2025
Summary of Benefits

Jan. 1, 2025–Dec. 31, 2025

MAPD PLANS

PriorityMedicare℠ Vital (PPO)
PriorityMedicare℠ Edge (PPO)
PriorityMedicare℠ Key (HMO-POS)
PriorityMedicare℠ Vintage (HMO-POS)
PriorityMedicare℠ Value (HMO-POS)
PriorityMedicare℠ Merit (PPO)
PriorityMedicare℠ (HMO-POS)

Priority Health™

The perfect Medicare plan is waiting for you in the next few pages.

Whether you're considering an HMO-POS or PPO plan, inside you'll find information to help you decide on the right Medicare plan.

Contact us

BY PHONE

Speak with Priority Health Medicare experts from 8 a.m. to 8 p.m., seven days a week.

Already a member?
Call 888.389.6648 (TTY users call 711)

Not a member yet?
Call 877.230.1560 (TTY users call 711)

ONLINE

Visit ***prioritymedicare.com*** to learn more about our plans and how Medicare works.

This information is not a complete description of benefits. Call 888.389.6648 (TTY 711) for more information. This doesn't list every service we cover or tell you if a deductible must be met before you pay the amount listed in this document. To get a complete list of services we cover including any limitations or exclusions, review the Evidence of Coverage document available online at ***prioritymedicare.com***.

Priority Health offers two kinds of Medicare plans: HMO-POS and PPO

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. We don't require you to get a referral to see a specialist, but your PCP can sometimes help you see one more quickly.

PPO stands for preferred provider organization (PPO). With these plans, we don't require you to get a referral to see a specialist for care. You'll get the most value from your plan when using in-network providers, but you can see any provider who participates with Medicare. You don't have to choose a PCP, although selecting one can help you coordinate care.

To confirm that your doctor, clinic or health center is part of the Priority Health Medicare network of providers, go to ***priorityhealth.com/findadoc***.

Eligibility

In order to join any of our Medicare Advantage plans, you need to be enrolled in Medicare Part A and Part B and live in our service area—which includes all 68 counties in the Lower Peninsula. There are no exclusions for pre-existing conditions.

Prescription coverage

All of our Medicare Advantage plans include prescription drug coverage. To make an informed decision about your Medicare plan, review our provider/pharmacy directory. You generally need to use network pharmacies to fill your prescriptions for covered Part D drugs. To save even more on your prescription costs, use a pharmacy in our preferred pharmacy network. Make sure to review the approved drug list, also called a formulary, to see which drugs are covered by our plans. You can find in-network pharmacies and approved drugs on our website at ***prioritymedicare.com***, or call the customer service number.

Get a free copy of the *2025 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.*

Important health insurance terms to know

To help you better understand our plans, here are some common terms you'll come across while researching:

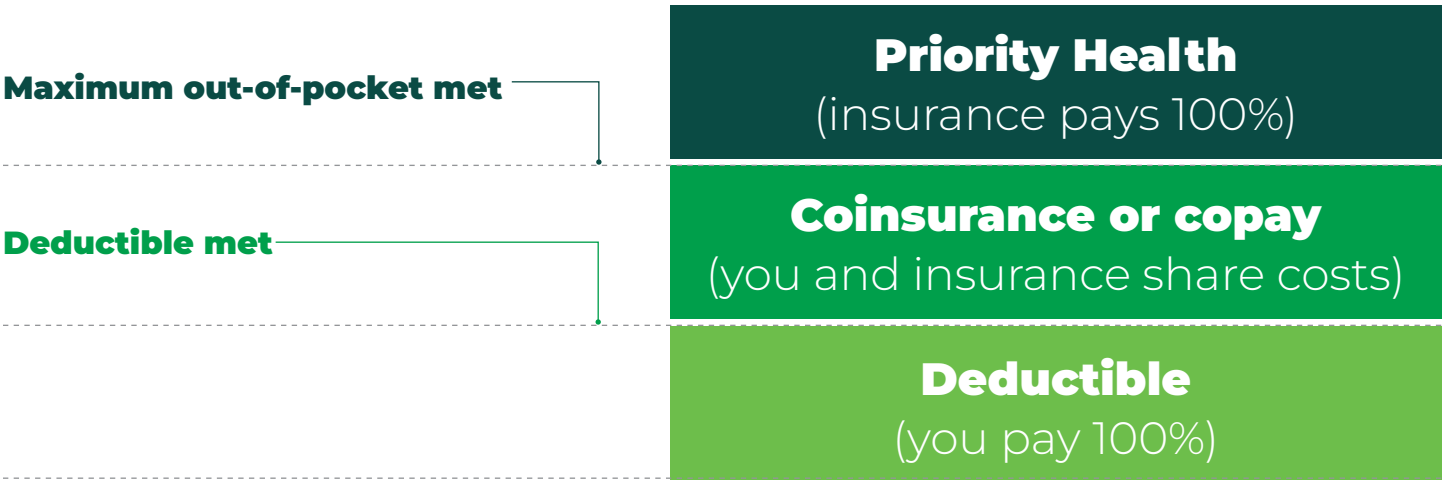
Deductible: This is the amount you pay each year before the health plan starts to pay for certain services, and you start paying a portion of the cost (copay or coinsurance).

Coinsurance: After you've paid your deductible, you may have a coinsurance as your portion of the cost for medical services or prescriptions. Coinsurance is a percentage of the cost of a medical service or prescription and is listed as a benefit in your health plan.

Copay: After you've paid your deductible, you may have a copay as your portion of the cost for medical services or prescriptions. This is a fixed amount you pay, generally at the time you receive a health care service or when you get a prescription filled.

Maximum out-of-pocket: This is the most you will pay for covered medical services for the year—this means Priority Health pays 100% of the cost after you hit this amount. Your coinsurance or copays count towards the maximum out-of-pocket; premiums and prescription costs do not.

How do health insurance costs work?



How does Original Medicare work with Medicare Advantage plans?

Original Medicare (health insurance from the federal government) may not be enough to cover all of your health care needs in retirement. Priority Health Medicare Advantage plans include everything that Original Medicare covers, plus extra benefits and services to help you save money and stay healthy.

	Original Medicare	Priority Health Medicare Advantage Plans
Covers your Medicare Part A and Part B services	●	●
Coverage in addition to Medicare Part A and B		●
Predictable copays and limits to what you'll pay out of pocket for medical care		●
Part D prescription drug coverage		●
Additional dental services		●
Free fitness membership*		●
Routine vision, including eyewear allowance		●
Routine hearing, including hearing aid coverage		●

Not available on **PriorityMedicare Vintage.*

$0
PPO Plans

Full benefits and affordable coverage

PriorityMedicare[SM] Vital (PPO)
PriorityMedicare[SM] Edge (PPO)

PREMIUMS AND BENEFITS

Benefits and what you should know	PriorityMedicare Vital (PPO)	PriorityMedicare Edge (PPO)
Plan availability Plans are available in the regions listed. *See table later in this document for a listing of counties by region.*	Regions 1, 2 and 5	
Monthly plan premium	$0 per month. You must keep paying your Medicare Part B premium but will receive a $540 Part B credit each year ($45 per month).	$0 per month. You must keep paying your Medicare Part B premium.
Deductible The amount you'll pay for most covered services before you start paying only copays or coinsurance and Priority Health pays the balance.	**Medical services** *In-network:* $375, applies to hospital and medical services, except for, primary care visits, specialty provide visits, outpatient mental health, psychiatric services, substance abuse and opioid treatment program services, partial hospitalization, home health services, acupuncture, chiropractic services, physical therapy, occupational therapy, speech therapy, podiatry, outpatient tests and lab, emergency care, urgently needed services, observation, ambulance, durable medical equipment, prosthetic devices, medical supplies, diabetic supplies, diabetic therapeutic shoes/inserts, kidney disease education services, preventive services and Part B insulin furnished through an item of durable medical equipment. *In-network and out-of-network (combined):* $375, applies to everything except acupuncture and insulin furnished through an item of durable medical	**Medical services** *In-network:* $195, applies to hospital and medical services, except for, primary care visits, specialty provide visits, outpatient mental health, psychiatric services, substance abuse and opioid treatment program services, partial hospitalization, home health services, acupuncture, chiropractic services, physical therapy, occupational therapy, speech therapy, podiatry, outpatient tests and lab, emergency care, urgently needed services, observation, ambulance, durable medical equipment, prosthetic devices, medical supplies, diabetic supplies, diabetic therapeutic shoes/inserts, kidney disease education services, preventive services and Part B insulin furnished through an item of durable medical equipment. *In-network and out-of-network (combined):* $195, applies to everything except acupuncture and insulin furnished through an item of durable medical

Benefits and what you should know	PriorityMedicare Vital (PPO)	PriorityMedicare Edge (PPO)
	equipment.	equipment.
	Prescription drugs (Part D) Tiers 1-2: $0 Tiers 3-5: $350	**Prescription drugs (Part D)** $0
Maximum out-of-pocket amount This is the most you pay for covered medical services for the year, excluding Part D prescription drugs.	*In-network and out-of-network (combined): $5,600:*	*In-network and out-of-network* (combined): $5,700

MEDICAL BENEFITS COVERED UNDER YOUR PLAN

Benefits and what you should know	PriorityMedicare Vital (PPO)	PriorityMedicare Edge (PPO)
Inpatient hospital coverage We cover an unlimited number of days for an inpatient hospital stay. Prior authorization may be required.	*In- and out-of-network:* $350 copay per day, days 1-5 $0 for additional hospital days	*In-network:* $350 copay per day, days 1-7 $0 for additional hospital days *Out-of-network:* 40% of the total cost per stay
Outpatient hospital coverage Prior authorization may be required.	**Outpatient hospital** *In- and out-of-network:* $0 copay for each rural health clinic visit. $350 copay for each Medicare-covered outpatient hospital facility visit. **Observation** *In- and out-of-network:* $120 copay per stay for each visit, including all services received.	**Outpatient hospital** *In-network:* $0 copay for each rural health clinic visit. $350 copay for each Medicare-covered outpatient hospital facility visit. *Out-of-network:* 40% of the total cost for each visit. **Observation** *In- and out-of-network:* $120 copay per stay for each visit, including all services received.
Ambulatory surgical center coverage	*In- and out-of-network:* $350 copay for each visit	*In-network:* $350 copay for each visit

Benefits and what you should know	PriorityMedicare Vital (PPO)	PriorityMedicare Edge (PPO)
Prior authorization may be required.		*Out-of-network:* 40% of the total cost for each visit
Doctor visits Prior authorization may be required for some specialist visits.	**Primary care physician (PCP)** *In- and out-of-network:* $0 copay for each office visit and surgical procedures performed in a PCP's office. **Specialist visit** *In- and out-of-network:* $0 copay for palliative care physician office visit. $0 copay for surgical procedures performed in a specialist's office. $50 copay for all other office visits.	**Primary care physician (PCP)** *In-network:* $0 copay for each office visit and surgical procedures performed in a PCP's office. *Out-of-network:* 40% of the total cost for each visit **Specialist visit** *In-network:* $0 copay for palliative care physician office visit. $0 copay for surgical procedures performed in a specialist's office. $35 copay for all other office visits. *Out-of-network:* 40% of the total cost for each visit
Preventive care Services that can help with prevention and early detection of many illnesses, disabilities, and diseases. Examples include annual wellness visit, breast cancer screening, diabetic screening, flu vaccine and more.	*In- and out-of-network:* $0 copay for each service	*In-network:* $0 copay for each service *Out-of-network:* 40% of the total cost for each service.
	A referral from your doctor may be required for some preventive services. Any additional preventive services approved by Medicare during the contract year will be covered.	
Emergency care This amount is waived if you are admitted as inpatient to the hospital within 24 hours from your emergency care visit.	*In- and out-of-network:* $120 copay for each visit	
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- and out-of-network:* $55 copay for each visit	*In- and out-of-network:* $30 copay for each visit

Benefits and what you should know	PriorityMedicare Vital (PPO)	PriorityMedicare Edge (PPO)
Outpatient diagnostic services (labs, radiology/imaging and X-rays) Prior authorization may be required for some services.	**Radiology/ imaging** *In- and out-of-network:* 20% of the total cost per day, per provider **Tests/procedures** *In- and out-of-network:* $0 copay per day, per provider **Lab services** *In- and out-of-network:* $0 copay for anticoagulant labs and all other Medicare-covered lab services. **Outpatient X-rays** *In- and out-of-network:* $40 copay per day, per provider **Radiation therapy** *In- and out-of-network:* $40 copay per day, per provider	**Radiology/ imaging** *In-network:* $270 copay per day, per provider **Tests/procedures** *In-network:* $0 copay per day, per provider **Lab services** *In-network:* $0 copay for anticoagulant labs and all other Medicare-covered lab services. **Outpatient X-rays** *In-network:* $20 copay per day, per provider **Radiation therapy** *In-network:* $40 copay per day, per provider *For all out-of-network services listed above*: 0% to 40% of the total cost per day, per provider ($0 copay for anticoagulant lab services).
Hearing services Medicare-covered exam performed by a primary care physician or specialist to diagnose and treat hearing and balance issues.	**Medicare-covered diagnostic hearing exam** *In- and out-of-network:* $0 - $50 copay for each office visit	**Medicare-covered diagnostic hearing exam** *In-network:* $0- $35 copay for each office visit *Out-of-network:* 40% of the total cost of each visit
Routine hearing services must be received from a TruHearing® provider.	**Routine hearing coverage (TruHearing® provider)** $0 copay for one routine hearing exam, per year. $0 copay for up to two (2) TruHearing-branded 'Advanced' hearing aids, one per ear, every two years.	**Routine hearing coverage (TruHearing® provider)** $0 copay for one routine hearing exam, per year. $295, $695, $1,095 or $1,495 copay, per ear per year, for hearing aids from top manufacturers depending on level selected

Benefits and what you should know	PriorityMedicare Vital (PPO)	PriorityMedicare Edge (PPO)
	Hearing aid cost includes a 60-day trial period, one year of post-purchase follow-up visits, 80 batteries per non-rechargeable hearing aid and a full 3-year manufacturer warranty	
Dental services Prior authorization may be required for Medicare-covered dental services. Delta Dental® is the preferred provider for additional dental services.	**Medicare-covered dental services** *In- and out-of-network:* $0-$350 copay for each visit, depending on the service performed. **Additional dental services** $0 copay for two cleanings (regular or periodontal maintenance) per year $0 copay for two exams per year $0 copay for one set of bitewing X-rays per year $0 copay for one brush biopsy per year $0 copay for periapical radiographs as needed. $0 copay for radiographs (full-mouth or panoramic x-rays) once every 24 months $1,500 annual maximum that applies for the following services: $0 copay for fillings (includes composite, resin, and amalgam), once per tooth, every 24 months. $0 copay for crown repairs, once per tooth every 24 months	**Medicare-covered dental services** *In-network* $0-$350 copay: for each visit, depending on the service performed. *Out-of-network:* 40% of the total cost for each service performed. **Additional dental services** $0 copay for two cleanings (regular or periodontal maintenance) per year $0 copay for two exams per year $0 copay for one set of bitewing X-rays per year $0 copay for one brush biopsy per year $0 copay for periapical radiographs as needed. $0 copay for radiographs (full-mouth or panoramic x-rays) once every 24 months

Benefits and what you should know	PriorityMedicare Vital (PPO)	PriorityMedicare Edge (PPO)
	$0 copay for simple extractions, once per tooth per lifetime. $0 copay for anesthesia, when used in conjunction with qualifying dental services.	
Vision services Medicare-covered exam performed by a specialist to diagnose and treat diseases and conditions of the eye and additional Medicare-covered services.	**Medicare-covered services** *In- and out-of-network:* $50 copay for each visit $0 copay for eyeglasses or contact lenses after cataract surgery. $0 copay for a yearly glaucoma screening	**Medicare-covered services** *In-network:* $35 copay for each visit $0 copay for eyeglasses or contact lenses after cataract surgery. $0 copay for a yearly glaucoma screening *Out-of-network:* 40% of the total cost for each visit, eyeglasses or contact lenses after cataract surgery, or for a yearly glaucoma screening
In-network routine vision services must be provided by an EyeMed® "Select" provider. If received by a non-EyeMed "Select" provider (out-of-network), you must seek reimbursement. In-network and out-of-network benefits cannot be combined.	**Routine vision services** *In-network:* $0 copay for one routine exam each year (includes dilation and refraction) $0 copay for one retinal imaging per year $125 eyewear allowance per year *Out-of-network:* Up to $125 reimbursement for eyewear Up to $50 reimbursement for one routine exam Up to $20 reimbursement for retinal imaging	**Routine vision services** *In-network:* $0 copay for one routine exam each year (includes dilation and refraction) $0 copay for one retinal imaging per year $100 eyewear allowance per year *Out-of-network:* Up to $100 reimbursement for eyewear Up to $50 reimbursement for one routine exam Up to $20 reimbursement for retinal imaging

Benefits and what you should know	PriorityMedicare Vital (PPO)	PriorityMedicare Edge (PPO)
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- and out-of-network:* $350 copay per day, days 1-5 $0 for additional hospital days **Outpatient therapy (individual or group)** *In- and out-of-network:* $20 copay for each visit	**Inpatient visit** *In-network:* $350 copay per day, days 1-5 $0 for additional hospital days *Out-of-network*: 40% of the total cost, per stay **Outpatient therapy (individual or group)** *In-network:* $20 copay for each visit *Out-of-network*: 40% of the total cost for each visit
Skilled Nursing Facility (SNF) Our plan covers up to 100 days each benefit period. A benefit period starts the day you go into a SNF and ends when you go for 60 days in a row without SNF care. Prior authorization may be required.	*In- and out-of-network:* Days 1-20: $0 copay each day Days 21-100: $203 copay each day	*In-network:* Days 1-20: $0 copay each day Days 21-100: $203 copay each day *Out-of-network:* 40% of the total cost per stay for each stay
Physical therapy	*In- and out-of-network:* $30 copay for each service	*In-network:* $40 copay for each service *Out-of-network:* 40% of the total cost for each service
Ambulance Prior authorization may be required.	*In- and out-of-network:* $265 copay each way	*In- and out-of-network:* $275 copay each way
Transportation	Not covered	

PRESCRIPTION DRUG BENEFITS

Prescription drug benefits	PriorityMedicare Vital (PPO)	PriorityMedicare Edge (PPO)
Medicare Part B drugs Prior authorization or step therapy may be required.	**Chemotherapy drugs** *In- and out-of-network:* 0% to 20% of the total cost for each drug **Other Part B drugs** *In- and out-of-network:* 0% to 20% of the total cost for each drug **Select home infusion drugs** *In- and out-of-network:* $0 copay for each drug. **Part B insulin** *In- and out-of-network:* 0% to 20% up to $35 of the total cost for a one-month supply of insulin administered through a durable medical equipment (DME) device (such as insulin pumps or continuous glucose monitors (CGM)).	

PART D OUTPATIENT PRESCRIPTION DRUGS		
Prescription drug benefits	PriorityMedicare Vital (PPO)	PriorityMedicare Edge (PPO)
Deductible stage You'll pay this amount before you begin paying copays or coinsurance only.	Tier 1-2: $0 Tiers 3-5: $350 *The deductible doesn't apply to covered insulins and most adult Part D vaccines. See initial coverage stage row for insulin cost sharing.	$0
Initial coverage stage You are in this stage until your out-of-pocket Part D drug costs reach $2,000.	Once you have paid your deductible (only required for drugs in tiers 3-5) you pay what is listed in the chart below.	You pay what is listed in the chart below.

PREFERRED RETAIL PHARMACY						
Prescription drug benefits	PriorityMedicare Vital (PPO)			PriorityMedicare Edge (PPO)		
Initial coverage stage	30-day	60-day	90-day	30-day	60-day	90-day
Tier 1 (Preferred generic)	$1	$2	$0	$2	$4	$0
Tier 2 (Generic)	$10	$20	$30	$8	$16	$24
Tier 3 (Preferred brand)	$35 for insulin and $42 for other drugs	$70 for insulin and $84 for other drugs	$105 for insulin and $126 for other drugs	$35 for insulin and 25% for other drugs	$70 for insulin and 25% for other drugs	$105 for insulin and 25% for other drugs
Tier 4 (Non-preferred drug)	$35 for insulin and 45% for other drugs	$70 for insulin and 45% for other drugs	$105 for insulin and 45% for other drugs	$35 for insulin and 40% for other drugs	$70 for insulin and 40% for other drugs	$105 for insulin and 40% for other drugs
Tier 5 (Specialty)	$35 for insulin and 28% for other drugs	N/A	N/A	$35 for insulin and 33% for other drugs	N/A	N/A
Your costs will be less for your covered drugs when you use a pharmacy in our preferred network (includes Meijer, Walgreens, Walmart, Family Fare Supermarkets, Costco and more), go to *prioritymedicare.com* to view the list in the provider/pharmacy directory.						

STANDARD RETAIL PHARMACY						
Prescription drug benefits	PriorityMedicare Vital (PPO)			PriorityMedicare Edge (PPO)		
Initial coverage stage	30-day	60-day	90-day	30-day	60-day	90-day
Tier 1 (Preferred generic)	$6	$12	$18	$7	$14	$21
Tier 2 (Generic)	$15	$30	$45	$15	$30	$45
Tier 3 (Preferred brand)	$35 for insulin and $47 for other drugs	$70 for insulin and $94 for other drugs	$105 for insulin and $141 for other drugs	$35 for insulin and 25% for other drugs	$70 for insulin and 25% for other drugs	$105 for insulin and 25% for other drugs
Tier 4 (Non-preferred drug)	$35 for insulin and 50% for other drugs	$70 for insulin and 50% for other drugs	$105 for insulin and 50% for other drugs	$35 for insulin and 45% for other drugs	$70 for insulin and 45% for other drugs	$105 for insulin and 45% for other drugs
Tier 5 (Specialty)	$35 for insulin and 28% for other drugs	N/A	N/A	$35 for insulin and 33% for other drugs	N/A	N/A

MAIL ORDER THROUGH EXPRESS SCRIPTS (ESI)						
Prescription drug benefits	PriorityMedicare Vital (PPO)			PriorityMedicare Edge (PPO)		
Initial coverage stage	30-day	60-day	90-day	30-day	60-day	90-day
Tier 1 (Preferred generic)	$1	$2	$0	$2	$4	$0
Tier 2 (Generic)	$10	$20	$0	$8	$16	$0
Tier 3 (Preferred brand)	$35 for insulin and $42 for other drugs	$70 for insulin and $84 for other drugs	$105 for insulin and $105 other drugs	$35 for insulin and 25% for other drugs	$70 for insulin and 25% for other drugs	$105 for insulin and 25% for other drugs
Tier 4 (Non-preferred drug)	$35 for insulin and 45% for other drugs	$70 for insulin and 45% for other drugs	$105 for insulin and 45% for other drugs	$35 for insulin and 40% for other drugs	$70 for insulin and 40% for other drugs	$105 for insulin and 40% for other drugs
Tier 5 (Specialty)	$35 for insulin and 28% for other drugs	N/A	N/A	$35 for insulin and 33% for other drugs	N/A	N/A

Prescription drug benefits	PriorityMedicare Vital (PPO)	PriorityMedicare Edge (PPO)
Catastrophic coverage stage	Once your out-of-pocket drug costs reach $2,000, the plan pays the full cost of your covered Part D drugs.	
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.	

OPTIONAL ENHANCED DENTAL AND VISION PACKAGE

Benefits and what you should know	PriorityMedicare Vital (PPO)	PriorityMedicare Edge (PPO)
Benefits	Additional coverage, including coverage for dental services and an additional vision allowance for use on eyeglasses or contacts	Additional coverage, including coverage for dental services and an additional vision allowance for use on eyeglasses or contacts
Premium	$39 per month. You must keep paying your Medicare Part B premium.	$49 per month. You must keep paying your Medicare Part B premium.
Deductible	$0	$0
Maximum plan benefit coverage amount	$2,500 for dental services and an additional $150 for eyewear, per calendar year	
Dental services Delta Dental® is the preferred provider for additional dental services.	$0 copay for one fluoride treatment per year $0 copay for emergency treatment for dental pain at no limit and anesthesia when used in conjunction with qualifying dental services 50% of the total cost of onlays, crowns and associated substructures, once per tooth, per lifetime 50% of the total cost of endodontics (root canals), once per tooth per lifetime 50% of the total cost of surgical extractions, once per tooth per lifetime 50% of the total cost of implants and implant repairs, per tooth, every 5 years 50% of the total cost of dentures, once every 60 months, denture relines and	$0 copay for one fluoride treatment per year, for fillings, (including composite resin and amalgam) once per tooth, every 24 months, and crown repairs once per tooth every 12 months $0 copay for emergency treatment for dental pain at no limit and anesthesia when used in conjunction with qualifying dental services. 50% of the total cost of onlays, crowns and associated substructures, once per tooth, per lifetime 50% of the total cost of endodontics (root canals), once per tooth per lifetime 50% of the total cost of simple (non-surgical) and surgical extractions, once per tooth per lifetime

Benefits and what you should know	PriorityMedicare Vital (PPO)	PriorityMedicare Edge (PPO)
	repairs, and bridge repairs, once every 36 months	50% of the total cost of implants and implant repairs, per tooth, every 5 years 50% of the total cost of dentures, once every 60 months, denture relines and repairs, and bridge repairs, once every 36 months
Vision services In-network vision services must be provided by an EyeMed® "Select" provider. If received by a non- EyeMed "Select" provider (out-of-network), you must seek reimbursement. In-network and out-of-network benefits cannot be combined.	$150 allowance/reimbursement per year for additional eyewear	

ADDITIONAL MEDICAL BENEFITS COVERED UNDER YOUR PLAN

Benefits and what you should know	PriorityMedicare Vital (PPO)	PriorityMedicare Edge (PPO)
Acupuncture	**Medicare-covered acupuncture for lower chronic back pain** *In- and out-of-network:* $20 copay per service **Non-Medicare covered routine acupuncture for other conditions** *In- and out-of-network:* $20 copay per visit (limit 6 visits every year)	
Annual preventive physical exam	*In- and out-of-network:* $0 copay for an exam	*In-network:* $0 copay for an exam *Out-of-network:* 40% of the total cost for an exam
	You're free to talk at your annual preventive exam. When we say no cost, we mean it- $0 annual physical exam, without the worry of being charged for an office visit. This is an opportunity for you and your physician to discuss any concerns or questions you have.	
Caregiver Support 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.	Not covered.	$0 copay for unlimited hours of caregiver support provided by Carallel®.
CogniFit®	$0 copay 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.	
Chiropractic Care	**Medicare-covered care** *In- and out-of-network:* $20 copay for each service	**Medicare-covered care** *In-network:* $20 copay for each service

Benefits and what you should know	PriorityMedicare Vital (PPO)	PriorityMedicare Edge (PPO)
	Non-Medicare covered routine care *In- and out-of-network:* $20 copay for each visit $40 copay for X-ray services performed once per year (this is in addition to an office visit)	*Out-of-network:* 40% of the total cost for each service **Non-Medicare covered routine care** *In-network:* $20 copay for each visit $20 copay for X-ray services performed once per year (this is in addition to an office visit)
	Limited to 12 non-Medicare covered routine chiropractic visits and one routine x-ray service per year whether done in- or out-of-network.	*Out-of-network:* 40% of the total cost for each visit/service Limited to 12 non-Medicare covered routine chiropractic visits and one routine x-ray per year whether done in- or out-of-network.
Dialysis	*In- and out-of-network:* 20% of the total cost for each service	*In-network:* 20% for each service *Out-of-network:* 40% for each service
Home health services Prior authorization may be required.	*In- and out-of-network:* $0 copay for each Medicare-covered service	
Medical equipment and supplies Examples include diabetic supplies (shoes/inserts, diabetic test strips), durable medical equipment (wheelchairs, oxygen, insulin pumps) and prosthetic	**Diabetes supplies** *In- and out-of-network:* $0 copay for each item **Durable medical equipment** *In- and out-of-network:* 20% of the total cost for each item	**Diabetes supplies** *In-network:* $0 for each item *Out-of-network:* 40% for each item **Durable medical equipment** *In-network:* 20% for each item *Out-of-network:* 30% for each item

Benefits and what you should know	PriorityMedicare Vital (PPO)	PriorityMedicare Edge (PPO)
devices (braces, artificial limbs). Diabetic test strips are limited to JJHCS and Bayer products when dispensed by a retail pharmacy or mail-order pharmacy. Prior authorization may be required.	**Prosthetic devices** *In- and out-of-network:* $0-20% for each item, depending on the device	**Prosthetic devices** *In-network:* $0-20% for each item, depending on the device. *Out-of-network:* 30% for each device
Over-the-counter (OTC) allowance Over-the-counter items are drugs and health related products that do not need a prescription such as allergy medication, eye drops, cough drops, nasal spray, vitamins and more.	$25 allowance per month for OTC items. Allowance does not rollover.	
	OTC items, home and bathroom safety devices and modifications can be purchased in participating stores (Meijer, Walmart, Walgreens, CVS, Kroger and more). Or, online at ***PriorityHealth.com/shopOTC***, by calling 833.415.4380 or by downloading the Priority Health OTC app.	
Podiatry services	**Medicare-covered podiatry** *In- and out-of-network:* $50 copay for each visit $0 copay for nail debridement and callous removal for members with specific conditions (up to 6 of each)	**Medicare-covered podiatry** *In-network:* $35 copay for each visit $0 copay for nail debridement and callous removal for members with specific conditions (up to 6 of each) Out-of-network: 40% of the total cost of each visit or service
Priority Health Travel Pass	**Out-of-area travel benefit** You'll pay in-network prices when seeking care from Medicare-participating providers anywhere in the U.S. outside of the lower peninsula of Michigan. Our partnership with Multiplan® can make accessing Medicare-participating providers even easier.	

Benefits and what you should know	PriorityMedicare Vital (PPO)	PriorityMedicare Edge (PPO)
	You may stay enrolled in the plan when outside of the service area for up to 12 months; residency remains in your plan's service area.	
	Worldwide urgent and emergent care Unlimited worldwide emergent and urgent care coverage. **Worldwide travel assistance program** $0 for emergency travel assistance services through Assist America® when you're more than 100 miles from home or in a foreign country. Assist America® provides pre-trip assistance to help you prepare for your travel, including finding a doctor or a pharmacy to fill your prescriptions at your destination and assistance while on your trip should a medical travel emergency arise, at no extra cost to you. You will still pay for benefits covered by Priority Health Medicare, such as emergency, urgent care, or prescription drug copays.	
Rehabilitation services	**Cardiac rehabilitation services** *In-and out-of-network:* $20 copay for each service	**Cardiac rehabilitation services** In-Network: $20 copay for each service Out-of-network: 40% of the total cost for each service
	Pulmonary rehabilitation and supervised exercise therapy (SET) services *In- and out-of-network:* $15 copay for each service	**Pulmonary rehabilitation and supervised exercise therapy (SET)services** *In-network:* $15 copay for each service *Out-of-network:* 40% of the total cost of each service

Benefits and what you should know	PriorityMedicare Vital (PPO)	PriorityMedicare Edge (PPO)
	Physical therapy, occupational therapy, and speech therapy services *In- and out-of-network:* $30 copay for each service	**Physical therapy, occupational therapy and speech therapy services** *In-network:* $40 copay for each service *Out-of-network:* 40% of the total cost of each service
One Pass® Fitness membership	$0 copay 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). • Meal delivery services to make healthy eating easy.	

Benefits and what you should know	PriorityMedicare Vital (PPO)	PriorityMedicare Edge (PPO)
Virtual care Online care you receive from the comfort of your home, or wherever you may be, with a virtual visit via video on your computer, smart phone, or tablet.	*In-network:* $0 copay 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 *Out-of-network:* Not covered	

PREMIUMS AND BENEFITS | Monthly Premiums

Counties	PriorityMedicare Vital (PPO)	PriorityMedicare Edge (PPO)
Region 1: Allegan, Barry, Kent, Lenawee, Ottawa	$0	$0
Region 2: Berrien, Calhoun, Cass, Ionia, Isabella, Kalamazoo, Mason, Midland, Missaukee, Montcalm, Muskegon, Newaygo, Oceana, Osceola, Otsego, St. Clair, Van Buren, Wexford	$0	$0
Region 3: Alcona, Antrim, Benzie, Charlevoix, Clare, Crawford, Grand Traverse, Hillsdale, Lake, Lapeer, Leelanau, Manistee, Mecosta, Monroe	N/A	N/A
Region 4: Alpena, Cheboygan, Eaton, Emmet, Gladwin, Gratiot, Iosco, Jackson, Kalkaska, Montmorency, Oscoda, Presque Isle, Roscommon, Sanilac, Shiawassee, St. Joseph	N/A	N/A
Region 5: Arenac, Bay, Branch, Clinton, Genesee, Huron, Ingham, Livingston, Macomb, Oakland, Ogemaw, Saginaw, Tuscola, Washtenaw, Wayne	$0	$0

HMO-POS Plans

Comprehensive benefits and affordable coverage

PriorityMedicare[SM] Vintage (HMO-POS)
PriorityMedicare[SM] Key (HMO-POS)
PriorityMedicare[SM] Value (HMO-POS)

PREMIUMS AND BENEFITS

Benefits and what you should know	PriorityMedicare Vintage (HMO-POS)	PriorityMedicare Key (HMO-POS)	PriorityMedicare Value (HMO-POS)
Plan availability Plans are available in the regions listed. *See table later in this document for a listing of counties by region.*	Regions 1, 2 and 5	Regions 1, 2, 3, 4 and 5	Regions 1, 2, 3, 4 and 5
Monthly plan premium	$0 per month. In addition, you must keep paying your Medicare Part B premium.	$0 per month. In addition, you must keep paying your Medicare Part B premium.	$18-$69 per month. In addition, you must keep paying your Medicare Part B premium.
Deductible The amount you'll pay for most covered services before you start paying only copays or coinsurance and Priority Health pays the balance.	**Medical services** *In-network* *:* $0 *Out-of-network:* $1,500 applies to hospital and medical services except for acupuncture and insulin furnished through an item of durable medical equipment.	**Medical services** *In-network:* Regions 1, 2 & 5: $275 Regions 3 & 4: $250 Deductible applies to hospital and medical services, except for, primary care visits, specialty provide visits, outpatient mental health, psychiatric services, substance abuse and opioid treatment program services, partial hospitalization, home health services, acupuncture, chiropractic services, physical therapy, occupational therapy, speech therapy, podiatry, outpatient tests and lab, emergency care, urgently	**Medical services** *In-network:* $0 *Out-of-network:* $1,000 applies to hospital and medical services except for acupuncture and insulin furnished through an item of durable medical equipment.

Benefits and what you should know	PriorityMedicare Vintage (HMO-POS)	PriorityMedicare Key (HMO-POS)	PriorityMedicare Value (HMO-POS)
		needed services, observation, ambulance, durable medical equipment, prosthetic devices, medical supplies, diabetic supplies, diabetic therapeutic shoes/inserts, kidney disease education services, preventive services and Part B insulin furnished through an item of durable medical equipment. *See table later in this document for a list of counties by region.* *Out-of-network:* $1,500 applies to hospital and medical services except for acupuncture and insulin furnished through an item of durable medical equipment.	
	Prescription drugs (Part D) $0	**Prescription drugs (Part D)** $0	**Prescription drugs (Part D)** $0
Maximum out-of-pocket amount This is the most you pay for covered medical services for the year, excluding Part D prescription drugs.	*In-network*: $5,300	*In-network:* $5,500	*In-network:* $4,900

MEDICAL BENEFITS COVERED UNDER YOUR PLAN

Benefits and what you should know	PriorityMedicare Vintage (HMO-POS)	PriorityMedicare Key (HMO-POS)	PriorityMedicare Value (HMO-POS)
Inpatient hospital coverage We cover an unlimited number of days for an inpatient hospital stay. Prior authorization may be required.	*In-network:* $320 copay per day, days 1-7 $0 copay for additional hospital days *Out-of-network:* 50% of the total cost per stay	*In-network:* $350 copay per day, days 1-7 $0 copay for additional hospital days *Out-of-network:* 50% of the total cost per stay	*In-network:* $325 copay per day, days 1-7 $0 copay for additional hospital days *Out-of-network:* 40% of the total cost per stay
Outpatient hospital coverage Prior authorization may be required.	**Outpatient hospital** *In-network:* $0 copay for each visit at a rural health clinic $350 copay for each visit at all other locations *Out-of-network:* 50% for each visit		**Outpatient hospital** *In-network:* $0 copay for each visit at a rural health clinic $325 copay for each visit at all other locations *Out-of-network: 4*0% for each visit
	Observation *In- and out-of-network:* $120 copay for each visit, including all services received		
Ambulatory surgical center coverage Prior authorization may be required.	*In-network:* $350 copay for each visit *Out-of-network:* 50% of the total cost for each visit		*In-network:* $325 copay for each visit *Out-of-network:* 40% of the total cost for each visit
Doctor visits Prior authorization may be required for some specialist visits.	**Primary care physician (PCP)** *In-network:* $0 copay for each office visit and surgical procedures performed in a PCP's office	**Primary care physician (PCP)** *In-network:* $0 copay for each office visit and surgical procedures performed in a PCP's office	**Primary care physician (PCP)** *In-network:* $0 copay for each office visit and surgical procedures performed in a PCP's office

Benefits and what you should know	PriorityMedicare Vintage (HMO-POS)	PriorityMedicare Key (HMO-POS)	PriorityMedicare Value (HMO-POS)
	Out-of-network: 50% of the total cost for each visit **Specialist visit** *In-network:* $0 copay for palliative care physician office visits $0 copay for surgical procedures performed in a specialist's office $35 copay for all other office visits *Out-of-network:* 50% of the total cost for each visit	*Out-of-network:* 50% of the total cost for each visit **Specialist visit** *In-network:* $0 copay for palliative care physician office visits $0 copay for surgical procedures performed in a specialist's office $40 copay for all other office visits *Out-of-network:* 50% of the total cost for each visit	*Out-of-network:* 40% of the total cost for each visit **Specialist visit** *In-network:* $0 copay for palliative care physician office visits $0 copay for surgical procedures performed in a specialist's office $35 copay for all other office visits *Out-of-network:* 40% of the total cost for each visit

Benefits and what you should know	PriorityMedicare Vintage (HMO-POS)	PriorityMedicare Key (HMO-POS)	PriorityMedicare Value (HMO-POS)
Preventive care Services that can help with prevention and early detection of many illnesses, disabilities, and diseases. Examples include annual wellness visit, breast cancer screening, diabetic screening, flu vaccine and more.	*In-network:* $0 copay for each service *Out-of-network:* 50% of the total cost for each service		*In-Network:* $0 copay for each service *Out-of-network:* 40% of the total cost for each service
	A referral from your doctor may be required for some preventive services. Any additional preventive services approved by Medicare during the contract year will be covered.		
Emergency care This amount is waived if you are admitted as inpatient to the hospital within 24 hours from your emergency care visit.	*In- and out-of-network:* $120 copay for each visit		
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- and out-of-network:* $50 copay for each visit		*In- and out-of-network:* $55 copay for each visit
Outpatient diagnostic services (labs, radiology/imaging, and X-rays) Prior authorization may be required for some services.	**Radiology/ imaging** *In-network:* $180 copay per day, per provider **Tests/procedures** *In-network:* $5 copay per day, per provider **Lab services** *In-network:* $0 for anticoagulant lab services, $5 for all other Medicare-covered lab services **Outpatient X-rays** *In-network:* $35 copay per day, per provider	**Radiology/ imaging** *In-network:* Regions 1, 2 & 5: $225 copay per day, per provider Regions 3 & 4: $210 copay per day, per provider *See table later in this document for a list of counties by region.* **Tests/procedures** *In-network:* $10 copay per day, per provider **Lab services** *In-network:* $0 for anticoagulant lab	**Radiology/ imaging** *In-network:* $225 copay per day, per provider **Tests/procedures** *In-network:* $10 copay per day, per provider **Lab services** *In-network:* $0 for anticoagulant lab services, $10 for all other Medicare-covered lab services **Outpatient X-rays** *In-network:* $35 copay per day, per provider

Benefits and what you should know	PriorityMedicare Vintage (HMO-POS)	PriorityMedicare Key (HMO-POS)	PriorityMedicare Value (HMO-POS)
	Radiation therapy *In-network:* $25 copay per day, per provider *For all out-of-network services listed above*: 0% to 50% of the total cost per day, per provider ($0 copay for anticoagulant lab services)	services, $10 for all other Medicare-covered lab services **Outpatient X-rays** *In-network:* $35 copay per day, per provider **Radiation therapy** *In-network:* $25 copay per day, per provider *For all out-of-network services listed above*: 0% to 50% of the total cost per day, per provider ($0 copay for anticoagulant lab services)	**Radiation therapy** *In-network:* $25 copay per day, per provider *For all out-of-network services listed above*: 0% to 40% of the total cost per day, per provider ($0 copay for anticoagulant lab services)
Hearing services Medicare-covered exam performed by a primary care physician or specialist to diagnose and treat hearing and balance issues. Routine hearing services must be received from a TruHearing® provider.	**Medicare-covered diagnostic hearing exam** *In-network:* $0 - $35 copay for each office visit *Out-of-network:* 50% of the total cost for each visit	**Medicare-covered diagnostic hearing exam** *In-network: $0 - $40 copay for each office visit* *Out-of-network:* 50% of the total cost for each visit	**Medicare-covered diagnostic hearing exam** *In-network:* $0 - $35 copay for each office visit *Out-of-network:* 40% of the total cost for each visit
	Routine hearing coverage (TruHearing® provider) $0 copay for one routine hearing exam, per year $295, $695, $1,095 or $1,495 copay, per ear per year, for hearing aids from top manufacturers depending on level selected.		
	Hearing aid cost includes a 60-day trial period, one year of post-purchase follow-up visits, 80 batteries per non-rechargeable hearing aid and a full 3-year manufacturer warranty.		
Dental services	**Medicare-covered dental services**	**Medicare-covered dental services**	**Medicare-covered dental services**

Benefits and what you should know	PriorityMedicare Vintage (HMO-POS)	PriorityMedicare Key (HMO-POS)	PriorityMedicare Value (HMO-POS)
Prior authorization may be required for Medicare-covered dental services.	*In-network:* $0-$350 copay for each visit, depending on the service performed *Out-of-network:* 50% of the total cost for each service	*In-network:* $0-$350 copay for each visit, depending on the service performed *Out-of-network:* 50% of the total cost for each service	*In-network:* $0-$325 for each visit, depending on the service performed *Out-of-network:* 40% of the total cost for each service
Delta Dental® is the preferred provider for additional dental services.	**Additional dental services** $0 copay for two cleanings (regular or periodontal maintenance) per year $0 copay for two exams per year $0 copay for one set of bitewing X-rays per year $0 copay for one brush biopsy per year $0 copay for periapical radiographs as needed $0 copay for radiographs (full-mouth or panoramic x-rays) once every 24 months	**Additional dental services** $0 copay for two cleanings (regular or periodontal maintenance) per year $0 copay for two exams per year $0 copay for one set of bitewing X-rays per year $0 copay for one brush biopsy per year $0 copay for periapical radiographs as needed $0 copay for radiographs (full-mouth or panoramic x-rays) once every 24 months $1,500 annual maximum that applies for the following services: $0 copay for fillings (includes composite, resin,	**Additional dental services** $0 copay for two cleanings (regular or periodontal maintenance) per year $0 copay for two exams per year $0 copay for one set of bitewing X-rays per year $0 copay for one brush biopsy per year $0 copay for periapical radiographs as needed $0 copay for radiographs (full-mouth or panoramic x-rays) once every 24 months $2,000 annual maximum that applies for the following services: $0 copay for fillings (includes composite, resin, and amalgam),

Benefits and what you should know	PriorityMedicare Vintage (HMO-POS)	PriorityMedicare Key (HMO-POS)	PriorityMedicare Value (HMO-POS)
		and amalgam), once per tooth, every 24 months $0 copay for crown repairs, once per tooth every 24 months $0 copay for simple extractions, once per tooth per lifetime $0 copay for anesthesia, when used in conjunction with qualifying dental services	once per tooth, every 24 months $0 copay for crown repairs, once per tooth every 24 months $0 copay for simple extractions, once per tooth per lifetime 50% of the total cost of root canals, once per tooth per lifetime $0 copay for anesthesia, when used in conjunction with qualifying dental services
Vision services Medicare-covered exam performed by a specialist to diagnose and treat diseases and conditions of the eye and additional Medicare-covered services.	**Medicare-covered services** *In-network:* $35 copay for each visit $0 copay for eyeglasses or contact lenses after cataract surgery. $0 copay for a yearly glaucoma screening	**Medicare-covered services** *In-network:* $40 copay for each visit $0 copay for eyeglasses or contact lenses after cataract surgery. $0 copay for a yearly glaucoma screening	**Medicare-covered services** *In-network:* $35 copay for each visit $0 copay for eyeglasses or contact lenses after cataract surgery. $0 copay for a yearly glaucoma screening
In-network routine vision services must be provided by an EyeMed® "Select" provider. If received by a non-EyeMed "Select" provider (out-of-network), you must seek reimbursement. In-network and out-of-network benefits cannot be combined.	*Out-of-network:* 50% of the total cost for each visit, eyeglasses or contact lenses after cataract surgery, or for a yearly glaucoma screening.		*Out-of-network:* 40% of the total cost for each visit, eyeglasses or contact lenses after cataract surgery, or for a yearly glaucoma screening.
	Routine vision services *In-network:*		

Benefits and what you should know	PriorityMedicare Vintage (HMO-POS)	PriorityMedicare Key (HMO-POS)	PriorityMedicare Value (HMO-POS)
	$0 copay for one routine exam each year (includes dilation and refraction) $0 copay for one retinal imaging per year $100 eyewear allowance per year *Out-of-network:* Up to $100 reimbursement for eyewear Up to $50 reimbursement for one routine exam Up to $20 reimbursement for retinal imaging		
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:* $275 copay per day, days 1-6 $0 copay for additional hospital days *Out-of-network:* 50% of the total cost per stay **Outpatient therapy (individual or group)** *In-network:* $20 copay for each visit *Out-of-network:* 50% of the total cost for each visit		**Inpatient visit** *In-network:* $325 copay per day, days 1-5 $0 copay for additional hospital days *Out-of-network:* 40% of the total cost per stay **Outpatient therapy (individual or group)** *In-network:* $20 copay for each visit *Out-of-network:* 40% of the total cost for each visit
Skilled Nursing Facility (SNF) Our plan covers up to 100 days each benefit period. A benefit period starts the day you go into a SNF and ends when you go for 60 days in a row without SNF care. Prior authorization may be required.	*In-network:* Days 1-20: $0 copay each day Days 21-100: $203 copay each day *Out-of-network:* 50% of the total cost per stay for each stay		*In-network:* Days 1-20: $0 copay each day Days 21-100: $203 copay each day *Out-of-network:* 40% of the total cost per stay for each stay

Benefits and what you should know	PriorityMedicare Vintage (HMO-POS)	PriorityMedicare Key (HMO-POS)	PriorityMedicare Value (HMO-POS)
Physical therapy	*In-network:* $25 copay for each service *Out-of-network:* 50% of the total cost for each service		*In-network:* $15 copay for each service *Out-of-network:* 40% of the total cost for each service
Ambulance Prior authorization may be required.	*In- and out-of-network:* $270 copay each way		*In- and out-of-network:* $265 copay each way
Transportation	$0 copay for up to 30 one-way trips every year to or from health-related locations, up to 100 miles per one way trip, including mileage reimbursement.	Not covered	Not covered

PRESCRIPTION DRUG BENEFITS

Prescription drug benefits	PriorityMedicare Vintage (HMO-POS)	PriorityMedicare Key (HMO-POS)	PriorityMedicare Value (HMO-POS)
Medicare Part B drugs Prior authorization or step therapy may be required.	**Chemotherapy drugs** *In- and out-of-network:* 0% to 20% of the total cost for each drug **Other Part B drugs** *In- and out-of-network:* 0% to 20% of the total cost for each drug **Select home infusion drugs** *In- and out-of-network:* $0 copay for each drug **Part B insulin** *In- and out-of-network:* 0% to 20% of the total cost up to $35 for a one-month supply of insulin administered through a durable medical equipment (DME) device item of durable medical equipment (such as insulin pumps or continuous glucose monitors (CGM)).		

PART D OUTPATIENT PRESCRIPTION DRUGS			
Prescription drug benefits	PriorityMedicare Vintage (HMO-POS)	PriorityMedicare Key (HMO-POS)	PriorityMedicare Value (HMO-POS)
Deductible stage You'll pay this amount before you begin paying copays or coinsurance only.	$0	$0	$0
Initial coverage stage You are in this stage until your out-of-pocket Part D drug costs reach $2,000.	You pay what is listed in the chart below.		

PREFERRED RETAIL PHARMACY									
Prescription drug benefits	PriorityMedicare Vintage (HMO-POS)			PriorityMedicare Key (HMO-POS)			PriorityMedicare Value (HMO-POS)		
Initial coverage stage	30 day	60-day	90-day	30-day	60-day	90-day	30-day	60-day	90-day
Tier 1 (Preferred generic)	$4	$8	$0	$4	$8	$0	$2	$4	$0
Tier 2 (Generic)	$15	$30	$45	$15	$30	$45	$10	$20	$30
Tier 3 (Preferred brand)	$35 for insulin and 25% for other drugs	$70 for insulin and 25% for other drugs	$105 for insulin and 25% for other drugs	$35 for insulin and 25% for other drugs	$70 for insulin and 25% for other drugs	$105 for insulin and 25% for other drugs	$35 for insulin and 25% for other drugs	$70 for insulin and 25% for other drugs	$105 for insulin and 25% for other drugs
Tier 4 (Non-preferred drug)	$35 for insulin and 40% for other drugs	$70 for insulin and 40% for other drugs	$105 for insulin and 40% for other drugs	$35 for insulin and 45% for other drugs	$70 for insulin and 45% for other drugs	$105 for insulin and 45% for other drugs	$35 for insulin and 50% for other drugs	$70 for insulin and 50% for other drugs	$105 for insulin and 50% for other drugs
Tier 5 (Specialty)	$35 for insulin and 33% for other drugs	N/A	N/A	$35 for insulin and 33% for other drugs	N/A	N/A	$35 for insulin and 33% for other drugs	N/A	N/A
Your costs will be less for your covered drugs when you use a pharmacy in our preferred network (includes Meijer, Walgreens, Walmart, Family Fare Supermarkets, Costco and more), go to *prioritymedicare.com* to view the list in the provider/pharmacy directory.									

STANDARD RETAIL PHARMACY									
Prescription drug benefits	PriorityMedicare Vintage (HMO-POS)			PriorityMedicare Key (HMO-POS)			PriorityMedicare Value (HMO-POS)		
Initial coverage stage	30-day	60-day	90-day	30-day	60-day	90-day	30-day	60-day	90-day
Tier 1 (Preferred generic)	$10	$20	$30	$10	$20	$30	$7	$14	$21
Tier 2 (Generic)	$20	$40	$60	$20	$40	$60	$15	$30	$45
Tier 3 (Preferred brand)	$35 for insulin and 25% for other drugs	$70 for insulin and 25% for other drugs	$105 for insulin and 25% for other drugs	$35 for insulin and 25% for other drugs	$70 for insulin and 25% for other drugs	$105 for insulin and 25% for other drugs	$35 for insulin and 25% for other drugs	$70 for insulin and 25% for other drugs	$105 for insulin and 25% for other drugs
Tier 4 (Non-preferred drug)	$35 for insulin and 45% for other drugs	$70 for insulin and 45% for other drugs	$105 for insulin and 45% for other drugs	$35 for insulin and 50% for other drugs	$70 for insulin and 50% for other drugs	$105 for insulin and 50% for other drugs	$35 for insulin and 50% for other drugs	$70 for insulin and 50% for other drugs	$105 for insulin and 50% for other drugs
Tier 5 (Specialty)	$35 for insulin and 33% for other drugs	N/A	N/A	$35 for insulin and 33% for other drugs	N/A	N/A	$35 for insulin and 33% for other drugs	N/A	N/A

MAIL ORDER THROUGH EXPRESS SCRIPTS (ESI)									
Prescription drug benefits	PriorityMedicare Vintage (HMO-POS)			PriorityMedicare Key (HMO-POS)			PriorityMedicare Value (HMO-POS)		
Initial coverage stage	30 day	60-day	90-day	30-day	60-day	90-day	30-day	60-day	90-day
Tier 1 (Preferred generic)	$4	$8	$0	$4	$8	$0	$2	$4	$0
Tier 2 (Generic)	$15	$30	$0	$15	$30	$0	$10	$20	$0
Tier 3 (Preferred brand)	$35 for insulin and 25% for other drugs	$70 for insulin and 25% for other drugs	$105 for insulin and 25% for other drugs	$35 for insulin and 25% for other drugs	$70 for insulin and 25% for other drugs	$105 for insulin and 25% for other drugs	$35 for insulin and 25% for other drugs	$70 for insulin and 25% for other drugs	$105 for insulin and 25% for other drugs
Tier 4 (Non-preferred drug)	$35 for insulin and 40% for other drugs	$70 for insulin and 40% for other drugs	$105 for insulin and 40% for other drugs	$35 for insulin and 45% for other drugs	$70 for insulin and 45% for other drugs	$105 for insulin and 45% for other drugs	$35 for insulin and 50% for other drugs	$70 for insulin and 50% for other drugs	$105 for insulin and 50% for other drugs
Tier 5 (Specialty)	$35 for insulin and 33% for other drugs	N/A	N/A	$35 for insulin and 33% for other drugs	N/A	N/A	$35 for insulin and 33% for other drugs	N/A	N/A

Prescription drug benefits	PriorityMedicare Vintage (HMO-POS)	PriorityMedicare Key (HMO-POS)	PriorityMedicare Value (HMO-POS)
Catastrophic coverage stage	Once your out-of-pocket drug costs reach $2,000, the plan pays the full cost of your covered Part D drugs.		
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.		

OPTIONAL ENHANCED DENTAL AND VISION PACKAGE

Benefits and what you should know	PriorityMedicare Vintage (HMO-POS)	PriorityMedicare Key (HMO-POS)	PriorityMedicare Value (HMO-POS)
Benefits	Additional dental coverage, including coverage for dental services and an additional vision allowance for use on eyeglasses or contacts		
Premium	Additional $49 per month. You must keep paying your Medicare Part B premium and your $0 monthly plan premium.	Additional $39 per month. You must keep paying your Medicare Part B premium and your $0 monthly plan premium.	Additional $37 per month. You must keep paying your Medicare Part B premium and your $18-$69 monthly plan premium.
Deductible	$0		
Maximum plan benefit coverage amount	$2,500 for dental services and an additional $150 for eyewear, per calendar year		$2,500 (in addition to the embedded dental services benefit for $4,500) for combined in- and out-of-network comprehensive dental services and an additional $150 for eyewear, per calendar year.
Dental Services Delta Dental® is the preferred provider for additional dental services.	$0 copay for one fluoride treatment per year, fillings (including composite resin and amalgam) once per tooth, every 24 month and crown repairs once per tooth every 12 months. $0 copay for emergency treatment for dental pain at no limit and anesthesia when used in conjunction	$0 copay for one fluoride treatment per year $0 copay for emergency treatment for dental pain at no limit and anesthesia when used in conjunction with qualifying dental services. 50% of the total cost of onlays, crowns and associated substructures, once per tooth, per lifetime	$0 copay for one fluoride treatment per year $0 copay for emergency treatment for dental pain at no limit and anesthesia when used in conjunction with qualifying dental services. 50% of the total cost of onlays, crowns and associated substructures, once per tooth, per lifetime

Benefits and what you should know	PriorityMedicare Vintage (HMO-POS)	PriorityMedicare Key (HMO-POS)	PriorityMedicare Value (HMO-POS)
	with qualifying dental services. 50% of the total cost of onlays, crowns and associated substructures, once per tooth, per lifetime 50% of the total cost of endodontics (root canals), once per tooth per lifetime 50% of the total cost of simple (non-surgical) and surgical extractions, once per tooth per lifetime 50% of the total cost of implants and implant repairs, per tooth, every 5 years 50% of the total cost of dentures, once every 60 months, denture relines and repairs, and bridge repairs, once every 36 months	50% of the total cost of endodontics (root canals), once per tooth per lifetime 50% of the total cost of surgical extractions, once per tooth per lifetime 50% of the total cost of implants and implant repairs, per tooth, every 5 years 50% of the total cost of dentures, once every 60 months, denture relines and repairs, and bridge repairs, once every 36 months	50% of the total cost of surgical extractions, once per tooth per lifetime 50% of the total cost of implants and implant repairs, per tooth, every 5 years 50% of the total cost of dentures and bridges, once every 60 months, denture relines and repairs, and bridge repairs, once every 36 months
Vision services In-network vision services must be provided by an EyeMed® "Select" provider. If received by a non- EyeMed "Select" provider (out-of-network), you must seek reimbursement. In-network and out-of-network benefits cannot be combined.	$150 allowance/reimbursement per year for additional eyewear		

ADDITIONAL MEDICAL BENEFITS COVERED UNDER YOUR PLAN

<table>
<tr><th>Benefits and what you should know</th><th>PriorityMedicare Vintage (HMO-POS)</th><th>PriorityMedicare Key (HMO-POS)</th><th>PriorityMedicare Value (HMO-POS)</th></tr>
<tr><td>Acupuncture</td><td colspan="3">Medicare-covered acupuncture for lower chronic back pain
In- and out-of-network: $20 copay per service

Non-Medicare covered routine acupuncture for other conditions
In- and out-of-network: $20 copay per visit (limit 6 visits every year)</td></tr>
<tr><td rowspan="2">Annual preventive physical exam</td><td colspan="2">In-network: $0 copay for an exam

Out-of-network: 50% of the total cost for an exam</td><td>In-network: $0 copay for an exam

Out-of-network: 40% of the total cost for an exam</td></tr>
<tr><td colspan="3">You’re free to talk at your annual preventive exam. When we say no cost, we mean it -- $0 annual physical exam, without the worry of being charged for an office visit. This is an opportunity for you and your physician to discuss any concerns or questions you have.</td></tr>
<tr><td>Caregiver Support
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.</td><td>$0 copay for unlimited hours of caregiver support provided by Carallel®.</td><td colspan="2">Not covered</td></tr>
<tr><td>CogniFit®</td><td>Not covered</td><td colspan="2">$0 copay

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.</td></tr>
<tr><td>Chiropractic care</td><td colspan="2">Medicare-covered care
In-network: $20 copay for each visit

Out-of-network: 50% of the total cost for each visit</td><td>Medicare-covered care

In-network: $20 copay for each visit</td></tr>
</table>

Benefits and what you should know	PriorityMedicare Vintage (HMO-POS)	PriorityMedicare Key (HMO-POS)	PriorityMedicare Value (HMO-POS)
	Non-Medicare covered routine care *In-network:* $20 copay for each visit $35 copay for X-ray services performed once per year. *Out-of-network*: 50% of the total cost for each visit and for X-ray services performed once per year. Limited to 12 non-Medicare covered routine visits per year in-network only.		*Out-of-network:* 40% of the total cost for each visit **Non-Medicare covered routine care** Not covered
Dialysis	*In-network:* 20% of the total cost for each service *Out-of-network:* 50% of the total cost for each service		*In-network:* 20% of the total cost for each service *Out-of-network:* 40% of the total cost for each service
Home health services Prior authorization may be required.	*In- and out-of-network:* $0 copay for each Medicare-covered service		
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 JJHCS and Bayer products when dispensed by a retail pharmacy or mail-order pharmacy. Prior authorization may be required.	**Diabetes supplies** *In-network:* $0 copay for each item *Out-of-network:* 50% of the total cost for each item **Durable medical equipment** *In-network:* 20% of the total cost for each item *Out-of-network:* 30% of the total cost for each item **Prosthetic devices** *In-network: $0* -20% of the total cost for each item, depending on the device. *Out-of-network:* 30% of the total cost for each device		**Diabetes supplies** *In-network:* $0 copay for each item *Out-of-network:* 40% of the total cost for each item **Durable medical equipment** *In-network:* 20% of the total cost for each item *Out-of-network:* 30% of the total cost for each item **Prosthetic devices** *In-network: $0* -20% of the total cost for each item,

Benefits and what you should know	PriorityMedicare Vintage (HMO-POS)	PriorityMedicare Key (HMO-POS)	PriorityMedicare Value (HMO-POS)
			depending on the device *Out-of-network:* 30% of the total cost for each device
Over-the-counter (OTC) allowance Over-the-counter items are drugs and health related products that do not need a prescription such as allergy medication, eye drops, cough drops, nasal spray, vitamins and more.	Not covered	Regions 1 & 2: $75 allowance per quarter Region 3 & 4: $45 allowance per quarter Region 5: $80 allowance per quarter **Quarterly allowances do not rollover. *See table later in this document for a list of counties by region.*	Region 1: $50 allowance per quarter Region 2, 3, 4 and 5: $25 allowance per quarter **Quarterly allowances do not rollover. *See table later in this document for a list of counties by region.*
		OTC items, home and bathroom safety devices and modifications can be purchased in participating stores (Meijer, Walmart, Walgreens, CVS, Kroger and more) and online at ***PriorityHealth.com/shopOTC***. You can also call 833.415.4380 or download the Priority Health OTC app.	
Podiatry services	**Medicare-covered podiatry** *In-network:* $35 copay for each visit $0 copay for nail debridement and callous removal for	**Medicare-covered podiatry** *In-network:* $40 copay for each visit $0 copay for nail debridement and callous removal for	**Medicare-covered podiatry** *In-network:* $35 copay for each visit $0 copay for nail debridement and callous removal for

Benefits and what you should know	PriorityMedicare Vintage (HMO-POS)	PriorityMedicare Key (HMO-POS)	PriorityMedicare Value (HMO-POS)
	members with specific conditions (up to 6 of each) *Out-of-network:* 50% of the total cost for each visit and service	members with specific conditions (up to 6 of each) *Out-of-network:* 50% of the total cost for each visit and service	members with specific conditions (up to 6 of each) *Out-of-network:* 40% of the total cost for each visit and service
Priority Health Travel Pass	**Out-of-area travel benefit** You'll pay in-network prices when seeking care from Medicare-participating providers anywhere in the U.S. outside of the lower peninsula of Michigan. Our partnership with Multiplan® can make accessing Medicare-participating providers even easier. You may stay enrolled in the plan when outside of the service area for up to 12 months as long as your permanent residency remains in your plan's service area. **Worldwide urgent and emergent care** Unlimited worldwide emergent and urgent care coverage. **Worldwide travel assistance program** $0 for emergency travel assistance services through Assist America® when you're more than 100 miles from home or in a foreign country. Assist America® provides pre-trip assistance to help you prepare for your travel, including finding a doctor or a pharmacy to fill your prescriptions at your destination and assistance while on your trip should a medical travel emergency arise, at no extra cost to you. You will still pay for benefits covered by Priority Health Medicare, such as emergency, urgent care, or prescription drug copays.		

Benefits and what you should know	PriorityMedicare Vintage (HMO-POS)	PriorityMedicare Key (HMO-POS)	PriorityMedicare Value (HMO-POS)
Rehabilitation services	**Cardiac rehabilitation services** *In-network:* $20 copay for each service *Out-of-network:* 50% of the total cost for each service	**Cardiac rehabilitation services** *In-network:* $20 copay for each service *Out-of-network:* 50% of the total cost for each service	**Cardiac rehabilitation services** *In-network:* $10 copay for each service *Out-of-network:* 40% of the total cost for each service
	Pulmonary rehabilitation and supervised exercise therapy (SET) services *In-network:* $15 copay for each service *Out-of-network:* 50% of the total cost for each service	**Pulmonary rehabilitation and supervised exercise therapy (SET) services** *In-network:* $15 copay for each service *Out-of-network:* 50% of the total cost for each service	**Pulmonary rehabilitation and supervised exercise therapy (SET) services** *In-network:* $10 copay for each service *Out-of-network:* 40% of the total cost for each service
	Physical therapy, occupational therapy, and speech therapy services *In-network:* $25 copay for each service *Out-of-network:* 50% of the total cost for each service	**Physical therapy, occupational therapy, and speech therapy services** *In-network:* $25 copay for each service *Out-of-network:* 50% of the total cost for each service	**Physical therapy, occupational therapy, and speech therapy services** *In-network:* $15 copay for each service *Out-of-network:* 40% of the total cost for each service

Benefits and what you should know	PriorityMedicare Vintage (HMO-POS)	PriorityMedicare Key (HMO-POS)	PriorityMedicare Value (HMO-POS)
One Pass® Fitness membership	Not covered	$0 copay 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) • Meal delivery services to make healthy eating easy	
Virtual care Online care you receive from the comfort of your home, or wherever you may be, with a virtual visit via video on your computer, smart phone, or tablet.	*In-network:* $0 copay 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 *Out-of-network:* Not covered		

PREMIUMS AND BENEFITS | Monthly Premiums

Counties	PriorityMedicare Vintage (HMO-POS)	PriorityMedicare Key (HMO-POS)	PriorityMedicare Value (HMO-POS)
Region 1: Allegan, Barry, Kent, Lenawee, Ottawa	$0	$0	$18

Counties	PriorityMedicare Vintage (HMO-POS)	PriorityMedicare Key (HMO-POS)	PriorityMedicare Value (HMO-POS)
Region 2: Berrien, Calhoun, Cass, Ionia, Isabella, Kalamazoo, Mason, Midland, Missaukee, Montcalm, Muskegon, Newaygo, Oceana, Osceola, Otsego, St. Clair, Van Buren, Wexford	$0	$0	$32
Region 3: Alcona, Antrim, Benzie, Charlevoix, Clare, Crawford, Grand Traverse, Hillsdale, Lake, Lapeer, Leelanau, Manistee, Mecosta, Monroe	N/A	$0	$69
Region 4: Alpena, Cheboygan, Eaton, Emmet, Gladwin, Gratiot, Iosco, Jackson, Kalkaska, Montmorency, Oscoda, Presque Isle, Roscommon, Sanilac, Shiawassee, St. Joseph	N/A	$0	$44
Region 5: Arenac, Bay, Branch, Clinton, Genesee, Huron, Ingham, Livingston, Macomb, Oakland, Ogemaw, Saginaw, Tuscola, Washtenaw, Wayne	$0	$0	$32

Highest coverage plans

More coverage for more peace of mind

PriorityMedicare[SM] (HMO-POS)
PriorityMedicare[SM] Merit (PPO)

PREMIUMS AND BENEFITS

Benefits and what you should know	PriorityMedicare (HMO-POS)	PriorityMedicare Merit (PPO)
Plan availability Plans are available in the regions listed. *See table later in this document for a listing of counties by region.*	Regions 1, 2, 3, 4 and 5	
Monthly plan premium	$55-$109 per month. You must keep paying your Medicare Part B premium.	$59-$118 per month. You must keep paying your Medicare Part B premium.
Deductible The amount you'll pay for most covered services before you start paying only copays or coinsurance and Priority Health pays the balance.	**Medical services** *In-network:* $0 *Out-of-network:* $500, applies to hospital and medical services except for acupuncture and insulin furnished through an item of durable medical equipment.	**Medical services** *In-network:* $0 *In-network and out-of-network: (combined):* $0
	Prescription drugs (Part D) $0	**Prescription drugs (Part D)** $0
Maximum out-of-pocket amount This is the most you pay for covered medical services for the year, excluding Part D prescription drugs.	*In-network: $4,500*	*In-network and out-of-network (combined): $4,100*

MEDICAL BENEFITS COVERED UNDER YOUR PLAN

Benefits and what you should know	PriorityMedicare (HMO-POS)	PriorityMedicare Merit (PPO)
Inpatient hospital coverage We cover an unlimited number of days for an inpatient hospital stay. Prior authorization may be required.	*In-network:* $225 copay per day, days 1-6 $0 for additional hospital days *Out-of-network:* 30% of the total cost per stay	*In-network:* $275 copay per day, days 1-6. $0 for additional hospital days *Out-of-network:* 30% of the total cost per stay
Outpatient hospital coverage Prior authorization may be required.	**Outpatient hospital** *In-network:*	**Outpatient hospital** *In-network:* $0 for each rural health clinic visit

Benefits and what you should know	PriorityMedicare (HMO-POS)	PriorityMedicare Merit (PPO)
	$0 for each rural health clinic visit $175 for each Medicare-covered outpatient hospital facility visit *Out-of-network:* 30% of the total cost for each visit **Observation** *In- and out-of-network:* $120 copay per stay for each visit, including all services received.	$225 for each Medicare-covered outpatient hospital facility visit *Out-of-network:* 30% of the total cost for each visit **Observation** *In- and out-of-network:* $120 copay per stay for each visit, including all services received.
Ambulatory surgical center coverage Prior authorization may be required.	*In-network:* $175 copay for each visit *Out-of-network:* 30% of the total cost for each visit	*In-network:* $225 copay for each visit *Out-of-network:* 30% of the total cost for each visit
Doctor visits Prior authorization may be required for some specialist visits.	**Primary care physician (PCP)** *In-network:* $0 copay for each office visit and surgical procedures performed in a PCP's office *Out-of-network:* 30% of the total cost for each visit **Specialist visit** *In-network:* $0 copay for palliative care physician office visit $0 copay for surgical procedures performed in a specialist's office $40 copay for all other office visits	**Primary care physician (PCP)** *In-network:* $0 copay for each office visit and surgical procedures performed in a PCP's office *Out-of-network:* 30% of the total cost for each visit **Specialist visit** *In-network:* $0 copay for palliative care physician office visit $0 copay for surgical procedures performed in a specialist's office $45 copay for all other office visits

Benefits and what you should know	PriorityMedicare (HMO-POS)	PriorityMedicare Merit (PPO)
	Out-of-network: 30% of the total cost for each visit	*Out-of-network:* 30% of the total cost for each visit
Preventive care Services that can help with prevention and early detection of many illnesses, disabilities, and diseases. Examples include annual wellness visit, breast cancer screening, diabetic screening, flu vaccine and more.	*In-network:* $0 copay for each service *Out-of-network:* 30% of the total cost for each service	
	A referral from your doctor may be required for some preventive services. Any additional preventive services approved by Medicare during the contract year will be covered.	
Emergency care This amount is waived if you are admitted as inpatient to the hospital within 24 hours from your emergency care visit.	*In- and out-of-network:* $120 copay for each visit	
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- and out-of-network:* $50 copay for each visit	*In- and out-of-network:* $55 copay for each visit
Outpatient diagnostic services (labs, radiology/imaging and X-rays) Prior authorization may be required for some services.	**Radiology/ imaging** *In-network:* $125 copay per day, per provider	**Radiology/ imaging** *In-network:* $125 copay per day, per provider
	Tests/procedures *In-network:* $30 copay per day, per provider	**Tests/procedures** *In-network:* $20 copay per day, per provider
	Lab services *In-network:* $0 for anticoagulant lab services, $30 for all other Medicare-covered lab services	**Lab services** *In-network:* $0 for anticoagulant labs, $20 for all other Medicare-covered lab services
	Outpatient X-rays *In-network:* $35 copay per day, per provider	**Outpatient X-rays** *In-network:* $35 copay per day, per provider
	Radiation therapy *In-network:* $20 copay per day, per provider *For all out-of-network services listed above:* $0-	**Radiation therapy** *In-network:* $30 copay per day, per provider *For all out-of-network services listed above:* $0-30% of the total

Benefits and what you should know	PriorityMedicare (HMO-POS)	PriorityMedicare Merit (PPO)
	30% of the total cost per day, per provider ($0 for anticoagulant lab services).	cost per day, per provider ($0 for anticoagulant lab services).
Hearing services Medicare-covered exam performed by a primary care physician or specialist to diagnose and treat hearing and balance issues.	**Medicare-covered diagnostic hearing exam** *In-network:* $0- $40 copay for each office visit *Out-of-network:* 30% of the total cost for each visit	**Medicare-covered diagnostic hearing exam** *In-network:* $0- $45 copay for each office visit *Out-of-network:* 30% of the total cost for each visit
Routine hearing services must be received from a TruHearing® provider.	**Routine hearing coverage (TruHearing® provider)** $0 copay for one routine hearing exam, per year $295, $695, $1,095 or $1,495 copay, per ear per year, for hearing aids from top manufacturers depending on level selected. Hearing aid cost includes a 60-day trial period, one year of post-purchase follow-up visits, 80 batteries per non-rechargeable hearing aid and a full 3-year manufacturer warranty.	
Dental services Prior authorization may be required for Medicare-covered dental services.	**Medicare-covered dental services** *In-network:* $0- $175 copay for each visit, depending on the service performed *Out-of-network:* 30% of the total cost for each service performed	**Medicare-covered dental services** *In-network:* $0- $225 copay for each visit, depending on the service performed *Out-of-network:* 30% of the total cost for each service performed
Delta Dental® is the preferred provider for additional dental services.	$0 for two cleanings (regular or periodontal maintenance) per year $0 for two exams per year $0 for one set of bitewing X-rays per year $0 for one brush biopsy per year $0 for periapical radiographs as needed $0 for radiographs (full-mouth or panoramic x-rays) once every 24 months	
Vision services Medicare-covered exam performed by a specialist to diagnose and treat diseases and conditions of the eye and	**Medicare-covered services** *In-network:* $40 copay for each visit	**Medicare-covered services** *In-network:* $45 copay for each visit

Benefits and what you should know	PriorityMedicare (HMO-POS)	PriorityMedicare Merit (PPO)
additional Medicare-covered services. In-network routine vision services must be provided by an EyeMed® "Select" provider. If received by a non-EyeMed "Select" provider (out-of-network), you must seek reimbursement. In-network and out-of-network benefits cannot be combined.	$0 copay for eyeglasses or contact lenses after cataract surgery $0 copay for a yearly glaucoma screening *Out-of-network:* 30% of the total cost for each service **Routine vision services** *In-network:* $0 copay for one routine exam each year (includes dilation and refraction) $0 copay for one retinal imaging per year $100 eyewear allowance per year *Out-of-network:* Up to $100 reimbursement for eyewear Up to $50 reimbursement for one routine exam Up to $20 reimbursement for retinal imaging	$0 copay for eyeglasses or contact lenses after cataract surgery $0 copay for a yearly glaucoma screening *Out-of-network:* 30% of the total cost for each service **Routine vision services** *In-network:* $0 copay for one routine exam each year (includes dilation and refraction) $0 copay for one retinal imaging per year $100 eyewear allowance per year *Out-of-network:* Up to $100 reimbursement for eyewear Up to $50 reimbursement for one routine exam Up to $20 reimbursement for retinal imaging
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:* $225 copay per day, days 1-6 $0 copay for additional hospital days *Out-of-network:* 30% of the total cost per stay **Outpatient therapy (individual or group)** *In-network:* $20 copay for each visit	**Inpatient visit** *In-network:* $350 copay per day, days 1-5 $0 copay for additional hospital days *Out-of-network:* 30% of the total cost per stay **Outpatient therapy (individual or group)** *In-network:* $20 copay for each visit

Benefits and what you should know	PriorityMedicare (HMO-POS)	PriorityMedicare Merit (PPO)
	Out-of-network: 30% of the total cost per visit	*Out-of-network:* 30% of the total cost per visit
Skilled Nursing Facility (SNF) Our plan covers up to 100 days each benefit period. A benefit period starts the day you go into a SNF and ends when you go for 60 days in a row without SNF care. Prior authorization may be required.	*In-network:* Days 1-20: $0 copay each day Days 21-100: $203 copay each day *Out-of-network:* 30% of the total cost per stay	
Physical therapy	*In-network:* $35 copay for each service *Out-of-network:* 30% of the total cost for each service	
Ambulance Prior authorization may be required.	*In- and out-of-network:* $210 copay each way	*In- and out-of-network:* $270 copay each way
Transportation	Not covered	

PRESCRIPTION DRUG BENEFITS

Prescription drug benefits	PriorityMedicare (HMO-POS)	PriorityMedicare Merit (PPO)
Medicare Part B drugs Prior authorization or step therapy may be required.	**Chemotherapy drugs** *In- and out-of-network:* 0% to 20% of the total cost for each drug **Other Part B drugs** *In- and out-of-network:* 0% to 20% of the total cost for each drug **Select home infusion drugs** *In- and out-of-network:* $0 copay for each drug **Part B insulin** *In- and out-of-network:* 0% to 20% up to $35 of the total cost for a one-month supply of insulin administered through a durable medical equipment (DME) device (such as insulin pumps or continuous glucose monitors (CGM)).	

PART D OUTPATIENT PRESCRIPTION DRUGS		
Prescription drug benefits	PriorityMedicare (HMO-POS)	PriorityMedicare Merit (PPO)
Deductible stage You'll pay this amount before you begin paying copays or coinsurance only.	$0	$0
Initial coverage stage You are in this stage until your out-of-pocket Part D drug costs reach $2,000.	You pay what is listed in the chart below.	

PREFERRED RETAIL PHARMACY						
Prescription drug benefits	PriorityMedicare (HMO-POS)			PriorityMedicare Merit (PPO)		
Initial coverage stage	30-day	60-day	90-day	30-day	60-day	90-day
Tier 1 (Preferred generic)	$1	$2	$0	$2	$4	$0
Tier 2 (Generic)	$8	$16	$24	$10	$20	$30
Tier 3 (Preferred brand)	$35 for insulin and 25% for other drugs	$70 for insulin and 25% for other drugs	$105 for insulin and 25% for other drugs	$35 for insulin and 25% for other drugs	$70 for insulin and 25% for other drugs	$105 for insulin and 25% for other drugs
Tier 4 (Non-preferred drug)	$35 for insulin and 45% for other drugs	$70 for insulin and 45% for other drugs	$105 for insulin and 45% for other drugs	$35 for insulin and 50% for other drugs	$70 for insulin and 50% for other drugs	$105 for insulin and 50% for other drugs
Tier 5 (Specialty)	$35 for insulin and 33% for other drugs	N/A	N/A	$35 for insulin and 33% for other drugs	N/A	N/A
Your costs will be less for your covered drugs when you use a pharmacy in our preferred network (includes Meijer, Walgreens, Walmart, Family Fare Supermarkets, Costco and more), go to *prioritymedicare.com* to view the list in the provider/pharmacy directory.						

STANDARD RETAIL PHARMACY						
Prescription drug benefits	PriorityMedicare (HMO-POS)			PriorityMedicare Merit (PPO)		
Initial coverage stage	30-day	60-day	90-day	30-day	60-day	90-day
Tier 1 (Preferred generic)	$6	$12	$18	$7	$14	$21
Tier 2 (Generic)	$13	$26	$39	$15	$30	$45
Tier 3 (Preferred brand)	$35 for insulin and 25% for other drugs	$70 for insulin and 25% for other drugs	$105 for insulin and 25% for other drugs	$35 for insulin and 25% for other drugs	$70 for insulin and 25% for other drugs	$105 for insulin and 25% for other drugs
Tier 4 (Non-preferred drug)	$35 for insulin and 45% for other drugs	$70 for insulin and 45% for other drugs	$105 for insulin and 45% for other drugs	$35 for insulin and 50% for other drugs	$70 for insulin and 50% for other drugs	$105 for insulin and 50% for other drugs
Tier 5 (Specialty)	$35 for insulin and 33% for other drugs	N/A	N/A	$35 for insulin and 33% for other drugs	N/A	N/A

MAIL ORDER THROUGH EXPRESS SCRIPTS (ESI)						
Prescription drug benefits	PriorityMedicare (HMO-POS)			PriorityMedicare Merit (PPO)		
Initial coverage stage	30-day	60- day	90-day	30-day	60-day	90-day
Tier 1 (Preferred generic)	$1	$2	$0	$2	$4	$0
Tier 2 (Generic)	$8	$16	$0	$10	$20	$0
Tier 3 (Preferred brand)	$35 for insulin and 25% for other drugs	$70 for insulin and 25% for other drugs	$105 for insulin and 25% for other drugs	$35 for insulin and 25% for other drugs	$70 for insulin and 25% for other drugs	$105 for insulin and 25% for other drugs
Tier 4 (Non-preferred drug)	$35 for insulin and 45% for other drugs	$70 for insulin and 45% for other drugs	$105 for insulin and 45% for other drugs	$35 for insulin and 50% for other drugs	$70 for insulin and 50% for other drugs	$105 for insulin and 50% for other drugs
Tier 5 (Specialty)	$35 for insulin and 33% for other drugs	N/A	N/A	$35 for insulin and 33% for other drugs	N/A	N/A

Prescription drug benefits	PriorityMedicare (HMO-POS)	PriorityMedicare Merit (PPO)
Catastrophic coverage stage	Once your out-of-pocket drug costs reach $2,000, the plan pays the full cost of your covered Part D drugs.	
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.	

OPTIONAL ENHANCED DENTAL AND VISION PACKAGE

Benefits and what you should know	PriorityMedicare (HMO-POS)	PriorityMedicare Merit (PPO)
Benefits	Additional dental coverage, including coverage for dental services and an additional vision allowance for use on eyeglasses or contacts	
Premium	An additional $49 per month. You must keep paying your Medicare Part B premium and your $55-$109 monthly plan premium.	An additional $49 per month. You must keep paying your Medicare Part B premium and your $59-$118 monthly plan premium.
Deductible	$0	$0
Maximum plan benefit coverage amount	$2,500 for dental services and an additional $150 for eyewear, per calendar year	
Dental services Delta Dental® is the preferred provider for additional dental services.	$0 copay for fillings, including composite resin and amalgam, once per tooth, every 24 months, crown repairs once per tooth every 12 months, one fluoride treatment per year, emergency treatment of dental pain, and anesthesia when used in conjunction with qualifying dental services, each year. 50% of the total cost for implants & implant repairs per tooth every 5 years 50% of the total cost for simple (non-surgical) and surgical extractions, once per tooth per lifetime 50% of the total cost for endodontics (root canals), once per tooth per lifetime 50% of the total cost of dentures once every 60 months, denture relines and repairs and bridge repairs, once every 36 months 50% of the total cost of onlays, crowns and associated substructures, once per tooth, every 60 months	
Vision services	$150 allowance/reimbursement per year for additional eyewear In-network vision services must be provided by an EyeMed® “Select” provider. If received by a non- EyeMed “Select” provider (out-of-network), you must seek reimbursement. In-network and out-of-network benefits cannot be combined.	

ADDITIONAL MEDICAL BENEFITS COVERED UNDER YOUR PLAN

Benefits and what you should know	PriorityMedicare (HMO-POS)	PriorityMedicare Merit (PPO)
Acupuncture	**Medicare-covered acupuncture for lower chronic back pain** *In- and out-of-network:* $20 copay per service **Non-Medicare covered routine acupuncture for other conditions** *In- and out-of-network:* $20 copay per visit (limit 6 visits every year)	
Annual preventive physical exam	*In-network:* $0 copay for an exam *Out-of-network:* 30% of the total cost for an exam You're free to talk at your annual preventive exam. When we say no cost, we mean it - $0 annual physical exam, without the worry of being charged for an office visit. This is an opportunity for you and your physician to discuss any concerns or questions you have.	
Cognifit®	$0 copay 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.	
Chiropractic care	**Medicare-covered care** *In-network:* $20 copay for each service *Out-of-network:* 30% of the total cost per service	
Dialysis	*In-network:* 20% of the total cost for each service *Out-of-network*: 30% of the total cost for each service	
Home health services Prior authorization may be required.	*In- and out-of-network:* $0 copay for each Medicare-covered service	

Benefits and what you should know	PriorityMedicare (HMO-POS)	PriorityMedicare Merit (PPO)
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 JJHCS and Bayer products when dispensed by a retail pharmacy or mail-order pharmacy. Prior authorization may be required.	**Diabetes supplies** *In-network:* $0 copay for each item *Out-of-network:* 30% of the total cost for each item **Durable medical equipment** *In-network:* 20% of the total cost for each item *Out-of-network:* 30% of the total cost for each item **Prosthetic devices** *In-network:* $0-20% of the total cost for each item, depending on the device *Out-of-network:* 30% of the total cost for each device	
Podiatry services	**Medicare-covered podiatry:** *In-network:* $40 copay for each visit $0 copay for nail debridement and callous removal for members with specific conditions (up to 6 of each) *Out-of-network:* 30% of the total cost for each visit	**Medicare-covered podiatry:** *In-network:* $45 copay for each visit $0 copay for nail debridement and callous removal for members with specific conditions (up to 6 of each) *Out-of-network:* 30% of the total cost for each visit

Benefits and what you should know	PriorityMedicare (HMO-POS)	PriorityMedicare Merit (PPO)
Priority Health Travel Pass	**Out-of-area travel benefit** You'll pay in-network prices when seeking care from Medicare-participating providers anywhere in the U.S. outside of the lower peninsula of Michigan. Our partnership with Multiplan® can make accessing Medicare-participating providers even easier. You may stay enrolled in the plan when outside of the service area for up to 12 months as long as your permanent residency remains in your plan's service area. **Worldwide urgent and emergent care** Unlimited worldwide emergent and urgent care coverage. **Worldwide travel assistance program** $0 for emergency travel assistance services through Assist America® when you're more than 100 miles from home or in a foreign country. Assist America® provides pre-trip assistance to help you prepare for your travel, including finding a doctor or a pharmacy to fill your prescriptions at your destination and assistance while on your trip should a medical travel emergency arise, at no extra cost to you. You will still pay for benefits covered by Priority Health Medicare, such as emergency, urgent care, or prescription drug copays.	
Rehabilitation services	**Cardiac rehabilitation services** *In-network:* $20 copay for each service *Out-of-network:* 30% of the total cost for each service	**Cardiac rehabilitation services** *In-network:* $20 copay for each service *Out-of-network:* 30% of the total cost for each service
	Pulmonary rehabilitation and supervised exercise therapy (SET) services *In-network:* $15 copay for each service *Out-of-network:* 30% of the total cost for each service	**Pulmonary rehabilitation and supervised exercise therapy (SET) services** *In-network:* $15 copay for each service *Out-of-network:* 30% of the total cost for each service

Benefits and what you should know	PriorityMedicare (HMO-POS)	PriorityMedicare Merit (PPO)
	Physical therapy, occupational therapy, and speech therapy services *In-network:* $35 copay for each service *Out-of-network:* 30% of the total cost for each service	**Physical therapy, occupational therapy, and speech therapy services** *In-network:* $35 copay for each service *Out-of-network:* 30% of the total cost for each service
One Pass® Fitness membership	$0 copay 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) • Meal delivery services to make healthy eating easy.	
Virtual care Online care you receive from the comfort of your home, or wherever you may be, with a virtual visit via video on your computer, smart phone, or tablet.	*In-network:* $0 copay 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 *Out-of-network:* Not covered	

PREMIUMS AND BENEFITS | Monthly Premiums

Counties	PriorityMedicare (HMO-POS)	PriorityMedicare Merit (PPO)
Region 1: Allegan, Barry, Kent, Lenawee, Ottawa	$70	$59
Region 2: Berrien, Calhoun, Cass, Ionia, Isabella, Kalamazoo, Mason, Midland, Missaukee, Montcalm, Muskegon, Newaygo, Oceana, Osceola, Otsego, St. Clair, Van Buren, Wexford	$75	$72
Region 3: Alcona, Antrim, Benzie, Charlevoix, Clare, Crawford, Grand Traverse, Hillsdale, Lake, Lapeer, Leelanau, Manistee, Mecosta, Monroe	$109	$104
Region 4: Alpena, Cheboygan, Eaton, Emmet, Gladwin, Gratiot, Iosco, Jackson, Kalkaska, Montmorency, Oscoda, Presque Isle, Roscommon, Sanilac, Shiawassee, St. Joseph	$99	$118
Region 5: Arenac, Bay, Branch, Clinton, Genesee, Huron, Ingham, Livingston, Macomb, Oakland, Ogemaw, Saginaw, Tuscola, Washtenaw, Wayne	$55	$95

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 expert at 877.230.1560 from 8 a.m. to 8 p.m. (TTY 711).

Understanding the benefits

- The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit ***prioritymedicare.com*** or call 877.230.1560 to view a copy of the EOC.
- Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the 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 for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- Review the formulary to make sure your drugs are covered.

Understanding important rules

- In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- Benefits, premiums and/or copayments/co-insurance may change on Jan. 1, 2026.
- Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for certain covered services for HMO-POS plans that are provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situations, non-contracted providers may deny care. In addition, you may pay a higher copay for services received by non-contracted providers.

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 help 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 any of the plan(s) below. (This does not include any Medicare Part B premium you may have to pay.)

- **Priority**Medicare Edge (PPO)
- **Priority**Medicare Key (HMO-POS)
- **Priority**Medicare Vintage (HMO-POS)
- **Priority**Medicare Vital (PPO)

PriorityMedicare Value℠ (HMO-POS)

Region 1: Allegan, Barry, Kent, Lenawee, Ottawa
If you receive Low Income Subsidy, your monthly premium will be $0.40.

Region 2: Berrien, Calhoun, Cass, Ionia, Isabella, Kalamazoo, Mason, Midland, Missaukee, Montcalm, Muskegon, Newaygo, Oceana, Osceola, Otsego, St. Clair, Van Buren, Wexford
If you receive Low Income Subsidy, your monthly premium will be $14.40.

Region 3: Alcona, Antrim, Benzie, Charlevoix, Clare, Crawford, Grand Traverse, Hillsdale, Lake, Lapeer, Leelanau, Manistee, Mecosta, Monroe
If you receive Low Income Subsidy, your monthly premium will be $51.40.

Region 4: Alpena, Cheboygan, Eaton, Emmet, Gladwin, Gratiot, Iosco, Jackson, Kalkaska, Montmorency, Oscoda, Presque Isle, Roscommon, Sanilac, Shiawasse, St. Joseph
If you receive Low Income Subsidy, your monthly premium will be $26.40.

Region 5: Arenac, Bay, Branch, Clinton, Genesee, Huron, Ingham, Livingston, Macomb, Oakland, Ogemaw, Saginaw, Tuscola, Washtenaw, Wayne
If you receive Low Income Subsidy, your monthly premium will be $14.40.

PriorityMedicare Merit℠ (PPO)

Region 1: Allegan, Barry, Kent, Lenawee, Ottawa
If you receive Low Income Subsidy, your monthly premium will be $32.40.

Region 2: Berrien, Calhoun, Cass, Ionia, Isabella, Kalamazoo, Mason, Midland, Missaukee, Montcalm, Muskegon, Newaygo, Oceana, Osceola, Otsego, St. Clair, Van Buren, Wexford
If you receive Low Income Subsidy, your monthly premium will be $45.40.

Region 3: Alcona, Antrim, Benzie, Charlevoix, Clare, Crawford, Grand Traverse, Hillsdale, Lake, Lapeer, Leelanau, Manistee, Mecosta, Monroe
If you receive Low Income Subsidy, your monthly premium will be $77.40.

Region 4: Alpena, Cheboygan, Eaton, Emmet, Gladwin, Gratiot, Iosco, Jackson, Kalkaska, Montmorency, Oscoda, Presque Isle, Roscommon, Sanilac, Shiawasse, St. Joseph
If you receive Low Income Subsidy, your monthly premium will be $91.40.

Region 5: Arenac, Bay, Branch, Clinton, Genesee, Huron, Ingham, Livingston, Macomb, Oakland, Ogemaw, Saginaw, Tuscola, Washtenaw, Wayne
If you receive Low Income Subsidy, your monthly premium will be $68.40.

PriorityMedicare[SM](HMO-POS)

Region 1: Allegan, Barry, Kent, Lenawee, Ottawa
If you receive Low Income Subsidy, your monthly premium will be $43.40.

Region 2: Berrien, Calhoun, Cass, Ionia, Isabella, Kalamazoo, Mason, Midland, Missaukee, Montcalm, Muskegon, Newaygo, Oceana, Osceola, Otsego, St. Clair, Van Buren, Wexford
If you receive Low Income Subsidy, your monthly premium will be $48.40.

Region 3: Alcona, Antrim, Benzie, Charlevoix, Clare, Crawford, Grand Traverse, Hillsdale, Lake, Lapeer, Leelanau, Manistee, Mecosta, Monroe
If you receive Low Income Subsidy, your monthly premium will be $82.40.

Region 4: Alpena, Cheboygan, Eaton, Emmet, Gladwin, Gratiot, Iosco, Jackson, Kalkaska, Montmorency, Oscoda, Presque Isle, Roscommon, Sanilac, Shiawasse, St. Joseph
If you receive Low Income Subsidy, your monthly premium will be $72.40.

Region 5: Arenac, Bay, Branch, Clinton, Genesee, Huron, Ingham, Livingston, Macomb, Oakland, Ogemaw, Saginaw, Tuscola, Washtenaw, Wayne
If you receive Low Income Subsidy, your monthly premium will be $28.40.

Priority Health'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 call Customer Service at 888.389.6648 (TTY 711) from 8 a.m. to 8 p.m., seven days a week.

Priority Health has been named to Newsweek's America's Best Customer Service 2024 list. Based on an independent survey of U.S. customers who have either made purchases, used services, or gathered information about products or services in the past three years.

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.

Priority Health's pharmacy network includes limited lower-cost, preferred pharmacies 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 whether there are any lower-cost preferred pharmacies in your area, please call 888.389.6648, TTY users 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. 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.

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