

**A Summary of Benefits Available Under Your  
PriorityMedicare<sup>SM</sup> Employer Group Plan**

# **PriorityMedicare<sup>SM</sup>**

## **Summary of Benefits for State of Michigan**

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Effective October 1, 2008 through September 30, 2009

Medicare Sales Phone Numbers:  
888 389-6676  
TTY/TDD 888 551-6761





## Section 1 - Introduction

### **Welcome!**

The following information is provided as a summary of benefits available under your State of Michigan **PriorityMedicare**<sup>SM</sup> plan. This summary is not intended as a substitute for your Evidence of Coverage (“EOC”). It is not a binding contract. Limitations and exclusions apply to benefits as listed below.

This Summary of Benefits tells you some features of the plan. It doesn't list every service we cover, every limitation, or every exclusion. To get a complete list of our benefits, please call **PriorityMedicare** and ask for the “Evidence of Coverage.”

### **Where is the State of Michigan PriorityMedicare plan available?**

The service area for this plan includes the following Michigan counties: Allegan, Antrim, Barry, Benzie, Crawford, Grand Traverse, Kalkaska, Kent, Leelanau, Manistee, Missaukee, Muskegon, Montcalm, Newaygo, Oceana, Osceola, Ottawa, Roscommon, and Wexford. Effective January 1, 2009, these counties will be added to the service area: Emmet, Hillsdale, Jackson, and Mecosta. You must live in one of these counties to join the plan.

### **Can I Choose My Doctors?**

**PriorityMedicare** has formed a network of doctors, specialists, and hospitals. You can use any doctor who is part of our network. The health providers in our network can change at any time. You can ask for a current Provider Directory for an up-to-date list. Our number is listed at the end of this introduction.

Please be advised: The **PriorityMedicare** network of providers is different than the Priority Health commercial network. Please refer to the **PriorityMedicare** Provider Directory for a list of participating doctors.

### **What Happens If I Go To A Doctor Who's Not In Your Network?**

If you choose to go to a doctor outside of our network, you must pay for these services yourself. Neither **PriorityMedicare** nor the Original Medicare Plan will pay for these services. For more information, please call the number at the end of this introduction.

### **Does My Plan Cover Medicare Part B Or Part D Drugs?**

**PriorityMedicare** covers both Medicare Part B prescription drugs and Part D prescription drugs.

### **Where Can I Get My Prescriptions If I Join This Plan?**

**PriorityMedicare** has formed a network of pharmacies. You can use any pharmacy in our network. In some cases, you may also go to pharmacies outside of our network. The pharmacies in our network can change at any time. You can ask for a current Pharmacy Network List. Our number is listed at the end of this introduction.

## **What Happens If I Go To A Pharmacy That's Not In Your Network?**

If you go to a pharmacy that's not in our network, you might have to pay more for your prescriptions. You also might have to follow special rules before getting your prescription in order for the prescription to be covered under our plan. For more information, call the telephone number at the end of this introduction.

## **What Is A Prescription Drug Formulary?**

**Priority**Medicare uses a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, or make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits our members' ability to fill their prescriptions, we will notify the affected enrollees before the change is made. We will send a formulary to you and you can see our complete formulary on our Web site at <http://www.priorityhealth.com/medicare08/druglist>.

If you are currently taking a drug that is not on our formulary or subject to additional requirements or limits, you may be able to get a temporary supply of the drug. You can contact us to request an exception or switch to an alternative drug listed on our formulary with your physician's help. Call us to see if you can get a temporary supply of the drug or for more details about our drug transition policy.

## **HOW CAN I GET EXTRA HELP WITH PRESCRIPTION DRUG PLAN COSTS?**

If you qualify for extra help with your Medicare prescription drug plan costs, your premium and costs at the pharmacy will be lower. When you join **Priority**Medicare Plus, Medicare will tell us how much extra help you are getting. Then we will let you know the amount you will pay. If you are not getting this extra help you can see if you qualify by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call this number 24 hours a day, 7 days a week.

## **What Are My Protections In This Plan?**

As a member of **Priority**Medicare, you have the right to request a coverage determination, which includes the right to request an exception, the right to file an appeal if we deny coverage for a prescription drug, and the right to file a grievance. You have the right to request a coverage determination if you want us to cover a Part D drug that you believe should be covered. An exception is a type of coverage determination. You may ask us for an exception if you believe you need a drug that is not on our list of covered drugs or believe you should get a non-preferred drug at a lower out-of-pocket cost. You can also ask for an exception to cost utilization rules, such as a limit on the quantity of a drug. If you think you need an exception, you should contact us before you try to fill your prescription at a pharmacy. Your doctor must provide a statement to support your exception request. If we deny coverage for your prescription drug(s), you have the right to appeal and ask us to review our decision. Finally, you have the right to file a grievance if you have any type of problem with us or one of our network pharmacies that does not involve coverage for a prescription drug.

## **What Is A Medication Therapy Management (MTM) Program?**

A Medication Therapy Management (MTM) Program is a free service we may offer. You may be invited to participate in a program designed for your specific health and pharmacy needs. You may decide not to participate, but it is recommended that you take full advantage of this covered service if you are selected. Contact **PriorityMedicare** for more details.

## **What If I Have Additional Questions?**

Please call us with questions related to the State of Michigan **PriorityMedicare** plan:

616 464-8850 or toll-free 888 389-6676  
TTY/TDD 616 464-8485 or toll-free 888 551-6761

### **Medicare Sales Hours:**

Monday – Friday, 8:30 a.m. – 5:00 p.m.

Or, visit us on the Web at *[priorityhealth.com/medicare](http://priorityhealth.com/medicare)*

For more information about Medicare, please call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week. Or visit [www.medicare.gov](http://www.medicare.gov) on the web.

If you have special needs, this document may be available in other formats.

## Section 2 – Summary of Benefits for State of Michigan PriorityMedicare

*October 1, 2008 through September 30, 2009*

**Prior Authorization:** Your Primary Care Provider (PCP) will coordinate prior authorization of your services under the HMO benefits of this plan. Services requiring prior authorization are:

- All elective admissions, including mental health or substance abuse services.
- Home health care and parenteral/enteral feedings
- Skilled nursing home facility and inpatient rehabilitation care
- Transplants and transplant evaluations
- Certain non-emergent outpatient radiology services: MRI, MRA, CT and PET scans
- Medical weight loss programs and surgery for obesity treatment
- Durable Medical Equipment (DME) over \$1,000 and all DME rentals
- Prosthetics and orthotics over \$1,000
- Infusion pumps (implantable and external)
- Non-emergent ambulance transportation
- Deep brain stimulation
- Automatic implantable cardioverter defibrillator (AICD)
- Radiofrequency catheter ablation for cardiac arrhythmia
- Stereotactic radiotherapy
- Nuclear cardiology
- Certain oral surgery services
- Certain injectable drugs
- All cosmetic and reconstructive surgery
- Experimental or investigational services
- Outpatient substance abuse services

Benefits	HMO Benefits
<b>Deductibles</b>	No deductible.
<b>Out-of-Pocket Maximums</b>	Not applicable.
<b>Maximum Individual Lifetime Benefit</b>	Not applicable.
<b>Other Important Information</b>	<p>You must elect a Primary Care Provider (PCP). You must coordinate all your care through your PCP and receive prior authorization from <b>PriorityMedicare</b> when required in order to receive HMO benefits.</p> <p><b>This plan replaces your current Medicare Part A &amp; B coverage. You must continue to pay the Medicare Part B premium each month.</b></p>
<b>Fee Schedules</b>	Benefits are covered at the Medicare published fee schedule (or at PriorityMedicare’s negotiated fee schedules, when applicable).
<b>Doctor and Hospital Choice</b> <b>(For more information, see Emergency and Urgently Needed Care below.)</b>	<p>No referral required for doctors, specialists, and hospitals. If you choose to go to a doctor outside of our network, you must pay for these services yourself. Neither PriorityMedicare nor the Original Medicare Plan will pay for these services.</p> <p>You may have to pay a separate copay for certain doctor office visits.</p>

Benefits	HMO Benefits
<p><b>Inpatient Hospital Care</b> (includes Rehabilitation Services) (includes related facility charges) Except in an emergency, prior authorization is required.</p>	<p>100% coverage for Inpatient Hospital services received at a network hospital.  Except in an emergency, you or your provider must obtain authorization from <b>Priority</b>Medicare.</p>
<p><b>Inpatient Mental Health</b> (Except in an emergency, your provider must obtain authorization from Priority Health.)  Contact the Behavioral Health Department at 616 464-8500 or 800 673-8043 to prior authorize services.</p>	<p>100% coverage.  Medicare beneficiaries may only receive 190 days in a Psychiatric Hospital in a lifetime.</p>
<p><b>Inpatient Substance Abuse</b> (Includes related facility charges.) Except in an emergency, your provider must obtain authorization from <b>Priority</b>Medicare.  Contact the Behavioral Health Department at 616 464-8500 or 800 673-8043 to prior authorize services.</p>	<p>100% coverage.</p>

Benefits	HMO Benefits
<p><b>Skilled Nursing Facility (SNF) or Inpatient Rehabilitation Care</b> (in a Medicare-certified skilled nursing facility)</p> <p>Authorization rules may apply for services. Contact plan for details.</p>	<p>100% coverage.</p> <p>Maximum of 730 days per Lifetime (combined benefit for all services).</p>
<p><b>Home Health Services</b> (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)</p> <p>Authorization rules may apply for services. Contact plan for details.</p>	<p>100% covered for Medicare-covered home health visits.</p>
<p><b>Hospice Care</b></p>	<p>When you enroll in a Medicare-certified hospice, your hospice services are paid by Original Medicare. Care in a non-Medicare certified hospice is not covered.</p>

Benefits	HMO Benefits
<p><b>Doctor Office Visits</b></p> <p>See "Routine Physical Exams," for more information.</p>	<p>You pay \$10 for each primary care doctor office visit or specialist visit for Medicare-covered services.</p>
<p><b>Chiropractic Services</b></p> <p>Coverage is for manual manipulation of the spine only. Services must be provided by a chiropractor or other qualified provider for the purposes of correcting subluxation. Routine care not covered.</p>	<p>You pay \$10 for each Medicare-covered visit.</p>
<p><b>Podiatry Services</b> (Medically necessary foot care, including care for medical conditions affecting the lower limbs.)</p> <p>Routine care not covered.</p>	<p>100% coverage. (Office visit copayment may apply.)</p>
<p><b>Allergy Services</b></p>	<p>100% coverage.</p>
<p><b>Outpatient Mental Health Services</b></p>	<p>For Medicare-covered Mental Health services, you pay \$10 for each visit.</p>
<p><b>Partial Hospitalization Mental Health Services</b></p> <p>Authorization rules may apply.</p>	<p>100% coverage.</p>
<p><b>Outpatient Substance Abuse Services</b></p> <p>Authorization rules may apply for services. Contact plan for details.</p>	<p>For Medicare-covered Mental Health services, you pay \$10 for each visit.</p>

Benefits	HMO Benefits
<p><b>Partial Hospitalization Substance Abuse Services</b> (Includes related facility charges)</p> <p>Authorization rules may apply for certain services. Contact plan for details.</p>	<p>100% coverage.</p>
<p><b>Outpatient Services/Surgery</b> Authorization rules may apply for certain services. Contact plan for details.</p>	<p>100% coverage.</p>
<p><b>Ambulance Services</b> (Medically necessary ambulance services.)</p>	<p>100% coverage.</p>
<p><b>Emergency Care</b></p> <p>Worldwide coverage.</p> <p>(You may go to any emergency room if you reasonably believe you need emergency care.)</p>	<p>You pay \$50 for each emergency room visit; you do not pay this amount if you are admitted to the hospital within 24 hours for the same condition.</p>
<p><b>Urgently Needed Care</b></p> <p>(This is NOT emergency care, and in most cases, is out of the service area.)</p>	<p>You pay \$10 for each Medicare-covered urgently needed care visit. You do not pay this amount if you are admitted to the hospital within 24 hours for the same condition.</p>
<p><b>Outpatient Rehabilitation Services</b> (Occupational Therapy, Physical Therapy, Speech, and Language Therapy, and Cardiac Therapy)</p>	<p>You pay \$10 for each covered visit up to a maximum out of pocket of \$200 per coverage period for physical, speech, and occupational therapy.</p> <p>You pay \$0 for cardiac therapy.</p>

<b>Benefits</b>	<b>HMO Benefits</b>
<p><b>Durable Medical Equipment</b> (Includes wheelchairs, oxygen, etc.)</p> <p>Authorization rules apply for purchases over \$1,000 and all rentals. Contact plan for details.</p>	<p>100% coverage.</p>
<p><b>Prosthetic &amp; Orthotic/Support Devices</b></p> <p>(includes braces, artificial limbs and eyes, etc.)</p> <p>Authorization rules apply for purchases over \$1,000 and all rentals. Contact plan for details.</p>	<p>100% coverage.</p>
<p><b>Diabetes Self-Monitoring, Training and Supplies</b></p> <p>(includes coverage for glucose monitors, test strips, lancets, screening tests, and self-management training)</p>	<p>100% coverage.</p>
<p><b>Diagnostic Tests, X-Rays, and Lab Services</b></p> <p>Authorization rules may apply for services. Contact plan for details.</p>	<p>100% coverage.</p>
<p><b>Imaging Services— (Includes MRI, MRA, CT Scans, PET Scans and Nuclear Cardiac Studies)</b></p> <p>Prior authorization required for non-emergent outpatient services. Contact plan for details</p>	<p>100% coverage.</p>

Benefits	HMO Benefits
<b>Bone Mass Measurement</b> (for people with Medicare who are at risk)	100% coverage.
<b>Colorectal Screening</b> (for people with Medicare age 50 and older or when you are high risk)	100% coverage.  The office visit copayment may apply.
<b>Immunizations</b> (Flu vaccine, Hepatitis B vaccine - for people with Medicare who are at risk, and pneumonia vaccine)	100% coverage.
<b>Mammograms - Annual Screening</b> (for all women with Medicare age 40 and older. One baseline mammogram covered for women with Medicare between age 35 and 39.)	100% coverage.
<b>Routine Pap Smears and Pelvic Exams</b> (for women with Medicare)	100% coverage.  The office visit copayment may apply.
<b>Prostate Cancer Screening Exams</b>  (covered once a year for men with Medicare age 50 and older)	100% coverage for Medicare-covered prostate cancer screening.
<b>Hemodialysis/End Stage Renal Diseases (ESRD)</b>	100% coverage.

Benefits	HMO Benefits
<b>Infertility Counseling &amp; Treatment</b> Limitations and exclusions apply.	80% coverage.  Office visit copay may apply.
<b>Vasectomy</b> Covered only when performed in a Physician's office or when in connection with other covered inpatient or outpatient surgery.	100% coverage.
<b>Tubal Ligation</b> (See below)	
<u>Physician service</u>	100% coverage.
<u>Outpatient facility services</u>	100% coverage.
<u>Inpatient facility charges</u>  (covered only when in connection with delivery or other covered inpatient surgery)	100% coverage.

Benefits	HMO Benefits
<p><b>Dental Services</b> Prior authorization applies.</p> <p>Preventive dental services (such as cleaning) not covered.</p>	<p>In general, you pay 100% for dental services.</p>
<p><b>Temporomandibular Joint Syndrome (TMJS) Treatment</b></p>	<p>80% coverage.</p>
<p><b>Orthognathic Treatment</b></p>	<p>80% coverage.</p>
<p><b>Certain Oral Surgery Services</b> Prior authorization applies. Limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease, or services that would be covered when provided by a doctor.</p>	<p>100% coverage.</p>

Benefits	HMO Benefits
<b>Hearing Services</b>	<p>100% coverage for routine hearing tests, including diagnostic hearing exams.</p> <p>You are covered for up to \$500 for hearing aids/hearing aid services every three years.</p>
<b>Vision Services</b>	<p>You pay \$10 for each eye exam for diagnosis and treatment of diseases and conditions of the eye.</p> <p>100% coverage for one pair of Medicare covered eyeglasses or contact lenses after each cataract surgery.</p> <p>You pay 100% for routine eye exams and glasses or contact lenses.</p> <p>Annual glaucoma screenings covered for people at risk.</p>
<b>Physical Examinations</b>	<p>You pay \$10 for each exam.</p> <p>You are covered up to 1 exam every year.</p>

Benefits	HMO Benefits
<p><b>Drugs covered under Part B (original Medicare)</b></p> <p>“Drugs” includes substances that are naturally present in the body, such as blood-clotting factors. Covered drugs include, but aren’t limited to, the following:</p> <ul style="list-style-type: none"> <li>• Drugs that usually aren’t self-administered by the patient and are injected while you are getting physician services.</li> <li>• Drugs you take using durable medical equipment (such as nebulizers) that was authorized by the plan.</li> <li>• Clotting factors you give yourself by injection if you have hemophilia.</li> <li>• Immunosuppressive drugs, if you have had an organ transplant that was covered by Medicare.</li> <li>• Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug.</li> <li>• Antigens.</li> <li>• Certain oral anti-cancer drugs and anti-nausea drugs.</li> <li>• Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, Erythropoietin (Epogen®) or Epoetin alfa, and Darboetin Alfa (Aranesp®).</li> <li>• Intravenous Immune Globulin for the treatment of primary immune deficiency diseases in your home.</li> </ul>	<p>100% covered for the cost for Part B-covered chemotherapy drugs.</p> <p><b>Other Part B drugs:</b></p> <p>Obtained in Plan Provider’s Office</p> <ul style="list-style-type: none"> <li>• You pay \$0 for each of these Medicare covered drugs. Office visit copayment may apply.</li> </ul> <p>Obtained in a Plan Pharmacy or Plan Mail Order Service:</p> <ul style="list-style-type: none"> <li>• You pay 20% co-insurance</li> </ul>

## Benefits

### Drugs Covered Under Medicare Part D Prescription Drug Benefit

This plan uses a formulary. A formulary is a preferred list of drugs selected to meet patient needs at a lower cost. If the formulary changes (and the change applies to you), you will be notified, in writing, before the change. For additional information about the drug formulary contact **PriorityMedicare**.

Different out-of-pocket costs may apply for people who

- have limited incomes,
- live in long term care facilities, or
- have access to Indian/Tribal/Urban (Indian Health Service).

The plan offers national in-network prescription coverage. This means that you will pay the same amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel).

Total coverage period drug costs are the total drug costs paid by both you and the plan.

The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.

Some drugs have quantity limits.

Your provider must get prior authorization from **PriorityMedicare** for certain drugs.

The plan will pay for certain over-the-counter drugs as part of its utilization management program. Some over-the-counter drugs are less expensive than prescription drugs and work just as well. Contact the plan for details.

If the actual cost of a drug is less than the normal copay amount for that drug, you will pay the actual cost, not the higher copay amount.

### In Network

- \$0 deductible.

#### Basic Coverage

Before your coverage period out-of-pocket drug costs reach \$4,050 for Medicare Part D Drugs:

#### Retail Pharmacy:

- \$5 copay for a one-month (31-day) supply of generic drugs.
- \$15 copay for a three-month (90-day) supply of generic drugs.
- \$10 copay for a one-month (31-day) supply of Brand drugs.
- \$30 copay for a three-month (90-day) supply of Brand drugs.

#### Long-Term Care Pharmacy:

- \$5 copay for a one-month (31-day) supply of generic drugs
- \$10 for a one-month (31-day) supply of Brand drugs.

#### Mail Order Pharmacy:

- \$5 copay for a three-month (90-day) supply of Generic drugs.
- \$10 copay for a three-month (90-day) supply of Brand drugs.

## Benefits

### Drugs Covered Under Medicare Part D Prescription Drug Benefit (continued)

#### Catastrophic Coverage

After your coverage period out-of-pocket drug costs reach \$4,050 for Medicare Part D Drugs:

#### Retail Pharmacy:

- For Generic drugs (including brand drugs treated as generic) for a one-month (31-day) supply, you pay the greater of \$2.25 copay **or** 5% coinsurance up to a maximum of \$5
- For Generic drugs (including brand drugs treated as generic) for a three-month (90-day) supply, you pay the greater of \$2.25 copay **or** 5% coinsurance up to a maximum of \$15
- For all other drugs for a one-month (31-day) supply, you pay the greater of \$5.60 copay **or** 5% coinsurance up to a maximum of \$10
- For all other drugs for a three-month (90-day) supply, you pay the greater of \$5.60 copay **or** 5% coinsurance up to a maximum of \$30

#### Mail Order Pharmacy:

- For Generic drugs (including brand drugs treated as generic) for a three-month (90-day) supply, you pay the greater of \$2.25 copay **or** 5% coinsurance up to a maximum of \$5
- For all other drugs for a three-month (90-day) supply, you pay the greater of \$5.60 copay **or** 5% coinsurance up to a maximum of \$10

**Benefits**

**Prescription Drug Benefits, continued**

**Drugs Covered  
Under Medicare Part D Prescription Drug Benefit**

**Out-of-Network**

Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may pay more than the copay if you get your drugs at an out-of-network pharmacy.



