Priority Health

Summary of Benefits

MAPD PLANS

PriorityMedicare® Vital (PPO)
PriorityMedicare® Smart Savings (HMO-POS)
PriorityMedicare® Edge (PPO)
PriorityMedicare® Key (HMO-POS)
PriorityMedicare® Vintage (HMO-POS)
PriorityMedicare® Value (HMO-POS)
PriorityMedicare® Merit (PPO)
PriorityMedicare® (HMO-POS)

2026

Jan. 1, 2026–Dec. 31, 2026

The perfect Medicare plan is waiting for you in the next few pages.

Whether you're considering an HMO-POS or PPO plan, inside you'll find information to help you decide on the right Medicare plan.

Contact us

BY PHONE

Speak with Priority Health Medicare experts. From 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 Monday–Friday from 8 a.m.–8 p.m. and Saturday from 8 a.m.–noon ET.

Already a member?
Call 888.389.6648 (TTY 711)

Not a member yet?
Call 833.352.4194 (TTY 711)

ONLINE

Visit ***prioritymedicare.com*** to learn more about our plans and how Medicare works.

This information is not a complete description of benefits. Call 888.389.6648 (TTY 711) for more information. This doesn't list every service we cover or tell you if a deductible must be met before you pay the amount listed in this document. To get a complete list of services we cover including any limitations or exclusions, review the Evidence of Coverage document online at ***prioritymedicare.com***.

Priority Health offers two kinds of Medicare plans: HMO-POS and PPO

HMO-POS stands for health maintenance organization (HMO) and point of service (POS). With this plan you can use providers in our network and pay less for services. The POS portion allows you to use out-of-network providers both within Michigan and across the United States, but you may pay more for these out-of-network services. You'll choose a primary care physician (PCP) to coordinate all your care. We don't require you to get a referral to see a specialist, but your PCP can sometimes help you see one more quickly.

PPO stands for preferred provider organization (PPO). With these plans, we don't require you to get a referral to see a specialist for care. You'll get the most value from your plan when using in-network providers, but you can see any provider who participates with Medicare. You don't have to choose a PCP, although selecting one can help you coordinate care.

To confirm that your doctor, clinic or health center is part of the Priority Health Medicare network of providers, go to ***priorityhealth.com/findadoc***.

Eligibility

In order to join any of our Medicare Advantage plans, you need to be enrolled in Medicare Part A and Part B and live in our service area—which includes all 68 counties in the Lower Peninsula. There are no exclusions for pre-existing conditions.

Prescription coverage

All of our Medicare Advantage plans include prescription drug coverage. To make an informed decision about your Medicare plan, review our provider/pharmacy directory. You generally need to use network pharmacies to fill your prescriptions for covered Part D drugs. To save even more on your prescription costs, use a pharmacy in our preferred pharmacy network. Make sure to review the approved drug list, also called a formulary, to see which drugs are covered by our plans. You can find in-network pharmacies and approved drugs on our website at ***prioritymedicare.com***, or call the Customer Care number.

Get a free copy of the *2026 Medicare & You* handbook. *View it online at* ***medicare.gov*** *or get a copy by calling 800.MEDICARE (800.633.4227), 24 hours a day, seven days a week. TTY users should call 833.352.4194.*

Important health insurance terms to know

To help you better understand our plans, here are some common terms you'll come across while researching:

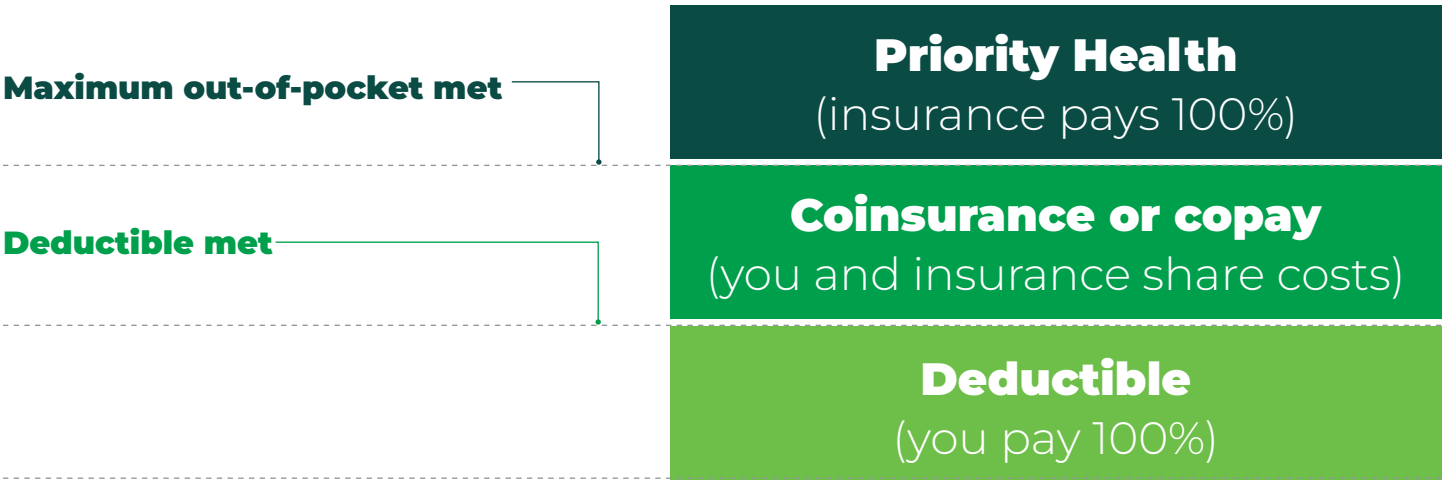
Deductible: This is the amount you pay each year before the health plan starts to pay for certain services, and you start paying a portion of the cost (copay or coinsurance).

Coinsurance: After you've paid your deductible, you may have a coinsurance as your portion of the cost for medical services or prescriptions. Coinsurance is a percentage of the cost of a medical service or prescription and is listed as a benefit in your health plan.

Copay: After you've paid your deductible, you may have a copay as your portion of the cost for medical services or prescriptions. This is a fixed amount you pay, generally at the time you receive a health care service or when you get a prescription filled.

Maximum out-of-pocket: This is the most you will pay for covered medical services for the year—this means Priority Health pays 100% of the cost after you hit this amount. Your coinsurance or copays count towards the maximum out-of-pocket; premiums and prescription costs do not.

How do health insurance costs work?



How does Original Medicare work with Medicare Advantage plans?

Original Medicare (health insurance from the federal government) may not be enough to cover all of your health care needs. Priority Health Medicare Advantage plans include everything that Original Medicare covers, plus extra benefits and services to help you save money and stay healthy.

	Original Medicare	Priority Health Medicare Advantage Plans
Covers your Medicare Part A and Part B services	●	●
Coverage in addition to Medicare Part A and B		●
Predictable copays and limits to what you'll pay out of pocket for medical care		●
Part D prescription drug coverage		●
Additional dental services		●
Free fitness membership*		●
Routine vision, including eyewear allowance		●
Routine hearing, including hearing aid coverage		●

Not available on **PriorityMedicare Vintage.*

$0 Plans

Full benefits and affordable coverage

PriorityMedicare Vital (PPO)
PriorityMedicare Edge (PPO)
PriorityMedicare Smart Savings (HMO-POS)

Premiums and Benefits

Counties	**Priority**Medicare Smart Savings (HMO-POS)	**Priority**Medicare Vital (PPO)	**Priority**Medicare Edge (PPO)
Region 1: Allegan, Barry, Kent, Lenawee, Ottawa	$0	$0	$0
Region 2: Berrien, Calhoun, Cass, Ionia, Isabella, Kalamazoo, Mason, Midland, Missaukee, Montcalm, Muskegon, Newaygo, Oceana, Osceola, Otsego, St. Clair, Van Buren, Wexford	$0	$0	$0
Region 3: Alcona, Antrim, Benzie, Charlevoix, Clare, Crawford, Grand Traverse, Hillsdale, Lake, Lapeer, Leelanau, Manistee, Mecosta, Monroe	N/A	N/A	N/A
Region 4: Alpena, Cheboygan, Eaton, Emmet, Gladwin, Gratiot, Iosco, Jackson, Kalkaska, Montmorency, Oscoda, Presque Isle, Roscommon, Sanilac, Shiawasse, St. Joseph	N/A	N/A	N/A
Region 5: Arenac, Bay, Branch, Clinton, Genesee, Huron, Ingham, Livingston, Macomb, Oakland, Ogemaw, Saginaw, Tuscola, Washtenaw, Wayne	$0	$0	$0

Premiums and Benefits

	PriorityMedicare Smart Savings (HMO-POS)	**Priority**Medicare Vital (PPO)	**Priority**Medicare Edge (PPO)
Monthly Premium, Deductible and Limits			
Monthly Plan Premium	$0 per month. In addition, you must keep paying your Medicare Part B premium but will receive the following	$0 per month. In addition, you must keep paying your Medicare Part B premium but will receive a $540	$0 per month. In addition, you must keep paying your Medicare Part B premium.

	PriorityMedicare Smart Savings (HMO-POS)	**Priority**Medicare Vital (PPO)	**Priority**Medicare Edge (PPO)
Monthly Plan Premium (continued)	Part B premium reduction each year. Regions 1 & 2: $1,200 Part B premium reduction each year ($100 per month) Region 5: $1,440 Part B premium reduction each year ($120 per month)	Part B premium reduction each year ($45 per month).	
Deductible The amount you'll pay for most covered services before you start paying only copays or coinsurance and Priority Health Medicare pays the balance. *In-network* deductible applies to hospital and medical services, 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 labs, 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 equipment, cardiac rehabilitation, pulmonary	**Medical services** *In-network*: $650	**Medical services** *In-network* (combined): $500	**Medical services** *In-network* (combined): $275

	PriorityMedicare Smart Savings (HMO-POS)	**Priority**Medicare Vital (PPO)	**Priority**Medicare Edge (PPO)
Deductible (continued) rehabilitation and supervised exercise therapy. *Out-of-network* applies to hospital and medical services except for acupuncture and insulin furnished through an item of durable medical equipment.	*Out-of-network*: $2,000 **Prescription drugs (Part D):** Tiers 1-2: $0 Tiers 3-5: $500	*Out-of-network* (combined): $500 **Prescription drugs (Part D):** Tiers 1-2: $0 Tiers 3-5: $450	*Out-of-network* (combined): $275 **Prescription drugs (Part D):** Tiers 1-2: $0 Tiers 3-5: $200
Maximum Out-of-Pocket Amount This is the most you pay for covered medical services for the year, excluding Part D prescription drugs.	*In-network*: $9,250	*In- and out-of-network* (combined): $6,300	*In- and out-of-network* (combined): $6,000
Hospital			
Inpatient hospital coverage* We cover an unlimited number of days for an inpatient hospital stay. *Prior authorization may be required.	*In-network*: $380 copay per day for days 1 - 7 $0 for additional hospital days *Out-of-network*: 50% of the total cost per stay	*In- and out-of-network*: $350 copay per day for days 1 - 7 $0 for additional hospital days	*In-network*: $350 copay per day for days 1 - 7 $0 for additional hospital days *Out-of-network*: 40% of the total cost per stay
Outpatient hospital coverage* **Outpatient hospital**	*In-network*: $0 copay for each visit at a rural health clinic $55 copay for each Medicare-covered outpatient wound care services	*In- and out-of-network*: $0 copay for each visit at a rural health clinic $50 copay for each Medicare-covered outpatient wound care services	*In-network*: $0 copay for each visit at a rural health clinic $35 copay for each Medicare-covered outpatient wound care services

	PriorityMedicare Smart Savings (HMO-POS)	**Priority**Medicare Vital (PPO)	**Priority**Medicare Edge (PPO)
Outpatient hospital coverage* (continued) **Observation services** *Prior authorization may be required.	$450 copay for each visit at all other locations *Out-of-network*: 50% of the total cost for each visit	$350 copay for each visit at all other locations	$350 copay for each visit at all other locations *Out-of-network*: 40% of the total cost for each visit
	In- and out-of-network: $115 copay per stay for each visit, including all services received	*In- and out-of-network*: $130 copay per stay for each visit, including all services received	
Ambulatory surgery center* *Prior authorization may be required.	*In-network*: $450 copay for each visit *Out-of-network*: 50% of the total cost for each visit	*In- and out-of-network*: $350 copay for each visit	*In-network*: $350 copay for each visit *Out-of-network*: 40% of the total cost for each visit
Doctor Visits and Preventive Care			
Doctor visits **Primary care physician (PCP)**	*In-network*: $0 copay for each office visit and surgical procedures performed in a PCP's office *Out-of-network*: 50% of the total cost for each visit	*In- and out-of-network*: $0 copay for each office visit and surgical procedures performed in a PCP's office	*In-network*: $0 copay for each office visit and surgical procedures performed in a PCP's office *Out-of-network*: 40% of the total cost for each visit
Specialist visit* *Prior authorization may be required for some specialist visits.	*In-network*: $0 copay for palliative care physician office visits	*In- and out-of-network*: $0 copay for palliative care physician office visits	*In-network*: $0 copay for palliative care physician office visits

	PriorityMedicare Smart Savings (HMO-POS)	**Priority**Medicare Vital (PPO)	**Priority**Medicare Edge (PPO)
Doctor visits (continued)	$0 copay for surgical procedures performed in a physician's office $55 copay for all other office visits *Out-of-network*: 50% of the total cost for each visit	$0 copay for surgical procedures performed in a physician's office $50 copay for all other office visits	$0 copay for surgical procedures performed in a physician's office $35 copay for all other office visits *Out-of-network*: 40% of the total cost for each visit
Preventive care Services that can help with prevention and early detection of many illnesses, disabilities, and diseases. Examples include annual wellness visit, breast cancer screening, diabetic screening, flu vaccine and more.	*In-network*: $0 copay for each service *Out-of-network*: 50% of the total cost for each service	*In- and out-of-network*: $0 copay for each service	*In-network*: $0 copay for each service *Out-of-network*: 40% of the total cost for each service
	Any additional preventive services approved by Medicare during the contract year will be covered.		
Emergency and Urgent Care			
Emergency care This amount is waived if you are admitted as inpatient to the hospital within 24 hours from your emergency care visit.	*In- and out-of-network*: $115 copay for each visit	*In- and out-of-network*: $130 copay for each visit	
Urgently needed services This amount is waived if you are admitted as inpatient to the hospital within 24 hours from your urgent care visit.	*In- and out-of-network*: $40 copay for each visit	*In- and out-of-network*: $50 copay for each visit	

	PriorityMedicare Smart Savings (HMO-POS)	**Priority**Medicare Vital (PPO)	**Priority**Medicare Edge (PPO)
Outpatient Diagnostic Tests, Radiation Therapy, X-rays and Labs			
Diagnostic services/labs/imaging*	*In-network*:	*In- and out-of-network*:	*In-network*:
Radiology/imaging	$300 copay per day, per provider	20% of the total cost per day, per provider	$270 copay per day, per provider
Diagnostic tests and procedures	$30 copay per day, per provider	$0 copay per day, per provider	$0 copay per day, per provider
Lab services	$0 copay for anticoagulant lab services, $30 copay for all other Medicare-covered lab services	$0 copay for anticoagulant labs and all other Medicare-covered lab services	$0 copay for anticoagulant labs and all other Medicare-covered lab services
Outpatient X-rays	$45 copay per day, per provider	$40 copay per day, per provider	$20 copay per day, per provider
Radiation therapy *Prior authorization may be required for some services.	$45 copay per day, per provider *Out-of-network*: 50% of the total cost per day, per provider ($0 copay for anticoagulant lab services)	$40 copay per day, per provider	$40 copay per day, per provider *Out-of-network*: 40% of the total cost per day, per provider ($0 copay for anticoagulant lab services)
Hearing / Dental / Vision			
Hearing services			
Medicare-covered diagnostic hearing exam Medicare-covered exam performed by a primary care physician or specialist to diagnose and treat hearing and balance issues.	*In-network*: $0 - $55 copay for each office visit *Out-of-network*: 50% of the total cost for each visit	*In- and out-of-network*: $0 - $50 copay for each office visit	*In-network*: $0 - $35 copay for each office visit *Out-of-network*: 40% of the total cost for each visit
Routine hearing coverage and hearing aids (TruHearing® provider) Routine hearing services and hearing aids must be received from a TruHearing® provider.	$0 copay for one routine hearing exam, per year $295 - $1,495 copay, per ear every	$0 copay for one routine hearing exam, per year $99 or $399 copay, per ear every two	$0 copay for one routine hearing exam, per year $295 - $1,495 copay, per ear every

	PriorityMedicare Smart Savings (HMO-POS)	**Priority**Medicare Vital (PPO)	**Priority**Medicare Edge (PPO)
Hearing services (continued)	year, for hearing aids from top manufacturers depending on level selected	years, for Advanced or Premium hearing aids from top manufacturers depending on level selected	year, for hearing aids from top manufacturers depending on level selected
	Hearing aid cost includes a 60-day trial period, one year of post-purchase follow-up visits, 80 batteries per non-rechargeable hearing aid and a full 3-year manufacturer warranty.		
Dental services*			
Medicare-covered dental services	*In-network*: $0 - $450 copay for each visit, depending on the service performed *Out-of-network*: 50% of the total cost for each service performed	*In- and out-of-network*: $0 - $350 copay for each visit, depending on the service performed	*In-network*: $0 - $350 copay for each visit, depending on the service performed *Out-of-network*: 40% of the total cost for each service performed
Additional dental services Delta Dental® is the preferred provider for additional dental services. *Prior authorization may be required for Medicare-covered dental services.	$0 copay for two cleanings (regular or periodontal maintenance) per year $0 copay for two exams per year $0 copay for one set of bitewing X-rays per year $0 copay for one brush biopsy per year $0 copay for periapical radiographs as needed $0 copay for radiographs (full-mouth or panoramic	$0 copay for two cleanings (regular or periodontal maintenance) per year $0 copay for two exams per year $0 copay for one set of bitewing X-rays per year $0 copay for one brush biopsy per year $0 copay for periapical radiographs as needed $0 copay for radiographs (full-mouth or panoramic	$0 copay for two cleanings (regular or periodontal maintenance) per year $0 copay for two exams per year $0 copay for one set of bitewing X-rays per year $0 copay for one brush biopsy per year $0 copay for periapical radiographs as needed $0 copay for radiographs (full-mouth or panoramic

	PriorityMedicare Smart Savings (HMO-POS)	**Priority**Medicare Vital (PPO)	**Priority**Medicare Edge (PPO)
Dental services* (continued)	X-rays) once every 24 months	X-rays) once every 24 months $1,500 annual maximum that applies for the following services: $0 copay for fillings (includes composite, resin, and amalgam), once per tooth, every 24 months $0 copay for crown repairs, once per tooth every 24 months $0 copay for simple extractions, once per tooth per lifetime $0 copay for anesthesia, when used in conjunction with qualifying dental services	X-rays) once every 24 months
Vision services **Medicare-covered services** Medicare-covered exam performed by a specialist to diagnose and treat diseases and conditions of the eye and additional Medicare-covered services.	*In-network*: $55 copay for each visit $0 copay for eyeglasses or contact lenses after cataract surgery $0 copay for a yearly glaucoma screening *Out-of-network*: 50% of the total cost for each visit,	*In- and out-of-network*: $50 copay for each visit $0 copay for eyeglasses or contact lenses after cataract surgery $0 copay for a yearly glaucoma screening	*In-network*: $35 copay for each visit $0 copay for eyeglasses or contact lenses after cataract surgery $0 copay for a yearly glaucoma screening *Out-of-network*: 40% of the total cost for each visit,

	PriorityMedicare Smart Savings (HMO-POS)	**Priority**Medicare Vital (PPO)	**Priority**Medicare Edge (PPO)
Vision services (continued) **Routine Vision Services** In-network routine vision services must be provided by an EyeMed® "Select" provider. If received by a non-EyeMed® "Select" provider (out-of-network), you must seek reimbursement. In-network and out-of-network benefits cannot be combined.	eyeglasses or contact lenses after cataract surgery, or for a yearly glaucoma screening *In-network*: $0 copay for one routine exam each year (includes dilation and refraction as necessary) $0 copay for one retinal imaging per year $100 eyewear allowance per year *Out-of-network*: Up to $100 reimbursement for eyewear Up to $50 reimbursement for one routine exam Up to $20 reimbursement for retinal imaging	*In-network*: $0 copay for one routine exam each year (includes dilation and refraction as necessary) $0 copay for one retinal imaging per year $125 eyewear allowance per year *Out-of-network*: Up to $125 reimbursement for eyewear Up to $50 reimbursement for one routine exam Up to $20 reimbursement for retinal imaging	eyeglasses or contact lenses after cataract surgery, or for a yearly glaucoma screening *In-network*: $0 copay for one routine exam each year (includes dilation and refraction as necessary) $0 copay for one retinal imaging per year $100 eyewear allowance per year *Out-of-network*: Up to $100 reimbursement for eyewear Up to $50 reimbursement for one routine exam Up to $20 reimbursement for retinal imaging
Mental Health Services			
Inpatient visits* We cover up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. *Prior authorization may be required.	*In-network*: $275 copay per day, days 1-6 $0 copay for additional hospital days *Out-of-network*: 50% of the total cost per stay	*In- and out-of-network*: $350 copay per day, days 1-5 $0 copay for additional hospital days	*In-network*: $350 copay per day, days 1-5 $0 copay for additional hospital days *Out-of-network*: 40% of the total cost per stay

	PriorityMedicare Smart Savings (HMO-POS)	**Priority**Medicare Vital (PPO)	**Priority**Medicare Edge (PPO)
Outpatient therapy (individual or group)	*In-network*: $20 copay for each visit *Out-of-network*: 50% of the total cost for each visit	*In- and out-of-network*: $20 copay for each visit	*In-network*: $20 copay for each visit *Out-of-network*: 40% of the total cost for each visit
Skilled Nursing Facility (SNF)			
Skilled nursing facility* Our plan covers up to 100 days each benefit period. A benefit period starts the day you go into a SNF and ends when you go for 60 days in a row without SNF care. *Prior authorization may be required.	*In-network*: $0 copay per day, days 1 - 20 $218 copay per day, days 21 - 100 *Out-of-network*: 50% of the total cost per stay for each stay	*In- and out-of-network*: $0 copay per day, days 1 - 20 $218 copay per day, days 21 - 100	*In-network*: $0 copay per day, days 1 - 20 $218 copay per day, days 21 - 100 *Out-of-network*: 40% of the total cost per stay for each stay
Outpatient Rehabilitation Services			
Physical therapy	*In-network*: $35 copay for each service *Out-of-network*: 50% of the total cost for each service	*In- and out-of-network*: $30 copay for each service	*In-network*: $40 copay for each service *Out-of-network*: 40% of the total cost for each service
Medical Transportation			
Ambulance* *Prior authorization may be required.	*In- and out-of-network*: $325 copay each way	*In- and out-of-network*: $265 copay each way	*In- and out-of-network*: $275 copay each way
Transportation	Not covered	Not covered	Not covered

	PriorityMedicare Smart Savings (HMO-POS)	**Priority**Medicare Vital (PPO)	**Priority**Medicare Edge (PPO)
Medicare Part B Drugs			
	In- and out-of-network:		
Chemotherapy drugs	0% - 20% of the total cost for each drug		
Other Part B drugs	0% - 20% of the total cost for each drug		
Select home infusion drugs	$0 copay for each drug		
Part B insulin *Prior authorization or step therapy may be required.	0% - 20% of the total cost up to $35 for a one-month supply of insulin administered through a durable medical equipment (DME) device item of durable medical equipment (such as insulin pumps or continuous glucose monitors (CGM)).		

Prescription Drug Benefits

Important Message About What You Pay for Vaccines - Our plan covers most Part D vaccines at no cost to you, no matter what cost-sharing tier it's on.

Important Message About What You Pay for Insulin - You won't pay more than $35 for a one-month supply and no more than $105 for a three-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on, even if you haven't paid your deductible.

PART D OUTPATIENT PRESCRIPTION DRUGS			
	PriorityMedicare Smart Savings (HMO-POS)	**Priority**Medicare Vital (PPO)	**Priority**Medicare Edge (PPO)
Stage 1: Deductible stage You'll pay this amount before you begin paying copays or coinsurance only.	Tier 1 - 2: $0 Tier 3 - 5: $500*	Tier 1 - 2: $0 Tier 3 - 5: $450*	Tier 1 - 2: $0 Tier 3 - 5: $200*
	*The deductible doesn't apply to covered insulins and most adult Part D vaccines. See initial coverage stage row for insulin cost-sharing.		
Stage 2: Initial coverage stage You are in this stage until your out-of-pocket Part D drug costs reach $2,100.	You pay what is listed in the chart below.		

STANDARD RETAIL PHARMACY						
	PriorityMedicare Smart Savings (HMO-POS)		**Priority**Medicare Vital (PPO)		**Priority**Medicare Edge (PPO)	
Standard Retail	**30-day supply**	**100-day supply**	**30-day supply**	**100-day supply**	**30-day supply**	**100-day supply**
Tier 1: Preferred generic	$6	$18	$6	$18	$7	$21
	30-day supply	**90-day supply**	**30-day supply**	**90-day supply**	**30-day supply**	**90-day supply**
Tier 2: Generic	$13	$39	$15	$45	$15	$45
Tier 3: Preferred brand*	$47	$141	$47	$141	25%	25%
Tier 4: Non-preferred drug*	25%	25%	25%	25%	30%	30%
Tier 5: Specialty*	27%	N/A	27%	N/A	30%	N/A

PREFERRED RETAIL PHARMACY						
	PriorityMedicare Smart Savings (HMO-POS)		**Priority**Medicare Vital (PPO)		**Priority**Medicare Edge (PPO)	
Preferred Retail	**30-day supply**	**100-day supply**	**30-day supply**	**100-day supply**	**30-day supply**	**100-day supply**
Tier 1: Preferred generic	$1	$0	$1	$0	$2	$0
	30-day supply	**90-day supply**	**30-day supply**	**90-day supply**	**30-day supply**	**90-day supply**
Tier 2: Generic	$8	$24	$10	$30	$8	$24
Tier 3: Preferred brand*	$42	$126	$42	$126	22%	22%
Tier 4: Non-preferred drug*	25%	25%	25%	25%	25%	25%
Tier 5: Specialty*	27%	N/A	27%	N/A	30%	N/A
Your costs will be less for your covered drugs when you use a pharmacy in our preferred network (includes Meijer, Walgreens, Walmart, Family Fare Supermarkets, Costco and more), go to ***prioritymedicare.com*** to view the list in the provider/pharmacy directory.						

PREFERRED MAIL ORDER						
	PriorityMedicare Smart Savings (HMO-POS)		**Priority**Medicare Vital (PPO)		**Priority**Medicare Edge (PPO)	
Preferred Mail Order	**30-day supply**	**100-day supply**	**30-day supply**	**100-day supply**	**30-day supply**	**100-day supply**
Tier 1: Preferred generic	$1	$0	$1	$0	$2	$0
	30-day supply	**90-day supply**	**30-day supply**	**90-day supply**	**30-day supply**	**90-day supply**
Tier 2: Generic	$8	$0	$10	$0	$8	$0
Tier 3: Preferred brand*	$42	$105	$42	$105	22%	22%
Tier 4: Non-preferred drug*	25%	25%	25%	25%	25%	25%
Tier 5: Specialty*	27%	N/A	27%	N/A	30%	N/A
Your costs will be less for your covered drugs when you use a pharmacy in our preferred network (includes Express Scripts and Amazon), go to ***prioritymedicare.com*** to view the list in the provider/pharmacy directory. *Specialty drugs are limited to a 30-day supply.						

	PriorityMedicare Smart Savings (HMO-POS)	**Priority**Medicare Vital (PPO)	**Priority**Medicare Edge (PPO)
Catastrophic coverage stage	Once your out-of-pocket drug costs reach $2,100, the plan pays the full cost of your covered Part D drugs.		
Long-term care (LTC)	If you are a resident of a long-term care (LTC) facility, you may get your prescription drugs through the facility's pharmacy as long as it is part of our network.		

Optional Enhanced Dental and Vision Package

Additional dental coverage, including coverage for dental services and an additional vision allowance for use on eyeglasses or contacts.

	PriorityMedicare Smart Savings (HMO-POS)	**Priority**Medicare Vital (PPO)	**Priority**Medicare Edge (PPO)
Premium	Additional $49 per month. You must keep paying your Medicare Part B premium and your $0 monthly plan premium.	Additional $43 per month. You must keep paying your Medicare Part B premium and your $0 monthly plan premium.	Additional $49 per month. You must keep paying your Medicare Part B premium and your $0 monthly plan premium.
Deductible	$0		
Maximum plan benefit coverage amount	$2,500 for comprehensive dental services and an additional $150 for eyewear, per calendar year		
Dental services Delta Dental® is the preferred provider for additional dental services.	$0 copay for one fluoride treatment and routine cleaning per year, fillings (including composite resin and amalgam) once per tooth, every 24 months and crown repairs once per tooth every 12 months $0 copay for emergency treatment for dental pain at no limit and anesthesia when used in conjunction with qualifying dental services 50% of the total cost of onlays, crowns and associated substructures, once per tooth, per lifetime	$0 copay for one fluoride treatment and routine cleaning per year $0 copay for emergency treatment for dental pain at no limit and anesthesia when used in conjunction with qualifying dental services 50% of the total cost of onlays, crowns and associated substructures, once per tooth, per lifetime	$0 copay for one fluoride treatment and routine cleaning per year, fillings (including composite resin and amalgam) once per tooth, every 24 months and crown repairs once per tooth every 12 months $0 copay for emergency treatment for dental pain at no limit and anesthesia when used in conjunction with qualifying dental services 50% of the total cost of onlays, crowns and associated substructures, once per tooth, per lifetime

	PriorityMedicare Smart Savings (HMO-POS)	**Priority**Medicare Vital (PPO)	**Priority**Medicare Edge (PPO)
Dental services (continued)	50% of the total cost of endodontics (root canals), once per tooth per lifetime 50% of the total cost of simple (non surgical) and surgical extractions, once per tooth per lifetime 50% of the total cost of implants and implant repairs, 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	50% of the total cost of endodontics (root canals), once per tooth per lifetime 50% of the total cost of surgical extractions, once per tooth per lifetime 50% of the total cost of implants and implant repairs, 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	50% of the total cost of endodontics (root canals), once per tooth per lifetime 50% of the total cost of simple (non surgical) and surgical extractions, once per tooth per lifetime 50% of the total cost of implants and implant repairs, 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
Vision services In-network vision services must be provided by an EyeMed® "Select" provider. If received by a non-EyeMed® "Select" provider (out-of-network), you must seek reimbursement. In-network and out-of-network benefits cannot be combined.	$150 allowance/ reimbursement per year for additional eyewear.	$150 allowance/ reimbursement per year for additional eyewear.	$150 allowance/ reimbursement per year for additional eyewear.

Additional Benefits

	PriorityMedicare Smart Savings (HMO-POS)	**Priority**Medicare Vital (PPO)	**Priority**Medicare Edge (PPO)
Additional Benefits			

	PriorityMedicare Smart Savings (HMO-POS)	**Priority**Medicare Vital (PPO)	**Priority**Medicare Edge (PPO)
Acupuncture	**Medicare-covered acupuncture for lower chronic back pain** *In- and out-of-network*: $20 copay per service **Non-Medicare-covered routine acupuncture for other conditions** *In- and out-of-network*: $20 copay per visit (limit 6 visits every year)		
Annual preventive physical exam	*In-network*: $0 copay for an exam *Out-of-network*: 50% of the total cost for an exam	*In- and out-of-network*: $0 copay for an exam	*In-network*: $0 copay for an exam *Out-of-network*: 40% of the total cost for an exam
	You're free to talk at your annual preventive exam. When we say no cost, we mean it — $0 annual physical exam, without the worry of being charged for an office visit. This is an opportunity for you and your physician to discuss any concerns or questions you have.		
Caregiver Support Carallel's Care Advocates provide telephonic support and research on topics like health insurance, emotional support, stress management, housing and transportation, and guidance on financial matters and legal concerns. Carallel also offers online tools and resources that provide personalized support tailored to your unique situation.	Not covered		$0 copay for unlimited hours of caregiver support provided by Carallel®.
Chiropractic services	**Medicare-covered care** *In-network*: $15 copay for each service *Out-of-network*: 50% of the total cost for each service	**Medicare-covered care** *In- and out-of-network*: $15 copay for each service	**Medicare-covered care** *In-network*: $15 copay for each service *Out-of-network*: 40% of the total cost for each service

	PriorityMedicare Smart Savings (HMO-POS)	**Priority**Medicare Vital (PPO)	**Priority**Medicare Edge (PPO)
Chiropractic services (continued)	**Non-Medicare-covered routine care** *In-network*: $15 copay for each service $45 copay for X-ray services performed once per year *Out-of-network*: Not covered	**Non-Medicare-covered routine care** *In- and out-of-network*: $15 copay for each service $40 copay for X-ray services performed once per year Limited to 12 non-Medicare-covered routine chiropractic visits and one routine X-ray service per year whether done in- or out-of-network	**Non-Medicare-covered routine care** *In-network*: $15 copay for each service $20 copay for X-ray services performed once per year *Out-of-network*: 40% of the total cost for each visit and for X-ray services performed once per year Limited to 12 non-Medicare-covered routine chiropractic visits and one routine X-ray service per year whether done in- or out-of-network
CogniFit®	$0 copay Access to the CogniFit® brain health program. Simply set up an account through One Pass® to access a collection of brain games to keep you interested, challenged, and engaged. CogniFit® works by training over 20 cognitive skills that we use daily such as working memory, perception, attention, reasoning and coordination.		
Dialysis	*In-network*: 20% of the total cost for each service *Out-of-network*: 50% of the total cost for each service	*In- and out-of-network*: 20% of the total cost for each service	*In-network*: 20% of the total cost for each service *Out-of-network*: 40% of the total cost for each service

	PriorityMedicare Smart Savings (HMO-POS)	**Priority**Medicare Vital (PPO)	**Priority**Medicare Edge (PPO)
Home health services* *Prior authorization may be required.	*In- and out-of-network*: $0 copay for each Medicare-covered service		
Medical equipment and supplies* Examples include diabetic supplies (shoes/inserts, diabetic test strips), durable medical equipment (wheelchairs, oxygen, insulin pumps) and prosthetic devices (braces, artificial limbs). Diabetic test strips are limited to Contour® and Acu-Chek® Guide products when dispensed by a retail pharmacy or mail-order pharmacy. *Prior authorization may be required.	**Diabetes supplies** *In-network*: $0 copay for each item *Out-of-network*: 50% of the total cost for each item **Durable medical equipment** *In-network*: 20% of the total cost for each item *Out-of-network*: 30% of the total cost for each item **Prosthetic devices** *In-network*: $0 - 20% of the total cost for each item, depending on the device *Out-of-network*: 30% of the total cost for each device	**Diabetes supplies** *In- and out-of-network*: $0 copay for each item **Durable medical equipment** *In- and out-of-network*: 20% of the total cost for each item **Prosthetic devices** *In- and out-of-network*: $0 - 20% of the total cost for each item, depending on the device	**Diabetes supplies** *In-network*: $0 copay for each item *Out-of-network*: 40% of the total cost for each item **Durable medical equipment** *In-network*: 20% of the total cost for each item *Out-of-network*: 30% of the total cost for each item **Prosthetic devices** *In-network*: $0 - 20% of the total cost for each item, depending on the device *Out-of-network*: 30% of the total cost for each device
One Pass® Fitness membership	$0 copay One Pass® can help you reach your fitness goals while finding new passions along the way. Find a routine that's right for you whether you work out at home or at the gym. One Pass® includes: • Access to the largest nationwide network of gyms and fitness locations • Live, digital fitness classes and on-demand workouts • Online brain training to improve your memory and focus (see CogniFit® for more information)		

	PriorityMedicare Smart Savings (HMO-POS)	**Priority**Medicare Vital (PPO)	**Priority**Medicare Edge (PPO)
Over-The-Counter (OTC) allowance Over-the-counter items are drugs and health related products that do not need a prescription such as allergy medication, eye drops, cough drops, nasal spray, vitamins and more.	Not covered	$45 allowance every three months** **Quarterly allowances do not rollover.	$55 allowance every three months** **Quarterly allowances do not rollover.
		OTC items, home and bathroom safety devices and modifications can be purchased in participating stores (Meijer, Walmart, Walgreens, CVS, Kroger and more) and online at ***PriorityHealth.com/shopOTC***. You can also call 833.415.4380 or download the Priority Health OTC app.	
Podiatry services	**Medicare-covered podiatry** *In-network*: $55 copay for each visit $0 copay for nail debridement and callous removal for members with specific conditions (up to 6 of each) *Out-of-network*: 50% of the total cost for each visit or service	**Medicare-covered podiatry** *In- and out-of-network*: $50 copay for each visit $0 copay for nail debridement and callous removal for members with specific conditions (up to 6 of each)	**Medicare-covered podiatry** *In-network*: $35 copay for each visit $0 copay for nail debridement and callous removal for members with specific conditions (up to 6 of each) *Out-of-network*: 40% of the total cost for each visit or service
Priority Health Travel Pass **Out-of-area travel benefit** **Worldwide urgent and emergent care**	You'll pay in-network prices when seeking care from Medicare-participating providers anywhere in the U.S. outside of the lower peninsula of Michigan. Go to ***priorityhealth.com/FindADoctor*** to find providers in our network. You may stay enrolled in the plan when outside of the service area for up to 12 months as long as your permanent residency remains in your plan's service area. Unlimited worldwide emergent and urgent care coverage.		

	PriorityMedicare Smart Savings (HMO-POS)	**Priority**Medicare Vital (PPO)	**Priority**Medicare Edge (PPO)
Priority Health Travel Pass (continued) **Worldwide travel assistance program**	$0 for emergency travel assistance services through Assist America® when you're more than 100 miles from home or in a foreign country. Assist America® provides pre-trip assistance to help you prepare for your travel, including finding a doctor or a pharmacy to fill your prescriptions at your destination and assistance while on your trip should a medical travel emergency arise, at no extra cost to you. You will still pay for benefits covered by Priority Health Medicare, such as emergency, urgent care, or prescription drug copays.		
Rehabilitation services			
Cardiac rehabilitation services	*In-network*: $10 copay for each service *Out-of-network*: 50% of the total cost for each service	*In- and out-of-network*: $10 copay for each service	*In-network*: $10 copay for each service *Out-of-network*: 40% of the total cost for each service
Pulmonary rehabilitation and supervised exercise therapy (SET) services	*In-network*: $10 copay for each service *Out-of-network*: 50% of the total cost for each service	*In- and out-of-network*: $10 copay for each service	*In-network*: $10 copay for each service *Out-of-network*: 40% of the total cost for each service
Physical therapy, occupational therapy, and speech therapy services	*In-network*: $35 copay for each service *Out-of-network*: 50% of the total cost for each service	*In- and out-of-network*: $30 copay for each service	*In-network*: $40 copay for each service *Out-of-network*: 40% of the total cost for each service
Virtual care Online care you receive from the comfort of your home, or wherever you may be, with a virtual visit via video on your computer, smart phone, or tablet.	*In-network*: $0 copay virtual visits with primary care, specialist and behavioral health providers Available 24/7, virtual visits let you see a provider for, and get treatment for, non-emergency care *Out-of-network*: Not covered		

HMO-POS Plans

Comprehensive benefits and affordable coverage

PriorityMedicare Vintage (HMO-POS)
PriorityMedicare Key (HMO-POS)
PriorityMedicare Value (HMO-POS)

Premiums and Benefits | Monthly Premiums

Counties	**Priority**Medicare Vintage (HMO-POS)	**Priority**Medicare Key (HMO-POS)	**Priority**Medicare Value (HMO-POS)
Region 1: Allegan, Barry, Kent, Lenawee, Ottawa	$8.80	$0	$32
Region 2: Berrien, Calhoun, Cass, Ionia, Isabella, Kalamazoo, Mason, Midland, Missaukee, Montcalm, Muskegon, Newaygo, Oceana, Osceola, Otsego, St. Clair, Van Buren, Wexford	$8.80	$0	$43
Region 3: Alcona, Antrim, Benzie, Charlevoix, Clare, Crawford, Grand Traverse, Hillsdale, Lake, Lapeer, Leelanau, Manistee, Mecosta, Monroe	N/A	$0	$80
Region 4: Alpena, Cheboygan, Eaton, Emmet, Gladwin, Gratiot, Iosco, Jackson, Kalkaska, Montmorency, Oscoda, Presque Isle, Roscommon, Sanilac, Shiawasse, St. Joseph	N/A	$0	$55
Region 5: Arenac, Bay, Branch, Clinton, Genesee, Huron, Ingham, Livingston, Macomb, Oakland, Ogemaw, Saginaw, Tuscola, Washtenaw, Wayne	$8.80	$0	$43

Premiums and Benefits

	PriorityMedicare Vintage (HMO-POS)	**Priority**Medicare Key (HMO-POS)	**Priority**Medicare Value (HMO-POS)
Monthly Premium, Deductible and Limits			
Monthly Plan Premium	$8.80 per month. In addition, you must keep paying your Medicare Part B premium.	$0 per month. In addition, you must keep paying your Medicare Part B premium.	$32 - $80 per month. In addition, you must keep paying your Medicare Part B premium.

	PriorityMedicare Vintage (HMO-POS)	**Priority**Medicare Key (HMO-POS)	**Priority**Medicare Value (HMO-POS)
Deductible The amount you'll pay for most covered services before you start paying only copays or coinsurance and Priority Health Medicare pays the balance.	**Medical services** *In-network*: $0	**Medical services** *In-network*: $375 deductible applies to hospital and medical services, except for, primary care visits, specialty provide 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 equipment, cardiac	**Medical services** *In-network*: $0

	PriorityMedicare Vintage (HMO-POS)	**Priority**Medicare Key (HMO-POS)	**Priority**Medicare Value (HMO-POS)
Deductible (continued) *Out-of-network* deductible applies to hospital and medical services except for acupuncture and insulin furnished through an item of durable medical equipment.		rehabilitation, pulmonary rehabilitation, and supervised exercise therapy. *Out-of-network*: $1,500 applies to hospital and medical services except for acupuncture and insulin furnished through an item of durable medical equipment. **Prescription drugs (Part D):** Tiers 1-2: $0 Tiers 3-5: $200	 *Out-of-network*: $1,000 applies to hospital and medical services except for acupuncture and insulin furnished through an item of durable medical equipment. **Prescription drugs (Part D):** Tiers 1-2: $0 Tiers 3-5: $100
Maximum Out-of-Pocket Amount This is the most you pay for covered medical services for the year, excluding Part D prescription drugs.	*In-network*: $5,600	*In-network*: $5,800	*In-network*: $5,100
Hospital			
Inpatient hospital coverage* We cover an unlimited number of days for an inpatient hospital stay. *Prior authorization may be required.	*In-network*: $400 copay per day for days 1 - 7 $0 copay for additional hospital days *Out-of-network*: 50% of the total cost per stay	*In-network*: $350 copay per day for days 1 - 7 $0 copay for additional hospital days *Out-of-network*: 50% of the total cost per stay	*In-network*: $325 copay per day for days 1 - 7 $0 copay for additional hospital days *Out-of-network*: 40% of the total cost per stay
Outpatient hospital coverage* **Outpatient hospital**	*In-network*: $0 copay for each visit at a rural health clinic $35 copay for each Medicare-covered	*In-network*: $0 copay for each visit at a rural health clinic $40 copay for each Medicare-covered	*In-network*: $0 copay for each visit at a rural health clinic $35 copay for each Medicare-covered

	PriorityMedicare Vintage (HMO-POS)	**Priority**Medicare Key (HMO-POS)	**Priority**Medicare Value (HMO-POS)
Outpatient hospital coverage* (continued) **Observation services** *Prior authorization may be required.	outpatient wound care services $350 copay for each visit at all other locations *Out-of-network*: 50% of the total cost for each visit	outpatient wound care services $350 copay for each visit at all other locations *Out-of-network*: 50% of the total cost for each visit	outpatient wound care services $325 copay for each visit at all other locations *Out-of-network*: 40% of the total cost for each visit
	In- and out-of-network: $130 copay per stay for each visit, including all services received		
Ambulatory surgery center* *Prior authorization may be required.	*In-network*: $350 copay for each visit *Out-of-network*: 50% of the total cost for each visit		*In-network*: $325 copay for each visit *Out-of-network*: 40% of the total cost for each visit
Doctor Visits and Preventive Care			
Doctor visits **Primary care physician (PCP)**	*In-network*: $0 copay for each office visit and surgical procedures performed in a PCP's office *Out-of-network*: 50% of the total cost for each visit	*In-network*: $0 copay for each office visit and surgical procedures performed in a PCP's office *Out-of-network*: 50% of the total cost for each visit	*In-network*: $0 copay for each office visit and surgical procedures performed in a PCP's office *Out-of-network*: 40% of the total cost for each visit
Specialist visit* *Prior authorization may be required for some specialist visits.	*In-network*: $0 copay for palliative care physician office visits $0 copay for surgical procedures performed in a physician's office	*In-network*: $0 copay for palliative care physician office visits $0 copay for surgical procedures performed in a physician's office	*In-network*: $0 copay for palliative care physician office visits $0 copay for surgical procedures performed in a physician's office

	PriorityMedicare Vintage (HMO-POS)	**Priority**Medicare Key (HMO-POS)	**Priority**Medicare Value (HMO-POS)
Doctor visits (continued)	$35 copay for all other office visits *Out-of-network*: 50% of the total cost for each visit	$40 copay for all other office visits *Out-of-network*: 50% of the total cost for each visit	$35 copay for all other office visits *Out-of-network*: 40% of the total cost for each visit
Preventive care Services that can help with prevention and early detection of many illnesses, disabilities, and diseases. Examples include annual wellness visit, breast cancer screening, diabetic screening, flu vaccine and more.	*In-network*: $0 copay for each service *Out-of-network*: 50% of the total cost for each service		*In-network*: $0 copay for each service *Out-of-network*: 40% of the total cost for each service
	Any additional preventive services approved by Medicare during the contract year will be covered.		
Emergency and Urgent Care			
Emergency care This amount is waived if you are admitted as inpatient to the hospital within 24 hours from your emergency care visit.	*In- and out-of-network*: $130 copay for each visit		
Urgently needed services This amount is waived if you are admitted as inpatient to the hospital within 24 hours from your urgent care visit.	*In- and out-of-network*: $50 copay for each visit		
Outpatient Diagnostic Tests, Radiation Therapy, X-rays and Labs			
Diagnostic services/labs/imaging*	*In-network*:	*In-network*:	*In-network*:
Radiology/imaging	$210 copay per day, per provider	Regions 1, 2 & 5: $225 copay per day, per provider Regions 3 & 4: $210 copay per day, per provider	$225 copay per day, per provider
Diagnostic tests and procedures	$5 copay per day, per provider	$10 copay per day, per provider	$10 copay per day, per provider
Lab services	$0 copay for anticoagulant lab services, $5 copay	$0 copay for anticoagulant lab services, $10 copay	$0 copay for anticoagulant lab services, $10 copay

	PriorityMedicare Vintage (HMO-POS)	**Priority**Medicare Key (HMO-POS)	**Priority**Medicare Value (HMO-POS)
Diagnostic services/labs/imaging* (continued) **Outpatient X-rays** **Radiation therapy** *Prior authorization may be required for some services.	for all other Medicare-covered lab services $35 copay per day, per provider $25 copay per day, per provider *Out-of-network*: 0% to 50% of the total cost per day, per provider ($0 copay for anticoagulant lab services)	for all other Medicare-covered lab services $35 copay per day, per provider $25 copay per day, per provider *Out-of-network*: 0% to 50% of the total cost per day, per provider ($0 copay for anticoagulant lab services)	for all other Medicare-covered lab services $35 copay per day, per provider $25 copay per day, per provider *Out-of-network*: 0% to 40% of the total cost per day, per provider ($0 copay for anticoagulant lab services)
Hearing / Dental / Vision			
Hearing services **Medicare-covered diagnostic hearing exam** Medicare-covered exam performed by a primary care physician or specialist to diagnose and treat hearing and balance issues.	*In-network*: $0 - $35 copay for each office visit *Out-of-network*: 50% of the total cost for each visit	*In-network*: $0 - $40 copay for each office visit *Out-of-network*: 50% of the total cost for each visit	*In-network*: $0 - $35 copay for each office visit *Out-of-network*: 40% of the total cost for each visit
Routine hearing coverage and hearing aids (TruHearing® provider) Routine hearing services and hearing aids must be received from a TruHearing® provider.	$0 copay for one routine hearing exam, per year $295 - $1,495 copay, per ear every year, for hearing aids from top manufacturers depending on level selected. Hearing aid cost includes a 60-day trial period, one year of post-purchase follow-up visits, 80 batteries per non-rechargeable hearing aid and a full 3-year manufacturer warranty.		
Dental services* **Medicare-covered dental services**	*In-network*: $0 - $350 copay for each visit, depending on the service performed *Out-of-network*: 50% of the total cost for each service performed	*In-network*: $0 - $350 copay for each visit, depending on the service performed *Out-of-network*: 50% of the total cost for each service performed	*In-network*: $0 - $325 copay for each visit, depending on the service performed *Out-of-network*: 40% of the total cost for each service performed

	PriorityMedicare Vintage (HMO-POS)	**Priority**Medicare Key (HMO-POS)	**Priority**Medicare Value (HMO-POS)
Dental services* (continued) **Additional dental services** Delta Dental® is the preferred provider for additional dental services. *Prior authorization may be required for Medicare-covered dental services.	$0 copay for two cleanings (regular or periodontal maintenance) per year $0 copay for two exams per year $0 copay for one set of bitewing X-rays per year $0 copay for one brush biopsy per year $0 copay for periapical radiographs as needed $0 copay for radiographs (full-mouth or panoramic X-rays) once every 24 months	$0 copay for two cleanings (regular or periodontal maintenance) per year $0 copay for two exams per year $0 copay for one set of bitewing X-rays per year $0 copay for one brush biopsy per year $0 copay for periapical radiographs as needed $0 copay for radiographs (full-mouth or panoramic X-rays) once every 24 months $1,500 annual maximum that applies for the following services: $0 copay for fillings (includes composite, resin, and amalgam), once per tooth, every 24 months $0 copay for crown repairs, once per tooth every 24 months $0 copay for simple extractions, once per tooth per lifetime	$0 copay for two cleanings (regular or periodontal maintenance) per year $0 copay for two exams per year $0 copay for one set of bitewing X-rays per year $0 copay for one brush biopsy per year $0 copay for periapical radiographs as needed $0 copay for radiographs (full-mouth or panoramic X-rays) once every 24 months $2,500 annual maximum that applies for the following services: $0 copay for fillings (includes composite, resin, and amalgam), once per tooth, every 24 months $0 copay for crown repairs, once per tooth every 24 months $0 copay for simple extractions, once per tooth per lifetime

	PriorityMedicare Vintage (HMO-POS)	**Priority**Medicare Key (HMO-POS)	**Priority**Medicare Value (HMO-POS)
Dental services* (continued)			50% of the total cost of root canals, once per tooth per lifetime $0 copay for anesthesia, when used in conjunction with qualifying dental services
Vision services **Medicare-covered services** Medicare-covered exam performed by a specialist to diagnose and treat diseases and conditions of the eye and additional Medicare-covered services.	*In-network*: $35 copay for each visit $0 copay for eyeglasses or contact lenses after cataract surgery $0 copay for a yearly glaucoma screening	*In-network*: $40 copay for each visit $0 copay for eyeglasses or contact lenses after cataract surgery $0 copay for a yearly glaucoma screening	*In-network*: $35 copay for each visit $0 copay for eyeglasses or contact lenses after cataract surgery $0 copay for a yearly glaucoma screening
	Out-of-network: 50% of the total cost for each visit, eyeglasses or contact lenses after cataract surgery, or for a yearly glaucoma screening.		*Out-of-network*: 40% of the total cost for each visit, eyeglasses or contact lenses after cataract surgery, or for a yearly glaucoma screening.
Routine Vision Services In-network routine vision services must be provided by an EyeMed® "Select" provider. If received by a non-EyeMed® "Select" provider (out-of-network), you must seek reimbursement. In-network and out-of-network benefits cannot be combined.	*In- and out-of-network*: $0 copay for one routine exam each year (includes dilation and refraction) $0 copay for one retinal imaging per year $100 eyewear allowance per year		

	PriorityMedicare Vintage (HMO-POS)	**Priority**Medicare Key (HMO-POS)	**Priority**Medicare Value (HMO-POS)
Mental Health Services			
Inpatient visits* We cover up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. *Prior authorization may be required.	*In-network*: $275 copay per day, days 1-6 $0 copay for additional hospital days *Out-of-network*: 50% of the total cost per stay		*In-network*: $325 copay per day, days 1-5 $0 copay for additional hospital days *Out-of-network*: 40% of the total cost per stay
Outpatient therapy (individual or group)	*In-network*: $20 copay for each visit *Out-of-network*: 50% of the total cost for each visit		*In-network*: $20 copay for each visit *Out-of-network*: 40% of the total cost for each visit
Skilled Nursing Facility (SNF)			
Skilled nursing facility* Our plan covers up to 100 days each benefit period. A benefit period starts the day you go into a SNF and ends when you go for 60 days in a row without SNF care. *Prior authorization may be required.	*In-network*: $0 copay per day, days 1 - 20 $218 copay per day, days 21 - 100 *Out-of-network*: 50% of the total cost per stay for each stay		*In-network*: $0 copay per day, days 1 - 20 $218 copay per day, days 21 - 100 *Out-of-network*: 40% of the total cost per stay for each stay
Outpatient Rehabilitation Services			
Physical therapy	*In-network*: $25 copay for each service *Out-of-network*: 50% of the total cost for each service		*In-network*: $15 copay for each service *Out-of-network*: 40% of the total cost for each service

	PriorityMedicare Vintage (HMO-POS)	**Priority**Medicare Key (HMO-POS)	**Priority**Medicare Value (HMO-POS)
Medical Transportation			
Ambulance* *Prior authorization may be required.	*In- and out-of-network*: $270 copay each way		*In- and out-of-network*: $265 copay each way
Transportation	Not covered		
Medicare Part B Drugs*			
Chemotherapy drugs **Other Part B drugs** **Select home infusion drugs** **Part B insulin** *Prior authorization or step therapy may be required.	*In- and out-of-network*: 0% - 20% of the total cost for each drug 0% - 20% of the total cost for each drug $0 copay for each drug 0% - 20% of the total cost up to $35 for a one-month supply of insulin administered through a durable medical equipment (DME) device item of durable medical equipment (such as insulin pumps or continuous glucose monitors (CGM)).		

Prescription Drug Benefits

Important Message About What You Pay for Vaccines - Our plan covers most Part D vaccines at no cost to you, no matter what cost-sharing tier it's on.

Important Message About What You Pay for Insulin - You won't pay more than $35 for a one-month supply and no more than $105 for a three-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.

PART D OUTPATIENT PRESCRIPTION DRUGS			
	PriorityMedicare Vintage (HMO-POS)	**Priority**Medicare Key (HMO-POS)	**Priority**Medicare Value (HMO-POS)
Stage 1: Deductible stage You'll pay this amount before you begin paying copays or coinsurance only.	Tier 1 - 5: $615*	Tier 1 - 2: $0 Tier 3 - 5: $200*	Tier 1 - 2: $0 Tier 3 - 5: $100*
	*The deductible doesn't apply to covered insulins and most adult Part D vaccines. See initial coverage stage row for insulin cost-sharing.		
Stage 2: Initial coverage stage You are in this stage until your out-of-pocket Part D drug costs reach $2,100.	You pay what is listed in the chart below.		

STANDARD RETAIL PHARMACY						
	PriorityMedicare Vintage (HMO-POS)		**Priority**Medicare Key (HMO-POS)		**Priority**Medicare Value (HMO-POS)	
Standard Retail	**30-day supply**	**100-day supply**	**30-day supply**	**100-day supply**	**30-day supply**	**100-day supply**
Tier 1: Preferred generic	$0	$0	$7	$21	$7	$21
	30-day supply	**90-day supply**	**30-day supply**	**90-day supply**	**30-day supply**	**90-day supply**
Tier 2: Generic	$15	$45	$15	$45	$15	$45
Tier 3: Preferred brand*	25%	25%	25%	25%	25%	25%
Tier 4: Non-preferred drug*	40%	40%	30%	30%	40%	40%
Tier 5: Specialty*	25%	N/A	30%	N/A	31%	N/A

PREFERRED RETAIL PHARMACY						
	PriorityMedicare Vintage (HMO-POS)		**Priority**Medicare Key (HMO-POS)		**Priority**Medicare Value (HMO-POS)	
Preferred Retail	**30-day supply**	**100-day supply**	**30-day supply**	**100-day supply**	**30-day supply**	**100-day supply**
Tier 1: Preferred generic	$0	$0	$2	$0	$2	$0
	30-day supply	**90-day supply**	**30-day supply**	**90-day supply**	**30-day supply**	**90-day supply**
Tier 2: Generic	$8	$24	$8	$24	$10	$30
Tier 3: Preferred brand*	25%	25%	22%	22%	22%	22%
Tier 4: Non-preferred drug*	35%	35%	25%	25%	35%	35%
Tier 5: Specialty*	25%	N/A	30%	N/A	31%	N/A
Your costs will be less for your covered drugs when you use a pharmacy in our preferred network (includes Meijer, Walgreens, Walmart, Family Fare Supermarkets, Costco and more), go to ***prioritymedicare.com*** to view the list in the provider/pharmacy directory.						

PREFERRED MAIL ORDER						
	PriorityMedicare Vintage (HMO-POS)		**Priority**Medicare Key (HMO-POS)		**Priority**Medicare Value (HMO-POS)	
Preferred Mail Order	**30-day supply**	**100-day supply**	**30-day supply**	**100-day supply**	**30-day supply**	**100-day supply**
Tier 1: Preferred generic	$0	$0	$2	$0	$2	$0
	30-day supply	**90-day supply**	**30-day supply**	**90-day supply**	**30-day supply**	**90-day supply**
Tier 2: Generic	$8	$0	$8	$0	$10	$0
Tier 3: Preferred brand*	25%	25%	22%	22%	22%	22%
Tier 4: Non-preferred drug*	35%	35%	25%	25%	35%	35%
Tier 5: Specialty*	25%	N/A	30%	N/A	31%	N/A
Your costs will be less for your covered drugs when you use a pharmacy in our preferred network (includes Express Scripts and Amazon), go to ***prioritymedicare.com*** to view the list in the provider/pharmacy directory. *Specialty drugs are limited to a 30-day supply.						

	PriorityMedicare Vintage (HMO-POS)	**Priority**Medicare Key (HMO-POS)	**Priority**Medicare Value (HMO-POS)
Catastrophic coverage stage	Once your out-of-pocket drug costs reach $2,100, the plan pays the full cost of your covered Part D drugs.		
Long-term care (LTC)	If you are a resident of a long-term care (LTC) facility, you may get your prescription drugs through the facility's pharmacy as long as it is part of our network.		

Optional Enhanced Dental and Vision Package

Additional dental coverage, including coverage for dental services and an additional vision allowance for use on eyeglasses or contacts.

	PriorityMedicare Vintage (HMO-POS)	**Priority**Medicare Key (HMO-POS)	**Priority**Medicare Value (HMO-POS)
Premium	Additional $49 per month. You must keep paying your Medicare Part B premium and your $8.80 monthly plan premium.	Additional $43 per month. You must keep paying your Medicare Part B premium and your $0 monthly plan premium.	Additional $37 per month. You must keep paying your Medicare Part B premium and your $32 - $80 monthly plan premium.
Deductible	$0		
Maximum plan benefit coverage amount	$2,500 for comprehensive dental services and an additional $150 for eyewear, per calendar year	$2,500 for comprehensive dental services and an additional $150 for eyewear, per calendar year	$2,500 for (in addition to the embedded dental services benefit for a total of $5,000 per year) for combined in- and out-of-network comprehensive dental services and an additional $150 for eyewear, per calendar year
Dental services Delta Dental® is the preferred provider for additional dental services.	$0 copay for one fluoride treatment, one routine cleaning per year, fillings (including composite resin and amalgam) once per tooth, every 24 months and crown repairs once per tooth every 12 months $0 copay for emergency treatment for dental pain at no limit and anesthesia when used in conjunction	$0 copay for one fluoride treatment and one routine cleaning per year $0 copay for emergency treatment for dental pain at no limit and anesthesia when used in conjunction	$0 copay for one fluoride treatment and one routine cleaning per year $0 copay for emergency treatment for dental pain at no limit and anesthesia when used in conjunction

	PriorityMedicare Vintage (HMO-POS)	**Priority**Medicare Key (HMO-POS)	**Priority**Medicare Value (HMO-POS)
Dental services (continued)	with qualifying dental services 50% of the total cost of onlays, crowns and associated substructures, once per tooth, per lifetime 50% of the total cost of endodontics (root canals), once per tooth per lifetime 50% of the total cost of simple (non-surgical) and surgical extractions, once per tooth per lifetime 50% of the total cost of implants and implant repairs, 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	with qualifying dental services 50% of the total cost of onlays, crowns and associated substructures, once per tooth, per lifetime 50% of the total cost of endodontics (root canals), once per tooth per lifetime 50% of the total cost of surgical extractions, once per tooth per lifetime 50% of the total cost of implants and implant repairs, 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	with qualifying dental services 50% of the total cost of onlays, crowns and associated substructures, once per tooth, per lifetime 50% of the total cost of surgical extractions, once per tooth per lifetime 50% of the total cost of implants and implant repairs, 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
Vision services In-network vision services must be provided by an EyeMed® “Select” provider. If received by a non-EyeMed® “Select” provider (out-of-network), you must seek reimbursement. In-network and out-of-network benefits cannot be combined.	$150 allowance/reimbursement per year for additional eyewear		

Additional Benefits

	PriorityMedicare Vintage (HMO-POS)	**Priority**Medicare Key (HMO-POS)	**Priority**Medicare Value (HMO-POS)
Additional Benefits			
Acupuncture	**Medicare-covered acupuncture for lower chronic back pain** *In- and out-of-network*: $20 copay per service **Non-Medicare-covered routine acupuncture for other conditions** *In- and out-of-network*: $20 copay per visit (limit 6 visits every year)		
Annual preventive physical exam	*In-network*: $0 copay for an exam *Out-of-network*: 50% of the total cost for an exam		*In-network*: $0 copay for an exam *Out-of-network*: 40% of the total cost for an exam
	You're free to talk at your annual preventive exam. When we say no cost, we mean it — $0 annual physical exam, without the worry of being charged for an office visit. This is an opportunity for you and your physician to discuss any concerns or questions you have.		
Chiropractic services	**Medicare-covered care** *In-network*: $15 copay for each service *Out-of-network*: 50% of the total cost for each service **Non-Medicare-covered routine care** *In-network*: $15 copay for each service $35 copay for X-ray services performed once per year *Out-of-network*: Not covered		**Medicare-covered care** *In-network*: $15 copay for each service *Out-of-network*: 40% of the total cost for each service **Non-Medicare-covered routine care** Not covered

	PriorityMedicare Vintage (HMO-POS)	**Priority**Medicare Key (HMO-POS)	**Priority**Medicare Value (HMO-POS)
CogniFit®	Not covered	$0 copay Access to the CogniFit® brain health program. Simply set up an account through One Pass® to access a collection of brain games to keep you interested, challenged, and engaged. CogniFit® works by training over 20 cognitive skills that we use daily such as working memory, perception, attention, reasoning and coordination.	
Dialysis	*In-network*: 20% of the total cost for each service *Out-of-network*: 50%of the total cost for each service		*In-network*: 20% of the total cost for each service *Out-of-network*: 40%of the total cost for each service
Home health services* *Prior authorization may be required.	*In- and out-of-network*: $0 copay for each Medicare-covered service		
Medical equipment and supplies* Examples include diabetic supplies (shoes/inserts, diabetic test strips), durable medical equipment (wheelchairs, oxygen, insulin pumps) and prosthetic devices (braces, artificial limbs). Diabetic test strips are limited to Contour® and Acu-Chek® Guide products when dispensed by a retail pharmacy or mail-order pharmacy. *Prior authorization may be required.	**Diabetes supplies** *In-network*: $0 copay for each item *Out-of-network*: 50% of the total cost for each item **Durable medical equipment** *In-network*: 20% of the total cost for each item *Out-of-network*: 30% of the total cost for each item **Prosthetic devices** *In-network*: $0 - 20% of the total cost for each item, depending on the device		**Diabetes supplies** *In-network*: $0 copay for each item *Out-of-network*: 40% of the total cost for each item **Durable medical equipment** *In-network*: 20% of the total cost for each item *Out-of-network*: 30% of the total cost for each item **Prosthetic devices** *In-network*: $0 - 20% of the total cost for each item, depending on the device

	PriorityMedicare Vintage (HMO-POS)	**Priority**Medicare Key (HMO-POS)	**Priority**Medicare Value (HMO-POS)
Medical equipment and supplies* (continued)	*Out-of-network*: 30% of the total cost for each device		*Out-of-network*: 30% of the total cost for each device
One Pass® Fitness membership	Not covered	$0 copay One Pass® can help you reach your fitness goals while finding new passions along the way. Find a routine that's right for you whether you work out at home or at the gym. One Pass® includes: • Access to the largest nationwide network of gyms and fitness locations • Live, digital fitness classes and on-demand workouts • Online brain training to improve your memory and focus (see CogniFit® for more information)	
Over-The-Counter (OTC) allowance Over-the-counter items are drugs and health related products that do not need a prescription such as allergy medication, eye drops, cough drops, nasal spray, vitamins and more. OTC items, home and bathroom safety devices and modifications can be purchased in participating stores (Meijer, Walmart, Walgreens, CVS, Kroger and more) and online at ***PriorityHealth.com/shopOTC***. You can also call 833.415.4380 or download the Priority Health OTC app.	$40 allowance every three months** **Quarterly allowances do not rollover. If eligible for Special Supplemental Benefits for the Chronically Ill (SSBCI) you may also use your OTC allowance towards healthy food and produce. See your Evidence of Coverage for more information.*	Regions 1 & 2: $75 allowance every three months** Region 3 & 4: $45 allowance every three months** Region 5: $60 allowance every three months** **Quarterly allowances do not rollover.	Not covered
Podiatry services	**Medicare-covered podiatry** *In-network*: $35 copay for each visit	**Medicare-covered podiatry** *In-network*: $40 copay for each visit	**Medicare-covered podiatry** *In-network*: $35 copay for each visit

	PriorityMedicare Vintage (HMO-POS)	**Priority**Medicare Key (HMO-POS)	**Priority**Medicare Value (HMO-POS)
Podiatry services (continued)	$0 copay for nail debridement and callous removal for members with specific conditions (up to 6 of each) *Out-of-network*: 50% of the total cost for each visit or service	$0 copay for nail debridement and callous removal for members with specific conditions (up to 6 of each) *Out-of-network*: 50% of the total cost for each visit or service	$0 copay for nail debridement and callous removal for members with specific conditions (up to 6 of each) *Out-of-network*: 40% of the total cost for each visit or service
Priority Health Travel Pass			
Out-of-area travel benefit	You'll pay in-network prices when seeking care from Medicare-participating providers anywhere in the U.S. outside of the lower peninsula of Michigan. Go to ***priorityhealth.com/FindADoctor*** to find providers in our network. You may stay enrolled in the plan when outside of the service area for up to 12 months as long as your permanent residency remains in your plan's service area.		
Worldwide urgent and emergent care	Unlimited worldwide emergent and urgent care coverage.		
Worldwide travel assistance program	$0 for emergency travel assistance services through Assist America® when you're more than 100 miles from home or in a foreign country. Assist America® provides pre-trip assistance to help you prepare for your travel, including finding a doctor or a pharmacy to fill your prescriptions at your destination and assistance while on your trip should a medical travel emergency arise, at no extra cost to you. You will still pay for benefits covered by Priority Health Medicare, such as emergency, urgent care, or prescription drug copays.		
Rehabilitation services			
Cardiac rehabilitation services	*In-network*: $10 copay for each service *Out-of-network*: 50% of the total cost for each service		*In-network*: $10 copay for each service *Out-of-network*: 40% of the total cost for each service
Pulmonary rehabilitation and supervised exercise therapy (SET) services	*In-network*: $10 copay for each service		*In-network*: $10 copay for each service

	PriorityMedicare Vintage (HMO-POS)	**Priority**Medicare Key (HMO-POS)	**Priority**Medicare Value (HMO-POS)
Rehabilitation services (continued) **Physical therapy, occupational therapy, and speech therapy services**	*Out-of-network*: 50% of the total cost for each service *In-network*: $25 copay for each service *Out-of-network*: 50% of the total cost for each service		*Out-of-network*: 40% of the total cost for each service *In-network*: $15 copay for each service *Out-of-network*: 40% of the total cost for each service
Virtual care Online care you receive from the comfort of your home, or wherever you may be, with a virtual visit via video on your computer, smart phone, or tablet.	*In-network*: $0 copay virtual visits with primary care, specialist and behavioral health providers Available 24/7, virtual visits let you see a provider for, and get treatment for, non-emergency care *Out-of-network*: Not covered		

Highest coverage plans

More coverage for more peace of mind

PriorityMedicare (HMO-POS)
PriorityMedicare Merit (PPO)

Premiums and Benefits | Monthly Premiums

Counties	**Priority**Medicare (HMO-POS)	**Priority**Medicare Merit (PPO)
Region 1: Allegan, Barry, Kent, Lenawee, Ottawa	$81	$70
Region 2: Berrien, Calhoun, Cass, Ionia, Isabella, Kalamazoo, Mason, Midland, Missaukee, Montcalm, Muskegon, Newaygo, Oceana, Osceola, Otsego, St. Clair, Van Buren, Wexford	$72	$83
Region 3: Alcona, Antrim, Benzie, Charlevoix, Clare, Crawford, Grand Traverse, Hillsdale, Lake, Lapeer, Leelanau, Manistee, Mecosta, Monroe	$120	$115
Region 4: Alpena, Cheboygan, Eaton, Emmet, Gladwin, Gratiot, Iosco, Jackson, Kalkaska, Montmorency, Oscoda, Presque Isle, Roscommon, Sanilac, Shiawasse, St. Joseph	$110	$129
Region 5: Arenac, Bay, Branch, Clinton, Genesee, Huron, Ingham, Livingston, Macomb, Oakland, Ogemaw, Saginaw, Tuscola, Washtenaw, Wayne	$66	$106

Premiums and Benefits

	PriorityMedicare (HMO-POS)	**Priority**Medicare Merit (PPO)
Monthly Premium, Deductible and Limits		
Monthly Plan Premium	$66 - $120 per month. In addition, you must keep paying your Medicare Part B premium.	$70 - $129 per month. In addition, you must keep paying your Medicare Part B premium.
Deductible The amount you'll pay for most covered services before you start paying only copays or coinsurance and Priority Health Medicare pays the balance.	**Medical services** *In-network*: $0 *Out-of-network*: $500, applies to hospital and medical services except for	**Medical services** *In-network*: $0 *In- and out-of-network* (combined): $0

	PriorityMedicare (HMO-POS)	**Priority**Medicare Merit (PPO)
Deductible (continued)	acupuncture and insulin furnished through an item of durable medical equipment. **Prescription drugs (Part D):** $0	**Prescription drugs (Part D):** $0
Maximum Out-of-Pocket Amount This is the most you pay for covered medical services for the year, excluding Part D prescription drugs.	*In-network*: $4,500	*In- and out-of-network* (combined): $4,200
Hospital		
Inpatient hospital coverage* We cover an unlimited number of days for an inpatient hospital stay. *Prior authorization may be required.	*In-network*: $225 copay per day for days 1 - 6 $0 copay for additional hospital days *Out-of-network*: 30% of the total cost per stay	*In-network*: $275 copay per day for days 1 - 6 $0 copay for additional hospital days *Out-of-network*: 30% of the total cost per stay
Outpatient hospital coverage* **Outpatient hospital**	*In-network*: $0 copay for each visit at a rural health clinic $40 copay for each Medicare-covered outpatient wound care services $175 copay for each visit at all other locations *Out-of-network*: 30% of the total cost for each visit	*In-network*: $0 copay for each visit at a rural health clinic $45 copay for each Medicare-covered outpatient wound care services $225 copay for each visit at all other locations *Out-of-network*: 30% of the total cost for each visit
Observation services *Prior authorization may be required.	*In- and out-of-network*: $130 copay per stay for each visit, including all services received	
Ambulatory surgery center* *Prior authorization may be required.	*In-network*: $175 copay for each visit *Out-of-network*: 30% of the total cost for each visit	*In-network*: $225 copay for each visit *Out-of-network*: 30% of the total cost for each visit

	PriorityMedicare (HMO-POS)	**Priority**Medicare Merit (PPO)
Doctor Visits and Preventive Care		
Doctor visits **Primary care physician (PCP)** **Specialist visit*** *Prior authorization may be required for some specialist visits.	*In-network*: $0 copay for each office visit and surgical procedures performed in a PCP's office *Out-of-network*: 30% of the total cost for each visit *In-network*: $0 copay for palliative care physician office visits $0 copay for surgical procedures performed in a physician's office $40 copay for all other office visits *Out-of-network*: 30% of the total cost for each visit	*In-network*: $0 copay for each office visit and surgical procedures performed in a PCP's office *Out-of-network*: 30% of the total cost for each visit *In-network*: $0 copay for palliative care physician office visits $0 copay for surgical procedures performed in a physician's office $45 copay for all other office visits *Out-of-network*: 30% of the total cost for each visit
Preventive care Services that can help with prevention and early detection of many illnesses, disabilities, and diseases. Examples include annual wellness visit, breast cancer screening, diabetic screening, flu vaccine and more.	*In-network*: $0 copay for each service *Out-of-network*: 30% of the total cost for each service	
	A referral from your doctor may be required for some preventive services. Any additional preventive services approved by Medicare during the contract year will be covered.	
Emergency and Urgent Care		
Emergency care This amount is waived if you are admitted as inpatient to the hospital within 24 hours from your emergency care visit.	*In- and out-of-network*: $130 copay for each visit	

	PriorityMedicare (HMO-POS)	**Priority**Medicare Merit (PPO)
Urgently needed services This amount is waived if you are admitted as inpatient to the hospital within 24 hours from your urgent care visit.	*In- and out-of-network*: $50 copay for each visit	*In- and out-of-network*: $55 copay for each visit
Outpatient Diagnostic Tests, Radiation Therapy, X-rays and Labs		
Diagnostic services/labs/imaging*	*In-network*:	*In-network*:
Radiology/imaging	$125 copay per day, per provider	$125 copay per day, per provider
Diagnostic tests and procedures	$30 copay per day, per provider	$20 copay per day, per provider
Lab services	$0 copay for anticoagulant lab services, $30 copay for all other Medicare-covered lab services	$0 copay for anticoagulant lab services, $20 copay for all other Medicare-covered lab services
Outpatient X-rays	$35 copay per day, per provider	$35 copay per day, per provider
Radiation therapy *Prior authorization may be required for some services.	$20 copay per day, per provider *Out-of-network*: 0% to 30% of the total cost per day, per provider ($0 copay for anticoagulant lab services)	$30 copay per day, per provider *Out-of-network*: 0% to 30% of the total cost per day, per provider ($0 copay for anticoagulant lab services)
Hearing / Dental / Vision		
Hearing services		
Medicare-covered diagnostic hearing exam Medicare-covered exam performed by a primary care physician or specialist to diagnose and treat hearing and balance issues.	*In-network*: $0 - $40 copay for each office visit *Out-of-network*: 30% of the total cost for each visit	*In-network*: $0 - $45 copay for each office visit *Out-of-network*: 30% of the total cost for each visit
Routine hearing coverage and hearing aids (TruHearing® provider) Routine hearing services and hearing aids must be received from a TruHearing® provider.	$0 copay for one routine hearing exam, per year $295 - $1,495 copay, per ear every year, for hearing aids from top manufacturers depending on level selected. Hearing aid cost includes a 60-day trial period, one year of post-purchase follow-up visits, 80 batteries per non-rechargeable hearing aid and a full 3-year manufacturer warranty.	

	PriorityMedicare (HMO-POS)	**Priority**Medicare Merit (PPO)
Dental services*		
Medicare-covered dental services	*In-network*: $0 - $175 copay for each visit, depending on the service performed *Out-of-network*: 30% of the total cost for each service performed	*In-network*: $0 - $225 copay for each visit, depending on the service performed *Out-of-network*: 30% of the total cost for each service performed
Additional dental services Delta Dental® is the preferred provider for additional dental services. *Prior authorization may be required for Medicare-covered dental services.	$0 copay for two cleanings (regular or periodontal maintenance) per year $0 copay for two exams per year $0 copay for one set of bitewing X-rays per year $0 copay for one brush biopsy per year $0 copay for periapical radiographs as needed $0 copay for radiographs (full-mouth or panoramic x-rays) once every 24 months	
Vision services		
Medicare-covered services Medicare-covered exam performed by a specialist to diagnose and treat diseases and conditions of the eye and additional Medicare-covered services.	*In-network*: $40 copay for each visit $0 copay for eyeglasses or contact lenses after cataract surgery $0 copay for a yearly glaucoma screening *Out-of-network*: 30% of the total cost for each service	*In-network*: $45 copay for each visit $0 copay for eyeglasses or contact lenses after cataract surgery $0 copay for a yearly glaucoma screening *Out-of-network*: 30% of the total cost for each service
Routine Vision Services In-network routine vision services must be provided by an EyeMed® "Select" provider. If received by a non-EyeMed® "Select" provider (out-of-network), you must seek reimbursement. In-network and out-of-network benefits cannot be combined.	*In-network*: $0 copay for one routine exam each year (includes dilation and refraction) $0 copay for one retinal imaging per year $100 eyewear allowance per year	*In-network*: $0 copay for one routine exam each year (includes dilation and refraction) $0 copay for one retinal imaging per year $100 eyewear allowance per year

	PriorityMedicare (HMO-POS)	**Priority**Medicare Merit (PPO)
Vision services (continued)	*Out-of-network*: Up to $100 reimbursement for eyewear Up to $50 reimbursement for one routine exam Up to $20 reimbursement for retinal imaging	*Out-of-network*: Up to $100 reimbursement for eyewear Up to $50 reimbursement for one routine exam Up to $20 reimbursement for retinal imaging
Mental Health Services		
Inpatient visits* We cover up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. *Prior authorization may be required.	*In-network*: $225 copay per day, days 1-6 $0 copay for additional hospital days *Out-of-network*: 30% of the total cost per stay	*In-network*: $350 copay per day, days 1-5 $0 copay for additional hospital days *Out-of-network*: 30% of the total cost per stay
Outpatient therapy (individual or group)	*In-network*: $20 copay for each visit *Out-of-network*: 30% of the total cost for each visit	*In-network*: $20 copay for each visit *Out-of-network*: 30% of the total cost for each visit
Skilled Nursing Facility (SNF)		
Skilled nursing facility* Our plan covers up to 100 days each benefit period. A benefit period starts the day you go into a SNF and ends when you go for 60 days in a row without SNF care. *Prior authorization may be required.	*In-network*: $0 copay per day, days 1 - 20 $218 copay per day, days 21 - 100 *Out-of-network*: 30% of the total cost per stay for each stay	
Outpatient Rehabilitation Services		
Physical therapy	*In-network*: $35 copay for each service *Out-of-network*: 30% of the total cost for each service	
Medical Transportation		
Ambulance* *Prior authorization may be required.	*In- and out-of-network*: $210 copay each way	*In- and out-of-network*: $270 copay each way

	PriorityMedicare (HMO-POS)	**Priority**Medicare Merit (PPO)
Transportation	Not covered	
Medicare Part B Drugs*		
Chemotherapy drugs **Other Part B drugs** **Select home infusion drugs** **Part B insulin** *Prior authorization or step therapy may be required.	*In- and out-of-network*: 0% - 20% of the total cost for each drug 0% - 20% of the total cost for each drug $0 copay for each drug 0% - 20% of the total cost up to $35 for a one-month supply of insulin administered through a durable medical equipment (DME) device item of durable medical equipment (such as insulin pumps or continuous glucose monitors (CGM)).	

Prescription Drug Benefits

Important Message About What You Pay for Vaccines - Our plan covers most Part D vaccines at no cost to you, no matter what cost-sharing tier it's on.

Important Message About What You Pay for Insulin - You won't pay more than $35 for a one-month supply and no more than $105 for a three-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.

PART D OUTPATIENT PRESCRIPTION DRUGS		
	PriorityMedicare (HMO-POS)	**Priority**Medicare Merit (PPO)
Stage 1: Deductible stage	$0	$0
Stage 2: Initial coverage stage You are in this stage until your out-of-pocket Part D drug costs reach $2,100.	You pay what is listed in the chart below.	

STANDARD RETAIL PHARMACY				
	PriorityMedicare (HMO-POS)		**Priority**Medicare Merit (PPO)	
Standard Retail	**30-day supply**	**100-day supply**	**30-day supply**	**100-day supply**
Tier 1: Preferred generic	$6	$18	$7	$21
	30-day supply	**90-day supply**	**30-day supply**	**90-day supply**
Tier 2: Generic	$13	$39	$15	$45
Tier 3: Preferred brand*	25%	25%	25%	25%
Tier 4: Non-preferred drug*	38%	38%	37%	37%
Tier 5: Specialty*	33%	N/A	33%	N/A

PREFERRED RETAIL PHARMACY				
	PriorityMedicare (HMO-POS)		**Priority**Medicare Merit (PPO)	
Preferred Retail	**30-day supply**	**100-day supply**	**30-day supply**	**100-day supply**
Tier 1: Preferred generic	$1	$0	$2	$0

PREFERRED RETAIL PHARMACY				
	PriorityMedicare (HMO-POS)		**Priority**Medicare Merit (PPO)	
	30-day supply	**90-day supply**	**30-day supply**	**90-day supply**
Tier 2: Generic	$8	$24	$10	$30
Tier 3: Preferred brand*	25%	25%	25%	25%
Tier 4: Non-preferred drug*	33%	33%	32%	32%
Tier 5: Specialty*	33%	N/A	33%	N/A
Your costs will be less for your covered drugs when you use a pharmacy in our preferred network (includes Meijer, Walgreens, Walmart, Family Fare Supermarkets, Costco and more), go to ***prioritymedicare.com*** to view the list in the provider/pharmacy directory.				

PREFERRED MAIL ORDER				
	PriorityMedicare (HMO-POS)		**Priority**Medicare Merit (PPO)	
Preferred Mail Order	**30-day supply**	**100-day supply**	**30-day supply**	**100-day supply**
Tier 1: Preferred generic	$1	$0	$2	$0
	30-day supply	**90-day supply**	**30-day supply**	**90-day supply**
Tier 2: Generic	$8	$0	$10	$0
Tier 3: Preferred brand*	25%	25%	25%	25%
Tier 4: Non-preferred drug*	33%	33%	32%	32%
Tier 5: Specialty*	33%	N/A	33%	N/A
Your costs will be less for your covered drugs when you use a pharmacy in our preferred network (includes Express Scripts and Amazon), go to ***prioritymedicare.com*** to view the list in the provider/pharmacy directory. *Specialty drugs are limited to a 30-day supply.				

	PriorityMedicare (HMO-POS)	**Priority**Medicare Merit (PPO)
Catastrophic coverage stage	Once your out-of-pocket drug costs reach $2,100, the plan pays the full cost of your covered Part D drugs.	
Long-term care (LTC)	If you are a resident of a long-term care (LTC) facility, you may get your prescription drugs through the facility's pharmacy as long as it is part of our network.	

Optional Enhanced Dental and Vision Package

Additional dental coverage, including coverage for dental services and an additional vision allowance for use on eyeglasses or contacts.

	PriorityMedicare (HMO-POS)	**Priority**Medicare Merit (PPO)
Premium	Additional $49 per month. You must keep paying your Medicare Part B premium and your $66 - $120 monthly plan premium.	Additional $49 per month. You must keep paying your Medicare Part B premium and your $70 - $129 monthly plan premium.
Deductible	$0	
Maximum plan benefit coverage amount	$2,500 for comprehensive dental services and an additional $150 for eyewear, per calendar year	
Dental services Delta Dental® is the preferred provider for additional dental services.	$0 copay for one fluoride treatment and routine cleaning per year, fillings (including composite resin and amalgam) once per tooth, every 24 months and crown repairs once per tooth every 12 months, emergency treatment of dental pain, and anesthesia when used in conjunction with qualifying dental services, each year. 50% of the total cost of onlays, crowns and associated substructures, once per tooth, every 60 months 50% of the total cost of endodontics (root canals), once per tooth per lifetime 50% of the total cost of simple (non-surgical) and surgical extractions, once per tooth per lifetime 50% of the total cost of implants and implant repairs, 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	
Vision services In-network vision services must be provided by an EyeMed® “Select” provider. If received by a non-EyeMed® “Select” provider (out-of-network), you must seek reimbursement. In-network and out-of-network benefits cannot be combined.	$150 allowance/reimbursement per year for additional eyewear	

Additional Benefits

	PriorityMedicare (HMO-POS)	**Priority**Medicare Merit (PPO)
Additional Benefits		
Acupuncture	**Medicare-covered acupuncture for lower chronic back pain** *In- and out-of-network*: $20 copay per service **Non-Medicare-covered routine acupuncture for other conditions** *In- and out-of-network*: $20 copay per visit (limit 6 visits every year)	
Annual preventive physical exam	*In-network*: $0 copay for an exam *Out-of-network*: 30% of the total cost for an exam	
	You're free to talk at your annual preventive exam. When we say no cost, we mean it — $0 annual physical exam, without the worry of being charged for an office visit. This is an opportunity for you and your physician to discuss any concerns or questions you have.	
Chiropractic services	**Medicare-covered care** *In-network*: $15 copay for each service *Out-of-network*: 30% of the total cost for each service	
CogniFit®	$0 copay Access to the CogniFit® brain health program. Simply set up an account through One Pass® to access a collection of brain games to keep you interested, challenged, and engaged. CogniFit® works by training over 20 cognitive skills that we use daily such as working memory, perception, attention, reasoning and coordination.	
Dialysis	*In-network*: 20% of the total cost for each service *Out-of-network*: 30% of the total cost for each service	
Home health services* *Prior authorization may be required.	*In- and out-of-network*: $0 copay for each Medicare-covered service	

	PriorityMedicare (HMO-POS)	**Priority**Medicare Merit (PPO)
Medical equipment and supplies* Examples include diabetic supplies (shoes/inserts, diabetic test strips), durable medical equipment (wheelchairs, oxygen, insulin pumps) and prosthetic devices (braces, artificial limbs). Diabetic test strips are limited to Contour® and Acu-Chek® Guide products when dispensed by a retail pharmacy or mail-order pharmacy. *Prior authorization may be required.	**Diabetes supplies** *In-network*: $0 copay for each item *Out-of-network*: 30% of the total cost for each item **Durable medical equipment** *In-network*: 20% of the total cost for each item *Out-of-network*: 30% of the total cost for each item **Prosthetic devices** *In-network*: $0 - 20% of the total cost for each item, depending on the device *Out-of-network*: 30%of the total cost for each device	
One Pass® Fitness membership	$0 copay One Pass® can help you reach your fitness goals while finding new passions along the way. Find a routine that's right for you whether you work out at home or at the gym. One Pass® includes: • Access to the largest nationwide network of gyms and fitness locations • Live, digital fitness classes and on-demand workouts • Online brain training to improve your memory and focus (see CogniFit® for more information)	
Podiatry services	**Medicare-covered podiatry** *In-network*: $40 copay for each visit $0 copay for nail debridement and callous removal for members with specific conditions (up to 6 of each) *Out-of-network*: 30% of the total cost for each visit and service	**Medicare-covered podiatry** *In-network*: $45 copay for each visit $0 copay for nail debridement and callous removal for members with specific conditions (up to 6 of each) *Out-of-network*: 30% of the total cost for each visit or service

	PriorityMedicare (HMO-POS)	**Priority**Medicare Merit (PPO)
Priority Health Travel Pass **Out-of-area travel benefit**	You'll pay in-network prices when seeking care from Medicare-participating providers anywhere in the U.S. outside of the lower peninsula of Michigan. Go to ***priorityhealth.com/FindADoctor*** to find providers in our network. You may stay enrolled in the plan when outside of the service area for up to 12 months as long as your permanent residency remains in your plan's service area.	
Worldwide urgent and emergent care	Unlimited worldwide emergent and urgent care coverage.	
Worldwide travel assistance program	$0 for emergency travel assistance services through Assist America® when you're more than 100 miles from home or in a foreign country. Assist America® provides pre-trip assistance to help you prepare for your travel, including finding a doctor or a pharmacy to fill your prescriptions at your destination and assistance while on your trip should a medical travel emergency arise, at no extra cost to you. You will still pay for benefits covered by Priority Health Medicare, such as emergency, urgent care, or prescription drug copays.	
Rehabilitation services **Cardiac rehabilitation services**	*In-network*: $10 copay for each service *Out-of-network*: 30% of the total cost for each service	
Pulmonary rehabilitation and supervised exercise therapy (SET) services	*In-network*: $10 copay for each service *Out-of-network*: 30% of the total cost for each service	
Physical therapy, occupational therapy, and speech therapy services	*In-network*: $35 copay for each service *Out-of-network*: 30% of the total cost for each service	
Virtual care Online care you receive from the comfort of your home, or wherever you may be, with a virtual visit via video on your computer, smart phone, or tablet.	*In-network*: $0 copay virtual visits with primary care, specialist and behavioral health providers	

	PriorityMedicare (HMO-POS)	**Priority**Medicare Merit (PPO)
Virtual care (continued)	Available 24/7, virtual visits let you see a provider for, and get treatment for, non-emergency care *Out-of-network*: Not covered	

Pre-enrollment checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules.

If you have any questions, you can call and speak to a Medicare expert at 833.352.4194 from 8 a.m. to 8 p.m. ET, 7 days a week (TTY 711).

Understanding the Benefits

- The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit ***prioritymedicare.com*** or call 833.352.4194 to view a copy of the EOC.
- Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you may pay a higher copay to see them.
- Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- Review the formulary to make sure your drugs are covered.

Understanding Important Rules

- In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- Benefits, premiums and/or copayments/coinsurance may change on Jan. 1, 2027.
- Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for certain covered services, the provider must agree to treat you. Except in an emergency or urgent situations, non-contracted providers may deny care. In addition, you may pay a higher copay for services received by non-contracted providers.

Priority Health monthly plan premium for people who get Extra Help from Medicare to help pay for their prescription drug costs

If you get extra help from Medicare to help pay for your Medicare prescription drug plan costs, your monthly plan premium will be lower than what it would be if you did not get extra help from Medicare.

If you get extra help, your monthly plan premium will be $0 for any of the plan(s) below. (This does not include any Medicare Part B premium you may have to pay.)

- **Priority**Medicare® Key (HMO-POS)
- **Priority**Medicare® Smart Savings (HMO-POS)
- **Priority**Medicare® Edge (PPO)
- **Priority**Medicare® Vintage (HMO-POS)
- **Priority**Medicare® Vital (PPO)

PriorityMedicare® Value (HMO-POS)

Region	Monthly premium if receiving Low Income Subsidy
Region 1: Allegan, Barry, Kent, Lenawee, Ottawa	$23.20
Region 2: Berrien, Calhoun, Cass, Ionia, Isabella, Kalamazoo, Mason, Midland, Missaukee, Montcalm, Muskegon, Newaygo, Oceana, Osceola, Otsego, St. Clair, Van Buren, Wexford	$34.20
Region 3: Alcona, Antrim, Benzie, Charlevoix, Clare, Crawford, Grand Traverse, Hillsdale, Lake, Lapeer, Leelanau, Manistee, Mecosta, Monroe	$71.20
Region 4: Alpena, Cheboygan, Eaton, Emmet, Gladwin, Gratiot, Iosco, Jackson, Kalkaska, Montmorency, Oscoda, Presque Isle, Roscommon, Sanilac, Shiawasse, St. Joseph	$46.20
Region 5: Arenac, Bay, Branch, Clinton, Genesee, Huron, Ingham, Livingston, Macomb, Oakland, Ogemaw, Saginaw, Tuscola, Washtenaw, Wayne	$34.20

PriorityMedicare® Merit (HMO-POS)

Region	Monthly premium if receiving Low Income Subsidy
Region 1: Allegan, Barry, Kent, Lenawee, Ottawa	$61.20
Region 2: Berrien, Calhoun, Cass, Ionia, Isabella, Kalamazoo, Mason, Midland, Missaukee, Montcalm, Muskegon, Newaygo, Oceana, Osceola, Otsego, St. Clair, Van Buren, Wexford	$74.20
Region 3: Alcona, Antrim, Benzie, Charlevoix, Clare, Crawford, Grand Traverse, Hillsdale, Lake, Lapeer, Leelanau, Manistee, Mecosta, Monroe	$106.20
Region 4: Alpena, Cheboygan, Eaton, Emmet, Gladwin, Gratiot, Iosco, Jackson, Kalkaska, Montmorency, Oscoda, Presque Isle, Roscommon, Sanilac, Shiawasse, St. Joseph	$120.20
Region 5: Arenac, Bay, Branch, Clinton, Genesee, Huron, Ingham, Livingston, Macomb, Oakland, Ogemaw, Saginaw, Tuscola, Washtenaw, Wayne	$97.20

PriorityMedicare® (HMO-POS)

Region	Monthly premium if receiving Low Income Subsidy
Region 1: Allegan, Barry, Kent, Lenawee, Ottawa	$72.40
Region 2: Berrien, Calhoun, Cass, Ionia, Isabella, Kalamazoo, Mason, Midland, Missaukee, Montcalm, Muskegon, Newaygo, Oceana, Osceola, Otsego, St. Clair, Van Buren, Wexford	$63.20
Region 3: Alcona, Antrim, Benzie, Charlevoix, Clare, Crawford, Grand Traverse, Hillsdale, Lake, Lapeer, Leelanau, Manistee, Mecosta, Monroe	$111.20
Region 4: Alpena, Cheboygan, Eaton, Emmet, Gladwin, Gratiot, Iosco, Jackson, Kalkaska, Montmorency, Oscoda, Presque Isle, Roscommon, Sanilac, Shiawasse, St. Joseph	$101.20
Region 5: Arenac, Bay, Branch, Clinton, Genesee, Huron, Ingham, Livingston, Macomb, Oakland, Ogemaw, Saginaw, Tuscola, Washtenaw, Wayne	$57.20

Priority Health's premium includes coverage for both medical services and prescription drug coverage.

If you aren't getting extra help, you can see if you qualify by calling:

- 1.800.Medicare or TTY users call 1.877.486.2048 (24 hours a day/7 days a week),
- Your State Medicaid Office, or
- The Social Security Administration at 1.800.772.1213. TTY users should call 1.800.325.0778 between 8 a.m. and 7 p.m., Monday through Friday.

If you have any questions, please contact our Customer Care team by calling 888.389.6648 (TTY 711). From 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 Monday–Friday from 8 a.m.–8 p.m. and Saturday from 8 a.m.–noon ET. You can also log in to your member account at ***priorityhealth.com*** to send us a message.

Priority Health has been named to Newsweek's America's Best Customer Service 2025 list. Based on an independent survey of U.S. customers who have either made purchases, used services, or gathered information about products or services in the past three years.

One Pass is a voluntary program. The One Pass program varies by plan/area. Information provided is not medical advice. Consult a health care professional before beginning any exercise program.

Priority Health'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 call 711, or consult the online pharmacy directory at ***prioritymedicare.com***.

*Benefit mentioned is part of a special supplemental benefit for chronically ill members with one of the following conditions: diabetes, chronic obstructive pulmonary disease (COPD), arrhythmias, depression, heart failure, prostate/breast/other cancers and bipolar disorder. This is not a complete list of qualifying conditions. Even if you have a qualifying condition, you will not necessarily qualify to receive the benefit because coverage of the item or service depends on if you are chronically ill as defined by CMS and meet all applicable eligibility requirements. To see if you qualify, contact our Customer Care team by calling 888.389.6648 (TTY 711).

Out-of-network/non-contracted providers are under no obligation to treat Priority Health members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

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