



# Summary of benefits

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

**Priority**Medicare® Employer HMO

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.

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# 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	\$425
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)	20% coinsurance
Outpatient Hospital	20% coinsurance
Ambulatory surgical center (ASC)	20% coinsurance



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

Benefit	Your in-network costs
PCP	\$20 copay*
Specialist	\$35 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"><li>• Abdominal Aortic Aneurysm Screening</li><li>• Annual preventative physical exam - (Free to talk and anytime within the calendar year)</li><li>• Annual wellness visit (Free to talk and anytime within the calendar year)</li><li>• Bone mass measurement</li><li>• Breast cancer screening (mammograms)</li><li>• Cardiovascular disease risk reduction</li><li>• Cardiovascular disease testing</li><li>• Cervical and vaginal cancer screening</li><li>• Colorectal cancer screening</li><li>• Depression screening</li><li>• Diabetes screening</li><li>• Diabetes self-management training</li><li>• Hepatitis C screening</li><li>• HIV screening</li><li>• Immunizations</li><li>• Medical nutrition therapy</li><li>• Medicare diabetes prevention program</li><li>• Obesity screening and therapy to promote sustained weight loss</li><li>• Prostate cancer screening</li><li>• Screening and counseling to reduce alcohol misuse</li><li>• Screening for lung cancer with dose computed tomography</li><li>• Screenings for sexually transmitted infections</li><li>• Smoking and tobacco use cessation</li><li>• Glaucoma screening</li><li>• Annual diabetic retinopathy screening</li><li>• Welcome to Medicare preventative visit</li></ul>	

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

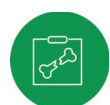
\*Deductible does not apply

# Overview of in-network benefits



## Emergency and urgent care

Benefit	Your in- and out-of-network costs
Emergency care	\$65 copay*
Urgently needed services	\$45 copay*



## Diagnostic services, x-rays, labs

Benefit	Your in-network costs
Labs	20% coinsurance
Anticoagulant labs	\$0 copay*
Outpatient diagnostic tests/procedures	20% coinsurance
Diagnostic radiology	20% coinsurance
X-rays	20% coinsurance



## 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.

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\*Deductible does not apply

# Overview of in-network benefits



## Dental services

Benefit	Your in-network costs
Dental services	Medicare-covered: \$20 copay* with a PCP \$35 copay* with a specialist 20% coinsurance at a outpatient hospital or ambulatory surgical center.  Routine: Not covered



## Vision services

Benefit	Your in-network costs
Diagnostic exam	\$35 copay*
Routine exam	\$35 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	20% coinsurance
Outpatient mental health (individual or group)	\$35 copay*
Outpatient substance abuse (individual or group)	\$35 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)	20% coinsurance



## Rehabilitation services

Benefit	Your in-network costs
Outpatient rehabilitation services (Physical, Occupational and Speech therapy)	\$35 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*
<b>Part B drugs</b> Obtained in a provider's office or outpatient setting	\$0 copay*
<b>Part B drugs</b> Obtained in a pharmacy or by mail order service	Up to 20% coinsurance*
<b>Part B Insulin</b>	20% coinsurance up to \$35 copay*

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\*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
<b>Tier 1</b> (Preferred generic) at 100-day fills)	\$5 copay	\$15 copay
<b>Tier 2</b> (Generic)	\$15 copay	\$45 copay
<b>Tier 3</b> (Preferred brand)	\$50 copay	\$150 copay
<b>Tier 4</b> (Non-preferred-brand drug)	\$80 copay	\$240 copay
<b>Tier 5</b> (Specialty)	20% coinsurance up to \$100 copay	Not offered

	Mail Order	
	30-day	90-day
<b>Tier 1</b> (Preferred generic at 100-day fills)	\$5 copay	\$10 copay
<b>Tier 2</b> (Generic)	\$15 copay	\$30 copay
<b>Tier 3</b> (Preferred brand)	\$50 copay	\$100 copay
<b>Tier 4</b> (Non-preferred-brand drug)	\$80 copay	\$160 copay
<b>Tier 5</b> (Specialty)	20% coinsurance up to \$100 copay	Not offered

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\*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	20% coinsurance

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*

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\*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	\$45 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.

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\*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.