Priority Health

2026

Annual Notice of Changes

PriorityMedicare® Value (HMO-POS) offered by Priority Health

January 1, 2026 – December 31, 2026

OMB Approval 0938-1051 (Expires: August 31, 2026)
H2320_110011402604_M

PriorityMedicare Value (HMO-POS) offered by Priority Health Medicare

Annual Notice of Change for 2026

You're enrolled as a member of **Priority**Medicare Value (HMO-POS).

This material describes changes to our plan's costs and benefits next year.

- **You have from October 15 – December 7 to make changes to your Medicare coverage for next year.** If you don't join another plan by December 7, 2025, you'll stay in **Priority**Medicare Value (HMO-POS).
- To change to a **different plan**, visit www.Medicare.gov or review the list in the back of your *Medicare & You 2026* handbook.
- Note this is only a summary of changes. More information about costs, benefits, and rules is in the *Evidence of Coverage*. Get a copy at ***priorityhealth.com/value26*** or call Customer Care at 888.389.6648 (TTY users call 711) to get a copy by mail.

More Resources

- This material is available for free in Spanish.
- Call Customer Care at 888.389.6648 (TTY users call 711) for more information. Oct. 1 – Mar. 31, we're available seven days a week from 8 a.m. – 8 p.m. ET. From Apr. 1 – Sept. 30, we're available Mon. – Fri. from 8 a.m. – 8 p.m. and Sat. 8 a.m. – noon ET. Calls to these numbers are free.
- This information is available in audio, Braille, and large print upon request.
- Coverage under this Plan qualifies as Qualifying Health Coverage (QHC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About PriorityMedicare Value (HMO-POS)

- Priority Health has HMO-POS and PPO plans with a Medicare contract. Enrollment in Priority Health Medicare depends on contract renewal.
- When this material says "we," "us," or "our," it means Priority Health Medicare. When it says "plan" or "our plan," it means **Priority**Medicare Value (HMO-POS).
- **If you do nothing by December 7, 2025, you'll automatically be enrolled in Priority**Medicare Value (HMO-POS). Starting January 1, 2026, you'll get your medical and drug coverage through **Priority**Medicare Value (HMO-POS). Go to Section 3 for more information about how to change plans and deadlines for making a change.

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Summary of Important Costs for 2026

	2025 (this year)	2026 (next year)
Monthly plan premium* * Your premium can be higher than this amount. Go to Section 1 for details.	$18 - $69	$32 - $80
Deductible	**In-Network** $0 **Out-of-Network** $1,000, except for acupuncture, immunizations and insulin furnished through an item of durable medical equipment.	**In-Network** $0 **Out-of-Network** $1,000, except for acupuncture, immunizations and insulin furnished through an item of durable medical equipment.
Maximum out-of-pocket amount This is the most you'll pay out of pocket for covered services. (Go to Section 1.2 for details.)	$4,900	$5,100
Primary care office visits	**In-Network** $0 copay per visit. **Out-of-Network** 40% of the total cost per visit with a PCP, after deductible.	**In-Network** $0 copay per visit. **Out-of-Network** 40% of the total cost per visit with a PCP, after deductible.
Specialist office visits	**In-Network** $0 to $35 copay per visit. **Out-of-Network** 40% of the total cost per visit with a specialist, after deductible.	**In-Network** $0 to $35 copay per visit. **Out-of-Network** 40% of the total cost per visit with a specialist, after deductible.

	2025 (this year)	2026 (next year)
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day.	**In-Network** For Medicare-covered hospital stays: $325 copay per day for days 1-7. $0 for additional hospital days. **Out-of-Network** For Medicare-covered hospital stays: 40% per stay, after deductible.	**In-Network** For Medicare-covered hospital stays: $325 copay per day for days 1-7. $0 for additional hospital days. **Out-of-Network** For Medicare-covered hospital stays: 40% of the total cost per stay, after deductible.
Part D drug coverage deductible (Go to Section 1.7 for details.)	$0	$100 on Tiers 3 - 5 except for covered insulin products and most adult Part D vaccines
Part D drug coverage (Go to Section 1.7 for details, including Yearly Deductible, Initial Coverage, and Catastrophic Coverage Stages.)	Copayment/Coinsurance during the Initial Coverage Stage: • **Drug Tier 1:** $2 copay at a preferred network pharmacy or $7 copay at a standard network pharmacy • **Drug Tier 2:** $10 copay at a preferred network pharmacy or $15 copay at a standard network pharmacy • **Drug Tier 3:** 25% of the total cost at a preferred network pharmacy or 25% of the total cost at a standard network pharmacy	Copayment/Coinsurance during the Initial Coverage Stage: • **Drug Tier 1:** $2 copay at a preferred network pharmacy or $7 copay at a standard network pharmacy • **Drug Tier 2:** $10 copay at a preferred network pharmacy or $15 copay at a standard network pharmacy • **Drug Tier 3:** 22% of the total cost at a preferred network pharmacy or 25% of the total cost at a standard network pharmacy

	2025 (this year)	2026 (next year)
Part D drug coverage (continued)	You pay $35 per month supply of each covered insulin product on this tier. • **Drug Tier 4:** 50% of the total cost at a preferred network pharmacy or 50% of the total cost at a standard network pharmacy You pay $35 per month supply of each covered insulin product on this tier. • **Drug Tier 5:** 33% of the total cost at a preferred network pharmacy or 33% of the total cost at a standard network pharmacy You pay $35 per month supply of each covered insulin product on this tier. Catastrophic Coverage Stage: During this payment stage, you pay nothing for your covered Part D drugs.	You pay $35 per month supply of each covered insulin product on this tier. • **Drug Tier 4:** 35% of the total cost at a preferred network pharmacy or 40% of the total cost at a standard network pharmacy You pay $35 per month supply of each covered insulin product on this tier. • **Drug Tier 5:** 31% of the total cost at a preferred network pharmacy or 31% of the total cost at a standard network pharmacy You pay $35 per month supply of each covered insulin product on this tier. Catastrophic Coverage Stage: During this payment stage, you pay nothing for your covered Part D drugs.

SECTION 1 Changes to Benefits & Costs for Next Year

Section 1.1 Changes to the Monthly Plan Premium

	2025 (this year)	2026 (next year)
Monthly plan premium (You must also continue to pay your Medicare Part B premium.)		
Region 1 Counties Allegan, Barry, Kent, Lenawee, Ottawa	$18	$32
Region 2 Counties Berrien, Calhoun, Cass, Ionia, Isabella, Kalamazoo, Mason, Midland, Missaukee, Montcalm, Muskegon, Newaygo, Oceana, Osceola, Otsego, St. Clair, Van Buren, Wexford	$32	$43
Region 3 Counties Alcona, Antrim, Benzie, Charlevoix, Clare, Crawford, Grand Traverse, Hillsdale, Lake, Lapeer, Leelanau, Manistee, Mecosta, Monroe	$69	$80
Region 4 Counties Alpena, Cheboygan, Eaton, Emmet, Gladwin, Gratiot, Iosco, Jackson, Kalkaska, Montmorency, Oscoda, Presque Isle, Roscommon, Sanilac, Shiawassee, St. Joseph	$44	$55
Region 5 Counties Arenac, Bay, Branch, Clinton, Genesee, Huron, Ingham, Livingston, Macomb, Oakland, Ogemaw, Saginaw, Tuscola, Washtenaw, Wayne	$32	$43

	2025 (this year)	2026 (next year)
Additional premium for optional supplemental benefits If you've enrolled in an optional supplemental benefit package, you'll pay this premium in addition to the monthly plan premium above. (You must also continue to pay your Medicare Part B premium.)	$37	$37

Factors that could change your Part D Premium Amount

- Late Enrollment Penalty - Your monthly plan premium will be *more* if you're required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that's at least as good as Medicare drug coverage (also referred to as creditable coverage) for 63 days or more.
- Higher Income Surcharge - If you have a higher income, you may have to pay an additional amount each month directly to the government for Medicare drug coverage.
- Extra Help - Your monthly plan premium will be *less* if you get Extra Help with your drug costs. Go to Section 4 for more information about Extra Help from Medicare.

Section 1.2 Changes to Your Maximum Out-of-Pocket Amount

Medicare requires all health plans to limit how much you pay out of pocket for the year. This limit is called the maximum out-of-pocket amount. Once you've paid this amount, you generally pay nothing for covered services for the rest of the calendar year.

	2025 (this year)	2026 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copayments and deductibles) **count** toward your maximum out-of-pocket amount. Your costs for prescription drugs **don't count** toward your maximum out-of-pocket amount.	$4,900	$5,100 Once you've paid $5,100 out of pocket for covered services, you'll pay nothing for your covered services for the rest of the calendar year.

Section 1.3 Changes to the Provider Network

Our network of providers has changed for next year. Review the 2026 *Provider/Pharmacy Directory* ***priorityhealth.com/value26*** to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network. Here's how to get an updated *Provider/ Pharmacy Directory*:

- Visit our website at ***priorityhealth.com/value26***.
- Call Customer Care at 888.389.6648 (TTY users call 711) to get current provider information or to ask us to mail you a *Provider/Pharmacy Directory*.

We can make changes to the hospitals, doctors, and specialists (providers) that are part of our plan during the year. If a mid-year change in our providers affects you, call Customer Care at 888.389.6648 (TTY users call 711) for help. For more information on your rights when a network provider leaves our plan, go to Chapter 3, Section 2.3 of your *Evidence of Coverage*.

Section 1.4 Changes to the Pharmacy Network

Amounts you pay for your prescription drugs can depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our network pharmacies. Our network includes pharmacies with preferred cost sharing, which may offer you lower cost sharing than the standard cost sharing offered by other network pharmacies for some drugs.

Our network of pharmacies has changed for next year. Review the 2026 *Provider/Pharmacy Directory* ***priorityhealth.com/value26*** to see which pharmacies are in our network. Here's how to get an updated *Provider/Pharmacy Directory*:

- Visit our website at ***priorityhealth.com/value26***.
- Call Customer Care at 888.389.6648 (TTY users call 711) to get current pharmacy information or to ask us to mail you a *Provider/Pharmacy Directory*.

We can make changes to the pharmacies that are part of our plan during the year. If a mid-year change in our pharmacies affects you, call Customer Care at 888.389.6648 (TTY users call 711) for help.

Section 1.5 Changes to Benefits & Costs for Medical Services

We are making changes to costs and benefits for certain medical services next year. The information below describes these changes.

	2025 (this year)	2026 (next year)
Chiropractic services	**In-Network** You pay $20 copay for each Medicare-covered chiropractic service.	**In-Network** You pay $15 copay for each Medicare-covered chiropractic service.
Dental services Routine dental	**In- and Out-of-Network** $2,000 maximum allowance	**In- and Out-of-Network** $2,500 maximum allowance
Diabetes self-management training, diabetic services and supplies	**In-Network** $0 copay for diabetic test strips limited to JJHCS (One Touch) and Contour products when dispensed by a retail or mail-order pharmacy. **Out-of-Network** 40% of the total cost for diabetic test strips limited to JJHCS (One Touch) and Contour products when dispensed by a retail or mail-order pharmacy.	**In-Network** $0 copay for diabetic test strips limited to Contour products when dispensed by a retail or mail-order pharmacy. **Out-of-Network** 40% of the total cost for diabetic test strips limited to Contour products when dispensed by a retail or mail-order pharmacy.
Emergency care	**In- and Out-of-Network** You pay $120 copay for each visit for Medicare-covered emergency care services.	**In- and Out-of-Network** You pay $130 copay for each visit for Medicare-covered emergency care services.
Enhanced dental and vision package	**In- and Out-of-Network** Routine cleanings are not covered. $4,500 (includes $2,000 embedded allowance) to use towards both embedded and enhanced	**In- and Out-of-Network** You pay $0 copay for one routine cleaning per year. $5,000 (includes $2,500 embedded allowance) to use towards both embedded and enhanced

	2025 (this year)	2026 (next year)
Enhanced dental and vision package (continued)	comprehensive dental benefits.	comprehensive dental benefits.
Outpatient hospital observation	**In- and Out-of-Network** You pay $120 copay for Medicare-covered outpatient observation services.	**In- and Out-of-Network** You pay $130 copay for Medicare-covered outpatient observation services.
Outpatient hospital services Wound care	**In-Network** You pay $325 copay for each Medicare-covered outpatient wound care service.	**In-Network** You pay $35 copay for each Medicare-covered outpatient wound care service.
Over the Counter (OTC)	**In- and Out-of-Network** You have $25 - $50 allowance per month towards OTC items and home and bathroom safety devices and modifications.	**In- and Out-of-Network** Not covered.
Skilled nursing facility (SNF) care	**In-Network** For Medicare-covered SNF stays, you pay $203 copay per day for days 21 - 100.	**In-Network** For Medicare-covered SNF stays, you pay $218 copay per day for days 21 - 100.
Urgently needed services	**In- and Out-of-Network** You pay $55 copay for Medicare-covered urgent care visit.	**In- and Out-of-Network** You pay $50 copay for Medicare-covered urgent care visit.
Worldwide emergency/urgently needed services	**In- and Out-of-Network** You pay $120 copay for each emergency services visit outside of the United States and its territories.	**In- and Out-of-Network** You pay $130 copay for each emergency services visit outside of the United States and its territories.

	2025 (this year)	2026 (next year)
Worldwide emergency/urgently needed services (continued)	You pay $55 copay for each urgently needed care visit outside of the United States and its territories.	You pay $50 copay for each urgently needed care visit outside of the United States and its territories.

Section 1.6 Changes to Part D Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a formulary or Drug List. A copy of our Drug List is provided electronically.

We made changes to our Drug List, which could include removing or adding drugs, changing the restrictions that apply to our coverage for certain drugs, or moving them to a different cost-sharing tier. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions, or if your drug has been moved to a different cost-sharing tier**.

Most of the changes in the Drug List are new for the beginning of each year. However, we might make other changes that are allowed by Medicare rules that will affect you during the calendar year. We update our online Drug List at least monthly to provide the most up-to-date list of drugs. If we make a change that will affect your access to a drug you're taking, we'll send you a notice about the change.

If you're affected by a change in drug coverage at the beginning of the year or during the year, review Chapter 9 of your *Evidence of Coverage* and talk to your prescriber to find out your options, such as asking for a temporary supply, applying for an exception, and/or working to find a new drug. Call Customer Care at 888.389.6648 (TTY users call 711) for more information.

Section 1.7 Changes to Prescription Drug Benefits & Costs

Do you get Extra Help to pay for your drug coverage costs?

If you're in a program that helps pay for your drugs (Extra Help), **the information about costs for Part D drugs may not apply to you**. We sent you a separate material, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs*, which tells you about your drug costs. If you get Extra Help and you don't get this material by September 30, 2025, call Customer Care at 888.389.6648 (TTY users call 711) and ask for the *LIS Rider*.

Drug Payment Stages

There are **3 drug payment stages**: the Yearly Deductible Stage, the Initial Coverage Stage, and the Catastrophic Coverage Stage. The Coverage Gap Stage and the Coverage Gap Discount Program no longer exist in the Part D benefit.

- ***Stage 1: Yearly Deductible***

  You start in this payment stage each calendar year. During this stage, you pay the full cost of your Tier 3 - 5 drugs until you've reached the yearly deductible.

- ***Stage 2: Initial Coverage***

  Once you pay the yearly deductible, you move to the Initial Coverage Stage. In this stage, our plan pays its share of the cost of your drugs, and you pay your share of the cost. You generally stay in this stage until your year-to-date total drug costs reach $2,100.

- ***Stage 3: Catastrophic Coverage***

  This is the third and final drug payment stage. In this stage, you pay nothing for your covered Part D drugs. You generally stay in this stage for the rest of the calendar year.

The Coverage Gap Discount Program has been replaced by the Manufacturer Discount Program. Under the Manufacturer Discount Program, drug manufacturers pay a portion of our plan's full cost for covered Part D brand name drugs and biologics during the Initial Coverage Stage and the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program don't count toward out-of-pocket costs.

Drug Costs in Stage 1: Yearly Deductible

The table shows your cost per prescription during this stage.

	2025 (this year)	2026 (next year)
Yearly Deductible	Because we have no deductible, this payment stage doesn't apply to you.	$100 During this stage, you pay $2 - $15 cost sharing for drugs on Tiers 1 and 2 and the full cost of drugs on Tiers 3 - 5 until you've reached the yearly deductible.

Drug Costs in Stage 2: Initial Coverage

The table shows your cost per prescription for a one-month (30-day) supply filled at a network pharmacy with standard and preferred cost sharing.

We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List. Most adult Part D vaccines are covered at no cost to you. For more information about the costs of vaccines, or information about the costs for a long-term supply, go to Chapter 6 of your *Evidence of Coverage*.

Once you've paid $2,100 out of pocket for covered Part D drugs, you'll move to the next stage (the Catastrophic Coverage Stage).

Initial Coverage Stage	2025 (this year)	2026 (next year)
Tier 1: **Preferred generic** We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	*Standard cost sharing:* You pay $7 per prescription. Your cost for a one-month mail-order prescription is $7. *Preferred cost sharing:* You pay $2 per prescription. Your cost for a one-month mail-order prescription is $2.	*Standard cost sharing:* You pay $7 per prescription. Your cost for a one-month mail-order prescription is $7. *Preferred cost sharing:* You pay $2 per prescription. Your cost for a one-month mail-order prescription is $2.
Tier 2: **Generic** We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	*Standard cost sharing:* You pay $15 per prescription. Your cost for a one-month mail-order prescription is $15. *Preferred cost sharing:* You pay $10 per prescription. Your cost for a one-month mail-order prescription is $10.	*Standard cost sharing:* You pay $15 per prescription. Your cost for a one-month mail-order prescription is $15. *Preferred cost sharing:* You pay $10 per prescription. Your cost for a one-month mail-order prescription is $10.

Initial Coverage Stage	2025 (this year)	2026 (next year)
Tier 3: **Preferred brand** We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	*Standard cost sharing:* You pay 25% of the total cost per prescription. You pay $35 per month supply of each covered insulin product on this tier. Your cost for a one-month mail-order prescription is 25%. *Preferred cost sharing:* You pay 25% of the total cost per prescription. You pay $35 per month supply of each covered insulin product on this tier. Your cost for a one-month mail-order prescription is 25%.	*Standard cost sharing:* You pay 25% of the total cost per prescription. You pay $35 per month supply of each covered insulin product on this tier. Your cost for a one-month mail-order prescription is 25%. *Preferred cost sharing:* You pay 22% of the total cost per prescription. You pay $35 per month supply of each covered insulin product on this tier. Your cost for a one-month mail-order prescription is 22%.
Tier 4: **Non-preferred drug** We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	*Standard cost sharing:* You pay 50% of the total cost per prescription. You pay $35 per month supply of each covered insulin product on this tier. Your cost for a one-month mail-order prescription is 50%. *Preferred cost sharing:* You pay 50% of the total cost per prescription.	*Standard cost sharing:* You pay 40% of the total cost per prescription. You pay $35 per month supply of each covered insulin product on this tier. Your cost for a one-month mail-order prescription is 40%. *Preferred cost sharing:* You pay 35% of the total cost per prescription.

Initial Coverage Stage	2025 (this year)	2026 (next year)
Tier 4: **Non-preferred drug (continued)**	You pay $35 per month supply of each covered insulin product on this tier. Your cost for a one-month mail-order prescription is 50%.	You pay $35 per month supply of each covered insulin product on this tier. Your cost for a one-month mail-order prescription is 35%.
Tier 5: **Specialty** We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	*Standard cost sharing:* You pay 33% of the total cost per prescription. You pay $35 per month supply of each covered insulin product on this tier. Your cost for a one-month mail-order prescription is 33%. *Preferred cost sharing:* You pay 33% of the total cost per prescription. You pay $35 per month supply of each covered insulin product on this tier. Your cost for a one-month mail-order prescription is 33%.	*Standard cost sharing:* You pay 31% of the total cost per prescription. You pay $35 per month supply of each covered insulin product on this tier. Your cost for a one-month mail-order prescription is 31%. *Preferred cost sharing:* You pay 31% of the total cost per prescription. You pay $35 per month supply of each covered insulin product on this tier. Your cost for a one-month mail-order prescription is 31%.

Changes to the Catastrophic Coverage Stage

If you reach the Catastrophic Coverage Stage, you pay nothing for your covered Part D drugs.

For specific information about your costs in the Catastrophic Coverage Stage, go to Chapter 6, Section 6 in your *Evidence of Coverage*.

SECTION 2 Administrative Changes

Description	2025 (this year)	2026 (next year)
Medicare Prescription Payment Plan	The Medicare Prescription Payment Plan is a payment option that began this year and can help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across the calendar year (January-December). You may be participating in this payment option.	If you're participating in the Medicare Prescription Payment Plan and stay in the same Part D plan, your participation will be automatically renewed for 2026. To learn more about this payment option, call us at 1.866.845.1803 (TTY users call 1.800.716.3231) or visit www.Medicare.gov

SECTION 3 How to Change Plans

To stay in Priority Medicare Value (HMO-POS)**, you don't need to do anything.** Unless you sign up for a different plan or change to Original Medicare by December 7, you'll automatically be enrolled in our **Priority**Medicare Value (HMO-POS).

If you want to change plans for 2026, follow these steps:

- **To change to a different Medicare health plan,** enroll in the new plan. You'll be automatically disenrolled from **Priority**Medicare Value (HMO-POS).
- **To change to Original Medicare with Medicare drug coverage,** enroll in the new Medicare drug plan. You'll be automatically disenrolled from **Priority**Medicare Value (HMO-POS).
- **To change to Original Medicare without a drug plan,** you can send us a written request to disenroll. Call Customer Care at 888.389.6648 (TTY users call 711) for more information on how to do this. Or call **Medicare** at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users can call 1-877-486-2048. If you don't enroll in a Medicare drug plan, you may pay a Part D late enrollment penalty (go to Section 1.1).
- **To learn more about Original Medicare and the different types of Medicare plans,** visit www.Medicare.gov, check the *Medicare & You 2026* handbook, call your State Health Insurance Assistance Program (go to Section 5), or call 1-800-MEDICARE (1-800-633-4227).

Section 3.1 Deadlines for Changing Plans

People with Medicare can make changes to their coverage from **October 15 – December 7** each year.

If you enrolled in a Medicare Advantage plan for January 1, 2026, and don't like your plan choice, you can switch to another Medicare health plan (with or without Medicare drug coverage) or switch to Original Medicare (with or without separate Medicare drug coverage) between January 1 – March 31, 2026.

Section 3.2 Are there other times of the year to make a change?

In certain situations, people may have other chances to change their coverage during the year. Examples include people who:

- Have Medicaid
- Get Extra Help paying for their drugs
- Have or are leaving employer coverage
- Move out of our plan's service area

If you recently moved into, or currently live in, an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (with or without Medicare drug coverage) or switch to Original Medicare (with or without separate Medicare drug coverage) at any time. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for 2 full months after the month you move out.

SECTION 4 Get Help Paying for Prescription Drugs

You may qualify for help paying for prescription drugs. Different kinds of help are available:

- **Extra Help from Medicare.** People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly drug plan premiums, yearly deductibles, and coinsurance. Also, people who qualify won't have a late enrollment penalty. To see if you qualify, call:
    - 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048, 24 hours a day, 7 days a week.
    - Social Security at 1-800-772-1213 between 8 a.m. and 7 p.m., Monday – Friday for a representative. Automated messages are available 24 hours a day. TTY users can call 1-800-325-0778.
    - Your State Medicaid Office.

- **Help from your state's pharmaceutical assistance program (SPAP).** Michigan has a program called Michigan Drug Assistance Program (MIDAP) that helps people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about the program, check with your State Health Insurance Assistance Program (SHIP). To get the phone number for your state, visit shiphelp.org, or call 1-800-MEDICARE.
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible people living with HIV/AIDS have access to life-saving HIV medications. To be eligible for the ADAP operating in your state, you must meet certain criteria, including proof of state residence and HIV status, low income as defined by the state, and uninsured/under-insured status. Medicare Part D drugs that are also covered by ADAP qualify for prescription cost-sharing help through the Michigan HIV/AIDS Drug Assistance Program (MIDAP). For information on eligibility criteria, covered drugs, how to enroll in the program, or, if you're currently enrolled, how to continue getting help, call 888.826.6565. Be sure, when calling, to inform them of your Medicare Part D plan name or policy number.
- **The Medicare Prescription Payment Plan.** The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage to help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across the calendar year (January – December). Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage plan with drug coverage) can use this payment option. **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.**

  Extra Help from Medicare and help from your SPAP and ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. All members are eligible to participate in the Medicare Prescription Payment Plan payment option. To learn more about this payment option, call us at 1.866.845.1803 (TTY users call 1.800.716.3231) or visit www.Medicare.gov.

SECTION 5 Questions?

Get Help from **Priority**Medicare Value (HMO-POS)

- **Call Customer Care at 888.389.6648. (TTY users call 711.)**

  Oct. 1 – Mar. 31, we're available seven days a week from 8 a.m. – 8 p.m. ET. From Apr. 1 – Sept. 30, we're available Mon. – Fri. from 8 a.m. – 8 p.m. and Sat. 8 a.m. – noon ET. Calls to these numbers are free.
- **Read your 2026 *Evidence of Coverage***

  This *Annual Notice of Change* gives you a summary of changes in your benefits and costs for 2026. For details, go to the 2026 *Evidence of Coverage* for **Priority**Medicare Value (HMO-POS). The *Evidence of Coverage* is the legal, detailed description of our

plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. Get the *Evidence of Coverage* on our website at ***priorityhealth.com/value26*** or call Customer Care at 888.389.6648 (TTY users call 711) to ask us to mail you a copy.

- **Visit *priorityhealth.com/value26***

  Our website has the most up-to-date information about our provider network (*Provider Directory/Pharmacy Directory*) and our *List of Covered Drugs* (formulary/Drug List).

Get Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. In Michigan, the SHIP is called Michigan Medicare/Medicaid Assistance Program (MMAP).

Call Michigan Medicare/Medicaid Assistance Program (MMAP) to get free personalized health insurance counseling. They can help you understand your Medicare plan choices and answer questions about switching plans. Call Michigan Medicare/Medicaid Assistance Program (MMAP) at 800.803.7174. Learn more about Michigan Medicare/Medicaid Assistance Program (MMAP) by visiting shiphelp.org/about-medicare/regional-ship-location/michigan.

Get Help from Medicare

- **Call 1-800-MEDICARE (1-800-633-4227)**

  You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users can call 1-877-486-2048.

- **Chat live with www.Medicare.gov**

  You can chat live at www.Medicare.gov/talk-to-someone.

- **Write to Medicare**

  You can write to Medicare at PO Box 1270, Lawrence, KS 66044

- **Visit www.Medicare.gov**

  The official Medicare website has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area.

- **Read *Medicare & You 2026***

  The *Medicare & You 2026* handbook is mailed to people with Medicare every fall. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. Get a copy at www.Medicare.gov or by calling 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

PriorityMedicare Value'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 should call 711, or consult the online *Provider/Pharmacy Directory* at ***priorityhealth.com/value26***.

Notice of Nondiscrimination

This Notice describes our nondiscrimination policy, availability of free language assistance, auxiliary aids and services and filing a grievance.

Discrimination is against the law

Priority Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. This includes sex characteristics, intersex traits, pregnancy or related conditions, sexual orientation, gender identity and/or sex stereotypes. Priority Health does not exclude people or treat them less favorably because of race, color, national origin, age, disability or sex.

Availability of free language assistance and auxiliary aids and services

Priority Health provides free language services to people whose primary language is not English, which may include:

- Qualified interpreters.
- Information written in other languages.

Priority Health provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:

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

If you need reasonable modifications, appropriate auxiliary aids and services or language assistance services, contact our Customer Service team:

- Medicare: 888.389.6648 (TTY: 711) from 8 a.m. - 8 p.m. Eastern time, seven days a week.
- Other plans: Call the number on the back of your member ID card or 800.942.0954 (TTY: 711).

Filing a grievance

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

Mail
Section 1557 Civil Rights Coordinator
Compliance Department MC 3230
Priority Health
1231 East Beltline Ave NE
Grand Rapids, MI 49525-4501

Phone
866.807.1931 (TTY: 711)

Fax
616.975.8850

Email
PH-compliance@priorityhealth.com

You can also file a civil rights complaint with the Office for Civil Rights (OCR) at the U.S. Department of Health and Human Services (HHS) by:

Mail
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

Phone
800.368.1019 (TTD: 800.537.7697)

Electronic form
ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available from the HHS website at ***hhs.gov/ocr/complaints/index.html***.

This Notice is available on Priority Health's website at ***priorityhealth.com/nondiscrimination***.

Last updated: December 2024

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

We offer free language assistance services and auxiliary aids and services.

Albanian (Shqip) - VINI RE: Nëse flisni shqip, shërbime falas të ndihmës së gjuhës janë në dispozicion për ju. Ndihma të përshtatshme dhe shërbime shtesë për të siguruar informacion në formate të përdorshme janë gjithashtu në dispozicion falas. Telefononi 1-800-942-0954 (TTY: 711) ose bisedoni me ofruesin tuaj të shërbimit.

Arabic (العربية) - تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1-800-942-0954 (TTY:711) أو تحدث إلى مقدم الخدمة.

Assyrian (ܣܘܪܝܝܐ) - ܚܫܘܒ ܗܘ: ܐܢ ܐܢܬ ܡܡܠܠ ܣܘܪܝܝܐ، ܫܪܘܬ ܕܥܕܪܐ ܒܠܫܢܐ ܕܝܠܟ ܒܚܠܦ ܠܟ. ܐܦ ܫܪܘܬ ܕܥܕܪܐ ܘܡܫܡܫ ܕܡܬܐܡܢ ܐܝܟ ܐܦ ܡܬܝܗܒ ܒܦܘܪܡܛ ܕܡܬܐܡܢ ܠܟ ܒܚܠܦ. ܛܠܦܢ 1-800-942-0954 (TTY:711) ܐܘ ܡܠܠ ܥܡ ܡܢ ܕܡܫܬܡܫ ܒܝܬ.

Bengali (বাংলা) - মনোযোগ দিন: যদি আপনি বাংলা বলেন তাহলে আপনার জন্য বিনামূল্যে ভাষা সহায়তা পরিষেবাদি উপলব্ধ রয়েছে। অ্যাক্সেসযোগ্য ফরম্যাটে তথ্য প্রদানের জন্য উপযুক্ত সহায়ক সহযোগিতা এবং পরিষেবাদিও বিনামূল্যে উপলব্ধ রয়েছে। 1-800-942-0954 (TTY: 711) নম্বরে কল করুন অথবা আপনার প্রদানকারীর সাথে কথা বলুন।

Chinese – Simplified (中文) - 注意：如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-800-942-0954（TTY：711）或咨询您的服务提供商。

Chinese – Traditional (中文) - 注意：如果您說[中文]，我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 1-800-942-0954 (TTY: 711) 或與您的提供者討論。

English - ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-942-0954 (TTY: 711) or speak to your provider.

French (Français) - ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-942-0954 (TTY: 711) ou parlez à votre fournisseur.

German (Deutsch) - ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-800-942-0954 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.

Greek (Ελληνικά) - ΠΡΟΣΟΧΗ: Εάν μιλάτε ελληνικά, υπάρχουν διαθέσιμες δωρεάν υπηρεσίες υποστήριξης στη συγκεκριμένη γλώσσα. Διατίθενται δωρεάν κατάλληλα βοηθήματα και υπηρεσίες για παροχή πληροφοριών σε προσβάσιμες μορφές. Καλέστε το 1-800-942-0954 (TTY: 711) ή απευθυνθείτε στον πάροχό σας.

Gujarati (ગુજરાતી) - ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઑક્ઝિલરી સહાય અને ઍક્સેસિબલ ફૉર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 1-800-942-0954 (TTY: 711) પર કૉલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.

Haitian Creole (Kreyòl Ayisyen) - ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd aladispozisyon w gratis pou lang ou pale a. Èd ak sèvis siplemantè apwopriye pou bay enfòmasyon nan fòma aksesib yo disponib gratis tou. Rele nan 1-800-942-0954 (TTY: 711) oswa pale avèk founisè w la.

Hindi (हिंदी) - ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-800-942-0954 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।

Hmong (Hmoob) - LUS CEEV TSHWJ XEEB: Yog hais tias koj hais Lus Hmoob muaj cov kev pab cuam txhais lus pub dawb rau koj. Cov kev pab thiab cov kev pab cuam ntxiv uas tsim nyog txhawm rau muab lus qhia paub ua cov hom ntaub ntawv uas tuaj yeem nkag cuag tau rau los kuj yeej tseem muaj pab dawb tsis xam tus nqi dab tsi ib yam nkaus. Hu rau 1-800-942-0954 (TTY: 711) los sis sib tham nrog koj tus kws muab kev saib xyuas kho mob.

Italian (Italiano) - ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l'1-800-942-0954 (TTY: 711) o parla con il tuo fornitore.

Japanese (日本語) - 注：日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル（誰もが利用できるよう配慮された）な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1-800-942-0954 (TTY: 711) までお電話ください。または、ご利用の事業者にご相談ください。

Korean (한국어) - 주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-800-942-0954 (TTY: 711) 번으로 전화하거나 서비스 제공업체에 문의하십시오.

Laos (ລາວ) - ເຊີນຊາບ: ຖ້າທ່ານເວົ້າພາສາ ລາວ, ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ມີເຄື່ອງຊ່ວຍ ແລະ ການບໍລິການແບບບໍ່ເສຍຄ່າທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້. ໂທຫາເບີ 1-800-942-0954 (TTY: 711) ຫຼື ລົມກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.

Polish (Polski) - UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 1-800-942-0954 (TTY: 711) lub porozmawiaj ze swoim dostawcą.

Russian (Русский) - ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-800-942-0954 (TTY:711) или обратитесь к своему поставщику услуг.

Serbian (Srbski) - PAŽNJA: Ako pricate srpski, besplatne jezicke uslugei su vam dostupne. Takođe, odgovarajuca pomocna sredstva i usluge za pružanje informacija u dostupnim formatima su takođe dostupni besplatno. Pozovite 1-800-942-0954 (TTY: 711) ili se obratite svom pružaocu usluga.

Spanish (Español) - ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-800-942-0954 (TTY: 711) o hable con su proveedor.

Tagalog - PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-800-942-0954 (TTY: 711) o makipag-usap sa iyong provider.

Urdu (اردو) - توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کے لیے زبان کی مفت مدد کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں 1-800-942-0954 (TTY: 711) پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔

Vietnamese (Việt) - LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-800-942-0954 (TTY: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

Source: lep.gov and *cms.gov*
Last updated: December 2024

prioritymedicare.com