Priority Health

2027
Annual Notice of Changes

PriorityMedicare® Edge (PPO)
Offered by Priority Health Medicare

January 1, 2027 - December 31, 2027

OMB Approval 0938-1051 (Expires: July 31, 2029)
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***Priority*Medicare Edge (PPO) offered by Priority Health Medicare**

Annual Notice of Change for 2027

You're enrolled as a member of **Priority**Medicare Edge (PPO).

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, 2026, you'll stay in **Priority**Medicare Edge (PPO).
- To change to a **different plan**, visit Medicare.gov or review the list in the back of your *Medicare & You 2027* 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/edge27*** or call Customer Care at 888.389.6648 (TTY users call 711) to get a copy by mail.

More Resources

- 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. This call is free.
- This information is available in audio, braille, and large print upon request.

About Priority Medicare Edge (PPO)

- 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 Edge (PPO).
- **If you do nothing by December 7, 2026, you'll automatically be enrolled in Priority**Medicare Edge (PPO). Starting January 1, 2027, you'll get your medical and drug coverage through **Priority**Medicare Edge (PPO). 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 2027

	2026 (this year)	2027 (next year)
Monthly plan premium* * Your premium can be higher than this amount. Go to Section 1 for details.	$0	$0
Deductible	**In-Network** $275, except for primary care visits, specialty provider 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** $405 (region 1) and $420 (regions 2 and 5), except for primary care visits, specialty provider 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, Part B insulin furnished through an item of durable medical

	2026 (this year)	2027 (next year)
Deductible (continued)		equipment, cardiac rehabilitation, intensive cardiac rehabilitation, supervised exercise therapy, and pulmonary rehabilitation. **In-Network and Out-of-Network (combined)** $405 (region 1) and $420 (regions 2 and 5), except for acupuncture, immunizations and insulin furnished through an item of durable medical equipment. Please see Section 2: Administrative Changes for your region.
	In-Network and Out-of-Network (combined) $275, 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.)	From network providers: $6,000 From network and out-of-network providers (combined): $6,000	From network providers: $7,100 From network and out-of-network providers (combined): $7,100
Primary care office visits	**In-Network** $0 copay per visit. **Out-of-Network** 40% of the total cost per visit, after deductible.	**In-Network** $0 copay per visit. **Out-of-Network** 40% of the total cost per visit, after deductible.
Specialist office visits	**In-Network** $0 to $35 copay per visit.	**In-Network** $0 to $40 (region 1), $45 (region 5) and $50 (region 2) copay per visit. Please see Section 2: Administrative Changes for your region.

	2026 (this year)	2027 (next year)
Specialist office visits (continued)	**Out-of-Network** 40% of the total cost per visit, after deductible.	**Out-of-Network** 40% of the total cost per visit, after deductible.
Inpatient hospital stays Includes various inpatient hospital stays such as acute care, rehabilitation and long-term care. An inpatient hospital stay starts the day you're formally admitted with a doctor's order and ends the day before you're discharged.	**In-Network** For Medicare-covered hospital stays: $350 copay per day for days 1 - 7, after deductible. $0 for additional hospital days, after deductible. **Out-of-Network** For Medicare-covered hospital stays: 40% of the total cost per stay, after deductible.	**In-Network** For Medicare-covered hospital stays: $450 copay per day for days 1 - 6, after deductible. $0 for additional hospital days, after deductible. **Out-of-Network** For Medicare-covered hospital stays: 40% of the total cost per stay, after deductible.
Part D drug coverage (Go to Section 1.7 for details, including Yearly Deductible, Initial Coverage, and Catastrophic Coverage Stages.)	Part D drug coverage deductible $200 on Tiers 3-5, except for covered insulin products and most adult Part D vaccines 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:** $8 copay at a preferred network pharmacy or $15	Part D drug coverage deductible $300 on Tiers 3-5, except for covered insulin products and most adult Part D vaccines 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:** $8 copay at a preferred network pharmacy or $15

	2026 (this year)	2027 (next year)
Part D drug coverage (continued)	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 You pay no more than $35 per month supply of each covered insulin product on this tier. • **Drug Tier 4:** 25% of the total cost at a preferred network pharmacy or 30% of the total cost at a standard network pharmacy You pay no more than $35 per month supply of each covered insulin product on this tier. • **Drug Tier 5:** 30% of the total cost at a preferred network pharmacy or 30% of the total cost at a standard network pharmacy You pay no more than $35 per month supply of each covered insulin product on this tier.	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 You pay no more than $35 per month supply of each covered insulin product on this tier. • **Drug Tier 4:** 25% of the total cost at a preferred network pharmacy or 30% of the total cost at a standard network pharmacy You pay no more than $35 per month supply of each covered insulin product on this tier. • **Drug Tier 5:** 30% of the total cost at a preferred network pharmacy or 30% of the total cost at a standard network pharmacy You pay no more than $35 per month supply of each covered insulin product on this tier.

	2026 (this year)	2027 (next year)
Part D drug coverage (continued)	Catastrophic Coverage Stage: During this payment stage, you pay nothing for your covered Part D drugs.	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

	2026 (this year)	2027 (next year)
Monthly plan premium (You must also continue to pay your Medicare Part B premium.)	$0	$0
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.)	$49	Enhanced Dental and Vision Option 1 - $42 Enhanced Dental and Vision Option 2 - $61 If you are currently enrolled in an Enhanced Dental and Vision plan, you will automatically be moved into Option 1 and will have to actively enroll in Option 2 to change your coverage.

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 Part D or 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.

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.

	2026 (this year)	2027 (next year)
In-network maximum out-of-pocket amount Your costs for covered medical services (such as copayments) from network providers **count** toward your in-network maximum out-of-pocket amount. Your costs for prescription drugs **don't count** toward your maximum out-of-pocket amount.	$6,000	$7,100 Once you've paid $7,100 out of pocket for covered services, you'll pay nothing for your covered services from network providers for the rest of the calendar year.
Combined maximum out-of-pocket amount Your costs for covered medical services (such as copayments) from in-network and out-of-network providers **count** toward your combined maximum out-of-pocket amount. Your costs for outpatient prescription drugs **don't count** toward your maximum out-of-pocket amount for medical services.	$6,000	$7,100 Once you've paid $7,100 out of pocket for covered services, you'll pay nothing for your covered services from in-network or out-of-network providers 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 2027 *Provider/Pharmacy Directory* at ***priorityhealth.com/edge27*** 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/edge27***.
- 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. You may have a special enrollment period if your provider leaves the plan network.

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 2027 *Provider/Pharmacy Directory* at ***priorityhealth.com/edge27*** to see which pharmacies are in our network. Here's how to get an updated *Provider/Pharmacy Directory*:

- Visit our website at ***priorityhealth.com/edge27***.
- 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

	2026 (this year)	2027 (next year)
Dental services Medicare-covered dental services	**In-Network** $35 copay for each Medicare-covered visit with a specialist.	**In-Network** $40 (region 1), $45 (region 5), and $50 (region 2) copay for each Medicare-covered visit with a specialist. Please see Section 2: Administrative Changes for your region.
	In and Out-of-Network $350 copay for Medicare-covered dental services at an outpatient hospital facility, after deductible.	**In and Out-of-Network** $425 copay for Medicare-covered dental services at an outpatient hospital facility, after deductible.
Non-Medicare covered dental services	**In and Out-of-Network** Fluoride treatment is not covered.	**In and Out-of-Network** $0 copay for one fluoride treatment every year.

	2026 (this year)	2027 (next year)
Durable medical equipment (DME) and related supplies	**In-Network** Continuous Glucose Monitors (CGM's) are not covered when obtained through a network retail or mail-order pharmacy.	**In-Network** 20% of the total cost for Continuous Glucose Monitors (CGM's) when obtained through a network retail or mail-order pharmacy. Covered products are limited to Dexcom and Freestyle Libre.
Enhanced dental and vision option 1 Optional supplemental benefits (available for an extra premium) If you are currently enrolled in an Enhanced Dental and Vision plan, you will automatically be moved into Option 1 and will have to actively enroll in Option 2 to change your coverage.	**In and Out-of-Network** $0 copay for one routine cleaning per plan year. $0 copay for one fluoride treatment per plan year. $2,500 annual maximum per year to use towards: $0 copay for emergency treatment and anesthesia. $0 copay for fillings (including composite resin and amalgam) once per tooth every 24 months and crown repairs once per tooth every 12 months. 50% of the total cost for other diagnostic exams (i.e. cone beams).	**In and Out-of-Network** $0 copay for one cleaning (regular or periodontal) per plan year. $0 copay for scaling and root planing once per quadrant per 24 month period. $1,500 annual maximum per year to use towards: 50% of the total cost for unlimited emergency treatment and anesthesia when used in conjunction with other services. 50% of the total cost for fillings (including composite resin and amalgam) once per tooth every 24 months and crown repairs once per tooth every 12 months. 50% of the total cost for other diagnostic exams (i.e. cone beams). 50% of the total cost for surgical periodontal procedures (i.e. osseous

	2026 (this year)	2027 (next year)
Enhanced dental and vision option 1 (continued)		surgery or gum grafts) once per quadrant every 36 months. 50% of the total cost of onlays, crowns, and associated substructures once per tooth every 5 years. 50% of the total cost of endodontics (root canals) once per tooth per lifetime. 50% of the total cost of simple and surgical extractions once per tooth per lifetime. 50% of the total cost of implants once 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.
	50% of the total cost of onlays, crowns, and associated substructures once per tooth every 5 years. 50% of the total cost of endodontics (root canals) once per tooth per lifetime. 50% of the total cost of simple and surgical extractions once per tooth per lifetime. 50% of the total cost of implants once 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. Scaling and root planing, surgical periodontics and bridges are <u>not</u> covered.	
Enhanced dental and vision option 2 Optional supplemental benefits (available for an extra premium) If you are currently enrolled in an Enhanced Dental and Vision plan, you will automatically be moved into Option 1 and will have to actively enroll in Option 2 to change your coverage.	<u>Not</u> covered.	**<u>In and Out-of-Network</u>** $0 copay for one cleaning (regular or periodontal) per plan year. $0 copay for scaling and root planing once per quadrant per 24 month period.

	2026 (this year)	2027 (next year)
Enhanced dental and vision option 2 (continued)		$2,000 annual maximum per year to use towards: 25% of the total cost for unlimited emergency treatment and anesthesia when used in conjunction with other services. 25% of the total cost for other diagnostic exams (i.e. cone beams) 25% of the total cost for fillings (including composite resin and amalgam) once per tooth every 24 months and crown repairs once per tooth every 12 months. 25% of the total cost for surgical periodontal procedures (i.e. osseous surgery or gum grafts) once per quadrant every 36 months. 25% of the total cost of onlays, crowns, and associated substructures once per tooth every 5 years. 25% of the total cost of endodontics (root canals) once per tooth per lifetime. 25% of the total cost of simple and surgical extractions once per tooth per lifetime.

	2026 (this year)	2027 (next year)
Enhanced dental and vision option 2 (continued)		25% of the total cost of implants once per tooth, every 5 years. 25% of the total cost of dentures and bridges once every 60 months, denture relines and repairs and bridge repairs once every 36 months. Flouride treatments are not covered through optional supplemental dental.
Enhanced disease management	**In and Out-of-Network** $0 copay for enhanced disease management services.	Enhanced disease management services are not covered.
Fitness (One Pass)	**Out-of-Network** Not covered.	**Out-of-Network** Up to $60 in reimbursement per plan year for comprehensive fitness benefit outside of the One Pass® network, whether in- or out-of-network, cannot be combined.
Hearing services Medicare-covered hearing services	**In-Network** $35 copay for each Medicare-covered diagnostic hearing exam with a specialist.	**In-Network** $40 (region 1), $45 (region 5), $50 (region 2) copay for each Medicare-covered diagnostic hearing exam with a specialist. Please see Section 2: Administrative Changes for your region.

	2026 (this year)	2027 (next year)
Hearing services (continued) Non-Medicare covered routine hearing services	**In-Network** $295 copay per hearing aid for Basic Aids. $695 copay per hearing aid for Standard Aids. $1,095 copay per hearing aid for Advanced Aids. $1,495 copay per hearing aid for Premium Aids. **Out-of-Network** Routine hearing exams and hearing aids are not covered.	**In-Network** Basic Aids are not covered. $399 copay per hearing aid for Standard Aids. $599 copay per hearing aid for Advanced Aids. $899 copay per hearing aid for Premium Aids. **Out-of-Network** 30% of the total cost for one routine hearing exam with a non-TruHearing provider (one per year whether in- or out-of-network, cannot be combined.) 50% of the total cost up to allowed amount, one hearing aid, per ear, every year whether in- or out-of-network, cannot be combined.
Inpatient hospital care	**In-Network** For Medicare-covered inpatient hospital stays, you pay: $350 copay per day, for days 1-7, after deductible. $0 for additional hospital days, after deductible.	**In-Network** For Medicare-covered inpatient hospital stays, you pay: $450 copay per day, for days 1-6, after deductible. $0 for additional hospital days, after deductible.
Outpatient diagnostic tests and therapeutic services and supplies	**In-Network** $0 copay per day, per provider, for Medicare-covered genetic testing.	**In-Network** $50 copay per day, per provider, for Medicare-covered genetic testing.

	2026 (this year)	2027 (next year)
Outpatient diagnostic tests and therapeutic services and supplies (continued)	$270 copay per day, per provider for Medicare-covered diagnostic nuclear medicine, after deductible. If your doctor finds and removes a polyp or other tissue during the colonoscopy or flexible sigmoidoscopy, the screening exam becomes a diagnostic exam and is subject to a $350 copay when performed in an outpatient hospital or a $350 copay when performed in a standalone facility, after deductible.	$640 copay per day, per provider for Medicare-covered diagnostic nuclear medicine, after deductible. If your doctor finds and removes a polyp or other tissue during the colonoscopy or flexible sigmoidoscopy, the screening exam becomes a diagnostic exam and is subject to a $0 copay when performed in an outpatient hospital or a $0 copay when performed in a standalone facility.
Outpatient hospital services	**In-Network** $350 copay for each Medicare-covered outpatient hospital facility visit, after deductible. $35 copay for each Medicare-covered wound care visit, after deductible.	**In-Network** $425 copay for each Medicare-covered outpatient hospital facility visit, after deductible. $40 (region 1), $45 (region 5), $50 (region 2) copay for each Medicare-covered wound care visit, after deductible. Please see Section 2: Administrative Changes for your region.
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers	**In-Network** For Medicare-covered services at an ambulatory surgical	**In-Network** For Medicare-covered services at an ambulatory surgical

	2026 (this year)	2027 (next year)
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers (continued)	center, you pay $350 copay, after deductible. For Medicare-covered services at an outpatient hospital facility, you pay $350 copay, after deductible.	center, you pay $425 copay, after deductible. For Medicare-covered services at an outpatient hospital facility, you pay $425 copay, after deductible.
Over the Counter (OTC)	**In and Out-of-Network** $55 allowance every three months to use towards OTC items and home and bathroom safety devices and modifications.	**In and Out-of-Network** $25 (regions 2 and 5) and $30 (region 1) allowance every three months to use towards OTC items and home and bathroom safety devices and modifications. Please see Section 2: Administrative Changes for your region.
Physician/Practitioner services, including doctor's office visits	**In-Network** $0-$35 copay for Medicare-covered specialty office visits. $0 copay for surgical procedures performed in a provider's office.	**In-Network** $0-$40 (region 1), $45 (region 5), $50 (region 2) copay for Medicare-covered specialty office visits. Please see Section 2: Administrative Changes for your region. $0 copay for simple surgical procedures done in a providers office (i.e. mole removals/sutures) $425 copay for moderate to major surgical procedures done in a providers office (i.e. carpal tunnel release and trigger finger release)

	2026 (this year)	2027 (next year)
Podiatry services	**In-Network** $35 copay for Medicare-covered podiatry office visits.	**In-Network** $40 (region 1), $45 (region 5), $50 (region 2) copay for Medicare-covered podiatry office visits. Please see Section 2: Administrative Changes for your region.
Virtual care Urgently needed services	**In and Out-of-Network** Urgently needed virtual visits are not covered.	**In-Network** $0 copay for urgently needed virtual visits. **Out-of-Network** Urgently needed virtual visits are not covered.
Vision care Medicare-covered vision services	**In-Network** $35 copay for each Medicare-covered exam to diagnose and treat diseases or conditions of the eye.	**In-Network** $40 (region 1), $45 (region 5), $50 (region 2) copay for each Medicare-covered exam to diagnose and treat diseases or conditions of the eye. Please see Section 2: Administrative Changes for your region.
Non-Medicare covered vision services	**In and Out-of-Network** Up to $50 reimbursement for one non-Medicare covered routine vision exam, including dilation and refraction as necessary. Up to $20 reimbursement for one non-Medicare covered retinal imaging.	**In and Out-of-Network** 40% of the total cost for one non-Medicare covered routine vision exam, including dilation and refraction as necessary. 40% of the total cost for one non-Medicare covered retinal imaging. These benefits are covered once per year whether done in- or

	2026 (this year)	2027 (next year)
Vision care (continued)		out-of-network, cannot be combined.

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 and posted online at ***priorityhealth.com/edge27***.

You can get the *complete* Drug List by calling Customer Care at 888.389.6648 (TTY users call 711) or visiting our website at (***priorityhealth.com/edge27***).

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, 2026, 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.

- ***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 reach 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 Out-of-Pocket costs reach $2,400.

- ***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.

Drug Costs in Stage 1: Yearly Deductible

The table shows your cost per prescription during this stage.

	2026 (this year)	2027 (next year)
Yearly Deductible	$200 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.	$300 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 $2,400 out of pocket for covered Part D drugs, you'll move to the next stage (the Catastrophic Coverage Stage).

	2026 (this year)	2027 (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 Your cost for a one-month mail-order prescription is $7. *Preferred cost sharing:* You pay $2 Your cost for a one-month mail-order prescription is $2.	*Standard cost sharing:* You pay $7 Your cost for a one-month mail-order prescription is $7. *Preferred cost sharing:* You pay $2 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 Your cost for a one-month mail-order prescription is $15. *Preferred cost sharing:* You pay $8 Your cost for a one-month mail-order prescription is $8.	*Standard cost sharing:* You pay $15 Your cost for a one-month mail-order prescription is $15. *Preferred cost sharing:* You pay $8 Your cost for a one-month mail-order prescription is $8.
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 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 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%.

	2026 (this year)	2027 (next year)
Tier 3: **Preferred brand (continued)**	*Preferred cost sharing:* You pay 22% of the total cost 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%.	*Preferred cost sharing:* You pay 22% of the total cost 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 30% of the total cost You pay $35 per month supply of each covered insulin product on this tier. Your cost for a one-month mail-order prescription is 30%. *Preferred cost sharing:* You pay 25% of the total cost 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 30% of the total cost You pay $35 per month supply of each covered insulin product on this tier. Your cost for a one-month mail-order prescription is 30%. *Preferred cost sharing:* You pay 25% of the total cost 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%.
Tier 5: **Specialty** We changed the tier for some of the drugs on our Drug List. To see	*Standard cost sharing:* You pay 30% of the total cost	*Standard cost sharing:* You pay 30% of the total cost

	2026 (this year)	2027 (next year)
Tier 5: **Specialty (continued)** if your drugs will be in a different tier, look them up on the Drug List.	You pay $35 per month supply of each covered insulin product on this tier. Your cost for a one-month mail-order prescription is 30%. *Preferred cost sharing:* You pay 30% of the total cost You pay $35 per month supply of each covered insulin product on this tier. Your cost for a one-month mail-order prescription is 30%.	You pay $35 per month supply of each covered insulin product on this tier. Your cost for a one-month mail-order prescription is 30%. *Preferred cost sharing:* You pay 30% of the total cost You pay $35 per month supply of each covered insulin product on this tier. Your cost for a one-month mail-order prescription is 30%.

SECTION 2 Administrative Changes

	2026 (this year)	2027 (next year)
Region 1 Counties	Allegan, Barry, Kent, Lenawee, Ottawa	Allegan, Barry, Ionia, Kent, Montcalm, Muskegon, Ottawa
Region 2 Counties	Berrien, Calhoun, Cass, Ionia, Kalamazoo, Montcalm, St. Clair, Van Buren	Berrien, Branch, Calhoun, Cass, Clinton, Eaton, Gratiot, Hillsdale, Ingham, Jackson, Kalamazoo, St. Joseph, Van Buren
Region 5 Counties	Branch, Clinton, Genessee, Ingham, Livingston, Macomb, Oakland, Saginaw, Washtenaw, Wayne	Genessee, Lapeer, Lenawee, Livingston, Macomb, Monroe, Oakland, Saginaw, St. Clair, Shiawassee, Washtenaw, Wayne

SECTION 3 How to Change Plans

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

If you want to change plans for 2027, follow these steps:

- **To change to a different Medicare health plan,** enroll in the new plan. You'll be automatically disenrolled from **Priority**Medicare Edge (PPO). Remember, not all Medicare health plans cover prescription drugs. Also, be aware that for many plans, you can't join a Medicare health plan and simultaneously purchase a prescription drug plan.
- **To change to Original Medicare with separate Medicare drug coverage,** you can enroll in a Part D plan, and you'll automatically be disenrolled from **Priority**Medicare Edge (PPO).
- **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 4).
- **To learn more about Original Medicare and the different types of Medicare plans,** visit Medicare.gov, check the *Medicare & You 2027* 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, 2027, 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, 2027.

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

In certain situations, people can 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 can 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 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. 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 2027. You do not need to submit a new election request to continue participating in 2027. **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. To learn more about this payment option, call us at 866.845.1803 (TTY users should call 800.716.3231) or visit Medicare.gov.

SECTION 5 Questions?

Get Help from **Priority**Medicare Edge (PPO)

- **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 2027 *Evidence of Coverage***

  This *Annual Notice of Change* gives you a summary of changes in your benefits and costs for 2027. For details, go to the 2027 *Evidence of Coverage* for **Priority**Medicare Edge (PPO). 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/edge27*** or call Customer Care at 888.389.6648 (TTY users call 711) to ask us to mail you a copy.

- **Visit *priorityhealth.com/edge27***

  Our website has the most up-to-date information about our provider network (*Provider/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 MI Options.

Call MI Options to get free personalized health insurance counseling. They can help you understand your Medicare plan choices and answer questions about switching plans. Call

MI Options at 800.803.7174. Learn more about MI Options by visiting michigan.gov/MDHHSMIOptions.

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 Medicare.gov**

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

- **Write to Medicare**

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

- **Visit 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 2027***

  The *Medicare & You 2027* 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 Medicare.gov or by calling 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

PriorityMedicare Edge'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/edge27***.

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 civil rights laws and does not discriminate, exclude people, or treat them differently on the basis of race, color, ethnicity, national origin, age, HIV status, marital status, sex (as defined by law and Priority Health policy), sexual orientation, gender identity or expression, disability, religion, socioeconomic status or source of payment for service, height, weight, veteran status, association or any other protected characteristic based on federal, state or local law.

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).

If you need reasonable modifications, appropriate auxiliary aids and services or language assistance services, visit ***priorityhealth.com/contact-us***.

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, ethnicity, national origin, age, HIV status, marital status, sex (as defined by law and Priority Health policy), sexual orientation, gender identity or expression, disability, religion, socioeconomic status or source of payment for service, height, weight, veteran status, association or any other protected characteristic based on federal, state, or local law, you can file a grievance in person or by mail, phone, fax or email. The Section 1557 Civil Rights Coordinator can answer questions and help 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. HHS
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

Phone. 800.368.1019 (TTD: 800.537.7697)

Form. ***hhs.gov/civil-rights/filing-a-complaint***

This Notice is available at ***priorityhealth.com/nondiscrimination***. *Last updated: June 2025*

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

Priority Health

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 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 800.942.0954 (TTY: 711) أو تحدث إلى مقدم الخدمة.

Assyrian (ܐܬܘܪܝܐ) - ܡܙܗܪܢܘܬܐ: ܐܢ ܐܢܬܘܢ ܡܡܠܠܝܬܘܢ ܐܬܘܪܝܐ، ܬܫܡܫܝܬܐ ܕܥܘܕܪܢܐ ܕܠܫܢܐ ܡܓܢܢܝܐ ܕܠܟܘܢ ܡܬܡܨܝܐ ܠܡܘܬܒܘܢ ܠܘܬܟܘܢ. ܐܦܝܢ ܡܬܡܨܝܢ ܬܫܡܫܝܬܐ ܘܡܣܥܝܢܘܬܐ ܕܚܒܘܫܐ ܕܐܬܝܢ ܡܣܡܟܐ ܐܘ ܐܢܐ ܕܐܝܬܝܢ ܠܘܬܟܘܢ ܡܓܢܐ. ܩܪܘܢ 800.942.0954 (TTY: 711) ܘܡܠܠܘ ܥܡ ܡܣܦܩܢܐ ܕܝܠܟܘܢ.

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। 800.942.0954 (TTY: 711) নম্বরে কল করুন অথবা আপনার প্রদানকারীর সাথে কথা বলুন।

Bosnian/Croatian (Bosanski/Hrvatski) - PAŽNJA: Ako govorite bosanski/hrvatski, dostupne su vam besplatne jezičke usluge. Odgovarajuća pomagala i usluge za pružanje informacija u pristupačnim formatima također se pružaju besplatno. Pozovite 800.942.0954 (TTY: 711) ili kontaktirajte svog pružatelja usluga.

Brazilian Portuguese (Português do Brasil) - ATENÇÃO: Se você fala português do Brasil, serviços gratuitos de assistência linguística estão disponíveis para você. Auxílios e serviços auxiliares apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 800.942.0954 (TTY: 711) ou fale com seu provedor.

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 800.942.0954（TTY：711）或咨询您的服务提供商。

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 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 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 800.942.0954 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.

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 800.942.0954 (TTY: 711) oswa pale avèk founisè w la.

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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। 800.942.0954 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।

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'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。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. 800.942.0954 (TTY: 711) 번으로 전화하거나 서비스 제공업체에 문의하십시오.

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 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 800.942.0954 (TTY: 711) или обратитесь к своему поставщику услуг.

Serbian (Srpski) - ПАЖЊА: Ако говорите језиком који није енглески, доступне су вам услуге бесплатне помоћи у вези језика. Одговарајућа помоћна средства и услуге ради пружања информација у приступачном формату су такође доступни без накнаде. Позовите 800.942.0954 (TTY: 711) или разговарајте са пружаоцем услуга.

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 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 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 800.942.0954 (TTY: 711) پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔

Vietnamese (Tiếng 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 800.942.0954 (TTY: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

Source: lep.gov and cms.gov Last updated: May 2025
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