Priority Health



Summary of Benefits

Highly Integrated Dual Eligible Special Needs Plan

PriorityMedicare® Dual Premier (HMO D-SNP)

Jan. 1, 2027–Dec. 31, 2027



Introduction

This document is a brief summary of the benefits and services covered by **Priority**Medicare Dual Premier. It includes answers to frequently asked questions, important contact information, an overview of benefits and services offered, and information about your rights as a member of **Priority**Medicare Dual Premier. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

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A. Disclaimers

✓ This is a summary of health services covered by **Priority**Medicare Dual Premier for 2027. This is only a summary. Please read the *Member Handbook* for the full list of benefits. You can contact Customer Care at 833.939.0983 or visit ***priorityhealth.com/dual27*** for a copy of the *Member Handbook*.

✓ For more information about Medicare, you can read the 2027 Medicare & You handbook. It has a summary of Medicare benefits, rights, and protections and answers to the most frequently asked questions about Medicare. You can get it at the Medicare website (www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

✓ For more information about **Priority**Medicare Dual Premier, you can check the Michigan Medicaid website at www.michigan.gov/medicaid, the Beneficiary Help Line: 1-800-642-3195 or email at beneficiarysupport@michigan.gov, or the Michigan Healthcare Help Line: 1-855-789-5610 (TTY 1-866-501-5656) from 8:00 a.m. to 7:00 p.m., Monday through Friday (except holidays) michigan.gov/mibridges or contact the MICH Office of the Ombudsman for free help. The MICH Ombudsman can help you with questions about or problems with the MICH program or our plan. The MICH Ombudsman is an independent program and isn't connected with this plan. The phone number is 1-888-746-6456. You can also visit the MICH Ombudsman's website at www.meji.org/mhlo.

✓ For questions about or problems with the MI Coordinated Health program or our plan, contact the MI Community, Home, and Health Ombudsman (MI CHHO) for free help. MI CHHO is an independent program and isn't connected with this plan. Call 1-888-746-6456 or visit the MI CHHO website at meji.org/michho/mhlo. To schedule an appointment with a person-centered options counselor, please call MI Options at 1-800-803-7174 8 a.m. to 8 p.m., Monday through Friday.

✓ **You can get this document for free in other formats, such as large print, braille, or audio. Call 833.939.0983 (TTY: 711). From Oct. 1–Mar. 31, we're available seven days a week from 8 a.m.–8 p.m. ET. From Apr. 1–Sept. 30, we're available Mon.–Fri. from 8 a.m.–8 p.m. and Sat. 8 a.m.-Noon ET. The call is free.**

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

- Contact our Customer Care team by calling 833.939.0983 (TTY: 711). From Oct. 1–Mar. 31, we're available seven days a week from 8 a.m.–8 p.m. ET. From Apr. 1–Sept. 30, we're available Mon.–Fri. from 8 a.m.–8 p.m. and Sat. 8 a.m.-Noon ET.

- Create and log in to your member account at ***member.priorityhealth.com*** to send us a secure message.
- Send a written request to:
  Priority Health
  1231 East Beltline Ave. NE
  MS: 1175
  Grand Rapids, MI 49525

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

✓ **Priority**Medicare Dual Premier (HMO D-SNP) is a health plan that contracts with both Medicare and Michigan Medicaid to provide benefits of both programs to enrollees. Enrollment depends on contract renewal.

✓ Help with certain chronic conditions is part of a special supplemental benefit for chronically ill members with one of the following conditions: diabetes, chronic obstructive pulmonary disease (COPD), arrhythmias, depression, heart failure, prostate/breast/other cancers, and bipolar disorder. This is not a complete list of qualifying conditions. Even if you have a qualifying condition, you will not necessarily qualify to receive the benefit because coverage of the item or service depends on if you are chronically ill as defined by CMS and meet all applicable eligibility requirements. To see if you qualify, contact our Customer Care team by calling 833.939.0983 (TTY 711).

✓ One Pass is a voluntary program. The One Pass program varies by plan/area. Information provided is not medical advice. Consult a health care professional before beginning any exercise program. Out-of-network/non-contracted providers are under no obligation to treat Priority Health members, except in emergency situations. Please call our customer service number or see your Member Handbook for more information, including the cost-sharing that applies to out-of-network services.

 If you have questions, please call **Priority**Medicare Dual Premier at **833.939.0983** (TTY 711). From 10/1–3/31, we're available seven days a week from 8 a.m.–8 p.m. ET. From 4/1–9/30, we're available Mon.–Fri. from 8 a.m.–8 p.m. and Sat. 8 a.m.–noon ET. The call is free. For more information, visit ***priorityhealth.com/dual27***.

B. Frequently asked questions (FAQ)

The following table lists frequently asked questions.

Frequently asked questions	Answers
What's a highly integrated special needs plan called MI Coordinated Health (MICH)?	MI Coordinated Health is a highly integrated dual eligible (HIDE) special needs plan (SNP) that provides benefits of both Medicare and Medicaid to enrollees. It's for people with both Medicare and Michigan Medicaid. A HIDE SNP Plan is an organization made up of doctors, hospitals, pharmacies, providers of long-term services, and other providers. It also has Care Managers to help you manage your providers and services. They all work together to provide the care you need.
Will I get the same Medicare and Medicaid benefits in PriorityMedicare Dual Premier that I get now?	You'll get most of your covered Medicare and Medicaid benefits directly from **Priority**Medicare Dual Premier. You'll work with a team of providers who will help determine what services will best meet your needs. This means that some of the services you get now may change based on your needs, and your doctor and care manager assessment. You may also get other benefits outside of your health plan the same way you do now, directly from a State or county agency. When you enroll in **Priority**Medicare Dual Premier, you and your care manager will work together to develop a care plan to address your health and support needs, reflecting your personal preferences and goals. If you're taking any Medicare Part D drugs that **Priority**Medicare Dual Premier doesn't normally cover, you can get a temporary supply, and we'll help you to transition to another drug or get an exception for **Priority**Medicare Dual Premier to cover your drug if medically necessary. For more information, call Customer Care at the numbers in the footer of this document. If you're currently getting services for mental health, substance use, or intellectual/developmental disability needs, you'll continue to get these services the same way you do now. When you enroll in **Priority**Medicare Dual Premier, you and your care manager will work together to develop a care plan to address your health and support needs.

Frequently asked questions	Answers
Can I use the same doctors I use now?	This is often the case. If your providers (including doctors, hospitals, therapists, pharmacies, and other health care providers) work with **Priority**Medicare Dual Premier and have a contract with us, you can keep going to them. • Providers with an agreement with us are "in-network." Network providers participate in our plan. That means they accept members of our plan and provide services our plan covers. **You must use the providers in PriorityMedicare Dual Premier's network.** If you use providers or pharmacies that aren't in our network, the plan may not pay for these services or drugs. • If you need urgent or emergency care or out-of-area dialysis services, you can use providers outside of **Priority**Medicare Dual Premier's plan. You can keep using your doctors and getting your current services for up to 90 days, or 180 days depending on the service, while your Care Plan is being completed. If you're currently under treatment with a provider that's out of **Priority**Medicare Dual Premier's network or have an established relationship with a provider that's out of **Priority**Medicare Dual Premier's network, call Customer Care to check about staying connected. To find out if your providers are in the plan's network, call Customer Care at the number in the footer of this document or read **Priority**Medicare Dual Premier's Provider/Pharmacy directory on the plan's website at ***prioritymedicare.com***. If you need urgent or emergent care or out-of-area dialysis services, you can use providers outside of the **Priority**Medicare Dual Premier service area. If **Priority**Medicare Dual Premier is new for you, we'll work with you to develop a care plan to address your needs.

Frequently asked questions	Answers
What's a PriorityMedicare Dual Premier care manager?	A Care Manager is a health professional who will help you get care and services that affect your health and wellbeing. You're assigned a Care Manager when you enroll with **Priority**Medicare Dual Premier. Your Care Manager will get to know you and will work with you, your doctors, and other care givers to make sure everything is working together for you. You can share your health history with your Care Manager and set goals for healthy living. Whenever you have a question or a problem about your health or services or care you're getting from us, you can call your Care Manager. **Your Care Manager is your "go-to" person** for **Priority**Medicare Dual Premier. Our goal in **Priority**Medicare Dual Premier is to meet your needs in a way that works for you. This is why we call our program "person-centered". The person-centered planning process is when you work with your Care Manager to create a care plan that's about **your** goals, choices, and abilities. When you create your care plan, you're welcome to involve people you feel are key to your success, such as family members, friends, or legal representatives.
What are Long-term Services and Supports (LTSS)?	Long-term Services and Supports are help for people who need assistance to do everyday tasks like bathing, toileting, getting dressed, making food, and taking medicine. Most of these services are provided at your home or in your community but could be provided in a nursing home or hospital. In some cases, a county or other agency may administer these services, and your care manager or care team will work with that agency.
What happens if I need a service but no one in PriorityMedicare Dual Premier's network can provide it?	Most services will be provided by our network providers. If you need a service that can't be provided within our network, **Priority**Medicare Dual Premier will pay for the cost of an out-of-network provider.
Where's PriorityMedicare Dual Premier available?	The service area for this plan includes: Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, Macomb, St. Joseph, Van Buren, and Wayne counties in Michigan. You must live in this area to join the plan.

Frequently asked questions	Answers
What's prior authorization?	Prior authorization means an approval from **Priority**Medicare Dual Premier to seek services outside of our network or to get services not routinely covered by our network **before** you get the services. **Priority**Medicare Dual Premier may not cover the service, procedure, item, or drug if you don't get prior authorization. **If you need urgent or emergency care or out-of-area dialysis services, you don't need to get prior authorization first**. **Priority**Medicare Dual Premier can provide you or your provider with a list of services or procedures that require you to get prior authorization from **Priority**Medicare Dual Premier before the service is provided. Refer to **Chapter 3**, of the *Member Handbook* to learn more about prior authorization. Refer to the Benefits Chart in **Chapter 4** of the *Member Handbook* to learn which services require a prior authorization. If you have questions about whether prior authorization is required for specific services, procedures, items, or drugs, call Customer Care at the number in the footer of this document for help.
What's a referral?	A referral means that your primary care provider (PCP) must give you approval to go to someone that isn't your PCP. A referral is different than a prior authorization. If you don't get a referral from your PCP **Priority**Medicare Dual Premier may not cover the services. **Priority**Medicare Dual Premier can provide you with a list of services that require you to get a referral from your PCP before the service is provided. You don't need a referral for certain specialists, such as women's health specialists. Refer to the *Member Handbook* to learn more about when you'll need to get a referral from your PCP.
Do I pay a monthly amount (also called a premium) under PriorityMedicare Dual Premier?	No. Because you have Medicaid you won't pay any monthly premiums, including your Medicare Part B premium, for your health coverage. You'll be required to keep paying any monthly Freedom to Work program premium you have if applicable. If you have questions about the Freedom to Work program, contact your local Michigan Department of Health & Human Services (MDHHS) office. You can find contact information for your local MDHHS office by visiting www.michigan.gov/mdhhs/0,5885,7-339-73970_5461---,00.
Do I pay a deductible as a member of PriorityMedicare Dual Premier?	No. You don't pay deductibles in **Priority**Medicare Dual Premier.

Frequently asked questions	Answers
What's the maximum out-of-pocket amount that I'll pay for medical services as a member of PriorityMedicare Dual Premier?	There's no cost sharing for medical services in **Priority**Medicare Dual Premier, so your annual out-of-pocket costs will be $0.
What is covered during deeming?	When enrolled within this plan, you are allowed to remain enrolled for up to three (3) months after the loss of Medicaid eligibility. This period of time is referred to as "deeming," which gives you a chance to get your redetermination paperwork sorted out with your caseworker. If you lose your Michigan Medicaid eligibility but can be expected to regain it within 3 months, we'll continue to provide all Medicare Advantage plan-covered Medicare benefits during the "deeming" period. We will no longer provide Michigan Medicaid covered benefits once you lose your Michigan Medicaid eligibility. Your coverage changes during the "deeming" period. You may have cost-share for medical services and prescription drugs that Michigan Medicaid would have covered.

C. List of covered services

The following table is a quick overview of what services you may need, your costs, and rules about the benefits.

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need hospital care	Inpatient hospital stay	$0	Prior authorization may apply.
	Outpatient hospital services, including observation	$0	Prior authorization may apply.
	Ambulatory surgical center (ASC) services	$0	Prior authorization may apply.
	Doctor or surgeon care	$0	Prior authorization may apply.
You want a doctor	Visits to treat an injury or illness	$0	Prior authorization may apply.
	Care to keep you from getting sick, such as flu shots and screenings to check for cancer	$0	
	Wellness visits, such as a physical	$0	Because you are a member of this plan, you will not be charged for the office visit no matter how much is discussed. This is an opportunity for you and your physician to talk about any concerns or questions you may have. The exam includes measurement of height, weight, body mass index, blood pressure, visual acuity screening and other routine measurements.
	"Welcome to Medicare" (preventive visit one time only)	$0	
	Specialist care	$0	
	Services to help manage your disease	$0	Prior authorization may apply.
You need emergency care	Emergency room services	$0	Emergency room services will be provided in- or out-of-network without prior authorization requirements.
	Urgent care	$0	Urgent care services will be provided in- or out-of-network without prior authorization requirements.

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need medical tests	Diagnostic radiology services (for example, X-rays or other imaging services, such as CAT scans or MRIs)	$0	Prior authorization may apply.
	Lab tests and diagnostic procedures, such as blood work	$0	Prior authorization may apply.
	Screening tests, such as tests to check for cancer	$0	Prior authorization may apply.
You need hearing/ auditory services	Hearing screenings	$0	
	Hearing aid evaluation and fitting	$0	Hearing aid evaluations and fittings must be done by a TruHearing provider.
	Hearing aids	$0 copay for up to two (2) TruHearing branded 'Advanced' hearing aids, one per ear, every three years.	Routine hearing services and hearing aids must be received from a TruHearing® provider. Benefit is limited to TruHearing®-branded Advanced aids which come in various styles and colors. Hearing aid purchase includes: • Ear molds • First year of follow-up visits • 60-day trial period • 3-year extended warranty • Batteries
You need dental care (continued on next page)	Dental check-ups and preventive care	$0	Dental check-ups, exams, x-rays, cleanings, fillings, tooth extractions, dentures and partial dentures, sealants, indirect restorations (crowns), root canal therapy/re-treatment of previous root canal, comprehensive periodontal evaluation, scaling in presence of inflammation, periodontal scaling and root planning, and other periodontal maintenance. For more information, visit priorityhealth.com/michigan-medicaid/member. Prior authorization may apply.

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need dental care (continued)	Restorative and emergency dental care	$0	For more information, visit priorityhealth.com/michigan-medicaid/member. Prior authorization may apply.
You need eye care	Eye exams	$0	One comprehensive routine eye exam every 24 months.
	Glasses or contact lenses	$0	One pair of glasses every 24 months, eyeglass frame OR contact lenses every 24 months. For more information, visit priorityhealth.com/michigan-medicaid/member.
You need behavioral health services	Behavioral health services	$0	Behavioral health services are provided through the plan or by a program other than **Priority**Medicare Dual Premier. **Priority**Medicare Dual Premier Care Managers can assist you in obtaining those services and coordinate them with the rest of your health care needs. Prior authorization may apply.
	Inpatient and outpatient care and community-based services for people who need behavioral health services	$0	Specialty behavioral health care services may be provided by a program other than **Priority**Medicare Dual Premier. Your **Priority**Medicare Dual Premier Care Manager can assist you in obtaining those services and coordinate them with the rest of your health care needs. Prior authorization may apply.
You need substance use disorder services	Substance use disorder services	$0	Substance use disorder services may be provided by a program other than **Priority**Medicare Dual Premier. Your **Priority**Medicare Dual Premier Care Manager can assist you in obtaining those services and coordinate them with the rest of your health care needs. Prior authorization may apply.

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need a place to live with people available to help you	Skilled nursing care	$0	Prior authorization may apply.
	Nursing home care	A Patient Pay Amount (PPA) may be required	Services are only available to individuals who meet the Michigan Medicaid Nursing Facility Level of Care Determination standards. Prior authorization may apply.
	Adult Foster Care and Group Adult Foster Care	$0	Services are only available to individuals on the MICH 1915(C) waiver and coverage is limited to the personal care supplement. Prior authorization may apply.
You need therapy after a stroke or accident	Occupational, physical, or speech therapy	$0	Prior authorization may apply.
You need help getting to health services	Ambulance services	$0	Prior authorization may apply.
	Emergency transportation	$0	Prior authorization may apply.
	Transportation to medical appointments and services	$0	We provide transportation free of charge for doctor's visits, lab visits, non-emergency hospital services, prescription pick-up, dental services, and other covered services. In some cases, we may provide bus tokens or if you have your own vehicle or someone else to drive you, you can request mileage reimbursement.
You need drugs to treat your illness or condition (continued on next page)	Medicare Part B drugs	$0	Part B drugs include drugs given by your doctor in their office, some oral cancer drugs, and some drugs used with certain medical equipment. Read the *Member Handbook* for more information on these drugs. Prior authorization or step therapy may apply.

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need drugs to treat your illness or condition (continued)	Medicare Part D drugs	Copays for drugs may vary based on the level of Extra Help you get. Please contact the plan for more details.	There may be limitations on the types of drugs covered. Please refer to **Priority**Medicare Dual Premier's *List of Covered Drugs* (*Drug List*) for more information. Once you or others on your behalf pay $2,400 you've reached the catastrophic coverage stage, and you pay $0 for all your Medicare drugs. Read the *Member Handbook* for more information on this stage.
	Tier 1: Preferred generic	$0 copay for a 30-day supply	Extended-day supplies are available for tiers 1-4 at retail and mail order pharmacy locations. Tier 5 is limited to a 30-day supply. A three-month supply has the same cost share as a one-month supply.
	Tier 2: Generic	$0 copay for a 30-day supply	
	Tier 3: Preferred brand	$0-$14.40 copay for a 30-day supply	
	Tier 4: Non-preferred drug	$0-$14.40 copay for a 30-day supply	
	Tier 5: Specialty	$0-$14.40 copay for a 30-day supply	
	Medicaid-covered drugs and OTCs	$0	There may be limitations on the types of drugs covered. Please refer to **Priority**Medicare Dual Premier's *List of Covered Drugs* (*Drug List*) for more information.
You need help getting better or have special health needs	Rehabilitation services	$0	Prior authorization may apply.
	Medical equipment for home care	$0	Prior authorization may apply.
	Dialysis services	$0	
You need foot care	Podiatry services	$0	Includes routine visits, nail debridement and callous removals for all members (up to 6 total).
	Orthotic services	$0	Prior authorization may apply.

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need durable medical equipment (DME) **Note:** This isn't a complete list of covered DME. For a complete list, contact Customer Care or refer to **Chapter 4** of the *Member Handbook*.	Wheelchairs, crutches, and walkers	$0	Prior authorization may apply.
	Nebulizers	$0	Prior authorization may apply.
	Oxygen equipment and supplies	$0	Prior authorization may apply.
You need help living at home (continued on next page)	Home health services	$0	Prior authorization may apply.
	Activities of Daily Living (ADLs): Eating, toileting, bathing, grooming, dressing, mobility, and transferring and Instrumental Activities of Daily Living (IADLs): Personal laundry, light housekeeping, shopping, meal preparation and clean up, and medication administration.	$0	In-home ADL and IADL services requiring hands-on assistance are provided through the MICH program. These services are called State Plan Personal Care Services. In-home ADL and IADL services requiring prompting, cueing, guiding, teaching, observing, or reminding to complete Activities of Daily Living (ADLs) are available to individuals who qualify and are enrolled in the MICH 1915 (c) waiver. These services are called Expanded Community Living Supports. Prior authorization may apply.

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need help living at home (continued)	1915(c) Waiver Home and Community Based Services: Adaptive Medical Equipment and Supplies Adult Day Program Assistive Technology Chore Services Environmental Modifications Expanded Community Living Supports Fiscal Intermediary Home Delivered Meals Individual Directed Goods and Services Non-Medical Transportation Personal Emergency Response System Preventive Nursing Private Duty Nursing Respite Vehicle Modifications	$0	These services are designed to help individuals remain in their homes as opposed to receiving nursing home care. They are provided by the plan and are only available to individuals who meet nursing facility level of care, who have qualifying service need, and who are enrolled in the MICH 1915 (c) waiver. Prior authorization may apply.
Additional services (continued on next page)	Acupuncture	$0	6 routine acupuncture visits are covered per year.
	Caregiver Support	$0	Carallel's Care Advocates provide telephonic support and research on topics like health insurance, emotional support, stress management, housing and transportation, and guidance on financial matters and legal concerns. Carallel also offers online tools and resources that provide personalized support tailored to your unique situation.
	Chiropractic services	$0	Routine chiropractic care is covered under the Medicare portion of your plan. There is a limit of 24 routine visits per year. The Medicare portion of your plan covers one x-ray service once per year.

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
Additional services (continued)	Fitness (CogniFit®)	$0	Access to the CogniFit® brain health program. Simply set up an account through One Pass® to access a collection of brain games to keep you interested, challenged, and engaged. CogniFit® works by training over 20 cognitive skills that we use daily such as working memory, perception, attention, reasoning, and coordination.
	Diabetes supplies and services	$0	Diabetic test strips are limited to Contour® and Accu-Chek® Guide products when dispensed by a retail pharmacy or mail-order pharmacy. There are no brand limitations when obtained through a durable medical equipment (DME) provider.
	Fitness (One Pass®)	$0	One Pass® can help you reach your fitness goals while finding new passions along the way. Find a routine that's right for you whether you work out at home or at the gym. One Pass® includes: • Access to the largest nationwide network of gyms and fitness locations • Live, digital fitness classes and on-demand workouts • Online brain training to improve your memory and focus (see CogniFit® for more information)
	PriorityFlex	$0	Allowance can be used for over-the-counter (OTC) items, home and bathroom safety devices and modifications. $65 per month for Barry, Branch, Macomb, and Wayne counties. $66 per month for Berrien, Calhoun, Cass, Kalamazoo, St. Joseph, and Van Buren counties. Allowance does not roll over. Refer to Chapter 4 of your Member Handbook to learn more.

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
	Special supplemental benefits for the chronically ill (SSBCI)	Special supplemental benefits for the chronically ill (SSBCI) may be available for members who are chronically ill and meet the eligibility criteria to qualify for healthy food and produce, meal delivery, select utilities, personal care items, household supplies, and pest control services. To qualify for SSBCI benefits your treating provider will be asked to complete a SSBCI Provider Attestation form. The information submitted is used to help determine whether: You have one or more qualifying chronic conditions that are life-threatening or significantly limit your overall health or function; You are at high risk of hospitalization or other adverse health outcomes;You require intensive care coordination; and The SSBCI benefit has a reasonable expectation of improving or maintaining your health or overall function.	
	Prosthetic services	$0	Prior authorization may apply.
	Radiation therapy	$0	Prior authorization may apply.
	Services to help manage your disease	$0	Prior authorization may apply.
	Virtual Care	$0	Virtual visits with primary care, specialist, and behavioral health providers. Available 24/7, virtual visits let you see a provider for, and get treatment for, non-emergency care.

The above summary of benefits is provided for informational purposes only and isn't a complete list of benefits. For a complete list and more information about your benefits, you can read the **Priority**Medicare Dual Premier *Member Handbook*. If you don't have a *Member Handbook*, call **Priority**Medicare Dual Premier Customer Care at the number in the footer of this document to get one. If you have questions, you can also call Customer Care or visit prioritymedicare.com.

Notes

D. Benefits covered outside of **Priority**Medicare Dual Premier

There are some services that you can get that aren't covered by **Priority**Medicare Dual Premier but are covered by Medicare, Medicaid, or a State or county agency. This isn't a complete list. Call Customer Care at the number in the footer of this document to find out about these services.

Other services covered by Medicare, Medicaid, or a State Agency	Your costs
Specialty behavioral health services may be provided by Michigan's Prepaid Insurance Health Plans (PIHPs).	$0
Community Transition Services (CTS) are provided through MDHHS.	$0
Certain hospice care services covered outside of **Priority**Medicare Dual Premier	$0

E. Services that **Priority**Medicare Dual Premier, Medicare, and Medicaid don't cover

This isn't a complete list. Call Customer Care at the numbers in the footer of this document to find out about other excluded services.

Services **Priority**Medicare **Dual Premier, Medicare, and Medicaid don't cover**	
Services considered not "reasonable and medically necessary" according to Medicare and Michigan Medicaid standards, unless we list these as covered services	A private room in a hospital, except when medically necessary.
Experimental medical and surgical treatments, items, and drugs, unless Medicare, a Medicare-approved clinical research study, or our plan covers them. Refer to Chapter 3 of the *Member Handbook* for more information on clinical research studies. Experimental treatment and items are those that aren't generally accepted by the medical community.	Cosmetic surgery or other cosmetic work, unless it's needed because of an accidental injury to improve a part of the body that isn't shaped right. However, we pay for reconstruction of a breast after a mastectomy and for treating the other breast to match it.
Surgical treatments for morbid obesity, except when medically necessary and Medicare pays for it.	Private duty nurses except for those that qualify for the waiver service.

F. Your rights as a member of the plan

As a member of **Priority**Medicare Dual Premier, you have certain rights. You can exercise these rights without being punished. You can also use these rights without losing your health care services. We'll tell you about your rights at least once a year. For more information on your rights, please read the *Member Handbook*. Your rights include, but aren't limited to, the following:

You have a right to respect, fairness, and dignity. This includes the right to:

- Get covered services without concern about medical condition, health status, receipt of health services, claims experience, medical history, disability (including mental impairment), marital status, age, sex (including sex stereotypes and gender identity) sexual orientation, national origin, race, color, religion, creed, or public assistance
- Get information in other languages and formats (for example, large print, braille, or audio) free of charge
- Be free from any form of physical restraint or seclusion

You have the right to get information about your health care. This includes information on treatment and your treatment options. This information should be in a language and format you can understand. This includes the right to get information on:

- Description of the services we cover
- How to get services
- How much services will cost you
- Names of health care providers and care manager

You have the right to make decisions about your care, including refusing treatment. This includes the right to:

- Choose a primary care provider (PCP) and change your PCP at any time during the year
- Use a women's health care provider without a referral
- Get your covered services and drugs quickly
- Know about all treatment options, no matter what they cost or whether they're covered
- Refuse treatment, even if your health care provider advises against it
- Stop taking medicine, even if your health care provider advises against it
- Ask for a second opinion. **Priority**Medicare Dual Premier will pay for the cost of your second opinion visit
- Make your health care wishes known in an advance directive

You have the right to timely access to care that doesn't have any communication or physical access barriers. This includes the right to:

- Get timely medical care
- Get in and out of a health care provider's office. This means barrier-free access for people with disabilities, in accordance with the Americans with Disabilities Act
- Have interpreters to help with communication with your health care providers and your health plan

You have the right to seek emergency and urgent care when you need it. This means you have the right to:

- Get emergency services without prior authorization in an emergency
- Use an out-of-network urgent or emergency care provider, when necessary

You have a right to confidentiality and privacy. This includes the right to:

- Ask for and get a copy of your medical records in a way that you can understand and to ask for your records to be changed or corrected
- Have your personal health information kept private
- Have privacy during treatment

You have the right to make complaints about your covered services or care. This includes the right to:

- File a complaint or grievance against us or our providers
- Ask for a State Hearing
- Get a detailed reason for why services were denied

For more information about your rights, you can read the *Member Handbook*. If you have questions, you can call **Priority**Medicare Dual Premier Customer Care at the number listed in the footer of this document.

You can also call the special Ombudsman for people who have Medicare and Medicaid at 888.746.6456, Monday-Friday, 8 a.m. to 5 p.m., or the Michigan Long Term Care Ombudsman at 866.485.9393, Monday-Friday, 8 a.m. to 5 p.m.

G. How to file a complaint or appeal a denied service

If you have a complaint or think **Priority**Medicare Dual Premier should cover something we denied, call Customer Care at the number in the footer of this document. You may be able to appeal our decision.

For questions about complaints and appeals, you can read **Chapter 9** of the *Member Handbook*. You can also call **Priority**Medicare Dual Premier Customer Care at the number in the footer of this document.

If you prefer, you may also send us your grievance in writing to:
Priority Health Medicare Grievances
1231 East Beltline NE, MS 1150
Grand Rapids, MI 49525
- Fax: 616.975.8827

To start an appeal, you, your doctor, or your representative must contact us.
- Call us at 833.939.0983
- Write to us at:
  PH Appeals Analyst
  1231 East Beltline NE, MS 1150
  Grand Rapids, MI 49525
- Fax: 616.975.8827

H. What to do if you suspect fraud

Most health care professionals and organizations that provide services are honest. Unfortunately, there may be some who are dishonest.

If you think a doctor, hospital or other pharmacy is doing something wrong, please contact us.

- Call us at **Priority**Medicare Dual Premier Customer Care. Phone numbers are in the footer of this document.
- Or, call the Medicaid Customer Service Center at 517.241.3740 TTY users may call 844.578.6563.
- Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users may call 1-877-486-2048. You can call these numbers for free.
- Or, contact the Michigan Attorney General's Health Care Fraud Division Hotline by phone at (800) 24-ABUSE [800-242-2873], by e-mail at hcf@michigan.gov or use the on-line Michigan Medicaid Fraud Complaint Form found at secure.ag.state.mi.us/complaints/medicaid.aspx.

Pre-enrollment checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules.

If you have any questions, you can call and speak to a Medicare sales expert at 888.309.5082 from 8 a.m. to 8 p.m. ET, 7 days a week (TTY 711).

Understanding the Benefits

- The *Member Handbook* provides a full list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit ***prioritymedicare.com*** or call 888.309.5082 to view a copy of the *Member Handbook*.
- Review the provider directory (or ask your provider) to make sure the providers you see now are in network. If they are not listed, it means you will likely have to select a new doctor.
- Review the pharmacy directory to make sure the pharmacy you use is in network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- Review the approved drug list to make sure your drugs are covered.

Understanding Important Rules

- Rules, benefits, premiums and/or copayments/coinsurance may change on January 1, 2028.
- Except in emergency or urgent situations, we do not cover services by out-of-network providers.
- This plan is a highly integrated dual eligible special needs plan (HIDE SNP). Your ability to enroll will be based on verification that you are entitled to both Medicare and medical assistance from a state plan under full Medicaid.

Priority Health monthly plan premium for people who get Extra Help from Medicare to help pay for their prescription drug costs

If you get Extra Help from Medicare to pay for your Medicare prescription drug plan costs, your monthly plan premium will be lower than what it would be if you did not get Extra Help from Medicare.

If you get extra help, your monthly plan premium will be $0 for the plan below. (This does not include any Medicare Part B premium you may have to pay.)

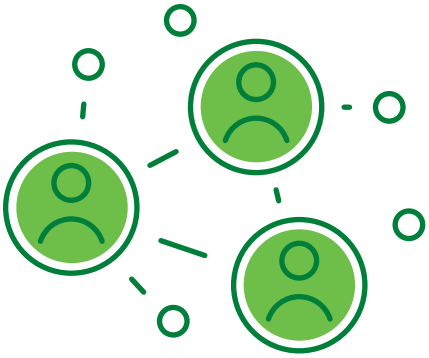
- **Priority**Medicare Dual Premier (HMO D-SNP)

PriorityMedicare Dual Premier's premium includes coverage for both medical services and prescription drug coverage.

If you aren't getting Extra Help, you can see if you qualify by calling:

- 1.800.Medicare or TTY users call 1.877.486.2048 (24 hours a day/7 days a week),
- Your State Medicaid Office, or
- The Social Security Administration at 1.800.772.1213. TTY users should call 1.800.325.0778 between 8 a.m. and 7 p.m., Monday through Friday.

If you have any questions, please contact our Customer Care team by calling 833.939.0983 (TTY 711). From Oct. 1–Mar. 31, we're available seven days a week from 8 a.m.–8 p.m. ET. From Apr. 1–Sept. 30, we're available Monday–Friday from 8 a.m.–8 p.m. and Saturday from 8 a.m.–noon ET. You can also log in to your member account at ***priorityhealth.com*** to send us a message.



Contact us

If you have general questions or questions about our plan, services, service area, billing, or Member ID Cards, please call Priority Medicare **Dual Premier Customer Care:**

833.939.0983
Calls to this number are free. From 10/1–3/31, we're available seven days a week from 8 a.m.–8 p.m. ET. From 4/1–9/30, we're available Mon.–Fri. from 8 a.m.–8 p.m. and Sat. 8 a.m.–noon ET. Customer Care also has free language interpreter services available for non-English speakers.

TTY 711
Calls to this number are free. From 10/1–3/31, we're available seven days a week from 8 a.m.–8 p.m. ET. From 4/1–9/30, we're available Mon.–Fri. from 8 a.m.–8 p.m. and Sat. 8 a.m.–noon ET.

If you have questions about your health:
Call your primary care provider (PCP). Follow your PCP's instructions for getting care when the office is closed.

If your PCP's office is closed, you can also call Priority Health's nurse advice line. A nurse will listen to your problem and tell you how to get care. The number for the nurse advice line is:
800.269.1260
Calls to this number are free and are available 24 hours a day, 7 days a week. **Priority**Medicare Dual Premier also has free language interpreter services available for non-English speakers.

TTY 711
Calls to this number are free and are available 24 hours a day, 7 days a week.

If you need immediate behavioral health care, please call the behavioral health department:

800.673.8043
Calls to this number are free and are available 24 hours a day, 7 days a week. **Priority**Medicare Dual Premier also has free language interpreter services available for non-English speakers.

TTY 711
Calls to this number are free. From 10/1–3/31, we're available seven days a week from 8 a.m.–8 p.m. ET. From 4/1–9/30, we're available Mon.–Fri. from 8 a.m.–8 p.m. and Sat. 8 a.m.–noon ET.



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