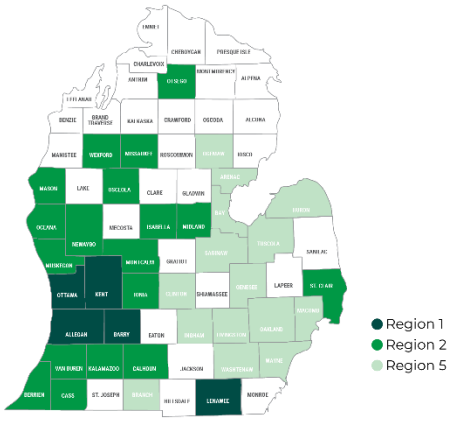
PriorityMedicare® Edge (PPO)
Regions 1, 2 and 5

- ✓ $0 monthly premium
- ✓ $0 copay for primary care provider (PCP) office visits
- ✓ $55/Q OTC allowance
- ✓ Unlimited caregiver support



Agent:

Phone: Email:

Benefit (in-network)	2026
Annual out-of-pocket maximum	$6,000 (combined INN/OON)
Medical deductible	$275 (combined INN/OON)
Services ahead of medical deductible	
Primary care provider	$0 copay
Specialist	$35 copay
PT/OT/ST	$40 copay
Outpatient diagnostic services	$0 copay for anticoagulant lab services
	$0 copay for all other lab services
	$0 copay for diagnostic procedures/tests
Ambulance and ambulance stabilization	$275 copay
Worldwide emergency care / urgently needed services	$130 copay / $50 copay
Observation	$130 copay for each observation visit, including all services received
Services after medical deductible	
Inpatient hospital	$350 copay per day, days 1–7
X-rays	$20 copay
Diagnostic radiology/imaging	$270 copay
Outpatient hospital coverage (ambulatory surgical center or outpatient hospital facility visit)	$350 copay

Benefit (in-network)	2026
Dental services (Delta Dental®)	$0 copay for two exams, two cleanings (regular or periodontal maintenance), one set of bitewing X-rays and one brush biopsy per year and other X-rays (e.g. panoramic) once every two years.
Routine vision (EyeMed®)	$0 copay for one routine exam (including refraction) and one retinal imaging, per year; $100 eyewear allowance each year. Reimbursement options for out-of-network services.
Routine hearing (TruHearing®)	$0 copay for one routine exam per year; four levels of hearing aid copays, ranging from $295 to $1,495 per ear, per year. Hearing aid cost includes all fittings and follow-up evaluations within the first year and 80 batteries per hearing aid.

Part D prescription drugs benefit overview

PriorityMedicare Edge has a $200 (tiers 3-5 only) prescription drug deductible.
Amounts shown are for the initial coverage period (until drug costs reach $2,100).

	Preferred pharmacy[1]		Preferred Mail Order[1]	
	30-day supply	100-day supply	30-day supply	100-day supply
Tier 1 (Preferred generic)	$2	$0	$2	$0
	30-day supply	90-day supply	30-day supply	90-day supply
Tier 2 (Generic)	$8	$24	$8	$0
Tier 3* (Preferred brand)	22%	22%	22%	22%
Tier 4* (Non-preferred)	25%	25%	25%	25%
Tier 5* (Specialty)	30%	N/A	30%	N/A
*Select insulin drugs	Up to $35 for each 30-day supply and up to $105 per 90-day supply			

[1]Priority Health's Medicare network includes limited lower-cost, preferred pharmacies across the United States. 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*.

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