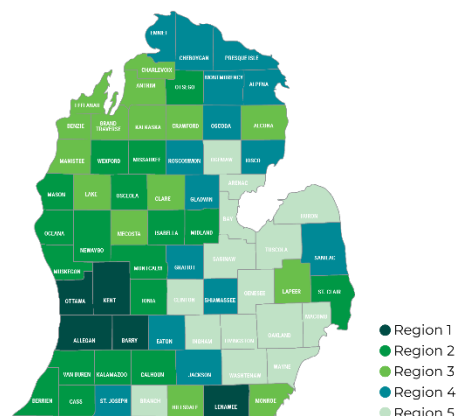


PriorityMedicare® Value (HMO-POS)

All regions

- ✓ \$32 to \$80 monthly premium, depending on region
- ✓ \$0 copay for primary care provider (PCP) office visits
- ✓ \$100 Rx deductible (tiers 3-5 only)
- ✓ \$2,500 embedded comprehensive dental



Agent:

Email:

Phone:

Benefit (in-network)	2026
Annual out-of-pocket maximum	\$5,100
Medical deductible	\$0
Primary care provider	\$0 copay
Specialist	\$35 copay
PT/OT/ST	\$15 copay
Outpatient diagnostic services	\$0 copay for anticoagulant lab services
	\$10 copay for all other lab services
	\$10 copay for diagnostic procedures/tests
Ambulance and ambulance stabilization	\$265 copay
Worldwide emergency care / urgently needed services	\$130 copay / \$50 copay
Observation	\$130 copay for each observation visit, including all services received
Inpatient hospital	\$325 copay per day, days 1–7
X-rays	\$35 copay
Diagnostic radiology/imaging	\$225 copay
Outpatient hospital coverage (ambulatory surgical center or outpatient hospital facility visit)	\$325 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.
	\$0 copay for fillings, crown repairs and simple (non-surgical) extractions and 50% of the total cost for root canals up to \$2,500 per year
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

Priority Medicare Value has a \$100 (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)	\$10	\$30	\$10	\$0
Tier 3* (Preferred brand)	22%	22%	22%	22%
Tier 4* (Non-preferred)	35%	35%	35%	35%
Tier 5* (Specialty)	31%	N/A	31%	N/A
*Select insulin drugs	Up to \$35 for each 30-day supply and up to \$105 per 90-day supply			

¹Priority 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.