Priority Health

2027
Certificate of Coverage

PriorityMedicare® Align (HMO-POS)
PriorityMedicare® Key (HMO-POS)
PriorityMedicare® Latitude (HMO-POS)
PriorityMedicare® (HMO-POS)
PriorityMedicare® Smart Savings (HMO-POS)
PriorityMedicare® Value (HMO-POS)

Offered by Priority Health Medicare

January 1, 2027 - December 31, 2027

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Priority Health

Thank you for being a Priority Health Medicare member.

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

If you enrolled in Optional Enhanced Dental and Vision package, Option 1, you will pay an additional $42 each month. If you enrolled in Option 2, you will pay an additional $61 each month. The Optional Enhanced Dental and Vision package options are above and beyond what is included in your Priority Health Medicare Advantage plan.

If you are not enrolled in one of our Optional Enhanced Dental and Vision packages and would like further details on cost, how to enroll and when you may enroll, please see your Evidence of Coverage, Chapter 4, Section 2.1 “Extra optional supplemental benefits you can buy.”

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

- **EyeMed®** at 844.366.5127
- **Delta Dental®** at 800.330.2732
- **TruHearing®** at 833.714.5356

For assistance on Saturday or Sunday, please contact Priority Health Medicare at 888.389.6648, from Oct. 1 – Mar. 31, we’re available from 8 a.m.– 8 p.m. ET. From Apr. 1 – Sept. 30, we’re available Sat. 8 a.m.-noon ET (TTY 711). Or, visit ***prioritymedicare.com*** and select **Already a member**.

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Vision Services (Mandatory & Optional)

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

If you have any questions about your routine vison coverage, contact EyeMed® Customer Service Department at 844.366.5127 (TTY 711), from 8 a.m. to 2 a.m. Monday-Saturday year-round. Sunday hours vary from 11:00 a.m. to 2:00 a.m. Oct. 1 - Mar. 31st and 11:00 a.m. to 8:00 p.m. April 1 - Sept. 30th.

What do I need when I go to my routine vision provider?

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

Why choose an EyeMed® "Select" Provider?

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

Finding an EyeMed® "Select" Provider?

To find an in-network provider (providers in EyeMed®'s "Select" network), go to ***prioritymedicare.com*** and use the "Find a Doctor" tool or call the EyeMed® Customer Service Department at 844.366.5127, from 8 a.m. to 2 a.m. Monday-Saturday year-round. Sunday hours vary from 11:00 a.m. to 2:00 a.m. Oct. 1 - Mar. 31st and 11:00 a.m. to 8:00 p.m. April 1 - Sept. 30th (TTY 711).

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

How payment is made to EyeMed® "Select" Network Providers

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

How to seek reimbursement when you use a Non-EyeMed® "Select" Network Provider

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

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

You can also request an out-of-network claim form be mailed to you by calling the EyeMed® Customer Service Department at 844.366.5127, from 8 a.m. to 2 a.m. Monday-Saturday year-round. Sunday hours vary from 11:00 a.m. to 2:00 a.m. Oct. 1 - Mar. 31st and 11:00 a.m. to 8:00 p.m. April 1 - Sept. 30th (TTY users should call 711).

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

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

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

Grievance and Appeal Procedures

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

Summary of MANDATORY Vision

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

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

Covered Services	EyeMed® "Select" Network Provider Benefits[1]	Non-EyeMed® "Select" Network Provider Benefits[4]	Frequency
Routine exam including refraction with dilation as necessary	$0 copay	Up to $50 reimbursement	Once per calendar year.
Retinal imaging	$0 copay	Up to $20 reimbursement	
Frames, lens and lens options benefits package (combined) Or <u>Contact lenses</u>	$100 allowance[2]; or	Up to $100 reimbursement[2]; or	
Conventional:	$100 allowance[2]; or	$100 reimbursement[2]; or	
Disposable:	$100 allowance[2]; or	$100 reimbursement[2]; or	
Medically necessary[3]: (For prescription contact lenses for only one eye, the Plan will pay on-half of the amount payable for contact lenses for both eyes)	$0 copay	Up to $210 reimbursement	

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

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

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

(4) You may choose to use benefits in-network with an EyeMed® "Select" provider OR see a Non-EyeMed® "Select" network provider (out-of-network provider) and seek reimbursement.

Additional Discounts for MANDATORY Vision (1)

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

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

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

(1) This is considered a Value-Added Items and Services (VAIS) and is not offered as a plan benefit under our Medicare Contract. VAIS are non-Medicare covered services or items offered by a provider/vendor to members of the plan who are responsible for the costs. Any disputes regarding these products and services may be subject to the grievance process.

Savings on Laser Vision Correction (1)

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

Discount:

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

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

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

[1] This is considered a Value-Added Items and Services (VAIS) and is not offered as a plan benefit under our Medicare Contract. VAIS are non-Medicare covered services or items offered by a provider/vendor to members of the plan who are responsible for the costs. Any disputes regarding these products and services may be subject to the grievance process.

Summary of OPTIONAL Enhanced Vision

This section provides information about the additional vision coverage that is part of the Optional Enhanced Dental and Vision packages. **If you enrolled in Option 1, you will pay an additional $42 each month. If you enrolled in Option 2, you will pay an additional $61 each month.** The chart below includes your covered services, cost and frequency, followed by additional savings & discounts available to you and exclusions.

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

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

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

Covered Services	EyeMed® "Select" Network Provider Benefits[1]	Non-EyeMed® "Select" Network Provider Benefits[3]	Frequency
Frames, lens and lens options benefits package (combined) Or <u>Contact lenses</u>	$250 allowance[2]; or	Up to $250 reimbursement[2]; or	Once per calendar year.
Conventional:	$250 allowance[2]; or	$250 reimbursement[2]; or	
Disposable: (For prescription contact lenses for only one eye, the Plan will pay on-half of the amount payable for contact lenses for both eyes)	$250 allowance[2]	$250 reimbursement[2]	

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

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

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

Additional Discounts for <u>OPTIONAL</u> Vision [1]

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

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

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

(1) This is considered a Value-Added Items and Services (VAIS) and is not offered as a plan benefit under our Medicare Contract. VAIS are non-Medicare covered services or items offered by a provider/vendor to members of the plan who are responsible for the costs. Any disputes regarding these products and services may be subject to the grievance process.

Savings on Laser Vision Correction (1)

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

Discount:

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

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

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

(1) This is considered a Value-Added Items and Services (VAIS) and is not offered as a plan benefit under our Medicare Contract. VAIS are non-Medicare covered services or items offered by a provider/vendor to members of the plan who are responsible for the costs. Any disputes regarding these products and services may be subject to the grievance process.

Exclusions for MANDATORY AND OPTIONAL Vision

No benefits will be paid for services or materials connected with or charges arising from:

1. Medical or surgical treatment, services or supplies for the treatment of the eye, eyes or supporting structures;
2. Refraction, when not provided as part of a Comprehensive Eye Examination;
3. Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof;
4. Orthoptic or vision training, subnormal vision aids and any associated supplemental testing;
5. Aniseikonic lenses;
6. Any Vision Examination or any corrective Vision Materials required by a Policyholder as a condition of employment;
7. Safety eyewear;
8. Solutions, cleaning products or frame cases;
9. Non-prescription sunglasses;
10. Plano (non-prescription) lenses;
11. Plano (non-prescription) contact lenses;
12. Two pair of glasses in lieu of bifocals;
13. Electronic vision devices;
14. Services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order;
15. Lost or broken lenses, frames, glasses, or contact lenses that are replaced before the next Benefit Frequency when Vision Materials would next become available.



Delta Dental Medicare Advantage™ Dental Plan

Welcome!

Good oral health is a vital part of good general health, and your Delta Dental® program is designed to promote regular dental visits. We encourage you to take advantage of this program by calling your Dentist today for an appointment.

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

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

We look forward to serving you!

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Medicare Advantage Supplemental Dental Plan

Priority Health Medicare – Mandatory
Group Number - 1179

Benefit Year: January 1, 2027 through December 31, 2027.

Maximum Payment: None.

Deductible: None.

*Services received from dentists who do NOT participate in the Delta Dental® Medicare Advantage PPO and Premier Network will result in your out-of-pocket costs being higher.

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

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

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

Benefits	Plan pays
Two preventive exams every year	100%
Two cleanings (regular or periodontal maintenance) every year	100%
One fluoride treatment every year	100%
One set (up to 4 films in a single visit) of bitewing x-rays every year	100%
Periapical radiographs as needed	100%
Radiographs (full-mouth or panoramic x-rays) once every 2 years	100%
One brush biopsy every year	100%

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

Procedure codes covered under MANDATORY dental

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

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

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

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

ADA Dental Code	Dental Procedure Description	Plan pay for Delta Dental® Medicare Advantage Dentist		Plan pay for Nonpartici-pating (out-of-network) Dentist		Frequency
		Opt 1	Opt 2	Opt 1	Opt 2	
D0100-D0999 Diagnostic						
D0120	periodic oral evaluation – established patient	100%	100%	100%	100%	Twice per calendar year (including examinations by a specialist) (D0150, D0160, D0180 count

ADA Dental Code	Dental Procedure Description	Plan pay for Delta Dental® Medicare Advantage Dentist		Plan pay for Nonpartici-pating (out-of-network) Dentist		Frequency
		Opt 1	Opt 2	Opt 1	Opt 2	
						towards frequency)
D0140	limited oral evaluation – problem focused	100%	100%	100%	100%	As needed for diagnosis of emergency condition
D0150	comprehensive oral evaluation – new or established patient	100%	100%	100%	100%	Once per 36 months
D0160	detailed and extensive oral evaluation – problem focused, by report	100%	100%	100%	100%	Once per 36 months
D0180	comprehensive periodontal evaluation – new or established patient	100%	100%	100%	100%	Once per calendar year
D0190	screening of a patient	100%	100%	100%	100%	Once per calendar year
D0210	intraoral – complete series	100%	100%	100%	100%	Once per two-year period
D0220*, D0230*, D0240*, D0250*	intraoral/extra-oral – periapical image, occlusal image	100%	100%	100%	100%	Covered service
D0270, D0272, D0273, D0274, D0277	bitewing x-rays	100%	100%	100%	100%	Once per calendar year
D0330	panoramic image	100%	100%	100%	100%	Once per two-year period

ADA Dental Code	Dental Procedure Description	Plan pay for Delta Dental® Medicare Advantage Dentist		Plan pay for Nonpartici-pating (out-of-network) Dentist		Frequency
		Opt 1	Opt 2	Opt 1	Opt 2	
Diagnostic Notes: • Bitewing X-rays are covered, except in years when you get the full-mouth or panoramic X-rays • Oral examinations and evaluations (not including limited problem focused evaluations or patient screenings) share frequencies • Full mouth and panoramic x-rays share frequencies						
D1000-D1999 Preventive						
D1110	prophylaxis – adult	100%	100%	100%	100%	Two per calendar year
D1206, D1208	topical application of fluoride	100%	100%	100%	100%	Once per calendar year
Preventive Notes: • Teeth cleanings (prophylaxes, full mouth debridement, scaling in the presence of inflammation and periodontal maintenance procedures) share frequencies • Prophylaxis is only payable on natural teeth and implants						
D4000-D4999 Periodontics						
D4910*	Periodontal maintenance	100%	100%	100%	100%	Included in the cleaning frequency of two per calendar year

Medicare Advantage Supplemental Dental Plan

Priority Health Medicare – Optional
Group Number - 1179

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

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

Benefit Year: January 1, 2027 through December 31, 2027

Maximum Payment: $1,500 (option 1) or $2,000 (option 2) on all services covered by the selected Optional Supplemental Plan. Cleaning, scaling and root planing do not apply to the annual maximum.

Deductible: None.

Optional Enhanced Dental Benefits

Group Number – 1179

This section provides information about the additional dental coverage that is part of the Optional Enhanced Dental and Vision package. If you enrolled in Option 1, you will pay an additional $42 each month. If you enrolled in Option 2 you will pay an additional $61 each month. The chart below is a summary of covered services with cost and frequency, followed by a more detailed chart of the covered services including procedure codes, and then exclusions and limitations.

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

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

Your dental plan will cover $1,500 (option 1) or $2,000 (option 2) of the allowable cost of covered services. Cleaning, scaling and root planing will not apply to the maximum.

Benefits	Option 1 Plan pays	Option 2 Plan pays
One cleaning (regular or periodontal)	100%	100%
Periodontics (scaling and root planing)	100%	100%
Annual maximum (**covers all benefits below**)	**$1,500**	**$2,000**
Other diagnostic exams (i.e. cone beams)	50%	75%
Restorative benefits (fillings, crown repairs, onlays and crowns)	50%	75%
Endodontics (root canals)	50%	75%
Periodontics (osseous surgery, gum grafts)	50%	75%
Prosthodontics, removable (dentures & denture repairs)	50%	75%
Prosthodontics, fixed (bridges and bridge repairs)	50%	75%
Implant and implant related services	50%	75%
Simple and surgical extractions	50%	75%
Emergency palliative treatment and anesthesia	50%	75%

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

Procedure codes covered under OPTIONAL dental

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

*Please note, certain procedures may require review or diagnostic information such as radiographs or patient treatment records for claims processing and final payment determinations. **If further clarification**

regarding your coverage and benefits is needed, please ask your dentist for a Pre-Service Organization Determination (PSOD).

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

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

ADA Dental Code	Dental Procedure Description	Plan pay for Delta Dental® Medicare Advantage Dentist		Plan pay for Nonpartici-pating (out-of-network) Dentist		Frequency
		Opt 1	Opt 2	Opt 1	Opt 2	
D0100-D0999 Diagnostic						
D0364, D0365, D0366, D0367	cone beam CT capture and interpretation	50%	75%	50%	75%	Once within a 12-month period
D1000-D1999 Preventive						
D1110	prophylaxis – adult	100%	100%	100%	100%	One per calendar year (in addition to the two covered in the mandatory benefit)
Preventive Notes: • Teeth cleanings (prophylaxes, full mouth debridement, scaling in the presence of inflammation and periodontal maintenance procedures) share frequencies • Prophylaxis is only payable on natural teeth and implants						
D2000-D2999 Restorative						
D2140, D2150, D2160, D2161, D2330,	amalgam and resin-based composite restoration, anterior and posterior	50%	75%	50%	75%	Amalgam and composite resin restorations are payable

ADA Dental Code	Dental Procedure Description	Plan pay for Delta Dental® Medicare Advantage Dentist		Plan pay for Nonpartici-pating (out-of-network) Dentist		Frequency
		Opt 1	Opt 2	Opt 1	Opt 2	
D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394						once in any two-year period, same tooth and same surface, regardless of the number or combination of restorations placed on a surface
D2542, D2543, D2544	onlay – metallic	50%	75%	50%	75%	Once per five-year period
D2642, D2643, D2644, D2662, D2663, D2664	onlay – porcelain/ ceramic or resin-based	50%	75%	50%	75%	Once per five-year period
D2710*, D2712*, D2720*, D2721*, D2722*, D2740*, D2750*, D2751*, D2752*, D2753*	crown – resin-based composite or porcelain ceramic	50%	75%	50%	75%	Once per five-year period
D2780*, D2781*, D2782*, D2783*	crown – ¾ cast or porcelain ceramic	50%	75%	50%	75%	Once per five-year period

ADA Dental Code	Dental Procedure Description	Plan pay for Delta Dental® Medicare Advantage Dentist		Plan pay for Nonpartici-pating (out-of-network) Dentist		Frequency
		Opt 1	Opt 2	Opt 1	Opt 2	
D2790*, D2791*, D2792*	crown – full cast	50%	75%	50%	75%	Once per five-year period
D2794*	crown – titanium and titanium alloys	50%	75%	50%	75%	Once per five-year period
D2910*	re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	50%	75%	50%	75%	Covered service
D2915*	re-cement or re-bond indirectly fabricated or prefabricated post and core	50%	75%	50%	75%	Covered service
D2920*	re-cement or re-bond crown	50%	75%	50%	75%	Covered service
D2921*	reattachment of tooth fragment, incisal edge or cusp	50%	75%	50%	75%	Covered service
D2928*, D2931*, D2932*, D2933*, D2934*	prefabricated crown	50%	75%	50%	75%	Covered service
D2940	placement of interim direct restoration	50%	75%	50%	75%	Once per tooth per lifetime and considered to be part of the fee when done in conjunction with a definitive restoration,

ADA Dental Code	Dental Procedure Description	Plan pay for Delta Dental® Medicare Advantage Dentist		Plan pay for Nonpartici-pating (out-of-network) Dentist		Frequency
		Opt 1	Opt 2	Opt 1	Opt 2	
						indirect pulp cap or endodontic treatment (including pulpotomy)
D2950*	core buildup, including any pins when required	50%	75%	50%	75%	Once per five-year period
D2951*	pin retention – per tooth, in addition to restoration	50%	75%	50%	75%	Once per tooth per lifetime
D2952*, D2954*	post and core in addition to crown	50%	75%	50%	75%	Once per five-year period
D2955*	post removal	50%	75%	50%	75%	Covered service
D2971*	additional procedures to customize a crown to fit under an existing partial denture framework	50%	75%	50%	75%	Per procedure review
D2976*	band stabilization – per tooth	50%	75%	50%	75%	Once per posterior permanent tooth per lifetime
D2980*, D2981*, D2982*, D2983*	repair necessitated by restorative material failure	50%	75%	50%	75%	Covered service

ADA Dental Code	Dental Procedure Description	Plan pay for Delta Dental® Medicare Advantage Dentist		Plan pay for Nonpartici-pating (out-of-network) Dentist		Frequency
		Opt 1	Opt 2	Opt 1	Opt 2	
Restorative Notes: • Subsequent minor restorations would not be a benefit within that five-year period on crowns or onlays • Crowns or onlays are payable only for extensive loss of tooth structure due to caries (decay) or fracture (lost or mobile tooth structure). Our standard for extensive loss of tooth structure is 50% tooth loss • Participating dentists may not charge members for recementation of a crown, onlay, inlay, or bridge within six months of the seating date • When implants are NOT covered, crowns over implants are NOT covered • Crowns on bridges are NOT covered if bridges are NOT covered • Amalgam and composite resin restorations are payable once in any two-year period by the same dentist, same tooth and same surface, regardless of the number or combination of restorations placed on a surface						
D3000-D3999 Endodontics						
D3220*	therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament	50%	75%	50%	75%	Covered service
D3221*	pulpal debridement, primary or permanent teeth	50%	75%	50%	75%	Covered service
D3222*	partial pulpotomy for apexogenesis – permanent tooth with incomplete root development	50%	75%	50%	75%	Once per tooth per lifetime; additional benefit will require review

ADA Dental Code	Dental Procedure Description	Plan pay for Delta Dental® Medicare Advantage Dentist		Plan pay for Nonpartici-pating (out-of-network) Dentist		Frequency
		Opt 1	Opt 2	Opt 1	Opt 2	
D3230*, D3240*	pulpal therapy (resorbable filling) – any tooth (excluding final restoration)	50%	75%	50%	75%	Covered service
D3310*, D3320*, D3330*	endodontic therapy, (excluding final restoration)	50%	75%	50%	75%	Covered service
D3332*	incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	50%	75%	50%	75%	Requires consultant review
D3333*	internal root repair of perforation defects	50%	75%	50%	75%	Requires consultant review
D3346*, D3347*, D3348*	retreatment of previous root canal therapy	50%	75%	50%	75%	Covered service
D3351*, D3352*, D3353	apexification/ recalcification (apical closure/ calcific repair of perforations, root resorption, root canal, pulp space, disinfection, etc.)	50%	75%	50%	75%	Requires consultant review
D3410*, D3421*, D3425*, D3426*	apicoectomy	50%	75%	50%	75%	Covered service
D3430*	retrograde filling – per root	50%	75%	50%	75%	Covered service

ADA Dental Code	Dental Procedure Description	Plan pay for Delta Dental® Medicare Advantage Dentist		Plan pay for Nonpartici-pating (out-of-network) Dentist		Frequency
		Opt 1	Opt 2	Opt 1	Opt 2	
D3450*	root amputation – per root	50%	75%	50%	75%	Covered service
D3471*, D3472*, D3473*	surgical repair of root resorption	50%	75%	50%	75%	Covered service
D3501*, D3502*, D3503*	surgical exposure of root surface without apicoectomy or repair of root resorption	50%	75%	50%	75%	Covered service
D3920*	hemisection (including any root removal), not including root canal therapy	50%	75%	50%	75%	Covered service
D3921*	decoronation or submergence of an erupted tooth	50%	75%	50%	75%	Requires consultant review
D4000-D4999 Periodontics						
D4210*, D4211*	gingivectomy or gingivoplasty	50%	75%	50%	75%	Once per 36-month period, per quadrant
D4240*, D4241*	gingival flap procedure, including root planing	50%	75%	50%	75%	Once per 36-month period
D4245*	apically positioned flap	50%	75%	50%	75%	Once per 36-month period
D4249*	clinical crown lengthening – hard tissue	50%	75%	50%	75%	Once per tooth per 24-month period
D4260*, D4261*	osseous surgery (including elevation	50%	75%	50%	75%	Once per 36-month period

ADA Dental Code	Dental Procedure Description	Plan pay for Delta Dental® Medicare Advantage Dentist		Plan pay for Nonpartici-pating (out-of-network) Dentist		Frequency
		Opt 1	Opt 2	Opt 1	Opt 2	
	of a full thickness flap and closure)					
D4263*, D4264*	bone replacement graft – retained natural tooth	50%	75%	50%	75%	Once per 36-month period
D4265*	biologic materials to aid in soft and osseous tissue regeneration	50%	75%	50%	75%	Once per 36-month period
D4266*, D4267*	guided tissue regeneration	50%	75%	50%	75%	Once per 36-month period
D4268*	surgical revision procedure, per tooth	50%	75%	50%	75%	Once per tooth per 36-month period
D4270*	pedicle soft tissue graft procedure	50%	75%	50%	75%	Once per tooth per 36-month period
D4273*, D4283*	autogenous connective tissue graft procedure	50%	75%	50%	75%	Once per 36-month period
D4274*	mesial/distal wedge procedure, single tooth	50%	75%	50%	75%	Once per 36-month period
D4275*, D4285*	non-autogenous connection tissue graft	50%	75%	50%	75%	Once per 36-month period
D4276*	combined connective tissue and double pedicle graft, per tooth	50%	75%	50%	75%	Once per 36-month period
D4277*, D4278*	free soft tissue graft procedure	50%	75%	50%	75%	Once per 36-month period

ADA Dental Code	Dental Procedure Description	Plan pay for Delta Dental® Medicare Advantage Dentist		Plan pay for Nonpartici-pating (out-of-network) Dentist		Frequency
		Opt 1	Opt 2	Opt 1	Opt 2	
D4341*, D4342*	periodontal scaling and root planing	100%	100%	100%	100%	Once per 24-month period. No more than two quadrants of scaling and root planing on the same date of service
D4346*	scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	100%	100%	100%	100%	Included in the cleaning frequency of three per calendar year
D4355*	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	100%	100%	100%	100%	Once in a lifetime (counts towards the frequency of a cleaning)
D4910*	Periodontal maintenance	100%	100%	100%	100%	Included in the cleaning frequency of three per calendar year
Periodontic Notes: • Root planning is payable once in any two-year period						
D5000-D5899 Prosthodontics (Removable)						
D5110*, D5120*, D5130*, D5140*	complete and immediate denture	50%	75%	50%	75%	Once per five-year period

ADA Dental Code	Dental Procedure Description	Plan pay for Delta Dental® Medicare Advantage Dentist		Plan pay for Nonpartici-pating (out-of-network) Dentist		Frequency
		Opt 1	Opt 2	Opt 1	Opt 2	
D5211*, D5212*, D5213*, D5214*	partial denture – resin base (including retentive/clasping materials, rests and teeth)	50%	75%	50%	75%	Once per five-year period
D5221*	immediate partial denture – resin base (including any retentive/clasping materials, rests and teeth)	50%	75%	50%	75%	Once per five-year period
D5221*, D5222*, D5223*, D5224*	immediate partial denture – resin base (including any retentive/clasping materials, rests and teeth)	50%	75%	50%	75%	Once per five-year period
D5225*, D5226*, D5227*, D5228*	partial denture – flexible base (including retentive/clasping materials, rests and teeth)	50%	75%	50%	75%	Once per five-year period
D5282*, D5283*, D5284*, D5286*	removable unilateral partial denture (including retentive/clasping materials, rests, and teeth)	50%	75%	50%	75%	Once per five-year period unless the loss of additional teeth requires the construction of a new appliance
D5410*, D5411*, D5421*, D5422*	adjust complete/partial denture	50%	75%	50%	75%	Covered service

ADA Dental Code	Dental Procedure Description	Plan pay for Delta Dental® Medicare Advantage Dentist		Plan pay for Nonpartici-pating (out-of-network) Dentist		Frequency
		Opt 1	Opt 2	Opt 1	Opt 2	
D5511*, D5512*, D5611*, D5612*, D5621*, D5622*, D5630*	repair broken complete or partial denture	50%	75%	50%	75%	Covered service
D5520*	replace missing or broken teeth – complete denture (per tooth)	50%	75%	50%	75%	Covered service
D5640*	replace missing or broken teeth – partial denture – per tooth	50%	75%	50%	75%	Covered service
D5650*	add tooth to existing partial denture, per tooth	50%	75%	50%	75%	Covered service
D5660*	add clasp to existing partial denture – per tooth	50%	75%	50%	75%	Covered service
D5670*, D5671*	replace all teeth and acrylic on cast metal framework	50%	75%	50%	75%	Covered service
D5710*, D5711*, D5720*, D5721*	rebase complete or partial denture	50%	75%	50%	75%	Once per 36-month period
D5725*	rebase hybrid prosthesis	50%	75%	50%	75%	Once per five-year period, per appliance
D5730, D5731,	reline complete or partial denture	50%	75%	50%	75%	Once per 36-month period

ADA Dental Code	Dental Procedure Description	Plan pay for Delta Dental® Medicare Advantage Dentist		Plan pay for Nonpartici-pating (out-of-network) Dentist		Frequency
		Opt 1	Opt 2	Opt 1	Opt 2	
D5740, D5741, D5750, D5751, D5760, D5761						
D5765*	soft liner for complete or partial removable denture – indirect	50%	75%	50%	75%	Once in a 36-month period
D5820, D5821	interim partial denture	50%	75%	50%	75%	Payable for the replacement of permanent anterior teeth within 30 calendar days of the extraction, absent of medical necessity
D5850, D5851	tissue conditioning	50%	75%	50%	75%	Twice per arch per any 36-month period

Prosthodontics (Removable) Notes:

- One complete upper denture and one complete lower denture, and any implant used to support a denture, are payable once in any five-year period
- A removable partial denture, a unilateral partial denture, an endosteal implant (other than to support a denture), or fixed bridge is payable once in any five-year period unless the loss of additional teeth requires the construction of a new appliance
- The allowance for a denture repair (including reline or rebase) will not exceed half the fee for a new denture

D6000-D6199 Implant Services

ADA Dental Code	Dental Procedure Description	Plan pay for Delta Dental® Medicare Advantage Dentist		Plan pay for Nonpartici-pating (out-of-network) Dentist		Frequency
		Opt 1	Opt 2	Opt 1	Opt 2	
D6010*	surgical placement of implant body; endosteal implant	50%	75%	50%	75%	Once per five-year period
D6013*	surgical placement of mini implant	50%	75%	50%	75%	Requires Consultant Review
D6049*	scaling and debridement of a single implant in the presence of peri-implantitis inflammation, bleeding upon probing and increased pocket depth, including cleaning of the implant surfaces without flap entry and closure	50%	75%	50%	75%	Once per tooth per 12-months
D6056*	prefabricated abutment – includes modification and placement	50%	75%	50%	75%	Once per five-year period
D6057*	custom abutment – includes placement	50%	75%	50%	75%	Once per five-year period
D6058*, D6059*, D6060*, D6061*, D6062*, D6063*, D6064*	abutment supported crown, any material	50%	75%	50%	75%	Once per five-year period

ADA Dental Code	Dental Procedure Description	Plan pay for Delta Dental® Medicare Advantage Dentist		Plan pay for Nonpartici-pating (out-of-network) Dentist		Frequency
		Opt 1	Opt 2	Opt 1	Opt 2	
D6065*, D6066*, D6067*, D6082*, D6083*, D6084*, D6086*, D6087*, D6088*	implant supported crown, any material	50%	75%	50%	75%	Once per five-year period
D6068*, D6069*, D6070*, D6071*, D6072*, D6073*, D6074*	abutment supported retainer for fixed partial denture	50%	75%	50%	75%	Once per five-year period
D6075*, D6076*, D6077*	implant supported retainer for fixed partial denture	50%	75%	50%	75%	Once per five-year period
D6080*	implant maintenance procedures – when a full arch fixed hybrid prosthesis is removed and reinserted, including cleansing of prosthesis and abutments	50%	75%	50%	75%	Once per 12-month period, per arch
D6081*	scaling and debridement of a single implant in the presence of mucositis, including inflammation,	50%	75%	50%	75%	Once per tooth per 12-months

ADA Dental Code	Dental Procedure Description	Plan pay for Delta Dental® Medicare Advantage Dentist		Plan pay for Nonpartici-pating (out-of-network) Dentist		Frequency
		Opt 1	Opt 2	Opt 1	Opt 2	
	bleeding upon probing and increased pocket depths; includes cleaning of the implant surfaces, without flap entry and closure					
D6089*	accessing and retorquing loose implant screw – per screw	50%	75%	50%	75%	Once per tooth per 24-month period, per implant
D6090*	repair of implant/ abutment supported prosthesis, by report	50%	75%	50%	75%	Covered service
D6092*, D6093*	re-cement implant/ abutment supported crown or fixed partial denture	50%	75%	50%	75%	Covered service
D6094*, D6097*	abutment supported crown	50%	75%	50%	75%	Once per five-year period
D6096*	remove broken implant retaining screw	50%	75%	50%	75%	Once per five-year period
D6098*	implant supported retainer – porcelain fused to predominantly based alloys	50%	75%	50%	75%	Once per five-year period
D6100*	implant removal, by report	50%	75%	50%	75%	Once per tooth or area per lifetime

ADA Dental Code	Dental Procedure Description	Plan pay for Delta Dental® Medicare Advantage Dentist		Plan pay for Nonpartici-pating (out-of-network) Dentist		Frequency
		Opt 1	Opt 2	Opt 1	Opt 2	
D6101*	debridement of a peri-implant defect and surface cleaning of exposed implant surfaces, including flap entry and closure	50%	75%	50%	75%	Covered service
D6102*	debridement and osseous contouring of a peri-implant defect; includes surface cleaning of exposed implant surfaces and flap entry and closure	50%	75%	50%	75%	Covered service
D6103*	bone graft for repair of peri-implant defect – does not include flap entry and closure	50%	75%	50%	75%	Covered service
D6104*	bone graft at time of implant placement	50%	75%	50%	75%	Covered service
D6105*	removal of implant body not requiring bone removal nor flap elevation	50%	75%	50%	75%	Covered service
D6106*, D6107*	guided tissue regeneration – per implant	50%	75%	50%	75%	Covered service
D6120*	implant supported retainer – porcelain fused to titanium and titanium alloys	50%	75%	50%	75%	Once per five-year period

ADA Dental Code	Dental Procedure Description	Plan pay for Delta Dental® Medicare Advantage Dentist		Plan pay for Nonpartici-pating (out-of-network) Dentist		Frequency
		Opt 1	Opt 2	Opt 1	Opt 2	
D6121*, D6122*, D6123*	implant supported retainer for metal fixed partial denture	50%	75%	50%	75%	Once per five-year period
D6180*	implant maintenance procedures when a full arch fixed hybrid prosthesis is not removed, including cleansing of prosthesis and abutments	50%	75%	50%	75%	Once per 12-month period, per arch
D6190*	radiographic/ surgical implant index, by report	50%	75%	50%	75%	Covered service
D6193*	replacement of an implant screw	50%	75%	50%	75%	Once per implant every 24 months
D6194*	abutment supported retainer crown for FPD – titanium and titanium alloys	50%	75%	50%	75%	Once per five-year period
D6195*	abutment supported retainer – porcelain fused to titanium and titanium alloys	50%	75%	50%	75%	Once per five-year period
D6197*	replacement of restorative material used to close an access opening of a screw-retained implant supported	50%	75%	50%	75%	Once per 24-month period

ADA Dental Code	Dental Procedure Description	Plan pay for Delta Dental® Medicare Advantage Dentist		Plan pay for Nonpartici-pating (out-of-network) Dentist		Frequency
		Opt 1	Opt 2	Opt 1	Opt 2	
	prosthesis, per implant					
Implant Services Notes: • Participating dentists may not charge members for recementation of a crown, onlay, inlay, or bridge within six months of the seating date • Participating dentists may not charge members for the replacement of an implant screw within six months of the initial placement of the prosthesis • Individual crowns over implants are payable at the prosthodontic benefit level • Implant maintenance procedures will share frequencies						
D6200-D6999 Prosthodontics (Fixed)						
D6205*, D6245*	pontic – indirect resin-based composite or porcelain/ceramic	50%	75%	50%	75%	Once per five-year period
D6210*, D6211*, D6212*, D6214*	pontic	50%	75%	50%	75%	Once per five-year period
D6240*, D6241*, D6242*, D6243*	pontic – porcelain fused	50%	75%	50%	75%	Once per five-year period
D6250*, D6251*, D6252*	pontic – porcelain fused	50%	75%	50%	75%	Once per five-year period
D6280*	implant maintenance procedures when a full arch removable implant/abutment supported denture is removed and	50%	75%	50%	75%	Once per 36-month period

ADA Dental Code	Dental Procedure Description	Plan pay for Delta Dental® Medicare Advantage Dentist		Plan pay for Nonpartici-pating (out-of-network) Dentist		Frequency
		Opt 1	Opt 2	Opt 1	Opt 2	
	reinserted, including cleansing of prosthesis and abutments – per arch					
D6545*	retainer – cast metal for resin bonded fixed prosthesis	50%	75%	50%	75%	Once per five-year period per consultant review
D6548*	retainer – porcelain/ ceramic for resin bonded fixed prosthesis	50%	75%	50%	75%	Once per five-year period per consultant review
D6549*	resin retainer – for resin bonded fixed prothesis	50%	75%	50%	75%	Once per five-year period per consultant review
D6600*, D6601*	retainer inlay – porcelain/ceramic	50%	75%	50%	75%	Once per five-year period per consultant review
D6602*, D6603*	retainer inlay – cast high noble metal	50%	75%	50%	75%	Once per five-year period per consultant review
D6604*, D6605*	retainer inlay – cast predominately base metal	50%	75%	50%	75%	Once per five-year period per consultant review
D6606*, D6607*	retainer inlay – cast noble metal	50%	75%	50%	75%	Once per five-year period per consultant review

ADA Dental Code	Dental Procedure Description	Plan pay for Delta Dental® Medicare Advantage Dentist		Plan pay for Nonpartici-pating (out-of-network) Dentist		Frequency
		Opt 1	Opt 2	Opt 1	Opt 2	
D6608*, D6609*	retainer onlay – porcelain/ceramic	50%	75%	50%	75%	Once per five-year period per consultant review
D6610*, D6611*	retainer onlay – cast high noble metal	50%	75%	50%	75%	Once per five-year period per consultant review
D6612*, D6613*	retainer onlay – cast predominately base metal	50%	75%	50%	75%	Once per five-year period per consultant review
D6614*, D6615*	retainer onlay – cast noble metal	50%	75%	50%	75%	Once per five-year period per consultant review
D6624*	retainer inlay – titanium	50%	75%	50%	75%	Once per five-year period per consultant review
D6634*	retainer onlay – titanium	50%	75%	50%	75%	Once per five-year period per consultant review
D6710*, D6740*	retainer crown – indirect resin-based composite or porcelain/ceramic	50%	75%	50%	75%	Once per five-year period per consultant review
D6720*, D6721*, D6722*	retainer crown – resin with high noble metal	50%	75%	50%	75%	Once per five-year period

ADA Dental Code	Dental Procedure Description	Plan pay for Delta Dental® Medicare Advantage Dentist		Plan pay for Nonpartici-pating (out-of-network) Dentist		Frequency
		Opt 1	Opt 2	Opt 1	Opt 2	
D6750*, D6751*, D6752*, D6753*	retainer crown – porcelain fused to high noble metal	50%	75%	50%	75%	Once per five-year period
D6780*, D6781*, D6782*, D6784*	retainer crown – ¾ cast	50%	75%	50%	75%	Once per five-year period per consultant review
D6783*	retainer crown – ¾ cast porcelain/ ceramic	50%	75%	50%	75%	Once per five-year period per consultant review
D6790*, D6791*, D6792*, D6794*	retainer crown – ¾ full cast	50%	75%	50%	75%	Once per five-year period per consultant review
D6930*	re-cement or re-bond fixed partial denture	50%	75%	50%	75%	Covered service
D6980*	fixed partial denture repair, necessitated by restorative material failure	50%	75%	50%	75%	Covered service
Prosthodontics (Fixed) Notes: • Fixed partial denture abutment and pontic procedures may require pre-operative radiographs						
D7000-D7999 Oral and Maxillofacial Surgery						
D7111*	extraction, coronal remnants – primary tooth	50%	75%	50%	75%	Once per tooth per lifetime
D7140*	extraction, erupted tooth or exposed	50%	75%	50%	75%	Once per tooth per lifetime

ADA Dental Code	Dental Procedure Description	Plan pay for Delta Dental® Medicare Advantage Dentist		Plan pay for Nonpartici-pating (out-of-network) Dentist		Frequency
		Opt 1	Opt 2	Opt 1	Opt 2	
	root (elevation and or forceps removal)					
D7210*	extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap, if indicated	50%	75%	50%	75%	Once per tooth per lifetime
D7220*, D7230*, D7240*	removal of impacted tooth	50%	75%	50%	75%	Once per tooth per lifetime
D7241*	removal of impacted tooth – completely bony, with unusual surgical complications	50%	75%	50%	75%	Once per tooth per lifetime
D7250*	removal of residual tooth roots (cutting procedure)	50%	75%	50%	75%	Once per tooth per lifetime
D7251*	coronectomy – intentional partial tooth removal	50%	75%	50%	75%	Once per tooth per lifetime
D7252*	partial extraction for immediate implant placement	50%	75%	50%	75%	Once per tooth, in conjunction with immediate implant placement
D7270*	tooth reimplantation and/ or stabilization of	50%	75%	50%	75%	Covered service

ADA Dental Code	Dental Procedure Description	Plan pay for Delta Dental® Medicare Advantage Dentist		Plan pay for Nonpartici-pating (out-of-network) Dentist		Frequency
		Opt 1	Opt 2	Opt 1	Opt 2	
	accidentally evulsed or displaced tooth					
D7280*	exposure of an unerupted tooth	50%	75%	50%	75%	Once per tooth per lifetime
D7282	mobilization of erupted or malpositioned tooth to aid eruption	50%	75%	50%	75%	Once per tooth per lifetime
D7283*	placement of device to facilitate eruption of impacted tooth	50%	75%	50%	75%	Covered service
D7284*	excisional biopsy of minor salivary glands	50%	75%	50%	75%	Twice per lifetime, absent of medical necessity
D7286	biopsy of oral tissue – soft	50%	75%	50%	75%	Two per calendar year
D7288	brush biopsy – transepithelial sample collection	100%	100%	100%	100%	Covered Service
D7290*	surgical repositioning of teeth	50%	75%	50%	75%	Covered service
D7291*	transseptal fiberotomy/supra crestal fiberotomy, by report	50%	75%	50%	75%	Covered service
D7292*	placement of temporary anchorage device (screw retained plate) requiring flap;	50%	75%	50%	75%	Covered service

ADA Dental Code	Dental Procedure Description	Plan pay for Delta Dental® Medicare Advantage Dentist		Plan pay for Nonpartici-pating (out-of-network) Dentist		Frequency
		Opt 1	Opt 2	Opt 1	Opt 2	
	includes device removal					
D7293*	placement of temporary anchorage device requiring flap; includes device removal	50%	75%	50%	75%	Covered service
D7294*	placement of temporary anchorage device without flap; includes device removal	50%	75%	50%	75%	Covered service
D7295*	harvest of bone for use in autogenous grafting procedure	50%	75%	50%	75%	Covered service
D7310*, D7311*	alveoloplasty in conjunction with extractions – per quadrant	50%	75%	50%	75%	Covered service
D7320*, D7321*	alveoloplasty not in conjunction with extractions per quadrant	50%	75%	50%	75%	Covered service
D7510*	incision and drainage of abscess – intraoral soft tissue	50%	75%	50%	75%	Covered service
D7511*	incision and drainage of abscess – intraoral soft tissue – complicated (includes drainage	50%	75%	50%	75%	Covered service

ADA Dental Code	Dental Procedure Description	Plan pay for Delta Dental® Medicare Advantage Dentist		Plan pay for Nonpartici-pating (out-of-network) Dentist		Frequency
		Opt 1	Opt 2	Opt 1	Opt 2	
	of multiple fascial spaces)					
D7910*	suture of recent small wounds up to 5 cm	50%	75%	50%	75%	Covered service
D7921*	collection and application of autologous blood concentrate product	50%	75%	50%	75%	Covered service
D7950*	osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla – autogenous or nonautogenous, by report	50%	75%	50%	75%	Covered service
D7951*	sinus augmentation with bone or bone substitutes via a lateral open approach	50%	75%	50%	75%	Covered service
D7952*	sinus augmentation via a vertical approach	50%	75%	50%	75%	Covered service
D7953*	bone replacement graft for ridge preservation – per site	50%	75%	50%	75%	Covered service
D7955*	repair of maxillofacial soft and/or hard tissue defect	50%	75%	50%	75%	Covered service

ADA Dental Code	Dental Procedure Description	Plan pay for Delta Dental® Medicare Advantage Dentist		Plan pay for Nonpartici-pating (out-of-network) Dentist		Frequency
		Opt 1	Opt 2	Opt 1	Opt 2	
D7970*	excision of hyperplastic tissue – per arch	50%	75%	50%	75%	Covered service
D7971*	excision of pericoronal gingiva	50%	75%	50%	75%	Covered service
D7996*	implant-mandible for augmentation purposes (excluding alveolar ridge), by report	50%	75%	50%	75%	Covered service
D9000-D9999 Adjunctive General Services						
D9110	palliative (emergency) treatment of dental pain – minor procedure	100%	100%	100%	100%	As needed for diagnosis of emergency condition
D9222*	administration of deep sedation/ general anesthesia – first 15 minute increment, or any portion thereof	100%	100%	100%	100%	Paid in conjunction with qualifying services
D9223*	administration of deep sedation/ general anesthesia – each subsequent 15 minute increment, or any portion thereof	100%	100%	100%	100%	Paid in conjunction with qualifying services
D9224	administration of general anesthesia with advanced airway – first 15 minute increment,	100%	100%	100%	100%	Paid in conjunction with qualifying services

ADA Dental Code	Dental Procedure Description	Plan pay for Delta Dental® Medicare Advantage Dentist		Plan pay for Nonpartici-pating (out-of-network) Dentist		Frequency
		Opt 1	Opt 2	Opt 1	Opt 2	
	or any portion thereof					
D9225	administration of general anesthesia with advanced airway – each subsequent 15 minute increment, or any portion thereof	100%	100%	100%	100%	Paid in conjunction with qualifying services
D9239*	administration of moderate sedation/ intravenous – first 15 minute increment or any portion thereof	100%	100%	100%	100%	Paid in conjunction with qualifying services
D9243*	administration of moderate sedation/ intravenous – each subsequent 15 minute increment or any portion thereof	100%	100%	100%	100%	Paid in conjunction with qualifying services
D9936*	cleaning and inspection of occlusal guard – per appliance	50%	75%	50%	75%	Once per 12-month period
D9944, D9946	occlusal guard – hard appliance	50%	75%	50%	75%	Once per five-year period
D9951	occlusal adjustment – limited	50%	75%	50%	75%	Payable three times in a five-year period

ADA Dental Code	Dental Procedure Description	Plan pay for Delta Dental® Medicare Advantage Dentist		Plan pay for Nonpartici-pating (out-of-network) Dentist		Frequency
		Opt 1	Opt 2	Opt 1	Opt 2	
D9952	occlusal adjustment – complete	50%	75%	50%	75%	Payable once in a five-year period

Definitions

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

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

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

Benefit Year – The calendar year.

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

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

Completion Dates – The date that treatment is complete. Some procedures may require more than one appointment before they can be completed. Treatment is complete:

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

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

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

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

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

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

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

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

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

- **Delta Dental® Medicare Advantage PPO Dentist** – a Dentist located in Michigan, Indiana, or Ohio who has signed an agreement with Delta Dental® for this Plan that is part of Delta Dental's® Medicare Advantage PPO Network.
- **Delta Dental® Medicare Advantage Premier Dentist** – a Dentist located in Michigan, Indiana, or Ohio who has signed an agreement with Delta Dental® for this Plan that is part of Delta Dental's® Medicare Advantage Premier Network.
- **Nonparticipating Dentist** – a Dentist who has not signed an agreement with Delta Dental® to become part of the Delta Dental® Medicare Advantage Premier or Delta Dental® Medicare Advantage PPO Network or is located in a state other than Michigan, Indiana or Ohio.

- **Out-of-Country Dentist** – a Dentist whose office is located outside the United States and its territories. These dentists are nonparticipating because Out-of-Country Dentists are not eligible to sign participating agreements with Delta Dental®.

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

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

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

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

Maximum Payment – The maximum dollar amount Delta Dental® will pay in any Benefit Year or lifetime for Covered Services.

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

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

Member – A person with coverage under This Plan.

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

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

Post-Service Claims – Claims for Benefits that are not conditioned on your seeking advance approval, certification, or authorization to receive the full

amount for any Covered Services. In other words, Post-Service claims arise when you receive the dental service or treatment before you file a Claim for Benefits.

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

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

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

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

This Plan – The dental coverage established for Members pursuant to this Member Handbook.

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

Selecting a Dentist

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

To verify that a Dentist is a Medicare Advantage Participating Dentist, you can use Delta Dental's® online Dentist Directory at ***deltadentalmi.com/find-a-dentist*** or call 800.330.2732 (TTY Users call 711). **When accessing Delta Dental's® online Dentist Directory you must select the link labeled Medicare Advantage PPO and Medicare Advantage Premier**.

IMPORTANT: If you receive services from a dentist that DOES NOT participate in Delta Dental's® Medicare Advantage Network YOU WILL BE

RESPONSIBLE for the difference between Delta Dental's® payment and the amount charged by the Nonparticipating dentist.

Accessing Your Benefits

To utilize your dental benefits, follow these steps:

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

   Delta Dental®
   Attention: Customer Service
   P.O. Box 9230
   Farmington Hills, MI 48333-9230

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

Notice of Claim Forms

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

Mail claims and completed information requests to:

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

Pre-Service Organization Determinations

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

Delta Dental®
Attention: Customer Service
P.O. Box 9230
Farmington Hills, MI 48333-9230

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

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

Written Notice of Claim and Time of Payment

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

a. describe the information needed,
b. explain why it is needed,
c. request an extension of time in which to decide the claim, and,
d. inform you or your Dentist that the information must be received within 60 days or your claim will be denied. You will receive a copy of any notice sent to your Dentist.

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

Authorized Representative

You may also appoint an authorized representative to deal with Priority Health on your behalf with respect to any benefit claim you file or any review of a denied claim you wish to pursue (see the Grievance and Appeals Procedure section). You should call Priority Health's Customer Care department, toll-free, at 888.389.6648, or write them at:

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

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

You will have to get that information from your representative. If you have not designated a representative, Priority Health will communicate directly with you.

How Payment is Made

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

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

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

Exclusions and Limitations

Exclusions

Delta Dental® will make no payment for the following services or supplies, unless otherwise specified in this Member Handbook. All charges for the same will be your responsibility (though your payment obligation may be

satisfied by insurance or some other arrangement for which you are eligible):

1. Services or supplies, as determined by Delta Dental, for correction of congenital or developmental malformations.
2. Cosmetic surgery or dentistry for aesthetic reasons, as determined by Delta Dental.
3. Services started or appliances started before a person became eligible under This Plan.
4. Prescription drugs (except intramuscular injectable antibiotics), premedication, medicaments/solutions, and relative analgesia.
5. General anesthesia and intravenous sedation for (a) surgical procedures, unless medically necessary, or (b) restorative dentistry.
6. Charges for hospitalization, laboratory tests, histopathological examinations and miscellaneous tests.
7. Charges for failure to keep a scheduled visit with the Dentist.
8. Services or supplies, as determined by Delta Dental, for which no valid dental need can be demonstrated.
9. Services or supplies, as determined by Delta Dental, that are investigational in nature, including services or supplies required to treat complications from investigational procedures.
10. Services or supplies, as determined by Delta Dental, which are specialized procedures or techniques.
11. Treatment by other than a Dentist, except for services performed by a licensed dental hygienist under the supervision of a licensed Dentist. Treatment rendered by any other licensed dental professional may be covered only as solely determined by the MAO and/or Delta Dental.
12. Services or supplies for which the patient is not legally obligated to pay, or for which no charge would be made in the absence of Delta Dental coverage.
13. Services or supplies received due to an act of war, declared or undeclared or terrorism.
14. Services or supplies covered under a hospital, surgical/medical or prescription drug program.
15. Services or supplies that are not within the categories of Benefits covered under the terms of this Member Handbook.
16. Fluoride rinses, self-applied fluorides, or desensitizing medicaments.
17. Interim caries arresting medicament.
18. Preventive control programs (including oral hygiene instruction, caries susceptibility tests, dietary control, tobacco counseling, immunization counseling, home care medicaments, etc.).
19. Lost, missing, or stolen appliances of any type.

20. Cosmetic dentistry, including repairs to facings posterior to the second bicuspid position.
21. Veneers.
22. Prefabricated crowns used as final restorations on permanent teeth.
23. Appliances, surgical procedures, and restorations for increasing vertical dimension; for altering, restoring, or maintaining occlusion; for replacing tooth structure loss resulting from attrition, abrasion, abfraction, or erosion; or for periodontal splinting.
24. Soft occlusal guard appliances.
25. Paste-type root canal fillings on permanent teeth.
26. Replacement, repair, relines or adjustments of occlusal guards.
27. Chemical curettage.
28. Services associated with overdentures.
29. Implant/abutment supported interim fixed denture for edentulous arch.
30. Metal bases on removable prostheses.
31. The replacement of teeth beyond the normal complement of teeth.
32. Personalization or characterization of any service or appliance.
33. Temporary crowns used for temporization during crown or bridge fabrication.
34. Posterior bridges in conjunction with partial dentures in the same arch, sharing at least one posterior edentulous space in common.
35. Precision abutments, attachments and stress breakers.
36. Biologic materials to aid in soft and osseous tissue regeneration when submitted on the same day as tooth extraction, periradicular surgery, soft tissue grafting, guided tissue regeneration and periodontal or implant bone grafting.
37. Bone replacement grafts and specialized implant surgical techniques, including radiographic/surgical implant index.
38. Indexing for osteotomy using dynamic robotic assisted or dynamic navigation.
39. Appliances, restorations, or services for the diagnosis or treatment of disturbances of the temporomandibular joint (TMJ).
40. Diagnostic photographs and cephalometric films.
41. 3-D scans and images, and printings of such scans or images.
42. Myofunctional therapy.
43. Mounted case analyses.
44. Molecular, antigen or antibody testing for a public health related pathogen.
45. Vaccinations.

46. Bone replacement grafts when performed in conjunction with a hemisection.
47. Fabrication, adjustment or repair of sleep apnea appliances.
48. The administration of a home sleep apnea test, or screening for sleep apnea related breathing disorders.
49. Fabrication, delivery, or titration of oral appliance therapy (OAT) morning repositioning device.
50. Fabrication and placement of a custom removable clear plastic temporary aesthetic appliance.
51. Removal of non-resorbable barrier.
52. Intraoral tomosynthesis images.
53. Any and all taxes applicable to the services.
54. Processing policies may otherwise exclude payment by Delta Dental for services or supplies.

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

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

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

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

28. Interim caries arresting medicament is not payable when done on the same day as the application of hydroxyapatite regeneration medicament when performed on the same tooth.
29. Application of hydroxyapatite regeneration medicament is not payable on the same day as a restoration or a fixed partial denture retainer when performed by the same dentist or dental office.
30. An occlusal adjustment, when performed on the same day as the delivery of an occlusal guard.
31. Reline, rebase, or any adjustment or repair within six months of the delivery of a denture.
32. Reline or any adjustment or repair to a sleep apnea appliance within six (6)-months of the delivery.
33. Tissue conditioning, when performed on the same day as the delivery of a denture or the reline or rebase of a denture.
34. Adjustments, temporary relines, or tissue conditioning within three months of delivery of an immediate denture.
35. Periapical and/or bitewing X-rays, when done within a clinically unreasonable period of time of performing full mouth X-rays, as determined solely by Delta Dental.
36. Charges or fees for overhead, internet/video connections, software, hardware or other equipment necessary to deliver services, including but not limited to teledentistry services.
37. Capture only images which are not associated with any interpretation or reporting.
38. Frenulectomy when performed on the same day as any other surgical procedure(s) in the same surgical area by the same dentist or dental office.
39. Surgical removal of implant body when performed within three (3) months of an implant/mini-implant on the same tooth by the same dentist or dental office.
40. Non-surgical implant removal when performed within six (6)-months of an implant/mini-implant on the same tooth by the same dentist or dental office.
41. Accessing and retorquing loose implant screw is not payable when performed on the same day as implant maintenance and repair procedures on an implant supported prosthesis by the same dentist or dental office.
42. Scaling and root planing when performed on the same day as surgical root repair or exposures.
43. Surgical repair or exposure of root when performed on the same day as endodontic or periodontal surgical procedures.
44. Intraorifice barriers.

45. Excision of benign lesions when performed in the same area and on the same day as another surgical procedure by the same dentist or dental office.
46. Processing policies may otherwise exclude payment by Delta Dental for services or supplies.

Limitations

The Benefits for the following services or supplies are limited as follows, unless otherwise specified in this Member Handbook. In addition to limitations listed in the Covered Code List, all charges for services or supplies that exceed these limitations will be your responsibility. All time limitations are measured from the applicable prior dates of services in our records or, at the request of your Medicare Advantage Organization, any dental plan:

1. Crowns or onlays are payable only for extensive loss of tooth structure, 50% loss of tooth structure or greater, due to caries (decay) or fracture (lost or mobile tooth structure).
2. When services in progress are interrupted, Delta Dental will not issue payment for any incomplete services; however, Delta Dental will calculate the Maximum Approved Fee that the dentist may charge you for such incomplete services, and those charges will be your responsibility. In the event the interrupted services are completed later by a Dentist, Delta Dental will review the claim to determine the amount of payment, if any, to the Dentist in accordance with Delta Dental's policies at the time services are completed.
3. Care terminated due to the death of a Member will be paid to the limit of Delta Dental's liability for the services completed or in progress.
4. Optional treatment: If you select a more expensive service than is customarily provided, Delta Dental may make an allowance for certain services based on the fee for the customarily provided service. You are responsible for the difference in cost. In all cases, Delta Dental will make the final determination regarding optional treatment and any available allowance. Listed below are services for which Delta Dental will provide an allowance for optional treatment. Remember, you are responsible for the difference in cost for any optional treatment.
    a. Overdentures – Delta Dental will pay only the amount that it would pay for a conventional denture, if covered.
    b. Inlays, regardless of the material used – Delta Dental will pay only the amount that it would pay for an amalgam or composite resin restoration, if covered.
    c. Implant/abutment supported complete or partial dentures – Delta Dental will pay only the amount that it would pay for a conventional denture, if covered.
    d. Foil restorations – Delta Dental will pay only the amount that it would pay for an amalgam or composite restoration, if covered.

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

5. Core buildups and other substructures are payable only when needed to retain a crown on a tooth with excessive breakdown due to caries (decay) and/or fractures.
6. Retention pins are payable once in any two-year period. Only one substructure per tooth is a Covered Service.
7. Processing policies may otherwise exclude payment by Delta Dental for services or supplies.

Coordination of Benefits

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

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

Definitions

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

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

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

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

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

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

Order of Benefits Determination Rules

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are defined by Centers for Medicare & Medicaid Services (CMS)

Effect on the Benefits of This Plan

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

Right of Recovery

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

Coordination Disputes

If you believe that we have not paid a claim properly, you should first attempt to resolve the problem by contacting us. You or your Dentist should contact

Delta Dental's® Customer Service department and ask them to check the claim to make sure it was processed correctly. You may do this by calling the toll-free number, 800.330.2732, and speaking to a telephone advisor. You may also mail your inquiry to the Customer Service Department at:

Delta Dental®
Attention: Customer Service
P.O. Box 9230
Farmington Hills, MI 48333-9230

You may also follow the Grievance and Appeals Procedure below.

Grievance and Appeals Procedures

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

There are two types of appeals.

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

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

Send appeals to the following:

Method	**Appeals for Medical Care – Contact Information**
WRITE	Appeals Coordinator, MS 1150 Priority Health Medicare 1231 East Beltline Ave. NE Grand Rapids, MI 49525

Method	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

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

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

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

The notice of any adverse determination regarding your appeal will

a. inform you of the specific reason(s) for the denial,
b. list the pertinent Plan provision(s) on which the denial is based,

c. contain a description of any additional information or material that is needed to decide the claim and an explanation of why such information is needed,
d. reference any internal rule, guideline, or protocol that was relied on in making the decision on review.

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

If you have a complaint or dispute, other than a Notice of Denial of Coverage, expressing dissatisfaction with the manner in which Priority Health or a dentist has provided dental services, you can contact Priority Health at the address listed above in this section or call Customer Care at 888.389.6648 within 60 days of the event. Priority Health will respond in writing to all grievances within 30 days of receipt.

Termination of Coverage

Your Delta Dental® coverage may automatically terminate:

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

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

Delta Dental's® obligation for payment of Benefits ends on the last day of coverage. This date is usually the first of the month following receipt of a valid, written request to disenroll that was accepted by your plan during a valid Medicare election period. However, Delta Dental® will make payment for Covered Services provided on or before the last day of coverage, as long as Delta Dental® receives a claim for those services within one year of the date of service.

General Conditions

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

Subrogation and Right of Reimbursement – If Delta Dental® provides Benefits under This Plan and you have a right to recover damages from another, Delta Dental® is subrogated to that right.

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

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

Obtaining and Releasing Information – While you are enrolled in This Plan, you agree to provide Delta Dental® with any information it needs to process your claim and administer Benefits for you. This includes allowing Delta Dental® access to your dental records.

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

Loss of Eligibility During Treatment – If a Member loses eligibility while receiving dental treatment, only Covered Services received while that person was covered under This Plan will be payable.

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

Late Claims Submission – Delta Dental® will make no payment for services or supplies if a claim for such has not been received by Delta Dental® within one year following the date the services or supplies were completed. In the event that a Participating Provider submits a claim more than one year from the date of service, Delta Dental® will deny that portion of the claim that Delta

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

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

Actions – You cannot bring an action on a legal claim arising out of or related to this Member Handbook unless you have provided at least 60 days' written notice to Delta Dental®, unless prohibited by applicable state law. In addition, you cannot bring an action more than three years after the legal claim first arose or after expiration of the applicable statute of limitations, whichever is shorter. Any person seeking to do so will be deemed to have waived his or her right to bring suit on such legal claim. Except as set forth above, this provision does not preclude you from seeking a judicial decision or pursuing other available legal remedies.

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

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

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

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

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

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

ANTI-FRAUD TOLL-FREE HOTLINE:

800.524.0147

Hearing Services (Mandatory)

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

If you have any questions about your coverage, contact TruHearing® at 833.714.5356, Monday through Friday from 8 a.m. to 8 p.m. ET, TTY users should call 711. For assistance on Saturday or Sunday, call Priority Health Medicare at 888.389.6648 (TTY users should call 711), from Oct. 1 – Mar. 31, we're available from 8 a.m.– 8 p.m. ET. From Apr. 1 – Sept. 30, we're available Sat. 8 a.m.-noon ET. Or write TruHearing® at:

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

Do I have to use a TrueHearing Network Provider?

Yes, you must use a TruHearing® Network Provider for services to be covered at the in-network rate.

Finding a TrueHearing Network Provider

Call TruHearing® at 833.714.5356.

Do I Have to Call TrueHearing Before I See a TrueHearing Network Provider?

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

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

What If I Use a Non- TrueHearing Network Provider?

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

How Payment is Made to TruHearing® Network Providers

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

Grievance and Appeal Procedures

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

SUMMARY OF **MANDATORY** HEARING

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

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

Covered Services	**TruHearing® Network Provider Benefits (1)**	**Frequency**
Hearing exam (routine)	$0 copay	Once per calendar year
Hearing aids through TruHearing® limited to Standard, Advanced and Premium hearing aids, available in various styles and colors. To access your in-network benefits, call TruHearing® at 833.714.5356 Monday through Friday from 8 a.m. to 8 p.m. ET to schedule an appointment.	Standard aid: $399 copay per hearing aid Advanced aid: $599 copay per hearing aid Premium aid: $899 copay per hearing aid	Up to two hearing aids every calendar year (one per ear, per year)

Hearing aids:

- Standard aids: Devices with good hearing performance that include features such as wind and noise reduction (or similar).

- Advanced aids: Advanced devices equipped to handle challenging listening environments.
- Premium aids: Full-featured devices that offer top-of-the-line hearing in all listening environments.

Hearing aid purchases include:

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

Exclusions for MANDATORY hearing

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

Notice of Privacy Practices

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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Notice of Nondiscrimination

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 (ܣܘܪܝܝܐ) - ܫܡܝܥ ܗܘ ܕܐܢ ܐܢܬ ܡܬܟܠܡ ܐܢ ܐܬ ܠܫܢ ܣܘܪܝܝܐ، ܐܝܟ ܐܢ ܐܬ ܠܫܢ ܣܘܪܝܝܐ: ܫܝܪܘܬ ܕܥܕ ܠܐ ܚܠܦ ܐܝܬ ܠܟ

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

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

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

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

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

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

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

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

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

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

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

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