



Summary of benefits

This booklet gives you a summary of the benefits you can expect when you choose a **Priority**Medicare® Employer plan.

PriorityMedicare® Employer HMO-POS

Christian Schools International (CSI)

January 1, 2026 - December 31, 2026

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

H2320_NCMS100010992611L_M 06302025

Overview of in-network benefits



Plan premium, deductible, part B rebate and maximum out-of-pocket (MOOP)

Monthly plan premium (Part C and D premium combined)	Contact benefit administrator
Part B rebate	Not applicable
Deductible	\$200
Maximum out-of-pocket responsibility (MOOP)	\$2,000



Medical and hospital benefits

Benefit	Your in-network costs
Inpatient Hospital (unlimited number of days covered by plan)	\$0 copay*
Outpatient Hospital	\$0 copay*
Ambulatory surgical center (ASC)	\$0 copay*



Primary Care provider (PCP), specialist, virtual and palliative care visits

Benefit	Your in-network costs
PCP	\$10 copay*
Specialist	\$25 copay*
Virtual visits	\$0 copay*
Palliative care visit	\$0 copay*

Prior authorization may apply for some benefits. Contact the plan for more information.

*Deductible does not apply

Overview of in-network benefits



Preventive services

Benefit	Your in-network costs
Preventative services covered but not limited to:	\$0 copay*
<ul style="list-style-type: none">• Abdominal Aortic Aneurysm Screening• Annual preventative physical exam - (Free to talk and anytime within the calendar year)• Annual wellness visit (Free to talk and anytime within the calendar year)• Bone mass measurement• Breast cancer screening (mammograms)• Cardiovascular disease risk reduction• Cardiovascular disease testing• Cervical and vaginal cancer screening• Colorectal cancer screening• Depression screening• Diabetes screening• Diabetes self-management training• Hepatitis C screening• HIV screening• Immunizations• Medical nutrition therapy• Medicare diabetes prevention program• Obesity screening and therapy to promote sustained weight loss• Prostate cancer screening• Screening and counseling to reduce alcohol misuse• Screening for lung cancer with dose computed tomography• Screenings for sexually transmitted infections• Smoking and tobacco use cessation• Glaucoma screening• Annual diabetic retinopathy screening• Welcome to Medicare preventative visit	

Prior authorization may apply for some benefits. Contact the plan for more information.

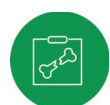
*Deductible does not apply

Overview of in-network benefits



Emergency and urgent care

Benefit	Your in- and out-of-network costs
Emergency care	\$65 copay*
Urgently needed services	\$40 copay*



Diagnostic services, x-rays, labs

Benefit	Your in-network costs
Labs	\$0 copay*
Anticoagulant labs	\$0 copay*
Outpatient diagnostic tests/procedures	\$0 copay*
Diagnostic radiology	\$150 copay*
X-rays	\$0 copay*



Hearing services

Benefit	Your in-network costs
Diagnostic exam	\$0 copay*
Routine exam	\$0 copay*
Hearing aids	Up to \$300 allowance* for hearing aids every three years.

Prior authorization may apply for some benefits. Contact the plan for more information.

*Deductible does not apply

Overview of in-network benefits



Dental services

Benefit	Your in-network costs
Dental services	Medicare-covered: \$10 copay* with a PCP \$25 copay* with a specialist \$0 copay* at a outpatient hospital or ambulatory surgical center. Routine: Not covered



Vision services

Benefit	Your in-network costs
Diagnostic exam	\$25 copay*
Routine exam	\$25 copay*
Eyewear allowance	\$0 copay* for Medicare-covered eyewear following a cataract surgery and up to \$60* allowance for routine eyewear per year.



Mental health services

Benefit	Your in-network costs
Inpatient mental health	\$0 copay*
Outpatient mental health (individual or group)	\$25 copay*
Outpatient substance abuse (individual or group)	\$25 copay*

Prior authorization may apply for some benefits. Contact the plan for more information.

*Deductible does not apply

Overview of in-network benefits



Skilled Nursing Facility (SNF)

Benefit	Your in-network costs
Skilled Nursing Facility (SNF)	\$0 copay*



Rehabilitation services

Benefit	Your in-network costs
Outpatient rehabilitation services (Physical, Occupational and Speech therapy)	\$25 copay*



Ambulance services

Benefit	Your in- and out-of-network costs
Ambulance services covered by Original Medicare	\$75 copay*
Ambulance stabilization when there is no transport	\$75 copay*



Transportation

Benefit	Your in-network costs
Transportation	Not covered

Prior authorization may apply for some benefits. Contact the plan for more information.

*Deductible does not apply

Overview of in-network benefits



Part B drugs

Benefit	Your in-network costs
Chemotherapy drugs	\$0 copay*
Part B drugs Obtained in a provider's office or outpatient setting	\$0 copay*
Part B drugs Obtained in a pharmacy or by mail order service	Up to 20% coinsurance*
Part B Insulin	20% coinsurance up to \$35 copay*

Prior authorization may apply for some benefits. Contact the plan for more information.

*Deductible does not apply

Overview of in-network benefits



Part D prescription drug benefits

Prescription drug deductible: \$0

	Standard retail pharmacy	
	30-day	90-day
Tier 1 (Preferred generic) at 100-day fills)	\$5 copay	\$15 copay
Tier 2 (Generic)	\$10 copay	\$30 copay
Tier 3 (Preferred brand)	\$40 copay	\$120 copay
Tier 4 (Non-preferred-brand drug)	\$70 copay	\$210 copay
Tier 5 (Specialty)	20% coinsurance up to \$100 copay	Not offered

	Mail Order	
	30-day	90-day
Tier 1 (Preferred generic at 100-day fills)	\$5 copay	\$10 copay
Tier 2 (Generic)	\$10 copay	\$20 copay
Tier 3 (Preferred brand)	\$40 copay	\$80 copay
Tier 4 (Non-preferred-brand drug)	\$70 copay	\$140 copay
Tier 5 (Specialty)	20% coinsurance up to \$100 copay	Not offered

Prior authorization may apply for some benefits. Contact the plan for more information.

*Deductible does not apply

Overview of in-network benefits

Part D prescription drug benefits continued

As an employer sponsored plan beneficiary, you will continue to pay the copays listed above until you reach your \$2,100 out of pocket maximum for prescription drug coverage. Once the maximum amount is met, you will pay \$0 and the plan will pay 100% of your out-of-pocket Medicare prescription drug costs.

Additional benefits covered under your plan



Diabetic supplies

Benefit	Your in-network costs
Diabetic supplies	\$0 copay*



Services to treat kidney disease

Benefit	Your in-network costs
Dialysis	\$0 copay*

Prior authorization may apply for some benefits. Contact the plan for more information.

*Deductible does not apply

Overview of in-network benefits



Foot care

Benefit	Your in-network costs
Podiatry (foot care)	\$0 copay*



Home care

Benefit	Your in-network costs
Home health care	\$0 copay



Medical equipment and supplies

Benefit	Your in-network costs
Durable medical equipment (DME)	20% coinsurance
Prosthetics	20% coinsurance



Cardiac and pulmonary rehabilitation

Benefit	Your in-network costs
Cardiac rehab	\$0 copay*
Pulmonary rehab	\$15 copay*

Prior authorization may apply for some benefits. Contact the plan for more information.

*Deductible does not apply

Overview of in-network benefits



Supplemental benefits covered under your plan

Benefit	Your in-network costs
Medicare-covered acupuncture	\$20 copay*
Routine acupuncture	\$20 copay*
Medicare-covered chiropractor	\$20 copay*
Routine chiropractor and Routine chiropractic x-ray	Not covered
Enhanced disease case management	\$0 copay*
Health and wellness education programs	\$0 copay*
In-home safety assessment	\$0 copay*
Nutritional education	\$0 copay*
Post-discharge in home medication reconciliation	\$0 copay*
Telemonitoring	\$0 copay*
Transplant – Lodging and transportation costs for you and a companion	The maximum reimbursement for reasonable transportation and lodging related to the of care for a Medicare-approved transplant is \$6,000*.

Prior authorization may apply for some benefits. Contact the plan for more information.

*Deductible does not apply

Overview of in-network benefits



Unlimited worldwide emergency coverage

Benefit	Your in- and out-of-network costs
Ambulance	\$75 copay*
Emergency room (ER)	\$65 copay*
Urgently needed services	\$40 copay*



Other supplemental benefits covered under your plan

\$0 copay* One Pass® fitness membership and well-being network that provides access to an extensive network of gym locations and online workout classes. CogniFit® helps seniors with their mental, social and physical well-being.

\$0 copay* Worldwide travel assistance through Assist America® when more than 100 miles from home.

Prior authorization may apply for some benefits. Contact the plan for more information.

*Deductible does not apply

Contact us



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



Email us any time. Visit **prioritymedicare.com** and click on **Contact Us** to send a secure email.

Please note that this is just a summary of the plans' benefits; it does not list every service we cover or list every limitation or exclusion. To get a complete list of services we cover including any limitations or exclusions, review the Evidence of Coverage document or call our customer service team at 888.389.6648, option 3 (TTY users should call 711). Another resource available to you when researching your Medicare options is the **2026 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).



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.