to participate in any Medicare-approved clinical research study, you don't need to tell us or get approval from us or your PCP. The providers that deliver your care as part of the clinical research study don't need to be part of our plan's network. (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.)

While you don't need our plan's permission to be in a clinical research study, we encourage you to notify us in advance when you choose to participate in Medicare-qualified clinical trials.

If you participate in a study not approved by Medicare, you'll be responsible for paying all costs for your participation in the study.

Section 5.2 Who pays for services in a clinical research study

Once you join a Medicare-approved clinical research study, Original Medicare covers the routine items and services you get as part of the study, including:

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

After Medicare pays its share of the cost for these services, our plan will pay the difference between the cost sharing in Original Medicare and your in-network cost sharing as a member of our plan. This means you'll pay the same amount for services you get as part of the study as you would if you got these services from our plan. However, you must submit documentation showing how much cost sharing you paid. Go to Chapter 7 for more information on submitting requests for payments.

> *Example of cost sharing in a clinical trial:* Let's say you have a lab test that costs $100 as part of the research study. Your share of the costs for this test is $20 under Original Medicare, but the test would be $10 under our plan. In this case, Original Medicare would pay $80 for the test, and you would pay the $20 copay required under Original Medicare. You would notify our plan that you got a qualified clinical trial service and submit documentation (like a provider bill) to our plan. Our plan would then directly pay you $10. This makes your net payment for the test $10, the same amount you'd pay under our plan's benefits.

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

- Generally, Medicare won't pay for the new item or service the study is testing unless Medicare would cover the item or service even if you weren't in a study.
- Items or services provided only to collect data and not used in your direct health care. For example, Medicare won't pay for monthly CT scans done as part of a study if your medical condition would normally require only one CT scan.
- Items and services provided by the research sponsors free of charge for people in the trial.

Get more information about joining a clinical research study

Get more information about joining a clinical research study in the Medicare publication *Medicare and Clinical Research Studies*, available at Medicare.gov/coverage/clinical-research-studies. You can also call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

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

Section 6.1 A religious non-medical health care institution

A religious non-medical health care institution is a facility that provides care for a condition that would ordinarily be treated in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against a member's religious beliefs, we'll instead cover care in a religious non-medical health care institution. This benefit is provided only for Part A inpatient services (non-medical health care services).

Section 6.2 How to get 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 conscientiously opposed to getting medical treatment that is **non-excepted**.

- **Non-excepted** medical care or treatment is any medical care or treatment that's *voluntary* and *not required* by any federal, state, or local law.
- **Excepted** medical treatment is medical care or treatment you get that's *not* voluntary or *is required* under federal, state, or local law.

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

- The facility providing the care must be certified by Medicare.
- Our plan only covers non-religious aspects of care.
- If you get services from this institution provided to you in a facility, the following conditions apply:
  - 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 in advance from our plan before you're admitted to the facility, or your stay won't be covered.

Refer to Chapter 4, Medical Benefits Chart, under "Inpatient care" for information about cost share. You have unlimited hospital days for this benefit.

SECTION 7 Rules for ownership of durable medical equipment

Section 7.1 You won't own some durable medical equipment after making a certain number of payments under our plan

Durable medical equipment (DME) includes items like 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 members to use in the home. The member always owns some DME items, like prosthetics. Other types of DME you must rent.

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. **As a member of PriorityMedicare Merit (PPO), you may acquire ownership of certain rented durable medical equipment items while a member of our plan after 13 consecutive payments.** Call Customer Care at 888.389.6648. (TTY users call 711) for more information.

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

If you didn't get ownership of the DME item while in our plan, you'll have to make 13 new consecutive payments after you switch to Original Medicare to own the DME item. The payments you made while enrolled in our plan don't count towards these 13 payments.

Example 1: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. The payments you made in Original Medicare don't count. You'll have to make 13 payments to our plan before owning the item.

Example 2: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. You didn't get ownership of the item while in our plan. You then go back to Original Medicare. You'll have to make 13 consecutive new payments to own the item once you rejoin Original Medicare. Any payments you already made (whether to our plan or to Original Medicare) don't count.

Section 7.2 Rules for oxygen equipment, supplies, and maintenance

If you qualify for Medicare oxygen equipment coverage **Priority**Medicare Merit (PPO) will cover:

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

If you leave **Priority**Medicare Merit (PPO) or no longer medically require oxygen equipment, the oxygen equipment must be returned.

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

Original Medicare requires an oxygen supplier to provide you with services for 5 years. During the first 36 months, you rent the equipment. For the remaining 24 months, the supplier provides the equipment and maintenance (you're still responsible for applicable cost sharing for oxygen). After 5 years, you can choose to stay with the same company or go to another company. At this point, the 5-year cycle starts over again, even if you stay with the same company, and you're again required to pay copayments for the first 36 months. If you join or leave our plan, the 5-year cycle starts over.

CHAPTER 4: Medical Benefits Chart (what's covered and what you pay)

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

The Medical Benefits Chart lists your covered services and shows how much you pay for each covered service as a member of **Priority**Medicare Merit (PPO). This section also gives information about medical services that aren't covered and explains limits on certain services.

Section 1.1 Out-of-pocket costs you may pay for covered services

Types of out-of-pocket costs you may pay for covered services include:

- **Copayment:** the fixed amount you pay each time you get certain medical services. You pay a copayment at the time you get the medical service. (The Medical Benefits Chart tells you more about your copayments.)
- **Coinsurance:** the percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service. (The Medical Benefits Chart tells you more about your coinsurance.)

Most people who qualify for Medicaid or for the Qualified Medicare Beneficiary (QMB) program don't pay deductibles, copayments or coinsurance. If you're in one of these programs, be sure to show your proof of Medicaid or QMB eligibility to your provider.

Section 1.2 What's the most you'll pay for covered medical services?

Under our plan, there are 2 different limits on what you pay out-of-pocket for covered medical services:

- Your **in-network maximum out-of-pocket amount (MOOP)** is $5,000. This is the most you pay during the calendar year for covered plan services you got from network providers. The amounts you pay for copayments and coinsurance for covered services from network providers count toward this in-network maximum out-of-pocket amount. (The amounts you pay for plan premiums, Part D drugs, and services from out-of-network providers don't count toward your in-network maximum out-of-pocket amount. These services are marked with an asterisk in the Medical Benefits Chart.) If you pay $5,000 for covered services from network providers, you won't have any out-of-pocket costs for the rest of the year when you see our network providers. However, you must continue to pay our plan premium and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

- Your **combined maximum out-of-pocket amount** is $5,000. This is the most you pay during the calendar year for covered plan services you got from both in-network and out-of-network providers. The amounts you pay for deductibles, copayments, and coinsurance for covered services count toward this combined maximum out-of-pocket amount. (The amounts you pay for plan premiums and for your Part D drugs don't count toward your combined maximum out-of-pocket amount. In addition, amounts you pay for some services don't count toward your combined maximum out-of-pocket amount. These services are marked with an asterisk in the Medical Benefits Chart.) If you pay $5,000 for covered services, you'll have 100% coverage and won't have any out-of-pocket costs for the rest of the year for covered services. However, you must continue to pay our plan premium and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Section 1.3 Providers aren't allowed to balance bill you

As a member of **Priority**Medicare Merit (PPO), you have an important protection because you only have to pay your cost-sharing amount when you get services covered by our plan. Providers can't bill you for additional separate charges, called **balance billing**. This protection applies even if we pay the provider less than the provider charges for a service and even if there's a dispute and we don't pay certain provider charges.

Here's how protection from balance billing works:

- If your cost sharing is a copayment (a set amount of dollars, for example, $15.00), you pay only that amount for any covered services from a network provider. You'll generally have higher copayments when you get care from out-of-network providers.
- If your cost sharing is a coinsurance (a percentage of the total charges), you never pay more than that percentage. However, your cost depends on which type of provider you see:
  - If you get covered services from a network provider, you pay the coinsurance percentage multiplied by our plan's reimbursement rate (this is set in the contract between the provider and our plan).
  - If you get covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers.
  - If you get covered services from an out-of-network provider who doesn't participate with Medicare, then you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers.
- If you think a provider has balance billed you, call Customer Care at 888.389.6648 (TTY users call 711).

SECTION 2 The Medical Benefits Chart shows your medical benefits and costs

The Medical Benefits Chart on the next pages lists the services **Priority**Medicare Merit (PPO) covers and what you pay out of pocket for each service (Part D drug coverage is covered in Chapter 5). The services listed in the Medical Benefits Chart are covered only when these requirements are met:

- Your Medicare-covered services must be provided according to Medicare coverage guidelines.
- Your services (including medical care, services, supplies, equipment, and Part B drugs) *must* be medically necessary. Medically necessary means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- For new enrollees, your MA coordinated care plan must provide a minimum 90-day transition period, during which time the new MA plan can't require prior authorization for any active course of treatment, even if the course of treatment was for a service that commenced with an out-of-network provider.
- Some services listed in the Medical Benefits Chart are covered as in-network services *only* if your doctor or other network provider gets approval from us in advance (sometimes called prior authorization).
    - Covered services that need approval in advance to be covered as in-network services are marked by the **checkmark symbol and a footnote**. These services not listed in the Medical Benefits Chart also require prior authorization, ***priorityhealth.com/27merit***.
    - You never need approval in advance for out-of-network services from out-of-network providers.
    - While you don't need approval in advance for out-of-network services, you or your doctor can ask us to make a coverage decision in advance.

Other important things to know about our coverage:

- For benefits where your cost sharing is a coinsurance percentage, the amount you pay depends on what type of provider you get the services from:
    - If you get covered services from a network provider, you pay the coinsurance percentage multiplied by our plan's reimbursement rate (as determined in the contract between the provider and our plan).
    - If you get covered services from an out-of-network provider who participates in Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers.
    - If you get covered services from an out-of-network provider who doesn't participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers.

- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay *more* in our plan than you would in Original Medicare. For others, you pay *less*. (To learn more about the coverage and costs of Original Medicare, go to your *Medicare & You 2027* handbook. View it online at Medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.)
- For preventive services covered at no cost under Original Medicare, we also cover those services at no cost to you.
- If Medicare adds coverage for any new services during 2027, either Medicare or our plan will cover those services.

This apple shows preventive services in the Medical Benefits Chart.

This star is next to benefits that our plan offers above and beyond what Original Medicare covers.

✓ This check mark is when a benefit requires prior authorization.

✻ This asterisk will be on services that doesn't apply to your maximum out-of-pocket amount.

Medical Benefits Chart

Covered Service	What you pay	
	In-Network	**Out-of-Network**
Abdominal aortic aneurysm screening A one-time screening ultrasound 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 (PA), nurse practitioner (NP), or clinical nurse specialist (CNS).	There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.	30% of the total cost for this preventive screening.
Acupuncture for chronic low back pain Covered services include: Up to 12 visits in 90 days are covered under the following circumstances:	$20 copay for each Medicare-covered service. Office visits related to Medicare-covered acupuncture services are not covered.	

Covered Service	What you pay	
	In-Network	Out-of-Network
Acupuncture for chronic low back pain (continued) For the purpose of this benefit, chronic low back pain is defined as: • Lasting 12 weeks or longer • Nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious disease, etc.) • Not associated with surgery • Not associated with pregnancy An additional 8 sessions will be covered for patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing. **Provider Requirements:** Physicians may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs), 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		

Covered Service	What you pay	
	In-Network	Out-of-Network
Acupuncture for chronic low back pain (continued) 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.		
Non-Medicare-covered routine acupuncture visits Covered services include: • Non-Medicare covered routine acupuncture visits and treatments for other conditions, such as; headaches, anxiety, sleep issues, osteoarthritis, chemotherapy side effects, and respiratory disorders. • Limited to 6 visits whether done in- or out-of-network.	$20 copay for each non-Medicare-covered acupuncture visit, up to 6 visits every year.	
Allergy shots and serum You are covered for allergy shots and Medicare-covered Part B serum (antigen) when medically necessary. A specialist copayment/coinsurance may apply, see **"Physician/Practitioner services, including doctor's office visits."** **Note:** For Medicare-covered allergy testing, see **"Outpatient diagnostic tests and therapeutic services and supplies."**	Up to 20% of the total cost for each Medicare-covered Part B drug obtained in a provider's office.	
Ambulance services Covered ambulance services, whether for an emergency or non-emergency situation, include fixed wing, rotary wing, and ground ambulance services, to the	$270 copay for each one-way Medicare-covered ambulance transport. $270 copay for each non-Medicare-covered ambulance stabilization when there is no transport.	

Covered Service	What you pay	
	In-Network	**Out-of-Network**
Ambulance services (continued) nearest appropriate facility that can provide care if they're furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by our plan. If the covered ambulance services aren't for an emergency situation, it should be documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required. ☆ 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. ☆ 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.*	Out-of-network cost-sharing will apply toward your combined out-of-pocket maximum.	
☆ **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	$0 copay for an annual preventive physical exam.	30% of the total cost for an annual preventive physical exam.

Covered Service	What you pay	
	In-Network	Out-of-Network
Annual preventive physical exam (continued) for you and your physician to talk about any concerns or questions you may have. The annual preventive physical exam DOES NOT include lab tests and immunizations. See **"Outpatient diagnostic tests and therapeutic services and supplies"** and **"Immunizations"** for cost share.		
Annual wellness visit If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once per calendar year. Like the annual preventive physical exam, you will not be charged for the office visit no matter how much is discussed with your physician. The annual wellness visit DOES NOT include lab tests and immunizations. See **"Outpatient diagnostic tests and therapeutic services and supplies"** and **"Immunizations"** for cost share. **Note:** Your first annual wellness visit can't take place within 12 months of your *Welcome to Medicare* preventive visit. However, you don't need to have had a *Welcome to Medicare* visit to be covered for annual wellness visits after you've had Part B for 12 months.	There is no coinsurance, copayment, or deductible for the annual wellness visit.	30% of the total cost for the annual wellness visit.
Bone mass measurement For qualified people (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following	There is no coinsurance, copayment, or deductible for	30% of the total cost for Medicare-covered bone mass measurements.

Covered Service	What you pay	
	In-Network	**Out-of-Network**
Bone mass measurement (continued) services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	Medicare-covered bone mass measurement.	
Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women aged 40 and older • Clinical breast exams once every 24 months A **breast cancer screening mammogram** (2D or 3D) is done when you have no signs or symptoms (asymptomatic) of breast disease. A **diagnostic mammogram** is done when you do have signs or symptoms of breast disease, a personal history of breast cancer or personal history of biopsy-proven benign breast disease. If you have a lump removed and sent to the lab for testing, this is considered diagnostic, regardless of whether you have a screening mammogram or a diagnostic mammogram. See **"Outpatient diagnostic tests and therapeutic services and supplies."**	There is no coinsurance, copayment, or deductible for covered screening mammograms.	30% of the total cost for screening mammograms.
Cardiac rehabilitation services Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are	$10 copay for each Medicare-covered cardiac rehabilitation services visit.	30% of the total cost for each Medicare-covered cardiac rehabilitation services visit.

Covered Service	What you pay	
	In-Network	**Out-of-Network**
Cardiac rehabilitation services (continued) covered for members who meet certain conditions with a doctor's order. Our plan covers these comprehensive programs if you've had at least one of these conditions: • Heart attack in the last 12 months • Coronary artery bypass surgery • Stable angina pectoris (chest pain) • Heart valve repair or replacement • Coronary angioplasty (a medical procedure used to open a blocked artery) or coronary stenting (a procedure used to keep an artery open) • Heart or heart and lung transplant • Stable chronic heart failure Coverage limitations: You can get up to 36 cardiac rehabilitation sessions. You can have 2 sessions per day (each lasting 1 hour), and the program can last up to 36 weeks. If you qualify, you may be able to get 36 more sessions that can be spread out over a longer time period.	$10 copay for each Medicare-covered intensive cardiac rehabilitation services visit.	30% of the total cost for each Medicare-covered intensive cardiac rehabilitation services visit.
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.	30% of the total cost for the Medicare-covered intensive behavioral therapy cardiovascular disease preventive benefit.

Covered Service	What you pay	
	In-Network	**Out-of-Network**
Cardiovascular disease screening tests Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).	There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.	30% of the total cost for Medicare-covered cardiovascular disease testing that is covered once every 5 years.
Cervical and vaginal cancer screening Covered services include: • Pap tests and pelvic exams once every 24 months for all women • One pap test every 12 months if at high risk of cervical or vaginal cancer or if of childbearing age and have had an abnormal pap test within the past 3 years • Human Papillomavirus (HPV) tests (as part of a Pap test) once every 5 years if you're aged 30-65 years and asymptomatic.	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.	30% of the total cost for Medicare-covered preventive Pap and pelvic exams.
Chiropractic services Covered services include: • Manual manipulation of the spine to correct a vertebral subluxation • Office visits and x-rays billed when receiving the Medicare-covered manual manipulation will not be covered.	$15 copay for each Medicare-covered chiropractic service.	30% of the total cost for each Medicare-covered chiropractic service.
Colorectal cancer screening The following screening tests are covered: • Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible	There is no copayment for a Medicare-covered colorectal cancer screening exam. If your doctor finds and removes a polyp or other tissue during	30% of the total cost for a Medicare-covered colorectal cancer screening exam. If your doctor finds and removes a polyp or other tissue during the

Covered Service	What you pay	
	In-Network	Out-of-Network
Colorectal cancer screening (continued) 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. • Computed tomography colonography for patients 45 years and older who are not 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, coverage of 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 colonoscopy 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 computed tomography colonography. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months.	the colonoscopy or flexible sigmoidoscopy, the screening exam becomes a diagnostic exam and is subject to $0 copay when performed in an outpatient hospital or a $0 copay when performed in a stand-alone facility.	colonoscopy or flexible sigmoidoscopy, the screening exam becomes a diagnostic exam and is subject to 30% of the total cost when performed in an outpatient hospital or 30% of the total cost when performed in a stand-alone facility.

Covered Service	What you pay	
	In-Network	Out-of-Network
Colorectal cancer screening (continued) • 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 patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare-covered non-invasive stool-based colorectal cancer screening test returns a positive result. • Colorectal cancer screening tests include a planned screening flexible sigmoidoscopy or screening colonoscopy that involves the removal of tissue or other matter, or other procedure furnished in connection with, as a result of, and in the same clinical encounter as the screening test. • Screenings for medical bowel irregularities, issues or symptoms (bleeding, etc.), previous polyps, or follow-up for a positive Cologuard or other non-invasive test are all considered Diagnostic Colonoscopies, therefore cost share may apply. Please see **"Outpatient surgery"** and **"Outpatient diagnostic tests and therapeutic services and supplies (labs/ pathology)"** benefits. A **screening colonoscopy** is a procedure to find colon polyps, cancer, or other colorectal related conditions in individuals with no signs or symptoms. A screening colonoscopy can become a		

Covered Service	What you pay	
	In-Network	Out-of-Network
Colorectal cancer screening (continued) diagnostic colonoscopy during the procedure itself, if that occurs see **"Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers"** or **"Outpatient diagnostic tests and therapeutic services and supplies"** for cost share. A **diagnostic colonoscopy** is performed in order to explain symptoms identified by your physician (for example, blood in stools, change in bowel movements, iron deficiency due to anemia, persistent abdominal pain, etc.), because you've had a previous colonoscopy that resulted in removal of polyps, or other colorectal related conditions. If your physician orders a diagnostic colonoscopy see **"Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers"** or **"Outpatient diagnostic tests and therapeutic services and supplies"** for cost share.		
Dental services In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) aren't covered by Original Medicare. However, Medicare pays for dental services in a limited number of circumstances, specifically when that 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	$0 copay for Medicare-covered surgical procedures performed by a physician/ practitioner in a provider's office. $45 copay for each Medicare-covered visit with a specialist. $225 copay for each Medicare-covered ambulatory surgical	30% of the total cost for Medicare-covered dental services.

Covered Service	What you pay	
	In-Network	Out-of-Network
Dental services (continued) cancer involving the jaw, or oral exams prior to organ transplantation.	center or outpatient hospital facility visit.	
Non-Medicare covered dental services* You have coverage for routine dental services when you visit either an in-network or out-of-network dentist. In-network dentists participate in the Delta Dental's Medicare Advantage PPO and Medicare Advantage Premier network. All other dentists are considered out-of-network. – Find an in-network dentist: Call Delta Dental at 800.330.2732 (TTY users should call 711), Monday through Friday 9 a.m. to 8 p.m. – Visiting ***deltadentalmi.com/Find-a-Dentist*** and selecting "Delta Dental Medicare Advantage PPO" or "Delta Dental Medicare Advantage Premier." Note: If you use an out-of-network dentist, you are still covered but may be responsible for paying more. For additional details about your dental benefits, go to ***priorityhealth.com/27merit*** to view your certificate of coverage (COC).	$0 copay for 2 preventive exams every year.* $0 copay for 2 cleanings (regular or periodontal maintenance) every year.* $0 copay for 1 set (up to 4 films in a single visit) of bitewing x-rays every year.* $0 copay for periapical radiographs as needed.* $0 copay for 1 brush biopsy every year.* $0 copay for radiographs (full-mouth or panoramic x-rays) once every 2 years.* $0 copay for 1 fluoride treatment every year.*	
Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	There is no coinsurance, copayment, or deductible for an annual depression screening visit.	30% of the total cost for an annual depression screening visit.
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of these	There is no coinsurance, copayment, or	30% of the total cost for the

Covered Service	What you pay	
	In-Network	**Out-of-Network**
Diabetes screening (continued) risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. You may be eligible for up to 2 diabetes screenings every 12 months following the date of your most recent diabetes screening test.	deductible for the Medicare-covered diabetes screening tests.	Medicare-covered diabetes screening tests.
Diabetes self-management training, diabetic services, and supplies For all people who have diabetes (insulin and non-insulin users), covered services include: • Supplies to monitor your blood glucose: blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors • For people with diabetes who have severe diabetic foot disease, one pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and 2 additional pairs of inserts, or one pair of depth shoes and 3 pairs of inserts (not including the non-customized removable inserts provided with such shoes) including fitting • Diabetes self-management training under certain conditions. • For other diabetic equipment and supplies (for example: insulin pumps	$0 copay for diabetic monitoring supplies. ○ Diabetic test strips are limited to Contour® and Accu-Chek® Guide products when dispensed by an in-network retail or mail-order pharmacy. ○ All other diabetic test strips may be obtained through a DME supplier. $0 copay for Medicare-covered diabetic therapeutic shoes or inserts. $0 copay for Medicare-covered diabetes self-management training services.	30% of the total cost for Medicare-covered diabetic monitoring supplies. 30% of the total cost for Medicare-covered diabetic therapeutic shoes or inserts. 30% of the total cost for Medicare-covered diabetes self-management training services.

Covered Service	What you pay	
	In-Network	Out-of-Network
Diabetes self-management training, diabetic services, and supplies (continued) and continuous glucose monitors (CGM)) see **"Durable medical equipment and related supplies"**.		
Durable medical equipment (DME) and related supplies* (For a definition of durable medical equipment, go to Chapter 12 and Chapter 3) Covered items include, but aren't limited to, wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers. We cover all medically necessary DME covered by Original Medicare. If our supplier in your area doesn't carry a particular brand or manufacturer, you can ask them if they can special order it for you. The most recent list of suppliers is available on our website at ***priorityhealth.com/27merit***. We also follow Medicare rules related to criteria for coverage of Medicare-covered items or supplies. For some equipment Medicare requires a certain amount of usage in order to continue a rental (for example, CPAP, etc.). If you don't meet the Medicare requirements for usage, you may not be able to continue the rental of this device. You must obtain DME & related supplies from a licensed DME provider.	20% of the total cost for Medicare-covered equipment and supplies. 20% of the total cost for Continuous Glucose Monitors (CGM's). ○ Continuous Glucose Monitors (CGM's) are limited to Dexcom® and Freestyle Libre® products when dispensed by an in-network retail or mail-order pharmacy. ○ All other Continuous Glucose Monitors (CGM's) may be obtained through a DME supplier. Your cost sharing for Medicare oxygen equipment coverage is 20%, every month.	30% of the total cost for Medicare-covered equipment and supplies. Your cost sharing for Medicare oxygen equipment coverage is 30%, every month. Your cost sharing will not change after being enrolled for 36 months. You will continue to be charged a cost share for oxygen; but not the machine rental.

Covered Service	What you pay	
	In-Network	**Out-of-Network**
Durable medical equipment (DME) and related supplies* (continued) Please see Chapter 3, Section 7.2 for additional details around oxygen equipment. ✓ *Prior authorization may apply.*	Your cost sharing will not change after being enrolled for 36 months. You will continue to be charged a cost share for oxygen; but not the machine rental. If prior to enrolling in **Priority**Medicare Merit (PPO) you had made 36 months of rental payment for oxygen equipment coverage, your cost sharing in **Priority**Medicare Merit (PPO) is 20%.	If prior to enrolling in **Priority**Medicare Merit (PPO) you had made 36 months of rental payment for oxygen equipment coverage, your cost sharing in **Priority**Medicare Merit (PPO) is 30%.
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services • Needed to evaluate or stabilize an emergency medical condition A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you're a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that's quickly getting worse. Cost sharing for necessary emergency services you get out-of-network is the	$130 copay for each Medicare-covered emergency room visit. Out-of-network cost sharing will apply toward your combined out-of-pocket maximum. Emergency care cost sharing is waived if you are admitted to the hospital within 24 hours for the same condition.	

Covered Service	What you pay	
	In-Network	Out-of-Network
Emergency care (continued) same as when you get these services in-network. For information on observation, see **"Outpatient hospital observation"**. You have emergency care coverage in the United States and worldwide. **Note:** If you get Part D Medicare-covered self-administered drugs in an emergency room setting, they may be covered under your prescription drug benefit on this plan. See Chapter 6, Section 7 for more information on what happens when you get a Part D drug in a medical setting.		
Fitness (One Pass®)* More access. Less hassle. Keep up your current fitness routine or try out a new club. With holistic health at the center, One Pass® plans are designed to give you the freedom to move freely and feel your best. One Pass® includes: • Access to the largest fitness networks in the nation • Live, digital fitness classes and on-demand workouts • Online brain training made just for you to help 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	$0 copay for One Pass® comprehensive fitness benefit.*	Up to $60 reimbursement every year for comprehensive fitness outside of the One Pass® network (cannot combine with in-network benefit)*

Covered Service	What you pay	
	In-Network	Out-of-Network
Fitness (One Pass®)* (continued) 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 Your One Pass® member code is a single code that allows you to access any fitness location in the network. Additionally, use it to access online fitness vendors and other One Pass® offerings. You may also call 866.756.9732 Monday – Friday from 9 a.m. to 10 p.m. EST to access your One Pass® member code and find a gym near you.		
Health and wellness education programs* These are programs focused on health conditions such as high blood pressure, cholesterol, asthma, COPD, diabetes, heart failure, kidney disease, and conditions requiring special diets. Support for stress, anxiety, and depression is also available. We offer these programs to enrich the health and lifestyles of our members. • Fitness (One Pass®)* • Health education* • In-home safety assessment* • Nutritional education* • Post-discharge in-home medication reconciliation* • Telemonitoring* For more information, please refer to the individual program listed in this medical benefits chart.	$0 copay for these services.*	

Covered Service	What you pay	
	In-Network	**Out-of-Network**
Health education* Health education includes: • Access to Teladoc 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 member portal 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 copay for these services.*	
Hearing services Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider.	$0 copay for each Medicare-covered diagnostic hearing exam with a primary care provider. $45 copay for each Medicare-covered diagnostic hearing exam with a specialist.	30% of the total cost for each Medicare-covered exam to diagnose and treat hearing and balance issues.

Covered Service	What you pay	
	In-Network	**Out-of-Network**
Non-Medicare covered routine hearing services:* Up to two hearing aids per year (limit 1 hearing aid per ear) and one routine hearing exam, whether done in- or out-of-network. In-network providers are covered through the TruHearing network. All other hearing providers are considered out-of-network (nonparticipating) providers. If the provider you choose is not a TruHearing provider you will still be covered but you may have to pay more. To use the in-network benefit you must see a TruHearing provider. Call 833.714.5356 to schedule an appointment (for TTY, dial 711). Hearing aid purchase includes: • First year of follow-up provider visits • 60-day trial period • 3-year extended warranty • 80 batteries per aid for non-rechargeable models Benefit does not include or cover any of the following: • Over-the-counter (OTC) hearing aids • Ear molds • Hearing aid accessories • Additional provider visits • Additional batteries; batteries when a rechargeable hearing aid is purchased • Hearing aids that are not in the applicable catalog • Costs associated with loss & damage warranty claims Costs associated with excluded items are the responsibility of the member and not covered by the plan.	$0 copay for one routine hearing exam every year*. Hearing aids – you pay the following: $399 per hearing aid for Standard Aids*. $599 per hearing aid for Advanced Aids*. $899 per hearing aid for Premium Aids*.	30% of the total cost for one routine hearing exam every year*. 50% of the total cost for hearing aids (one per ear, per year)*.

Covered Service	What you pay	
	In-Network	**Out-of-Network**
Non-Medicare covered routine hearing services:* (continued) To access your in-network benefits, you must contact TruHearing® provider. Just call 833.714.5356 from Monday through Friday from 8 a.m. to 8 p.m. ET. For additional details about your TruHearing® benefits, go to ***priorityhealth.com/27merit*** to view your certificate of coverage (COC).		
HIV screening For people who ask for an HIV screening test or are at increased risk for HIV infection, we cover: • One screening exam every 12 months If you are pregnant, we cover: • Up to 3 screening exams during a pregnancy	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.	30% of the total cost for Medicare-covered preventive HIV screenings.
Home health agency care Before you get home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but aren't limited to: • Part-time or intermittent skilled nursing and home health aide services (to be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech therapy	$0 copay for Medicare-covered home health services.	

Covered Service	What you pay	
	In-Network	Out-of-Network
Home health agency care (continued) • Medical and social services • Medical equipment and supplies **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.		
Home infusion therapy Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to a person at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Covered services include, but aren't limited to: • Professional services, including nursing services, furnished in accordance with our plan of care • Patient training and education not otherwise covered under the durable medical equipment benefit • Remote monitoring • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier This benefit includes supplies/services associated with home infusion drugs. Only drugs listed in the formulary with the "HI" designation are covered under this home infusion therapy benefit. Cost share will apply for all other drugs	$0 copay for home infusion supplies, services, and drugs.	

Covered Service	What you pay	
	In-Network	Out-of-Network
Home infusion therapy (continued) administered in the home setting, see **"Medicare Part B prescription drugs."** ✓ *Prior authorization may apply.*		
Hospice care You're eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. You can get care from any Medicare-certified hospice program. Our plan is obligated to help you find Medicare-certified hospice programs in our 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 for symptom control and pain relief • Short-term respite care • Home care When you're admitted to a hospice, you have the right to stay in our plan; if you stay in our plan you must continue to pay plan premiums. **For hospice services and services covered by Medicare Part A or B that are related to your terminal prognosis:** Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A and Part B services related to your terminal prognosis. While you're in the hospice program, your hospice provider will bill	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not **Priority**Medicare Merit (PPO).	
	$0 copay for an initial Medicare-covered hospice consultation.	30% of the total cost for an initial Medicare-covered hospice consultation.

Covered Service	What you pay	
	In-Network	Out-of-Network
Hospice care (continued) Original Medicare for the services Original Medicare pays for. You'll be billed Original Medicare cost sharing. **For services covered by Medicare Part A or B not related to your terminal prognosis:** If you need non-emergency, non-urgently needed services covered under Medicare Part A or B that aren't related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network and follow plan rules (like if there's a requirement to get prior authorization). • If you get the covered services from a network provider and follow plan rules for getting service, you pay only our plan cost-sharing amount for in-network services • If you get the covered services from an out-of-network provider, your share of the costs for covered services may be higher. **For services covered by Priority**Medicare Merit (PPO) **but not covered by Medicare Part A or B: Priority**Medicare Merit (PPO) will continue to cover plan-covered services that aren't covered under Part A or B whether or not they're related to your terminal prognosis. You pay our plan cost-sharing amount for these services. **For drugs that may be covered by our plan's Part D benefit:** If these drugs are unrelated to your terminal hospice condition, you pay cost sharing. If they're related to your terminal hospice condition, you pay Original Medicare cost sharing. Drugs are never covered by both		

Covered Service	What you pay	
	In-Network	Out-of-Network
Hospice care (continued) hospice and our plan at the same time. For more information, go to Chapter 5, Section 9.4. **Note**: If you need non-hospice care (care that's not related to your terminal prognosis), contact us to arrange the services. Our plan covers hospice consultation services (one-time only) for a terminally ill person who hasn't elected the hospice benefit.		
Immunizations Covered Medicare Part B services include: • Pneumonia vaccines • Flu/influenza shots (or vaccines), once each flu/influenza season in the fall and winter, with additional flu/influenza shots (or vaccines) if medically necessary • Hepatitis B vaccines if you've never received a complete series, you don't know your vaccination history, or you have any other condition that puts you 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 also cover most other adult vaccines under our Part D drug benefit. Go to Chapter 6, Section 8 for more information. Vaccines covered under our Part D prescription drug benefit should be obtained, if possible, at a vaccine network pharmacy, which are indicated	There is no coinsurance, copayment, or deductible for the pneumonia, flu/influenza, Hepatitis B, and COVID-19 vaccines.	30% of the total cost for pneumonia, flu/influenza, Hepatitis B, and COVID-19 vaccines.

Covered Service	What you pay	
	In-Network	Out-of-Network
Immunizations (continued) with a "v" in the *Provider/Pharmacy Directory*. Our plan covers most Part D vaccines at no cost to you. Call Customer Care for more information. When a Part D Medicare-covered immunization is received in a provider's office or outpatient setting, you will pay the cost of the immunization and administration to the provider. We will reimburse you as described in Chapter 6, Section 8. Examples of routine vaccines covered under our Part D benefit include shingles vaccine (Zoster/Shingrix) and Tetanus (Td/Tdap).		
In-home safety assessment* An in-home safety assessment will be performed by a health care provider if you do not qualify for one under original Medicare's home health benefit. The assessment will focus on both medical & behavioral hazards, such as your risk for falls or injuries and how to prevent them and identify and/or modify home hazards throughout your home.	$0 copay for in-home safety assessment services.*	
Inpatient hospital care Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day. There's no limit to the number of days covered by our plan. Your inpatient hospital cost sharing will	For Medicare-covered inpatient hospital stays, you pay: $360 copay per day, days 1-6. $0 for additional hospital days.	For Medicare-covered inpatient hospital stays, you pay: 30% of the total cost per stay.

Covered Service	What you pay	
	In-Network	Out-of-Network
Inpatient hospital care (continued) apply each time you are admitted. This includes when transferring from one facility to another or within the same facility between levels of care. Covered services include but aren't limited to: • 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 • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy • Inpatient substance abuse services • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we'll arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you're a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to		

Covered Service	What you pay	
	In-Network	Out-of-Network
Inpatient hospital care (continued) accept the Original Medicare rate. If **Priority**Medicare Merit (PPO) provides transplant services at a location outside the pattern of care for transplants in your community and you choose to get transplants at this distant location, we'll arrange or pay for appropriate lodging and transportation costs for you and a companion. • Blood - including storage and administration. Coverage of whole blood and packed red cells. ☆ Coverage begins with the first pint of blood that you need. • 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 from the Medicare fact sheet *Medicare Hospital Benefits* 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.*		
Inpatient services in a psychiatric hospital Covered services include mental health care services that require a hospital stay.	For Medicare-covered inpatient mental health care stays, you pay:	For Medicare-covered inpatient mental health care stays, you pay:

Covered Service	What you pay	
	In-Network	**Out-of-Network**
Inpatient services in a psychiatric hospital (continued) There's a 190-day lifetime limit for inpatient services in a psychiatric hospital. The 190-day 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.*	$350 copay per day, days 1-5. $0 for additional hospital days.	30% of the total cost per stay.
Inpatient stay: Covered services you get 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	$0 copay for Medicare-covered services received from the inpatient facility. $0 copay for Medicare-covered prosthetic devices and supplies received from the inpatient facility or an outpatient provider when implanted as part of a surgery. 20% of the total cost for all other Medicare-covered prosthetic devices and supplies and Medicare-covered DME received from an outpatient provider.	30% of the total cost for Medicare-covered services received from the inpatient facility. 30% of the total cost for Medicare-covered prosthetic devices and supplies received from an inpatient facility and Medicare-covered prosthetic devices and supplies and DME received from an outpatient provider.

Covered Service	What you pay	
	In-Network	Out-of-Network
Inpatient stay: Covered services you get in a hospital or SNF during a non-covered inpatient stay* (continued) • 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.*		
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor. We cover 3 hours of one-on-one counseling services during the first year you get medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed in the next calendar year.	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.	30% of the total cost for members eligible for Medicare-covered medical nutrition therapy services.
Medicare Diabetes Prevention Program (MDPP) **MDPP services are covered for eligible people under all Medicare health plans.**	There is no coinsurance, copayment, or deductible for the MDPP benefit.	30% of the total cost for the MDPP benefit.

Covered Service	What you pay	
	In-Network	Out-of-Network
Medicare Diabetes Prevention Program (MDPP) (continued) MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustain weight loss and a healthy lifestyle.		
Medicare Part B drugs **These drugs are covered under Part B of Original Medicare. Members of our plan get coverage for these drugs through our plan. Covered drugs include:** • Drugs that usually aren't self-administered by the patient and are injected or infused while you get physician, hospital outpatient, or ambulatory surgical 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 were authorized by our plan • The Alzheimer's drug, Leqembi®, (generic name lecanemab) is administered intravenously. In addition to medication costs, you may need additional scans and tests before and/or during treatment that could add to your overall costs. Talk to your doctor about what scans and tests you may need as part of your treatment • Clotting factors you give yourself by injection if you have hemophilia	For certain Part B drugs, you may be required to try a different drug first. **Part B chemotherapy/radiation** Up to 20% of the total cost for each Medicare-covered Part B drug. **Part B drugs obtained in a provider's office or outpatient setting** Up to 20% of the total cost for each Medicare-covered Part B drug. **Part B drugs obtained at a pharmacy/mail-order** Up to 20% of the total cost for each Medicare-covered Part B drug. There may be a fee for the administration of the Part B medication. Insulin administered through an item of durable medical equipment (such as insulin pumps or continuous glucose monitors (CGM)) will be capped at $35. You will pay 20% and will never pay more than $35 for a one-month supply.	

Covered Service	What you pay	
	In-Network	Out-of-Network
Medicare Part B drugs (continued) • 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 drug coverage covers immunosuppressive drugs if Part B doesn't cover them • Injectable osteoporosis drugs, if you're homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and can't self-administer the drug • 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) of 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		

Covered Service	What you pay	
	In-Network	Out-of-Network
Medicare Part B drugs (continued) 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 End-Stage Renal Disease (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-epoetin beta) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases • Parenteral and enteral nutrition (intravenous and tube feeding) This link will take you to a list of Part B drugs that may be subject to Step Therapy: ***prioityhealth.com/DrugInfo*** Click on Medicare Part B Prior Authorization and Step Therapy criteria. We also cover some vaccines under our Part B and most adult vaccines under our Part D drug benefit.		

Covered Service	What you pay	
	In-Network	Out-of-Network
Medicare Part B drugs (continued) Chapter 5 explains our Part D drug benefit, including rules you must follow to have prescriptions covered. What you pay for Part D drugs through our plan is explained in Chapter 6. ✓ *Prior authorization may apply.*		
Nutrition education* General nutrition education includes both individual and group classes or counseling sessions. These may occur in-home or in an outpatient setting and are provided by a Registered Dietician. For people with diabetes, renal (kidney) disease or after a kidney transplant, see **"Medical Nutrition Therapy."**	$0 copay for nutrition education.*	
Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.	30% of the total cost for preventive obesity screening and therapy.
Opioid treatment program services Members of our plan with opioid use disorder (OUD) can get coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services: • U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications	$20 copay for Medicare-covered opioid treatment services.	30% of the total cost for Medicare-covered opioid treatment services.

Covered Service	What you pay	
	In-Network	**Out-of-Network**
Opioid treatment program services (continued) • Dispensing and administration of MAT medications (if applicable) • Substance use counseling • Individual and group therapy • Toxicology testing • Intake activities • Periodic assessments Please see **"Virtual care"** in this medical benefits chart for information on what virtual opioid treatment services are covered.		
Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but aren't limited to: • X-rays • Radiation (radium and isotope) therapy including technician materials and supplies • Surgical supplies, such as dressings • Splints, casts, and other devices used to reduce fractures and dislocations • Laboratory tests • Blood - including storage and administration. Coverage of whole blood and packed red cells. 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 problem. • Other outpatient diagnostic tests (for example; allergy testing, genetic testing, sleep studies)	**Outpatient x-rays and ultrasounds** $35 copay per day, per provider for Medicare-covered x-ray and ultrasound services. **Therapeutic radiology services** $30 copay per day, per provider for Medicare-covered services (such as radiation treatment for cancer). **Diagnostic radiology services** $125 copay per day, per provider, for Medicare-covered services (such as MRIs and CT scans). $640 copay, per day, per provider, for Medicare-covered	**Outpatient x-rays and ultrasounds** 30% of the total cost per day, per provider for Medicare-covered x-rays and ultrasounds services. **Therapeutic radiology services** 30% of the total cost per day, per provider for Medicare-covered services (such as radiation treatment for cancer). **Diagnostic radiology services** 30% of the total cost per day, per provider, for Medicare-covered services (such as MRIs and CT scans). 30% of the total cost, per day, per provider, for Medicare-covered

Covered Service	What you pay	
	In-Network	**Out-of-Network**
Outpatient diagnostic tests and therapeutic services and supplies (continued) ✓ *Prior authorization may apply.* For a definition of nuclear medicine, please see Chapter 12.	diagnostic nuclear medicine services. **Blood services** $0 copay for blood. **Medical supplies** 20% of the total cost for Medicare-covered surgical supplies, splints, casts, and other devices. **Lab services** $20 copay per day, per provider, for Medicare-covered lab services. $0 copay per day, per provider, for Medicare-covered anticoagulant lab services. $50 copay per day, per provider, for Medicare-covered genetic testing. **Pathology** $20 copay per day, per provider, for Medicare-covered pathology services. **Diagnostic tests and procedures** $20 copay per day, per provider for Medicare-covered diagnostic procedures and tests.	diagnostic nuclear medicine services. **Blood services** $0 copay for blood. **Medical supplies** 30% of the total cost for Medicare-covered surgical supplies, splints, casts, and other devices. **Lab services** 30% of the total cost per day, per provider, for Medicare-covered lab services. $0 copay per day, per provider, for Medicare-covered anticoagulant lab services. $50 copay per day, per provider, for Medicare-covered genetic testing. **Pathology** 30% of the total cost per day, per provider, for Medicare-covered pathology services. **Diagnostic tests and procedures** 30% of the total cost per day, per provider for Medicare-covered diagnostic procedures and tests.

Covered Service	What you pay	
	In-Network	Out-of-Network
Outpatient hospital observation Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet 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 licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you aren't sure if you're an outpatient, ask the hospital staff. Get more information from the Medicare fact sheet *Medicare Hospital Benefits* 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. **Note:** If you get Part D Medicare-covered self-administered drugs in an outpatient setting, they may be covered under your prescription drug benefit on this plan. See Chapter 6, Section 7 for more information on what happens when you get a Part D drug in a medical setting.	$130 copay per stay for Medicare-covered outpatient hospital observation services, including all services received.	

Covered Service	What you pay	
	In-Network	Out-of-Network
Outpatient hospital services We cover medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but aren't limited to: • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery • Laboratory and diagnostic tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it • X-rays and other radiology services billed by the hospital • Medical supplies such as splints and casts • Certain drugs and biologicals you can't give yourself • Wound Care services • Diagnostic colonoscopies **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you aren't sure if you're an outpatient, ask the hospital staff. For information on services provided in a rural health clinic, see **"Rural Health Clinic"** within this Medical Benefits Chart.	$225 copay for each Medicare-covered outpatient hospital facility visit. $45 copay for each Medicare-covered outpatient wound care services. You may receive other services while in an outpatient hospital facility. The cost share for those services can be found in this Medical Benefits Chart.	30% of the total cost for each Medicare-covered outpatient hospital facility visit. 30% of the total cost for each Medicare-covered outpatient wound care services. You may receive other services while in an outpatient hospital facility. The cost share for those services can be found in this Medical Benefits Chart.

Covered Service	What you pay	
	In-Network	Out-of-Network
Outpatient hospital services (continued) **Note:** If you get Part D Medicare-covered self-administered drugs in an outpatient setting, they may be covered under your prescription drug benefit on this plan. See Chapter 6, Section 7 for more information on what happens when you get a Part D drug in a medical setting. ✓ *Prior authorization may apply.*		
Outpatient mental health care Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker (CSW), clinical nurse specialist (CNS), licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), nurse practitioner (NP), physician assistant (PA), or other Medicare-qualified mental health care professional as allowed under applicable state laws. **Note:** If you get Part D Medicare-covered self-administered drugs in an outpatient setting, they may be covered under your prescription drug benefit on this plan. See Chapter 6, Section 7 for more information on what happens when you get a Part D drug in a medical setting. Please see **"Virtual care"** in this medical benefits chart for information on what services are covered.	$20 copay for each Medicare-covered individual therapy visit with a psychiatrist. $20 copay for each Medicare-covered group therapy visit with a psychiatrist. $20 copay for each Medicare-covered individual therapy visit with a mental health care professional (non-psychiatrist). $20 copay for each Medicare-covered group therapy visit with a mental health care professional (non-psychiatrist).	30% of the total cost for each Medicare-covered individual therapy visit with a psychiatrist. 30% of the total cost for each Medicare-covered group therapy visit with a psychiatrist. 30% of the total cost for each Medicare-covered individual therapy visit with a mental health care professional (non-psychiatrist). 30% of the total cost for each Medicare-covered group therapy visit with a mental health care professional (non-psychiatrist).
Outpatient rehabilitation services Covered services include physical therapy, occupational therapy, and	$35 copay for each Medicare-covered occupational therapy visit.	30% of the total cost for each Medicare-covered occupational therapy visit.

Covered Service	What you pay	
	In-Network	Out-of-Network
Outpatient rehabilitation services (continued) speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).	$35 copay for each Medicare-covered physical and/or speech therapy visit.	30% of the total cost for each Medicare-covered physical and/or speech therapy visit.
Outpatient substance use disorder services Medically necessary services to treat alcohol or drug abuse are covered when provided in an outpatient setting (i.e., provider office, clinic, or hospital outpatient department). **Note:** If you get Part D Medicare-covered self-administered drugs in an outpatient setting, they may be covered under your prescription drug benefit on this plan. See Chapter 6, Section 7 for more information on what happens when you get a Part D drug in a medical setting.	$20 copay for each Medicare-covered individual therapy visit. $20 copay for each Medicare-covered group therapy visit.	30% of the total cost for each Medicare-covered individual therapy visit. 30% of the total cost for each Medicare-covered group therapy visit.
Outpatient surgery, including services provided 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 and pay the cost-sharing amounts for outpatient surgery. Even if	For Medicare-covered services at an ambulatory surgical center, you pay $225 copay. For Medicare-covered services at an outpatient hospital facility, you pay $225 copay.	For Medicare-covered services at an ambulatory surgical center, you pay 30% of the total cost. For Medicare-covered services at an outpatient hospital facility, you pay 30% of the total cost.

Covered Service	What you pay	
	In-Network	Out-of-Network
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers (continued) you stay in the hospital overnight, you might still be considered an outpatient. **Note:** If you get Part D Medicare-covered self-administered drugs in an outpatient setting, they may be covered under your prescription drug benefit on this plan. See Chapter 6, Section 7 for more information on what happens when you get a Part D drug in a medical setting. ✓ *Prior authorization may apply.*		
Partial hospitalization services and intensive outpatient services* *Partial hospitalization* is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center that's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office and is an alternative to inpatient hospitalization. *Intensive outpatient service* is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a Federally Qualified Health Center, or a rural health clinic that's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office but less intense than partial hospitalization.	$55 copay per day for Medicare-covered partial hospitalization services. $55 copay per day for Medicare-covered intensive outpatient services.	40% of the total cost per day for Medicare-covered partial hospitalization services. 40% of the total cost per day for Medicare-covered intensive outpatient services.

Covered Service	What you pay	
	In-Network	**Out-of-Network**
Partial hospitalization services and intensive outpatient services* (continued) Call our Behavioral Health department at 800.673.8043 with questions. ✓ *Prior authorization may apply.*		
Physician/practitioner services, including doctor's office visits Covered services include: • Medically necessary medical care or surgery services you get in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams performed by your PCP or specialist, if your doctor orders it to see if you need medical treatment • If you're living with a long-term illness and want to talk to a physician about getting relief from the symptoms and physical and mental stress, visit a palliative care physician. • Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home • Telehealth services to diagnose, evaluate, or treat symptoms of a stroke, regardless of your location • Telehealth services for members with a substance use disorder or	$0 copay for each Medicare-covered primary care visit. $0 copay for each palliative care physician office visit. $0 copay for simple surgical procedures done in a providers office (ex: mole removals and sutures). $225 copay for moderate to major surgical procedures done in a providers office (ex: carpal tunnel release and trigger finger release surgeries). $45 copay for all other Medicare-covered specialist office visits. $50 copay for each urgently needed Medicare-covered visit in a physician's office after hours.	30% of the total cost for each Medicare-covered primary care visit. 30% of the total cost for each palliative care physician office visit. 30% of the total cost for simple surgical procedures done in a providers office (ex: mole removals and sutures). 30% of the total cost for moderate to major surgical procedures done in a providers office (ex: carpal tunnel release and trigger finger release surgeries). 30% of the total cost for all other Medicare-covered specialty office visits. $50 copay for each urgently needed Medicare-covered visit in a physician's office after hours.

Covered Service	What you pay	
	In-Network	Out-of-Network

Physician/practitioner services, including doctor's office visits (continued)
co-occurring mental health disorder, regardless of their location
• 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 getting 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		

Covered Service	What you pay	
	In-Network	Out-of-Network
Physician/practitioner services, including doctor's office visits (continued) • Consultation your doctor has with other doctors by phone, internet, or electronic health record • Second opinion prior to surgery Please see **"Virtual care"** in this medical benefits chart for information on what virtual physician/practitioner visits are covered. **Note:** To determine if your provider is a PCP or a Specialist, see Chapter 3, Section 2.1. **Note:** For definitions of simple and moderate to major procedures, see Chapter 12. ✓ *Prior authorization may apply.*		
Podiatry services Covered services include: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) • Routine foot care for members with certain medical conditions affecting the lower limbs	$45 copay for each Medicare-covered visit. $0 copay for nail debridement visits & callous removal visits, for members with specific medical conditions affecting the lower limbs.	30% of the total cost for each Medicare-covered visit. 30% of the total cost for nail debridement visits & callous removal visits, for members with specific medical conditions affecting the lower limbs.
Post-discharge in-home medication reconciliation* Immediately following hospital or SNF inpatient stay, a qualified health care provider, in cooperation with your physician, will review/reconcile a complete medication regimen. They will ensure new medications are obtained	$0 copay for post discharge in-home medication reconciliation services.*	

Covered Service	What you pay	
	In-Network	Out-of-Network
Post-discharge in-home medication reconciliation* (continued) 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.		
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 including the fee for injecting the drug, if applicable • 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	There is no coinsurance, copayment, or deductible for the PrEP benefit.	30% of the total cost for the PrEP benefit.
Prostate cancer screening exams For men aged 50 and older, covered services include the following once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test You get a PSA screening if you have no signs or symptoms (asymptomatic) of prostate cancer or related prostate conditions. If you've had a previous PSA	There is no coinsurance, copayment, or deductible for an annual PSA test. $0 copay for an annual Medicare-covered digital rectal exam.	30% of the total cost for an annual PSA test. 30% of the total cost for an annual Medicare-covered digital rectal exam.

Covered Service	What you pay	
	In-Network	Out-of-Network
Prostate cancer screening exams (continued) that was elevated or are being treated for conditions which may lead to prostate cancer which include but are not limited to prostatitis (inflammation of the prostate) or benign prostatic hyperplasia (enlargement of the prostate), or have had prostate cancer, your PSA test may be considered diagnostic. See **"Outpatient diagnostic tests and therapeutic services and supplies".**		
Prosthetic and orthotic devices and related supplies Devices (other than dental) that 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; as well as colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic and orthotic devices, and repair and/or replacement of prosthetic and orthotic devices. Also includes some coverage following cataract removal or cataract surgery – go to *Vision Care* later in this table for more detail. ✓ *Prior authorization may apply.*	$0 copay for devices implanted as part of a surgery in an ambulatory surgery center or outpatient hospital facility. 20% of the total cost for all other Medicare-covered prosthetic devices and supplies.	30% of the total cost for Medicare-covered Prosthetic devices and supplies.
Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary	$10 copay for each Medicare-covered pulmonary rehabilitation services visit.	30% of the total cost for each Medicare-covered pulmonary rehabilitation services visit.

Covered Service	What you pay	
	In-Network	Out-of-Network
Pulmonary rehabilitation services (continued) rehabilitation from the doctor treating the chronic respiratory disease.		
Rural Health Clinic Rural health clinics are located in non-urbanized areas. These clinics offer outpatient primary care and preventive health services to people in medically underserved or shortage areas. The following lab tests are provided at rural health clinics, see **"Outpatient diagnostic tests and therapeutic services and supplies"** for cost share, within this Medical Benefits Chart: • Stick or tablet chemical urine exam or both • Hemoglobin or hematocrit • Blood sugar • Occult blood stool specimens exam • Pregnancy tests • Primary culturing to send to a certified laboratory	$0 copay for each rural health clinic visit.	30% of the total cost for each rural health clinic visit.
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults (including pregnant women) who misuse alcohol but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.	30% of the total cost for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.

Covered Service	What you pay	
	In-Network	**Out-of-Network**
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 cover 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.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for the Hepatitis C Virus.	30% of the total cost for the Medicare-covered screening for Hepatitis C Virus.
Screening for lung cancer with low dose computed tomography (LDCT) For qualified people, an LDCT is covered every 12 months. **Eligible members are** people age 50 – 77 who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and who currently smoke or have quit smoking within the last 15 years, who get an order for LDCT during a lung cancer screening counseling and shared decision-making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. *For LDCT lung cancer screenings after the initial LDCT screening:* the members must get an order for LDCT lung cancer screening, which may be furnished	There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision-making visit or for the LDCT.	30% of the total cost for the Medicare-covered counseling and shared decision-making visit or for the LDCT.

Covered Service	What you pay	
	In-Network	Out-of-Network
Screening for lung cancer with low dose computed tomography (LDCT) (continued) during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide lung cancer screening counseling and shared decision-making visit for later lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.		
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to 2 individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.	30% of the total cost for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.

Covered Service	What you pay	
	In-Network	**Out-of-Network**
Services to treat kidney disease Kidney disease and dialysis services include: • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to 6 sessions of kidney disease education services per lifetime • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3, or when your provider for this service is temporarily unavailable or inaccessible) • Inpatient dialysis treatments (if you're admitted as an inpatient to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) Certain drugs for dialysis are covered under Medicare Part B. For information about coverage for Part B Drugs, go to **Medicare Part B drugs** in this table.	$0 copay for Medicare-covered kidney disease education services. 20% of the total cost for each Medicare-covered renal dialysis service with an in-network provider or when you are outside of the plan's service area.	30% of the total cost for Medicare-covered kidney disease education services. 30% of the total cost for each Medicare-covered renal dialysis service with an out-of-network provider when you are in the plan's service area.

Covered Service	What you pay	
	In-Network	Out-of-Network
Skilled nursing facility (SNF) care (For a definition of skilled nursing facility care, go to Chapter 12. Skilled nursing facilities are sometimes called SNFs.) Covered up to 100 days per benefit period (based on medical and rehab necessity determined prior to admission and on an ongoing basis). A benefit period starts the day you go into a skilled nursing facility. The benefit period ends when you go for 60 days in a row without skilled nursing care. If you go into a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have. **No prior hospital stay is required.** Covered services include but aren't limited to: • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy and speech therapy • Drugs administered to you as part of our plan of care (this includes substances naturally present in the body, such as blood clotting factors.) • Blood - including storage and administration. Coverage of whole blood and packed red cells. Coverage begins with the first pint of blood that you need. • Medical and surgical supplies ordinarily provided by SNFs	For Medicare-covered SNF stays, you pay: $0 copay per day, days 1-20. $218 copay per day, days 21-100.	For Medicare-covered SNF stays, you pay: 30% of the total cost per stay.

Covered Service	What you pay	
	In-Network	Out-of-Network
Skilled nursing facility (SNF) care (continued) • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services Generally, you get SNF care from network facilities. Under certain conditions listed below, you may be able to pay in-network cost sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment. • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care) • A SNF where your spouse or domestic partner is living at the time you leave the hospital ✓ *Prior authorization may apply.*		
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) Smoking and tobacco use cessation counseling is covered for outpatient and hospitalized patients who meet these criteria: • Use tobacco, regardless of whether they exhibit signs or symptoms of tobacco-related disease • Are competent and alert during counseling	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.	30% of the total cost for the Medicare-covered smoking and tobacco use cessation preventive benefits.

Covered Service	What you pay	
	In-Network	Out-of-Network
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) (continued) • A qualified physician or other Medicare-recognized practitioner provides counseling We cover 2 cessation attempts per year (each attempt may include a maximum of 4 intermediate or intensive sessions, with the patient getting up to 8 sessions per year.)		
Supervised exercise therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD). Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant (PA), or nurse practitioner (NP)/clinical nurse specialist (CNS) who must be trained in both basic and advanced life support techniques SET may be covered beyond 36 sessions over 12 weeks for an additional 36	$10 copay for each Medicare-covered SET visit.	30% of the total cost for each Medicare-covered SET visit.

Covered Service	What you pay	
	In-Network	Out-of-Network
Supervised exercise therapy (SET) (continued) sessions over an extended period of time if deemed medically necessary by a health care provider.		
Telemonitoring services* Telemonitoring or other remote monitoring services for heart failure, uncontrolled diabetes, chronic obstructive pulmonary disease (COPD), cardiovascular conditions and hypertension. Includes specially adapted equipment, telecommunications, and technology to monitor health conditions across a distance.	$0 copay for telemonitoring services.*	
Urgently needed services A plan-covered service requiring immediate medical attention that's not an emergency is an urgently needed service if either you're temporarily outside our plan's service area, or, even if you're inside our plan's service area, it's unreasonable given your time, place, and circumstances to get this service from network providers. Our plan must cover urgently needed services and only charge you in-network cost sharing. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable. You have coverage for urgently needed services in the United States	$50 copay for each Medicare-covered urgent care visit. Out-of-network cost sharing will apply toward your combined out-of-pocket maximum. Urgently needed care services cost sharing is waived if you are admitted to the hospital within 24 hours for the same condition.	

Covered Service	What you pay	
	In-Network	Out-of-Network
Urgently needed services (continued) and worldwide. **Note:** If you get Part D Medicare-covered self-administered drugs in an outpatient setting, they may be covered under your prescription drug benefit on this plan. See Chapter 6, Section 7 for more information on what happens when you get a Part D drug in a medical setting.		
Virtual care *(also referred to as telehealth services, virtual check-ins or eVisits.)* Members have the option to receive health care services in places like your home from the following providers: • Primary care providers (PCPs) • Specialists • Behavioral health providers • Urgent care Covered telehealth services include virtual visits, evaluations, communication via telephone, or video (computer, smart phone, tablet, online patient portal). Ask one of our network providers if they can do virtual visits. • Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home • Telehealth services to diagnose, evaluate, or treat symptoms of a stroke, regardless of your location • Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location	$0 copay for virtual visits.	Not covered.

Covered Service	What you pay	
	In-Network	Out-of-Network

Virtual care (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
• Consultation your doctor has with other doctors by phone, internet, or electronic health record		

Covered Service	What you pay	
	In-Network	Out-of-Network
Vision care Covered services include: • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts • For people who are at high risk for glaucoma, we cover one glaucoma screening each year. People at high risk of glaucoma include people with a family history of glaucoma, people with diabetes, African Americans who are age 50 and older and Hispanic Americans who are 65 or older • For people with diabetes, screening for diabetic retinopathy is covered once per year • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. If you have 2 separate cataract operations, you can't reserve the benefit after the first surgery and purchase 2 eyeglasses after the second surgery **Note:** Medicare does not cover refraction tests used to determine a prescription for eyeglasses or contact lenses. If you receive a refraction test during a Medicare-covered eye exam to diagnose or treat an eye disease or condition, the refraction portion of the visit is not covered.	Medicare-covered vision care: $45 copay for each Medicare-covered exam to diagnose and treat diseases or conditions of the eye. $0 copay for annual glaucoma screenings. $0 copay for annual diabetic retinopathy screening. $0 copay for Medicare-covered eyewear after cataract surgery.	Medicare-covered vision care: 30% of the total cost for each eye exam to diagnose and treat diseases and conditions of the eye. 30% of the total cost for an annual glaucoma screening. 30% of the total cost for annual diabetic retinopathy screening. 30% of the total cost for one pair of eyeglasses or contact lenses after cataract surgery.

Covered Service	What you pay	
	In-Network	**Out-of-Network**
Non-Medicare-covered routine vision care* You have coverage for routine vision care when you visit either an in-network or out-of-network vision provider (cannot combine). In-network providers are covered through the EyeMed "Select" network. All other vision providers are considered out-of-network providers. Find an in-network vision provider: • Call EyeMed at 844.366.5127, Monday through Friday from 8 a.m. to 8 p.m. • Visit ***eyemed.com*** and select "Find an eye doctor" then choose the "Select" network to search for an in-network provider. Note: If you use an out-of-network vision provider, you are still covered but will have to seek reimbursement and may be responsible for paying more. Note: Routine visits billed as a diagnostic exam are subject to the Medicare-covered eye exam cost-share listed above. For additional details about your routine vision care benefits, go to ***priorityhealth.com/27merit*** to view your certificate of coverage (COC).	**Covered services with an EyeMed "Select" provider:** $0 copay for one non-Medicare covered routine vision exam, including dilation and refraction as necessary.* $0 copay for one non-Medicare covered retinal imaging.* $100 allowance for non-Medicare covered eyewear.*	**Services with a non-EyeMed "Select" provider:** 30% of the total cost for one non-Medicare covered routine vision exam, including dilation and refraction as necessary.* 30% of the total cost for one non-Medicare covered retinal imaging.* Up to $100 reimbursement for non-Medicare covered eyewear.*
Welcome to Medicare preventive visit Our plan covers the one-time *Welcome to Medicare* preventive visit. The visit includes a review of your health, as well as education and counseling about preventive services you need (including certain screenings and shots (or	There is no coinsurance, copayment, or deductible for the *Welcome to Medicare* preventive visit.	30% of the total cost for the *Welcome to Medicare* preventive visit.

Covered Service	What you pay	
	In-Network	Out-of-Network
Welcome to Medicare preventive visit (continued) vaccines)), and referrals for other care if needed. **Important:** We cover the *Welcome to Medicare* preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you want to schedule your *Welcome to Medicare* preventive visit.		

Section 2.1 Extra optional supplemental benefits you can buy

Our plan offers some extra benefits that aren't covered by Original Medicare and not included in your benefits package. These extra benefits are called **Optional Supplemental Benefits.** If you want these optional supplemental benefits, you must sign up for them and you may have to pay an additional premium for them. The optional supplemental benefits described in this section are subject to the same appeals process as any other benefits.

PriorityMedicare Merit (PPO) offers two optional supplemental dental and vision benefits, called the Enhanced dental and vision packages. The benefits included in these Optional Supplemental Benefit packages are listed below. To access the dental and vision certificate of coverage (COC) please visit ***priorityhealth.com/27merit*** or contact Customer Care to request a hard copy.

How much will I pay?
The premium amount for the enhanced dental and vision Option 1 is $42 and Option 2 is $61.

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

When can I enroll?
An enhanced dental and vision package is offered to all Medicare beneficiaries enrolling into the **Priority**Medicare Merit (PPO) plan at the time of enrollment or up to two months after

your **Priority**Medicare Merit (PPO) plan's effective date. For example, if your **Priority**Medicare Merit (PPO) plan's effective date is January 1, you can enroll in an enhanced dental and vision package through the end of February. Your effective date is the first of the month following receipt of your completed and signed enrollment form. Once you are enrolled in an enhanced dental and vision package, you remain continuously enrolled in this plan.

How/when do I pay?
The way you choose to pay your Medicare Advantage premium, or your Part D late enrollment penalty, will automatically be the same method that's used to pay your monthly premium for the enhanced dental and vision package. There is no monthly premium for the **Priority**Medicare Merit (PPO) and if you do not have a Part D late enrollment penalty, then you may choose one of the payment options - pay by check or money order, through electronic funds transfer (EFT) or through a deduction from your Social Security check. If we have not received your premium payment by the date it is due, we will notify you in writing, 60 days before your membership in the enhanced dental and vision package is subject to end. For more information about how to pay your premium or what to do if you are having trouble paying your Part D late enrollment penalty see Chapter 1, Section 3.

What if I sign up & decide I want to disenroll?
You may voluntarily disenroll from the enhanced dental and vision package in writing at:

Priority Health
Medicare Enrollment, MS 1175
1231 E. Beltline NE
Grand Rapids, MI 49525

or email to:

PH-MedicareEnrollment@priorityhealth.com

For your convenience, you can find a disenrollment form on ***priorityhealth.com*** and click on **Already a Member**. Your disenrollment will be effective on the first day of the month following receipt of your completed and signed disenrollment request. Benefits will cease on the last day of the month in which you are enrolled. You do not need to pay any monthly premiums after your termination date unless you have a past balance due. If you paid a complete annual premium, you are entitled to a pro-rated refund for the remaining portion of the year. You will be refunded within 30 calendar days of receipt of your disenrollment. If coverage is terminated during the calendar year, you may not re-enroll until the next annual election or special election period.

Optional Supplemental Benefits Chart

Covered Service	Option 1	Option 2
Dental Services* In-network (participating) dentists are those in Delta Dental®'s Medicare	$0 copay for one routine cleaning per year (regular or periodontal.*	$0 copay for one routine cleaning per year (regular or periodontal.*

Covered Service	Option 1	Option 2
Dental Services* (continued) Advantage PPO and Medicare Advantage Premier network. All other dentists are considered out-of-network (nonparticipating) dentists. If the dentist you select is not a Delta Dental® Medicare Advantage Participating Dentist, you will still be covered, but you may have to pay more. You can find participating dentists by calling 800.330.2732 (TTY users should call 711), Monday through Friday 9 a.m. to 8 p.m. or search online at ***deltadentalmi.com/Find-a-Dentist***. When accessing Delta Dental®'s online Dentist Directory, you must select the link labeled Delta Dental® Medicare Advantage PPO and Delta Dental® Medicare Advantage Premier.	$0 copay for scaling and root planing once per quadrant per 24 month period.* $1,500 annual maximum per year to use towards: 50% of the total cost for other diagnostic services (i.e. cone beams)* 50% of the total cost for emergency treatment for dental pain at no limit and anesthesia when used in conjunction with qualifying dental services.* 50% of the total cost for fillings (including composite resin and amalgam) once per tooth every 24 months and crown repairs once per tooth every 12 months.* 50% of the total cost for surgical periodontal (i.e. osseous surgery or gum grafts) once per quadrant every 36 months.* 50% of the total cost of onlays, crowns and associated substructures, once per tooth, every 5 years.*	$0 copay for scaling and root planing once per quadrant per 24 month period.* $2,000 annual maximum per year to use towards: 25% of the total cost for other diagnostic services (i.e. cone beams)* 25% of the total cost for emergency treatment for dental pain at no limit and anesthesia when used in conjunction with qualifying dental services.* 25% of the total cost for fillings (including composite resin and amalgam) once per tooth every 24 months and crown repairs once per tooth every 12 months.* 25% of the total cost for surgical periodontal (i.e. osseous surgery or gum grafts) once per quadrant every 36 months.* 25% of the total cost of onlays, crowns and associated substructures, once per tooth, every 5 years.*

Covered Service	Option 1	Option 2
Dental Services* (continued)	50% of the total cost of endodontics (root canals), once per tooth per lifetime.* 50% of the total cost of simple and surgical extractions, once per tooth per lifetime.* 50% of the total cost of implants and implant repairs, once per tooth, every 5 years.* 50% of the total cost of dentures and bridges, once every 60 months, denture relines and repairs, and bridge repairs, once every 36 months.*	25% of the total cost of endodontics (root canals), once per tooth per lifetime.* 25% of the total cost of simple and surgical extractions, once per tooth per lifetime.* 25% of the total cost of implants and implant repairs, once per tooth, every 5 years.* 25% of the total cost of dentures and bridges, once every 60 months, denture relines and repairs, and bridge repairs, once every 36 months.*
Vision Services* In-network vision services must be provided by an EyeMed® "Select" provider. If received by a non- EyeMed® "Select" provider (out-of-network), you must seek reimbursement. In-network and out-of-network benefits cannot be combined. Eyewear allowance can be used towards: frames, lens, lens options, conventional contacts or disposable contacts. These cannot be used in conjunction with in-store promotions.	$150 additional allowance/reimbursement per year for eyewear.*	

Section 2.2 Get care using your plan's visitor/traveler benefit

As a member of our plan, we offer a visitor/traveler program called the Priority Health Travel Benefit.

- The Priority Health Travel Benefit allows you to receive all plan covered services at in-network cost sharing while visiting or traveling anywhere in the United States and its territories when you're outside the lower peninsula of Michigan (our plans service area).
- If you don't permanently move but are continuously away from our plan's service area for more than 6 months, we usually must disenroll you from our plan. However, with the Priority Health Travel Benefit you can stay enrolled when you're outside of our service area for less than 12 months.
- When choosing to receive care from out-of-network providers (those that do not contract with our plan) when you're in the lower peninsula of Michigan, please see Chapter 3, Section 2.4 (How to get care from out-of-network providers) for more information.

Here are some important things to know:

- Check with the provider to confirm their participation in Medicare.
  - Except in certain situations, we cannot pay a provider who has opted out of Medicare or is listed on one of Medicare's exclusion lists.
- To find a Medicare-participating provider, we encourage you to call Customer Care at 888.389.6648 for assistance or go online to ***priorityhealth.com/27merit*** and search by using the Find a Doctor tool.
- For non-Medicare covered dental services, these benefits are managed by Delta Dental.
  - The Priority Health Travel Benefit allows you to receive in-network benefits when using a dentist that is outside of Delta Dental's service area (Michigan, Ohio, and Indiana). Otherwise, you will need to use dentists in the Delta Dental Medicare Advantage PPO and Delta Dental Medicare Advantage Premier network.
  - To find a provider go to ***providers4you.com/medicareadvantagetraveler*** or call 800.330.2732 (TTY users should call 711), Monday through Friday 8 a.m. to 8 p.m.
  - Out-of-network dental providers have not agreed to accept the plan's payment as payment in full. You may be responsible for any difference between the provider's charge and the amount the plan pays.

Worldwide Travel Assistance Program*

Assist America offers you travel assistance services for both medical and non-medical emergencies while traveling internationally or domestically while 100 miles away from home for less than 90 consecutive days. Services are available 24/7/365.

- Assist America's Operations Center is staffed by trained, multilingual assistance personnel who can provide immediate recommendations for any emergency situation.
- Emergency evacuation or transportation services are available to the nearest facility capable of providing proper care, if care is not locally available.
- Assist America will arrange and pay for a loved one to join a member who is traveling alone and is expected to be hospitalized for more than seven days.

- When a prescription is lost or left behind, Assist America works with the prescribing physician and a local pharmacy to replace the member's medicine.
- In the event that a member passes away while traveling, Assist America will arrange and pay for the required documents, preparation of remains and transport to bring the mortal remains to a funeral home near the member's place of residence.

Contact Assist America: within the US by calling 800.872.1414, outside the US by calling +1.609.986.1234, or by downloading the free Assist America travel app. The Assist America reference number for Priority Health Medicare members is 01-AA-PHP-12123M.

Note: Assist America does not reimburse for transportation services they do not arrange. No claims for reimbursement will be accepted.

SECTION 3 Services that aren't covered by our plan (exclusions)

This section tells you what services are *excluded* from Medicare coverage and therefore, aren't covered by this plan.

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

If you get services that are excluded (not covered), you must pay for them yourself except under the specific conditions listed below. Even if you get the excluded services at an emergency facility, the excluded services are still not covered, and our plan won't pay for them. The only exception is if the service is appealed and decided upon appeal to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we made to not cover a medical service, go to Chapter 9, Section 5.3.)

Services not covered by Medicare	Covered only under specific conditions
Acupuncture	Available for people with chronic low back pain under certain circumstances Routine acupuncture services covered under your plan are described in Chapter 4, Section 2 of the Medical Benefits Chart
Assistive listening devices Including but not limited to telephone amplifiers and alerting devices	Not covered under any condition
Beds Mattresses, oscillating, bed baths (home	Not covered under any condition

Services not covered by Medicare	Covered only under specific conditions
type), boards, lifter (elevator), lounges (power or manual)	
Blood Glucose Analyzers Reflectance colorimeter	Not covered under any condition
Cosmetic surgery or procedures	Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance
Custodial care Custodial care is personal care that doesn't require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing	Not covered under any condition
Drugs (Part B under your medical benefit) (Non-chemotherapy and biologicals) used for conditions not approved by Food and Drug Administration (FDA), such as biomedical hormones, and not covered under Medicare.	Not covered under any condition
Drugs (Part D under your prescription drug benefit) Purchased from or obtained while in another country including those obtained on a cruise ship that are considered self-administered. These are considered non-FDA approved.	Not covered under any condition
Experimental medical and surgical procedures, equipment, and medications Experimental procedures and items are those items and procedures determined by Original Medicare to not be generally accepted by the medical community	May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan (Go to Chapter 3, Section 5 for more information on clinical research studies)

Services not covered by Medicare	Covered only under specific conditions
Fees charged for care by your immediate relatives or members of your household	Not covered under any condition
Full-time nursing care in your home	Not covered under any condition
Home-delivered meals	Not covered under any condition
Home health services	Medicare covers medically necessary part-time or intermittent skilled nursing care.
Homemaker services include basic household help, including light housekeeping or light meal preparation.	Not covered under any condition
Knee walker	Not covered under any condition
Lab tests Not medically necessary under Medicare coverage criteria.	Not covered under any condition
Lift Chair Chair/recliner portion is not covered	The lifting mechanism of a lift chair may be covered if determined by Priority Health to meet medical necessity criteria.
Massage therapy Performed by a massage therapist	Not covered under any condition
Naturopath services (uses natural or alternative treatments)	Not covered under any condition
Orthopedic shoes or supportive devices for the feet	Shoes that are part of a leg brace and are included in the cost of the brace. Orthopedic or therapeutic shoes for people with diabetic foot disease.
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television	Not covered under any condition
Physical exams and other services Required by third parties such as obtaining or maintaining employment or participation in employee programs, required for insurance or licensing, requested sports	Not covered under any condition

Services not covered by Medicare	Covered only under specific conditions
physicals, or on court order or required for parole or probation.	
Pre-operative testing and visits Including but not limited to labs, x-rays, EKGs, EEGs, cardiac monitoring, and physician office visits that are performed strictly for pre-operative clearance when no underlying medical condition exists for testing or visit.	Covered only when the testing or office visit is related to an underlying medical condition.
Private duty nurses	Not covered under any condition
Private room in a hospital	Covered only when medically necessary
Residential Treatment Whose main purpose is to remove the member from his/her environment to prevent the reoccurrence of a condition such as but not limited to eating disorders, alcohol addiction, etc.	Not covered under any condition
Reversal of sterilization procedures and or non-prescription contraceptive supplies	Not covered under any condition
Routine foot care	Some limited coverage provided according to Medicare guidelines (e.g., if you have diabetes)
Services considered not reasonable and necessary, according to Original Medicare standards	Not covered under any condition
Structural modifications Including but not limited to ramps, doorways, elevators and stairway elevators	Not covered under any condition
Temporomandibular Joint Syndrome (TMJ) Medicare care or services provided to evaluate or treat temporomandibular joint dysfunction (TMJD) or temporomandibular	Not covered under any condition

Services not covered by Medicare	Covered only under specific conditions
joint syndrome (TMJS) including dental care or dental services.	
Transportation Including commercial or private air transport, car, taxi, bus, gurney van, and wheelchair van even if it is the only way to travel to a network provider.	Fixed wing transportation is included with ambulance services.
VA Services provided to veterans in Veterans Affairs (VA) facilities.	Not covered under any condition
Vision services Radial keratotomy and keratoplasty to treat refractive defects, laser astigmatism correction, LASIK and LASEK surgery and other low vision aids. Nonconventional intraocular lenses (IOLs) following cataract surgery (for example a presbyopia-correcting IOL)	Not covered under any condition
War related Items or services needed whether due or related to injuries caused by war or an act of war are not covered.	Not covered under any condition
Weight loss Treatment, including but not limited to non-Medicare covered weight loss programs and meal programs	Not covered under any condition
Wigs	Not covered under any condition

CHAPTER 5:
Using plan coverage for Part D drugs

SECTION 1 Basic rules for our plan's Part D drug coverage

Go to the Medical Benefits Chart in Chapter 4 for Medicare Part B drug benefits and hospice drug benefits.

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

- You must have a provider (a doctor, dentist, or other prescriber) write you a prescription that's valid under applicable state law.
- Your prescriber must not be on Medicare's Exclusion or Preclusion Lists.
- You generally must use a network pharmacy to fill your prescription. (Go to Section 2) or you can fill your prescription through our plan's mail-order service.
- Your drug must be on our plan's Drug List (go to Section 3).
- Your drug must be used for a medically accepted indication. A "medically accepted indication" is a use of the drug that's either approved by the FDA or supported by certain references. (Go to Section 3 for more information about a medically accepted indication.)
- Your drug may require approval from our plan based on certain criteria before we agree to cover it. (Go to Section 4 for more information.)

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

In most cases, your prescriptions are covered *only* if they're filled at our plan's network pharmacies. (Go to Section 2.4 for information about when we cover prescriptions filled at out-of-network pharmacies.)

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

Section 2.1 Network pharmacies

Find a network pharmacy in your area

To find a network pharmacy, go to your *Provider/Pharmacy Directory*, visit our website (***prioityhealth.com/27merit***), and/or call Customer Care at 888.389.6648 (TTY users call 711).

You may go to any of our network pharmacies. Some network pharmacies provide preferred cost sharing, which may be lower than the cost sharing at a pharmacy that offers standard

cost sharing. The *Provider/Pharmacy Directory* will tell you which network pharmacies offer preferred cost sharing. Contact us to find out more about how your out-of-pocket costs could vary for different drugs.

If your pharmacy leaves the network

If the pharmacy you use leaves our plan's network, you'll have to find a new pharmacy in the network. If the pharmacy you use stays in our network but no longer offers preferred cost sharing, you may want to switch to a different network or preferred pharmacy, if available. To find another pharmacy in your area, call Customer Care at 888.389.6648 (TTY users call 711) or use the *Provider/Pharmacy Directory*. You can also find information on our website at ***priorityhealth.com/27merit***.

Specialized pharmacies

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

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care (LTC) facility. Usually, an LTC facility (such as a nursing home) has its own pharmacy. If you have difficulty getting Part D drugs in an LTC facility, call Customer Care at 888.389.6648 (TTY users call 711).
- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.
- Pharmacies that dispense drugs restricted by the FDA to certain locations or that require special handling, provider coordination, or education on its use. To locate a specialized pharmacy, go to your *Provider/Pharmacy Directory* ***priorityhealth.com/27merit*** or call Customer Care at 888.389.6648 (TTY users call 711).

Section 2.2 Our plan's mail-order service

For certain kinds of drugs, you can use our plan's network mail-order service. Generally, the drugs provided through mail order are drugs you take on a regular basis, for a chronic or long-term medical condition. The drugs that aren't available through Express Scripts Mail Order are marked with an "NE" in our Drug List. These drugs may be available through Amazon.

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

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

To get order forms and information about filling your prescriptions by mail call Customer Care or visit our website at ***priorityhealth.com/27merit***. If you use a mail-order pharmacy that's not in our plan's network, your prescription will not be covered.

Usually, a mail-order pharmacy order will be delivered to you in no more than 14 days. However, sometimes your mail-order may be delayed. If your order doesn't arrive before you run out of medication, please call Customer Care in order to get permission to obtain up to a 30-day supply of your prescription from a local network retail pharmacy.

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

- You used mail-order services with this plan in the past, or
- You sign up for automatic delivery of all new prescriptions received directly from health care providers. You can ask for automatic delivery of all new prescriptions at any time by calling the Customer Care number on the back of your card.

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

If you used mail order in the past and don't want the pharmacy to automatically fill and ship each new prescription, contact us by calling the Customer Care number on the back of your card.

If you never used our mail-order delivery and/or decide to stop automatic fills of new prescriptions, the pharmacy will contact you each time it gets a new prescription from a health care provider to see if you want the medication filled and shipped immediately. It's important to respond each time you're contacted by the pharmacy to let them know whether to ship, delay, or cancel the new prescription.

To opt out of automatic deliveries of new prescriptions received directly from your health care provider's office, contact us by calling the Customer Care number on the back of your card.

Amazon - New prescriptions the pharmacy gets directly from your doctor's office.
After the pharmacy gets a prescription from a health care provider, it will contact you to see if you want the medication filled immediately or at a later time. It's important to respond each time you're contacted by the pharmacy to let them know whether to ship, delay, or stop the new prescription.

Express Scripts and Amazon - 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 will contact 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 but still want the mail-order pharmacy to send you your prescription, contact your pharmacy 14 days before your current prescription will run out. This will ensure your order is shipped to you in time.

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

If you get a refill automatically by mail that you don't want, you may be eligible for a refund.

Section 2.3 How to get a long-term supply of drugs

When you get a long-term supply of drugs, your cost sharing may be lower. Our plan offers 2 ways to get a long-term supply (also called an extended supply) of maintenance drugs on our plan's Drug List. (Maintenance drugs are drugs you take on a regular basis, for a chronic or long-term medical condition.)

1. Some retail pharmacies in our network allow you to get a long-term supply of maintenance drugs (which offer preferred cost sharing) at a lower cost-sharing amount. Other retail pharmacies may not agree to the lower cost-sharing amounts. In this case you'll be responsible for the difference in price. Your *Provider/Pharmacy Directory* ***prioritiyhealth.com/27merit*** tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call Customer Care at 888.389.6648 (TTY users call 711) for more information.
2. You can also get maintenance drugs through our mail-order program. Go to Section 2.2 for more information.

Section 2.4 Using a pharmacy that's not in our plan's network

Generally, we cover drugs filled at an out-of-network pharmacy *only* when you aren't able to use a network pharmacy. We also have network pharmacies outside of our service area where you can get prescriptions filled as a member of our plan. **Check first with Customer Care at 888.389.6648 (TTY users call 711)** to see if there's a network pharmacy nearby.

We cover prescriptions filled at an out-of-network pharmacy only in these circumstances:

- If you're 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're trying to fill a prescription drug that's 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's not covered under Medicare Part B (e.g., emergency room, urgent care setting, etc.). Go to Chapter 6, Section 7 and 8.
- 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.

If you must use an out-of-network pharmacy, you'll generally have to pay the full cost (rather than your normal cost share) at the time you fill your prescription. You can ask us to reimburse you for our share of the cost. (Go to Chapter 7, Section 2 for information on how to ask our plan to pay you back.) You may be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost we would cover at an in-network pharmacy.

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

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

Our plan has a *List of Covered Drugs (*formulary*)*. In this *Evidence of Coverage,* **we call it the Drug List**.

The drugs on this list are selected by our plan with the help of doctors and pharmacists. The list meets Medicare's requirements and has been approved by Medicare. The Drug List only shows drugs covered under Medicare Part D.

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

- Approved by the FDA for the diagnosis or condition for which it's prescribed, or
- Supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information System.

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

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

A generic drug is a prescription drug that has the same active ingredients as the brand name drug. Biological products have alternatives called biosimilars. Generally, generics and biosimilars work just as well as the brand name drug or original biological product 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.

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

Drugs that aren't on the Drug List

Our plan doesn't cover all prescription drugs.

- In some cases, the law doesn't allow any Medicare plan to cover certain types of drugs. (For more information, go to Section 7.)
- In other cases, we decided not to include a particular drug on the Drug List.
- In some cases, you may be able to get a drug that's not on the Drug List. (For more information, go to Chapter 9.)

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

Every drug on our plan's Drug List is in one of 5 cost-sharing tiers. In general, the higher the tier, the higher your cost for the drug:

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

To find out which cost-sharing tier your drug is in, look it up in our plan's Drug List. The amount you pay for drugs in each cost-sharing tier is shown in Chapter 6.

Section 3.3 How to find out if a specific drug is on the Drug List

To find out if a drug is on our Drug List, you have these options:

- Check the most recent Drug List we provided electronically.
- Visit our plan's website (***priorityhealth.com/27merit***). The Drug List on the website is always the most current.
- Call Customer Care at 888.389.6648 (TTY users call 711) to find out if a particular drug is on our plan's Drug List or ask for a copy of the list.
- Use our plan's "Real-Time Benefit Tool" ***member.priorityhealth.com/login*** to search for drugs on the Drug List to get an estimate of what you'll pay and see if there are

alternative drugs on the Drug List that could treat the same condition. You can also call Customer Care at 888.389.6648 (TTY users call 711).

SECTION 4 Drugs with restrictions on coverage

Section 4.1 Why some drugs have restrictions

For certain prescription drugs, special rules restrict how and when our plan covers them. A team of doctors and pharmacists developed these rules to encourage you and your provider to use drugs in the most effective ways. To find out if any of these restrictions apply to a drug you take or want to take, check the Drug List.

If a safe, lower-cost drug will work just as well medically as a higher-cost drug, our plan's rules are designed to encourage you and your provider to use that lower-cost option.

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 health care provider, and different restrictions or cost sharing may apply to the different versions of the drug (for example, 10 mg versus 100 mg; one per day versus 2 per day; tablet versus liquid).

Section 4.2 Types of restrictions

If there's a restriction for your drug, it usually means that you or your provider has to take extra steps for us to cover the drug. Call Customer Care at 888.389.6648 (TTY users call 711) to learn what you or your provider can do to get coverage for the drug. **If you want us to waive the restriction for you, you need to use the coverage decision process and ask us to make an exception.** We may or may not agree to waive the restriction for you (go to Chapter 9).

Getting plan approval in advance

For certain drugs, you or your provider needs to get approval from our plan based on specific criteria before we agree to cover the drug for you. This is called **prior authorization**. This is put in place to ensure medication safety and help guide appropriate use of certain drugs. If you don't get this approval, your drug might not be covered by our plan. Our plan's prior authorization criteria can be obtained by calling Customer Care at 888.389.6648 (TTY users call 711) or on our website ***priorityhealth.com/medicare/drug-coverage/covered-drugs/requirements***.

Trying a different drug first

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

Our plan's step therapy criteria can be obtained by calling Customer Care at 888.389.6648 (TTY users call 711) or on our website ***priorityhealth.com/medicare/drug-coverage/covered-drugs/requirements***.

Quantity limits

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

SECTION 5 What you can do if one of your drugs isn't covered the way you'd like

There are situations where a prescription drug you take, or that you and your provider think you should take, isn't on our Drug List or has restrictions. For example:

- The drug might not be covered at all. Or a generic version of the drug may be covered but the brand name version you want to take isn't covered.
- The drug is covered, but there are extra rules or restrictions on coverage.
- The drug is covered, but in a cost-sharing tier that makes your cost sharing more expensive than you think it should be.

If your drug is in a cost-sharing tier that makes your cost more expensive than you think it should be, go to Section 5.1 to learn what you can do.

If your drug isn't on the Drug List or is restricted, here are options for what you can do:

- You may be able to get a temporary supply of the drug.
- You can change to another drug.
- You can ask for an **exception** and ask our plan to cover the drug or remove restrictions from the drug.

You may be able to get a temporary supply

Under certain circumstances, our plan must provide a temporary supply of a drug you're already taking. This temporary supply gives you time to talk with your provider about the change.

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

- **If you're a new member,** we'll cover a temporary supply of your drug during the first **90 days** of your membership in our plan.
- **If you were in our plan last year,** we'll cover a temporary supply of your drug during the first **90 days** of the calendar year.

- This temporary supply will be for a maximum of 30 days. If your prescription is written for fewer days, we'll allow multiple fills to provide up to a maximum of 30 days of medication. The prescription must be filled at a network pharmacy. (Note that a long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)
- **For members who've been in our plan for more than 90 days and live in a long-term care facility and need a supply right away:** We'll cover one 31-day emergency supply of a particular drug, or less if your prescription is written for fewer days. This is in addition to the above temporary supply.
- Per CMS regulations, **Priority**Medicare Merit (PPO) provides members experiencing a level-of-care change with a transition supply of at least 30 days of medication unless the prescription is written for fewer days.

For questions about a temporary supply, call Customer Care at 888.389.6648 (TTY users call 711).

During the time when you're using a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. You have 2 options:

Option 1. You can change to another drug

Talk with your provider about whether a different drug covered by our plan may work just as well for you. Call Customer Care at 888.389.6648 (TTY users call 711) to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

Option 2. You can ask for an exception

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

If you're a current member and a drug you take will be removed from the formulary or restricted in some way for next year, we'll tell you about any change before the new year. You can ask for an exception before next year and we'll give you an answer 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.

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

Section 5.1 What to do if your drug is in a cost-sharing tier you think is too high

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

You can change to another drug

If your drug is in a cost-sharing tier you think is too high, talk to your provider. There may be a different drug in a lower cost-sharing tier that might work just as well for you. Call Customer Care at 888.389.6648 (TTY users call 711) to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

You can ask for an exception

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

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

Drugs in our Tier 5 – Specialty Tier aren't eligible for this type of exception. We don't lower the cost-sharing amount for drugs in this tier.

SECTION 6 Our Drug List can change during the year

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

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

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

Information on changes to drug coverage

When changes to the Drug List occur, we post information on our website about those changes. We also update our online Drug List regularly. Sometimes you'll get direct notice if changes are made to a drug you take.

Changes to drug coverage that affect you during this plan year

- **Adding new drugs to the Drug List and immediately removing or making changes to a like drug on the Drug List.**
  - When adding a new version of a drug to the Drug List, we may immediately remove a like drug from the Drug List, move the like drug to a different cost-sharing tier, add new restrictions, or both. The new version of the drug will be on the same or a lower cost-sharing tier and with the same or fewer restrictions.
  - We'll make these immediate changes only if we add a new generic version of a brand name or add certain new biosimilar versions of an original biological product that was already on the Drug List.
  - We may make these changes immediately and tell you later, even if you take the drug that we remove or make changes to. If you take the like drug at the time we make the change, we'll tell you about any specific change we made.
- **Adding drugs to the Drug List and removing or making changes to a like drug on the Drug List**.
  - When adding another version of a drug to the Drug List, we may remove a like drug from the Drug List, move it to a different cost-sharing tier, add new restrictions, or both. The version of the drug that we add will be on the same or a lower cost-sharing tier and with the same or fewer restrictions.
  - We'll make these changes only if we add a new generic version of a brand name drug or add certain new biosimilar versions of an original biological product that was already on the Drug List.
  - We'll tell you at least 30 days before we make the change or tell you about the change and cover a 30-day fill of the version of the drug you're taking.
- **Removing unsafe drugs and other drugs on the Drug List that are withdrawn from the market.**
  - Sometimes a drug may be deemed unsafe or taken off the market for another reason. If this happens, we may immediately remove the drug from the Drug List. If you take that drug, we'll tell you after we make the change.
- **Making other changes to drugs on the Drug List.**
  - We may make other changes once the year has started that affect drugs you are taking. For example, we based on FDA boxed warnings or new clinical guidelines recognized by Medicare.
  - We'll tell you at least 30 days before we make these changes or tell you about the change and cover an additional 30-day fill of the drug you're taking.

If we make any of these changes to any of the drugs you take, talk with your prescriber about the options that would work best for you, including changing to a different drug to treat your condition, or asking for a coverage decision to satisfy any new restrictions on the drug you're taking. You or your prescriber can ask us for an exception to continue covering the drug or

version of the drug you've been taking. For more information on how to ask for a coverage decision, including an exception, go to Chapter 9.

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

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

In general, changes that won't affect you during the current plan year are:

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

If any of these changes happen for a drug you take (except for market withdrawal, a generic drug replacing a brand name drug, or other change noted in the sections above), the change won't affect your use or what you pay as your share of the cost until January 1 of the next year.

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

SECTION 7 Types of drugs we don't cover

Some kinds of prescription drugs are *excluded*. This means Medicare doesn't pay for these drugs.

If you get drugs that are excluded, you must pay for them yourself. If you appeal and the requested drug is found not to be excluded under Part D, we'll pay for or cover it. (For information about appealing a decision, go to Chapter 9.)

Here are 3 general rules about drugs that Medicare drug plans won't cover under Part D:

- Our plan's Part D drug coverage can't cover a drug that would be covered under Medicare Part A or Part B.
- Our plan can't cover a drug purchased outside the United States or its territories.
- Our plan can't cover *off-label* use of a drug when the use isn't supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information System. *Off-label* use is any use of the drug other than those indicated on a drug's label as approved by the FDA.

In addition, by law, the following categories of drugs aren't covered by Medicare drug plans:

- Non-prescription drugs (also called over-the-counter drugs)
- Drugs used to promote fertility
- Drugs used for the relief of cough or cold symptoms
- Drugs used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs used for the treatment of sexual or erectile dysfunction
- Drugs used for treatment of anorexia, weight loss, or weight gain
- Outpatient drugs for which the manufacturer requires associated tests or monitoring services be purchased only from the manufacturer as a condition of sale

If you get Extra Help to pay for your prescriptions, Extra Help won't pay for drugs that aren't normally covered. If you have drug coverage through Medicaid, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Contact your state Medicaid program to determine what drug coverage may be available to you. (Find phone numbers and contact information for Medicaid in Chapter 2, Section 6.)

SECTION 8 How to fill a prescription

To fill your prescription, provide our plan membership information (which can be found on your membership card) at the network pharmacy you choose. The network pharmacy will automatically bill our plan for *our* share of your drug cost. You need to pay the pharmacy *your* share of the cost when you pick up your prescription.

If you don't have our plan membership information with you, you or the pharmacy can call our plan to get the information, or you can ask the pharmacy to look up our 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.** You can then **ask us to reimburse you** for our share. Go to Chapter 7, Section 2 for information about how to ask our plan for reimbursement.

SECTION 9 Part D drug coverage in special situations

Section 9.1 In a hospital or a skilled nursing facility for a stay covered by our plan

If you're admitted to a hospital or to a skilled nursing facility for a stay covered by our plan, we'll generally cover the cost of your prescription drugs during your stay. Once you leave the hospital or skilled nursing facility, our plan will cover your prescription drugs as long as the drugs meet all our rules for coverage described in this chapter.

Section 9.2 As a resident in a long-term care (LTC) facility

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

Check your *Provider/Pharmacy Directory* ***priorityhealth.com/27merit*** to find out if your LTC facility's pharmacy or the one it uses is part of our network. If it isn't, or if you need more information or help, call Customer Care at 888.389.6648 (TTY users call 711). If you're in an LTC facility, we must ensure that you're able to routinely get your Part D benefits through our network of LTC pharmacies.

If you're a resident in an LTC facility and need a drug that's not on our Drug List or restricted in some way, go to Section 5 for information about getting a temporary or emergency supply.

Section 9.3 If you also have drug coverage from an employer or retiree group plan

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

In general, if you have employee or retiree group coverage, the drug coverage you get from us will be *secondary* to your group coverage. That means your group coverage pays first.

Special note about creditable coverage:

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

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

Keep any notices about creditable coverage because you may need these notices later to show that you maintained creditable coverage. If you didn't get a creditable coverage notice, ask for a copy from the employer or retiree group's benefits administrator or the employer or union.

Section 9.4 If you're in Medicare-certified hospice

Hospice and our plan don't cover the same drug at the same time. If you're enrolled in Medicare hospice and require certain drugs (e.g., anti-nausea drugs, laxatives, pain medication or anti-anxiety drugs) that aren't covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must get notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent delays in getting these drugs that should be covered by our plan, ask your hospice provider or prescriber to provide notification before your prescription is filled.

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

SECTION 10 Programs on drug safety and managing medications

We conduct drug use reviews to help make sure our members get safe and appropriate care.

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

- Possible medication errors
- Drugs that may not be necessary because you take another similar drug to treat the same condition
- Drugs that may not be safe or appropriate because of your age or gender
- Certain combinations of drugs that could harm you if taken at the same time
- Prescriptions for drugs that have ingredients you're allergic to
- Possible errors in the amount (dosage) of a drug you take
- Unsafe amounts of opioid pain medications

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

Section 10.1 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 prescribers to make sure your use of opioid medications is appropriate and medically necessary. Working with your prescribers, if we decide your use of prescription opioid or benzodiazepine medications may not be safe, we may limit how you can get those medications. If we place you in our DMP, the limitations may be:

- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain pharmacy(ies)
- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain 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 prescriber or pharmacy. You'll have an opportunity to tell us which prescribers or pharmacies you prefer to use, and about any other information you think is important for us to know. After you've had the opportunity to respond, if we decide to limit your coverage for these medications, we'll send you another letter confirming the limitation. If you think we made a mistake or you disagree with our decision or with the limitation, you and your prescriber have the right to appeal. If you appeal, we'll review your case and give you a new decision. If we continue to deny any part of your request about the limitations that apply to your access to medications, we'll automatically send your case to an independent reviewer outside of our plan. Go to Chapter 9 for information about how to ask for an appeal.

You won't be placed in our DMP if you have certain medical conditions, such as cancer-related pain or sickle cell disease, you're getting hospice, palliative, or end-of-life care, or live in a long-term care facility.

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

We have a program that can help our members with complex health needs. Our program is called a Medication Therapy Management (MTM) program. This program is voluntary and free. A team of pharmacists and doctors developed the program for us to help make sure our members get the most benefit from the drugs they take.

Some members who have certain chronic diseases and take medications that exceed a specific amount of drug costs or are in a DMP to help them use opioids safely may be able to get services through an MTM program. If you qualify for the program, a pharmacist or other health professional will give you a comprehensive review of all your medications. During the review, you can talk about your medications, your costs, and any problems or questions you have about your prescription and over the counter medications. You'll get a written summary which has a recommended to-do list that includes steps you should take to get the best results from your medications. You'll also get a medication list that will include all the medications you're taking, how much you take, and when and why you take them. In addition, members in the MTM program will get information on the safe disposal of prescription medications that are controlled substances.

It's a good idea to talk to your doctor about your recommended to-do list and medication list. Bring the summary with you to your visit or anytime you talk with your doctors, pharmacists, and other health care providers. Keep your medication list up to date and with you (for example, with your ID) in case you go to the hospital or emergency room.

If we have a program that fits your needs, we'll automatically enroll you in the program and send you information. If you decide not to participate, notify us and we'll withdraw you. For questions about this program, call Customer Care at 888.389.6648 (TTY users call 711).

CHAPTER 6: What you pay for Part D drugs

SECTION 1 What you pay for Part D drugs

If you're in a program that helps pay for your drugs, **some information in this** *Evidence of Coverage* **about the costs for Part D prescription drugs may not apply to you.** We 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, call Customer Care at 888.389.6648 (TTY users call 711) and ask for the *LIS Rider*.

We use "drug" in this chapter to mean a Part D prescription drug. Not all drugs are Part D drugs. Some drugs are covered under Medicare Part A or Part B and other drugs are excluded from Medicare coverage by law.

To understand the payment information, you need to know what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Chapter 5 explains these rules. When you use our plan's "Real-Time Benefit Tool" to look up drug coverage (https://member.priorityhealth.com/login), the cost you see shows an estimate of the out-of-pocket costs you're expected to pay. You can also get information provided by the "Real-Time Benefit Tool" by calling Customer Care at 888.389.6648 (TTY users call 711).

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

There are 3 different types of out-of-pocket costs for covered Part D drugs that you may be asked to pay:

- **Deductible** is the amount you pay for drugs before our plan starts to pay our share.
- **Copayment** is a fixed amount you pay each time you fill a prescription.
- **Coinsurance** is a percentage of the total cost you pay each time you fill a prescription.

Section 1.2 How Medicare calculates your out-of-pocket costs

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

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

Your out-of-pocket costs **include** the payments listed below (as long as they are for covered Part D drugs, and you followed the rules for drug coverage explained in Chapter 5):

- The amount you pay for drugs when you're in the following drug payment stages:
  - The Initial Coverage Stage
- Any payments you made during this calendar year as a member of a different Medicare drug plan before you joined our plan
- 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, State Pharmaceutical Assistance Programs (SPAPs), and most charities

Moving to the Catastrophic Coverage Stage:

When you (or those paying on your behalf) have spent a total of $2,400 in out-of-pocket costs within the calendar year, you move from the Initial Coverage Stage to the Catastrophic Coverage Stage.

These payments aren't included in your out-of-pocket costs

Your out-of-pocket costs **don't include** any of these types of payments:

- Your monthly plan premium
- Drugs you buy outside the United States and its territories
- Drugs that aren't covered by our plan
- Drugs you get at an out-of-network pharmacy that don't meet our plan's requirements for out-of-network coverage
- Non-Part D drugs, including prescription drugs and vaccines covered by Part A or Part B and other drugs excluded from coverage by Medicare
- Payments you make toward drugs not normally covered in a Medicare Drug Plan
- Payments for your drugs made by certain insurance plans and government-funded health programs such as TRICARE and the Veterans Health Administration (VA)
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Workers' Compensation)
- Payments made by drug manufacturers under the Manufacturer Discount Program

Reminder: If any other organization like the ones listed above pays part or all your out-of-pocket costs for drugs, you're required to tell our plan by calling Customer Care at 888.389.6648 (TTY users call 711).

Tracking your out-of-pocket total costs

- The *Part D Explanation of Benefits* (EOB) you get includes the current total of your out-of-pocket costs. When this amount reaches $2,400, the *Part D EOB* will tell you that you left the Initial Coverage Stage and moved to the Catastrophic Coverage Stage.
- **Make sure we have the information we need.** Go to Section 3.1 to learn what you can do to help make sure our records of what you spent are complete and up to date.

SECTION 2 Drug payment stages for **Priority**Medicare Merit (PPO) members

There are **3 drug payment stages** for your drug coverage under **Priority**Medicare Merit (PPO). How much you pay for each prescription depends on what stage you're in when you get a prescription filled or refilled. Details of each stage are explained in this chapter. The stages are:

- **Stage 1: Yearly Deductible Stage**
- **Stage 2: Initial Coverage Stage**
- **Stage 3: Catastrophic Coverage Stage**

SECTION 3 Your *Part D Explanation of Benefits (EOB)* explains which payment stage you're in

Our plan keeps track of your prescription drug costs and the payments you make when you get prescriptions at the pharmacy. This way, we can tell you when you move from one drug payment stage to the next. We track 2 types of costs:

- **Out-of-Pocket Costs:** this is how much you paid. This includes what you paid when you get a covered Part D drug, any payments for your drugs made by family or friends, and 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).
- **Total Drug Costs:** this is the total of all payments made for your covered Part D drugs. It includes what our plan paid, what you paid, and what other programs or organizations paid for your covered Part D drugs.

If you filled one or more prescriptions through our plan during the previous month, we'll send you a *Part D EOB*. The *Part D EOB* includes:

- **Information for that month.** This report gives payment details about prescriptions you filled during the previous month. It shows the total drug costs, what our plan paid, and what you and others paid on your behalf.

- **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 displays the total drug price, and information about changes in price from first fill for each prescription claim of the same quantity.
- **Available lower cost alternative prescriptions.** This shows information about other available drugs with lower cost sharing for each prescription claim, if applicable.

Section 3.1 Help us keep our information about your drug payments up to date

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

- **Show your membership card every time you get a prescription filled.** This helps make sure we know about the prescriptions you fill and what you pay.
- **Make sure we have the information we need.** There are times you may pay for the entire cost of a prescription drug. In these cases, we won't automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, give us copies of your receipts. **Examples of when you should give us copies of your drug receipts:**
    - When you purchase a covered drug at a network pharmacy at a special price or use a discount card that's not part of our plan's benefit.
    - When you pay a copayment for drugs provided under a drug manufacturer patient assistance program.
    - Any time you buy covered drugs at out-of-network pharmacies or pay the full price for a covered drug under special circumstances.
    - If you're billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 7, Section 2.
- **Send us information about the payments others 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 charities count toward your out-of-pocket costs. Keep a record of these payments and send them to us so we can track your costs.
- **Check the written report we send you.** When you get a *Part D EOB*, look it over to be sure the information is complete and correct. If you think something is missing or you have questions, call Customer Care at 888.389.6648 (TTY users call 711). The *Part D EOB* may be available electronically by visiting our website, ***express-scripts.com***, or you can request a printed copy be mailed to you by calling Customer Care. Be sure to keep these reports.

SECTION 4 There is no deductible for **Priority**Medicare Merit (PPO)

There is no deductible for **Priority**Medicare Merit (PPO). You begin in the Initial Coverage Stage when you fill your first prescription of the year. Go to Section 5 for information about your coverage in the Initial Coverage Stage.

SECTION 5 The Initial Coverage Stage

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

During the Initial Coverage Stage, our plan pays its share of the cost of your covered drugs, and you pay your share (your copayment or coinsurance amount). Your share of the cost will vary depending on the drug and where you fill your prescription.

Our plan has 5 cost-sharing tiers

Every drug on our plan's Drug List is in one of 5 cost-sharing tiers. In general, the higher the cost-sharing tier number, the higher your cost for the drug:

- **Tier 1 – Preferred generic.** This is the lowest tier and includes preferred generic drugs.
- **Tier 2 – Generic.** This tier includes generic drugs.
- **Tier 3 – Preferred brand.** This tier includes preferred brand drugs and some generic drugs. You pay $35 per month supply of each covered insulin product on this tier.
- **Tier 4 – Non-preferred drug.** This tier includes non-preferred brand drugs and some high-cost generic drugs. You pay $35 per month supply of each covered insulin product on this tier.
- **Tier 5 – Specialty.** This is the highest tier and includes specialty drugs, which are limited to a maximum of a 30-day supply per prescription or refill. You pay $35 per month supply of each covered insulin product on this tier.

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

Your pharmacy choices

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

- A network retail pharmacy that offers preferred cost sharing. Costs may be less at pharmacies that offer preferred cost sharing
- A network retail pharmacy that offers standard cost sharing
- A pharmacy that isn't in our plan's network. We cover prescriptions filled at out-of-network pharmacies in only limited situations. Go to Chapter 5, Section 2.4 to find out when we'll cover a prescription filled at an out-of-network pharmacy

- Our plan's preferred mail-order pharmacies, Express Scripts and Amazon, that offer preferred cost sharing. Costs may be less at mail-order pharmacies that offer preferred cost sharing
- A network mail-order pharmacy that offers standard cost sharing

For more information about these pharmacy choices and filling your prescriptions, go to Chapter 5 and our plan's *Provider/Pharmacy Directory* ***prioritiyhealth.com/27merit***.

Section 5.2 Your costs for a *one-month* supply of a covered drug

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

The amount of the copayment or coinsurance depends on the cost-sharing tier.

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

Your costs for a *one-month* supply of a covered Part D drug

Tier	**Standard retail cost sharing (in-network)** (up to a 30-day supply)	**Preferred retail cost sharing (in-network)** (up to a 30-day supply)	**Standard mail-order cost sharing** (up to a 30-day supply)	**Preferred mail-order (Amazon) cost sharing** (up to a 30-day supply)	**Long-term care (LTC) cost sharing** (up to a 31-day supply)	**Out-of-network cost sharing** (Coverage is limited to certain situations; go to Chapter 5 for details.) (up to a 30-day supply)
Cost-Sharing Tier 1 (Preferred generic)	$7 copay	$2 copay	$7 copay	$2 copay	$7 copay	$7 copay
Cost-Sharing Tier 2 (Generic)	$15 copay	$10 copay	$15 copay	$10 copay	$15 copay	$15 copay
Cost-Sharing Tier 3 (Preferred brand)	25% of the total cost	25% of the total cost	25% of the total cost	25% of the total cost	25% of the total cost	25% of the total cost
Cost-Sharing Tier 4 (Non-preferred drug)	34% of the total cost	29% of the total cost	34% of the total cost	29% of the total cost	34% of the total cost	34% of the total cost
Cost-Sharing Tier 5 (Specialty)	33% of the total cost					

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

Go to Section 8 of this chapter for more information on cost sharing for Part D vaccines.

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

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

If you get less than a full month's supply of certain drugs, you won't have to pay for the full month's supply.

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

Section 5.4 Your costs for a *long-term* (up to a three-month) supply of a covered Part D drug

For some drugs, you can get a long-term supply (also called an extended supply). A long-term supply is up to a three-month supply.

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

Your costs for a *long-term* (up to a three-month) supply of a covered Part D drug

Tier	**Standard retail cost sharing (in-network)** (up to a three-month supply)	**Preferred retail cost sharing (in-network)** (up to a three-month supply)	**Standard mail-order cost sharing** (up to a three-month supply)	**Preferred mail-order (Express Scripts and Amazon) cost sharing** (up to a three-month supply)
Cost-Sharing Tier 1 (Preferred generic)	$21 copay	$0 copay	$21 copay	$0 copay
Cost-Sharing Tier 2 (Generic)	$45 copay	$30 copay	$45 copay	$0 copay
Cost-Sharing Tier 3 (Preferred brand)	25% of the total cost	25% of the total cost	25% of the total cost	25% of the total cost
Cost-Sharing Tier 4 (Non-preferred drug)	34% of the total cost	29% of the total cost	34% of the total cost	29% of the total cost
Cost-Sharing Tier 5 (Specialty)	A long-term supply is not available for drugs in Tier 5.			

You won't pay more than $70 for up to a 2-month supply or $105 for up to a 3-month supply of each covered insulin product regardless of the cost-sharing tier.

Section 5.5 You stay in the Initial Coverage Stage until your out-of-pocket costs for the year reach $2,400

You stay in the Initial Coverage Stage until your total out-of-pocket costs reach $2,400. You then move to the Catastrophic Coverage Stage.

The *Part D EOB* you get will help you keep track of how much you, our plan, and any third parties have spent on your behalf for your drugs during the year. Not all members will reach the $2,400 out-of-pocket limit in a year.

We'll let you know if you reach this amount. Go to Section 1.2 for more information on how Medicare calculates your out-of-pocket costs.

SECTION 6 The Catastrophic Coverage Stage

In the Catastrophic Coverage Stage, you pay nothing for covered Part D drugs. You enter the Catastrophic Coverage Stage when your out-of-pocket costs reach the $2,400 limit for the

calendar year. Once you're in the Catastrophic Coverage Stage, you'll stay in this payment stage until the end of the calendar year.

- During this payment stage, you pay nothing for your covered Part D drugs.

SECTION 7 Additional benefits information

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

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

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

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

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

- When you get the Part D covered drug, you will pay for the entire cost of the drug.
- You can then ask our plan to pay our share of the cost by using the procedures that are described in Chapter 7 of this document (*Asking us to pay our share of a bill you have received for covered medical services or drugs*).
- You will be reimbursed the amount you paid less your normal copayment for the Part D covered drug less any difference between the amount the doctor or outpatient facility charges and what we normally pay. (If you get Extra Help, we will reimburse you for this difference.)

SECTION 8 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 Part B. Other vaccines are considered Part D drugs. You can find these vaccines listed in our plan's Drug List. Our plan covers most adult Part D vaccines at no cost to you. Refer to our plan's Drug List or call Customer Care at 888.389.6648 (TTY users call 711) for coverage and cost-sharing details about specific vaccines.

There are 2 parts to our coverage of Part D vaccines:

- The first part is the cost of **the vaccine itself.**

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

Your costs for a Part D vaccine depend on 3 things:

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

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

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

Below are 3 examples of ways you might get a Part D vaccine.

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

- For most adult Part D vaccines, you pay nothing.
- For other Part D vaccines, you pay the pharmacy your coinsurance or copayment for the vaccine itself, which includes the cost of giving you the vaccine.
- Our plan will pay the remainder of the costs.

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

- When you get the vaccine, you may have to pay the entire cost of the vaccine itself and the cost for the provider to give it to you.
- You can then ask our plan to pay our share of the cost by using the procedures described in Chapter 7.
- For most adult Part D vaccines, you'll be reimbursed the full amount you paid. For other Part D vaccines, you'll be reimbursed the amount

you paid less any coinsurance or copayment for the vaccine (including administration), and less any difference between the amount the doctor charges and what we normally pay. (If you get Extra Help, we'll reimburse you for this difference.)

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

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

CHAPTER 7: Asking us to pay our share of a bill for covered medical services or drugs

SECTION 1 Situations when you should ask us to pay our share for covered services or drugs

Sometimes when you get medical care or a prescription drug, you may need to pay the full cost. Other times, you may find you pay more than you expected under the coverage rules of our plan, or you may get a bill from a provider. In these cases, you can ask our plan to pay you back (reimburse you). It's your right to be paid back by our plan whenever you've paid more than your share of the cost for medical services or drugs covered by our plan. There may be deadlines that you must meet to get paid back. Go to Section 2 of this chapter.

There may also be times when you get a bill from a provider for the full cost of medical care you got or for more than your share of cost sharing. First, try to resolve the bill with the provider. If that doesn't work, send the bill to us instead of paying it. We'll look at the bill and decide whether the services should be covered. If we decide they should be covered, we'll pay the provider directly. If we decide not to pay it, we'll notify the provider. You should never pay more than plan-allowed cost sharing. If this provider is contracted, you still have the right to treatment.

Examples of situations in which you may need to ask our plan to pay you back or to pay a bill you got:

1. **When you got medical care from a provider who's not in our plan's network**

   When you got care from a provider who isn't part of our network, you're only responsible for paying your share of the cost. (Your share of the cost may be higher for an out-of-network provider than for a network provider.) Ask the provider to bill our plan for our share of the cost.

   - Emergency providers are legally required to provide emergency care. You're only responsible for paying your share of the cost for emergency or urgently needed services. If you pay the entire amount yourself at the time you get the care, ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you made.
   - You may get a bill from the provider asking for payment you think you don't owe. Send us this bill, along with documentation of any payments you already made.
     - If the provider is owed anything, we'll pay the provider directly.
     - If you already paid more than your share of the cost of the service, we'll determine how much you owed and pay you back for our share of the cost.

- While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare. Except for emergency care, we can't pay a provider who isn't eligible to participate in Medicare. If the provider isn't eligible to participate in Medicare, you'll be responsible for the full cost of the services you get.

2. When a network provider sends you a bill you think you shouldn't pay

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

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

3. If you're retroactively enrolled in our plan

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

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

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

If you go to an out-of-network pharmacy, the pharmacy may not be able to submit the claim directly to us. When that happens, you have to pay the full cost of your prescription.

Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost. Remember that we only cover out-of-network pharmacies in limited circumstances. Go to Chapter 5, Section 2.4 to learn about these circumstances. We may not pay you back the difference between what you paid for the drug at the out-of-network pharmacy and the amount we'd pay at an in-network pharmacy.

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

   If you don't have our plan membership card with you, you can ask the pharmacy to call our plan or look up our plan enrollment information. If the pharmacy can't get the enrollment information they need right away, you may need to pay the full cost of the prescription yourself.

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

   You may pay the full cost of the prescription because you find the drug isn't covered for some reason.

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

When you send us a request for payment, we'll review your request and decide whether the service or drug should be covered. This is called making a **coverage decision**. If we decide it should be covered, we'll pay for our share of the cost for the service or drug. If we deny your request for payment, you can appeal our decision. Chapter 9 has information about how to make an appeal.

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

You can ask us to pay you back by sending us a request in writing. If you send a request in writing, send your bill and documentation of any payment you have made. It's a good idea to make a copy of your bill and receipts for your records. **You must submit your claim to us within one year** of the date you got the service, item, or drug. For Part D Pharmacy claims, **you must submit your claim to us within three years** of the date you got the drug.

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

- You don't have to use the form, but it'll help us process the information faster.
- Download a copy of the form from our website (***priorityhealth.com/27merit***) or call Customer Care at 888.389.6648 (TTY users call 711) and ask for the form.

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

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

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

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

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

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

- If we decide the medical care or drug is covered and you followed all the rules, we'll pay for our share of the cost. Our share of the cost might not be 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 for a drug is higher than our negotiated price). If you already paid for the service or drug, we'll mail your reimbursement of our share of the cost to you. If you haven't paid for the service or drug yet, we'll mail the payment directly to the provider.
- If we decide the medical care or drug is *not* covered, or you did *not* follow all the rules, we won't pay for our share of the cost. We'll send you a letter explaining the reasons why we aren't sending the payment and your right to appeal that decision.

Section 3.1 If we tell you that we won't pay for all or part of the medical care or drug, you can make an appeal

If you think we made a mistake in turning down your request for payment or the amount we're paying, you can make an appeal. If you make an appeal, it means you're asking us to change the decision we made when we turned down your request for payment. The appeals process is a formal process with detailed procedures and important deadlines. For the details on how to make this appeal, go to Chapter 9.

CHAPTER 8: Your rights and responsibilities

SECTION 1 Our plan must honor your rights and cultural sensitivities

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

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

Our plan has free interpreter services available to answer questions from non-English speaking members. We can also give you information in braille, in large print, or other alternate formats at no cost if you need it. We're required to give you information about our plan's benefits in a format that's accessible and appropriate for you. To get information from us in a way that works for you, call Customer Care at 888.389.6648 (TTY users call 711).

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

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

If you have any trouble getting information from our plan in a format that's accessible and appropriate for you, seeing a women's health specialist or finding a network specialist, call to file a grievance with Customer Care at 888.389.6648 (TTY users call 711). You can also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights 1-800-368-1019 or TTY 1-800-537-7697.

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

You have the right to choose a provider in our plan's network. You also have the right to go to a women's health specialist (such as a gynecologist) without a referral and still pay the in-network cost-sharing amount.

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

If you think you aren't getting your medical care or Part D drugs within a reasonable amount of time, Chapter 9 tells what you can do.

Section 1.3 We must protect the privacy of your personal health information

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

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

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- Except for the circumstances noted below, if we intend to give your health information to anyone who isn't providing your care or paying for your care, *we're required to get written permission from you or someone you have given legal power to make decisions for you first*.
- There are certain exceptions that don't require us to get your written permission first. These exceptions are allowed or required by law.
    - We're required to release health information to government agencies that are checking on quality of care.
    - Because you're a member of our plan through Medicare, we're required to give Medicare your health information including information about your Part D drugs. If Medicare releases your information for research or other uses, this will be done according to federal statutes and regulations; typically, this requires that information that uniquely identifies you not be shared.

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

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

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

If you have questions or concerns about the privacy of your personal health information, call Customer Care at 888.389.6648 (TTY users call 711).

Go to Chapter 11, *Legal Notices*, for our complete privacy policy.

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

As a member of **Priority**Medicare Merit (PPO), you have the right to get several kinds of information from us.

If you want any of the following kinds of information, call Customer Care at 888.389.6648 (TTY users call 711):

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

Section 1.5 You have the right to know your treatment options and participate in decisions about your care

You have the right to get full information from your doctors and other health care providers. Your providers must explain your medical condition and your treatment choices *in a way that you can understand*.

You also have the right to participate fully in decisions about your health care. To help you make decisions with your doctors about what treatment is best for you, your rights include the following:

- **To know about all your choices.** You have the right to be told about all treatment options recommended for your condition, no matter what they cost or whether they're covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.

- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say "no."** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. If you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.

You have the right to give instructions about what's to be done if you can't make medical decisions for yourself

Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you're in this situation. This means *if you want to*, you can:

- Fill out a written form to give **someone the legal authority to make medical decisions for you** if you ever become unable to make decisions for yourself.
- **Give your doctors written instructions** about how you want them to handle your medical care if you become unable to make decisions for yourself.

Legal documents you can use to give directions in advance in these situations are called **advance directives**. Documents like a **living will** and **power of attorney for health care** are examples of advance directives.

How to set up an advance directive to give instructions:

- **Get a form.** You can get an advance directive form from your lawyer, a social worker, or some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare.
- **Fill out the form and sign it.** No matter where you get this form, it's a legal document. Consider having a lawyer help you prepare it.
- **Give copies of the form to the right people.** Give a copy of the form to your doctor and to the person you name on the form who can make decisions for you if you can't. You may want to give copies to close friends or family members. Keep a copy at home.

If you know ahead of time that you're going to be hospitalized, and you signed an advance directive, **take a copy with you to the hospital**.

- The hospital will ask whether you signed an advance directive form and whether you have it with you.
- If you didn't sign an advance directive form, the hospital has forms available and will ask if you want to sign one.

Filling out an advance directive is your choice (including whether you want to sign one if you're in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you signed an advance directive.

If your instructions aren't followed

If you sign an advance directive and you believe that a doctor or hospital didn't follow the instructions in it, you can file a complaint with the Department of Licensing & Regulatory Affairs, Bureau of Community and Health Systems:

Health Facility Complaints
P.O. Box 30664
Lansing, MI 48909

Phone: 800.882.6006
Fax: 517.335.7167
Email: ***BCHS-Complaints@michigan.gov***

Section 1.6 You have the right to make complaints and ask us to reconsider decisions we made

If you have any problems, concerns, or complaints and need to ask for coverage, or make an appeal, Chapter 9 of this document tells what you can do. Whatever you do—ask for a coverage decision, make an appeal, or make a complaint—**we're required to treat you fairly.**

Section 1.7 If you believe you're being treated unfairly, or your rights aren't being respected

If you believe you've been treated unfairly or your rights haven't been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY users call 1-800-537-7697), or call your local Office for Civil Rights.

If you believe you've been treated unfairly or your rights haven't been respected, *and* it's *not* about discrimination, you can get help dealing with the problem you're having from these places:

- **Call Customer Care at 888.389.6648 (TTY users call 711)**
- **Call your local SHIP** at 800.803.7174
- **Call Medicare** at 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048)

Section 1.8 How to get more information about your rights

Get more information about your rights from these places:

- **Call Customer Care at 888.389.6648 (TTY users call 711)**

- **Call your local SHIP** at 800.803.7174
- **Contact Medicare**
  - Visit Medicare.gov to read the publication *Medicare Rights & Protections* (available at: Medicare Rights & Protections)
  - Call 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048)

SECTION 2 Your responsibilities as a member of our plan

Things you need to do as a member of our plan are listed below. For questions, call Customer Care at 888.389.6648 (TTY users call 711).

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this *Evidence of Coverage* to learn what's covered and the rules you need to follow to get covered services.
  - Chapters 3 and 4 give details about medical services.
  - Chapters 5 and 6 give details about Part D drug coverage.
- **If you have any other health coverage or drug coverage in addition to our plan, you're required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and other health care providers that you're enrolled in our plan.** Show our plan membership card whenever you get medical care or Part D drugs.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
  - To help get the best care, tell your doctors and other health providers about your health problems. Follow the treatment plans and instructions you and your doctors agree on.
  - Make sure your doctors know all the drugs you're taking, including over-the-counter drugs, vitamins, and supplements.
  - If you have questions, be sure to ask and get an answer you can understand.
- **Be considerate.** We expect our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe.** As a plan member, you're responsible for these payments:
  - You must pay our plan premiums.
  - You must continue to pay your Medicare Part B premiums to stay a member of our plan.
  - For most of your medical services or drugs covered by our plan, you must pay your share of the cost when you get the service or drug.
  - If you're required to pay a late enrollment penalty, you must pay the penalty to keep your drug coverage.

  - If you're required to pay the extra amount for Part D because of your yearly income, you must continue to pay the extra amount directly to the government to stay a member of our plan.
- **If you move *within* our plan service area, we need to know** so we can keep your membership record up to date and know how to contact you.
- **If you move *outside* our plan service area, you can't stay a member of our plan.**
- **If you move, tell Social Security (or the Railroad Retirement Board).**

CHAPTER 9: If you have a problem or complaint (coverage decisions, appeals, complaints)

SECTION 1 What to do if you have a problem or concern

This chapter explains 2 types of processes for handling problems and concerns:

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

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

The information in this chapter will help you identify the right process to use and what to do.

Section 1.1 Legal terms

There are legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people. To make things easier, this chapter uses more familiar words in place of some legal terms.

However, it's sometimes important to know the correct legal terms. To help you know which terms to use to get the right help or information, we include these legal terms when we give details for handling specific situations.

SECTION 2 Where to get more information and personalized help

We're always available to help you. Even if you have a complaint about our treatment of you, we're obligated to honor your right to complain. You should always call Customer Care at 888.389.6648 (TTY users call 711) for help. In some situations, you may also want help or guidance from someone who isn't connected with us. Two organizations that can help are:

State Health Insurance Assistance Program (SHIP)

Each state has a government program with trained counselors. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you're having. They can also answer questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free.

MI Options – Contact Information	
Call	**800.803.7174 or dial 211**
Write	**MI Options** **PO Box 30676** **Lansing, MI 48909**
Website	**michigan.gov/MDHHSMIOptions**

Medicare

You can also contact Medicare for help:

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

SECTION 3 Which process to use for your problem

Is your problem or concern about your benefits or coverage?

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

Yes.

Go to **Section 4**, **A guide to coverage decisions and appeals.**

No.

Go to **Section 10**, **How to make a complaint about quality of care**, **waiting times**, **customer service or other concerns.**

Coverage decisions and appeals

SECTION 4 A guide to coverage decisions and appeals

Coverage decisions and appeals deal 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 Medicare Part B drugs as **medical care**. You may use the coverage decision and appeals process for issues such as whether something is covered or not and the way in which something is covered.

Asking for coverage decisions before you get services

If you want to know if we'll cover medical care before you get it, you can ask us to make a coverage decision for you. A coverage decision is a decision we make about your benefits and coverage or about the amount we'll pay for your medical care. For example, if our plan network doctor refers you to a medical specialist not inside the network, this referral is considered a favorable coverage decision unless either you or your network doctor can show that you got a standard denial notice for this medical specialist, or the *Evidence of Coverage* makes it clear that the referred service is never covered under any condition. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we'll cover a particular medical service or refuse to provide medical care you think you need.

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

We make a coverage decision whenever we decide what's covered for you and how much we pay. In some cases, we might decide medical care isn't covered or is no longer covered for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision, whether before or after you get a benefit, and you aren't satisfied, you can **appeal** the decision. An appeal is a formal way of asking us to review and change a coverage decision we made. Under certain circumstances, you can ask for an expedited or **fast appeal** of a coverage decision. Your appeal is handled by different reviewers than those who made the original decision.

When you appeal a decision for the first time, this is called a Level 1 appeal. In this appeal, we review the coverage decision we made to check to see if we properly followed the rules. When we complete the review, we give you our decision.

In limited circumstances a request for a Level 1 appeal will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so, or if you ask for your request to be withdrawn. If we dismiss a request for a Level 1 appeal, we'll send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

If we say no to all or part of your Level 1 appeal for medical care, your appeal will automatically go on to a Level 2 appeal conducted by an independent review organization not connected to us.

- You don't need to do anything to start a Level 2 appeal. Medicare rules require we automatically send your appeal for medical care to Level 2 if we don't fully agree with your Level 1 appeal.
- Go to **Section 5.4** of this chapter for more information about Level 2 appeals for medical care.
- Part D appeals are discussed further in Section 6.

If you aren't satisfied with the decision at the Level 2 appeal, you may be able to continue through additional levels of appeal (this chapter explains the Level 3, 4, and 5 appeals processes).

Section 4.1 Get help asking for a coverage decision or making an appeal

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

- **Call Customer Care at 888.389.6648 (TTY users call 711)**
- **Get free help** from your State Health Insurance Assistance Program
- **Your doctor can make a request for you.** If your doctor helps with an appeal past Level 2, they need to be appointed as your representative. Call Customer Care at 888.389.6648 (TTY users call 711) and ask for the *Appointment of Representative* form. (The form is also available at CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf.)
    - For medical care or Part B drugs, your doctor can ask for a coverage decision or a Level 1 appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2.
    - For Part D drugs, your doctor or other prescriber can ask for a coverage decision or a Level 1 appeal on your behalf. If your Level 1 appeal is denied, your doctor or prescriber can ask for a Level 2 appeal.
- **You can ask someone to act on your behalf.** You can name another person to act for you as your representative to ask for a coverage decision or make an appeal.
    - If you want a friend, relative, or other person to be your representative, call Customer Care at 888.389.6648 (TTY users call 711) and ask for the *Appointment of Representative* form. (The form is also available at CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf.) This form gives that person permission to act on your behalf. It must be signed by you and by the person you want to act on your behalf. You must give us a copy of the signed form.
    - We can accept an appeal request from a representative without the form, but we can't complete our review until we get it. If we don't get the form before our deadline for making a decision on your appeal, your appeal request will be

dismissed. If this happens, we'll send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.

- **You also have the right to hire a lawyer.** You can contact your own lawyer or get the name of a lawyer from your local bar association or other referral service. There are groups that will give you free legal services if you qualify. However, **you aren't required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 4.2 Rules and deadlines for different situations

There are 4 different situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. We give the details for each of these situations in this chapter:

- **Section 5:** Medical care: How to ask for a coverage decision or make an appeal
- **Section 6:** Part D drugs: How to ask for a coverage decision or make an appeal
- **Section 7:** How to ask us to cover a longer inpatient hospital stay if you think you're being discharged too soon
- **Section 8:** How to ask us to keep covering certain medical services if you think your coverage is ending too soon (*Applies only to these services:* home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

If you're not sure which information applies to you, call Customer Care at 888.389.6648 (TTY users call 711). You can also get help or information from your SHIP.

SECTION 5 Medical care: How to ask for a coverage decision or make an appeal

Section 5.1 What to do if you have problems getting coverage for medical care or want us to pay you back for our share of the cost of your care

Your benefits for medical care are described in Chapter 4 in the Medical Benefits Chart. In some cases, different rules apply to a request for a Part B drug. In those cases, we'll explain how the rules for Part B drugs are different from the rules for medical items and services.

This section tells what you can do if you're in any of the 5 following situations:

1. You aren't getting certain medical care you want, and you believe this is covered by our plan. **Ask for a coverage decision. Section 5.2**.
2. Our plan won't approve the medical care your doctor or other medical provider wants to give you, and you believe this care is covered by our plan. **Ask for a coverage decision. Section 5.2**.

3. You got medical care that you believe should be covered by our plan, but we said we won't pay for this care. **Make an appeal. Section 5.3**.
4. You got and paid for medical care that you believe should be covered by our plan, and you want to ask our plan to reimburse you for this care. **Send us the bill. Section 5.5**.
5. You're told that coverage for certain medical care you've been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health. **Make an appeal. Section 5.3**.

Note: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, go to Sections 7 and 8. Special rules apply to these types of care.

Section 5.2 How to ask for a coverage decision

Legal Terms:

A coverage decision that involves your medical care is called an **organization determination.**

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

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

A standard coverage decision is usually made within 7 calendar days when the medical item or service is subject to our prior authorization rules or 72 hours for Part B drugs. A fast coverage decision is generally made within 72 hours, for medical services, or 24 hours for Part B drugs. To get a fast coverage decision, you must meet 2 requirements:

- You may *only ask* for coverage for medical items and/or services (not requests for payment for items and/or services you already got).
- You can get a fast coverage decision *only* if using the standard deadlines could cause serious harm to your health or hurt your ability to regain function.

If your doctor tells us that your health requires a fast coverage decision, we'll automatically agree to give you a fast coverage decision.

If you ask for a fast coverage decision on your own, without your doctor's support, we'll decide whether your health requires that we give you a fast coverage decision. If we don't approve a fast coverage decision, we'll send you a letter that:

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

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

- Start by calling, writing, or faxing our plan to make your request for us to authorize or provide coverage for the medical care you want. You, your doctor, or your representative can do this. Chapter 2 has contact information.

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

For standard coverage decisions we use the standard deadlines.

This means we'll give you an answer within 7 calendar days after we get your request for a medical item or service that is subject to our prior authorization rules. If your requested medical item or service is not subject to our prior authorization rules. If your request is for a Part B drug, we'll give you an answer within 72 hours after we get your request.

- **However,** if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
- If you believe we *shouldn't* take extra days, you can file a *fast complaint*. We'll give you an answer to your complaint as soon as we make the decision. (The process for making a complaint is different from the process for coverage decisions and appeals. Go to Section 10 for information on complaints.)

For fast coverage decisions we use an expedited timeframe.

A fast coverage decision means we'll answer within 72 hours if your request is for a medical item or service. If your request is for a Part B drug, we'll answer within 24 hours.

- **However,** if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
- If you believe we *shouldn't* take extra days, you can file a *fast complaint*. (Go to Section 10 for information on complaints.) We'll call you as soon as we make the decision.
- If our answer is no to part or all of what you asked for, we'll send you a written statement that explains why we said no.

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

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

Section 5.3 How to make a Level 1 appeal

Legal Terms:

An appeal to our plan about a medical care coverage decision is called a plan **reconsideration.**

A fast appeal is also called an **expedited reconsideration.**

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

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

- If you're appealing a decision we made about coverage for care, you and/or your doctor need to decide if you need a fast appeal. If your doctor tells us that your health requires a fast appeal, we'll give you a fast appeal.
- The requirements for getting a fast appeal are the same as those for getting a fast coverage decision in Section 5.2.

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

- **If you're asking for a standard appeal, submit your standard appeal in writing.** Chapter 2 has contact information.
- **If you're asking for a fast appeal, make your appeal in writing or call us.** Chapter 2 has contact information.
- **You must make your appeal request within 65 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for asking for an appeal.
- **You can ask for a copy of the information regarding your medical decision. You and your doctor may add more information to support your appeal.**

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

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

Deadlines for a fast appeal

- For fast appeals, 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 us to.
  - If you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time if your request is for a Part B drug.
  - If we don't give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we're required to automatically send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. The independent review organization will notify you in writing when it gets your appeal. Section 5.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for,** we must authorize or provide the coverage we agreed to within 72 hours after we get your appeal.
- **If our answer is no to part or all of what you asked for,** we'll automatically forward your appeal to the independent review organization for a Level 2 appeal. The independent review organization will notify you in writing when it gets your appeal.

Deadlines for a standard appeal

- For standard appeals, we must give you our answer **within 30 calendar days** after we get your appeal. If your request is for a Part B drug you didn't get yet, we'll give you our answer **within 7 calendar days** after we get your appeal. We'll give you our decision sooner if your health condition requires us to.
  - However, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
  - If you believe we shouldn't take extra days, you can file a fast complaint. When you file a fast complaint, we'll give you an answer to your complaint within 24 hours. (Go to Section 10 of this chapter for information on complaints.)
  - If we don't give you an answer by the deadline (or by the end of the extended time period), we'll send your request to a Level 2 appeal, where an independent review organization will review the appeal. The independent review organization will notify you in writing when it gets your appeal. Section 5.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for,** we must authorize or provide the coverage within 30 calendar days if your request is for a medical item or service, or **within 7 calendar days** if your request is for a Part B drug.
- **If our plan says no to part or all of your appeal,** we'll automatically send your appeal to the independent review organization for a Level 2 appeal. The independent review organization will notify you in writing when it gets your appeal.

Section 5.4 The Level 2 appeal process

Legal Term:

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

The **independent review organization is an independent organization hired by Medicare.** 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.

Step 1: The independent review organization reviews your appeal.

- We'll send the information about your appeal to this organization. This information is called your **case file**. **You have the right to ask us for a copy of your case file.**
- You have a right to give the independent review organization additional information to support your appeal.
- Reviewers at the independent review organization will take a careful look at all the information about your appeal.

If you had a fast appeal at Level 1, you'll also have a fast appeal at Level 2.

- For the fast appeal, the independent review organization must give you an answer to your Level 2 appeal **within 72 hours** of when it gets your appeal.
- If your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days.** If they take extra days, they will notify you in writing. The independent review organization can't take extra time to make a decision if your request is for a Part B drug.

If you had a standard appeal at Level 1, you'll also have a standard appeal at Level 2.

- For the standard appeal, if your request is for a medical item or service, the independent review organization must give you an answer to your Level 2 appeal **within 30 calendar days** of when it gets your appeal. If your request is for a Part B drug, the independent review organization must give you an answer to your Level 2 appeal **within 7 calendar days** of when it gets your appeal.
- If your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days.** If they take extra days, they will notify you in writing. The independent review organization can't take extra time to make a decision if your request is for a Part B drug.

Step 2: The independent review organization gives you its answer.

The independent review organization will tell you its decision in writing and explain the reasons for it.

- **If the independent review organization says yes to part or all of a request for a medical item or service,** we must authorize the medical care coverage within 72 hours or provide the service within 14 calendar days after we get the decision from the independent review organization for **standard requests**. For **expedited requests**, we have **72 hours** from the date we get the decision from the independent review organization.
- **If the independent review organization says yes to part or all of a request for a Part B drug,** we must authorize or provide the Part B drug within **72 hours** after we get the decision from the independent review organization for **standard requests**. For **expedited requests** we have **24 hours** from the date we get the decision from the independent review organization.
- **If this organization says no to part or all of your appeal**, it means they agree with us that your request (or part of your request) for coverage for medical care shouldn't be approved. (This is called **upholding the decision** or **turning down your appeal**.) In this case, the independent review organization will send you a letter that:
  - Explains the decision.
  - Lets you know about your right to a Level 3 appeal if the dollar value of the medical care coverage meets a certain minimum. The written notice you get from the independent review organization will tell you the dollar amount you must meet to continue the appeals process.
  - Tells you how to file a Level 3 appeal.

Step 3: If your case meets the requirements, you choose whether you want to take your appeal further.

- There are 3 additional levels in the appeals process after Level 2 (for a total of 5 levels of appeal). If you want to go to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 explains the Level 3, 4, and 5 appeals processes.

Section 5.5 If you're asking us to pay you for our share of a bill you got for medical care

Chapter 7 describes when you may need to ask for reimbursement or to pay a bill you got from a provider. It also tells how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from us

If you send us the paperwork asking for reimbursement, you're asking for a coverage decision. To make this decision, we'll check to see if the medical care you paid for is covered. We'll also check to see if you followed the rules for using your coverage for medical care.

- **If we say yes to your request**: If the medical care is covered and you followed the rules, we'll send you the payment for our share of the cost typically within 30 calendar days, but no later than 60 calendar days after we get your request. If you haven't paid for the medical care, we'll send the payment directly to the provider.
- **If we say no to your request**: If the medical care is *not* covered, or you did *not* follow all the rules, we won't send payment. Instead, we'll send you a letter that says we won't pay for the medical care and the reasons why.

If you don't agree with our decision to turn you down, **you can make an appeal**. If you make an appeal, it means you're asking us to change the coverage decision we made when we turned down your request for payment.

To make this appeal, follow the process for appeals in Section 5.3. For appeals concerning reimbursement, note:

- We must give you our answer within 60 calendar days after we get your appeal. If you're asking us to pay you back for medical care you already got and paid for, you aren't allowed to ask for a fast appeal.
- If the independent review organization decides we should pay, we must send you or the provider the payment within 30 calendar days. If the answer to your appeal is yes at any stage of the appeals process after Level 2, we must send the payment you asked for to you or the provider within 60 calendar days.

SECTION 6 Part D drugs: How to ask for a coverage decision or make an appeal

Section 6.1 What to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits include coverage for many prescription drugs. To be covered, the drug must be used for a medically accepted indication. (Go to Chapter 5 for more information about a medically accepted indication.) For details about Part D drugs, rules, restrictions, and costs, go to Chapters 5 and 6. **This section is about your Part D drugs only.** To keep things simple, we generally say *drug* in the rest of this section, instead of repeating *covered outpatient prescription drug* or *Part D drug* every time. We also use the term Drug List instead of *List of Covered Drugs* or formulary.

- If you don't know if a drug is covered or if you meet the rules, you can ask us. Some drugs require you to get approval from us before we'll cover it.

- If your pharmacy tells you that your prescription can't be filled as written, the pharmacy will give you a written notice explaining how to contact us to ask for a coverage decision.

Part D coverage decisions and appeals

Legal Term:

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

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

- Asking to cover a Part D drug that's not on our plan's Drug List. **Ask for an exception. Section 6.2**
- Asking to waive a restriction on our plan's coverage for a drug (such as limits on the amount of the drug you can get, prior authorization criteria, or the requirement to try another drug first). **Ask for an exception. Section 6.2**
- Asking to pay a lower cost-sharing amount for a covered drug on a higher cost-sharing tier. **Ask for an exception. Section 6.2**
- Asking to get pre-approval for a drug. **Ask for a coverage decision. Section 6.4**
- Pay for a prescription drug you already bought. **Ask us to pay you back. Section 6.4**

If you disagree with a coverage decision we made, you can appeal our decision.

This section tells you both how to ask for coverage decisions and how to request an appeal.

Section 6.2 Asking for an exception

Legal Terms:

Asking for coverage of a drug that's not on the Drug List is a **formulary exception.**

Asking for removal of a restriction on coverage for a drug is a **formulary exception.**

Asking to pay a lower price for a covered non-preferred drug is a **tiering exception.**

If a drug isn't covered in the way you'd like it to be covered, you can ask us to make an **exception**. An exception is a type of coverage decision.

For us to consider your exception request, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. Here are 3 examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a Part D drug that's not on our Drug List.** If we agree to cover a drug not on the Drug List, you'll need to pay the cost-sharing amount that applies to drugs in Tier 4 for Non-Preferred Drugs. You can't ask for an exception to the cost-sharing amount we require you to pay for the drug when we agree to cover a drug not on the Drug list.
2. **Removing a restriction for a covered drug.** Chapter 5 describes the extra rules or restrictions that apply to certain drugs on our Drug List. If we agree to make an exception and waive a restriction for you, you can ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.
3. **Changing coverage of a drug to a lower cost-sharing tier.** Every drug on our Drug List is in one of 5 cost-sharing tiers. In general, the lower the cost-sharing tier number, the less you pay as your share of the cost of the drug.
   - If our Drug List contains alternative drug(s) for treating your medical condition that are in a lower cost-sharing tier than your drug, you can ask us to cover your drug at the cost-sharing amount that applies to the alternative drug(s).
   - If the drug you're taking is a biological product you can ask us to cover your drug at a lower cost-sharing amount. This would be the lowest tier that contains biological product alternatives for treating your condition.
   - If the drug you're taking is a brand name drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains brand name alternatives for treating your condition.
   - If the drug you're taking is a generic drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains either brand or generic alternatives for treating your condition.
   - You 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.

Section 6.3 Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

Your doctor or other prescriber must give us a statement that explains the medical reasons you're 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 typically includes more than one drug for treating a particular condition. These different possibilities are called **alternative** drugs. If an alternative drug would be just as

effective as the drug you're requesting and wouldn't cause more side effects or other health problems, we generally *won't* approve your request for an exception. If you ask us for a tiering exception, we generally *won't* approve your request for an exception unless all the alternative drugs in the lower cost-sharing tier(s) won't work as well for you or are likely to cause an adverse reaction or other harm.

We can say yes or no to your request

- If we approve your request for an exception, our approval usually is valid until the end of our plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say no to your request, you can ask for another review by making an appeal.

Section 6.4 How to ask for a coverage decision, including an exception

Legal Term:

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

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

Standard coverage decisions are made within **72 hours** after we get your request. **Fast coverage decisions** are made within **24 hours** after we get your request.

If your health requires it, ask us to give you a fast coverage decision. **To get a fast coverage decision, you must meet 2 requirements:**

- You must be asking for a drug you didn't get yet. (You can't ask for a fast coverage decision to be paid back for a drug you have already bought.)
- Using the standard deadlines could cause serious harm to your health or hurt your ability to function.
- **If your doctor or other prescriber tells us that your health requires a fast coverage decision, we'll automatically give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor or prescriber's support, we'll decide whether your health requires that we give you a fast coverage decision.** If we don't approve a fast coverage decision, we'll send you a letter that:
    - Explains that we'll use the standard deadlines.
    - Explains if your doctor or other prescriber asks for the fast coverage decision, we'll automatically give you a fast coverage decision.
    - Tells you how you can file a fast complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you asked for. We'll answer your complaint within 24 hours of receipt.

Step 2: Ask for a standard coverage decision or a fast coverage decision.

Start by calling, writing, or faxing our plan to ask us to authorize or provide coverage for the medical care you want. You can also access the coverage decision process through our website. We must accept any written request, including a request submitted on the *CMS Model Coverage Determination Request Form*, which is available on our website ***priorityhealth.com/CoverageDetermination***. Chapter 2 has contact information. To help us process your request, include your name, contact information, and information that shows which denied claim is being appealed.

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

- **If you're asking for an exception, provide the supporting statement,** which is the medical reason for the exception. Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary.

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

Deadlines for a fast coverage decision

- We must generally give you our answer **within 24 hours** after we get your request.
  - For exceptions, we'll give you our answer within 24 hours after we get your doctor's supporting statement. We'll give you our answer sooner if your health requires us to.
  - If we don't meet this deadline, we're required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. We'll let you know in writing if your request has been sent to the independent review organization.
- **If our answer is yes to part or all of what you asked for,** we must provide the coverage we agreed to within 24 hours after we get your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you asked for,** we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

Deadlines for a standard coverage decision about a drug you didn't get yet

- We must generally give you our answer **within 72 hours** after we get your request.
  - For exceptions, we'll give you our answer within 72 hours after we get your doctor's supporting statement. We'll give you our answer sooner if your health requires us to.
  - If we don't meet this deadline, we're required to send your request to Level 2 of the appeals process, where it'll be reviewed by an independent review organization.

We'll let you know in writing if your request has been sent to the independent review organization.

- **If our answer is yes to part or all of what you asked for,** we must **provide the coverage** we agreed to **within 72 hours** after we get your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you asked for,** we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

Deadlines for a standard coverage decision about payment for a drug you have already bought

- We must give you our answer **within 14 calendar days** after we get your request.
  - If we don't meet this deadline, we're required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. We'll let you know in writing if your request has been sent to the independent review organization.
- **If our answer is yes to part or all of what you asked for,** we're also required to make payment to you within 14 calendar days after we get your request.
- **If our answer is no to part or all of what you asked for,** we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

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

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

Section 6.5 How to make a Level 1 appeal

Legal Terms:

An appeal to our plan about a Part D drug coverage decision is called a **plan redetermination.**

A fast appeal is called an **expedited redetermination.**

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

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

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

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

- **For standard appeals, submit a written request or call us.** Chapter 2 has contact information.
- **For fast appeals, either submit your appeal in writing or call us at 888.389.6648.** Chapter 2 has contact information.
- **We must accept any written request,** including a request submitted on the *CMS Model Redetermination Request Form, which is available on our website* ***priorityhealth.com/27merit***. Include your name, contact information, and information about your claim to help us process your request.
- **You must make your appeal request within 65 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information in your appeal and add more information.** You and your doctor may add more information to support your appeal.

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

- When we review your appeal, we take another careful look at all the information about your coverage request. We check to see if we were following all the rules when we said no to your request. We may contact you or your doctor or other prescriber to get more information.

Deadlines for a fast appeal

- For fast appeals, we must give you our answer **within 72 hours after we get your appeal**. We'll give you our answer sooner if your health requires us to.
  - If we don't give you an answer within 72 hours, we're required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. We'll let you know in writing if your request has been sent to the independent review organization. Section 6.6 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for,** we must provide the coverage we agreed to within 72 hours after we get your appeal.
- **If our answer is no to part or all of what you asked for,** we'll send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a standard appeal for a drug you didn't get yet

- For standard appeals, we must give you our answer **within 7 calendar days** after we get your appeal. We'll give you our decision sooner if you didn't get the drug yet and your health condition requires us to do so.
  - If we don't give you a decision within 7 calendar days, we're required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. We'll let you know in writing if your request has been sent to the independent review organization. Section 6.6 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for,** we must provide the coverage as quickly as your health requires, but no later than **7 calendar days** after we get your appeal.
- **If our answer is no to part or all of what you asked for,** we'll send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a standard appeal about payment for a drug you 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're required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. We'll let you know in writing if your request has been sent to the independent review organization.
- **If our answer is yes to part or all of what you asked for,** we're also required to make payment to you within **30 calendar days** after we get your request.
- **If our answer is no to part or all of what you asked for,** we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

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

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

Section 6.6 How to make a Level 2 appeal

Legal Term:

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

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

Step 1: You (or your representative or your doctor or other prescriber) must contact the independent review organization and ask for a review of your case.

- If we say no to your Level 1 appeal, the written notice we send you will include **instructions on how to make a Level 2 appeal** with the independent review organization. These instructions will tell who can make this Level 2 appeal, what deadlines you must follow, and how to reach the independent review organization.
- **You must make your appeal request within 65 calendar days** from the date on the written notice.
- If we did not complete our review within the applicable timeframe or make an unfavorable decision regarding an **at-risk** determination under our drug management program, we'll automatically forward your request to the IRE. We'll let you know in writing if your request has been sent to the independent review organization.
- We'll send the information about your appeal to the independent review organization. This information is called your **case file**. **You have the right to ask us for a copy of your case file**.
- You have a right to give the independent review organization additional information to support your appeal.

Step 2: The independent review organization reviews your appeal.

- Reviewers at the independent review organization will take a careful look at all the information about your appeal.

Deadlines for fast appeal

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

Deadlines for standard appeal

- For standard appeals, the independent review organization must give you an answer to your Level 2 appeal **within 7 calendar days** after it gets your appeal if it is for a drug you didn't get yet. If you're asking us to pay you back for a drug you already bought, the independent review organization must give you an answer to your Level 2 appeal **within 14 calendar days** after it gets your request.

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

For fast appeals:

- **If the independent review organization says yes to part or all of what you asked for,** we must provide the drug coverage that was approved by the independent review organization **within 24 hours** after we get the decision from the independent review organization.

For standard appeals:

- **If the independent review organization says yes to part or all of your request for coverage,** we must **provide the drug coverage** that was approved by the independent review organization **within 72 hours** after we get the decision from the independent review organization.
- **If the independent review organization says yes to part or all of your request to pay you back** for a drug you already bought, we're required to **send payment to you within 30 calendar days** after we get the decision from the independent review organization.

What if the independent review organization says no to your appeal?

If this organization says no **to part or all of** your appeal, it means they agree with our decision not to approve your request (or part of your request). (This is called **upholding the decision**. It's also called **turning down your appeal**.) In this case, the independent review organization will send you a letter that:

- Explains the decision.
- Lets you know about your right to a Level 3 appeal if the dollar value of the drug coverage you're asking for meets a certain minimum. If the dollar value of the drug coverage you're asking for is too low, you can't make another appeal and the decision at Level 2 is final.
- Tells you the dollar value that must be in dispute to continue with the appeals process.

Step 4: If your case meets the requirements, you choose whether you want to take your appeal further.

- There are 3 additional levels in the appeals process after Level 2 (for a total of 5 levels of appeal).
- If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 7 How to ask us to cover a longer inpatient hospital stay if you think you're being discharged too soon

When you're admitted to a hospital, you have the right to get all covered hospital services necessary to diagnose and treat your illness or injury.

During your covered hospital stay, your doctor and the hospital staff will work with you to prepare for the day you leave the hospital. They'll help arrange for care you may need after you leave.

- The day you leave the hospital is called your **discharge date**.

- When your discharge date is decided, your doctor or the hospital staff will tell you.
- If you think you're being asked to leave the hospital too soon, you can ask for a longer hospital stay, and your request will be considered.

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

Within 2 calendar days of being admitted to the hospital, you'll be given a written notice called *An Important Message from Medicare about Your Rights*. Everyone with Medicare gets a copy of this notice. If you don't get the notice from someone at the hospital (for example, a caseworker or nurse), ask any hospital employee for it. If you need help, call Customer Care at 888.389.6648 (TTY users call 711) or 1-800-MEDICARE (1-800-633-4227). (TTY users call 1-877-486-2048).

1. **Read this notice carefully and ask questions if you don't understand it.** It tells you:
   - Your right to get Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
   - Your right to be involved in any decisions about your hospital stay.
   - Where to report any concerns you have about quality of your hospital care.
   - Your right to **request an immediate review** of the decision to discharge you if you think you're being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date, so we'll cover your hospital care for a longer time.
2. **You'll be asked to sign the written notice to show that you got it and understand your rights.**
   - You or someone who is acting on your behalf will be asked to sign the notice.
   - Signing the notice shows *only* that you got the information about your rights. The notice doesn't give your discharge date. Signing the notice **doesn't mean** you're agreeing on a discharge date.
3. **Keep your copy** of the notice so you have the information about making an appeal (or reporting a concern about quality of care) if you need it.
   - If you sign the notice more than 2 calendar days before your discharge date, you'll get another copy before you're scheduled to be discharged.
   - To look at a copy of this notice in advance, call Customer Care at 888.389.6648 (TTY users call 711) or 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can also get the notice online at CMS.gov/Medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

Section 7.2 How to make a Level 1 appeal to change your hospital discharge date

To ask us to cover your inpatient hospital services for a longer time, use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it.** If you have questions or need help, call Customer Care at 888.389.6648 (TTY users call 711). Or call your State Health Insurance Assistance Program (SHIP) for personalized help.

MI Options – Contact Information	
Call	800.803.7174 or dial 211
Write	MI Options PO Box 30676 Lansing, MI 48909
Website	michigan.gov/MDHHSMIOptions

SHIP contact information is available in Chapter 2, Section 3.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It checks to see if your planned discharge date is medically appropriate for you. The **Quality Improvement Organization** is a group of doctors and other health care professionals who are paid by the federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare. These experts aren't part of our plan.

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

How can you contact this organization?

- The written notice you got (*An Important Message from Medicare About Your Rights*) tells you how to reach this organization. Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2.

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than midnight the day of your discharge.**
  - **If you meet this deadline,** you can stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision from the Quality Improvement Organization.

  - **If you don't meet this deadline, contact us**. If you decide to stay in the hospital after your planned discharge date, *you may have to pay all the costs* for hospital care you get after your planned discharge date.
- Once you ask for an immediate review of your hospital discharge the Quality Improvement Organization will contact us. By noon of the day after we're contacted, we'll give you a **Detailed Notice of Discharge**. This notice gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.
- You can get a sample of the **Detailed Notice of Discharge** by calling Customer Care at 888.389.6648 (TTY users call 711) or 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. Or you can get a sample notice online at CMS.gov/Medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

Step 2: The Quality Improvement Organization conducts an independent review of your case.

- Health professionals at the Quality Improvement Organization (the *reviewers*) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you can if you want.
- The reviewers will also look at your medical information, talk with your doctor, and review information that we and the hospital gave them.
- By noon of the day after the reviewers told us of your appeal, you'll get a written notice from us that gives your planned discharge date. This notice also explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

Step 3: Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal.

What happens if the answer is yes?

- If the independent review organization says *yes*, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.**
- You'll have to keep paying your share of the costs (such as deductibles or copayments if these apply). In addition, there may be limitations on your covered hospital services.

What happens if the answer is no?

- If the independent review organization says *no*, they're saying that your planned discharge date is medically appropriate. If this happens, **our coverage for your inpatient hospital services will end** at noon on the day *after* the Quality Improvement Organization gives you its answer to your appeal.
- If the independent review organization says *no* to your appeal and you decide to stay in the hospital, **you may have to pay the full cost** of hospital care you get after noon on

the day after the Quality Improvement Organization gives you its answer to your appeal.

Step 4: If the answer to your Level 1 appeal is no, you decide if you want to make another appeal.

- If the Quality Improvement Organization said *no* to your appeal, *and* you stay in the hospital after your planned discharge date, you can make another appeal. Making another appeal means you're going to *Level 2* of the appeals process.

Section 7.3 How to make a Level 2 appeal to change your hospital discharge date

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at its decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your stay after your planned discharge date.

Step 1: Contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 calendar days** after the day the Quality Improvement Organization said *no* to your Level 1 appeal. You can ask for this review only if you stay in the hospital after the date your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all the information about your appeal.

Step 3: Within 14 calendar days of receipt of your request for a Level 2 appeal, the reviewers will decide on your appeal and tell you their decision.

If the independent review organization says yes:

- **We must reimburse you** for our share of the costs of hospital care you got since noon on the day after the date your first appeal was turned down by the Quality Improvement Organization. **We must continue providing coverage for your inpatient hospital care for as long as it is medically necessary.**
- You must continue to pay your share of the costs and coverage limitations may apply.

If the independent review organization says no:

- It means they agree with the decision they made on your Level 1 appeal.
- The notice you get will tell you in writing what you can do if you want to continue with the review process.

Step 4: If the answer is no, you need to decide whether you want to take your appeal further by going to Level 3.

- There are 3 additional levels in the appeals process after Level 2 (for a total of 5 levels of appeal). If you want to go to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 8 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

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

When we decide it's time to stop covering any of these 3 types of care for you, we're required to tell you in advance. When your coverage for that care ends, *we'll stop paying our share of the cost for your care.*

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.

Section 8.1 We'll tell you in advance when your coverage will be ending

Legal Term:

Notice of Medicare Non-Coverage. It tells you how you can ask for a **fast-track appeal.** Asking for a fast-track appeal is a formal, legal way to ask for a change to our coverage decision about when to stop your care.

1. **You get a notice in writing** at least 2 calendar days before our plan is going to stop covering your care. The notice tells you:
   - The date when we'll stop covering the care for you.
   - How to request a fast-track appeal to ask us to keep covering your care for a longer period of time.
2. **You, or someone who is acting on your behalf, will be asked to sign the written notice to show that you got it.** Signing the notice shows *only* that you got the information about when your coverage will stop. **Signing it doesn't mean you agree** with our plan's decision to stop care.

Section 8.2 How to make a Level 1 appeal to have our plan cover your care for a longer time

If you want to ask us to cover your care for a longer period of time, you'll need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it.** If you have questions or need help, call Customer Care at 888.389.6648 (TTY users call 711). Or call your State Health Insurance Assistance Program (SHIP) for personalized help.

MI Options – Contact Information	
Call	800.803.7174 or dial 211
Write	MI Options PO Box 30676 Lansing, MI 48909
Website	michigan.gov/MDHHSMIOptions

SHIP contact information is available in Chapter 2, Section 3.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It decides if the end date for your care is medically appropriate. The **Quality Improvement Organization** is a group of doctors and other health care experts who are paid by the federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing plan decisions about when it's time to stop covering certain kinds of medical care. These experts aren't part of our plan.

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

How can you contact this organization?

- The written notice you got (*Notice of Medicare Non-Coverage*) tells you how to reach this organization. Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2.

Act quickly:

- You must contact the Quality Improvement Organization to start your appeal **by noon of the day before the effective date** on the *Notice of Medicare Non-Coverage*.
- If you miss the deadline, and you want to file an appeal, you still have appeal rights. Contact the Quality Improvement Organization using the contact information on the

Notice of Medicare Non-Coverage. The name, address, and phone number of the Quality Improvement Organization for your state may also be found in Chapter 2.

Step 2: The Quality Improvement Organization conducts an independent review of your case.

Legal Term:

Detailed Explanation of Non-Coverage. Notice that gives details on reasons for ending coverage.

What happens during this review?

- Health professionals at the Quality Improvement Organization (the *reviewers*) will ask you, or your representative, why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you can if you want.
- The independent review organization will also look at your medical information, talk with your doctor, and review information our plan gives them.
- By the end of the day the reviewers tell us of your appeal, you'll get the *Detailed Explanation of Non-Coverage* from us that explains in detail our reasons for ending our coverage for your services.

Step 3: Within one full day after they have all the information they need; the reviewers will tell you their decision.

What happens if the reviewers say yes?

- If the reviewers say *yes* to your appeal, then **we must keep providing your covered service for as long as it's medically necessary.**
- You'll have to keep paying your share of the costs (such as deductibles or copayments, if these apply). There may be limitations on your covered services.

What happens if the reviewers say no?

- If the reviewers say *no*, then **your coverage will end on the date we told you.**
- If you decide to keep getting the home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* this date when your coverage ends, **you'll have to pay the full cost** of this care yourself.

Step 4: If the answer to your Level 1 appeal is no, you decide if you want to make another appeal.

- If reviewers say *no* to your Level 1 appeal – <u>and</u> you choose to continue getting care after your coverage for the care has ended – then you can make a Level 2 appeal.

Section 8.3 How to make a Level 2 appeal to have our plan cover your care for a longer time

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at the decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end.

Step 1: Contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 calendar days** after the day when the Quality Improvement Organization said *no* to your Level 1 appeal. You can ask for this review only if you continued getting care after the date your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all the information about your appeal.

Step 3: Within 14 calendar days of receipt of your appeal request, reviewers will decide on your appeal and tell you their decision.

What happens if the independent review organization says yes?

- **We must reimburse you** for our share of the costs of care you got since the date when we said your coverage would end. **We must continue providing coverage** for the care for as long as it's medically necessary.
- You must continue to pay your share of the costs and there may be coverage limitations that apply.

What happens if the independent review organization says no?

- It means they agree with the decision made to your Level 1 appeal.
- The notice you get will tell you in writing what you can do if you want to continue with the review process. It will give you details about how to go to the next level of appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

Step 4: If the answer is no, you'll need to decide whether you want to take your appeal further.

- There are 3 additional levels of appeal after Level 2, for a total of 5 levels of appeal. If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 9 Taking your appeal to Levels 3, 4, and 5

Section 9.1 Appeal Levels 3, 4, and 5 for Medical Service 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 dollar value of the item or medical service you appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you can't appeal any further. The written response you get to your Level 2 appeal will explain how to make a Level 3 appeal.

For most situations that involve appeals, the last 3 levels of appeal work in much the same way as the first 2 levels. Here's who handles the review of your appeal at each of these levels.

Level 3 appeal

An **Administrative Law Judge** or an attorney adjudicator who works for the federal government will review your appeal and give you an answer.

- **If the Administrative Law Judge or attorney adjudicator says yes to your appeal, the appeals process *may* or *may not* be over.** Unlike a decision at a Level 2 appeal, we have the right to appeal a Level 3 decision that's favorable to you. If we decide to appeal it will go to a Level 4 appeal.
  - If we decide *not* to appeal, we must authorize or provide you with the medical care within 60 calendar days after we get the Administrative Law Judge's or attorney adjudicator's decision.
  - If we decide to appeal the decision, we'll send you a copy of the Level 4 appeal request with any accompanying documents. We may wait for the Level 4 appeal decision before authorizing or providing the medical care in dispute.
- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process *may* or *may not* be over.**
  - If you decide to accept the decision that turns down your appeal, the appeals process is over.
  - If you don't want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

Level 4 appeal

The **Medicare Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the federal government.

- **If the answer is yes, or if the Council denies our request to review a favorable Level 3 appeal decision, the appeals process *may* or *may not* be over.** Unlike a

decision at Level 2, we have the right to appeal a Level 4 decision that is favorable to you. We'll decide whether to appeal this decision to Level 5.

  - If we decide *not* to appeal the decision, we must authorize or provide you with the medical care within 60 calendar days after getting the Council's decision.
  - If we decide to appeal the decision, we'll let you know in writing.

- **If the answer is no or if the Council denies the review request, the appeals process *may* or *may not* be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you don't want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal, the notice you get will tell you whether the rules allow you to go to a Level 5 appeal and how to continue with a Level 5 appeal.

Level 5 appeal

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

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

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

This section may be 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 to additional levels of appeal. If the dollar amount is less, you can't appeal any further. The written response you get to your Level 2 appeal will explain who to contact and what to do to ask for a Level 3 appeal.

For most situations that involve appeals, the last 3 levels of appeal work in much the same way as the first 2 levels. Here's who handles the review of your appeal at each of these levels.

Level 3 appeal

An Administrative Law Judge or an attorney adjudicator who works for the federal government will review your appeal and give you an answer.

- **If the answer is yes, the appeals process is over**. We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge or attorney adjudicator **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we get the decision.

- **If the answer is no, the appeals process *may* or *may not* be over**.
  - If you decide to accept the decision that turns down your appeal, the appeals process is over.
  - If you don't want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

Level 4 appeal

The **Medicare Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the federal government.

- **If the answer is yes, the appeals process is over**. We must **authorize or provide the drug coverage** that was approved by the Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we get the decision.
- **If the answer is no, the appeals process *may* or *may not* be over.**
  - If you decide to accept the decision that turns down your appeal, the appeals process is over.
  - If you don't want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal or denies your request to review the appeal, the notice will tell you whether the rules allow you to go on to a Level 5 appeal. It will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 appeal

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

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

Making complaints

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

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

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

Complaint	Example
Quality of your medical care	• Are you unhappy with the quality of the care you got (including care in the hospital)?
Respecting your privacy	• Did someone not respect your right to privacy or share confidential information?
Disrespect, poor customer service, or other negative behaviors	• Has someone been rude or disrespectful to you? • Are you unhappy with our Customer Care? • Do you feel you're being encouraged to leave our plan?
Waiting times	• Are you having trouble getting an appointment, or waiting too long to get it? • Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our Customer Care or other staff at our plan? ○ Examples include waiting too long on the phone, in the waiting or exam room, or getting a prescription.
Cleanliness	• Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
Information you get from us	• Did we fail to give you a required notice? • Is our written information hard to understand?
Timeliness (These types of complaints are all related to the *timeliness* of our actions related to	If you asked for a coverage decision or made an appeal, and you think we aren't responding quickly enough, you can make a complaint about our slowness. Here are examples: • You asked us for a *fast coverage decision* or a *fast appeal,* and we said no; you can make a complaint.

Complaint	Example
coverage decisions and appeals)	• You believe we aren't meeting the deadlines for coverage decisions or appeals; you can make a complaint. • You believe we aren't meeting deadlines for covering or reimbursing you for certain medical items or services or drugs that were approved; you can make a complaint. • You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.

Section 10.2 How to make a complaint

Legal Terms:

A **complaint** is also called a **grievance.**

Making a complaint is called **filing a grievance.**

Using the process for complaints is called **using the process for filing a grievance.**

A **fast complaint** is called an **expedited grievance.**

Step 1: Contact us promptly – either by phone or in writing.

- **Calling Customer Care at 888.389.6648 (TTY users call 711) is usually the first step.** If there's anything else you need to do, Customer Care will let you know.
- **If you don't want to call (or you called and weren't satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we'll respond to your complaint in writing.
- **You can ask someone to act on your behalf.** You can name another person to act for you as your representative to ask for a coverage decision or make an appeal.
  - If you want a friend, relative, or other person to be your representative, call Customer Care at 888.389.6648 (TTY users call 711) and ask for the *Appointment of Representative* form. (The form is also available at CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf. This form gives that person permission to act on your behalf. It must be signed by you and by the person you want to act on your behalf. You must give us a copy of the signed form.
  - We can accept an appeal request from a representative without the form, but we can't complete our review until we get it. If we don't get the form before our deadline for making a decision on your appeal, your appeal request will be dismissed. If this happens, we'll send you a written notice explaining your right to

ask the independent review organization to review our decision to dismiss your appeal.

- **You also have the right to hire a lawyer.** You can contact your own lawyer or get the name of a lawyer from your local bar association or other referral service. There are groups that will give you free legal services if you qualify. However, **you aren't required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.
- For standard grievances, we attempt to resolve concerns during the first point of contact. If this is not possible, then we will attempt to do so within 30 calendar days from the date of receipt of your grievance. We may extend the time frame by up to 14 calendar days if you ask for an extension or if we need additional information and delay our response in your best interest.
- You may request an expedited grievance whenever we extend the time frame to make an organization or coverage determination, extend the time frame to make a decision for a reconsideration or redetermination, deny your request for an expedited appeal, or deny your request for an expedited organization determination. If you wish to file an expedited grievance you may contact Customer Care at 888.389.6648. For expedited grievances, we respond verbally within 24 hours if the grievance is received orally. If the expedited grievance is received in a written format, we will respond verbally within 24 hours AND in writing within three (3) calendar days after the verbal notification.
- The **deadline** for making a complaint is 60 calendar days from the time you had the problem you want to complain about.

Step 2: We look into your complaint and give you our answer.

- **If possible, we'll answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call.
- **Most complaints are answered within 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, **we can take up to 14 more calendar days** (44 calendar days total) to answer your complaint. If we decide to take extra days, we'll tell you in writing.
- **If you're making a complaint because we denied your request for a fast coverage decision or a fast appeal, we'll automatically give you a fast complaint.** If you have a fast complaint, it means we'll give you **an answer within 24 hours**.
- **If we don't agree** with some or all of your complaint or don't take responsibility for the problem you're complaining about, we'll include our reasons in our response to you.

Section 10.3 You can also make complaints about quality of care to the Quality Improvement Organization

When your complaint is about *quality of care*, you have 2 extra options:

- **You can make your complaint directly to the Quality Improvement Organization.** The Quality Improvement Organization is a group of practicing doctors and other

health care experts paid by the federal government to check and improve the care given to Medicare patients. Chapter 2 has contact information.

Or

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

Section 10.4 You can also tell Medicare about your complaint

You can submit a complaint about **Priority**Medicare Merit (PPO) directly to Medicare. To submit a complaint to Medicare, go to Medicare.gov/my/medicare-complaint. You can also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users call 1-877-486-2048.

CHAPTER 10: Ending membership in our plan

SECTION 1 Ending your membership in our plan

Ending your membership in **Priority**Medicare Merit (PPO) may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you decide you *want* to leave. Sections 2 and 3 give information on ending your membership voluntarily.
- There are also limited situations where we're required to end your membership. Section 5 tells you about situations when we must end your membership.

If you're leaving our plan, our plan must continue to provide your medical care and prescription drugs, and you'll continue to pay your cost share until your membership ends.

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

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

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

- **The Open Enrollment Period** is from **October 15 to December 7**.
- **Choose to keep your current coverage or make changes to your coverage for the upcoming year**. If you decide to change to a new plan, you can choose any of the following types of coverage:
  - Another Medicare health plan, with or without drug coverage,
  - Original Medicare *with* a separate Medicare drug plan, or
  - Original Medicare *without* a separate Medicare drug plan.
    - If you choose this option and receive Extra Help, Medicare may enroll you in a drug plan, unless you opt out of automatic enrollment.

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

- **Your membership will end in our plan** when your new plan's coverage starts on January 1.

Section 2.2 You can end your membership during the Medicare Advantage Open Enrollment Period

You can make *one* change to your health coverage during the **Medicare Advantage Open Enrollment Period** each year.

- **The Medicare Advantage Open Enrollment Period** is from January 1 to March 31 and also for new Medicare beneficiaries who are enrolled in an MA plan, from the month of entitlement to Part A and Part B until the last day of the 3rd month of entitlement.
- **During the Medicare Advantage Open Enrollment Period** you can:
  - Switch to another Medicare Advantage Plan with or without drug coverage.
  - Disenroll from our plan and get coverage through Original Medicare. If you switch to Original Medicare during this period, you can also join a separate Medicare drug plan at the same time.
- **Your membership will end** on the first day of the month after you enroll in a different Medicare Advantage plan, or we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare drug plan, your membership in the drug plan will start the first day of the month after the drug plan gets your enrollment request.

Section 2.3 In certain situations, you can end your membership during a Special Enrollment Period

In certain situations, members of **Priority**Medicare Merit (PPO) may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period**.

You may be eligible to end your membership during a Special Enrollment Period if any of the following situations apply to you. These are just examples. For the full list you can contact our plan, call Medicare, or visit Medicare.gov.

- Usually, when you move
- If you have Medicaid
- If you're eligible for Extra Help paying for Medicare drug coverage
- If we violate our contract with you
- If you're getting care in an institution, such as a nursing home or long-term care (LTC) hospital
- If you enroll in the Program of All-inclusive Care for the Elderly (PACE)
- **Note:** If you're in a drug management program, you may not be able to change plans. Chapter 5, Section 10 tells you more about drug management programs.

Enrollment time periods vary depending on your situation.

To find out if you're eligible for a Special Enrollment Period, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. If you're eligible to end your

membership because of a special situation, you can choose to change both your Medicare health coverage and drug coverage. You can choose:

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

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

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

If you get Extra Help from Medicare to pay your drug coverage costs: 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 opt out of automatic enrollment.

Section 2.4 Get more information about when you can end your membership

If you have questions about ending your membership you can:

- **Call Customer Care at 888.389.6648 (TTY users call 711)**
- Find the information in the ***Medicare & You 2027*** handbook
- Call **Medicare** at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048

SECTION 3 How to end your membership in our plan

The table below explains how you can end your membership in our plan.

To switch from our plan to:	Here's what to do:
Another Medicare health plan	• Enroll in the new Medicare health plan. • You'll automatically be disenrolled from **Priority**Medicare Merit (PPO) when your new plan's coverage starts.
Original Medicare *with* a separate Medicare drug plan	• Enroll in the new Medicare drug plan. • You'll automatically be disenrolled from **Priority**Medicare Merit (PPO) when your new drug plan's coverage starts.

To switch from our plan to:	Here's what to do:
Original Medicare *without* a separate Medicare drug plan	• **Send us a written request to disenroll**. Call Customer Care at 888.389.6648 (TTY users call 711) if you need more information on how to do this. • You can also call **Medicare** at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users call 1-877-486-2048. • You'll be disenrolled from **Priority**Medicare Merit (PPO) when your coverage in Original Medicare starts.

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

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

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

SECTION 5 **Priority**Medicare Merit (PPO) must end your plan membership in certain situations

PriorityMedicare Merit (PPO) must end your membership in our plan if any of the following happen:

- If you no longer have Medicare Part A and Part B
- If you move out of our service area
- If you're away from our service area for more than 6 months
  - If you move or take a long trip, call Customer Care at 888.389.6648 (TTY users call 711) to find out if the place you're moving or traveling to is in our plan's area
- If you become incarcerated (go to prison)
- If you're no longer a United States citizen or national, or an eligible noncitizen
- If you lie or withhold information about other insurance, you have that provides prescription drug coverage

- If you intentionally give us incorrect information when you're enrolling in our plan, and that information affects your eligibility for our plan. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
- 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. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get medical care. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
  - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General
- If you don't pay our plan premiums for 90 days.
- We must notify you in writing that you have 90 days to pay our plan premium before we end your membership.
- If you're required to pay the extra Part D amount because of your income and you don't pay it, Medicare will disenroll you from our plan and you'll lose drug coverage
- If you don't pay the Optional Supplemental plan premium, we reserve the right to end your membership in your Optional Supplemental plan. This means your membership in the optional plan will end but you'll remain a member of your Priority Health Medicare plan.
  - We must give you advance notice in writing that you have not paid your premium.
  - This written notice sent 60 days prior to the date your Optional Supplemental plan will end serves to tell you of our intent to terminate benefits.
  - If you don't pay your premium by the date stated in your advance notice of involuntary termination of your Optional Supplemental plan, we'll disenroll you.
  - We won't be able to reinstate your benefits until the following plan year or special election period (SEP).
  - All claims incurred after your supplemental benefits are terminated will be your responsibility.
- If you are required to pay the extra Part D amount because of your income and you don't pay it, Medicare will disenroll you from our plan and you will lose prescription drug coverage.

If you have questions or want more information on when we can end your membership, call Customer Care at 888.389.6648 (TTY users call 711).

Section 5.1 We can't ask you to leave our plan for any health-related reason

PriorityMedicare Merit (PPO) isn't allowed to ask you to leave our plan for any health-related reason.

What should you do if this happens?

If you feel you're being asked to leave our plan because of a health-related reason, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

Section 5.2 You have the right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership.

CHAPTER 11: Legal notices

SECTION 1 Notice about governing law

The principal law that applies to this *Evidence of Coverage* document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services (CMS). In addition, other federal laws may apply and, under certain circumstances, the laws of the state you live in. This may affect your rights and responsibilities even if the laws aren't included or explained in this document.

SECTION 2 Notice about nondiscrimination

We don't discriminate based on 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. All organizations that provide Medicare Advantage Plans, like our plan, must obey federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get federal funding, and any other laws and rules that apply for any other reason.

If you want more information or have concerns about discrimination or unfair treatment, call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights. You can also review information from the Department of Health and Human Services' Office for Civil Rights at HHS.gov/ocr/index.html.

If you have a disability and need help with access to care, call Customer Care at 888.389.6648 (TTY users call 711). If you have a complaint, such as a problem with wheelchair access, Customer Care can help.

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, **Priority**Medicare Merit (PPO), as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any state laws.

SECTION 4 Notice about coordinating benefits with Third Party Payers

Section 4.1 Recovery Rights

As explained in Chapter 2, Section 7 ("How other insurance works with our plan"), we coordinate benefits with third party payers under rules established by Medicare. We incorporate those Medicare rules into this *Evidence of Coverage* (see "More Information," below) to the extent permitted by law. Third-party payers include (but are not limited to) other health plan coverage, liability insurance (such as automobile liability or homeowners insurance), underinsured/uninsured motorist coverage, "Med-Pay" coverage, workers' compensation plans or insurance, no-fault insurance, self-funded entities that provide such coverage, and any other entity or person who would be a primary payer under the Medicare Secondary Payer provisions. Under the Medicare rules, we have rights to recover amounts we pay for services for which third-party payers are responsible, including amounts third-party payers pay to you.

Section 4.2 Subrogation and Reimbursement

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

Section 4.3 Lien on Proceeds

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

Section 4.4 Notice of Possible Third-Party Payer

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

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

Section 4.5 Cooperation

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

Section 4.6 More Information

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

Section 4.7 Definition

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

SECTION 5 Notice about *Evidence of Coverage* – Terms are Binding

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

SECTION 6 Notice about Coverage Decisions and Appeal Rights

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

SECTION 7 Notice of Privacy Practices

Notice of Privacy Practices

Priority Health

Effective Date: August 12, 2026
This Notice explains how we may use and share your health information. It also explains how you can get a copy of this information. Please read it carefully.

Our commitment to your privacy
Priority Health and its related companies work to keep your protected health information (PHI) private and secure. When you join a Priority Health plan or use covered services, we may collect, create, use, store, or share your PHI. This may include information about your plan, claims, health care, medical conditions, prescriptions, payments, and coverage.

We are required by law to:

- Maintain the privacy and security of your PHI.
- Provide you this Notice describing our legal duties and privacy practices.
- Follow the terms of this Notice currently in effect.
- Notify you if a breach of your unsecured PHI occurs.

When required, we limit how we use, share, and ask for your PHI. Federal and state laws, including HIPAA, may give added protection to some health information. This may include mental health, HIV/AIDS, genetic data, and substance use disorder records.

Who this notice applies to
This Notice applies when Priority Health is your health plan or is responsible for following HIPAA rules. It does not apply when Priority Health or one of its related companies provides services for another organization.

This notice also applies to Priority Health and Corewell Health when they work together through an Organized Health Care Arrangement (OHCA). They may share your protected health information (PHI) for treatment, payment, and health care operations related to this arrangement. Priority Health may change who takes part in the OHCA.

These organizations may be separate, but they work together to improve quality and coordinate care. We may also share PHI with companies that provide services for us, such as billing, data review, customer service, technology, or office support. Our contracts require these companies to protect your PHI and follow the law.

How we use and share your information without your authorization
We may use or share your PHI without your written authorization for the following reasons.

Treatment
We may use or share your PHI to support your health care treatment. For example, we may share information about your prescription drugs or care management needs with a provider.

Payment
We may use or share your PHI to pay for your health care services and administer your benefits. This may include using or disclosing PHI to:

- Collect premiums;
- Determine coverage;
- Process and pay medical, pharmacy, dental, or other health-related claims;
- Coordinate benefits with another health plan;
- Obtain or provide information related to prior authorizations;
- Review medical necessity;
- Resolve billing or payment issues; or
- Answer questions about claims or coverage.

Health Care Operations
We may use or share PHI to run and improve the health plan. This may include:

- Quality assessment and improvement;
- Case management and care coordination;
- Disease management programs;
- Utilization review;
- Customer service;
- Enrollment and disenrollment activities;
- Underwriting, rating, or renewal activities;
- Business planning and management;
- Auditing, legal, compliance, and fraud prevention activities;
- Accreditation, licensing, and regulatory activities; and
- Evaluating provider performance or health plan performance.

We will not use or share genetic information for underwriting purposes.

Disclosures to group health plan sponsors
This section applies to fully funded group health plans. We may share limited information to the plan sponsor of your group health plan, usually your employer or another organization that sponsors the plan. For example, Priority Health may share whether you are enrolled or disenrolled from the group health plan.

We may also share summary health information to the plan sponsor. Summary health information generally removes most direct identifiers and may be used by the plan sponsor to obtain premium bids, evaluate plan costs, or decide whether to modify, amend, or terminate the group health plan. We may also share de-identified health information to the plan sponsor. De-identified information is information that no longer can identify an individual, and for which there is no reasonable basis to believe that it can be used to identify an individual. De-identified information is not considered PHI and is no longer covered by HIPAA.

If the plan sponsor has taken the steps required by federal privacy regulations, Priority Health may share PHI to the plan sponsor only for plan administration purposes the plan sponsor performs on behalf of the group health plan. The plan sponsor may not use PHI for employment-related actions or decisions unless permitted by law.

Additional permitted uses and disclosures
We may use or share your health information without your written permission when the law allows. This may include:

- Improving quality, customer service, and your experience;
- Sending surveys or other messages; you may ask us to stop some messages;
- Reporting diseases, abuse, or neglect;
- Taking part in audits and reviews;
- Following court orders and other legal requests;
- Sharing information with a jail or law officer if you are in custody;
- Helping prevent a serious risk to health or safety;
- Supporting workers' compensation programs;
- Helping with organ donation or transplants;
- Supporting military or national security needs;
- Working with coroners, medical examiners, or funeral directors; or
- Telling you about health programs or services related to your coverage.

We may remove details that identify you or combine your information with information from others. We may use this information for research, data review, staff training, and service improvements. Since this information does not identify you, it does not have the same HIPAA protections.

Use of technologies (including artificial intelligence)
We may use technologies, including artificial intelligence (AI), automated tools, data analysis, or similar technologies. These tools may help us:

- Manage and coordinate your care;
- Improve quality and safety;
- Find possible fraud, waste, or misuse;
- Review how health care services are used;
- Schedule services and prepare records;
- Provide customer service; and
- Find possible health risks or care needs.

These tools may review your health information. This helps our teams provide timely and effective service. People still review the results and make decisions when required by law, contract, or Priority Health policy.

We use these tools in ways that follow privacy, security, and other laws. When outside companies provide these tools, our contracts require them to protect your information.

Uses where you have a choice
You may have a choice before we share some of your health information. You can tell us if we may share it with family, close friends, or others who help with your care or its cost.

If you cannot tell us your choice, we may share the information when we believe it is best for you. We may also share it to help prevent a serious risk to someone's health or safety.

How we use and share your information with your permission
We will get your permission for uses such as:

- Using your information for marketing when required by law;
- Selling your health information;
- Using or sharing disclosing psychotherapy notes, except as permitted by law;

- Certain uses involving substance use disorder records when authorization or consent is required; or
- Research uses or disclosures when your authorization is required by law.

You may revoke your authorization at any time in writing. Revocation will not apply to actions already taken.

Special protections

Some health information may have extra protections under federal or state law. This may include:

- Substance use disorder treatment records;
- Psychotherapy notes;
- Mental health information;
- HIV/AIDS and certain communicable disease information;
- Genetic information; and
- Other information protected by law.

We will protect this information as required by law.

Substance use disorder (part 2)

Priority Health may receive and keep records about substance use disorder treatment. These records may come from programs or providers that diagnose, treat, or refer people for care. Some of these records are protected by a federal law called 42 C.F.R. Part 2.

If you give written permission, we may use or share these records for treatment, payment, and health plan work. We will only use or share them as allowed by law.

Federal law limits how these records may be used against you in a legal or government case. They may only be used if you give written permission or a court allows it.

We will not use or share these records for fundraising unless the law allows it and we have your permission when needed. You may ask us to stop sending fundraising messages that use this information.

Personal and social information related to health

We may collect and keep personal and social information related to your health. Personal information may include your race, ethnic background, language, disability status, sexual orientation, or gender identity. Social information may include your housing, transportation, or access to healthy food. We protect this information as explained in this Notice.

We may use this information to:

- Send you health education;
- Create programs that help improve health;
- Help you get the care you need;
- Learn about your language or access needs;
- Provide language or other support services; and
- Improve care and community health.

We do not use this information to decide your benefits, set your plan cost, or approve health coverage. We do not share it with people or groups that are not allowed to receive it, unless the law allows or requires us to do so.

Retention of PHI
We retain PHI and related records after your coverage ends as required or permitted by applicable law and our record retention policies. The health care industry must follow State and Federal laws for data retention. Those laws require Priority Health to retain records for periods of time. Priority Health's retention policy and practices are in alignment with these State and Federal laws. We may continue to maintain, use, or share your PHI for claims administration, appeals, audits, legal compliance, regulatory reporting, or other health plan operations. Privacy and security protections continue to apply to the PHI we maintain after your coverage ends.

Your Rights
You have the following rights regarding your PHI.

Access and Copies
You have the right to inspect and obtain a copy of PHI we maintain about you. This record set would include enrollment, payment, claims, case management, medical management, and other records we use to make decisions about you. This right does not include certain limited categories such as psychotherapy notes.

- Requests must be made in writing using the appropriate form.
- We respond within 30 days, unless an extension is required.
- A reasonable, cost-based fee may be charged for copies.
- In some cases, your request may be denied. If so, you may request a review of the denial.

Amendments
You may ask to amend PHI about you in a record set if you think it is inaccurate. Your request must be made in writing and explain why the information should be amended. Priority Health may deny the request in certain instances. We may deny your request if:

- We did not create the information.
- The information is not part of our records.
- You are not allowed to review the information.
- We find that the information is correct and complete.

Accounting of Disclosures
You may ask to receive a list of certain disclosures made over the past six years (excluding treatment, payment, and operations). There may be a charge if there are multiple requests within 12 months.

Restrictions
You have the right to ask us to limit how we use or share your health information.

- We are not required to agree to all restrictions requested, except in certain instances.
- If we agree to a restriction, we will comply with it except in emergency situations or as required by law.

Confidential Communications
You may request that we contact you in a specific way or at a specific location.

- For example, you may request contact at a work address instead of home, or by a specific contact method.
- We will accommodate reasonable requests as required by law.

Copy of Notice
You may ask for a copy of this notice at any time. Even if you agreed to receive this notice electronically, you may still receive a paper copy. You may obtain a copy of this notice on our website or by contacting Priority Health.

Breach Notification
You have the right to be notified if your health information is affected by a breach.

- Notifications will be provided in accordance with applicable legal requirements

Choose Someone to Act for You
If you have given someone medical power of attorney, if someone is your legal guardian, or if another person has legal authority to act for you, that person may exercise your rights and make choices about your PHI. Priority Health may require documentation verifying their authority.

Changes to this Notice
We may change this notice and how we protect your information. The new notice may apply to information we already have and information we get later. If we make a change, we will post the new notice on our website. You may also ask us for a copy. We will send it to members when required by law.

Complaints and Contact Information
If you have questions or believe your privacy rights have been violated, you may contact:

- **Priority Health - Privacy Office**
  Address: 100 Corewell Dr. MC 6481, Grand Rapids, MI 49503
  Phone: 616-486-4113
  Email: privacy@priorityhealth.com
- **Priority Health - Customer Care**: 1-800-942-0954
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-800-368-1019, or visiting https://www.hhs.gov/hipaa/filing-a-complaint/index.html
- You will not be retaliated against for filing a complaint.

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CHAPTER 12: Definitions

Ambulatory Surgical Center – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center doesn't exceed 24 hours.

Annual Enrollment Period – The time period of October 15 until December 7 of each year when members can change their health or drug plans or switch to Original Medicare.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or prescription drugs or payment for services or drugs you already got. You may also make an appeal if you disagree with our decision to stop services that you're getting.

Balance Billing – When a provider (such as a doctor or hospital) bills a patient more than our plan's allowed cost-sharing amount. As a member of **Priority**Medicare Merit (PPO), you only have to pay our plan's cost-sharing amounts when you get services covered by our plan. We don't allow providers to **balance bill** or otherwise charge you more than the amount of cost sharing our plan says you must pay.

Benefit Period – The way that Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you have not received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

Biological Product – A prescription drug that is made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and can't be copied exactly, so alternative forms are called biosimilars. (Go to "**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 prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit that begins when you (or other qualified parties on your behalf) have spent $2,400 for Part D covered drugs during the covered year. During this payment stage, you pay nothing for your covered Part D drugs.

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

Chronic-Care Special Needs Plan (C-SNP) – C-SNPs are SNPs that restrict enrollment to MA eligible people who have specific severe and chronic diseases.

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

Combined Maximum Out-of-Pocket Amount – This is the most you'll pay in a year for all services from both network (preferred) providers and out-of-network (non-preferred) providers. Go to Chapter 4, Section 1 for information about your combined maximum out-of-pocket amount.

Complaint – The formal name for making a complaint is **filing a grievance.** The complaint process is used *only* for certain types of problems. This includes problems about quality of care, waiting times, and the customer service you get. It also includes complaints if our plan doesn't follow the time periods in the appeal process.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

Copayment (or copay) – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription drug. A copayment is a set amount (for example $10), rather than a percentage.

Cost Sharing – Cost sharing refers to amounts that a member has to pay when services or drugs are gotten. (This is in addition to our plan's monthly plan premium.) Cost sharing includes any combination of the following 3 types of payments: 1) any deductible amount a plan may impose before services or drugs are covered; 2) any fixed copayment amount that a plan requires when a specific service or drug is gotten; or 3) any coinsurance amount, a percentage of the total amount paid for a service or drug, that a plan requires when a specific service or drug is gotten.

Cost-Sharing Tier – Every drug on the list of covered drugs is in one of 5 cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.

Coverage Determination – A decision about whether a drug prescribed for you is covered by our plan and the amount, if any, you're required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under our plan, that isn't a coverage determination. You need to call or write to our

plan to ask for a formal decision about the coverage. Coverage determinations are called **coverage decisions** in this document.

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

Covered Services – The term we use to mean all the health care services and supplies that are covered by our plan.

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty if they decide to enroll in Medicare prescription drug coverage later.

Custodial Care – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you don't need skilled medical care or skilled nursing care. Custodial care, provided by people who don't have professional skills or training, includes help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

Customer Care – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals.

Daily cost-sharing rate – A daily cost-sharing rate may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you're required to pay a copayment. A daily cost-sharing rate is the copayment divided by the number of days in a month's supply. Here is an example: If your copayment for a one-month supply of a drug is $30, and a one-month's supply in our plan is 30 days, then your daily cost-sharing rate is $1 per day.

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

Disenroll or **Disenrollment** – The process of ending your membership in our plan.

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

Drug List – See Formulary

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

Dually Eligible Individual – A person who is eligible for Medicare and Medicaid coverage.

Durable Medical Equipment (DME) – Certain medical equipment that is ordered by your doctor for medical reasons. Examples include: walkers, wheelchairs, crutches, powered mattress systems, diabetic supplies, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, or hospital beds ordered by a provider for use in the home.

Emergency – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you're a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

Emergency Care – Covered services that are: 1) provided by a provider qualified to furnish emergency services; and 2) needed to treat, evaluate, or stabilize an emergency medical condition.

Evidence of Coverage (EOC) and Disclosure Information – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

Exception – A type of coverage decision that, if approved, allows you to get a drug that isn't on our formulary (a formulary exception), or get a non-preferred drug at a lower cost-sharing level (a tiering exception). You may also ask for an exception if our plan requires you to try another drug before getting the drug you're asking for, if our plan requires a prior authorization for a drug and you want us to waive the criteria restriction, or if our plan limits the quantity or dosage of the drug you're asking for (a formulary exception).

Extra Help – A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

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

Generic Drug – A prescription drug that is approved by the FDA as having the same active ingredient(s) as the brand name drug. Generally, a generic drug works the same as a brand name drug and usually costs less.

Grievance – A type of complaint you make about our plan, providers, or pharmacies, including a complaint concerning the quality of your care. This doesn't involve coverage or payment disputes.

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 (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises).

Hospice – A benefit that provides special treatment for a member who has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less. Our plan must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums, you're still a member of our plan. You can still get all medically necessary services as well as the supplemental benefits we offer.

Hospital Inpatient Stay – A hospital stay when you have been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an outpatient. See also **Observation** and **Outpatient**.

In-Network Maximum Out-of-Pocket Amount – The most you'll pay for covered services gotten from network (preferred) providers. After you have reached this limit, you won't have to pay anything when you get covered services from network providers for the rest of the contract year. However, until you reach your combined out-of-pocket amount, you must continue to pay your share of the costs when you seek care from an out-of-network (non-preferred) provider.

Income Related Monthly Adjustment Amount (IRMAA) – If your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium. Less than 5% of people with Medicare are affected, so most people won't pay a higher premium.

Initial Coverage Stage – This is the stage after you pay your deductible (if you have one) and before your out-of-pocket costs for the year have reached the out-of-pocket threshold amount.

Initial Enrollment Period – When you're first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. If you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

Institutional-Equivalent Special Needs Plan (IE-SNP) – An IE-SNP restricts enrollment to MA eligible people who live in the community but need the level of care a facility offers.

Institutional Special Needs Plan (I-SNP) – I-SNPs restrict enrollment to MA eligible people who live in the community but need the level of care a facility offers, or who live (or are expected to live) for at least 90 days straight in certain long-term facilities. I-SNPs include the following types of plans: Institutional-equivalent SNPs (IE-SNPs) Hybrid Institutional SNPs (HI-SNPs), and Facility-based Institutional SNPs (FI-SNPs).

Interchangeable Biosimilar – A biosimilar that may be used as a substitute for an original biosimilar product 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 – See Formulary

Low Income Subsidy (LIS) – Go to Extra Help.

Major Surgical Procedures – Complex operative interventions involving the penetration of major body cavities, extensive tissue dissection, or alteration of vital anatomy, requiring general anesthesia or deep regional blocks.

Manufacturer Discount Program – A program under which drug manufacturers pay a portion of our plan's full cost for covered Part D brand name drugs and biologics. Discounts are based on agreements between the federal government and drug manufacturers.

Maximum Fair Price – The price Medicare negotiated for a selected drug.

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

Medically Accepted Indication – A use of a drug that is either approved by the FDA or supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information system.

Medically Necessary – Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

Medicare – The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be i) an HMO, ii) a PPO, iii) a Private Fee-for-Service (PFFS) plan, or iv) a Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP). In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**.

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

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans must cover all the services that are covered by Medicare Part A and B. The term

Medicare-Covered Services doesn't include the extra benefits, such as vision, dental, or hearing, that a Medicare Advantage plan may offer.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in our plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Special Needs Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Medicare Prescription Drug Coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

Medication Therapy Management (MTM) program – 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.

Medigap (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill *gaps* in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

Member (Member of our Plan, or Plan Member) – A person with Medicare who is eligible to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Moderate Surgical Procedures – Procedures that require conscious, moderate, or deep sedation, or extensive regional nerve blocks, necessitating continuous monitoring of the member's vital signs and a dedicated recovery period.

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

Network Provider – **Provider** is the general term for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the state to provide health care services. **Network providers** have an agreement with our plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Network providers are also called **plan providers**.

Nuclear Medicine – Radiology in which radioisotopes (compounds containing radioactive forms of atoms) are introduced into the body for the purpose of imaging, evaluating organ function, or localizing disease or tumors.

Open Enrollment Period – The time period of October 15 until December 7 of each year when members can change their health or drug plans or switch to Original Medicare.

Optional Supplemental Benefits – Non-Medicare-covered benefits that can be purchased for an additional premium and aren't included in your package of benefits. You must voluntarily elect Optional Supplemental Benefits in order to get them.

Organization Determination – A decision our plan makes about whether items or services are covered or how much you have to pay for covered items or services. Organization determinations are called coverage decisions in this document.

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 is also called a reference product.

Original Medicare (Traditional Medicare or Fee-for-Service Medicare) – Original Medicare is offered by the government, and not a private health plan such as Medicare Advantage plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has 2 parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Pharmacy – A pharmacy that doesn't have a contract with our plan to coordinate or provide covered drugs to members of our plan. Most drugs you get from out-of-network pharmacies aren't covered by our plan unless certain conditions apply.

Out-of-Network Provider or Out-of-Network Facility – A provider or facility that doesn't have a contract with our plan to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that aren't employed, owned, or operated by our plan.

Out-of-Pocket Costs – Go to the definition for cost sharing above. A member's cost-sharing requirement to pay for a portion of services or drugs received is also referred to as the member's out-of-pocket cost requirement.

Out-of-Pocket Threshold – The maximum amount you pay out of pocket for Part D drugs.

PACE plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term services and supports (LTSS) for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible. People enrolled in PACE plans get both their Medicare and Medicaid benefits through our plan.

Part C – Go to Medicare Advantage (MA) Plan.

Part D – The voluntary Medicare Prescription Drug Benefit Program.

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

Part D Late Enrollment Penalty – An amount added to your monthly plan premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more after you're first eligible to join a Part D plan.

Preferred Cost Sharing – Preferred cost sharing means lower cost sharing for certain covered Part D drugs at certain network pharmacies.

Preferred Provider Organization (PPO) plan – A Preferred Provider Organization plan is a Medicare Advantage Plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they're gotten from network or out-of-network providers. Member cost sharing will generally be higher when plan benefits are gotten from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services gotten from network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both in-network (preferred) and out-of-network (non-preferred) providers.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Preventive services – Health care services that help you stay healthy, detect health problems early, determine the most effective treatments, and prevent certain diseases. Preventive services include exams, shots, lab tests, and screenings. They also include programs for health monitoring, and counseling and education to help you take care of your own health.

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

Prior Authorization – Approval in advance to get services and/or certain drugs based on specific criteria. In the network portion of a PPO, some in-network medical services are covered only if your doctor or other network provider gets prior authorization from our plan. In a PPO, you don't need prior authorization to get out-of-network services. However, you may want to check with our plan before getting services from out-of-network providers to confirm that the service is covered by our plan and what your cost-sharing responsibility is. Covered services that need prior authorization are marked in the Medical Benefits Chart in Chapter 4. Covered drugs that need prior authorization are marked in the formulary and our criteria are posted on our website.

Prosthetics and Orthotics – Medical devices including, 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 practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients.

Quantity Limits – A management tool that is designed to limit the use of a drug for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

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

Referral – A written order from your primary care doctor for you to visit a specialist or get certain medical services. Without a referral, our plan may not pay for services from a specialist.

Rehabilitation Services – These services include inpatient rehabilitation care, physical therapy (outpatient), speech and language therapy, and occupational therapy.

Selected Drug – A drug covered under Part D for which Medicare negotiated a Maximum Fair Price.

Self-administered – A self-administered drug is one you would normally take on your own by taking it orally, putting it on your skin (topical), injecting subcutaneously, or inhaling it.

Service Area – A geographic area where you must live to join a particular health plan. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. Our plan must disenroll you if you permanently move out of our plan's service area.

Simple Surgical Procedures – Procedures that can be performed at the bedside, in the same exam room as the visit, using minimal additional equipment, supplies or medications.

Skilled Nursing Facility (SNF) Care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Special Enrollment Period – A set time when members can change their health or drug plan or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you're getting Extra Help with your prescription drug costs, if you move into a nursing home, or if we violate our contract with you.

Special Needs Plan – A special type of Medicare Advantage Plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who live in a nursing home, or who have certain chronic medical conditions.

Standard Cost Sharing – Standard cost sharing is cost sharing other than preferred cost sharing offered at a network pharmacy.

Step Therapy – A utilization tool that requires you to first try another drug to treat your medical condition before we'll cover the drug your physician may have initially prescribed.

Supplemental Security Income (SSI) – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits aren't the same as Social Security benefits.

Urgently Needed Services – A plan-covered service requiring immediate medical attention that's not an emergency is an urgently needed service if either you're temporarily outside our plan's service area, or it's unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.

Notice of Nondiscrimination

Priority Health

This Notice describes our nondiscrimination policy, availability of free language assistance, auxiliary aids and services and filing a grievance.

Discrimination is against the law

Priority Health complies with applicable civil rights laws and does not discriminate, exclude people, or treat them differently on the basis of race, color, ethnicity, national origin, age, HIV status, marital status, sex (as defined by law and Priority Health policy), sexual orientation, gender identity or expression, disability, religion, 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.

Availability of free language assistance and auxiliary aids and services

Priority Health provides free language services to people whose primary language is not English, which may include:

- Qualified interpreters.
- Information written in other languages.

Priority Health provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:

- Qualified sign language interpreters.
- Written information in other formats (e.g. large print, audio, accessible electronic).

If you need reasonable modifications, appropriate auxiliary aids and services or language assistance services, visit ***priorityhealth.com/contact-us***.

Filing a grievance

If you believe that Priority Health has failed to provide these services or discriminated in another way on the basis of race, color, ethnicity, national origin, age, HIV status, marital status, sex (as defined by law and Priority Health policy), sexual orientation, gender identity or expression, disability, religion, 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, you can file a grievance in person or by mail, phone, fax or email. The Section 1557 Civil Rights Coordinator can answer questions and help file a grievance by:

Mail. Section 1557 Civil Rights Coordinator
Compliance Department MC 3230
Priority Health
1231 East Beltline Ave NE
Grand Rapids, MI 49525-4501

Phone. 866.807.1931 (TTY: 711)

Fax. 616.975.8850

Email. ***PH-compliance@priorityhealth.com***

You can also file a civil rights complaint with the Office for Civil Rights (OCR) at the U.S. Department of Health and Human Services (HHS) by:

Mail. HHS
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

Phone. 800.368.1019 (TTD: 800.537.7697)

Form. ***hhs.gov/civil-rights/filing-a-complaint***

This Notice is available at ***priorityhealth.com/nondiscrimination***. *Last updated: June 2025*

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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 (ܣܘܪܝܐܝܐ) - ܫܡܘܥܐ ܕܝܡܐ: ܐܢܬܘܢ ܡܠܠܝܢ ܣܘܪܝܬܐ، ܡܬܝܠܝܢ ܠܟܘܢ ܫܪܘܬܐ ܕܡܬܪܓܡܢܘܬܐ ܕܠܫܢܐ ܕܚܢܡܐ. ܐܦܠܘ ܗܘܝܢ ܡܬܝܠܝܢ ܫܪܘܬܐ ܕܡܬܪܓܡܢܘܬܐ ܕܡܬܚܘܐ ܕܡܬܝܠܝܢ ܠܟܘܢ ܒܚܢܡܐ ܕܠܐ ܡܚܝܒܐ ܘܐܦܠܘ ܫܪܘܬܐ ܕܡܬܝܠܝܢ ܠܟܘܢ ܒܦܪܡܛܐ ܕܡܬܝܠܝܢ ܠܡܫܡܫܐ. ܨܠܘ ܠܡܠܦܢ 800.942.0954 (TTY: 711) ܐܘ ܡܠܠܘ ܥܡ ܡܫܡܫܢܟܘܢ.

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 također 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.

continued >

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.

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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.

Source: lep.gov and cms.gov *Last updated: May 2025*

10003-304 H8379_NCMS400040102558BG_C 04302025
Y0056_NCMS400040102558BG_C 04302025
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Call	888.389.6648 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.
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Website	***priorityhealth.com/27merit***

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OMB Approval 0938-1051 (Expires: July 31, 2029)
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