Priority Health®

2022 Summary of Benefits

PriorityMedicare Key℠ (HMO-POS)
PriorityMedicare Edge℠ (PPO)
PriorityMedicare Compass℠ (PPO)
PriorityMedicare Vital℠ (PPO)

PriorityMedicare Ideal℠ (PPO)
PriorityMedicare Value℠ (HMO-POS)

PriorityMedicare Merit℠ (PPO)
PriorityMedicare℠ (HMO-POS)
PriorityMedicare Select℠ (PPO)

JANUARY 1, 2022–DECEMBER 31, 2022

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.

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 available 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.

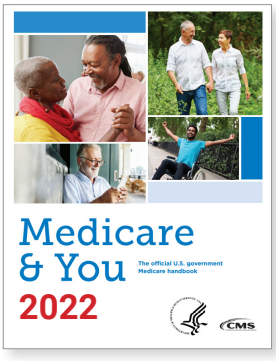
To confirm that your doctor, clinic or health center is part of the Priority Health Medicare network of providers, go to *priorityhealth.com/findadoc*.

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 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 our customer service number.

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.



*Get a free copy of the **2022 Medicare & You** handbook. View it online at **medicare.gov** or get a copy by calling 800.MEDICARE (800.633.4227), 24 hours a day, seven days a week. TTY users should call 877.486.2048.*

Contact us

Speak with Priority Health Medicare experts from 8 a.m. to 8 p.m., seven days a week (TTY users call 711).

Already a member? Call 888.389.6648
Not a member yet? Call 888.230.0365

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

Important health insurance terms to know

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

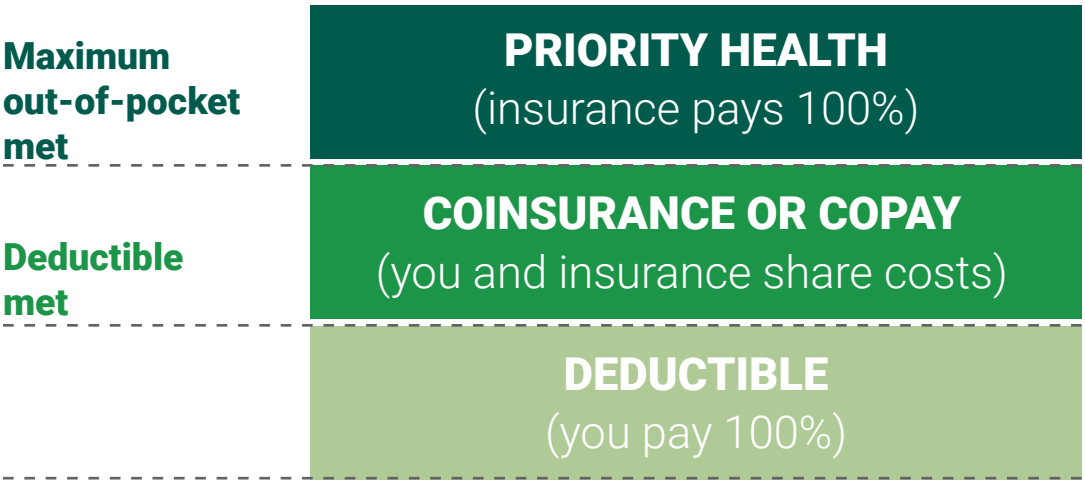
Deductible: This is the amount you pay each year before the health plan starts to pay for certain services, and you start paying a portion of the cost (copay or coinsurance). Priority Health Medicare Advantage plans do not have an in-network medical deductible, so you'll start paying only your copay or coinsurance right away. Some plans, like our PPO plans, don't have an out-of-network medical deductible either.

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 in retirement. 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 gym membership		✓
Routine vision, including eyewear allowance		✓
Routine hearing, including hearing aid coverage		✓

$0 plans

Rich benefits and affordable coverage

Key

A $0 plan with our richest dental coverage through Delta Dental, $0 medical and Rx deductibles, plus insulin savings in the coverage gap and so many extras.

Edge

Our top-selling $0 plan. $0 primary care visits, $0 labs, $0 preventive services and $0 medical and Rx deductibles.

Compass

Our $0 plan that includes a $0 medical and Rx deductible along with $0 for primary care visits and preventive services, plus companion care with Papa and dental with Delta Dental.

Vital

A $0 plan with an open network, low maximum out-of-pocket, a monthly Part B credit and lots of extras, like OTC, dental, vision and a monthly produce allowance for those who are eligible.

$0 plans | PREMIUMS AND BENEFITS

Benefits and what you should know	**Priority**Medicare Key (HMO-POS)	**Priority**Medicare Edge (PPO)	**Priority**Medicare Compass (PPO)	**Priority**Medicare Vital (PPO)
Plan availability Plans are available in regions listed. *See page 21 for a listing of counties by region.*	Regions 1–5	Regions 1, 2 and 5	Regions 3 and 4	Regions 1, 2 and 5
Monthly plan premium	$0 per month. You must keep paying your Medicare Part B premium.			$0 per month. You must keep paying your Medicare Part B premium, but will receive a $360 Part B credit each year ($30 per month) if you enroll in this plan.
Deductible The amount you'll pay for most covered services before you start paying only copays or coinsurance and Priority Health pays the balance.	**Medical services** *In-network:* $0 *Out-of-network:* $1,500 **Prescription drugs (Part D)** $0	**Medical services** *In-network and out-of-network (combined):* $0 **Prescription drugs (Part D**) $0	**Medical services** *In-network and out-of-network (combined):* $0 **Prescription drugs (Part D)** $0	**Medical services** *In-network and out-of-network (combined):* $0 **Prescription drugs (Part D)** Tiers 1–2: $0 Tiers 3–5: $350
Maximum out-of-pocket responsibility This is the most you pay for covered medical services for the year, excluding Part D prescription drugs.	*In-network:* $5,000 (regions 1, 2 and 5) $5,500 (regions 3 and 4) ***See page 21 for a list of counties by region***.	*In-network and out-of-network services (combined):* $5,300	*In-network and out-of-network services (combined):* $5,650	*In-network and out-of-network services (combined):* $4,700

MEDICAL BENEFITS COVERED UNDER YOUR PLAN

Benefits and what you should know	**Priority**Medicare Key (HMO-POS)	**Priority**Medicare Edge (PPO)	**Priority**Medicare Compass (PPO)	**Priority**Medicare Vital (PPO)
Inpatient hospital coverage We cover an unlimited number of days for an inpatient hospital stay. Prior authorization may be required.	*In-network:* Days 1–6: $325 each day Days 7 and beyond: $0 each day *Out-of-network:* 50% for each stay	*In-network:* Days 1–5: $350 each day Days 6 and beyond: $0 each day *Out-of-network:* 40% for each stay	*In-network:* Days 1–5: $350 each day Days 6 and beyond: $0 each day *Out-of-network:* 45% for each stay	*In-network and out-of-network:* Days 1–4: $435 each day Days 5 and beyond: $0 each day
Outpatient hospital coverage Prior authorization may be required.	**Ambulatory surgical center** *In-network:* $290 for each visit *Out-of-network:* 50% for each visit **Outpatient hospital** *In-network:* $0 for each visit at a rural health clinic (regions 1, 2 and 5) $10 for each visit at a rural health clinic (regions 3 and 4) $290 for each visit at all other locations *Out-of-network:* 50% for each visit ***See page 21 for a list of counties by region.***	**Ambulatory surgical center** *In-network:* $325 for each visit *Out-of-network:* 40% for each visit **Outpatient hospital** *In-network:* $0 for each visit at a rural health clinic $325 for each visit at all other locations *Out-of-network:* 40% for each visit	**Ambulatory surgical center** *In-network:* $325 for each visit *Out-of-network:* 45% for each visit **Outpatient hospital** *In-network:* $0 for each visit at a rural health clinic $325 for each visit at all other locations *Out-of-network:* 45% for each visit	**Ambulatory surgical center** *In-network and out-of-network:* 20% for each visit **Outpatient hospital** *In-network and out-of-network:* $0 for each visit at a rural health clinic 20% for each visit at all other locations
	Observation *In-network and out-of-network:* $90 for each visit, including all services received			**Observation** *In-network and out-of-network:* 20% for each visit and all services received

Benefits and what you should know	**Priority**Medicare Key (HMO-POS)	**Priority**Medicare Edge (PPO)	**Priority**Medicare Compass (PPO)	**Priority**Medicare Vital (PPO)
Doctor visits Prior authorization may be required for some specialist visits.	**Primary care physician (PCP)** *In-network:* $0 for each office visit (regions 1, 2 and 5) $10 for each office visit (regions 3 and 4) $0 for surgical procedures performed in a PCP's office *Out-of-network:* 50% for each visit **Specialist visit** *In-network:* $0 for palliative care physician office visit $0 for surgical procedures performed in a specialist's office $45 for all other office visits *Out-of-network:* 50% for each visit ***See page 21 for a list of counties by region.***	**Primary care physician (PCP)** *In-network:* $0 for each office visit *Out-of-network:* 40% for each visit **Specialist visit** *In-network:* $0 for palliative care physician office visit $0 for surgical procedures performed in a specialist's office $45 for all other office visits *Out-of-network:* 40% for each visit	**Primary care physician (PCP)** *In-network:* $0 for each office visit *Out-of-network:* 45% for each visit **Specialist visit** *In-network:* $0 for palliative care physician office visit $0 for surgical procedures performed in a specialist's office $50 for all other office visits *Out-of-network:* 45% for each visit	**Primary care physician (PCP)** *In-network and out-of-network:* $0 for each office visit **Specialist visit** *In-network and out-of-network:* $0 for palliative care physician office visit $0 for surgical procedures performed in a specialist's office 20% for all other office visits
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 for each service *Out-of-network:* 50% for each service	*In-network:* $0 for each service *Out-of-network:* 40% for each service	*In-network:* $0 for each service *Out-of-network:* 45% for each service	*In-network and out-of-network:* $0 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 care This amount is waived if you are admitted as inpatient to the hospital within 24 hours from your emergency care visit.	*In-network and out-of-network:* $90 for each visit			*In-network and out-of-network:* 20% for each visit up to $90

Benefits and what you should know	**Priority**Medicare Key (HMO-POS)	**Priority**Medicare Edge (PPO)	**Priority**Medicare Compass (PPO)	**Priority**Medicare Vital (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-network and out-of-network:* $50 for each visit	*In-network and out-of-network:* $30 for each visit	*In-network and out-of-network:* $30 for each visit	*In-network and out-of-network:* 20% for each visit up to $65
Outpatient diagnostic services (labs, radiology/imaging and X-rays) Prior authorization may be required for some services.	**Radiology/imaging** *In-network:* $150 per day, per provider **Tests/procedures** *In-network:* $10 per day, per provider **Lab services** *In-network:* $0–$10 per day, per provider ($0 for anticoagulant lab services) **Outpatient X-rays** *In-network:* $35 per day, per provider **Radiation therapy** *In-network:* $25 per day, per provider *For all out-of-network services listed above:* $0–50% per day, per provider ($0 for anticoagulant lab services)	**Radiology/imaging** *In-network:* $275 per day, per provider **Tests/procedures** *In-network:* $0 per day, per provider **Lab services** *In-network:* $0 per day, per provider **Outpatient X-rays** *In-network:* $20 per day, per provider **Radiation therapy** *In-network:* $40 per day, per provider *For all out-of-network services listed above:* $0–40% per day, per provider ($0 for anticoagulant lab services)	**Radiology/imaging** *In-network:* $275 per day, per provider **Tests/procedures** *In-network:* $20 per day, per provider **Lab services** *In-network:* $0–$20 per day, per provider ($0 for anticoagulant lab services) **Outpatient X-rays** In-network: $20 per day, per provider **Radiation therapy** *In-network:* $40 per day, per provider *For all out-of-network services listed above:* $0–45% per day, per provider ($0 for anticoagulant lab services)	**Radiology/imaging** *In-network and out-of-network:* 20% per day, per provider **Tests/procedures** *In-network and out-of-network:* 20% per day, per provider **Lab services** *In-network and out-of-network:* $0 per day, per provider **Outpatient X-rays** *In-network and out-of-network:* 20% per day, per provider **Radiation therapy** *In-network and out-of-network:* 20% per day, per provider

<table>
<tr><th>Benefits and what you should know</th><th>PriorityMedicare Key (HMO-POS)</th><th>PriorityMedicare Edge (PPO)</th><th>PriorityMedicare Compass (PPO)</th><th>PriorityMedicare Vital (PPO)</th></tr>
<tr><td rowspan="2">Hearing services
Medicare-covered exam performed by a primary care physician or specialist to diagnose and treat hearing and balance issues.

Routine hearing coverage must be received from a TruHearing® provider.</td><td>Medicare-covered diagnostic hearing exam
In-network:
$0–$45 for each office visit (regions 1, 2 and 5)

$10–$45 for each office visit (regions 3 and 4)

Out-of-network: 50% for each visit

See page 21 for a list of counties by region.</td><td>Medicare-covered diagnostic hearing exam
In-network: $0–$45 for each visit

Out-of-network: 40% for each visit</td><td>Medicare-covered diagnostic hearing exam
In-network: $0–$50 for each visit

Out-of-network: 45% for each visit</td><td>Medicare-covered diagnostic hearing exam
In-network or out-of-network: $0–20% for each visit</td></tr>
<tr><td colspan="3">Routine hearing coverage (TruHearing provider)
$0 for one routine hearing exam, per year

$295, $695, $1,095 or $1,495 copay, per ear per 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 and 80 batteries per hearing aid (re-chargeable not included)</td><td>Routine hearing coverage (TruHearing provider)
$0 for one routine hearing exam, per year

$0 copay for up to two (2) TruHearing-branded ‘Advanced’ hearing aids, one per ear per year

Hearing aid cost includes a 60-day trial period, one-year of post-purchase follow-up visits and 80 batteries per hearing aid (re-chargeable not included)</td></tr>
</table>

<table>
<tr><th>Benefits and what you should know</th><th>PriorityMedicare Key (HMO-POS)</th><th>PriorityMedicare Edge (PPO)</th><th>PriorityMedicare Compass (PPO)</th><th>PriorityMedicare Vital (PPO)</th></tr>
<tr><td rowspan="2">Dental services
Prior authorization may be required for Medicare-covered dental services.

Delta Dental® is the preferred provider for additional dental services.</td><td>Medicare-covered dental services
In-network:
$0–$290 for each visit, depending on the service performed (regions 1, 2 and 5)

$10–$290 for each visit, depending on the service performed (regions 3 and 4)

Out-of-network: 50% for each visit

See page 21 for a list of counties by region.</td><td>Medicare-covered dental services
In-network: $0–$325 for each visit, depending on the service performed

Out-of-network: 40% for each visit</td><td>Medicare-covered dental services
In-network: $0–$325 for each visit, depending on the service performed

Out-of-network: 45% for each visit</td><td>Medicare-covered dental services
In-network and out-of-network: $0–20% for each visit</td></tr>
<tr><td>Additional dental services
$0 for two cleanings (regular or periodontal maintenance) per year

$0 for two exams per year

$0 for one set of bitewing X-rays per year

$0 for one brush biopsy per year

$0 for other X-rays (i.e. panoramic) once every two years

★ 50% for fillings including composite resin on front and back teeth and crown repairs, no limit

★ 50% for non-surgical simple extractions, no limit</td><td colspan="3">Additional dental services
$0 for two cleanings (regular or periodontal maintenance) per year

$0 for two exams per year

$0 for one set of bitewing X-rays per year

$0 for one brush biopsy per year

$0 for other X-rays (i.e. panoramic) once every two years</td></tr>
</table>

Benefits and what you should know	**Priority**Medicare Key (HMO-POS)	**Priority**Medicare Edge (PPO)	**Priority**Medicare Compass (PPO)	**Priority**Medicare Vital (PPO)
Vision 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 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 benefit cannot be combined.	**Medicare-covered services** *In-network:* $45 for each visit $0 for eyeglasses or contact lenses after cataract surgery $0 for a yearly glaucoma screening *Out-of-network:* 50% for each visit, eyeglasses or contact lenses after cataract surgery, or for a yearly glaucoma screening	**Medicare covered services** *In-network:* $45 for each visit $0 for eyeglasses or contact lenses after cataract surgery $0 for a yearly glaucoma screening *Out-of-network:* 40% for each visit, eyeglasses or contact lenses after cataract surgery, or for a yearly glaucoma screening	**Medicare-covered services** *In-network:* $50 for each visit $0 for eyeglasses or contact lenses after cataract surgery $0 for a yearly glaucoma screening *Out-of-network*: 45% for each visit, eyeglasses or contact lenses after cataract surgery, or for a yearly glaucoma screening	**Medicare-covered services** *In-network and out-of-network:* 20% for each visit $0 for eyeglasses or contact lenses after cataract surgery $0 for a yearly glaucoma screening
	Routine vision services *In-network:* $0 for one routine exam each year (includes dilation and refraction) $0 for one retinal imaging per year $100 eyewear allowance per year *Out-of-network:* Up to $50 reimbursement for one routine exam Up to $20 reimbursement for retinal imaging Up to $100 reimbursement for eyewear			
Mental health care We cover up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. Prior authorization may be required.	**Inpatient visit** *In-network:* Days 1–6: $275 each day Days 7 and beyond: $0 each day *Out-of-network:* 50% for each stay **Outpatient therapy (individual or group)** *In-network:* $20 for each visit *Out-of-network:* 50% for each visit	**Inpatient visit** *In-network:* Days 1–5: $350 each day Days 6 and beyond: $0 each day *Out-of-network:* 40% for each stay **Outpatient therapy (individual or group)** *In-network:* $20 for each visit *Out-of-network:* 40% for each visit	**Inpatient visit** *In-network:* Days 1–5: $350 each day Days 6 and beyond: $0 each day *Out-of-network:* 45% for each stay **Outpatient therapy (individual or group)** In-network: $20 for each visit *Out-of-network:* 45% for each visit	**Inpatient visit** *In-network and out-of-network:* Days 1–4: $435 each day Days 5 and beyond: $0 each day **Outpatient therapy (individual or group)** *In-network and out-of-network:* 20% for each visit

Benefits and what you should know	**Priority**Medicare Key (HMO-POS)	**Priority**Medicare Edge (PPO)	**Priority**Medicare Compass (PPO)	**Priority**Medicare Vital (PPO)
Skilled Nursing Facility (SNF) 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:* Days 1–20: $0 each day Days 21–100: $188 each day *Out-of-network:* 50% for each stay	*In-network:* Days 1–20: $0 each day Days 21–100: $188 each day *Out-of-network:* 40% for each stay	*In-network:* Days 1–20: $0 each day Days 21–100: $188 each day *Out-of-network:* 45% for each stay	*In-network and out-of-network:* Days 1–20: $0 each day Days 21–100: $188 each day
Physical therapy	*In-network:* $30 for each service *Out-of-network:* 50% for each service	*In-network:* $40 for each service *Out-of-network:* 40% for each service	*In-network:* $40 for each service *Out-of-network:* 45% for each service	*In-network and out-of-network:* 20% for each service
Ambulance Prior authorization may be required.	*In-network or out-of-network:* $250 each way	*In-network or out-of-network:* $275 each way	*In-network or out-of-network:* $275 each way	*In-network and out-of-network:* 20% each way
Transportation	Not covered			

PRESCRIPTION DRUG BENEFITS

Prescription drug benefits	**Priority**Medicare Key (HMO-POS)	**Priority**Medicare Edge (PPO)	**Priority**Medicare Compass (PPO)	**Priority**Medicare Vital (PPO)
Medicare Part B drugs Prior authorization or step therapy may be required.	**Chemotherapy drugs** *In-network or out-of-network:* 20% for each drug **Other Part B drugs** *In-network or out-of-network:* 20% for each drug **Select home infusion drugs** *In-network or out-of-network:* $0 for each drug			

PART D OUTPATIENT PRESCRIPTION DRUGS				
Prescription drug benefits	**Priority**Medicare Key (HMO-POS)	**Priority**Medicare Edge (PPO)	**Priority**Medicare Compass (PPO)	**Priority**Medicare Vital (PPO)
Deductible stage You'll pay this amount before you begin paying copays or coinsurance only.	$0	$0	$0	Tiers 1–2: $0 Tiers 3–5: $350
Initial coverage stage You are in this stage until your drug total reaches $4,430, which includes what you pay out-of-pocket and what we pay for your covered drugs.	You pay what is listed in the chart on the following page.	You pay what is listed in the chart on the following page.	You pay what is listed in the chart on the following page.	Once you have paid your deductible (only required for drugs in Tiers 3–5) you pay what is listed in the chart on the following page.

PREFERRED RETAIL PHARMACY

Prescription drug benefits	PriorityMedicare Key (HMO-POS)			PriorityMedicare Edge (PPO)			PriorityMedicare Compass (PPO)			PriorityMedicare Vital (PPO)		
Initial coverage stage	30-day supply	60-day supply	90-day supply	30-day supply	60-day supply	90-day supply	30-day supply	60-day supply	90-day supply	30-day supply	60-day supply	90-day supply
Tier 1 (Preferred generic)	$4	$8	$12	$2	$4	$6	$4	$8	$12	$1	$2	$3
Tier 2 (Generic)	$15	$30	$45	$8	$16	$24	$15	$30	$45	$10	$20	$30
Tier 3 (Preferred brand)	Lantis/Toujeo insulins: $35	$70	$105	$38	$76	$114	$42	$84	$126	$42	$84	$126
	All other drugs: $42	$84	$126									
Tier 4 (Non-preferred drug)	45%	45%	45%	40%	40%	40%	45%	45%	45%	45%	45%	45%
Tier 5 (Specialty)	33%	N/A	N/A	33%	N/A	N/A	33%	N/A	N/A	26%	N/A	N/A

Your costs will be less for your covered drugs when you use a pharmacy in our preferred network (includes Meijer, Walgreens, Walmart, Rite Aid, Kroger, Family Fare Supermarkets, Costco and more), go to ***prioritymedicare.com*** to view the list in the provider/pharmacy directory.

STANDARD RETAIL PHARMACY

Prescription drug benefits	PriorityMedicare Key (HMO-POS)			PriorityMedicare Edge (PPO)			PriorityMedicare Compass (PPO)			PriorityMedicare Vital (PPO)		
Initial coverage stage	30-day supply	60-day supply	90-day supply	30-day supply	60-day supply	90-day supply	30-day supply	60-day supply	90-day supply	30-day supply	60-day supply	90-day supply
Tier 1 (Preferred generic)	$10	$20	$30	$7	$14	$21	$10	$20	$30	$6	$12	$18
Tier 2 (Generic)	$20	$40	$60	$13	$26	$39	$20	$40	$60	$15	$30	$45
Tier 3 (Preferred brand)	Lantis/Toujeo insulins: $35	$70	$105	$43	$86	$129	$47	$94	$141	$47	$94	$141
	All other drugs: $47	$94	$141									
Tier 4 (Non-preferred drug)	50%	50%	50%	45%	45%	45%	50%	50%	50%	50%	50%	50%
Tier 5 (Specialty)	33%	N/A	N/A	33%	N/A	N/A	33%	N/A	N/A	26%	N/A	N/A

MAIL ORDER THROUGH EXPRESS SCRIPTS (ESI)

Prescription drug benefits	PriorityMedicare Key (HMO-POS)			PriorityMedicare Edge (PPO)			PriorityMedicare Compass (PPO)			PriorityMedicare Vital (PPO)		
Initial coverage stage	30-day supply	60-day supply	90-day supply	30-day supply	60-day supply	90-day supply	30-day supply	60-day supply	90-day supply	30-day supply	60-day supply	90-day supply
Tier 1 (Preferred generic)	$4	$8	$0	$2	$4	$0	$4	$8	$0	$1	$2	$0
Tier 2 (Generic)	$15	$30	$0	$8	$16	$0	$15	$30	$0	$10	$20	$0
Tier 3 (Preferred brand)	Lantis/Toujeo insulins: $35	$70	$87.50	$38	$76	$95	$42	$84	$105	$42	$84	$105
	All other drugs: $42	$84	$105									
Tier 4 (Non-preferred drug)	45%	45%	45%	40%	40%	40%	45%	45%	45%	45%	45%	45%
Tier 5 (Specialty)	33%	N/A	N/A	33%	N/A	N/A	33%	N/A	N/A	26%	N/A	N/A

Prescription drug benefits	**Priority**Medicare Key (HMO-POS)	**Priority**Medicare Edge (PPO)	**Priority**Medicare Compass (PPO)	**Priority**Medicare Vital (PPO)
Coverage gap stage (also known as the "donut hole")	Once the total yearly drug costs (what you've paid plus what we've paid) reach $4,430 you enter the coverage gap and then you pay a percentage of the cost we have negotiated for the drug: • 25% of what we would pay for the covered brand name drug • 25% of what we would pay for the covered generic drug This plan offers additional gap coverage for select insulins: Lyumjev, Humalog, Humulin 100 unit/ml products, Lantus & Toujeo. During the Coverage Gap stage, your out-of-pocket costs for a 30-day supply of Lyumjev, Humalog or Humulin 100 unit/ml products will be $15 (preferred retail pharmacy) or $20 (standard retail pharmacy) and a 30-day supply of Lantus & Toujeo will be $35. When your out-of-pocket drug costs reach $7,050, this is the end of the coverage gap stage.	Once the total yearly drug costs (what you've paid plus what we've paid) reach $4,430 you enter the coverage gap and then you pay a percentage of the cost we have negotiated for the drug: • 25% of what we would pay for the covered brand name drug • 25% of what we would pay for the covered generic drug When your out-of-pocket drug costs reach $7,050, this is the end of the coverage gap stage.		
Catastrophic coverage stage	Once your out-of-pocket drug costs reach $7,050 you will pay the larger amount, which is either: • 5% of the cost of the drug, or • $3.95 for generics, and • $9.85 for all other 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

Benefits and what you should know	**Priority**Medicare Key (HMO-POS)	**Priority**Medicare Edge (PPO)	**Priority**Medicare Compass (PPO)	**Priority**Medicare Vital (PPO)
Benefits	Additional dental coverage, including coverage for dental services and an additional vision allowance for use on eyeglasses or contacts			
Premium	$23 per month. You must keep paying your Medicare Part B premium.	$29 per month. You must keep paying your Medicare Part B premium.		
Deductible	$0			
Maximum plan benefit coverage amount	$2,500 for dental services and an additional $150 for eyewear, per calendar year			

Benefits and what you should know	**Priority**Medicare Key (HMO-POS)	**Priority**Medicare Edge (PPO)	**Priority**Medicare Compass (PPO)	**Priority**Medicare Vital (PPO)
Dental services Delta Dental® is the preferred provider for additional dental services.	$0 copay for fillings, including composite resin on front and back teeth, crown repair, emergency treatment of dental pain, one fluoride treatment and anesthesia, each year. 50% of the cost for restorative, endodontics, crowns, relines & repairs and oral surgery, each year. 50% of the cost for implants & implant repairs per tooth every 5 years	$0 copay for fillings, including composite resin on front and back teeth, crown repair, emergency treatment of dental pain, one fluoride treatment and anesthesia, each year. 50% of the cost for restorative, endodontics, crowns, relines & repairs and oral surgery, each year. 50% of the cost for non-surgical simple extractions, each year. No limit. 50% of the cost for implants & implant repairs per tooth every 5 years		
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 benefit cannot be combined.	$150 additional eyewear allowance/reimbursement per year			

ADDITIONAL MEDICAL BENEFITS COVERED UNDER YOUR PLAN

Benefits and what you should know	**Priority**Medicare Key (HMO-POS)	**Priority**Medicare Edge (PPO)	**Priority**Medicare Compass (PPO)	**Priority**Medicare Vital (PPO)
Acupuncture	**Medicare-covered acupuncture for lower chronic back pain** *In-network and out-of-network:* $20 per visit **Non-Medicare covered routine acupuncture for other conditions** *In-network:* $20 per visit (limit 6 per year) *Out-of-network:* Not covered	**Medicare-covered acupuncture for lower chronic back pain** *In-network and out-of-network:* $20 per visit **Non-Medicare covered routine acupuncture for other conditions** *In-network and out-of-network:* $20 per visit (limit 6 per year)		
Annual preventive physical 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.	*In-network:* $0 for an exam *Out-of-network*: 50% for an exam	*In-network:* $0 for an exam *Out-of-network*: 40% for an exam	*In-network:* $0 for an exam *Out-of-network:* 45% for an exam	*In-network and out-of-network:* $0 for an exam

Benefits and what you should know	**Priority**Medicare Key (HMO-POS)	**Priority**Medicare Edge (PPO)	**Priority**Medicare Compass (PPO)	**Priority**Medicare Vital (PPO)
BrainHQ Access to online exercises and games that improve memory, attention, brain speed and more. Train on any device like a computer, tablet or smartphone.	$0			
Chiropractic care	**Medicare-covered care** *In-network:* $20 for each visit *Out-of-network:* 50% for each visit **Non-Medicare covered routine care** *In-network:* $20 for each visit (limit 12 per year) $35 for X-ray services performed once per year *Out-of-network:* Not covered	**Medicare-covered care** *In-network:* $20 for each visit *Out-of-network:* 40% for each visit **Non-Medicare covered routine care** *In-network:* $20 for each visit $20 for X-ray services performed once per year *Out-of-network:* 40% for each visit and for X-ray services performed once per year Limited to 12 non-Medicare covered routine visits per year whether done in- or out-of-network.	**Medicare-covered care** *In-network:* $20 for each visit *Out-of-network:* 45% for each visit **Non-Medicare covered routine care** *In-network:* $20 for each visit $20 for X-ray services performed once per year *Out-of-network:* 45% for each visit and for X-ray services performed once per year Limited to 12 non-Medicare covered routine visits per year whether done in- or out-of-network.	**Medicare-covered care** *In-network and out-of-network:* 20% for each visit **Non-Medicare covered routine care** *In-network and out-of-network:* 20% for each visit 20% for X-ray services performed once per year Limited to 12 non-Medicare covered routine visits per year whether done in- or out-of-network.
Companion care with Papa Papa connects college students ("Papa Pals") to Medicare members who need assistance with transportation (no mileage limit), house chores, technology lessons, grocery delivery, companionship, and other senior services. All plans with Papa include Papa Care Concierge. A team of caring individuals who can help you navigate your benefits, schedule doctor appointments, find providers and so much more.	Not covered	$0 for up to 6 hours of in-person or virtual companion care visits each month and unlimited Papa Care Concierge.	$0 for up to 3 hours of in-person or virtual companion care visits each month and unlimited Papa Care Concierge.	Not covered

<table>
<tr><th>Benefits and what you should know</th><th>PriorityMedicare Key (HMO-POS)</th><th>PriorityMedicare Edge (PPO)</th><th>PriorityMedicare Compass (PPO)</th><th>PriorityMedicare Vital (PPO)</th></tr>
<tr><td>Dialysis</td><td>In-network: 20% for each service

Out-of-network: 50% for each service</td><td>In-network: 20% for each service

Out-of-network: 40% for each service</td><td>In-network: 20% for each service

Out-of-network: 45% for each service</td><td>In-network and out-of-network: 20% for each service</td></tr>
<tr><td>Home health services
Prior authorization may be required.</td><td colspan="4">In-network and out-of-network: $0 for each Medicare-covered service</td></tr>
<tr><td>Meal benefit
Home-delivered meals, provided through Mom's Meals following a discharge from a hospital (acute or psychiatric) or Skilled Nursing Facility (SNF) stay</td><td colspan="4">$0 for 28 meals following a discharge (limit 4 times per year)</td></tr>
<tr><td rowspan="3">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 JJHCS and Bayer products when dispensed by a retail pharmacy or mail-order pharmacy.

Prior authorization may be required.</td><td>Diabetes supplies
In-network: $0 for each item

Out-of-network: 50% for each item</td><td>Diabetes supplies
In-network: $0 for each item

Out-of-network: 40% for each item</td><td>Diabetes supplies
In-network: $0 for each item

Out-of-network: 45% for each item</td><td>Diabetes supplies
In-network and out-of-network: $0 for each item</td></tr>
<tr><td colspan="3">Durable medical equipment
In-network: 20% for each item

Out-of-network: 30% for each item

Prosthetic devices
In-network: $0–20% for each item, depending on the device

Out-of-network: 30% for each device</td><td>Durable medical equipment
In-network and out-of-network: 20% for each item

Prosthetic devices
In-network and out-of-network: 20% for each device</td></tr>
<tr><td colspan="4"></td></tr>
<tr><td rowspan="2">Over-the-counter (OTC) allowance + Healthy Savings Program
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.

The Healthy Savings Program allows members to save on healthier foods.</td><td>$70 per quarter for OTC items (regions 1, 2 and 5)

$45 per quarter for OTC items (regions 3 and 4)

See page 21 for a list of counties by region.</td><td>$50 per quarter for OTC items</td><td>$25 per quarter for OTC items</td><td>$40 per quarter for OTC items</td></tr>
<tr><td colspan="4">OTC items can be purchased in participating stores (Walmart, Walgreens, CVS, Kroger and more). Or, online at HealthyBenefitsPlus.com/PHMOTC or by phone, with free 2-day shipping included.

Save up to $2,500 a year with discounts on healthier food options when shopping in-store only at the same participating stores (Walmart, Walgreens, CVS, Kroger and more). Just scan your OTC card at check-out to take advantage of the savings.</td></tr>
</table>

Benefits and what you should know	**Priority**Medicare Key (HMO-POS)	**Priority**Medicare Edge (PPO)	**Priority**Medicare Compass (PPO)	**Priority**Medicare Vital (PPO)
Produce allowance Allows members to save on healthy produce each month.	Not covered	Not covered	Not covered	$10 per month for qualifying members to use in-store toward produce at participating stores (Walmart, Kroger and more) and at ***walmart.com*** for in-store pickup. Amount loaded to your OTC card each month. Use at check-out to take advantage of your produce allowance.
Podiatry services	*In-network:* $45 for each office visit $0 for nail debridement and callous removal for members with specific conditions (up to 6 of each) *Out-of-network:* 50% for each visit and service	*In-network:* $45 for each office visit $0 for nail debridement and callous removal for members with specific conditions (up to 6 of each) *Out-of-network:* 40% for each visit and service	*In-network:* $50 for each office visit $0 for nail debridement and callous removal for members with specific conditions (up to 6 of each) *Out-of-network:* 45% for each visit and service	*In-network and out-of-network:* 20% for each office visit and service
Priority Health Travel Pass	**Out-of-state travel benefit** You'll pay in-network prices when seeking care from Medicare-participating providers anywhere in the U.S. outside of Michigan. Our partnership with Multiplan® can make accessing Medicare-participating providers even easier. 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 plans 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 but also assistance while on your trip should a medical travel emergency arise, like needing help replacing lost or forgotten prescriptions (costs may apply for the prescription drugs), retrieval of vehicles or other valuable property left stranded because of a medical situation and more, 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, pulmonary rehabilitation services and supervised exercise therapy (SET) services** *In-network:* $30 for each service *Out-of-network:* 50% for each service	**Cardiac, pulmonary rehabilitation services and supervised exercise therapy (SET) services** *In-network:* $30 for each service *Out-of-network:* 40% for each service	**Cardiac, pulmonary rehabilitation services and supervised exercise therapy (SET) services** *In-network:* $30 for each service *Out-of-network:* 45% for each service	**Cardiac, pulmonary rehabilitation services and supervised exercise therapy (SET) services** *In-network and out-of-network:* 20% for each service

Benefits and what you should know	**Priority**Medicare Key (HMO-POS)	**Priority**Medicare Edge (PPO)	**Priority**Medicare Compass (PPO)	**Priority**Medicare Vital (PPO)
Rehabilitation services, ***continued***	**Physical therapy, occupational therapy and speech therapy services** *In-network:* $30 for each service *Out-of-network:* 50% for each service	**Physical therapy, occupational therapy and speech therapy services** *In-network:* $40 for each service *Out-of-network:* 40% for each service	**Physical therapy, occupational therapy and speech therapy services** *In-network:* $40 for each service *Out-of-network:* 45% for each service	**Physical therapy, occupational therapy and speech therapy services** *In-network and out-of-network:* 20% for each service
SilverSneakers® Fitness membership	$0 membership at thousands of participating SilverSneakers fitness centers nationwide. Plus, options for working out from the comfort of your home with access to members-only virtual exercise classes and online workshops with the SilverSneakers GO™ fitness app or SilverSneakers home fitness kits. You can also sign up for Tuition Rewards® through SilverSneakers to earn money towards college tuition for family members. The SilverSneakers® program is provided by Tivity Health®. All programs and services may not be available in all areas.			
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 or smart phone or tablet.	*In-network:* $0 virtual visits with primary care, specialist and behavioral health providers. Available 24/7, virtual visits lets you see a provider for and get treatment for non-emergency care. *Out-of-network:* Not covered			

$0 plans | MONTHLY PREMIUMS

Counties	**Priority**Medicare Key (HMO-POS)	**Priority**Medicare Edge (PPO)	**Priority**Medicare Compass (PPO)	**Priority**Medicare Vital (PPO)
Region 1: Allegan, Barry, Kent, Lenawee, Ottawa	$0	$0	**Priority**Medicare Compass is not available in these counties.	$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	$0	**Priority**Medicare Edge is not available in these counties.	$0	**Priority**Medicare Vital not available in these counties.
Region 4: Alpena, Cheboygan, Eaton, Emmet, Gladwin, Gratiot, Iosco, Jackson, Kalkaska, Montmorency, Oscoda, Presque Isle, Roscommon, Sanilac, Shiawassee, St. Joseph	$0		$0	
Region 5: Arenac, Bay, Branch, Clinton, Genesee, Huron, Ingham, Livingston, Macomb, Oakland, Ogemaw, Saginaw, Tuscola, Washtenaw, Wayne	$0	$0	**Priority**Medicare Compass is not available in these counties.	$0

Mid-tier plans

More care and coverage

Ideal
Extra care and services for an affordable monthly premium.

Value
Get more care for an affordable cost, including insulin coverage in the gap and low-cost rehab options.

Mid-tier plans | PREMIUMS AND BENEFITS

Benefits and what you should know	**Priority**Medicare Ideal (PPO)	**Priority**Medicare Value (HMO-POS)
Plan availability Plans are available in regions listed. *See page 33 for a listing of counties by region.*	Regions 1–5	
Monthly plan premium	$24 per month. In addition, you must keep paying your Medicare Part B premium.	$16–$72 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 pays the balance.	**Medical services** *In-network and out-of-network (combined):* $0 **Prescription drugs (Part D)** Tiers 1–2: $0 Tiers 3–5: $125	**Medical services** *In-network:* $0 *Out-of-network:* $1,000 **Prescription drugs (Part D)** Tiers 1–2: $0 Tiers 3–5: $75
Maximum out-of-pocket responsibility This is the most you pay for covered medical services for the year, excluding Part D prescription drugs.	*In-network and out-of-network services (combined):* $5,800	*In-network:* $4,900

MEDICAL BENEFITS COVERED UNDER YOUR PLAN

Benefits and what you should know	**Priority**Medicare Ideal (PPO)	**Priority**Medicare Value (HMO-POS)
Inpatient hospital coverage We cover an unlimited number of days for an inpatient hospital stay. Prior authorization may be required.	*In-network:* Days 1-6: $300 each day Days 7 and beyond: $0 each day *Out-of-network:* 45% for each stay	*In-network:* Days 1-5: $325 each day Days 6 and beyond: $0 each day *Out-of-network:* 40% for each stay
Outpatient hospital coverage Prior authorization may be required.	**Ambulatory surgical center** *In-network:* $250 for each visit *Out-of-network:* 45% for each visit **Outpatient hospital** *In-network:* $15 for each visit at a rural health clinic $250 for each visit at all other locations *Out-of-network:* 45% for each visit **Observation** *In-network and out-of-network:* $90 for each visit, including all services received	**Ambulatory surgical center** *In-network:* $225 for each visit *Out-of-network:* 40% for each visit **Outpatient hospital** *In-network:* $5 for each visit at a rural health clinic $225 for each visit at all other locations *Out-of-network:* 40% for each visit **Observation** *In-network and out-of-network:* $90 for each visit, including all services received
Doctor visits Prior authorization may be required for some specialist visits.	**Primary care physician (PCP)** *In-network:* $15 for each office visit $0 for surgical procedures performed in a PCP's office *Out-of-network:* 45% for each visit **Specialist visit** *In-network:* $0 for palliative care physician office visit $0 for surgical procedures performed in a specialist's office $45 for all other office visits *Out-of-network:* 45% for each visit	**Primary care physician (PCP)** *In-network:* $5 for each office visit $0 for surgical procedures performed in a PCP's office *Out-of-network:* 40% for each visit **Specialist visit** *In-network:* $0 for palliative care physician office visit $0 for surgical procedures performed in a specialist's office $45 for all other office visits *Out-of-network:* 40% 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 for each service *Out-of-network:* 45% for each service	*In-network:* $0 for each service *Out-of-network:* 40% 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.	

Benefits and what you should know	**Priority**Medicare Ideal (PPO)	**Priority**Medicare Value (HMO-POS)
Emergency care This amount is waived if you are admitted as inpatient to the hospital within 24 hours from your emergency care visit.	*In-network and out-of-network:* $90 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-network and out-of-network:* $50 for each visit	*In-network and out-of-network:* $55 for each visit
Outpatient diagnostic services (labs, radiology/ imaging and X-rays) Prior authorization may be required for some services.	**Radiology/imaging** *In-network:* $150 per day, per provider **Tests/procedures** *In-network:* $15 per day, per provider **Lab services** *In-network:* $0–$15 per day, per provider ($0 for anticoagulant lab services) **Outpatient X-rays** *In-network:* $40 per day, per provider **Radiation therapy** *In-network:* $30 per day, per provider *For all out-of-network services listed above:* $0–45% per day, per provider ($0 for anticoagulant lab services)	**Radiology/imaging** *In-network:* $225 per day, per provider **Tests/procedures** *In-network:* $10 per day, per provider **Lab services** *In-network:* $0–$10 per day, per provider ($0 for anticoagulant lab services) **Outpatient X-rays** *In-network:* $35 per day, per provider **Radiation therapy** *In-network:* $25 per day, per provider *For all out-of-network services listed above:* $0–40% per day, per provider ($0 for anticoagulant lab services)
Hearing services Medicare-covered exam performed by a primary care physician or specialist to diagnose and treat hearing and balance issues. Routine hearing coverage must be received from a TruHearing® provider.	**Medicare-covered diagnostic hearing exam** *In-network:* $15–$45 for each visit *Out-of-network:* 45% for each visit	**Medicare-covered diagnostic hearing exam** *In-network:* $5–$45 for each visit *Out-of-network:* 40% for each visit
	Routine hearing coverage (TruHearing provider) $0 for one routine hearing exam, per year $295, $695, $1,095 or $1,495 copay, per ear per 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 and 80 batteries per hearing aid (re-chargeable not included)	

Benefits and what you should know	**Priority**Medicare Ideal (PPO)	**Priority**Medicare Value (HMO-POS)
Dental services Prior authorization may be required for Medicare-covered dental services. Delta Dental® is the preferred provider for additional dental services.	**Medicare-covered dental services** *In-network:* $15–$250 for each visit, depending on the service performed *Out-of-network:* 45% for each visit **Additional dental services** $0 for two cleanings (regular or periodontal maintenance) per year $0 for two exams per year $0 for one set of bitewing x-rays per year $0 for one brush biopsy per year $0 for other x-rays (i.e. panoramic) once every two years	**Medicare-covered dental services** *In-network:* $5–$225 for each visit, depending on the service performed *Out-of-network:* 40% for each visit **Additional dental services** $0 for two cleanings (regular or periodontal maintenance) per year $0 for two exams per year $0 for one set of bitewing x-rays per year $0 for one brush biopsy per year $0 for other x-rays (i.e. panoramic) once every two years
Vision 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 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 benefit cannot be combined.	**Medicare-covered services** *In-network:* $45 for each visit $0 for eyeglasses or contact lenses after cataract surgery $0 for a yearly glaucoma screening *Out-of-network:* 45% for each visit, eyeglasses or contact lenses after cataract surgery or a yearly glaucoma screening	**Medicare-covered services** *In-network:* $45 for each visit $0 for eyeglasses or contact lenses after cataract surgery $0 for a yearly glaucoma screening *Out-of-network:* 40% for each visit, eyeglasses or contact lenses after cataract surgery or for a yearly glaucoma screening
	Routine vision services *In-network:* $0 for one routine exam each year (includes dilation and refraction) $0 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 care We cover up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. Prior authorization may be required.	**Inpatient visit** *In-network:* Days 1–6: $290 each day Days 7 and beyond: $0 each day *Out-of-network:* 45% for each stay **Outpatient therapy (individual or group)** *In-network:* $20 for each visit *Out-of-network:* 45% for each visit	**Inpatient visit** *In-network:* Days 1–5: $325 each day Days 6 and beyond: $0 each day *Out-of-network:* 40% for each stay **Outpatient therapy (individual or group)** *In-network:* $20 for each visit *Out-of-network:* 40% for each visit

Benefits and what you should know	**Priority**Medicare Ideal (PPO)	**Priority**Medicare Value (HMO-POS)
Skilled Nursing Facility (SNF) 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:* Days 1–20: $0 each day Days 21–100: $188 each day *Out-of-network:* 45% for each stay	*In-network:* Days 1–20: $0 each day Days 21–100: $188 each day *Out-of-network:* 40% for each stay
Physical therapy	*In-network:* $40 for each service *Out-of-network*: 45% for each service	*In-network:* $40 for each service *Out-of-network:* 40% for each service
Ambulance Prior authorization may be required.	*In-network and out-of-network:* $275 each way	*In-network and out-of-network:* $250 each way
Transportation	Not covered	

PRESCRIPTION DRUG BENEFITS

Prescription drug benefits	**Priority**Medicare Ideal (PPO)	**Priority**Medicare Value (HMO-POS)
Medicare Part B drugs Prior authorization or step therapy may be required.	**Chemotherapy drugs** *In-network or out-of-network:* 20% for each drug **Other Part B drugs** *In-network or out-of-network:* 20% for each drug **Select home infusion drugs** *In-network or out-of-network:* $0 for each drug	

PART D OUTPATIENT PRESCRIPTION DRUGS		
Prescription drug benefits	**Priority**Medicare Ideal (PPO)	**Priority**Medicare Value (HMO-POS)
Deductible stage You'll pay this amount before you begin paying copays or coinsurance only.	Tiers 1–2: $0 Tiers 3–5: $125	Tiers 1–2: $0 Tiers 3–5: $75* *Insulins Lantus and Toujeo in Tier 3 do not apply to deductible.
Initial coverage stage You are in this stage until your drug total reaches $4,430, which includes what you pay out-of-pocket and what we pay for your covered drugs.	Once you have paid your deductible (only required for drugs in Tiers 3–5) you pay what is listed in the chart below.	

PREFERRED RETAIL PHARMACY						
Prescription drug benefits	**Priority**Medicare Ideal (PPO)			**Priority**Medicare Value (HMO-POS)		
Initial coverage stage	30-day supply	60-day supply	90-day supply	30-day supply	60-day supply	90-day supply
Tier 1 (Preferred generic)	$4	$8	$12	$2	$4	$6
Tier 2 (Generic)	$13	$26	$39	$10	$20	$30
Tier 3 (Preferred brand)	$42	$84	$126	Lantis/Toujeo insulins:		
				$35	$70	$105
				All other drugs:		
				$42	$84	$126
Tier 4 (Non-preferred drug)	50%	50%	50%	50%	50%	50%
Tier 5 (Specialty)	30%	N/A	N/A	31%	N/A	N/A
Your costs will be less for your covered drugs when you use a pharmacy in our preferred network (includes Meijer, Walgreens, Walmart, Rite Aid, Kroger, Family Fare Supermarkets, Costco and more), go to ***prioritymedicare.com*** to view the list in the provider/pharmacy directory.						

STANDARD RETAIL PHARMACY						
Prescription drug benefits	**Priority**Medicare Ideal (PPO)			**Priority**Medicare Value (HMO-POS)		
Initial coverage stage	30-day supply	60-day supply	90-day supply	30-day supply	60-day supply	90-day supply
Tier 1 (Preferred generic)	$9	$18	$27	$7	$14	$21
Tier 2 (Generic)	$18	$36	$54	$15	$30	$45
Tier 3 (Preferred brand)	$47	$94	$141	Lantis/Toujeo insulins:		
				$35	$70	$105
				All other drugs:		
				$47	$94	$141
Tier 4 (Non-preferred drug)	50%	50%	50%	50%	50%	50%
Tier 5 (Specialty)	30%	N/A	N/A	31%	N/A	N/A

MAIL ORDER THROUGH EXPRESS SCRIPTS (ESI)						
Prescription drug benefits	**Priority**Medicare Ideal (PPO)			**Priority**Medicare Value (HMO-POS)		
Initial coverage stage	30-day supply	60-day supply	90-day supply	30-day supply	60-day supply	90-day supply
Tier 1 (Preferred generic)	$4	$8	$0	$2	$4	$0
Tier 2 (Generic)	$13	$26	$0	$10	$20	$0
Tier 3 (Preferred brand)	$42	$84	$105	Lantis/Toujeo insulins:		
				$35	$70	$87.50
				All other drugs:		
				$42	$84	$105
Tier 4 (Non-preferred drug)	50%	50%	50%	50%	50%	50%
Tier 5 (Specialty)	30%	N/A	N/A	31%	N/A	N/A

Prescription drug benefits	**Priority**Medicare Ideal (PPO)	**Priority**Medicare Value (HMO-POS)
Coverage gap stage (also known as the "donut hole")	Once the total yearly drug costs (what you've paid plus what we've paid) reach $4,430 you enter the coverage gap and then you pay a percentage of the cost we have negotiated for the drug: • 25% of what we would pay for the covered brand name drug • 25% of what we would pay for the covered generic drug When your out-of-pocket drug costs reach $7,050, this is the end of the coverage gap stage.	Once the total yearly drug costs (what you've paid plus what we've paid) reach $4,430 you enter the coverage gap and then you pay a percentage of the cost we have negotiated for the drug: • 25% of what we would pay for the covered brand name drug • 25% of what we would pay for the covered generic drug This plan offers additional gap coverage for select insulins: Lyumjev, Humalog, Humulin 100 unit/ml products, Lantus & Toujeo. During the Coverage Gap stage, your out-of-pocket costs for a 30-day supply of Lyumjev, Humalog or Humulin 100 unit/ml products will be $10 (preferred retail pharmacy) or $15 (standard retail pharmacy) and for a 30-day supply of Lantus and Toujeo will be $35. When your out-of-pocket drug costs reach $7,050, this is the end of the coverage gap stage.
Catastrophic coverage stage	Once your out-of-pocket drug costs reach $7,050 you will pay the larger amount, which is either: • 5% of the cost of the drug, or • $3.95 for generics, and • $9.85 for all other 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

Benefits and what you should know	**Priority**Medicare Ideal (PPO)	**Priority**Medicare Value (HMO-POS)
Benefits	Additional dental coverage, including coverage for dental services and an additional vision allowance for use on eyeglasses or contacts.	
Premium	Additional $29 per month. You must keep paying your Medicare Part B premium and your $24 monthly plan premium.	Additional $29 per month. You must keep paying your Medicare Part B premium and your $16–$72 monthly plan premium.
Deductible	$0	
Maximum plan benefit coverage amount	$2,500 for dental services and $150 for eyewear, per calendar year.	
Dental services Delta Dental® is the preferred provider for additional dental services.	$0 copay for fillings, including composite resin on anterior and posterior teeth, crown repair, emergency treatment of dental pain, one fluoride treatment and anesthesia, each year. 50% of the cost for restorative, endodontics, crowns, relines and repairs, oral surgery and simple extractions, each year. And, 50% of the cost for implants and implant repairs per tooth every 5 years.	
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 benefit cannot be combined.	$150 additional eyewear allowance/reimbursement per year	

ADDITIONAL MEDICAL BENEFITS COVERED UNDER YOUR PLAN

Benefits and what you should know	**Priority**Medicare Ideal (PPO)	**Priority**Medicare Value (HMO-POS)
Acupuncture	**Medicare-covered acupuncture for lower chronic back pain** *In-network and out-of-network:* $20 per visit **Non-Medicare covered routine acupuncture for other conditions** *In-network and out-of-network:* $20 per visit (limit 6 per year)	**Medicare-covered acupuncture for lower chronic back pain** *In-network and out-of-network:* $20 per visit **Non-Medicare covered routine acupuncture for other conditions** *In-network:* $20 per visit (limit 6 per year) *Out-of-network:* Not covered
Annual preventive physical 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.	*In-network:* $0 for an exam *Out-of-network:* 45% for an exam	*In-network:* $0 for exam *Out-of-network:* 40% for an exam
BrainHQ Access to online exercises and games that improve memory, attention, brain speed and more. Train on any device like a computer, tablet or smartphone.	$0	
Chiropractic care	**Medicare-covered care** *In-network:* $20 for each visit *Out-of-network:* 45% for each visit **Non-Medicare covered routine care** *In-network:* $20 for each visit $40 for X-ray services performed once per year *Out-of-network:* 45% for each visit and for X-ray services performed once per year Limited to 12 non-Medicare covered routine visits per year whether done in- or out-of-network.	**Medicare-covered care** *In-network:* $20 for each visit *Out-of-network:* 40% for each visit

Benefits and what you should know	**Priority**Medicare Ideal (PPO)	**Priority**Medicare Value (HMO-POS)
Companion care with Papa Papa connects college students ("Papa Pals") to Medicare members who need assistance with transportation (no mileage limit), house chores, technology lessons, grocery delivery, companionship, and other senior services. All plans with Papa include Papa Care Concierge. A team of caring individuals who can help you navigate your benefits, schedule doctor appointments, find providers and so much more.	$0 for up to 6 hours of in-person or virtual companion care visits each month and unlimited Papa Care Concierge.	Not covered
Dialysis	*In-network:* 20% for each service *Out-of-network:* 45% for each service	*In-network:* 20% for each service *Out-of-network:* 40% for each service
Home health services Prior authorization may be required.	In-network and out-of-network: $0 for each Medicare-covered service	
Meal benefit Home-delivered meals, provided through Mom's Meals following a discharge from a hospital (acute or psychiatric) or Skilled Nursing Facility (SNF) stay.	$0 for 28 meals following a discharge (limit 4 times per year)	
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 JJHCS and Bayer products when dispensed by a retail pharmacy or mail-order pharmacy. Prior authorization may be required.	**Diabetes supplies** *In-network:* $0 for each item *Out-of-network:* 45% for each item	**Diabetes supplies** *In-network:* $0 for each item *Out-of-network:* 40% for each item
	Durable medical equipment *In-network:* 20% for each item *Out-of-network:* 30% for each item **Prosthetic devices** *In-network:* $0–20% for each item, depending on the device *Out-of-network:* 30% for each device	

Benefits and what you should know	**Priority**Medicare Ideal (PPO)	**Priority**Medicare Value (HMO-POS)
Over-the-counter (OTC) allowance + Healthy Savings Program 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. The Healthy Savings Program allows members to save on healthier foods.	$75 per quarter for OTC items	$25 per quarter for OTC items
	OTC items can be purchased in participating stores (Walmart, Walgreens, CVS, Kroger and more). Or, online at ***HealthyBenefitsPlus.com/PHMOTC*** or by phone, with free 2-day shipping included. Save up to $2,500 a year with discounts on healthier food options when shopping in-store only at the same participating stores (Walmart, Walgreens, CVS, Kroger and more). Just scan your OTC card at check-out to take advantage of the savings.	
Podiatry services	*In-network:* $45 for each office visit $0 for nail debridement and callous removal for members with specific conditions (up to 6 of each) *Out-of-network:* 45% for each visit and service	*In-network:* $45 for each office visit $0 for nail debridement and callous removal for members with specific conditions (up to 6 of each) *Out-of-network:* 40% for each visit and service
Priority Health Travel Pass	**Out-of-state travel benefit** You'll pay in-network prices when seeking care from Medicare-participating providers anywhere in the U.S. outside of Michigan. Our partnership with Multiplan can make accessing Medicare-participating providers even easier. 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 plans 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 but also assistance while on your trip should a medical travel emergency arise, like needing help replacing lost or forgotten prescriptions (costs may apply for the prescription drugs), retrieval of vehicles or other valuable property left stranded because of a medical situation and more, 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, pulmonary rehabilitation services and supervised exercise therapy (SET) services** *In-network:* $10 for each service *Out-of-network:* 45% for each service **Physical therapy, occupational therapy and speech therapy services** In-network: $40 for each service *Out-of-network:* 45% for each service	**Cardiac, pulmonary rehabilitation services and supervised exercise therapy (SET) services** *In-network:* $10 for each service *Out-of-network:* 40% for each service **Physical therapy, occupational therapy and speech therapy services** In-network: $40 for each service *Out-of-network:* 40% for each service

Benefits and what you should know	**Priority**Medicare Ideal (PPO)	**Priority**Medicare Value (HMO-POS)
SilverSneakers® Fitness membership	$0 membership at thousands of participating SilverSneakers fitness centers nationwide. Plus, options for working out from the comfort of your home with access to members-only virtual exercise classes and online workshops with the SilverSneakers GO™ fitness app or SilverSneakers home fitness kits. You can also sign up for Tuition Rewards® through SilverSneakers to earn money towards college tuition for family members. The SilverSneakers® program is provided by Tivity Health®. All programs and services may not be available in all areas.	
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 or smart phone or tablet.	*In-network:* $0 virtual visits with primary care, specialist and behavioral health providers. Available 24/7, virtual visits lets you see a provider for and get treatment for non-emergency care. *Out-of-network:* Not covered	

Mid-tier plans | MONTHLY PREMIUMS

Counties	**Priority**Medicare Ideal (PPO)	**Priority**Medicare Value (HMO-POS)
Region 1: Allegan, Barry, Kent, Lenawee, Ottawa	$24	$16
Region 2: Berrien, Calhoun, Cass, Ionia, Isabella, Kalamazoo, Mason, Midland, Missaukee, Montcalm, Muskegon, Newaygo, Oceana, Osceola, Otsego, St. Clair, Van Buren, Wexford	$24	$35
Region 3: Alcona, Antrim, Benzie, Charlevoix, Clare, Crawford, Grand Traverse, Hillsdale, Lake, Lapeer, Leelanau, Manistee, Mecosta, Monroe	$24	$72
Region 4: Alpena, Cheboygan, Eaton, Emmet, Gladwin, Gratiot, Iosco, Jackson, Kalkaska, Montmorency, Oscoda, Presque Isle, Roscommon, Sanilac, Shiawassee, St. Joseph	$24	$47
Region 5: Arenac, Bay, Branch, Clinton, Genesee, Huron, Ingham, Livingston, Macomb, Oakland, Ogemaw, Saginaw, Tuscola, Washtenaw, Wayne	$24	$50

Highest coverage plans

More coverage for more peace of mind

Merit, Medicare, Select

Our maximum-coverage options with lower copays, no prescription drug deductible and a low maximum out-of-pocket for total peace of mind.

Highest coverage plans | PREMIUMS AND BENEFITS

Benefits and what you should know	**Priority**Medicare Merit (PPO)	**Priority**Medicare (HMO-POS)	**Priority**Medicare Select (PPO)
Plan availability Plans are available in regions listed. *See page 45 for a listing of counties by region.*	Regions 1–5		
Monthly plan premium	$63–$121 per month. In addition, you must keep paying your Medicare Part B premium.	$74–$127 per month. In addition, you must keep paying your Medicare Part B premium.	$149–$225 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 pays the balance.	**Medical services** *In-network and out-of-network (combined):* $0 **Prescription drugs (Part D)** $0	**Medical services** *In-network:* $0 *Out-of-network:* $500 **Prescription drugs (Part D)** $0	**Medical services** *In-network and out-of-network (combined):* $0 **Prescription drugs (Part D)** $0
Maximum out-of-pocket responsibility This is the most you pay for covered medical services for the year, excluding Part D prescription drugs.	*In-network and out-of-network services (combined):* $4,100	*In-network:* $4,500	*In-network and out-of-network services (combined):* $3,500

MEDICAL BENEFITS COVERED UNDER YOUR PLAN

Benefits and what you should know	**Priority**Medicare Merit (PPO)	**Priority**Medicare (HMO-POS)	**Priority**Medicare Select (PPO)
Inpatient hospital coverage We cover an unlimited number of days for an inpatient hospital stay. Prior authorization may be required.	*In-network:* Days 1–5: $375 each day Days 6 and beyond: $0 each day *Out-of-network:* 30% for each stay	*In-network:* Days 1–6: $225 each day Days 7 and beyond: $0 each day *Out-of-network:* 30% for each stay	*In-network:* Days 1–6: $200 each day Days 7 and beyond: $0 each day *Out-of-network:* 30% for each stay
Outpatient hospital coverage Prior authorization may be required.	**Ambulatory surgical center** *In-network:* $225 for each visit *Out-of-network:* 30% for each visit **Outpatient hospital** *In-network:* $20 for each visit at a rural health clinic $225 for each visit for all other locations *Out-of-network:* 30% for each visit	**Ambulatory surgical center** *In-network:* $175 for each visit *Out-of-network:* 30% for each visit **Outpatient hospital** *In-network:* $10 for each visit at a rural health clinic $175 for each visit for all other locations *Out-of-network:* 30% for each visit	**Ambulatory surgical center** *In-network:* $200 for each visit *Out-of-network:* 30% for each visit **Outpatient hospital** *In-network:* $15 for each visit at a rural health clinic $200 for each visit for all other locations *Out-of-network:* 30% for each visit
	Observation *In-network and out-of-network:* $90 for each visit, including all services received		
Doctor visits Prior authorization may be required for some specialist visits.	**Primary care physician (PCP)** *In-network:* $20 for each office visit $0 for surgical procedures performed in a PCP's office *Out-of-network:* 30% for each visit **Specialist visit** *In-network:* $0 for palliative care physician office visit $0 for surgical procedures performed in a specialist's office $45 for all other office visits *Out-of-network:* 30% for each visit	**Primary care physician (PCP)** *In-network:* $10 for each office visit $0 for surgical procedures performed in a PCP's office *Out-of-network:* 30% for each visit **Specialist visit** *In-network:* $0 for palliative care physician office visit $0 for surgical procedures performed in a specialist's office $40 for all other office visits *Out-of-network:* 30% for each visit	**Primary care physician (PCP)** *In-network:* $15 for each office visit $0 for surgical procedures performed in a PCP's office *Out-of-network:* 30% for each visit **Specialist visit** *In-network:* $0 for palliative care physician office visit $0 for surgical procedures performed in a specialist's office $40 for all other office visits *Out-of-network:* 30% for each visit

Benefits and what you should know	**Priority**Medicare Merit (PPO)	**Priority**Medicare (HMO-POS)	**Priority**Medicare Select (PPO)
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 for each service *Out-of-network:* 30% 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 care This amount is waived if you are admitted as inpatient to the hospital within 24 hours from your emergency care visit.	*In-network and out-of-network:* $90 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-network and out-of-network:* $55 for each visit	*In-network and out-of-network:* $50 for each visit	*In-network and out-of-network:* $50 for each visit
Outpatient diagnostic services (labs, radiology/ imaging and X-rays) Prior authorization may be required for some services.	**Radiology/imaging** *In-network:* $125 per day, per provider **Tests/procedures** *In-network:* $20 per day, per provider **Lab services** *In-network:* $0–$20 per day, per provider ($0 for anticoagulant lab services) **Outpatient X-rays** *In-network:* $35 per day, per provider **Radiation therapy** *In-network:* $30 per day, per provider *For all out-of-network services listed above:* $0–30% per day, per provider ($0 for anticoagulant lab services)	**Radiology/imaging** *In-network:* $125 per day, per provider **Tests/procedures** *In-network:* $30 per day, per provider **Lab services** *In-network:* $0–$30 per day, per provider ($0 for anticoagulant lab services) **Outpatient X-rays** *In-network:* $35 per day, per provider **Radiation therapy** *In-network:* $20 per day, per provider *For all out-of-network services listed above:* $0–30% per day, per provider ($0 for anticoagulant lab services)	**Radiology/imaging** *In-network:* $75 per day, per provider **Tests/procedures** *In-network:* $20 per day, per provider **Lab services** *In-network:* $0–$20 per day, per provider ($0 for anticoagulant lab services) **Outpatient X-rays** *In-network:* $30 per day, per provider **Radiation therapy** *In-network:* $25 per day, per provider *For all out-of-network services listed above:* $0–30% per day, per provider ($0 for anticoagulant lab services)

Benefits and what you should know	**Priority**Medicare Merit (PPO)	**Priority**Medicare (HMO-POS)	**Priority**Medicare Select (PPO)
Hearing services Medicare-covered exam performed by a primary care physician or specialist to diagnose and treat hearing and balance issues. Routine hearing coverage must be received from a TruHearing® provider.	**Medicare-covered diagnostic hearing exam** *In-network:* $20–$45 for each visit *Out-of-network:* 30% for each visit	**Medicare-covered diagnostic hearing exam** *In-network:* $10–$40 for each visit *Out-of-network:* 30% for each visit	**Medicare-covered diagnostic hearing exam** *In-network:* $15–$40 for each visit *Out-of-network:* 30% for each visit
	Routine hearing coverage (TruHearing provider) $0 for one routine hearing exam, per year $295, $695, $1,095 or $1,495 copay, per ear per 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 and 80 batteries per hearing aid (re-chargeable not included)		
Dental services Prior authorization may be required for Medicare-covered dental services. Delta Dental® is the preferred provider for additional dental services.	**Medicare-covered dental services** *In-network:* $20–$225 for each visit, depending on the service performed *Out-of-network:* 30% for each visit	**Medicare-covered dental services** *In-network:* $10–$175 for each visit, depending on the service performed *Out-of-network:* 30% for each visit	**Medicare-covered dental services** *In-network:* $15–$200 for each visit, depending on the service performed *Out-of-network:* 30% for each visit
	Additional dental services $0 for two cleanings (regular or periodontal maintenance) per year $0 for two exams per year $0 for one set of bitewing X-rays per year $0 for one brush biopsy per year $0 for other X-rays (i.e. panoramic) once every two years		

Benefits and what you should know	**Priority**Medicare Merit (PPO)	**Priority**Medicare (HMO-POS)	**Priority**Medicare Select (PPO)
Vision 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 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 benefit cannot be combined.	**Medicare-covered services** *In-network:* $45 for each visit $0 for eyeglasses or contact lenses after cataract surgery $0 for a yearly glaucoma screening *Out-of-network:* 30% for each visit, eyeglasses or contact lenses after cataract surgery, or for a yearly glaucoma screening	**Medicare-covered services** *In-network:* $40 for each visit $0 for eyeglasses or contact lenses after cataract surgery $0 for a yearly glaucoma screening *Out-of-network:* 30% for each visit, eyeglasses or contact lenses after cataract surgery, or for a yearly glaucoma screening	**Medicare-covered services** *In-network:* $40 for each visit $0 for eyeglasses or contact lenses after cataract surgery $0 for a yearly glaucoma screening *Out-of-network:* 30% for each visit, eyeglasses or contact lenses after cataract surgery, or for a yearly glaucoma screening
	Routine vision services *In-network:* $0 for one routine exam each year (includes dilation and refraction) $0 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 care We cover up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. Prior authorization may be required.	**Inpatient visit** *In-network:* Days 1–5: $350 each day Days 6 and beyond: $0 each day *Out-of-network:* 30% for each stay	**Inpatient visit** *In-network:* Days 1–6: $225 each day Days 7 and beyond: $0 each day *Out-of-network:* 30% for each stay	**Inpatient visit** *In-network:* Days 1–6: $200 each day Days 7 and beyond: $0 each day *Out-of-network:* 30% for each stay
	Outpatient therapy (individual or group) *In-network:* $20 for each visit *Out-of-network:* 30% for each visit		
Skilled Nursing Facility (SNF) 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:* Days 1–20: $0 each day Days 21–100: $188 each day *Out-of-network:* 30% for each stay		
Physical therapy	*In-network:* $35 for each service *Out-of-network:* 30% for each service	*In-network:* $35 for each service *Out-of-network:* 30% for each service	*In-network:* $30 for each service *Out-of-network:* 30% for each service

Benefits and what you should know	**Priority**Medicare Merit (PPO)	**Priority**Medicare (HMO-POS)	**Priority**Medicare Select (PPO)
Ambulance Prior authorization may be required.	*In-network and out-of-network:* $250 each way	*In-network and out-of-network:* $200 each way	*In-network and out-of-network:* $200 each way
Transportation	Not covered		

PRESCRIPTION DRUG BENEFITS

Prescription drug benefits	**Priority**Medicare Merit (PPO)	**Priority**Medicare (HMO-POS)	**Priority**Medicare Select (PPO)
Medicare Part B drugs Prior authorization or step therapy may be required.	**Chemotherapy drugs** In-network and out-of-network: 20% for each drug **Other Part B drugs** In-network and out-of-network: 20% for each drug **Select home infusion drugs** In-network and out-of-network: $0 for each drug		

PART D OUTPATIENT PRESCRIPTION DRUGS			
Prescription drug benefits	**Priority**Medicare Merit (PPO)	**Priority**Medicare (HMO-POS)	**Priority**Medicare Select (PPO)
Deductible stage You'll pay this amount before you begin paying copays or coinsurance only.	$0	$0	$0
Initial coverage stage You are in this stage until your drug total reaches $4,430, which includes what you pay out-of-pocket and what we pay for your covered drugs.	You pay what is listed in the chart below.		

HIGHEST COVERAGE

PREFERRED RETAIL PHARMACY									
Prescription drug benefits	**Priority**Medicare Merit (PPO)			**Priority**Medicare (HMO-POS)			**Priority**Medicare Select (PPO)		
Initial coverage stage	30-day supply	60-day supply	90-day supply	30-day supply	60-day supply	90-day supply	30-day supply	60-day supply	90-day supply
Tier 1 (Preferred generic)	$2	$4	$6	$1	$2	$3	$1	$2	$3
Tier 2 (Generic)	$10	$20	$30	$8	$16	$24	$7	$14	$21
Tier 3 (Preferred brand)	$42	$84	$126	$38	$76	$114	$37	$74	$111
Tier 4 (Non-preferred drug)	50%	50%	50%	45%	45%	45%	45%	45%	45%
Tier 5 (Specialty)	33%	N/A	N/A	33%	N/A	N/A	33%	N/A	N/A
Your costs will be less for your covered drugs when you use a pharmacy in our preferred network (includes Meijer, Walgreens, Walmart, Rite Aid, Kroger, Family Fare Supermarkets, Costco and more), go to ***prioritymedicare.com*** to view the list in the provider/pharmacy directory.									

STANDARD RETAIL PHARMACY									
Prescription drug benefits	**Priority**Medicare Merit (PPO)			**Priority**Medicare (HMO-POS)			**Priority**Medicare Select (PPO)		
Initial coverage stage	30-day supply	60-day supply	90-day supply	30-day supply	60-day supply	90-day supply	30-day supply	60-day supply	90-day supply
Tier 1 (Preferred generic)	$7	$14	$21	$6	$12	$18	$6	$12	$18
Tier 2 (Generic)	$15	$30	$45	$13	$26	$39	$12	$24	$36
Tier 3 (Preferred brand)	$47	$94	$141	$43	$86	$129	$42	$84	$126
Tier 4 (Non-preferred drug)	50%	50%	50%	45%	45%	45%	50%	50%	50%
Tier 5 (Specialty)	33%	N/A	N/A	33%	N/A	N/A	33%	N/A	N/A

MAIL ORDER THROUGH EXPRESS SCRIPTS (ESI)									
Prescription drug benefits	**Priority**Medicare Merit (PPO)			**Priority**Medicare (HMO-POS)			**Priority**Medicare Select (PPO)		
Initial coverage stage	30-day supply	60-day supply	90-day supply	30-day supply	60-day supply	90-day supply	30-day supply	60-day supply	90-day supply
Tier 1 (Preferred generic)	$2	$4	$0	$1	$2	$0	$1	$2	$0
Tier 2 (Generic)	$10	$20	$0	$8	$16	$0	$7	$14	$0
Tier 3 (Preferred brand)	$42	$84	$105	$38	$76	$95	$37	$74	$92.50
Tier 4 (Non-preferred drug)	50%	50%	50%	45%	45%	45%	45%	45%	45%
Tier 5 (Specialty)	33%	N/A	N/A	33%	N/A	N/A	33%	N/A	N/A

Prescription drug benefits	**Priority**Medicare Merit (PPO)	**Priority**Medicare (HMO-POS)	**Priority**Medicare Select (PPO)
Coverage gap stage (also known as the "donut hole")	Once the total yearly drug costs (what you've paid plus what we've paid) reach $4,430 you enter the coverage gap and then you pay a percentage of the cost we have negotiated for the drug: • 25% of what we would pay for the covered brand name drug • 25% of what we would pay for the covered generic drug When your out-of-pocket drug costs reach $7,050, this is the end of the coverage gap stage.		
Catastrophic coverage stage	Once your out-of-pocket drug costs reach $7,050 you will pay the larger amount, which is either: • 5% of the cost of the drug, or • $3.95 for generics, and • $9.85 for all other 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

Prescription drug benefits	**Priority**Medicare Merit (PPO)	**Priority**Medicare (HMO-POS)	**Priority**Medicare Select (PPO)
Benefits	Additional dental coverage, including coverage for dental services and an additional vision allowance for use on eyeglasses or contacts.		
Premium	Additional $29 per month. You must keep paying your Medicare Part B premium and your $63–$121 monthly plan premium.	Additional $29 per month. You must keep paying your Medicare Part B premium and your $74–$127 monthly plan premium.	Additional $29 per month. You must keep paying your Medicare Part B premium and your $149–$225 monthly plan premium.
Deductible	$0		
Maximum plan benefit coverage amount	$2,500 for 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 fillings, including composite resin on anterior and posterior teeth, crown repair, emergency treatment of dental pain, one fluoride treatment and anesthesia, each year 50% of the cost for restorative, endodontics, crowns, relines and repairs, oral surgery and simple extractions each year. 50% of the cost for implants and implant repairs per tooth every 5 years		
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 benefit cannot be combined.	$150 additional eyewear allowance/reimbursement per year		

ADDITIONAL MEDICAL BENEFITS COVERED UNDER YOUR PLAN

Prescription drug benefits	**Priority**Medicare Merit (PPO)	**Priority**Medicare (HMO-POS)	**Priority**Medicare Select (PPO)
Acupuncture	**Medicare-covered acupuncture for lower chronic back pain** *In-network and out-of-network:* $20 per visit **Non-Medicare covered routine acupuncture for other conditions** *In-network and out-of-network:* $20 per visit (limit 6 per year)	**Medicare-covered acupuncture for lower chronic back pain** *In-network and out-of-network:* $20 per visit **Non-Medicare covered routine acupuncture for other conditions** *In-network:* $20 per visit (limit 6 per year) *Out-of-network:* Not covered	**Medicare-covered acupuncture for lower chronic back pain** *In-network and out-of-network:* $20 per visit **Non-Medicare covered routine acupuncture for other conditions** *In-network and out-of-network:* $20 per visit (limit 6 per year)
Annual preventive physical 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.	*In-network:* $0 for an exam *Out-of-network:* 30% for an exam		

HIGHEST COVERAGE

Prescription drug benefits	**Priority**Medicare Merit (PPO)	**Priority**Medicare (HMO-POS)	**Priority**Medicare Select (PPO)
BrainHQ Access to online exercises and games that improve memory, attention, brain speed and more. Train on any device like a computer, tablet or smartphone.	$0		
Chiropractic care	**Medicare-covered care** *In-network:* $20 for each visit *Out-of-network:* 30% for each visit		
Dialysis	*In-network:* 20% for services *Out-of-network:* 30% for services		
Home health services Prior authorization may be required.	*In-network and out-of-network:* $0 for each Medicare-covered service		
Meal benefit Home-delivered meals, provided through Mom's Meals following a discharge from a hospital (acute or psychiatric) or Skilled Nursing Facility (SNF) stay.	$0 for 28 meals following a discharge (limit 4 times per year)		
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 JJHCS and Bayer products when dispensed by a retail pharmacy or mail-order pharmacy. Prior authorization may be required.	**Diabetes supplies** *In-network:* $0 for each item *Out-of-network:* 30% for each item **Durable medical equipment** *In-network:* 20% for each item *Out-of-network:* 30% for each item **Prosthetic devices** *In-network:* $0–20% for each item, depending on the device *Out-of-network:* 30% for each device		
Podiatry services	*In-network:* $45 for each office visit $0 for nail debridement and callous removal for members with specific conditions (up to 6 of each) *Out-of-network:* 30% for each visit and service	*In-network:* $40 for each office visit $0 for nail debridement and callous removal for members with specific conditions (up to 6 of each) *Out-of-network:* 30% for each visit and service	*In-network:* $40 for each office visit $0 for nail debridement and callous removal for members with specific conditions (up to 6 of each) *Out-of-network:* 30% for each visit and service

Prescription drug benefits	**Priority**Medicare Merit (PPO)	**Priority**Medicare (HMO-POS)	**Priority**Medicare Select (PPO)
Priority Health Travel Pass	**Out-of-state travel benefit** You'll pay in-network prices when seeking care from Medicare-participating providers anywhere in the U.S. outside of Michigan. Our partnership with Multiplan can make accessing Medicare-participating providers even easier. 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 plans 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 but also assistance while on your trip should a medical travel emergency arise, like needing help replacing lost or forgotten prescriptions (costs may apply for the prescription drugs), retrieval of vehicles or other valuable property left stranded because of a medical situation and more, 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, pulmonary rehabilitation services and supervised exercise therapy (SET) services** *In-network:* $25 for each service *Out-of-network:* 30% for each service **Physical therapy, occupational therapy and speech therapy services** *In-network:* $35 for each service *Out-of-network:* 30% for each service	**Cardiac, pulmonary rehabilitation services and supervised exercise therapy (SET) services** *In-network:* $20 for each service *Out-of-network:* 30% for each service **Physical therapy, occupational therapy and speech therapy services** *In-network:* $35 for each service *Out-of-network:* 30% for each service	**Cardiac, pulmonary rehabilitation services and supervised exercise therapy (SET) services** *In-network:* $15 for each service *Out-of-network:* 30% for each service **Physical therapy, occupational therapy and speech therapy services** *In-network:* $30 for each service *Out-of-network:* 30% for each service
SilverSneakers® Fitness membership	$0 membership at thousands of participating SilverSneakers fitness centers nationwide. Plus, options for working out from the comfort of your home with access to members-only virtual exercise classes and online workshops with the SilverSneakers GO™ fitness app or SilverSneakers home fitness kits. You can also sign up for Tuition Rewards® through SilverSneakers to earn money towards college tuition for family members. The SilverSneakers® program is provided by Tivity Health®. All programs and services may not be available in all areas.		
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 or smart phone or tablet.	*In-network:* $0 virtual visits with primary care, specialist and behavioral health providers. Available 24/7, virtual visits lets you see a provider for and get treatment for non-emergency care. *Out-of-network:* Not covered		

Highest coverage plans | MONTHLY PREMIUMS

Counties	**Priority**Medicare Merit (PPO)	**Priority**Medicare (HMO-POS)	**Priority**Medicare Select (PPO)
Region 1: Allegan, Barry, Kent, Lenawee, Ottawa	$63	$74	$159
Region 2: Berrien, Calhoun, Cass, Ionia, Isabella, Kalamazoo, Mason, Midland, Missaukee, Montcalm, Muskegon, Newaygo, Oceana, Osceola, Otsego, St. Clair, Van Buren, Wexford	$76	$85	$149
Region 3: Alcona, Antrim, Benzie, Charlevoix, Clare, Crawford, Grand Traverse, Hillsdale, Lake, Lapeer, Leelanau, Manistee, Mecosta, Monroe	$107	$119	$208
Region 4: Alpena, Cheboygan, Eaton, Emmet, Gladwin, Gratiot, Iosco, Jackson, Kalkaska, Montmorency, Oscoda, Presque Isle, Roscommon, Sanilac, Shiawassee, St. Joseph	$121	$103	$225
Region 5: Arenac, Bay, Branch, Clinton, Genesee, Huron, Ingham, Livingston, Macomb, Oakland, Ogemaw, Saginaw, Tuscola, Washtenaw, Wayne	$98	$127	$214

Enrollment checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. Use the checklist to help you make a smart decision about your health care. If you have any questions, you can call and speak to a Medicare expert at **888.230.0365** from 8 a.m. to 8 p.m. (TTY 711).

UNDERSTANDING THE BENEFITS

- Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services for which you routinely see a doctor. Visit *prioritymedicare.com* or call 888.230.0365 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 or you may pay more.
- 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.

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/co-insurance may change on January 1, 2023.
- Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for certain covered services for HMO-POS plans that are provided by a non-contracted provider, the provider may not (or would need to) 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'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*.

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.