PriorityHealth

Summary of benefits

PriorityMedicare[SM] (Employer HMO-POS)

Michigan Public School Employees Retirement System

January 1, 2018 – December 31, 2018

NCMS_1000_1099_1824Y 09122017 Basic

Priority Health has HMO-POS and PPO plans with a Medicare contract.
Enrollment in Priority Health Medicare depends on contract renewal.

This booklet gives you a summary of the benefits you can expect when you choose a **Priority**Medicare (Employer HMO-POS) plan. Inside you'll find information you can use to make a Medicare decision you'll feel good about.

Please note that this is just a summary of the plans' benefits; it doesn't list every service we cover or list every limitation or exclusion. To get a complete list of services we cover including any limitations or exclusions, review the Evidence of Coverage document available online at *priorityhealth.com/mpsers* or by calling our customer service number. For additional information, call us at 888.389.6648, option 3 (TTY users should call 711).

Introduction

HMO-POS stands for Health Maintenance Organization (HMO) and Point of Service (POS). With this plan you can use providers in our network and pay less for services. The POS portion allows you to use out-of-network providers both within Michigan and across the United States, but you may pay more for these out-of-network services. You'll choose a primary care physician (PCP) to coordinate all your care. You typically don't need a referral to see a specialist, but your doctor can sometimes help you get in to see one more quickly.

Prescription coverage

This employer group plan includes prescription drug coverage. You'll want to review our *Provider/Pharmacy Directory* because you generally need to use network pharmacies to fill your prescriptions for covered Part D drugs. You can also find pharmacies near you that are part of our preferred pharmacy network to save more on your prescriptions. You will also want to review our formulary or the list of drugs our plan covers. You can find both of these documents on our website at *priorityhealth.com/mpsers* or call our customer service number.

Eligibility

To join **Priority**Medicare (Employer HMO-POS), you must be entitled to Medicare Part A and be enrolled in Medicare Part B.

Contact us

If you have questions, call one of our Priority Health Medicare experts at 888.389.6648, option 3, from 8 a.m. to 8 p.m., seven days a week (TTY users call 711):

Email us anytime. Visit *priorityhealth.com/mpsers* and click on Contact Us to send a secure email.

Visit *priorityhealth.com/mpsers* and learn more about our plans and how Medicare works.

Another resource available to you when researching your Medicare options is the *2018 Medicare & You* handbook. View it online at *medicare.gov* or get a copy by calling 800.MEDICARE (800.633.4227), 24 hours a day, seven days a week. TTY users should call 877.486.2048.

Benefit	**Priority**Medicare (Employer HMO-POS)
MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES	
Monthly plan premium	In addition to the Medicare Part B premium, you may be required to pay a premium contribution as defined by your employer or union group. Ask your benefits plan administrator for details.
Deductible What you pay each year for some in-network and out-of-network medical services or Part D prescription drugs before you pay a copayment ($) or coinsurance (%). Your medical and Part D prescription drug deductible are separate amounts.	**Medical services** In-network (HMO): $250 Out-of-network (POS): $500 **Prescription drugs (Part D)** Tiers 1-5: $0 (you do not have a deductible).
Maximum out-of-pocket responsibility *(does not include prescription drugs)* The most you pay for covered medical services for the year.	In-network (HMO): $2,100 Out-of-network (POS): $3,000
Lifetime maximum for out-of-network (POS) medical services.	There is a limit to how much we will pay for your out-of-network (POS) health care services in your lifetime. Your lifetime maximum benefit is $1,000,000 for covered services. After you reach this level, you will pay 100% for out-of-network (POS) services with the exception of ambulance, emergency care, urgently needed care, and post stabilization care.
Inpatient hospital care We cover an unlimited number of days for inpatient hospital stay. Prior authorization may be required.	In-network (HMO): 10% for each stay Out-of-network (POS): 30% for each stay

Benefit	**Priority**Medicare (Employer HMO-POS)
Outpatient hospital coverage Prior authorization may be required.	**Ambulatory surgical center** In-network (HMO): 10% for each visit Out-of-network (POS): 30% for each visit **Outpatient hospital** In-network (HMO): • $0 for each observation visit • 10% for each outpatient hospital visit Out-of-network (POS): 30% for each visit
Doctor visits Prior authorization may be required for some specialist visits.	**Primary care physician visit** In-network (HMO): • $0 for surgical procedures performed in a PCP's office • $20 for each office visit Out-of-network (POS): 30% for each visit **Specialist visit** In-network (HMO): • $0 for surgical procedures performed in a specialist's office • $35 for each office visit Out-of-network (POS): 30% for each visit
Preventive care Any additional preventive services approved by Medicare during the contract year will be covered. A referral from your doctor may be required for some preventive services.	In-network (HMO): $0 for each visit Out-of-network (POS): 30% for each visit
Emergency care This amount is waived if you are admitted as inpatient to the hospital within 24 hours from your emergency care visit.	In-network (HMO) or out-of-network (POS): $75 for each visit

Benefit	**Priority**Medicare (Employer HMO-POS)
Urgently needed services This amount is waived if you are admitted as inpatient to the hospital within 24 hours from your urgent care visit.	In-network (HMO) or out-of-network (POS): $45 for each visit
Outpatient diagnostic services (labs, radiology/imaging and x-rays) This includes what you pay for radiology/imaging services such as a CT scan or MRI, tests/procedures, lab services, outpatient x-rays and radiation therapy. Prior authorization may be required for some services. Please contact the plan for more information.	**Radiology/imaging services** In-network (HMO): $150 for each service Out-of-network (POS): 30% for each service **Tests/procedures** In-network (HMO): 10% for each service Out-of-network (POS): 30% for each service **Lab services** In-network (HMO): 10% for each service Out-of-network (POS): 30% for each service **Outpatient x-rays** In-network (HMO): 10% for each service Out-of-network (POS): 30% for each service **Radiation therapy** In-network (HMO): 10% for each service Out-of-network (POS): 30% for each service
Hearing services Diagnostic hearing services are administered by Priority Health providers. Routine hearing services are administered through TruHearing. Call 855-205-6382 to locate a TruHearing provider and to schedule an appointment for a hearing exam or to discuss hearing aids.	**Medicare-covered diagnostic hearing services** In-network (HMO): $0 for each visit Out-of-network (POS): 30% for each visit **Routine hearing services** *Exam* In-network: $0 for one exam every 2 years Out-of-network: Not covered *Hearing aids* In-network: You pay $499 per ear for an advanced-level hearing aid or $799 per ear for a premium-level hearing aid each plan year. Out-of-network: Not covered

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Vision services	**Medicare-covered vision services** In-network (HMO): • $0 for a yearly glaucoma screening • $0 for eyeglasses or contact lenses after cataract surgery • $35 for each exam to diagnose and treat diseases and conditions of the eye Out-of-network (POS): 30% for each visit or service
Mental health care We cover up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. Prior authorization may be required.	**Inpatient visit** In-network (HMO): 10% for each stay Out-of-network (POS): 30% for each stay **Outpatient group therapy visit** In-network (HMO): $20 for each visit Out-of-network (POS): 30% for each visit **Outpatient individual therapy visit** In-network (HMO): $20 for each visit Out-of-network (POS): 30% for each visit
Skilled nursing facility (SNF) Prior authorization may be required.	In-network (HMO): 10% for each stay *Limited to 100 days each benefit period, renewable after 60 days of non-confinement* Out-of-network (POS): 30% for each stay *Limited to 45 days each benefit period, renewable after 60 days of non-confinement*
Rehabilitation services	**Occupational therapy visit** In-network (HMO): $35 for each visit Out-of-network (POS): 30% for each visit **Physical therapy and speech and language therapy visit** In-network (HMO): $35 for each visit Out-of-network (POS): 30% for each visit *Limited to 60 visits each plan year for out-of-network occupational, physical, and speech and language therapy visits*

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Ambulance Prior authorization may be required.	In-network (HMO) or out-of-network (POS): $100 for each trip
Transportation	Not covered
Foot Care *(podiatry services)* Foot exams or medical/surgical treatment of injuries and diseases of the feet. Routine foot care is covered if you meet certain conditions.	In-network (HMO): $0 for each visit Out-of-network (POS): 30% for each visit
Medical equipment and supplies Examples include diabetic supplies (shoes/inserts, diabetic test strips), durable medical equipment (wheelchairs, oxygen, insulin pumps), and prosthetic devices (braces, artificial limbs). Diabetic test strips are limited to One Touch (JJHCS) and Breeze/Contour (Bayer) products when dispensed by a retail pharmacy or mail order pharmacy. Prior authorization may be required.	**Diabetes supplies** In-network (HMO): $0 for each item Out-of-network (POS): 30% for each item **Durable medical equipment** In-network (HMO): 20% for each item Out-of-network (POS): 50% for each item **Prosthetic devices** In-network (HMO): 0-20% for each item, depending on the device Out-of-network (POS): 50% for each device

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Wellness (fitness) program	$0 for a fitness membership at a participating Silver&Fit® fitness center or for up to two home fitness kits with the Silver&Fit home fitness program. **More about the Silver&Fit® Exercise and Healthy Aging Program** The Silver&Fit program has locations nationwide. For more information on fitness centers, or if you prefer to participate in the home fitness program, visit *SilverandFit.com* and register to use the website. To find a participating fitness center go to Find a Fitness Facility and search for one near you on the website. You may also call toll-free 888.894.0525 (TTY 711), Monday through Friday, 8 a.m. to 9 p.m., to enroll in the program. *The Silver&Fit program is provided by American Specialty Health Fitness, Inc., a subsidiary of American Specialty Health Incorporated (ASH). All programs and services are not available in all areas. Silver&Fit is a federally registered trademarks of ASH.*
PRESCRIPTION DRUG BENEFITS	
Medicare Part B drugs Prior authorization may be required.	**Chemotherapy drugs** In-network (HMO): $0 for each drug Out-of-network (POS): $0 for each drug **Other Part B drugs, obtained in a provider setting** In-network (HMO): 10% for each drug Out-of-network (POS): 30% for each drug **Other Part B drugs, obtained in a pharmacy or by mail order** In-network (HMO): 20% for each drug Out-of-network (POS): 20% for each drug **Home infusion drugs** In-network (HMO): $0 for each drug Out-of-network (POS): 30% for each drug

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PART D OUTPATIENT PRESCRIPTION DRUG			
Deductible stage	Tiers 1-5: $0 (you do not have a deductible)		
Initial coverage stage	You are in this stage until your drug total reaches $3,750, which includes what you pay out-of-pocket & what we pay for your covered drugs.		
PREFERRED RETAIL PHARMACY COST-SHARING			
Initial coverage stage	**One-month supply**	**Two-month supply**	**Three-month supply**
Tier 1 (preferred generic)	$9	$18	$27
Tier 2 (generic)	$9	$18	$27
Tier 3 (preferred brand)	$40	$80	$120
Tier 4 (non-preferred)	$70	$140	$210
Tier 5 (specialty tier)	20% up to a $100 maximum	Not offered	Not offered
Your costs will be less for your covered drugs when you use a pharmacy in our preferred network (includes Meijer, Walgreens, Wal-Mart, Rite Aid, Family Fare Supermarkets, Costco and more), go to *priorityhealth.com/mpsers* to view the list in the *2018 Provider/Pharmacy Directory*.			
STANDARD RETAIL PHARMACY COST-SHARING			
Initial coverage stage	**One-month supply**	**Two-month supply**	**Three-month supply**
Tier 1 (preferred generic)	$15	$30	$45
Tier 2 (generic)	$15	$30	$45
Tier 3 (preferred brand)	$45	$90	$135
Tier 4 (non-preferred)	$75	$150	$225
Tier 5 (specialty tier)	20% up to a $100 maximum	Not offered	Not offered
MAIL ORDER COST-SHARING			
Initial coverage stage	**One-month supply**	**Two-month supply**	**Three-month supply**
Tier 1 (preferred generic)	$9	$18	$18
Tier 2 (generic)	$9	$18	$18
Tier 3 (preferred brand)	$40	$80	$80
Tier 4 (non-preferred)	$70	$140	$140
Tier 5 (specialty tier)	20% up to a $100 maximum	Not offered	Not offered

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Coverage gap stage (also known as the "donut hole")	Once the total yearly drug cost (what you've paid plus what we've paid) reaches $3,750 you enter the coverage gap. As an employer sponsored plan, when you enter the coverage gap you continue to pay the same cost share as you did in your initial coverage stage until your costs total $5,000, which is the end of the coverage gap. Not everyone will enter the coverage gap.
Catastrophic coverage stage	Once your drug costs reach $5,000, you will pay the larger amount, which is either: • 5% of the cost of the drug, or • $3.35 for generic, and • $8.35 for all other drugs
Non-Medicare Part D drugs covered under your prescription drug benefit	We offer additional coverage for some prescription drugs not normally covered by a Medicare Part D prescription drug plan. These drugs are noted in your formulary with an "ED" (excluded drug).
Long term care (LTC)	If you are a resident of a long-term care (LTC) facility, you may get your prescription drugs through the facility's pharmacy as long as it is part of our network. Check the *2018 Provider/Pharmacy Directory* available at *priorityhealth.com/mpsers* or call Customer Service if you have questions.
ADDITIONAL MEDICAL BENEFITS COVERED UNDER YOUR PLAN	
Annual preventive physical exam	In-network (HMO): $0 for an annual exam Out-of-network (POS): 30% for an annual exam
Chiropractic care Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position)	In-network (HMO): $20 for each visit Out-of-network (POS): 50% for each visit up to a maximum of $300 each plan year, after that you pay 100% for services.
Remote access technologies Also known as virtual care, which is visiting with a health care professional over the phone, through email or using online video	In-network (HMO): $0 for each visit Out-of-network (POS): Not covered

Notice of Nondiscrimination and Language Assistance Services

Priority Health complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Priority Health does not exclude people or treat them differently because of race, color, national origin, age, disability or sex. Federal law requires that we provide you with this Notice of Nondiscrimination and Language assistance services.

Free aids and services:
Priority Health provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Priority Health provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact Priority Health customer service by calling the number at the back of your membership ID card (TTY users call 711).

To file a civil rights grievance:
If you believe that Priority Health has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

Priority Health Compliance Department
Attention: Civil Rights Coordinator
1231 East Beltline Ave NE
Grand Rapids, MI 49525-4501
Toll free: 866.807.1931 (TTY users call 711) Fax: 616.975.8850

PH-compliance@priorityhealth.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Priority Health Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at *ocrportal.hhs.gov*, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1.800.368.1019, 800.537.7697 (TDD)
Complaint forms are available at *hhs.gov/ocr/office/file/index.html.*

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ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.888.389.6648 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888.983.8466 (رقم هاتف الصم والبكم: 117).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1.888.389.6648（TTY：711）。

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CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1.888.389.6648 (TTY: 711).

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1.888.389.6648 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1.888.389.6648 (TTY: 711)번으로 전화해 주십시오.

লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন 1.888.389.6648 (TTY: 711)।

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1.888.389.6648 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1.888.389.6648 (TTY: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1.888.389.6648 (TTY: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1.888.389.6648（TTY:711）まで、お電話にてご連絡ください。

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1.888.389.6648 (телетайп: 711).

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1.888.389.6648 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1.888.389.6648 (TTY: 711).

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This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums, and/or copayments may change each plan year. You must continue to pay your Medicare Part B premium.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

Priority Health Medicare's pharmacy network offers limited access to pharmacies with preferred cost sharing in Michigan. The lower costs advertised in our plan materials for these pharmacies may not be available at the pharmacy you use. For up-to-date information about our network pharmacies, including pharmacies with preferred cost sharing, please call 888.389.6648, TTY users should call 711, or consult the online pharmacy directory at prioritymedicare.com.

Out-of-network/non-contracted providers are under no obligation to treat Priority Health members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

