



# 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 PPO

City of Detroit Police & Fire Department

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 benefits administrator
Part B rebate	\$125
Deductible	\$0
Maximum out-of-pocket responsibility (MOOP)	\$750



## Medical and hospital benefits

Benefit	Your in-network costs
Inpatient Hospital (unlimited number of days covered by plan)	\$0 copay per stay
Outpatient Hospital	\$100 copay
Ambulatory surgical center (ASC)	\$100 copay



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

Benefit	Your in-network costs
PCP	\$0 copay
Specialist	\$5 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.

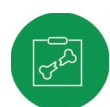
\*Deductible does not apply

# Overview of in-network benefits



## Emergency and urgent care

Benefit	Your in-network costs
Emergency care	\$75 copay
Urgently needed services	\$25 copay



## Diagnostic services, x-rays, labs

Benefit	Your in-network costs
Labs	\$0 copay
Anticoagulant labs	\$0 copay
Outpatient diagnostic tests/procedures	10% coinsurance
Diagnostic radiology	10% coinsurance
X-rays	\$25 copay



## Hearing services

Benefit	Your in-network costs
Diagnostic exam	\$15 copay
Routine exam	\$0 copay with TruHearing provider
Hearing aids	\$0 copay for one hearing aid per ear, per plan year with a TruHearing provider.

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\*Deductible does not apply

# Overview of in-network benefits



## Dental services

Benefit	Your in-network costs
Dental services	Medicare-covered: \$0 copay with a PCP \$5 copay with a specialist \$100 copay at outpatient hospital or ambulatory surgical center  Routine: Not covered



## Vision services

Benefit	Your in-network costs
Diagnostic exam	\$15 copay
Routine exam	\$15 copay
Eyewear allowance	\$0 for Medicare-covered eyewear after cataract surgery.



## Mental health services

Benefit	Your in-network costs
Inpatient mental health	\$0 copay per stay
Outpatient substance abuse (individual or group)	\$15 copay
Outpatient mental health (individual or group)	\$15 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 for days 1-20, 10% coinsurance days 21-100



## Rehabilitation services

Benefit	Your in-network costs
Outpatient rehabilitation services (Physical, Occupational and Speech therapy)	\$0 copay



## Ambulance services

Benefit	Your in-network costs
Ambulance services covered by Original Medicare	\$100 copay
Ambulance stabilization when there is no transport	\$100 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



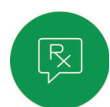
## Part B drugs

Benefit	Your in-network costs
Chemotherapy drugs	Up to 10% coinsurance
<b>Part B drugs</b> Obtained in a provider's office or outpatient setting	Up to 10% coinsurance
<b>Part B drugs</b> Obtained in a pharmacy or by mail order service	Up to 10% coinsurance
<b>Part B Insulin</b>	10% 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)	\$10 copay	\$20 copay
<b>Tier 2</b> (Generic)	\$10 copay	\$20 copay
<b>Tier 3</b> (Preferred brand)	\$30 copay	\$60 copay
<b>Tier 4</b> (Non-preferred-brand drug)	50% coinsurance (\$60 min/\$120 max)	50% coinsurance (\$60 min/\$120 max)
<b>Tier 5</b> (Specialty)	33% coinsurance (\$100 min/\$600max)	Not offered

	Preferred retail pharmacy	
	30-day	90-day
<b>Tier 1</b> (Preferred generic at 100-day fills)	\$5 copay	\$0 copay
<b>Tier 2</b> (Generic)	\$5 copay	\$0 copay
<b>Tier 3</b> (Preferred brand)	\$30 copay	\$60 copay
<b>Tier 4</b> (Non-preferred-brand drug)	50% coinsurance (\$60 min/\$120 max)	50% coinsurance (\$60 min/\$120 max)
<b>Tier 5</b> (Specialty)	33% coinsurance (\$100 min/\$600max)	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

	Mail Order	
	30-day	90-day
<b>Tier 1</b> (Preferred generic at 100-day fills)	\$5 copay	\$0 copay
<b>Tier 2</b> (Generic)	\$5 copay	\$0 copay
<b>Tier 3</b> (Preferred brand)	\$30 copay	\$60 copay
<b>Tier 4</b> (Non-preferred-brand drug)	50% coinsurance (\$60 min/\$120 max)	50% coinsurance (\$60 min/\$120 max)
<b>Tier 5</b> (Specialty)	33% coinsurance (\$100 min/\$600max)	Not offered

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.

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

\*Deductible does not apply

# Overview of in-network benefits

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	10% coinsurance



## Foot care

Benefit	Your in-network costs
Podiatry (foot care)	\$5 copay



## Home care

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

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

\*Deductible does not apply

# Overview of in-network benefits



## Medical equipment and supplies

Benefit	Your in-network costs
Durable medical equipment (DME)	\$0 copay
Prosthetics	\$0 copay



## Cardiac and pulmonary rehabilitation

Benefit	Your in-network costs
Cardiac rehab	\$0 copay
Pulmonary rehab	\$0 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	\$15 copay
Routine acupuncture	\$15 copay up to six visits per year
Medicare-covered chiropractor	\$15 copay
Routine chiropractor and Routine chiropractic x-ray	\$15 copay up to 12 visits per year and \$25 copay for one x-ray per year
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-network costs
Ambulance	\$100 copay
Emergency room (ER)	\$75 copay
Urgent care	\$25 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.

\$50 per quarter for over-the-counter items (allowances do not rollover).

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](https://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](https://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.