

2027 Medicare Advantage Comparison

HAP Medicare Superior (HMO) H2354-028 vs. Priority Latitude (HMO-POS) H2320-034 - Region 4

Medical benefit	HAP Medicare Superior (HMO) H2354-028	Priority Latitude (HMO-POS) H2320-034 - Region 4
Monthly premium / Part B	\$0 separate monthly plan premium. Continue Part B premium.	\$0 monthly plan premium. Continue Part B premium.
Plan type / network	HMO. In-network benefits shown; routine out-of-network care generally not covered except as specified for emergency/urgent care.	HMO-POS. In-network costs shown. Out-of-network generally 50% of total cost; providers are not required to accept the plan except emergency/urgent care.
Medical deductible	\$0 medical deductible.	\$600 in-network / \$2,000 out-of-network. In-network deductible applies to hospital/medical services, but NOT PCP, specialist, outpatient mental health, PT/OT/ST, labs/tests, ER, urgent care, observation, ambulance, DME and several other listed services.
Medical MOOP	\$5,800 in-network.	\$9,850 in-network (Part D excluded).
Inpatient hospital	\$375/day days 1-6; \$0 days 7-90; unlimited days.	\$400/day, days 1-6; \$0 additional hospital days. Subject to in-network medical deductible.
Outpatient hospital	Surgical \$375/visit; non-surgical \$150/visit.	\$400 per outpatient hospital visit; \$40 wound care. Outpatient hospital visit is subject to medical deductible.
Ambulatory surgery center	\$325/visit.	\$400 per ASC visit. Subject to medical deductible.
Primary care	\$0/visit.	\$0 office visit/simple office surgery; \$400 moderate/major office surgery.
Specialist	\$40/visit.	\$40 office visit; \$0 palliative care/simple office surgery; \$400 moderate/major office surgery.
Emergency room	\$130 worldwide; waived if admitted.	\$115 in/out of network; waived if admitted inpatient within 24 hours.
Urgent care	\$50 worldwide.	\$40 in/out of network; waived if admitted inpatient within 24 hours.
CT/MRI / diagnostic imaging	Other outpatient diagnostic tests \$200; CT/MRI/PET/nuclear medicine \$275; routine X-rays \$35; therapeutic radiation/chemotherapy \$60.	Diagnostic nuclear medicine \$640/day/provider; other diagnostic radiology \$225/day/provider; diagnostic tests/procedures \$10/day/provider; outpatient X-ray \$35/day/provider; radiation therapy \$25/day/provider.
Lab services	\$0 laboratory tests.	\$0 anticoagulant labs; \$50 genetic testing; \$10 all other Medicare-covered labs.
Skilled nursing facility	\$0/day days 1-20; \$221/day days 21-100.	\$0/day days 1-20; \$218/day days 21-100.
Ambulance	\$300/trip.	\$270 each way, in and out of network.
PT / OT / speech	PT/OT/ST \$40/visit.	PT/OT/ST: \$25 per service in-network.

Front: medical benefits. Amounts are 2027 in-network member cost sharing unless otherwise stated. Prior authorization may apply.

2027 Prescription Drugs & Extra Benefits

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Benefit	HAP Medicare Superior (HMO) H2354-028	Priority Latitude (HMO-POS) H2320-034 - Region 4
Part D deductible	\$200 Tiers 3-5.	\$0 Tiers 1-2; \$300 Tiers 3-5.
Part D - 30/31 day	Preferred retail: T1 \$0; T2 \$8; T3 20%; T4 48%; T5 31%. Standard retail: T1 \$7; T2 \$14; T3 22%; T4 50%; T5 31%.	Preferred retail, 30-day: T1 \$2; T2 \$8; T3 22%; T4 25%; T5 30%. Standard retail: T1 \$7; T2 \$15; T3 25%; T4 30%; T5 30%.
Part D - extended supply	Preferred retail 3-month: T1 \$0; T2 \$24; T3 20%; T4 48%. Preferred mail 3-month: T1 \$0; T2 \$0; T3 20%; T4 48%. T5 30-day only.	Preferred retail: T1 \$0 / 100-day; T2 \$24 / 90-day; T3 22%; T4 25%. Preferred mail: T1 \$0 / 100-day; T2 \$0 / 90-day; T3 22%; T4 25%. T5 limited to 30-day.
Dental	Delta Dental PPO: \$0 for 2 exams, 2 cleanings/periodontal cleanings, 2 fluoride, brush biopsy, 1 bitewing set/year; 50% simple extractions/oral surgery/root canals/fillings; 75% onlays/crowns/crown repairs. \$1,500 annual max. Optional dental \$38.90/mo adds up to \$2,000 max.	Included additional dental: \$0 for 2 cleanings, 2 exams, bitewings, brush biopsy, periapical X-rays as needed, full-mouth/panoramic X-rays every 24 months, and 1 fluoride treatment/year. Medicare-covered dental: \$0-\$400 depending service. Optional Dental/Vision: \$42/mo (Option 1, \$1,500 dental max) or \$61/mo (Option 2, \$2,000 dental max), plus \$150 eyewear.
Vision	EyeMed: \$0 routine exam yearly; \$150 annual contacts/eyeglasses allowance; 20% discount over allowance. Medicare-covered PCP eye exam \$0; specialist \$40.	Routine EyeMed Select exam \$0 yearly + retinal imaging \$0 yearly; \$100 annual eyewear allowance. Medicare-covered eye specialist visit \$40.
Hearing	NationsHearing: \$0 routine exam yearly; up to 2 hearing aids/year at \$0-\$1,575 each. Medicare-covered PCP exam \$0; specialist \$40.	Routine hearing exam \$0 yearly; TruHearing aids \$399-\$899 per ear each year depending level. Medicare-covered diagnostic hearing exam \$0-\$40.
OTC / Flex	Flex Card: \$30/quarter for dental, vision, hearing and OTC; no rollover.	OTC Plus \$33 every 3 months; no rollover. Eligible SSBCI members may also use allowance for healthy food/produce.
Fitness	One Pass \$0.	One Pass \$0 in-network; gym/fitness network, digital classes, brain training and one home fitness kit/year.
Travel / away from home	Worldwide emergency and urgent care as stated in plan benefits.	In-network prices with Medicare-participating providers anywhere in U.S. outside Lower Peninsula of Michigan; unlimited worldwide emergency/urgent coverage.

Source: 2027 carrier Summary of Benefits documents supplied for this project. Drug costs shown are plan-level cost sharing; formulary status, utilization management, pharmacy network and LIS/Extra Help can change the member's actual cost. Verify provider, pharmacy and drug participation for the individual beneficiary.