2023

Summary of Benefits

PriorityMedicare Edge℠ (PPO)
PriorityMedicare Compass℠ (PPO)
PriorityMedicare Vital℠ (PPO)

PriorityMedicare Key℠ (HMO-POS)
PriorityMedicare ONE℠ (HMO-POS)

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

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

JANUARY 1, 2023–DECEMBER 31, 2023

Priority Health®

The perfect Medicare plan is waiting for you in the next few pages. Whether you're considering an HMO-POS or PPO plan, inside you'll find information to help you decide on the right Medicare plan.

Contact us

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 888.481.2090.

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

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

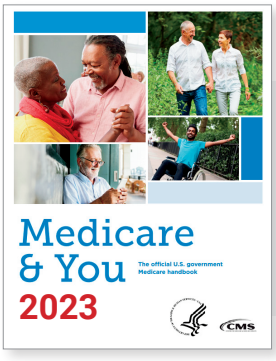
To confirm that your doctor, clinic or health center is part of the Priority Health Medicare network of providers, go to *priorityhealth.com/findadoc*.

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, also called a formulary, to see which drugs are covered by our plans. You can find in-network pharmacies and approved drugs on our website at *prioritymedicare.com*, or call the customer 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 *2023 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.*

Important health insurance terms to know

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

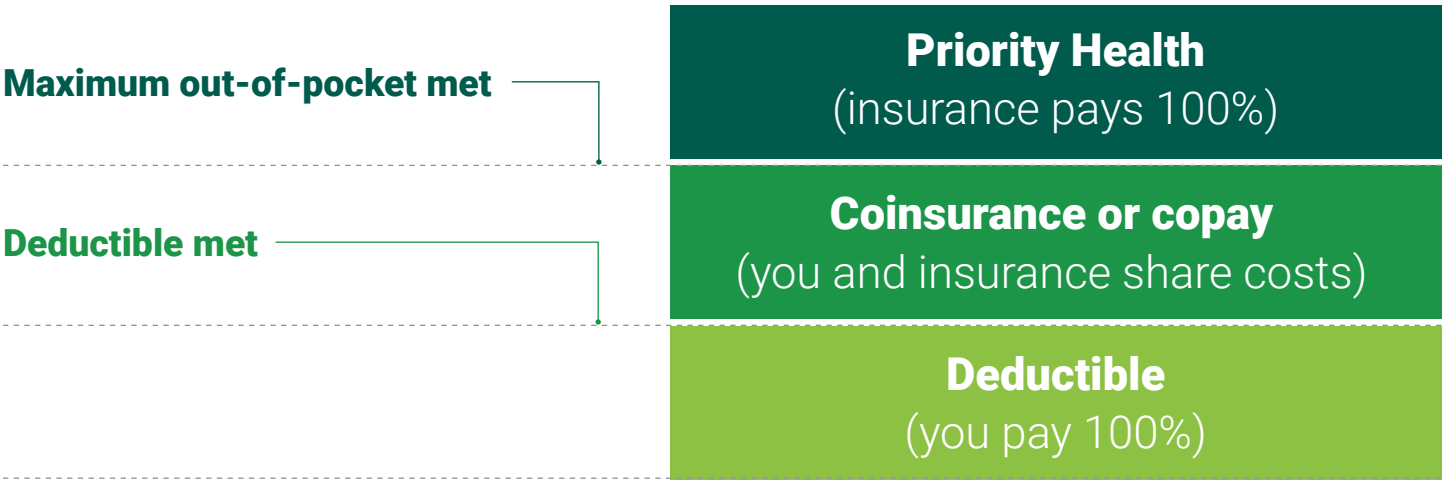
Deductible: This is the amount you pay each year before the health plan starts to pay for certain services, and you start paying a portion of the cost (copay or coinsurance). Priority Health Medicare Advantage plans do not have an in-network medical deductible, so you'll start paying only your copay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

Rich benefits and affordable coverage

Edge

Our top-selling $0 PPO plan. Benefits include $0 primary care visits, $0 labs, and $0 medical and Rx deductible, OTC and companion care through the PriorityCare benefit.

Compass

Now with an open network, this $0 plan includes a $0 medical and Rx deductible along with $0 for primary care visits, plus companion care through the PriorityCare benefit.

Vital

An open network $0 plan with a low maximum out-of-pocket, a $30 monthly Part B credit and lots of extras, like OTC, dental, vision and a monthly food allowance for those who are eligible.

PREMIUMS AND BENEFITS | $0 PPO Plans

Benefits and what you should know	**Priority**Medicare Edge (PPO)	**Priority**Medicare Compass (PPO)	**Priority**Medicare Vital (PPO)
Plan availability Plans are available in regions listed. *See table later in this document for a listing of counties by region.*	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.	$0 per month. You must keep paying your Medicare Part B premium but you 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-* 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 amount 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):* $5,300	*In-network-* and *out-of-network services (combined):* $5,650	*In-network-* and *out-of-network services (combined):* $4,900

MEDICAL BENEFITS COVERED UNDER YOUR PLAN

Benefits and what you should know	**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 1-5: $350 each day Days 6 and beyond: $0 each day *Out-of-network:* 40% per stay	*In- and out-of-network:* Days 1-5: $350 each day Days 6 and beyond: $0 each day	*In- and out-of-network:* Days 1-5: $350 each day Days 6 and beyond: $0 each day

Benefits and what you should know	**Priority**Medicare Edge (PPO)	**Priority**Medicare Compass (PPO)	**Priority**Medicare Vital (PPO)
Outpatient hospital coverage Prior authorization may be required.	**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	**Outpatient hospital** *In- and out-of-network:* $0 for each visit at a rural health clinic $325 for each visit at all other locations	**Outpatient hospital** *In- and out-of-network:* $0 for each visit at a rural health clinic $300 for each visit at all other locations
	Observation *In- and out-of-network:* $110 for each visit, including all services received	**Observation** *In- and out-of-network:* $110 for each visit, including all services received	**Observation** *In- and out-of-network:* $110 for each visit, including all services received
Ambulatory surgical center coverage Prior authorization may be required.	*In-network:* $325 for each visit *Out-of-network:* 40% for each visit	*In- and out-of-network:* $325 for each visit	*In- and out-of-network:* $300 for each visit
Doctor visits Prior authorization may be required for some specialist visits.	**Primary care physician (PCP)** *In-network:* $0 for each office visit $0 for surgical procedures performed in a PCP's office *Out-of-network:* 40% for each visit	**Primary care physician (PCP)** *In- and out-of-network:* $0 for each office visit $0 for surgical procedures performed in a PCP's office	**Primary care physician (PCP)** *In- and out-of-network:* $0 for each office visit $0 for surgical procedures performed in a PCP's office
	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	**Specialist visit** *In- and out-of-network:* $0 for palliative care physician office visit $0 for surgical procedures performed in a specialist's office $50 for all other office visits	**Specialist visit** *In- and out-of-network:* $0 for palliative care physician office visit $0 for surgical procedures performed in a specialist's office $50 for all other office visits
Preventive care	*In-network:*	*In- and out-of-network:*	*In- and out-of-network:*

Benefits and what you should know	**Priority**Medicare Edge (PPO)	**Priority**Medicare Compass (PPO)	**Priority**Medicare Vital (PPO)
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.	$0 for each service *Out-of-network:* 40% for each service	$0 for each service	$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- and out-of-network:* $110 for each visit		
Urgently needed services This amount is waived if you are admitted as inpatient to the hospital within 24 hours from your urgent care visit.	*In- and out-of-network:* $30 for each visit	*In- and out-of-network:* $30 for each visit	*In- and out-of-network:* $60 for each visit
Outpatient diagnostic services (labs, radiology/imaging and X-rays) Prior authorization may be required for some services.	**Radiology/ imaging** *In-network:* $270 per day, per provider **Tests/procedures** *In-network:* $0 per day, per provider **Lab services** *In-network:* $0 per day, per provider ($0 for anticoagulant lab services) **Outpatient X-rays** *In-network:* $20 per day, per provider	**Radiology/ imaging** *In- and out-of-network:* $275 per day, per provider **Tests/procedures** *In- and out-of-network:* $20 per day, per provider **Lab services** *In- and out-of-network:* $0-$20 per day, per provider ($0 for anticoagulant lab services) **Outpatient X-rays** *In- and out-of-network:* $20 per day, per provider	**Radiology/ imaging** *In- and out-of-network:* 20% per day, per provider **Tests/procedures** *In- and out-of-network:* $0 per day, per provider **Lab services** *In- and out-of-network:* $0 per day, per provider ($0 for anticoagulant lab services) **Outpatient X-rays** *In- and out-of-network:* $40 per day, per provider

Benefits and what you should know	**Priority**Medicare Edge (PPO)	**Priority**Medicare Compass (PPO)	**Priority**Medicare Vital (PPO)
Outpatient diagnostic services (labs, radiology/imaging and X-rays) *(continued)*	**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)	**Radiation therapy** *In- and out-of-network:* $40 per day, per provider	**Radiation therapy** *In- and out-of-network:* $40 per day, per provider
Hearing services Medicare-covered exam performed by a primary care physician or specialist to diagnose and treat hearing and balance issues. Routine hearing services must be received from a TruHearing® provider.	**Medicare-covered diagnostic hearing exam** *In-network:* $0-$45 for each office visit *Out-of-network:* 40% for each visit	**Medicare-covered diagnostic hearing exam** *In- and out-of-network:* $0-$50 for each office visit	**Medicare-covered diagnostic hearing exam** *In- and out-of-network:* $0-$50 for each office 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		**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, 80 batteries per non-rechargeable hearing aid and a full 3-year manufacturer warranty		
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:* $0-$325 for each visit, depending on the service performed *Out-of-network:* 40% for each service	**Medicare-covered dental services** *In- and out-of-network:* $0-$325 for each visit, depending on the service performed	**Medicare-covered dental services** *In- and out-of-network:* $0-$300 for each visit, depending on the service performed

Benefits and what you should know	**Priority**Medicare Edge (PPO)	**Priority**Medicare Compass (PPO)	**Priority**Medicare Vital (PPO)
Dental services (*continued*)	**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		**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 $1,500 annual maximum that applies to the following services: $0 for fillings (includes composite resin and amalgam), once per tooth, every 24 months $0 for simple extractions, once per tooth per lifetime $0 for crown repairs, once per tooth every 12 months $0 for anesthesia, no limit when used during any of the services above
Vision services Medicare-covered exam performed by a specialist to diagnose and treat diseases and conditions of the eye and additional Medicare-covered services.	**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- and out-of-network:* $50 for each visit $0 for eyeglasses or contact lenses after cataract surgery $0 for a yearly glaucoma screening	**Medicare-covered services** *In- and out-of-network:* $50 for each visit $0 for eyeglasses or contact lenses after cataract surgery $0 for a yearly glaucoma screening

Benefits and what you should know	**Priority**Medicare Edge (PPO)	**Priority**Medicare Compass (PPO)	**Priority**Medicare Vital (PPO)
Vision services *(continued)* 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.	**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		**Routine vision services** *In- and out-of-network:* $0 for one routine exam each year (includes dilation and refraction) $0 for one retinal imaging per year $125 eyewear allowance per year *Out-of-network:* Up to $125 reimbursement for eyewear Up to $50 reimbursement for one routine exam Up to $20 reimbursement for retinal imaging
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:* 40% per stay **Outpatient therapy (individual or group)** *In-network:* $20 for each visit *Out-of-network:* 40% for each visit	**Inpatient visit** *In- and out-of-network:* Days 1-5: $350 each day Days 6 and beyond: $0 each day **Outpatient therapy (individual or group)** *In- and out-of-network:* $20 for each visit	**Inpatient visit** *In- and out-of-network:* Days 1-5: $350 each day Days 6 and beyond: $0 each day **Outpatient therapy (individual or group)** *In- and out-of-network:* $20 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:* 40% for each stay	*In- and out-of-network:* Days 1-20: $0 each day Days 21-100: $188 each day	*In- and out-of-network:* Days 1-20: $0 each day Days 21-100: $196 each day

Benefits and what you should know	**Priority**Medicare Edge (PPO)	**Priority**Medicare Compass (PPO)	**Priority**Medicare Vital (PPO)
Physical therapy	*In-network:* $40 for each service *Out-of-network:* 40% for each service	*In- and out-of-network:* $40 for each service	*In- and out-of-network:* $40 for each service
Ambulance Prior authorization may be required.	*In- and out-of-network:* $275 each way	*In- and out-of-network:* $325 each way	*In- and out-of-network:* $265 each way
Transportation	Not covered		

PRESCRIPTION DRUG BENEFITS

Prescription drug benefits	**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- and out-of-network:* 20% for each drug **Other Part B drugs** *In- and out-of-network:* 20% for each drug **Select home infusion drugs:** *In- and out-of-network:* $0 for each drug		

PART D OUTPATIENT PRESCRIPTION DRUGS			
Prescription drug benefits	**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	Tiers 1-2: $0 Tiers 3-5: $350* *Covered insulins (defined by Medicare) do not apply to deductible.
Initial coverage stage You are in this stage until your drug total reaches $4,660, 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.		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 Edge (PPO)			**Priority**Medicare Compass (PPO)			**Priority**Medicare 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
Tier 1 (Preferred generic)	$2	$4	$0	$4	$8	$0	$1	$2	$0
Tier 2 (Generic)	$8	$16	$24	$15	$30	$45	$10	$20	$30
Tier 3 (Preferred brand)	$38	$76	$114	$42	$84	$126	$42	$84	$126
Tier 4 (Non-preferred drug)	40%	40%	40%	45%	45%	45%	45%	45%	45%
Tier 5 (Specialty)	33%	N/A	N/A	33%	N/A	N/A	26%	N/A	N/A
Covered Insulin (defined by Medicare)	Up to $35	Up to $70	Up to $105	Up to $35	Up to $70	Up to $105	Up to $35	Up to $70	Up to $105
Vaccines (defined by Medicare)	$0 for certain vaccines regardless of the drug tier the vaccine is in.								

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, Dollar General and Dollar Tree). Go to *prioritymedicare.com* to view the list in the provider/pharmacy directory.

STANDARD RETAIL PHARMACY									
Prescription drug benefits	**Priority**Medicare Edge (PPO)			**Priority**Medicare Compass (PPO)			**Priority**Medicare 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
Tier 1 (Preferred generic)	$7	$14	$21	$11	$22	$33	$6	$12	$18
Tier 2 (Generic)	$15	$30	$45	$20	$40	$60	$15	$30	$45
Tier 3 (Preferred brand)	$47	$94	$141	$47	$94	$141	$47	$94	$141
Tier 4 (Non-preferred drug)	45%	45%	45%	50%	50%	50%	50%	50%	50%
Tier 5 (Specialty)	33%	N/A	N/A	33%	N/A	N/A	26%	N/A	N/A
Covered Insulin (defined by Medicare)	Up to $35	Up to $70	Up to $105	Up to $35	Up to $70	Up to $105	Up to $35	Up to $70	Up to $105
Vaccines (defined by Medicare)	$0 for certain vaccines regardless of the drug tier the vaccine is in.								

MAIL ORDER THROUGH EXPRESS SCRIPTS (ESI)									
Prescription drug benefits	**Priority**Medicare Edge (PPO)			**Priority**Medicare Compass (PPO)			**Priority**Medicare 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
Tier 1 (Preferred generic)	$2	$4	$0	$4	$8	$0	$1	$2	$0
Tier 2 (Generic)	$8	$16	$0	$15	$30	$0	$10	$20	$0
Tier 3 (Preferred brand)	$38	$76	$95	$42	$84	$105	$42	$84	$105
Tier 4 (Non-preferred drug)	40%	40%	40%	45%	45%	45%	45%	45%	45%
Tier 5 (Specialty)	33%	N/A	N/A	33%	N/A	N/A	26%	N/A	N/A
Covered Insulin (defined by Medicare)	Up to $35	Up to $70	Up to $105	Up to $35	Up to $70	Up to $105	Up to $35	Up to $70	Up to $105

Prescription drug benefits	**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 $4,660 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 During the Coverage Gap stage, your out-of-pocket cost for covered insulins (defined by Medicare) will be the same as what you pay in the initial coverage stage whether you fill your prescription at a preferred or standard pharmacy. When your out-of-pocket drug costs reach $7,400, this is the end of the coverage gap stage.		
Catastrophic coverage stage	Once your out-of-pocket drug costs reach $7,400 you will pay the larger amount, which is either: • 5% of the drug, or • $4.15 for generics and • $10.35 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 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	$38.00 per month. You must keep paying your Medicare Part B premium.	$38.00 per month. You must keep paying your Medicare Part B premium.	$29.00 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		
Dental services Delta Dental® is the preferred provider for additional dental services.	$0 for fillings, including composite resin and amalgam, once per tooth, every 24 months, crown repair once per tooth every 12 months and one fluoride treatment per year $0 for emergency treatment for dental pain and anesthesia- no limit 50% of the cost of onlays, crowns and associated substructures, once per tooth, every 60 months		$0 copay for one fluoride treatment per year $0 for emergency treatment of dental pain, and anesthesia- no limit
	50% of the cost of endodontics, once per tooth every 24 months 50% of the cost of surgical extractions, once per tooth per lifetime 50% of the cost for non-surgical simple extractions, once per tooth per lifetime 50% of the cost for implants & implant repairs once per tooth every 5 years 50% of the cost for dentures once every 60 months, denture relines and repairs and bridge repairs, once every 36 months		50% of the cost for surgical extractions, once per tooth per lifetime 50% of the cost for endodontics, once per tooth, every 24 months 50% of the cost of dentures once every 60 months, denture relines and repairs and bridge repairs, once every 36 months 50% of the cost of implants and implant related services, once per tooth every 5 years 50% of the cost of onlays, crowns and associated substructures, once per tooth, every 60 months

Benefits and what you should know	**Priority**Medicare Edge (PPO)	**Priority**Medicare Compass (PPO)	**Priority**Medicare Vital (PPO)
Vision services In-network vision services must be provided by an EyeMed® "Select" provider. If received by a non- EyeMed "Select" provider (out-of-network), you must seek reimbursement. In-network and out of-network benefits cannot be combined.	$150 additional eyewear allowance/reimbursement per year		

ADDITIONAL MEDICAL BENEFITS COVERED UNDER YOUR PLAN

Benefits and what you should know	**Priority**Medicare Edge (PPO)	**Priority**Medicare Compass (PPO)	**Priority**Medicare Vital (PPO)
Abridge	$0 A smartphone based application that securely records medical conversations during patient appointments.* Once the recording is complete the Abridge app will transcribe the conversation and pull out any key information (prescription refills, follow up appointments, etc.). The app also allows members to share the transcripts with caregivers/family as they wish. **Medical professionals must verbally consent to being recorded.*		
Acupuncture	**Medicare-covered acupuncture for lower chronic back pain** *In- and out-of-network:* $20 per visit **Non-Medicare covered routine acupuncture for other conditions** *In- and out-of-network:* $20 per visit (limit 6 visits each 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:* 40% for an exam	*In- and out-of-network:* $0 for an exam	*In- and out-of-network:* $0 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		

Benefits and what you should know	**Priority**Medicare Edge (PPO)	**Priority**Medicare Compass (PPO)	**Priority**Medicare Vital (PPO)
Chiropractic care	**Medicare-covered care** *In-network:* $20 for each visit *Out-of-network:* 40% for each visit	**Medicare-covered care** *In- and out-of-network:* $20 for each visit	**Medicare-covered care** *In- and out-of-network:* $20 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.	**Non-Medicare covered routine care** *In- 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.	**Non-Medicare covered routine care** *In- and out-of-network:* $20 for each visit $40 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.
PriorityCare Services provided by Papa, including: 1. *Companion care* - Papa provides you with access to Papa Pals, a network of friendly helpers available both in-person and virtually via a phone call. Papa Pals offer companionship and can assist with everyday tasks such as transportation, grocery shopping and much more. 2. *Papa Care Concierge* - a team of individuals who can help you navigate your benefits, schedule doctor appointments, and find providers. 3. *Caregiver support* - consultation and guidance plus digital resources to **PriorityCare *(continued)***	$0 for up to 72 hours per year of in-person or virtual companion care visits per year plus unlimited Papa Care Concierge and caregiver support services.	$0 for up to 36 hours per year of in-person or virtual companion care visits per year plus unlimited Papa Care Concierge and caregiver support services.	Not covered

Benefits and what you should know	**Priority**Medicare Edge (PPO)	**Priority**Medicare Compass (PPO)	**Priority**Medicare Vital (PPO)
reduce the stress of care-giving related responsibilities and improve confidence in caring for loved ones.			
Dialysis	*In-network:* 20% for each service *Out-of-network:* 40% for each service	*In- and out-of-network:* 20% for each service	*In- and out-of-network:* 20% for each service
Home health services Prior authorization may be required.	*In- 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:* 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	**Diabetes supplies** *In- and out-of-network:* $0 for each item **Durable medical equipment** *In- and out-of-network:* 20% for each item **Prosthetic devices** *In- and out-of-network:* $0-20% for each item, depending on the device	**Diabetes supplies** *In- and out-of-network:* $0 for each item **Durable medical equipment** *In- and out-of-network:* 20% for each item **Prosthetic devices** *In- and out-of-network:* $0-20% for each item, depending on the device
Over-the-counter (OTC) items 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.	$60 allowance per quarter for OTC items	$35 allowance per quarter for OTC items	Not covered – See "OTC Plus"
	OTC items can be purchased in participating stores (Walmart, Walgreens, CVS, Kroger and more). Or, online at *PriorityHealth.com/OTC* or by phone, or by mail using the plan's OTC catalog for home delivery.		

Benefits and what you should know	**Priority**Medicare Edge (PPO)	**Priority**Medicare Compass (PPO)	**Priority**Medicare Vital (PPO)
OTC Plus Use your OTC Plus card to purchase over-the-counter drugs and health-related products that do not need a prescription such as; allergy medication, eye drops, cough drops, nasal spray, vitamins and more. Members who qualify for Special Supplemental Benefits for the Chronically Ill (SSBCI) may also use their OTC Plus card to purchase healthy foods such as vegetables, fruits, meats, milk and more.	Not covered – See "OTC items"	Not covered – See "OTC items"	$20 allowance per month for OTC items and if eligible, healthy food. Eligible OTC items and healthy food can be purchased from participating retail locations (Kroger, Walgreens, CVS, Walmart and more). OTC items may also be purchased online at *PriorityHealth.com/OTC*, by phone or by mail using the plan's OTC catalog for home delivery.
Podiatry services	*In-network:* $45 for each 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- and out-of-network:* $50 for each visit $0 for nail debridement and callous removal for members with specific conditions (up to 6 of each)	*In- and out-of-network:* $50 for each visit $0 for nail debridement and callous removal for members with specific conditions (up to 6 of each)
Priority Health Travel Pass	**Out-of-area travel benefit** You'll pay in-network prices when seeking care from Medicare-participating providers anywhere in the U.S. outside of the lower peninsula of Michigan. 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		

Benefits and what you should know	**Priority**Medicare Edge (PPO)	**Priority**Medicare Compass (PPO)	**Priority**Medicare Vital (PPO)
Priority Health Travel Pass *(continued)*	emergency arise, like needing help replacing lost or forgotten prescriptions (costs may apply for the prescriptions 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:* $20 for each service *Out-of-network:* 40% for each service	**Cardiac, pulmonary rehabilitation services and supervised exercise therapy (SET) services** *In- and out-of-network:* $20 for each service	**Cardiac, pulmonary rehabilitation services and supervised exercise therapy (SET) services** *In- and out-of-network:* $20 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- and out-of-network:* $40 for each service	**Physical therapy, occupational therapy and speech therapy services** *In- and out-of-network:* $40 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 SilverSneaker 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, smart phone or tablet.	*In-network:* $0 virtual visits with primary care, specialist, and behavioral health providers. Available 24/7, virtual visits let you see a provider for, and get treatment for, non-emergency care. *Out-of-network:* Not covered		

PREMIUMS AND BENEFITS | Monthly Premiums

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

$0 HMO-POS plans

Rich benefits and affordable coverage

Key

Our top-selling $0 plan with our richest dental coverage through Delta Dental, $0 medical and Rx deductible, plus a quarterly OTC allowance and so many extras.

ONE

This $0 plan leverages the partnership between Priority Health and Beaumont Health Spectrum Health to bring you a more integrated experience. Plus, many ways to keep living well with health concerns, like transportation to and from doctor's appointments, OTC Plus and PriorityCare for help around the house and more.

The ONE plan still allows you to see any provider in our Medicare network, including but not limited to Beaumont Health Spectrum Health providers.

PREMIUMS AND BENEFITS | $0 HMO-POS Plans

Benefits and what you should know	**Priority**Medicare Key (HMO-POS)	**Priority**Medicare ONE (HMO-POS)
Plan availability	Regions 1, 2, 3, 4 and 5	Kent, Ottawa, Macomb, Oakland and Wayne
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.
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:* $0 *Out-of-network:* $1,000 **Prescription drugs (Part D)** $0
Maximum out-of-pocket amount This is the most you pay for covered medical services for the year, excluding Part D prescription drugs.	*In-network:* $5,000 (regions 1, 2 and 5) $5,500 (regions 3 and 4) ***See table later in this document for a list of counties by region.***	*In-network:* $4,300

MEDICAL BENEFITS COVERED UNDER YOUR PLAN

Benefits and what you should know	**Priority**Medicare Key (HMO-POS)	**Priority**Medicare ONE (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: $325 each day Days 7 and beyond: $0 each day *Out-of-network:* 50% per stay	*In-network:* Days 1-7: $285 each day Days 8 and beyond: $0 each day *Out-of-network:* 50% per stay
Outpatient hospital coverage Prior authorization may be required.	**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	**Outpatient hospital** *In-network:* $0 for each visit at a rural health clinic $285 for each visit at all other locations *Out-of-network:* 50% for each visit
Outpatient hospital coverage *(continued)*	***See table later in this document for a list of counties by region.***	

Benefits and what you should know	**Priority**Medicare Key (HMO-POS)	**Priority**Medicare ONE (HMO-POS)
	Observation *In- and out-of-network:* $110 for each visit, including all services received	**Observation** *In- and out-of-network:* $110 for each visit, including all services received
Ambulatory surgical center coverage Prior authorization may be required.	*In-network:* $290 for each visit *Out-of-network:* 50% for each visit	*In-network:* $285 for each visit *Out-of-network:* 50% for each visit
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 table later in this document for a list of counties by region.***	**Primary care physician (PCP)** *In-network:* $0 for each office visit $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 $35 for all other office visits *Out-of-network:* 50% 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:* 50% for each service	*In-network:* $0 for each service *Out-of-network:* 50% 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 Key (HMO-POS)	**Priority**Medicare ONE (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- and out-of-network:* $110 for each visit	*In- and out-of-network:* $110 for each visit
Urgently needed services This amount is waived if you are admitted as inpatient to the hospital within 24 hours from your urgent care visit.	*In- and out-of-network:* $50 for each visit	*In- and out-of-network:* $35 for each visit
Outpatient diagnostic services (labs, radiology/imaging and X-rays) Prior authorization may be required for some services.	**Radiology/ imaging** *In-network:* $160 per day, per provider (regions 1, 2, 3 and 4) $130 per day, per provider (region 5) ***See table later in this document for a list of counties by region.*** **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:* $175 per day, per provider **Tests/procedures** *In-network:* $0 per day, per provider **Lab services** *In-network:* $0 per day, per provider ($0 for anticoagulant lab services) **Outpatient X-rays** *In-network:* $20 per day, per provider **Radiation therapy** *In-network:* $35 per day, per provider *For all out-of-network services listed above*: $0-50% 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 services must be received from a TruHearing® provider.	**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 table later in this document for a list of counties by region.***	**Medicare-covered diagnostic hearing exam** *In-network:* $0-$35 for each office visit *Out-of-network:* 50% for each visit

Benefits and what you should know	**Priority**Medicare Key (HMO-POS)	**Priority**Medicare ONE (HMO-POS)
Hearing services *(continued)*	**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, 80 batteries per non-rechargeable hearing aid and a full 3-year manufacturer warranty	
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:* $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 service ***See table later in this document for a list of counties by region.***	**Medicare-covered dental services** *In-network:* $0-$285 for each visit, depending on the service performed *Out-of-network:* 50% for each service
	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 $1,500 annual maximum that applies to the following services: $0 for fillings (includes composite resin and amalgam), once per tooth, every 24 months $0 for simple extractions, once per tooth per lifetime $0 for crown repairs, once per tooth every 12 months $0 for anesthesia, no limit when used during any of the services above	**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 services** *In-network:* $45 for each visit	**Medicare-covered services** *In-network:* $35 for each visit

Benefits and what you should know	**Priority**Medicare Key (HMO-POS)	**Priority**Medicare ONE (HMO-POS)
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.	$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 **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	$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 **Routine vision services** *In-network:* $0 for one routine exam each year (includes dilation and refraction) $0 for one retinal imaging per year $175 eyewear allowance per year *Out-of-network:* Up to $175 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: $275 each day Days 7 and beyond: $0 each day *Out-of-network:* 50% per stay **Outpatient therapy (individual or group)** *In-network:* $20 for each visit *Out-of-network:* 50% for each visit	**Inpatient visit** *In-network:* Days 1-7: $285 each day Days 8 and beyond: $0 each day *Out-of-network:* 50% per stay **Outpatient therapy (individual or group)** *In-network:* $20 for each visit *Out-of-network:* 50% 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:* 50% for each stay	*In-network:* Days 1-20: $0 each day Days 21-100: $196 each day *Out-of-network:* 50% for each stay
Physical therapy	*In-network:* $30 for each service *Out-of-network:* 50% for each service	*In-network:* $20 for each service *Out-of-network:* 50% for each service

Benefits and what you should know	**Priority**Medicare Key (HMO-POS)	**Priority**Medicare ONE (HMO-POS)
Ambulance Prior authorization may be required.	*In- and out-of-network:* $270 each way	*In- and out-of-network:* $285 each way
Transportation	Not covered	$0 for up to 30 one-way trips every year to or from health-related locations, up to 30 miles max per one way trip.

PRESCRIPTION DRUG BENEFITS

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

PART D OUTPATIENT PRESCRIPTION DRUGS		
Prescription drug benefits	**Priority**Medicare Key (HMO-POS)	**Priority**Medicare ONE (HMO-POS)
Deductible stage You'll pay this amount before you begin paying copays or coinsurance only.	$0	$0
Initial coverage stage You are in this stage until your drug total reaches $4,660, 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.	

PREFERRED RETAIL PHARMACY						
Prescription drug benefits	**Priority**Medicare Key (HMO-POS)			**Priority**Medicare ONE (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	$0	$0	$0
Tier 2 (Generic)	$15	$30	$45	$10	$20	$30
Tier 3 (Preferred brand)	$42	$84	$126	$42	$84	$126
Tier 4 (Non-preferred drug)	45%	45%	45%	45%	45%	45%
Tier 5 (Specialty)	33%	N/A	N/A	33%	N/A	N/A
Covered Insulin (defined by Medicare)	Up to $35	Up to $70	Up to $105	Up to $35	Up to $70	Up to $105
Vaccines (defined by Medicare)	$0 for certain vaccines regardless of the drug tier the vaccine is in.					

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, Dollar General and Dollar Tree). Go to *prioritymedicare.com* to view the list in the provider/pharmacy directory.

STANDARD RETAIL PHARMACY						
Prescription drug benefits	**Priority**Medicare Key (HMO-POS)			**Priority**Medicare ONE (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)	$10	$20	$30	$6	$12	$18
Tier 2 (Generic)	$20	$40	$60	$20	$40	$60
Tier 3 (Preferred brand)	$47	$94	$141	$47	$94	$141
Tier 4 (Non-preferred drug)	50%	50%	50%	50%	50%	50%
Tier 5 (Specialty)	33%	N/A	N/A	33%	N/A	N/A
Covered Insulin (defined by Medicare)	Up to $35	Up to $70	Up to $105	Up to $35	Up to $70	Up to $105
Vaccines (defined by Medicare)	$0 for certain vaccines regardless of the drug tier the vaccine is in.					

MAIL ORDER THROUGH EXPRESS SCRIPTS (ESI)						
Prescription drug benefits	**Priority**Medicare Key (HMO-POS)			**Priority**Medicare ONE (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	$0	$0	$0
Tier 2 (Generic)	$15	$30	$0	$10	$20	$0
Tier 3 (Preferred brand)	$42	$84	$105	$42	$84	$105
Tier 4 (Non-preferred drug)	45%	45%	45%	45%	45%	45%
Tier 5 (Specialty)	33%	N/A	N/A	33%	N/A	N/A
Covered Insulin (defined by Medicare)	Up to $35	Up to $70	Up to $105	Up to $35	Up to $70	Up to $105

Prescription drug benefits	**Priority**Medicare Key (HMO-POS)	**Priority**Medicare ONE (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 $4,660 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 During the Coverage Gap stage, your out-of-pocket cost for covered insulins (defined by Medicare) will be the same as what you pay in the initial coverage stage whether you fill your prescription at a preferred or standard pharmacy. When your out-of-pocket drug costs reach $7,400, this is the end of the coverage gap stage.	
Catastrophic coverage stage	Once your out-of-pocket drug costs reach $7,400 you will pay the larger amount, which is either: • 5% of the drug, or • $4.15 for generics and • $10.35 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 ONE (HMO-POS)
Benefits	Additional dental coverage, including coverage for dental services and an additional vision allowance for use on eyeglasses or contacts	
Premium	$29.00 per month. You must keep paying your Medicare Part B premium.	$38.00 per month. You must keep paying your Medicare Part B premium.
Deductible	$0	$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. **Dental services**	$0 copay for one fluoride treatment each year $0 for emergency treatment for dental pain and anesthesia- no limit 50% of the cost for implants & implant repairs per tooth every 5 years	$0 for fillings, including composite resin and amalgam, once per tooth, every 24 months*, crown repair once per tooth every 12 months and one fluoride treatment per year $0 for emergency treatment for dental pain and anesthesia- no limit

Benefits and what you should know	**Priority**Medicare Key (HMO-POS)	**Priority**Medicare ONE (HMO-POS)
(continued)	50% of the cost for surgical extractions, once per tooth per lifetime 50% of the cost for endodontics, once per tooth, every 24 months 50% of the cost of dentures once every 60 months, denture relines and repairs and bridge repairs, once every 36 months 50% of the cost of onlays, crowns and associated substructures, once per tooth, every 60 months	50% of the cost of onlays, crowns and associated substructures, once per tooth, every 60 months 50% of the cost of endodontics, once per tooth every 24 months 50% of the cost of surgical extractions, once per tooth per lifetime 50% of the cost for non-surgical simple extractions, once per tooth per lifetime 50% of the cost for implants & implant repairs per tooth every 5 years 50% of the cost for dentures once every 60 months, denture relines and repairs and bridge repairs, once every 36 months
Vision services In-network vision services must be provided by an EyeMed® "Select" provider. If received by a non- EyeMed "Select" provider (out-of-network), you must seek reimbursement. In-network and out of-network benefits cannot be combined.	$150 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 ONE (HMO-POS)
Abridge	$0 A smartphone based application that securely records medical conversations during patient appointments.* Once the recording is complete the Abridge app will transcribe the conversation and pull out any key information (prescription refills, follow up appointments, etc.). The app also allows members to share the transcripts with caregivers/family as they wish. **Medical professionals must verbally consent to being recorded.*	
Acupuncture	**Medicare-covered acupuncture for lower chronic back pain** *In- and out-of-network:* $20 per visit **Non-Medicare covered routine acupuncture for other conditions** *In- and out-of-network:* $20 per visit (limit 6 visits each 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	
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 $35 for X-ray services performed once per year *Out-of-network:* 50% for each visit and for X-ray services performed once per year	**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 $20 for X-ray services performed once per year *Out-of-network:* 50% for each visit and for X-ray services performed once per year

Benefits and what you should know	**Priority**Medicare Key (HMO-POS)	**Priority**Medicare ONE (HMO-POS)
Chiropractic care *(continued)*	Limited to 12 non-Medicare covered routine visits per year whether done in- or out-of-network.	Limited to 12 non-Medicare covered routine visits per year whether done in- or out-of-network.
PriorityCare Services provided by Papa, including: 1. *Companion care* - Papa provides you with access to Papa Pals, a network of friendly helpers available both in-person and virtually via a phone call. Papa Pals offer companionship and can assist with everyday tasks such as transportation, grocery shopping and much more. 2. *Papa Care Concierg e-* a team of individuals who can help you navigate your benefits, schedule doctor appointments and find providers. 3. *Caregiver support* - consultation and guidance plus digital resources to reduce the stress of care-giving related responsibilities and improve confidence in caring for loved ones.	Not covered	$0 for up to 100 hours per year of in-person or virtual companion care visits per year plus unlimited Papa Care Concierge and caregiver support services.
Dialysis	*In-network:* 20% for each service *Out-of-network:* 50% for each service	
Home health services Prior authorization may be required.	*In- 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	**Diabetes supplies** *In-network:* $0 for each item *Out-of-network:* 50% for each item **Durable medical equipment**	**Diabetes supplies** *In-network:* $0 for each item *Out-of-network:* 50% for each item **Durable medical equipment**

Benefits and what you should know	**Priority**Medicare Key (HMO-POS)	**Priority**Medicare ONE (HMO-POS)
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.	*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	*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
Over-the-counter (OTC) items 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.	$80 allowance per quarter for OTC items (regions 1 and 2) $55 per quarter for OTC items (regions 3 and 4) $75 per quarter for OTC items (region 5) ***See table later in this document for a list of counties by region.*** OTC items can be purchased in participating stores (Walmart, Walgreens, CVS, Kroger and more). Or, online at *PriorityHealth.com/OTC* or by phone, or by mail using the plan's OTC catalog for home delivery.	Not covered – See "OTC Plus"
OTC Plus Use your OTC Plus card to purchase over-the-counter drugs and health-related products that do not need a prescription such as; allergy medication, eye drops, cough drops, nasal spray, vitamins and more. Members who qualify for Special Supplemental Benefits for the Chronically Ill (SSBCI) may also use their OTC Plus card to purchase healthy foods such as vegetables, fruits, meats, milk and more.	Not covered – See "OTC items"	$15 allowance per month for OTC items and if eligible, healthy food. Eligible OTC items and healthy food can be purchased from participating retail locations (Kroger, Walgreens, CVS, Walmart and more). OTC items may also be purchased online at *PriorityHealth.com/OTC*, by phone or by mail using the plan's OTC catalog for home delivery.
Podiatry services	**Medicare-covered podiatry:** *In-network:* $45 for each visit $0 for nail debridement and callous removal for members with	**Medicare-covered podiatry:** *In-network:* $35 for each visit $0 for nail debridement and callous removal for members with

Benefits and what you should know	**Priority**Medicare Key (HMO-POS)	**Priority**Medicare ONE (HMO-POS)
	specific conditions (up to 6 of each) *Out-of-network:* 50% for each visit and service **Non-Medicare covered routine podiatry services:** Not covered	specific conditions (up to 6 of each) *Out-of-network:* 50% for each visit and service **Non-Medicare covered routine podiatry services:** $0 for each service (limit 6 per year)
Priority Health Travel Pass	**Out-of-area travel benefit** You'll pay in-network prices when seeking care from Medicare-participating providers anywhere in the U.S. outside of the lower peninsula of Michigan. 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 prescriptions 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:* $20 for each service *Out-of-network:* 50% for each service **Physical therapy, occupational therapy and speech therapy services** *In-network:* $30 for each service	**Cardiac, pulmonary rehabilitation services and supervised exercise therapy (SET) services** *In-network:* $20 for each service *Out-of-network:* 50% for each service **Physical therapy, occupational therapy and speech therapy services** *In-network:* $20 for each service

Benefits and what you should know	**Priority**Medicare Key (HMO-POS)	**Priority**Medicare ONE (HMO-POS)
	Out-of-network: 50% for each service	*Out-of-network:* 50% 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 SilverSneaker 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, smart phone or tablet.	*In-network:* $0 virtual visits with primary care, specialist and behavioral health providers. Available 24/7, virtual visits let you see a provider for, and get treatment for, non-emergency care. *Out-of-network:* Not covered	

PREMIUMS AND BENEFITS | Monthly Premiums

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

Mid-tier plans

More care and coverage

Ideal

Extra care and services, including PriorityCare and OTC, for an affordable monthly premium.

Value

Get more care to manage conditions for an affordable cost, including $5 PCP visit copays, a quarterly OTC allowance and low-cost rehab options.

PREMIUMS AND BENEFITS | Mid-tier plans

Benefits and what you should know	**Priority**Medicare Ideal (PPO)	**Priority**Medicare Value (HMO-POS)
Plan availability Plans are available in regions listed. *See table later in this document for a listing of counties by region.*	Regions 1, 2, 3, 4 and 5	
Monthly plan premium	$25 per month. In addition, you must keep paying your Medicare Part B premium.	$15-$71 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 amount 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% per stay	*In-network:* Days 1-5: $325 each day Days 6 and beyond: $0 each day *Out-of-network:* 40% per stay
Outpatient hospital coverage Prior authorization may be required.	**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- and out-of-network:* $110 for each visit, including all services received	**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- and out-of-network:* $110 for each visit, including all services received

Benefits and what you should know	**Priority**Medicare Ideal (PPO)	**Priority**Medicare Value (HMO-POS)
Ambulatory surgical center coverage Prior authorization may be required.	*In-network:* $250 for each visit *Out-of-network:* 45% for each visit	*In-network:* $225 for each visit *Out-of-network:* 40% for each visit
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.	
Emergency care This amount is waived if you are admitted as inpatient to the hospital within 24 hours from your emergency care visit.	*In- and out-of-network:* $110 for each visit	
Urgently needed services This amount is waived if you are admitted as inpatient to the hospital within 24 hours from your urgent care visit.	*In- and out-of-network:* $50 for each visit	*In- and out-of-network:* $55 for each visit

Benefits and what you should know	**Priority**Medicare Ideal (PPO)	**Priority**Medicare Value (HMO-POS)
Outpatient diagnostic services (labs, radiology/imaging and X-rays) Prior authorization may be required for some services.	**Radiology/ imaging** *In-network:* $140 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 services must be received from a TruHearing® provider.	**Medicare-covered diagnostic hearing exam** *In-network:* $15-$45 for each office visit *Out-of-network:* 45% for each visit	**Medicare-covered diagnostic hearing exam** *In-network:* $5-$45 for each office 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, 80 batteries per non-rechargeable hearing aid and a full 3-year manufacturer warranty	
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 service	**Medicare-covered dental services** *In-network:* $5-$225 for each visit, depending on the service performed *Out-of-network:* 40% for each service

Benefits and what you should know	**Priority**Medicare Ideal (PPO)	**Priority**Medicare Value (HMO-POS)
Dental services *(continued)*	**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 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
	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% per 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% per 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- and out-of-network:* $240 each way	*In- and out-of-network:* $265 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- and out-of-network:* 20% for each drug **Other Part B drugs** *In- and out-of-network:* 20% for each drug **Select home infusion drugs:** *In- and 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* *Covered insulins (defined by Medicare) do not apply to deductible.	Tiers 1-2: $0 Tiers 3-5: $75* *Covered insulins (defined by Medicare) do not apply to deductible.
Initial coverage stage You are in this stage until your drug total reaches $4,660, 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	$0	$2	$4	$0
Tier 2 (Generic)	$13	$26	$39	$10	$20	$30
Tier 3 (Preferred brand)	$42	$84	$126	$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
Covered Insulin (defined by Medicare)	Up to $35	Up to $70	Up to $105	Up to $35	Up to $70	Up to $105
Vaccines (defined by Medicare)	$0 for certain vaccines regardless of the drug tier the vaccine is in.					
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, Dollar General and Dollar Tree). 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	$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
Covered Insulin (defined by Medicare)	Up to $35	Up to $70	Up to $105	Up to $35	Up to $70	Up to $105
Vaccines (defined by Medicare)	$0 for certain vaccines regardless of the drug tier the vaccine is in.					

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	$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
Covered Insulin (defined by Medicare)	Up to $35	Up to $70	Up to $105	Up to $35	Up to $70	Up to $105

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 $4,660 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 During the Coverage Gap stage, your out-of-pocket cost for covered insulins (defined by Medicare) will be the same as what you pay in the initial coverage stage whether you fill your prescription at a preferred or standard pharmacy. When your out-of-pocket drug costs reach $7,400, this is the end of the coverage gap stage.	
Catastrophic coverage stage	Once your out-of-pocket drug costs reach $7,400 you will pay the larger amount, which is either: • 5% of the drug, or • $4.15 for generics and • $10.35 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 $38.00 per month. You must keep paying your Medicare Part B premium and your $25 monthly plan premium.	Additional $38.00 per month. You must keep paying your Medicare Part B premium and your $15-$71 monthly plan 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 Ideal (PPO)	**Priority**Medicare Value (HMO-POS)
Dental services Delta Dental® is the preferred provider for additional dental services.	$0 for fillings, including composite resin and amalgam, once per tooth, every 24 months, crown repair once per tooth every 12 months and one fluoride treatment per year $0 for emergency treatment for dental pain and anesthesia-no limit 50% of the cost of onlays, crowns and associated substructures, once per tooth, every 60 months 50% of the cost of endodontics, once per tooth every 24 months 50% of the cost of surgical extractions, once per tooth per lifetime 50% of the cost for non-surgical simple extractions, once per tooth per lifetime 50% of the cost for implants & implant repairs per tooth every 5 years 50% of the cost of dentures once every 60 months, denture relines and repairs and bridge repairs, once every 36 months	
Vision services In-network vision services must be provided by an EyeMed® "Select" provider. If received by a non- EyeMed "Select" provider (out-of-network), you must seek reimbursement. In-network and out of-network benefits cannot be combined.	$150 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)
Abridge	$0 A smartphone based application that securely records medical conversations during patient appointments.* Once the recording is complete the Abridge app will transcribe the conversation and pull out any key information (prescription refills, follow up appointments, etc.). The app also allows members to share the transcripts with caregivers/family as they wish. **Medical professionals must verbally consent to being recorded.*	

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- and out-of-network:* $20 per visit **Non-Medicare covered routine acupuncture for other conditions** *In- and out-of-network:* $20 per visit (limit 6 visits each 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:* 45% for an exam	*In-network:* $0 for an 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 **Non-Medicare covered routine care** Not covered

Benefits and what you should know	**Priority**Medicare Ideal (PPO)	**Priority**Medicare Value (HMO-POS)
PriorityCare Services provided by Papa, including: 1. *Companion care* - Papa provides you with access to Papa Pals, a network of friendly helpers available both in-person and virtually via a phone call. Papa Pals offer companionship and can assist with everyday tasks such as transportation, grocery shopping and much more. 2. *Papa Care Concierge* - a team of individuals who can help you navigate your benefits, schedule doctor appointments and find providers. 3. *Caregiver support* - consultation and guidance plus digital resources to reduce the stress of care-giving related responsibilities and improve confidence in caring for loved ones.	$0 for up to 72 hours per year of in-person or virtual companion care visits per year plus unlimited Papa Care Concierge and caregiver support services.	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- 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).	**Diabetes supplies** *In-network:* $0 for each item *Out-of-network:* 45% for each item **Durable medical equipment** *In-network:* 20% for each item *Out-of-network:* 30% 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

Benefits and what you should know	**Priority**Medicare Ideal (PPO)	**Priority**Medicare Value (HMO-POS)
Medical equipment and supplies *(continued)* 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.	**Prosthetic devices** *In-network:* $0-20% for each item, depending on the device *Out-of-network:* 30% for each device	**Prosthetic devices** *In-network:* $0-20% for each item, depending on the device *Out-of-network:* 30% for each device
Over-the-counter (OTC) items 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.	$80 allowance per quarter for OTC items	$25 allowance per quarter for OTC items
	OTC items can be purchased in participating stores (Walmart, Walgreens, CVS, Kroger and more). Or, online at *PriorityHealth.com/OTC* or by phone, or by mail using the plan's OTC catalog for home delivery.	
Podiatry services	*In-network:* $45 for each 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 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-area travel benefit** You'll pay in-network prices when seeking care from Medicare-participating providers anywhere in the U.S. outside of the lower peninsula of Michigan. 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 prescriptions 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.	

Benefits and what you should know	**Priority**Medicare Ideal (PPO)	**Priority**Medicare Value (HMO-POS)
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
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 SilverSneaker 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, smart phone or tablet.	*In-network:* $0 virtual visits with primary care, specialist and behavioral health providers. Available 24/7, virtual visits let you see a provider for, and get treatment for, non-emergency care. *Out-of-network:* Not covered	

PREMIUMS AND BENEFITS | Monthly Premiums

Counties	**Priority**Medicare Ideal (PPO)	**Priority**Medicare Value (HMO-POS)
Region 1: Allegan, Barry, Kent, Lenawee, Ottawa	$25	$15
Region 2: Berrien, Calhoun, Cass, Ionia, Isabella, Kalamazoo, Mason, Midland, Missaukee, Montcalm, Muskegon, Newaygo, Oceana, Osceola, Otsego, St. Clair, Van Buren, Wexford	$25	$34
Region 3: Alcona, Antrim, Benzie, Charlevoix, Clare, Crawford, Grand Traverse, Hillsdale, Lake, Lapeer, Leelanau, Manistee, Mecosta, Monroe	$25	$71
Region 4: Alpena, Cheboygan, Eaton, Emmet, Gladwin, Gratiot, Iosco, Jackson, Kalkaska, Montmorency, Oscoda, Presque Isle, Roscommon, Sanilac, Shiawassee, St. Joseph	$25	$46
Region 5: Arenac, Bay, Branch, Clinton, Genesee, Huron, Ingham, Livingston, Macomb, Oakland, Ogemaw, Saginaw, Tuscola, Washtenaw, Wayne	$25	$34

Highest coverage plans

More coverage for more peace of mind

Merit, Medicare, Select

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

PREMIUMS AND BENEFITS | Highest coverage plans

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 table later in this document for a listing of counties by region.*	Regions 1, 2, 3, 4 and 5		
Monthly plan premium	$61-$119 per month. In addition, you must keep paying your Medicare Part B premium.	$61-$115 per month. In addition, you must keep paying your Medicare Part B premium.	$147-$223 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 amount 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% per stay	*In-network:* Days 1-6: $225 each day Days 7 and beyond: $0 each day *Out-of-network:* 30% per stay	*In-network:* Days 1-6: $200 each day Days 7 and beyond: $0 each day *Out-of-network:* 30% per stay
Outpatient hospital coverage Prior authorization may be required.	**Outpatient hospital** *In-network:* $20 for each visit at a rural health clinic $225 for each visit at all other locations *Out-of-network:* 30% for each visit	**Outpatient hospital** *In-network:* $10 for each visit at a rural health clinic $175 for each visit at all other locations *Out-of-network:* 30% for each visit	**Outpatient hospital** *In-network:* $15 for each visit at a rural health clinic $200 for each visit at all other locations *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)
Outpatient hospital coverage *(continued)*	**Observation** *In- and out-of-network:* $110 for each visit, including all services received	**Observation** *In- and out-of-network:* $110 for each visit, including all services received	**Observation** *In- and out-of-network:* $110 for each visit, including all services received
Ambulatory surgical center coverage Prior authorization may be required.	*In-network:* $225 for each visit *Out-of-network:* 30% for each visit	*In-network:* $175 for each visit *Out-of-network:* 30% for each visit	*In-network:* $200 for each visit *Out-of-network:* 30% for each visit
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	**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	**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 $45 for all other office visits *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	**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
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	*In-network:* $0 for each service *Out-of-network:* 30% for each service	*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	*In- and out-of-network:* $110 for each visit		

Benefits and what you should know	**Priority**Medicare Merit (PPO)	**Priority**Medicare (HMO-POS)	**Priority**Medicare Select (PPO)
This amount is waived if you are admitted as inpatient to the hospital within 24 hours from your emergency care visit.			
Urgently needed services This amount is waived if you are admitted as inpatient to the hospital within 24 hours from your urgent care visit.	*In- and out-of-network:* $55 for each visit	*In- and out-of-network:* $50 for each visit	*In- 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)
Hearing services Medicare-covered exam performed by a primary care physician or specialist to diagnose and treat hearing and balance issues.	**Medicare-covered diagnostic hearing exam** *In-network:* $20-$45 for each office visit *Out-of-network:* 30% for each visit	**Medicare-covered diagnostic hearing exam** *In-network:* $10-$40 for each office visit *Out-of-network:* 30% for each visit	**Medicare-covered diagnostic hearing exam** *In-network:* $15-$40 for each office visit *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)
Hearing services *(continued)* Routine hearing services must be received from a TruHearing® provider.	**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, 80 batteries per non-rechargeable hearing aid and a full 3-year manufacturer warranty		
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 service	**Medicare-covered dental services** *In-network:* $10-$175 for each visit, depending on the service performed *Out-of-network:* 30% for each service	**Medicare-covered dental services** *In-network:* $15-$200 for each visit, depending on the service performed *Out-of-network:* 30% for each service
	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:* 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

Benefits and what you should know	**Priority**Medicare Merit (PPO)	**Priority**Medicare (HMO-POS)	**Priority**Medicare Select (PPO)
Vision services *(continued)*	**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% per stay **Outpatient therapy (individual or group)** *In-network:* $20 for each visit *Out-of-network:* 30% for each visit	**Inpatient visit** *In-network:* Days 1-6: $225 each day Days 7 and beyond: $0 each day *Out-of-network:* 30% per stay **Outpatient therapy (individual or group)** *In-network:* $20 for each visit *Out-of-network:* 30% for each visit	**Inpatient visit** *In-network:* Days 1-6: $200 each day Days 7 and beyond: $0 each day *Out-of-network:* 30% per 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	*In-network:* Days 1-20: $0 each day Days 21-100: $188 each day *Out-of-network:* 30% for each stay	*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
Ambulance Prior authorization may be required.	*In- and out-of-network:* $270 each way	*In- and out-of-network:* $210 each way	*In- and out-of-network:* $215 each way

Benefits and what you should know	**Priority**Medicare Merit (PPO)	**Priority**Medicare (HMO-POS)	**Priority**Medicare Select (PPO)
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- and out-of-network:* 20% for each drug **Other Part B drugs** *In- and out-of-network:* 20% for each drug **Select home infusion drugs:** *In- 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 $4,660, 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.		

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	$0	$1	$2	$0	$1	$2	$0
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
Covered Insulin (defined by Medicare)	Up to $35	Up to $70	Up to $105	Up to $35	Up to $70	Up to $105	Up to $35	Up to $70	Up to $105
Vaccines (defined by Medicare)	$0 for certain vaccines regardless of the drug tier the vaccine is in.								

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, Dollar General and Dollar Tree). 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
Covered Insulin (defined by Medicare)	Up to $35	Up to $70	Up to $105	Up to $35	Up to $70	Up to $105	Up to $35	Up to $70	Up to $105
Vaccines (defined by Medicare)	$0 for certain vaccines regardless of the drug tier the vaccine is in.								

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
Covered Insulin (defined by Medicare)	Up to $35	Up to $70	Up to $105	Up to $35	Up to $70	Up to $105	Up to $35	Up to $70	Up to $105

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 $4,660 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 During the Coverage Gap stage, your out-of-pocket cost for covered insulins (defined by Medicare) will be the same as what you pay in the initial coverage stage whether you fill your prescription at a preferred or standard pharmacy. When your out-of-pocket drug costs reach $7,400, this is the end of the coverage gap stage.		
Catastrophic coverage stage	Once your out-of-pocket drug costs reach $7,400 you will pay the larger amount, which is either: • 5% of the drug, or • $4.15 for generics and • $10.35 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 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 $38.00 per month. You must keep paying your Medicare Part B premium and your $61-$119 monthly plan premium.	Additional $38.00 per month. You must keep paying your Medicare Part B premium and your $61-$115 monthly plan premium.	Additional $38.00 per month. You must keep paying your Medicare Part B premium and your $147-$223 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 for fillings, including composite resin and amalgam, once per tooth, every 24 months, crown repair once per tooth every 12 months and one fluoride treatment per year $0 for emergency treatment for dental pain and anesthesia- no limit 50% of the cost of onlays, crowns and associated substructures, once per tooth, every 60 months 50% of the cost of endodontics, once per tooth every 24 months 50% of the cost of surgical extractions, once per tooth per lifetime 50% of the cost for non-surgical simple extractions, each year, once per tooth per lifetime 50% of the cost for implants & implant repairs per tooth every 5 years 50% of the cost of dentures once every 60 months, denture relines and repairs and bridge repairs, once every 36 months		
Vision services In-network vision services must be provided by an EyeMed® "Select" provider. If received by a non- EyeMed "Select" provider (out-of-network), you must seek reimbursement. In-network and out of-network benefits cannot be combined.	$150 additional eyewear allowance/reimbursement per year		

ADDITIONAL MEDICAL BENEFITS COVERED UNDER YOUR PLAN

Benefits and what you should know	**Priority**Medicare Merit (PPO)	**Priority**Medicare (HMO-POS)	**Priority**Medicare Select (PPO)
Abridge	$0 A smartphone based application that securely records medical conversations during patient appointments.* Once the recording is complete the Abridge app will transcribe the conversation and pull out any key information (prescription refills, follow up appointments, etc.). The app also allows members to share the transcripts with caregivers/family as they wish. **Medical professionals must verbally consent to being recorded.*		
Acupuncture	**Medicare-covered acupuncture for lower chronic back pain** *In- and out-of-network:* $20 per visit **Non-Medicare covered routine acupuncture for other conditions** *In- and out-of-network:* $20 per visit (limit 6 visits each 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		
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 each service *Out-of-network:* 30% for each service		
Home health services	*In- and out-of-network:* $0 for each Medicare-covered service		

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Prior authorization may be required.			
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		
Over-the-counter (OTC) items Over-the-counter items are drugs and health related products that do not need a prescription such as; allergy medication, eye drops, cough drops, nasal spray, vitamins and more.	Not covered	$25 allowance per quarter for OTC items OTC items can be purchased in participating stores (Walmart, Walgreens, CVS, Kroger and more). Or, online at *PriorityHealth.com/OTC* or by phone, or by mail using the plan's OTC catalog for home delivery.	Not covered
Podiatry services	*In-network:* $45 for each visit	*In-network:* $40 for each visit	*In-network:* $40 for each visit

Benefits and what you should know	**Priority**Medicare Merit (PPO)	**Priority**Medicare (HMO-POS)	**Priority**Medicare Select (PPO)
	$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	$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	$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
Priority Health Travel Pass	**Out-of-area travel benefit** You'll pay in-network prices when seeking care from Medicare-participating providers anywhere in the U.S. outside of the lower peninsula of Michigan. 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 prescriptions 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:* $20 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	**Cardiac, pulmonary rehabilitation services and supervised exercise therapy (SET) services** *In-network:* $15 for each service *Out-of-network:* 30% for each service
Rehabilitation services *(continued)*	**Physical therapy, occupational therapy and speech therapy services** *In-network:* $35 for each service	**Physical therapy, occupational therapy and speech therapy services** *In-network:* $35 for each service	**Physical therapy, occupational therapy and speech therapy services** *In-network:* $30 for each service

Benefits and what you should know	**Priority**Medicare Merit (PPO)	**Priority**Medicare (HMO-POS)	**Priority**Medicare Select (PPO)
	Out-of-network: 30% for each service	*Out-of-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 SilverSneaker 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, smart phone or tablet.	*In-network:* $0 virtual visits with primary care, specialist and behavioral health providers. Available 24/7, virtual visits let you see a provider for, and get treatment for, non-emergency care. *Out-of-network:* Not covered		

PREMIUMS AND BENEFITS | Monthly Premiums

Counties	**Priority**Medicare Merit (PPO)	**Priority**Medicare (HMO-POS)	**Priority**Medicare Select (PPO)
Region 1: Allegan, Barry, Kent, Lenawee, Ottawa	$61	$76	$157
Region 2: Berrien, Calhoun, Cass, Ionia, Isabella, Kalamazoo, Mason, Midland, Missaukee, Montcalm, Muskegon, Newaygo, Oceana, Osceola, Otsego, St. Clair, Van Buren, Wexford	$74	$81	$147
Region 3: Alcona, Antrim, Benzie, Charlevoix, Clare, Crawford, Grand Traverse, Hillsdale, Lake, Lapeer, Leelanau, Manistee, Mecosta, Monroe	$105	$115	$206
Region 4: Alpena, Cheboygan, Eaton, Emmet, Gladwin, Gratiot, Iosco, Jackson, Kalkaska, Montmorency, Oscoda, Presque Isle, Roscommon, Sanilac, Shiawassee, St. Joseph	$119	$105	$223
Region 5: Arenac, Bay, Branch, Clinton, Genesee, Huron, Ingham, Livingston, Macomb, Oakland, Ogemaw, Saginaw, Tuscola, Washtenaw, Wayne	$96	$61	$212

Pre-enrollment checklist

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

If you have any questions, you can call and speak to a Medicare expert at **888.481.2090** from 8 a.m. to 8 p.m. (TTY 711).

Understanding the benefits

- The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit ***prioritymedicare.com*** or call 888.481.2090 to view a copy of the EOC.
- Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- Review the formulary to make sure your drugs are covered.

Understanding important rules

- In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- Benefits, premiums and/or copayments/co-insurance may change on January 1, 2024.
- 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 must agree to treat you. Except in an emergency or urgent situations, non-contracted providers may deny care. In addition, you may pay a higher copay for services received by non-contracted providers.

Priority Health'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.