Priority Health



Summary of Benefits + Enrollment Form

MAPD PLANS

PriorityMedicare® Edge (PPO)
PriorityMedicare® Merit (PPO)
PriorityMedicare® Align (HMO-POS)
PriorityMedicare® Key (HMO-POS)
PriorityMedicare® Latitude (HMO-POS)
PriorityMedicare® (HMO-POS)
PriorityMedicare® Smart Savings (HMO-POS)
PriorityMedicare® Value (HMO-POS)

Jan. 1, 2027–Dec. 31, 2027

Priority Health offers two kinds of Medicare plans: HMO-POS and PPO.

Whether you're considering an HMO-POS or PPO plan, you'll find information to help you decide on the right Medicare plan.

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.

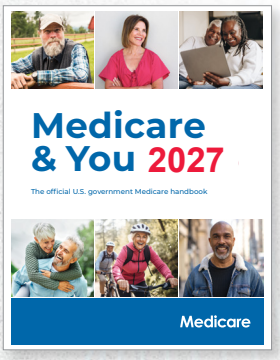
To confirm that your doctor, clinic or health center is part of the Priority Health Medicare network of providers, go to ***priorityhealth.com/provider-directory***.

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.

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 Care number.



Get a free copy of the *2027 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 888.309.5084.

Priority Health

Medicare enrollment form

MAPD Plans

Thank you for choosing a Medicare plan from Priority Health.

Please follow these helpful tips to avoid delays in processing your enrollment.

To enroll online visit ***prioritymedicare.com***. The Provider/Pharmacy Directory, Evidence of Coverage and Formulary are also available here.

Who can use this form?
People with Medicare who want to join a Medicare Advantage Plan.

To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

Important: To join a Medicare Advantage Plan, you must also have both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

When do I use this form?
You can join a plan:

- Between October 15–December 7 each year (for coverage starting January 1)
- Reminder: If you want to join a plan during fall open enrollment (October 15–December 7), the plan must get your completed form by December 7.
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans, known as a Special Enrollment Period (SEP).

Visit ***medicare.gov*** to learn more about when you can sign up for a plan.

Enrollment Form checklist

- ☐ Choose an enrollment eligibility selection that applies to you on the third page.
- ☐ Check the appropriate box for the plan you wish to join.
- ☐ Choose a primary care provider (PCP), if applicable. To confirm that your doctor, clinic or health center is part of the Priority Health Medicare network of providers, go to ***priorityhealth.com/provider-directory*** or call our Medicare Experts at the phone number listed on the second page.
- ☐ Complete your Medicare Insurance information from your Medicare red, white and blue card or attach a photocopy of your Medicare card as proof that you have Medicare Parts A and B coverage.
- ☐ Choose how you would like to pay your premium and check the appropriate box. There are two options available for paying your plan premium. You can choose to receive a monthly bill and pay by mail or automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) check.
- ☐ Sign and date the form.

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Mail your completed enrollment form in the enclosed postage-paid envelope. Or, if you do not have a postage-paid envelope, you can send your completed enrollment form to Priority Health, MS 1175, 1231 E. Beltline, Grand Rapids, MI 49525. You may also scan the completed form and email it to ***PH-MedicareEnrollment@priorityhealth.com***.

If you have any questions or you would prefer that we send you information in another format, such as large print or Braille, call our Medicare experts toll-free at 888.309.5084, from 8 a.m.–8 p.m., seven days a week. TTY users should call 711.

Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

En español: Llame a Priority Health at 888.309.5084. TTY 711 o a Medicare gratis al 1-800-633-4227 y oprima el 8 para asistencia en español y un representante estará disponible para asistirle.

For individuals experiencing homelessness, if you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., social security checks) may be considered your permanent residence address.

Medicare Enrollment Request Form

Attestation of Eligibility for an Enrollment Period

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year.

There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box for the statement that applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

Choose one of the following:

☐ I am new to Medicare (example: recently enrolled in Medicare Parts A and B).

☐ I had Medicare prior to now, but I am now turning 65.

☐ I am electing to enroll during the annual enrollment period (Oct. 15 through Dec. 7).

☐ I am enrolled in a Medicare Advantage plan and want to make a one-time change during the Medicare Advantage Open Enrollment Period (MA OEP).

☐ I am leaving or recently lost employer or union coverage on (insert date) (MM/DD/YYYY)____/_____/_____ (example: retiring and losing coverage through an employer).

☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost or will lose this drug coverage on (insert date)____/_____/_____.

☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date) ____/_____/_____.

☐ I recently had a change in my Medicaid coverage on (insert date) ____/_____/_____ (example: new to Medicaid, had a change in level of Medicaid assistance, or lost Medicaid).

☐ I recently had a change in my extra help paying for Medicare prescription drug coverage on (insert date) ____/_____/_____ (example: new to extra help, had a change in the level of extra help, or lost extra help).

☐ I belong to a pharmacy assistance program provided by my state.

☐ I was enrolled in a Special Needs Plan (SNP) but I recently lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date)____/_____/_____.

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☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.

☐ I recently left a PACE program on (insert date) ____/_____/_____.

☐ I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date) ____/_____/_____.

☐ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long-term care facility). I moved/will move into/out of the facility on (insert date) ____/_____/_____.

☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) ____/_____/_____.

☐ I recently obtained lawful presence status in the United States. I received this status on (insert date)____/_____/_____.

☐ I recently was released from incarceration. I was released on (insert date) ____/_____/_____.

☐ I was affected by an emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA) or by a Federal, state, or local government entity. One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster.

If none of these statements apply to you or you're not sure, please contact Priority Health Medicare to see if you are eligible to enroll. Call toll-free 888.309.5084 (TTY users should call 711), 8 a.m.–8 p.m., seven days a week.

To enroll in Priority Health Medicare, please provide the following information

Check which plan you want to enroll in:

Legacy Regions

Plan name	☐ **Priority**Medicare **(HMO-POS)**	☐ **Priority**Medicare **Smart Savings (HMO-POS)**	☐ **Priority**Medicare **Value (HMO-POS)**	☐ **Priority**Medicare **Merit (PPO)**
Region 1	$98 per month	$0 per month	$47 per month	$100 per month
Region 2	$103 per month	$0 per month	$75 per month	$119 per month
Region 3	$148 per month	***Priority****Medicare Smart Savings is not available in these regions*	$111 per month	$156 per month
Region 4	$131 per month		$80 per month	$163 per month
Region 5	$97 per month	$0 per month	$74 per month	$141 per month

Region 1: Allegan, Barry, Kent, Lenawee, Ottawa

Region 2: Berrien, Calhoun, Cass, Ionia, Isabella, Kalamazoo, Mason, Midland, Missaukee, Montcalm, Muskegon, Newaygo, Oceana, Osceola, Otsego, St. Clair, Van Buren, Wexford

Region 3: Alcona, Antrim, Benzie, Charlevoix, Clare, Crawford, Grand Traverse, Hillsdale, Lake, Lapeer, Leelanau, Manistee, Mecosta, Monroe

Region 4: Alpena, Cheboygan, Eaton, Emmet, Gladwin, Gratiot, Iosco, Jackson, Kalkaska, Montmorency, Oscoda, Presque Isle, Roscommon, Sanilac, Shiawassee, St. Joseph

Region 5: Arenac, Bay, Branch, Clinton, Genesee, Huron, Ingham, Livingston, Macomb, Oakland, Ogemaw, Saginaw, Tuscola, Washtenaw, Wayne

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To enroll in Priority Health Medicare, please provide the following information

Check which plan you want to enroll in:

Geographic Regions

Plan name	☐ **Priority**Medicare **Key (HMO-POS)**	☐ **Priority**Medicare **Align (HMO-POS)**	☐ **Priority**Medicare **Latitude (HMO-POS)**	☐ **Priority**Medicare **Edge (PPO)**
Region 1	$0 per month	$6.28 per month	***Priority****Medicare Latitude is not available in these regions*	$0 per month
Region 2	$0 per month	$6.28 per month		$0 per month
Region 3	***Priority****Medicare Key is not available in these regions*	***Priority****Medicare Align is not available in these regions*	$0 per month	***Priority****Medicare Edge is not available in these regions*
Region 4			$0 per month	
Region 5	$0 per month	$6.28 per month	***Priority****Medicare Latitude is not available in this region*	$0 per month

Region 1: Allegan, Barry, Ionia, Kent, Montcalm, Muskegon, Ottawa

Region 2: Berrien, Branch, Calhoun, Cass, Clinton, Eaton, Gratiot, Hillsdale, Ingham, Jackson, Kalamazoo, St. Joseph, Van Buren

Region 3: Antrim, Benzie, Charlevoix, Clare, Emmet, Grand Traverse, Isabella, Kalkaska, Lake Leelanau, Manistee, Mecosta, Midland, Missaukee, Newaygo, Oceana, Osceola, Wexford

Region 4: Alcona, Alpena, Arenac, Bay, Cheboygan, Crawford, Gladwin, Huron, Iosco, Montmorency, Ogemaw, Oscoda, Otsego, Presque Isle, Roscommon, Sanilac, Tuscola

Region 5: Genesee, Lapeer, Lenawee, Livingston, Macomb, Monroe, Oakland, Saginaw, St. Clair, Shiawassee, Washtenaw, Wayne

Optional coverage

Do you want to enroll in, or continue your current enrollment in either **Enhanced Dental and Vision package**?
If you are already enrolled in an Enhanced Dental and Vision package, you will automatically be moved into option 1. Would you like to continue your current enrollment? If you are not already enrolled, do you wish to enroll in option 1 or option 2? ☐ Option 1 ($42 additional monthly premium) ☐ Option 2 ($61 additional monthly premium) ☐ Decline

These packages are offered in addition to the standard dental and vision benefit that's included in our plans. You're not required to enroll in an Enhanced Dental and Vision package. You may also choose to add this coverage anytime within two months from your Priority Health Medicare Advantage plan effective date.

Last name	First name	M.I. (optional)

Birth date ____/____/_____ MM DD YYYY	Sex ☐ M ☐ F	Phone number that we may use to contact you: ( ) ☐ Landline (home phone) ☐ Mobile phone	Alternate number that we may use to contact you (optional): ( ) ☐ Landline (home phone) ☐ Mobile phone

Permanent residence street address (P.O. Box is not allowed unless you're an individual experiencing homelessness)

City	County	State	ZIP code

Mailing street address (only if different from your permanent residence address)

City	County	State	ZIP code

Email address (optional)	Check the box below to opt-in to receiving certain plan documents by email. ☐ Annual Notice of Change document

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Priority Health Medicare? ☐ Yes ☐ No

Name of other coverage	Member number for this coverage	Group number for this coverage

Medicare insurance information

Please take out your red, white and blue Medicare card to complete this section.

Fill out this information as it appears on your Medicare card.
– OR –
Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Name (as it appears on your Medicare card):

Medicare Number: _____

Is entitled to: Effective date:

HOSPITAL (Part A) ____/____/____

MEDICAL (Part B) ____/____/____

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

Additional questions

Answering these questions is your choice.
You can't be denied coverage because you don't fill them out.

List your Primary Care Physician (PCP):

First name of PCP	Last name of PCP

Do you work? ☐ Yes ☐ No Does your spouse (if applicable) work? ☐ Yes ☐ No

Please check one of the boxes below if you would prefer that we send you information in a language other than English or an accessible format: ☐ Spanish ☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD

Please contact Priority Health at 888.389.6648 (TTY 711) if you need information in an accessible format other than what's listed above. From Oct. 1–Mar. 31, we're available seven days a week from 8 a.m.–8 p.m. ET. From Apr. 1–Sept. 30, we're available Mon.–Fri. from 8 a.m.–8 p.m. and Sat. 8 a.m.–noon ET. You can also log into your member account at ***priorityhealth.com*** to send us a message.

Paying your plan premium

You can pay your monthly plan premium, if there is one, (including any late enrollment penalty that you may have or may owe) by mail each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month.

If you are assessed a Part D-Income Related Monthly Adjustment Amount (D-IRMAA), you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security or Railroad Retirement Board benefit check or be billed directly by Medicare or RRB. Do NOT pay Priority Health the Part D-IRMAA.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. For more information about this extra help, contact your local Social Security office, or call Social Security at 800.772.1213. TTY users should call 800.325.0778. You can also apply for extra help online at ***socialsecurity.gov/prescriptionhelp***. If you don't select a payment option, you will get a bill each month.

Please choose one premium payment option:

☐ **Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check.**
I receive monthly benefits from: ☐ Social Security ☐ RRB

The Social Security/RRB deduction will begin once Social Security or RRB approves the deduction. Depending on when this is approved, you may receive a mailed invoice. In most cases, when Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from the deduction date listed above. If Social Security or RRB does not approve your request for Social Security deduction, we'll send you a monthly invoice for your monthly premiums. Should you disenroll from this plan, Social Security will refund your premium in your benefit check.

☐ **Get a bill monthly and pay the plan directly by mail or phone.**

STOP! Please read this important information

If you currently have health coverage from an employer or union, joining Priority Health Medicare could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Priority Health Medicare. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Please read and sign below

By completing this enrollment application, I agree to the following:

- Priority Health Medicare plans are Medicare Advantage plans and have a contract with the federal government. I will need to keep my Medicare Parts A and B. I can be in only one Medicare Advantage plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare Advantage health plan or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. Enrollment in this plan is generally for the entire calendar year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (Example: Oct. 15 - Dec. 7 of every year) or under certain special circumstances.

- Priority Health Medicare serves a specific service area. If I move out of the area that Priority Health Medicare serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of Priority Health Medicare, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Priority Health Medicare when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that Priority Health Medicare provides coverage for me in the United States and around the world for emergency and urgent care.

- I understand that if Priority Health has not received my plan premium by the first of the month, they will send a notice letting me know that my membership in the Medicare Advantage plan and/or Enhanced Dental and Vision package (if applicable), may end if they do not receive my premium payment in full, within 90 calendar days.

- For **Priority**Medicare Align, **Priority**Medicare Edge, **Priority**Medicare Key, **Priority**Medicare Latitude, **Priority**Medicare, **Priority**Medicare Merit, **Priority**Medicare Smart Savings and **Priority**Medicare Value plan enrollees: I understand that when my Priority Health Medicare coverage begins, I must get all of my medical and prescription drug benefits from Priority Health. Benefits and services provided by Priority Health and contained in my Priority Health "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Priority Health will pay for benefits or services that are not covered.

- **For Optional Enhanced Dental and Vision package enrollees**, I understand that the dental and vision services included in these packages are offered through vendors contracted with Priority Health Medicare. Benefit/coverage details, the amount you pay when using participating and non-participating providers, limits/exclusions, etc. can be found in the Evidence of Coverage or Certificate of Coverage document. The dental benefit is offered through Delta Dental. In-network benefits apply to services provided by a Delta Dental Medicare Advantage PPO or Medicare Advantage Premier participating dentist, in Michigan, Ohio or Indiana. All other dentists are considered out-of-network (nonparticipating) dentists. If the Dentist you select is not a Delta Dental Medicare Advantage Participating Dentist, you will still be covered, but you may have to pay more. The vision benefit is offered through EyeMed. In-network benefits apply to services provided by an EyeMed 'Select' network participating provider. Services provided by non-participating EyeMed Select providers are reimbursable up to a set dollar amount. Enrollment in this plan is generally for the entire calendar year. Although, I may leave this plan at any time. Please contact us or refer to your EOC (Chapter 4, Section 2.2) for instructions on how to disenroll.

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- I understand that if I am getting assistance from a sales agent, broker or other individual employed by or contracted with Priority Health Medicare, he/she may be paid based on my enrollment in Priority Health Medicare.

- **Release of Information:** By joining this Medicare health plan, I acknowledge that Priority Health Medicare will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Priority Health Medicare will release my information including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

- I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the state where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that 1) this person is authorized under state law to complete this enrollment and 2) documentation of this authority is available upon request from Medicare.

Signature	Today's date __ __ / __ __ / __ __ __ __

A paper form can only be accepted with a handwritten signature. Electronic, digital or typed signatures are not permitted per the Centers for Medicare and Medicaid services.

If you are the authorized representative, sign above and complete the following fields:		
Last name	First name	
Street address		
City	State	ZIP code
Phone number (XXX) XXX-XXXX	**Relationship to Enrollee:** ☐ Power of attorney ☐ Guardian ☐ Conservator	

To help keep our records up-to-date and/or if additional actions need to take place on behalf of the member once enrolled, you may provide documentation to help verify legal guardianship agreements by either scan and email or mail legal documents to: Priority Health, MS 1115, 1231 E. Beltline Ave NE, Grand Rapids, MI 49525. You may also create a member account and send the documentation via secure message.

Privacy Act Statement
The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

Important
Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See the "Enrollment form checklist" on the first and second pages to send your completed form to the plan.

PRA Disclosure Statement
According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this collection is 0938-1378. The time required to complete this information collection is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, and gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

OMB No. 0938-1378 Expires: 02/28/2029

For individuals and agents helping enrollee with completing this form only:	
Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form.	
Name	Relationship to enrollee
Signature	Date MM/DD/YYYY

Agent information	
Referring agent number	Referring agent National Producer Number
Field Market Organization (FMO) name (if applicable)	
Agent received application on:	FMO received application on (if applicable):
Scope of Appointment completed: ☐ Yes (Date completed: _____/_____/_____) ☐ No (Reason: _____)	

Priority Health has HMO-POS and PPO plans with a Medicare contract. Enrollment in Priority Health Medicare depends on contract renewal. Y0056_100010702700_C ©2026 Priority Health MR296 PH38285-3.1 07/26

Premiums, Deductibles, and Limits

	Priority Medicare Edge (PPO)	**Priority** Medicare Key (HMO-POS)	**Priority** Medicare Latitude (HMO-POS)	**Priority** Medicare Smart Savings (HMO-POS)
Monthly Plan Premium	$0 per month. In addition, you must keep paying your Medicare Part B premium.			$0 per month. In addition, you must keep paying your Medicare Part B premium but will receive the following Part B premium reduction each year. Region 1: $1,164 ($97 per month) Region 2: $1,140 ($95 per month) Region 5: $1,392 ($116 per month) Please see monthly premium section for your region.
Deductible The amount you'll pay for most covered services before you start paying only copays or coinsurance and Priority Health Medicare pays the balance.	**Medical services** *In-network* (combined): Region 1: $405 Region 2: $420 Region 5: $420	**Medical services** *In-network*: Region 1: $370 Region 2: $375 Region 5: $375 Please see monthly premium section for your region.	**Medical services** *In-network*: $600	**Medical services** *In-network*: $650

	Priority Medicare Edge (PPO)	**Priority** Medicare Key (HMO-POS)	**Priority** Medicare Latitude (HMO-POS)	**Priority** Medicare Smart Savings (HMO-POS)
Deductible (continued)	*Out-of-network* (combined): Region 1: $405 Region 2: $420 Region 5: $420 Please see monthly premium section for your region. **Prescription drugs (Part D):** Tiers 1-2: $0 Tiers 3-5: $300	*Out-of-network*: $1,500 **Prescription drugs (Part D):** Tiers 1-2: $0 Tiers 3-5: $300	*Out-of-network*: $2,000 **Prescription drugs (Part D):** Tiers 1-2: $0 Tiers 3-5: $300	*Out-of-network*: $2,000 **Prescription drugs (Part D):** Tiers 1-2: $0 Tiers 3-5: $700
	In-network medical deductible applies to hospital and medical services, except for, primary care visits, specialty provider visits, outpatient mental health, psychiatric services, substance abuse and opioid treatment program services, partial hospitalization, home health services, acupuncture, chiropractic services, physical therapy, occupational therapy, speech therapy, podiatry, outpatient tests and labs, emergency care, urgently needed services, observation, ambulance, durable medical equipment, prosthetic devices, medical supplies, diabetic supplies, diabetic therapeutic shoes/inserts, kidney disease education services, preventive services, Part B insulin furnished through an item of durable medical equipment, cardiac rehabilitation, pulmonary rehabilitation and supervised exercise therapy. *Out-of-network* medical deductible applies to hospital and medical services except for acupuncture, immunizations, and insulin furnished through an item of durable medical equipment.			
Maximum Out-of-Pocket Amount This is the most you pay for covered medical services for the year, excluding Part D prescription drugs.	*In- and out-of-network* (combined): $7,100	*In-network*: $6,950	*In-network*: $9,850	*In-network*: $9,850

Monthly Premiums

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

Counties	Priority Medicare Smart Savings (HMO-POS)
Region 1: Allegan, Barry, Kent, Lenawee, Ottawa	$0
Region 2: Berrien, Calhoun, Cass, Ionia, Isabella, Kalamazoo, Mason, Midland, Missaukee, Montcalm, Muskegon, Newaygo, Oceana, Osceola, Otsego, St. Clair, Van Buren, Wexford	$0
Region 3: Alcona, Antrim, Benzie, Charlevoix, Clare, Crawford, Grand Traverse, Hillsdale, Lake, Lapeer, Leelanau, Manistee, Mecosta, Monroe	N/A
Region 4: Alpena, Cheboygan, Eaton, Emmet, Gladwin, Gratiot, Iosco, Jackson, Kalkaska, Montmorency, Oscoda, Presque Isle, Roscommon, Sanilac, Shiawasse, St. Joseph	N/A

Counties	Priority Medicare Edge (PPO)	Priority Medicare Key (HMO-POS)	Priority Medicare Latitude (HMO-POS)
Region 5: Genessee, Lapeer, Lenawee, Livingston, Macomb, Monroe, Oakland, Saginaw, St. Clair, Shiawassee, Washtenaw, Wayne	$0	N/A	N/A

Counties	Priority Medicare Smart Savings (HMO-POS)
Region 5: Arenac, Bay, Branch, Clinton, Genesee, Huron, Ingham, Livingston, Macomb, Oakland, Ogemaw, Saginaw, Tuscola, Washtenaw, Wayne	$0

Part C Benefits

	Priority Medicare Edge (PPO)	Priority Medicare Key (HMO-POS)	Priority Medicare Latitude (HMO-POS)	Priority Medicare Smart Savings (HMO-POS)
Hospital				
Inpatient hospital coverage* We cover an unlimited number of days for an inpatient hospital stay. *Prior authorization may be required.	*In-network*: $450 copay per day for days 1 - 6 $0 copay for additional hospital days *Out-of-network*: 40% of the total cost per stay	*In-network*: $415 copay per day for days 1 - 7 $0 copay for additional hospital days *Out-of-network*: 50% of the total cost per stay	*In-network*: $400 copay per day for days 1 - 6 $0 copay for additional hospital days *Out-of-network*: 50% of the total cost per stay	*In-network*: $460 copay per day for days 1 - 5 $0 copay for additional hospital days *Out-of-network*: 50% of the total cost per stay
Outpatient hospital coverage* **Outpatient hospital**	*In-network*: $0 copay for each visit at a rural health clinic	*In-network*: $0 copay for each visit at a rural health clinic	*In-network*: $0 copay for each visit at a rural health clinic	*In-network*: $0 copay for each visit at a rural health clinic

	Priority Medicare Edge (PPO)	**Priority** Medicare Key (HMO-POS)	**Priority** Medicare Latitude (HMO-POS)	**Priority** Medicare Smart Savings (HMO-POS)
Outpatient hospital coverage* (continued)	Region 1: $40 Region 2: $50 Region 5: $45 copay for each Medicare-covered outpatient wound care services	$40 copay for each Medicare-covered outpatient wound care services	$40 copay for each Medicare-covered outpatient wound care services	$60 copay for each Medicare-covered outpatient wound care services
	$425 copay for each outpatient hospital visit	$350 copay for each outpatient hospital visit	$400 copay for each outpatient hospital visit	$450 copay for each outpatient hospital visit
	Out-of-network: 40% of the total cost for each visit	*Out-of-network*: 50% of the total cost for each visit	*Out-of-network*: 50% of the total cost for each visit	*Out-of-network*: 50% of the total cost for each visit
Observation services *Prior authorization may be required.	*In- and out-of-network*: $130 copay per stay for each visit, including all services received		*In- and out-of-network*: $115 copay per stay for each visit, including all services received	
Ambulatory surgery center* *Prior authorization may be required.	*In-network*: $425 copay for each visit	*In-network*: $350 copay for each visit	*In-network*: $400 copay for each visit	*In-network*: $450 copay for each visit
	Out-of-network: 40% of the total cost for each visit	*Out-of-network*: 50% of the total cost for each visit	*Out-of-network*: 50% of the total cost for each visit	*Out-of-network*: 50% of the total cost for each visit
Doctor Visits and Preventive Care				
Doctor visits **Primary care physician (PCP)**	*In-network*: $0 copay for each office visit and simple	*In-network*: $0 copay for each office visit and simple	*In-network*: $0 copay for each office visit and simple	*In-network*: $0 copay for each office visit and simple

	Priority Medicare Edge (PPO)	**Priority** Medicare Key (HMO-POS)	**Priority** Medicare Latitude (HMO-POS)	**Priority** Medicare Smart Savings (HMO-POS)
Doctor visits (continued)	surgical procedures done in a provider's office (i.e. mole removals/ sutures)	surgical procedures done in a provider's office (i.e. mole removals/ sutures)	surgical procedures done in a provider's office (i.e. mole removals/ sutures)	surgical procedures done in a provider's office (i.e. mole removals/ sutures)
	$425 copay for moderate to major surgical procedures done in a provider's office (i.e. carpal tunnel and trigger finger release surgery)	$350 copay for moderate to major surgical procedures done in a provider's office (i.e. carpal tunnel and trigger finger release surgery)	$400 copay for moderate to major surgical procedures done in a provider's office (i.e. carpal tunnel and trigger finger release surgery)	$450 copay for moderate to major surgical procedures done in a provider's office (i.e. carpal tunnel and trigger finger release surgery)
	Out-of-network: 40% of the total cost for each visit	*Out-of-network*: 50% of the total cost for each visit	*Out-of-network*: 50% of the total cost for each visit	*Out-of-network*: 50% of the total cost for each visit
Specialist visit* *Prior authorization may be required for some specialist visits.	*In-network*: $0 copay for palliative care physician office visits	*In-network*: $0 copay for palliative care physician office visits	*In-network*: $0 copay for palliative care physician office visits	*In-network*: $0 copay for palliative care physician office visits
	$0 copay for each office visit and simple surgical procedures done in a specialist's office (i.e. mole removals/ sutures)	$0 copay for each office visit and simple surgical procedures done in a specialist's office (i.e. mole removals/ sutures)	$0 copay for each office visit and simple surgical procedures done in a specialist's office (i.e. mole removals/ sutures)	$0 copay for each office visit and simple surgical procedures done in a specialist's office (i.e. mole removals/ sutures)

	Priority Medicare Edge (PPO)	**Priority** Medicare Key (HMO-POS)	**Priority** Medicare Latitude (HMO-POS)	**Priority** Medicare Smart Savings (HMO-POS)
Doctor visits (continued)	$425 copay for moderate to major surgical procedures done in a specialist's office (i.e. carpal tunnel and trigger finger release surgery) Region 1: $40 Region 2: $50 Region 5: $45 copay for all other specialty office visits *Out-of-network*: 40% of the total cost for each visit	$350 copay for moderate to major surgical procedures done in a specialist's office (i.e. carpal tunnel and trigger finger release surgery) $40 copay for all other specialty office visits *Out-of-network*: 50% of the total cost for each visit	$400 copay for moderate to major surgical procedures done in a specialist's office (i.e. carpal tunnel and trigger finger release surgery) $40 copay for all other specialty office visits *Out-of-network*: 50% of the total cost for each visit	$450 copay for moderate to major surgical procedures done in a specialist's office (i.e. carpal tunnel and trigger finger release surgery) $60 copay for all other specialty office visits *Out-of-network*: 50% of the total cost 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 copay for each service *Out-of-network*: 40% of the total cost for each service	*In-network*: $0 copay for each service *Out-of-network*: 50% of the total cost for each service		
	Any additional preventive services approved by Medicare during the contract year will be covered.			
Emergency and Urgent Care				
Emergency care This amount is waived if you are admitted as inpatient to the hospital within 24 hours	*In- and out-of-network*: $130 copay for each visit		*In- and out-of-network*: $115 copay for each visit	

	Priority Medicare Edge (PPO)	**Priority** Medicare Key (HMO-POS)	**Priority** Medicare Latitude (HMO-POS)	**Priority** Medicare Smart Savings (HMO-POS)
Emergency care (continued) 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*: $50 copay for each visit		*In- and out-of-network*: $40 copay for each visit	
Outpatient Diagnostic Tests, Radiation Therapy, X-rays and Labs				
Diagnostic services/labs/ imaging*	*In-network*:	*In-network*:	*In-network*:	*In-network*:
Radiology/imaging	$640 copay per day, per provider for diagnostic nuclear medicine services $270 copay per day, per provider for all other diagnostic radiology services	$640 copay per day, per provider for diagnostic nuclear medicine services $225 copay per day, per provider for all other diagnostic radiology services	$640 copay per day, per provider for diagnostic nuclear medicine services $225 copay per day, per provider for all other diagnostic radiology services	$640 copay per day, per provider for diagnostic nuclear medicine services $300 copay per day, per provider for all other diagnostic radiology services
Diagnostic tests and procedures	$0 copay per day, per provider	$20 copay per day, per provider	$10 copay per day, per provider	$35 copay per day, per provider
Lab services	$0 copay for anticoagulant lab services $50 copay for genetic testing	$0 copay for anticoagulant lab services $50 copay for genetic testing	$0 copay for anticoagulant lab services $50 copay for genetic testing	$0 copay for anticoagulant lab services $50 copay for genetic testing

	Priority Medicare Edge (PPO)	**Priority** Medicare Key (HMO-POS)	**Priority** Medicare Latitude (HMO-POS)	**Priority** Medicare Smart Savings (HMO-POS)
Diagnostic services/labs/ imaging* (continued) **Outpatient X-rays** **Radiation therapy** *Prior authorization may be required for some services.	$0 copay for all other Medicare-covered lab services $20 copay per day, per provider $40 copay per day, per provider *Out-of-network*: 40% of the total cost per day, per provider ($0 copay for anticoagulant lab services)	$20 copay for all other Medicare-covered lab services $35 copay per day, per provider $25 copay per day, per provider *Out-of-network*: 50% of the total cost per day, per provider ($0 copay for anticoagulant lab services)	$10 copay for all other Medicare-covered lab services $35 copay per day, per provider $25 copay per day, per provider *Out-of-network*: 50% of the total cost per day, per provider ($0 copay for anticoagulant lab services)	$35 copay for all other Medicare-covered lab services $45 copay per day, per provider $85 copay per day, per provider *Out-of-network*: 50% of the total cost per day, per provider ($0 copay for anticoagulant lab services)
Hearing / Dental / Vision				
Hearing services **Medicare-covered diagnostic hearing exam** Medicare-covered exam performed by a primary care physician or specialist to diagnose and treat hearing and balance issues.	*In-network*: Region 1: $0 - $40 copay Region 2: $0 - $50 copay Region 5: $0 - $45 copay for each office visit Please see monthly premium section for you region *Out-of-network*: 40% of the total	*In-network*: $0 - $40 copay for each office visit *Out-of-network*: 50% of the total cost for each visit	*In-network*: $0 - $40 copay for each office visit *Out-of-network*: 50% of the total cost for each visit	*In-network*: $0 - $60 copay for each office visit *Out-of-network*: 50% of the total cost for each visit

	Priority Medicare Edge (PPO)	**Priority** Medicare Key (HMO-POS)	**Priority** Medicare Latitude (HMO-POS)	**Priority** Medicare Smart Savings (HMO-POS)
Hearing services (continued)	cost for each visit			
Routine hearing coverage and hearing aids In-network routine hearing services must be provided by a TruHearing® provider. If received by a non-TruHearing® provider (out-of-network), you must seek reimbursement. In-network and out-of-network benefits cannot be combined	*In-network*: $0 copay for one routine hearing exam, per year $399 - $899 copay, per ear every 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.			
	Out-of-network: $0 copay for one routine hearing exam every year. 50% of the total cost cost cost per hearing aid (one per ear per year).	*Out-of-network*: Not covered		
Dental services* **Medicare-covered dental services**	*In-network*: $0 - $425 copay for each visit, depending on the service performed *Out-of-network*: 40% of the total cost for each service performed	*In-network*: $0 - $350 copay for each visit, depending on the service performed *Out-of-network*: 50% of the total cost for each service performed	*In-network*: $0 - $400 copay for each visit, depending on the service performed *Out-of-network*: 50% of the total cost for each service performed	*In-network*: $0 - $450 copay for each visit, depending on the service performed *Out-of-network*: 50% of the total cost for each service performed
Additional dental services	$0 copay for two cleanings (regular or periodontal maintenance) per year $0 copay for two exams per year			

	Priority Medicare Edge (PPO)	**Priority** Medicare Key (HMO-POS)	**Priority** Medicare Latitude (HMO-POS)	**Priority** Medicare Smart Savings (HMO-POS)
Dental services* (continued) Delta Dental® is the preferred provider for additional dental services. *Prior authorization may be required for Medicare-covered dental services.	$0 copay for one set of bitewing X-rays per year $0 copay for one brush biopsy per year $0 copay for periapical radiographs as needed $0 copay for radiographs (full-mouth or panoramic X-rays) once every 24 months $0 copay for 1 fluoride treatment every year			
Vision services **Medicare-covered 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*: Region 1: $40 Region 2: $50 Region 5: $45 copay for each visit Please see the monthly premium section for your region	*In-network*: $40 copay for each visit	*In-network*: $40 copay for each visit	*In-network*: $60 copay for each visit
	$0 copay for eyeglasses or contact lenses after cataract surgery	$0 copay for eyeglasses or contact lenses after cataract surgery	$0 copay for eyeglasses or contact lenses after cataract surgery	$0 copay for eyeglasses or contact lenses after cataract surgery
	$0 copay for a yearly glaucoma screening	$0 copay for a yearly glaucoma screening	$0 copay for a yearly glaucoma screening	$0 copay for a yearly glaucoma screening
	Out-of-network: 40% of the total cost for each visit, eyeglasses or contact lenses after cataract surgery, or for a	*Out-of-network*: 50% of the total cost for each visit, eyeglasses or contact lenses after cataract surgery, or for a yearly glaucoma screening.		

	Priority Medicare Edge (PPO)	**Priority** Medicare Key (HMO-POS)	**Priority** Medicare Latitude (HMO-POS)	**Priority** Medicare Smart Savings (HMO-POS)
Vision services (continued) **Routine Vision 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 benefits cannot be combined.	yearly glaucoma screening.			
	In-network: $0 copay for one routine exam each year (includes dilation and refraction) $0 copay for one retinal imaging per year $100 eyewear allowance per year			
	Out-of-network Up to $100 reimbursement for non-Medicare covered eyewear	*Out-of-network* Up to $100 reimbursement for eyewear		
	40% of the total cost for one non-Medicare covered routine vision exam, including dilation and refraction as necessary	Up to $50 reimbursement for one routine exam		
	40% of the total cost for one non-Medicare covered retinal imaging	Up to $20 reimbursement for retinal imaging		
Mental Health Services				
Inpatient visits* We cover up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital.	*In-network*: $350 copay per day, days 1-5 $0 copay for additional hospital days	*In-network*: $275 copay per day, days 1-6 $0 copay for additional hospital days	*In-network*: $350 copay per day, days 1-5 $0 copay for additional hospital days	*In-network*: $275 copay per day, days 1-6 $0 copay for additional hospital days

	Priority Medicare Edge (PPO)	**Priority** Medicare Key (HMO-POS)	**Priority** Medicare Latitude (HMO-POS)	**Priority** Medicare Smart Savings (HMO-POS)
Inpatient visits* (continued) *Prior authorization may be required.	*Out-of-network*: 40% of the total cost per stay	*Out-of-network*: 50% of the total cost per stay	*Out-of-network*: 50% of the total cost per stay	*Out-of-network*: 50% of the total cost per stay
Outpatient therapy (individual or group)	*In-network*: $20 copay for each visit *Out-of-network*: 40% of the total cost for each visit	*In-network*: $20 copay for each visit *Out-of-network*: 50% of the total cost for each visit		
Skilled Nursing Facility (SNF)				
Skilled nursing facility* 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*: $0 copay per day, days 1 - 20 $218 copay per day, days 21 - 100 *Out-of-network*: 40% of the total cost per stay for each stay	*In-network*: $0 copay per day, days 1 - 20 $218 copay per day, days 21 - 100 *Out-of-network*: 50% of the total cost per stay for each stay		
Outpatient Rehabilitation Services				
Physical therapy	*In-network*: $40 copay for each service *Out-of-network*: 40% of the total cost for each service	*In-network*: $25 copay for each service *Out-of-network*: 50% of the total cost for each service		*In-network*: $50 copay for each service *Out-of-network*: 50% of the total cost for each service

	Priority Medicare Edge (PPO)	**Priority** Medicare Key (HMO-POS)	**Priority** Medicare Latitude (HMO-POS)	**Priority** Medicare Smart Savings (HMO-POS)
Medical Transportation				
Ambulance* *Prior authorization may be required.	*In- and out-of-network*: $275 copay each way	*In- and out-of-network*: $270 copay each way		*In- and out-of-network*: $360 copay each way
Transportation	Not covered			
Medicare Part B Drugs*				
Chemotherapy drugs	*In- and out-of-network*: Up to 20% of the total cost for each drug			
Other Part B drugs	Up to 20% of the total cost for each drug			
Select home infusion drugs	$0 copay for each drug			
Part B insulin *Prior authorization or step therapy may be required.	Up to 20% of the total cost, with a maximum of $35 per month supply of insulin administered through an insulin pump.			

Prescription Drug Benefits

Important Message About What You Pay for Vaccines - Our plan covers most Part D vaccines at no cost to you, no matter what cost-sharing tier it's on, even if you haven't paid your deductible.

Important Message About What You Pay for Insulin - You won't pay more than $35 for a one-month supply and no more than $105 for a three-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on, even if you haven't paid your deductible.

PART D OUTPATIENT PRESCRIPTION DRUGS				
	PriorityMedicare Edge (PPO)	**Priority**Medicare Key (HMO-POS)	**Priority**Medicare Latitude (HMO-POS)	**Priority**Medicare Smart Savings (HMO-POS)
Stage 1: Deductible stage	Tier 1 - 2: $0 Tier 3 - 5: $300*	Tier 1 - 2: $0 Tier 3 - 5: $300*	Tier 1 - 2: $0 Tier 3 - 5: $300*	Tier 1 - 2: $0 Tier 3 - 5: $700*

PART D OUTPATIENT PRESCRIPTION DRUGS				
	PriorityMedicare Edge (PPO)	**Priority**Medicare Key (HMO-POS)	**Priority**Medicare Latitude (HMO-POS)	**Priority**Medicare Smart Savings (HMO-POS)
You'll pay this amount before you begin paying copays or coinsurance only.	*The deductible doesn't apply to covered insulins and most adult Part D vaccines.			
Stage 2: Initial coverage stage You are in this stage until your out-of-pocket Part D drug costs reach $2,400.	You pay what is listed in the chart below.			

STANDARD RETAIL PHARMACY								
	PriorityMedicare Edge (PPO)		**Priority**Medicare Key (HMO-POS)		**Priority**Medicare Latitude (HMO-POS)		**Priority**Medicare Smart Savings (HMO-POS)	
Standard Retail	**30-day supply**	**100-day supply**	**30-day supply**	**100-day supply**	**30-day supply**	**100-day supply**	**30-day supply**	**100-day supply**
Tier 1: Preferred generic	$7	$21	$7	$21	$7	$21	$6	$18
	30-day supply	**90-day supply**	**30-day supply**	**90-day supply**	**30-day supply**	**90-day supply**	**30-day supply**	**90-day supply**
Tier 2: Generic	$15	$45	$15	$45	$15	$45	$12	$36
Tier 3: Preferred brand	25%	25%	25%	25%	25%	25%	$47	$141
Tier 4: Non-preferred drug	30%	30%	30%	30%	30%	30%	25%	25%
Tier 5: Specialty*	30%	N/A	30%	N/A	30%	N/A	25%	N/A

PREFERRED RETAIL PHARMACY								
	PriorityMedicare Edge (PPO)		**Priority**Medicare Key (HMO-POS)		**Priority**Medicare Latitude (HMO-POS)		**Priority**Medicare Smart Savings (HMO-POS)	
Preferred Retail	**30-day supply**	**100-day supply**	**30-day supply**	**100-day supply**	**30-day supply**	**100-day supply**	**30-day supply**	**100-day supply**
Tier 1: Preferred generic	$2	$0	$2	$0	$2	$0	$1	$0
	30-day supply	**90-day supply**	**30-day supply**	**90-day supply**	**30-day supply**	**90-day supply**	**30-day supply**	**90-day supply**
Tier 2: Generic	$8	$24	$8	$24	$8	$24	$7	$21
Tier 3: Preferred brand	22%	22%	22%	22%	22%	22%	$42	$126
Tier 4: Non-preferred drug	25%	25%	25%	25%	25%	25%	25%	25%
Tier 5: Specialty*	30%	N/A	30%	N/A	30%	N/A	25%	N/A
Your costs will be less for your covered drugs when you use a pharmacy in our preferred network (includes Meijer, Walgreens, Walmart, Family Fare Supermarkets, Costco and more), go to ***prioritymedicare.com*** to view the list in the provider/pharmacy directory.								

PREFERRED MAIL ORDER								
	PriorityMedicare Edge (PPO)		**Priority**Medicare Key (HMO-POS)		**Priority**Medicare Latitude (HMO-POS)		**Priority**Medicare Smart Savings (HMO-POS)	
Preferred Mail Order	**30-day supply**	**100-day supply**	**30-day supply**	**100-day supply**	**30-day supply**	**100-day supply**	**30-day supply**	**100-day supply**
Tier 1: Preferred generic	$2	$0	$2	$0	$2	$0	$1	$0
	30-day supply	**90-day supply**	**30-day supply**	**90-day supply**	**30-day supply**	**90-day supply**	**30-day supply**	**90-day supply**
Tier 2: Generic	$8	$0	$8	$0	$8	$0	$7	$0
Tier 3: Preferred brand	22%	22%	22%	22%	22%	22%	$42	$105

PREFERRED MAIL ORDER								
	PriorityMedicare Edge (PPO)		**Priority**Medicare Key (HMO-POS)		**Priority**Medicare Latitude (HMO-POS)		**Priority**Medicare Smart Savings (HMO-POS)	
Tier 4: Non-preferred drug	25%	25%	25%	25%	25%	25%	25%	25%
Tier 5: Specialty*	30%	N/A	30%	N/A	30%	N/A	25%	N/A
Your costs will be less for your covered drugs when you use a pharmacy in our preferred network (includes Express Scripts and Amazon), go to ***prioritymedicare.com*** to view the list in the provider/ pharmacy directory. *Specialty drugs are limited to a 30-day supply.								

	PriorityMedicare Edge (PPO)	**Priority**Medicare Key (HMO-POS)	**Priority**Medicare Latitude (HMO-POS)	**Priority**Medicare Smart Savings (HMO-POS)
Catastrophic coverage stage	Once your out-of-pocket drug costs reach $2,400, the plan pays the full cost of your covered Part D 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

Additional dental coverage, including coverage for dental services and an additional vision allowance for use on eyeglasses or contacts.

	Priority Medicare Edge (PPO)	**Priority** Medicare Key (HMO-POS)	**Priority** Medicare Latitude (HMO-POS)	**Priority** Medicare Smart Savings (HMO-POS)
Premium	**Enhanced Dental and Vision** **Option 1:** $42 per month **Option 2:** $61 per month You must keep paying your Medicare Part B premium and your $0 monthly plan premium.			
Deductible	$0			

	Priority Medicare Edge (PPO)	**Priority** Medicare Key (HMO-POS)	**Priority** Medicare Latitude (HMO-POS)	**Priority** Medicare Smart Savings (HMO-POS)
Maximum plan benefit coverage amount	$1,500 - $2,000 for comprehensive dental services, depending on the option you choose and an additional $150 for eyewear, per calendar year			
Dental services Delta Dental® is the preferred provider for additional dental services.	*In- and out-of-network* **Option 1:** $0 copay for one cleaning (regular or periodontal) per plan year $0 copay for scaling and root planing once per quadrant per 24 month period $1,500 annual maximum per year to use towards: 50% of the total cost for unlimited emergency treatment and anesthesia when used in conjunction with other services 50% of the total cost for fillings (including composite resin and amalgam) once per tooth every 24 months and crown repairs once per tooth every 12 months 50% of the total cost for other diagnostic services (i.e. cone beams) 50% of the total cost for surgical periodontal procedures (i.e. osseous surgery or gum grafts) once per quadrant every 36 months 50% of the total cost of onlays, crowns, and associated substructures once per tooth every 5 years 50% of the total cost of endodontics (root canals) once per tooth per lifetime 50% of the total cost of simple and surgical extractions once per tooth per lifetime 50% of the total cost of implants once per tooth, every 5 years 50% of the total cost of dentures and bridges once every 60 months, denture relines and repairs and bridge repairs once every 36 months **Option 2:** $0 copay for one cleaning (regular or periodontal) per plan year $0 copay for scaling and root planing once per quadrant per 24 month period			

	Priority Medicare Edge (PPO)	**Priority** Medicare Key (HMO-POS)	**Priority** Medicare Latitude (HMO-POS)	**Priority** Medicare Smart Savings (HMO-POS)
Dental services (continued)	$2,000 annual maximum per year to use towards: 25% of the total cost for unlimited emergency treatment and anesthesia when used in conjunction with other services 25% of the total cost for fillings (including composite resin and amalgam) once per tooth every 24 months and crown repairs once per tooth every 12 months 25% of the total cost for other diagnostic services (i.e. cone beams) 25% of the total cost for surgical periodontal procedures (i.e. osseous surgery or gum grafts) once per quadrant every 36 months 25% of the total cost of onlays, crowns, and associated substructures once per tooth every 5 years 25% of the total cost of endodontics (root canals) once per tooth per lifetime 25% of the total cost of simple and surgical extractions once per tooth per lifetime 25% of the total cost of implants once per tooth, every 5 years 25% of the total cost of dentures and bridges 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 allowance/reimbursement per year for additional eyewear.			

Additional Benefits

	Priority Medicare Edge (PPO)	**Priority** Medicare Key (HMO-POS)	**Priority** Medicare Latitude (HMO-POS)	**Priority** Medicare Smart Savings (HMO-POS)
Additional Benefits				
Acupuncture	**Medicare-covered acupuncture for lower chronic back pain** *In- and out-of-network*: $20 copay per service **Non-Medicare-covered routine acupuncture for other conditions** *In- and out-of-network*: $20 copay per visit (limit 6 visits every year)			
Annual preventive physical exam	*In-network*: $0 copay for an exam *Out-of-network*: 40% of the total cost for an exam	*In-network*: $0 copay for an exam *Out-of-network*: 50% of the total cost for an 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.			
Caregiver Support Carallel's Care Advocates provide telephonic support and research on topics like health insurance, emotional support, stress management, housing and transportation, and guidance on financial matters and legal concerns. Carallel also offers online tools and resources that provide personalized support tailored to your unique situation.	*In- and out-of-network*: $0 copay for caregiver support provided by Carallel®.	Not covered	*In-network*: $0 copay for caregiver support provided by Carallel®. *Out-of-network*: Not covered	Not covered

	Priority Medicare Edge (PPO)	**Priority** Medicare Key (HMO-POS)	**Priority** Medicare Latitude (HMO-POS)	**Priority** Medicare Smart Savings (HMO-POS)
Chiropractic services	**Medicare-covered care** *In-network*: $15 copay for each service *Out-of-network*: 40% of the total cost for each service **Non-Medicare-covered routine care** *In-network*: $15 copay for each service $20 copay for X-ray services performed once per year *Out-of-network*: 40% of the total cost for each visit and for X-ray services performed once per year Limited to 12 non-Medicare-covered routine chiropractic visits and one routine X-ray service per year whether done in- or out-of-network	**Medicare-covered care** *In-network*: $15 copay for each service *Out-of-network*: 50% of the total cost for each service **Non-Medicare-covered routine care** *In-network*: $15 copay for each service $35 copay for X-ray services performed once per year *Out-of-network*: Not covered		**Medicare-covered care** *In-network*: $15 copay for each service *Out-of-network*: 50% of the total cost for each service **Non-Medicare-covered routine care** *In-network*: $15 copay for each service $45 copay for X-ray services performed once per year *Out-of-network*: Not covered

	Priority Medicare Edge (PPO)	**Priority** Medicare Key (HMO-POS)	**Priority** Medicare Latitude (HMO-POS)	**Priority** Medicare Smart Savings (HMO-POS)
Dialysis	*In-network*: 20% of the total cost for each service *Out-of-network*: 40% of the total cost for each service	*In-network*: 20% of the total cost for each service *Out-of-network*: 50% of the total cost for each service		
Home health services* *Prior authorization may be required.	*In- and out-of-network*: $0 copay for each Medicare-covered service			
Medical equipment and supplies* Examples include diabetic supplies (shoes/inserts, diabetic test strips), durable medical equipment (wheelchairs, oxygen, insulin pumps, continuous glucose monitors (CGM's)) and prosthetic devices (braces, artificial limbs). Diabetic test strips are limited to Contour® and Accu-Chek® Guide products when dispensed by an in-network retail or mail-order pharmacy. Continuous glucose monitors (CGM's) are limited to Dexcom® and Freestyle Libre® products when dispensed by an in-network retail or mail-order pharmacy. There are no brand limitations when obtained through a	**Diabetes supplies** *In-network*: $0 copay for each item *Out-of-network*: 40% of the total cost for each item **Durable medical equipment** *In-network*: 20% of the total cost for each item *Out-of-network*: 30% of the total cost for each item **Prosthetic devices** *In-network*: $0 - 20% of the	**Diabetes supplies** *In-network*: $0 copay for each item *Out-of-network*: 50% of the total cost for each item **Durable medical equipment** *In-network*: 20% of the total cost for each item *Out-of-network*: 30% of the total cost for each item **Prosthetic devices** *In-network*: $0 - 20% of the total cost for each item, depending on the device		

<table>
<tr><th></th><th>Priority
Medicare Edge
(PPO)</th><th>Priority
Medicare Key
(HMO-POS)</th><th>Priority
Medicare
Latitude
(HMO-POS)</th><th>Priority
Medicare Smart
Savings
(HMO-POS)</th></tr>
<tr><td>Medical equipment and supplies* (continued)
durable medical equipment (DME) provider.
*Prior authorization may be required.</td><td>total cost for each item, depending on the device

Out-of-network: 30% of the total cost for each device</td><td colspan="3">

Out-of-network:
30% of the total cost for each device</td></tr>
<tr><td>One Pass®

Fitness membership

CogniFit®</td><td colspan="4">

In-network
$0 copay

One Pass® can help you reach your fitness goals while finding new passions along the way. Find a routine that’s right for you whether you work out at home or at the gym.

One Pass® includes:

• Access to the largest nationwide network of gyms and fitness locations
• Live, digital fitness classes and on-demand workouts
• Online brain training to improve your memory and focus
• One at home fitness kit per plan year

$0 copay

Access to the CogniFit® brain health program. Simply set up an account through One Pass® to access a collection of brain games to keep you interested, challenged, and engaged.

CogniFit® works by training over 20 cognitive skills that we use daily such as working memory, perception, attention, reasoning and coordination.</td></tr>
<tr><td>Out-of-network
Up to $60 reimbursement every year for comprehensive fitness benefit</td><td colspan="3">Out-of-network
<u>Not</u> covered</td></tr>
</table>

	Priority Medicare Edge (PPO)	**Priority** Medicare Key (HMO-POS)	**Priority** Medicare Latitude (HMO-POS)	**Priority** Medicare Smart Savings (HMO-POS)
One Pass® (continued)	outside of the One Pass network (cannot combine with in-network benefit)			
Over-The-Counter (OTC) allowance 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.	Region 1: $30 Region 2: $25 Region 5: $25 allowance every three months** Please see the monthly premium section for your region. **Quarterly allowances do not rollover.	Region 1: $40 Region 2: $30 Region 5: $40 allowance every three months** Please see the monthly premium section for your region. **Quarterly allowances do not rollover.	Not covered	Not covered
	OTC items, home and bathroom safety devices and modifications can be purchased in participating stores (Meijer, Walmart, Walgreens, CVS, Kroger and more) and online at ***PriorityHealth.com/shopOTC***. You can also call 833.415.4380 or download the Priority Health OTC app.			
Over-The-Counter Plus (OTC) allowance 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	Not covered	Region 3: $40 Region 4: $33 allowance every three months** Please see the monthly premium section for your region.	Not covered

	Priority Medicare Edge (PPO)	**Priority** Medicare Key (HMO-POS)	**Priority** Medicare Latitude (HMO-POS)	**Priority** Medicare Smart Savings (HMO-POS)
OTC items, home and bathroom safety devices and modifications can be purchased in participating stores (Meijer, Walmart, Walgreens, CVS, Kroger and more) and online at ***PriorityHealth.com/shopOTC***. You can also call 833.415.4380 or download the Priority Health OTC app.			**Quarterly allowances do not rollover. If eligible for Special Supplemental Benefits for the Chronically Ill (SSBCI) you may also use your OTC allowance towards healthy food and produce. See your Evidence of Coverage for more information.*	
Podiatry services	**Medicare-covered podiatry** *In-network*: Region 1: $40 Region 2: $50 Region 5: $45 copay for each visit Please see the monthly premium section for your region $0 copay for nail debridement and callous removal for members with	**Medicare-covered podiatry** *In-network*: $40 copay for each visit $0 copay for nail debridement and callous removal for members with	**Medicare-covered podiatry** *In-network*: $40 copay for each visit $0 copay for nail debridement and callous removal for members with	**Medicare-covered podiatry** *In-network*: $60 copay for each visit $0 copay for nail debridement and callous removal for members with

	Priority Medicare Edge (PPO)	**Priority** Medicare Key (HMO-POS)	**Priority** Medicare Latitude (HMO-POS)	**Priority** Medicare Smart Savings (HMO-POS)
Podiatry services (continued)	specific conditions *Out-of-network*: 40% of the total cost for each visit or service	specific conditions *Out-of-network*: 50% of the total cost for each visit or service	specific conditions *Out-of-network*: 50% of the total cost for each visit or service	specific conditions *Out-of-network*: 50% of the total cost for each visit or service
Priority Health Travel Benefit				
Out-of-area travel	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. Go to ***priorityhealth.com/provider-directory*** to find providers in our network. 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 plan's 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 and assistance while on your trip should a medical travel emergency arise, 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 rehabilitation services	*In-network*: $10 copay for each service *Out-of-network*: 40% of the total cost for each service	*In-network*: $10 copay for each service *Out-of-network*: 50% of the total cost for each service		*In-network*: $10 copay for each service *Out-of-network*: 50% of the total cost for each service

	Priority Medicare Edge (PPO)	**Priority** Medicare Key (HMO-POS)	**Priority** Medicare Latitude (HMO-POS)	**Priority** Medicare Smart Savings (HMO-POS)
Rehabilitation services (continued)				
Pulmonary rehabilitation and supervised exercise therapy (SET) services	*In-network*: $10 copay for each service *Out-of-network*: 40% of the total cost for each service	*In-network*: $10 copay for each service *Out-of-network*: 50% of the total cost for each service		*In-network*: $10 copay for each service *Out-of-network*: 50% of the total cost for each service
Physical therapy, occupational therapy, and speech therapy services	*In-network*: $40 copay for each service *Out-of-network*: 40% of the total cost for each service	*In-network*: $25 copay for each service *Out-of-network*: 50% of the total cost for each service		*In-network*: $35 copay for occupational therapy services $50 copay for physical therapy and speech therapy services *Out-of-network*: 50% of the total cost for each service
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 copay virtual visits with primary care, specialist, urgent care, 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, Deductibles, and Limits

	PriorityMedicare Align (HMO-POS)	**Priority**Medicare Value (HMO-POS)
Monthly Plan Premium	$6.28 per month. In addition, you must keep paying your Medicare Part B premium.	$47 - $111 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 Medicare pays the balance.	**Medical services** *In-network*: $0 *Out-of-network*: $1,500, applies to hospital and medical services except for acupuncture and insulin furnished through an item of durable medical equipment. **Prescription drugs (Part D):** Tiers 1-5: $700	**Medical services** *In-network*: $0 *Out-of-network*: $1,000 applies to hospital and medical services except for acupuncture and insulin furnished through an item of durable medical equipment. **Prescription drugs (Part D):** Tiers 1-2: $0 Tiers 3-5: $225
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*: $6,800	*In-network*: $6,000

Monthly Premiums

Counties	**Priority** Medicare Align (HMO-POS)
Region 1: Allegan, Barry, Ionia, Kent, Montcalm, Muskegon, Ottawa	$6.28
Region 2: Berrien, Branch, Calhoun, Cass, Clinton, Eaton, Gratiot, Hillsdale, Ingham, Jackson, Kalamazoo, St. Joseph, Van Buren	$6.28

Counties	**Priority** Medicare Value (HMO-POS)
Region 1: Allegan, Barry, Kent, Lenawee, Ottawa	$47
Region 2: Berrien, Calhoun, Cass, Ionia, Isabella, Kalamazoo, Mason, Midland, Missaukee, Montcalm, Muskegon, Newaygo, Oceana,	$75

Counties	Priority Medicare Align (HMO-POS)
Region 3: Antrim, Benzie, Charlevoix, Clare, Emmet, Grand Traverse, Isabella, Kalkaska, Lake, Leelanau, Manistee, Mason, Mecosta, Midland, Missaukee, Newaygo, Oceana, Osceola, Wexford	N/A
Region 4: Alcona, Alpena, Arenac, Bay, Cheboygan, Crawford, Gladwin, Huron, Iosco, Montmorency, Ogemaw, Oscoda, Otsego, Presque Isle, Roscommon, Sanilac, Tuscola	N/A
Region 5: Genessee, Lapeer, Lenawee, Livingston, Macomb, Monroe, Oakland, Saginaw, St. Clair, Shiawassee, Washtenaw, Wayne	$6.28

Counties	Priority Medicare Value (HMO-POS)
Osceola, Otsego, St. Clair, Van Buren, Wexford	
Region 3: Alcona, Antrim, Benzie, Charlevoix, Clare, Crawford, Grand Traverse, Hillsdale, Lake, Lapeer, Leelanau, Manistee, Mecosta, Monroe	$111
Region 4: Alpena, Cheboygan, Eaton, Emmet, Gladwin, Gratiot, Iosco, Jackson, Kalkaska, Montmorency, Oscoda, Presque Isle, Roscommon, Sanilac, Shiawasse, St. Joseph	$80
Region 5: Arenac, Bay, Branch, Clinton, Genesee, Huron, Ingham, Livingston, Macomb, Oakland, Ogemaw, Saginaw, Tuscola, Washtenaw, Wayne	$74

Part C Benefits

	PriorityMedicare Align (HMO-POS)	PriorityMedicare Value (HMO-POS)
Hospital		
Inpatient hospital coverage* We cover an unlimited number of days for an inpatient hospital stay. *Prior authorization may be required.	*In-network*: $400 copay per day for days 1 - 7 $0 copay for additional hospital days *Out-of-network*: 50% of the total cost per stay	*In-network*: $325 copay per day for days 1 - 7 $0 copay for additional hospital days *Out-of-network*: 40% of the total cost per stay

	PriorityMedicare Align (HMO-POS)	**Priority**Medicare Value (HMO-POS)
Outpatient hospital coverage*		
Outpatient hospital	*In-network*: $0 copay for each visit at a rural health clinic $40 copay for each Medicare-covered outpatient wound care services $415 copay for each outpatient hospital visit *Out-of-network*: 50% of the total cost for each visit	*In-network*: $0 copay for each visit at a rural health clinic $35 copay for each Medicare-covered outpatient wound care services $325 copay for each outpatient hospital visit *Out-of-network*: 40% of the total cost for each visit
Observation services *Prior authorization may be required.	*In- and out-of-network*: $130 copay per stay for each visit, including all services received	
Ambulatory surgery center* *Prior authorization may be required.	*In-network*: $415 copay for each visit *Out-of-network*: 50% of the total cost for each visit	*In-network*: $325 copay for each visit *Out-of-network*: 40% of the total cost for each visit
Doctor Visits and Preventive Care		
Doctor visits		
Primary care physician (PCP)	*In-network*: $0 copay for each office visit and simple surgical procedures done in a provider's office (i.e. mole removals/sutures) $415 copay for moderate to major surgical procedures done in a provider's office (i.e. carpal tunnel and trigger finger release surgery)	*In-network*: $0 copay for each office visit and simple surgical procedures done in a provider's office (i.e. mole removals/sutures) $325 copay for moderate to major surgical procedures done in a provider's office (i.e. carpal tunnel and trigger finger release surgery)

	PriorityMedicare Align (HMO-POS)	**Priority**Medicare Value (HMO-POS)
Doctor visits (continued) **Specialist visit*** *Prior authorization may be required for some specialist visits.	*Out-of-network*: 50% of the total cost for each visit *In-network*: $0 copay for palliative care physician office visits $0 copay for each office visit and simple surgical procedures done in a specialist's office (i.e. mole removals/sutures) $415 copay for moderate to major surgical procedures done in a specialist's office (i.e. carpal tunnel and trigger finger release surgery) $40 copay for all other specialty office visits *Out-of-network*: 50% of the total cost for each visit	*Out-of-network*: 40% of the total cost for each visit *In-network*: $0 copay for palliative care physician office visits $0 copay for each office visit and simple surgical procedures done in a specialist's office (i.e. mole removals/sutures) $325 copay for moderate to major surgical procedures done in a specialist's office (i.e. carpal tunnel and trigger finger release surgery) $35 copay for all other specialty office visits *Out-of-network*: 40% of the total cost 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 copay for each service *Out-of-network*: 50% of the total cost for each service	*In-network*: $0 copay for each service *Out-of-network*: 40% of the total cost for each service
	Any additional preventive services approved by Medicare during the contract year will be covered.	
Emergency and Urgent Care		
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*: $130 copay for each visit	

	PriorityMedicare Align (HMO-POS)	**Priority**Medicare Value (HMO-POS)
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 copay for each visit	
Outpatient Diagnostic Tests, Radiation Therapy, X-rays and Labs		
Diagnostic services/labs/imaging* **Radiology/imaging** **Diagnostic tests and procedures** **Lab services** **Outpatient X-rays** **Radiation therapy** *Prior authorization may be required for some services.	*In-network*: $640 copay per day, per provider for diagnostic nuclear medicine services $250 copay per day, per provider for all other diagnostic radiology services $10 copay per day, per provider $0 copay for anticoagulant lab services $50 copay for genetic testing $10 copay for all other Medicare-covered lab services $35 copay for all Medicare-covered x-rays $25 copay per day, per provider *Out-of-network*: 0% - 50% of the total cost per day, per provider ($0 copay for anticoagulant lab services)	*In-network*: $640 copay per day, per provider for diagnostic nuclear medicine services $225 copay per day, per provider for all other diagnostic radiology services $10 copay per day, per provider $0 copay for anticoagulant lab services $50 copay for genetic testing $10 copay for all other Medicare-covered lab services $35 copay for all Medicare-covered x-rays $25 copay per day, per provider *Out-of-network*: 0% to 40% of the total cost per day, per provider ($0 copay for anticoagulant lab services)
Hearing / Dental / Vision		
Hearing services **Medicare-covered diagnostic hearing exam** Medicare-covered exam performed by	*In-network*: $0 - $40 copay for each office visit	*In-network*: $0 - $35 copay for each office visit

	PriorityMedicare Align (HMO-POS)	**Priority**Medicare Value (HMO-POS)
Hearing services (continued) a primary care physician or specialist to diagnose and treat hearing and balance issues.	*Out-of-network*: 50% of the total cost for each visit	*Out-of-network*: 40% of the total cost for each visit
Routine hearing coverage and hearing aids In-network routine hearing services must be provided by a TruHearing® provider. If received by a non-TruHearing® provider (out-of-network), you must seek reimbursement.	$0 copay for one routine hearing exam, per year $399 - $899 copay, per ear every 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* **Medicare-covered dental services**	*In-network*: $0 - $415 copay for each visit, depending on the service performed *Out-of-network*: 50% of the total cost for each service performed	*In-network*: $0 - $325 copay for each visit, depending on the service performed *Out-of-network*: 40% of the total cost for each service performed
Additional dental services Delta Dental® is the preferred provider for additional dental services. *Prior authorization may be required for Medicare-covered dental services.	$0 copay for two cleanings (regular or periodontal maintenance) per year $0 copay for two exams per year $0 copay for one set of bitewing X-rays per year $0 copay for one brush biopsy per year $0 copay for periapical radiographs as needed $0 copay for radiographs (full-mouth or panoramic x-rays) once every 24 months $0 copay for 1 fluoride treatment every year	
Vision services **Medicare-covered services** Medicare-covered exam performed by a specialist to diagnose and treat diseases and conditions of the eye	*In-network*: $40 copay for each visit	*In-network*: $35 copay for each visit

	PriorityMedicare Align (HMO-POS)	**Priority**Medicare Value (HMO-POS)
Vision services (continued) and additional Medicare-covered services.	$0 copay for eyeglasses or contact lenses after cataract surgery $0 copay for a yearly glaucoma screening *Out-of-network*: 50% of the total cost for each visit, eyeglasses or contact lenses after cataract surgery, or for a yearly glaucoma screening.	$0 copay for eyeglasses or contact lenses after cataract surgery $0 copay for a yearly glaucoma screening *Out-of-network*: 40% of the total cost for each visit, eyeglasses or contact lenses after cataract surgery, or for a yearly glaucoma screening.
Routine Vision 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 benefits cannot be combined.	*In-network*: $0 copay for one routine exam each year (includes dilation and refraction) $0 copay 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 Services		
Inpatient visits* We cover up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. *Prior authorization may be required.	*In-network*: $350 copay per day, days 1-5 $0 copay for additional hospital days *Out-of-network*: 50% of the total cost per stay	*In-network*: $325 copay per day, days 1-5 $0 copay for additional hospital days *Out-of-network*: 40% of the total cost per stay
Outpatient therapy (individual or group)	*In-network*: $20 copay for each visit *Out-of-network*: 50% of the total cost for each visit	*In-network*: $20 copay for each visit *Out-of-network*: 40% of the total cost for each visit
Skilled Nursing Facility (SNF)		

	PriorityMedicare Align (HMO-POS)	**Priority**Medicare Value (HMO-POS)
Skilled nursing facility* 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*: $0 copay per day, days 1 - 20 $218 copay per day, days 21 - 100 *Out-of-network*: 50% of the total cost per stay for each stay	*In-network*: $0 copay per day, days 1 - 20 $218 copay per day, days 21 - 100 *Out-of-network*: 40% of the total cost per stay for each stay
Outpatient Rehabilitation Services		
Physical therapy	*In-network*: $25 copay for each service *Out-of-network*: 50% of the total cost for each service	*In-network*: $15 copay for each service *Out-of-network*: 40% of the total cost for each service
Medical Transportation		
Ambulance* *Prior authorization may be required.	*In- and out-of-network*: $270 copay each way	*In- and out-of-network*: $265 copay each way
Transportation	Not covered	
Medicare Part B Drugs*		
Chemotherapy drugs **Other Part B drugs** **Select home infusion drugs** **Part B insulin** *Prior authorization or step therapy may be required.	*In- and out-of-network*: Up to 20% of the total cost for each drug Up to 20% of the total cost for each drug $0 copay for each drug Up to 20% of the total cost, with a maximum of $35 per month supply of insulin administered through an insulin pump.	

Prescription Drug Benefits

Important Message About What You Pay for Vaccines - Our plan covers most Part D vaccines at no cost to you, no matter what cost-sharing tier it's on, even if you haven't paid your deductible.

Important Message About What You Pay for Insulin - You won't pay more than $35 for a one-month supply and no more than $105 for a three-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on, even if you haven't paid your deductible.

PART D OUTPATIENT PRESCRIPTION DRUGS		
	PriorityMedicare Align (HMO-POS)	**Priority**Medicare Value (HMO-POS)
Stage 1: Deductible stage You'll pay this amount before you begin paying copays or coinsurance only.	Tier 1 - 5: $700*	Tier 1 - 2: $0 Tier 3 - 5: $225*
	*The deductible doesn't apply to covered insulins and most adult Part D vaccines.	
Stage 2: Initial coverage stage You are in this stage until your out-of-pocket Part D drug costs reach $2,400.	You pay what is listed in the chart below.	

STANDARD RETAIL PHARMACY				
	PriorityMedicare Align (HMO-POS)		**Priority**Medicare Value (HMO-POS)	
Standard Retail	**30-day supply**	**100-day supply**	**30-day supply**	**100-day supply**
Tier 1: Preferred generic	$0	$0	$7	$21
	30-day supply	**90-day supply**	**30-day supply**	**90-day supply**
Tier 2: Generic	$15	$45	$15	$45
Tier 3: Preferred brand	25%	25%	25%	25%
Tier 4: Non-preferred drug	34%	34%	34%	34%
Tier 5: Specialty*	25%	N/A	30%	N/A

PREFERRED RETAIL PHARMACY				
	PriorityMedicare Align (HMO-POS)		PriorityMedicare Value (HMO-POS)	
Preferred Retail	**30-day supply**	**100-day supply**	**30-day supply**	**100-day supply**
Tier 1: Preferred generic	$0	$0	$2	$0
	30-day supply	**90-day supply**	**30-day supply**	**90-day supply**
Tier 2: Generic	$8	$24	$10	$30
Tier 3: Preferred brand	25%	25%	22%	22%
Tier 4: Non-preferred drug	29%	29%	29%	29%
Tier 5: Specialty*	25%	N/A	30%	N/A
Your costs will be less for your covered drugs when you use a pharmacy in our preferred network (includes Meijer, Walgreens, Walmart, Family Fare Supermarkets, Costco and more), go to ***prioritymedicare.com*** to view the list in the provider/pharmacy directory.				

PREFERRED MAIL ORDER				
	PriorityMedicare Align (HMO-POS)		PriorityMedicare Value (HMO-POS)	
Preferred Mail Order	**30-day supply**	**100-day supply**	**30-day supply**	**100-day supply**
Tier 1: Preferred generic	$0	$0	$2	$0
	30-day supply	**90-day supply**	**30-day supply**	**90-day supply**
Tier 2: Generic	$8	$0	$10	$0
Tier 3: Preferred brand	25%	25%	22%	22%
Tier 4: Non-preferred drug	29%	29%	29%	29%
Tier 5: Specialty*	25%	N/A	30%	N/A
Your costs will be less for your covered drugs when you use a pharmacy in our preferred network (includes Express Scripts and Amazon), go to ***prioritymedicare.com*** to view the list in the provider/pharmacy directory. *Specialty drugs are limited to a 30-day supply.				

	PriorityMedicare Align (HMO-POS)	**Priority**Medicare Value (HMO-POS)
Catastrophic coverage stage	Once your out-of-pocket drug costs reach $2,400, the plan pays the full cost of your covered Part D 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

Additional dental coverage, including coverage for dental services and an additional vision allowance for use on eyeglasses or contacts.

	PriorityMedicare Align (HMO-POS) (033)	**Priority**Medicare Value (HMO-POS) (029)
Premium	**Enhanced Dental and Vision** **Option 1:** $42 per month **Option 2:** $61 per month You must keep paying your Medicare Part B premium and your $6.28 monthly plan premium.	**Enhanced Dental and Vision** **Option 1:** $42 per month **Option 2:** $61 per month You must keep paying your Medicare Part B premium and your $47 - $111 monthly plan premium.
Deductible	$0	
Maximum plan benefit coverage amount	$1,500 - $2,000 for comprehensive dental services, depending on the option you choose and an additional $150 for eyewear, per calendar year	
Dental services Delta Dental® is the preferred provider for additional dental services.	*In- and out-of-network* **Option 1:** $0 copay for one cleaning (regular or periodontal) per plan year $0 copay for scaling and root planing once per quadrant per 24 month period $1,500 annual maximum per year to use towards: 50% of the total cost for unlimited emergency treatment and anesthesia when used in conjunction with other services	

	PriorityMedicare Align (HMO-POS) (033)	**Priority**Medicare Value (HMO-POS) (029)
Dental services (continued)	50% of the total cost for fillings (including composite resin and amalgam) once per tooth every 24 months and crown repairs once per tooth every 12 months 50% of the total cost for other diagnostic services (i.e. cone beams) 50% of the total cost for surgical periodontal procedures (i.e. osseous surgery or gum grafts) once per quadrant every 36 months 50% of the total cost of onlays, crowns, and associated substructures once per tooth every 5 years 50% of the total cost of endodontics (root canals) once per tooth per lifetime 50% of the total cost of simple and surgical extractions once per tooth per lifetime 50% of the total cost of implants once per tooth, every 5 years 50% of the total cost of dentures and bridges once every 60 months, denture relines and repairs and bridge repairs once every 36 months **Option 2:** $0 copay for one cleaning (regular or periodontal) per plan year $0 copay for scaling and root planing once per quadrant per 24 month period $2,000 annual maximum per year to use towards: 25% of the total cost for unlimited emergency treatment and anesthesia when used in conjunction with other services 25% of the total cost for fillings (including composite resin and amalgam) once per tooth every 24 months and crown repairs once per tooth every 12 months 25% of the total cost for other diagnostic services (i.e. cone beams)	

	PriorityMedicare Align (HMO-POS) (033)	**Priority**Medicare Value (HMO-POS) (029)
Dental services (continued)	25% of the total cost for surgical periodontal procedures (i.e. osseous surgery or gum grafts) once per quadrant every 36 months 25% of the total cost of onlays, crowns, and associated substructures once per tooth every 5 years 25% of the total cost of endodontics (root canals) once per tooth per lifetime 25% of the total cost of simple and surgical extractions once per tooth per lifetime 25% of the total cost of implants once per tooth, every 5 years 25% of the total cost of dentures and bridges 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 allowance/reimbursement per year for additional eyewear.	

Additional Benefits

	PriorityMedicare Align (HMO-POS)	**Priority**Medicare Value (HMO-POS)
Additional Benefits		
Acupuncture	**Medicare-covered acupuncture for lower chronic back pain** *In- and out-of-network*: $20 copay per service **Non-Medicare-covered routine acupuncture for other conditions**	

	PriorityMedicare Align (HMO-POS)	**Priority**Medicare Value (HMO-POS)
Acupuncture (continued)	*In- and out-of-network*: $20 copay per visit (limit 6 visits every year)	
Annual preventive physical exam	*In-network*: $0 copay for an exam *Out-of-network*: 50% of the total cost for an exam	*In-network*: $0 copay for an exam *Out-of-network*: 40% of the total cost for an 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.	
Caregiver Support Carallel's Care Advocates provide telephonic support and research on topics like health insurance, emotional support, stress management, housing and transportation, and guidance on financial matters and legal concerns. Carallel also offers online tools and resources that provide personalized support tailored to your unique situation.	$0 copay for unlimited hours of caregiver support provided by Carallel®.	Not covered
Chiropractic services	**Medicare-covered care** *In-network*: $15 copay for each service *Out-of-network*: 50% of the total cost for each service **Non-Medicare-covered routine care** *In-network*: $15 copay for each service $35 copay for X-ray services performed once per year	**Medicare-covered care** *In-network*: $15 copay for each service *Out-of-network*: 40% of the total cost for each service **Non-Medicare-covered routine care** Not covered

	PriorityMedicare Align (HMO-POS)	**Priority**Medicare Value (HMO-POS)
Chiropractic services (continued)	*Out-of-network*: Not covered	
Dialysis	*In-network*: 20% of the total cost for each service *Out-of-network*: 50% of the total cost for each service	*In-network*: 20% of the total cost for each service *Out-of-network*: 40% of the total cost for each service
Home health services* *Prior authorization may be required.	*In- and out-of-network*: $0 copay for each Medicare-covered service	
Medical equipment and supplies* Examples include diabetic supplies (shoes/inserts, diabetic test strips), durable medical equipment (wheelchairs, oxygen, insulin pumps, continuous glucose monitors (CGM's)) and prosthetic devices (braces, artificial limbs). Diabetic test strips are limited to Contour® and Accu-Chek® Guide products when dispensed by an in-network retail or mail-order pharmacy. Continuous glucose monitors (CGM's) are limited to Dexcom® and Freestyle Libre® products when dispensed by an in-network retail or mail-order pharmacy. There are no brand limitations when obtained through a durable medical equipment (DME) provider. *Prior authorization may be required.	**Diabetes supplies** *In-network*: $0 copay for each item *Out-of-network*: 50% of the total cost for each item **Durable medical equipment** *In-network*: 20% of the total cost for each item *Out-of-network*: 30% of the total cost for each item **Prosthetic devices** *In-network*: $0 - 20% of the total cost for each item, depending on the device *Out-of-network*: 30% of the total cost for each device	**Diabetes supplies** *In-network*: $0 copay for each item *Out-of-network*: 40% of the total cost for each item **Durable medical equipment** *In-network*: 20% of the total cost for each item *Out-of-network*: 30% of the total cost for each item **Prosthetic devices** *In-network*: $0 - 20% of the total cost for each item, depending on the device *Out-of-network*: 30% of the total cost for each device

	PriorityMedicare Align (HMO-POS)	**Priority**Medicare Value (HMO-POS)
One Pass® **Fitness membership**	Not covered	$0 copay One Pass® can help you reach your fitness goals while finding new passions along the way. Find a routine that's right for you whether you work out at home or at the gym. One Pass® includes: • Access to the largest nationwide network of gyms and fitness locations • Live, digital fitness classes and on-demand workouts • Online brain training to improve your memory and focus • One at home fitness kit per plan year
CogniFit®	Not covered	$0 copay Access to the CogniFit® brain health program. Simply set up an account through One Pass® to access a collection of brain games to keep you interested, challenged, and engaged. CogniFit® works by training over 20 cognitive skills that we use daily such as working memory, perception, attention, reasoning and coordination.
OTC Plus Over-the-counter items are drugs and health related products that do not need a prescription such as allergy	Region 1: $40 Region 2: $35 Region 5: $39	Not covered

	PriorityMedicare Align (HMO-POS)	**Priority**Medicare Value (HMO-POS)
medication, eye drops, cough drops, nasal spray, vitamins and more. OTC items, home and bathroom safety devices and modifications can be purchased in participating stores (Meijer, Walmart, Walgreens, CVS, Kroger and more) and online at ***PriorityHealth.com/shopOTC***. You can also call 833.415.4380 or download the Priority Health OTC app.	allowance every three months** **Quarterly allowances do not rollover. If eligible for Special Supplemental Benefits for the Chronically Ill (SSBCI) you may also use your OTC allowance towards healthy food and produce. See your Evidence of Coverage for more information.* Please see the monthly premium section for your region.	
Podiatry services	**Medicare-covered podiatry** *In-network*: $40 copay for each visit $0 copay for nail debridement and callous removal for members with specific conditions (up to 6 of each) *Out-of-network*: 50% of the total cost for each visit or service	**Medicare-covered podiatry** *In-network*: $35 copay for each visit $0 copay for nail debridement and callous removal for members with specific conditions (up to 6 of each) *Out-of-network*: 40% of the total cost for each visit or service
Priority Health Travel Benefit **Out-of-area travel** **Worldwide urgent and emergent care**	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. Go to ***priorityhealth.com/provider-directory*** to find providers in our network. 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 plan's service area. Unlimited worldwide emergent and urgent care coverage.	

	PriorityMedicare Align (HMO-POS)	**Priority**Medicare Value (HMO-POS)
Priority Health Travel Benefit (continued) **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 and assistance while on your trip should a medical travel emergency arise, 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 rehabilitation services	*In-network*: $10 copay for each service *Out-of-network*: 50% of the total cost for each service	*In-network*: $10 copay for each service *Out-of-network*: 40% of the total cost for each service
Pulmonary rehabilitation and supervised exercise therapy (SET) services	*In-network*: $10 copay for each service *Out-of-network*: 50% of the total cost for each service	*In-network*: $10 copay for each service *Out-of-network*: 40% of the total cost for each service
Physical therapy, occupational therapy, and speech therapy services	*In-network*: $25 copay for each service *Out-of-network*: 50% of the total cost for each service	*In-network*: $15 copay for each service *Out-of-network*: 40% of the total cost for each service
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 copay virtual visits with primary care, specialist, urgent care, 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	

Notes

Premiums, Deductibles, and Limits

	PriorityMedicare (HMO-POS)	PriorityMedicare Merit (PPO)
Monthly Plan Premium	$97 - $148 per month. In addition, you must keep paying your Medicare Part B premium.	$100 - $163 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 Medicare pays the balance.	**Medical services** *In-network*: $0 *Out-of-network*: $500, applies to hospital and medical services except for acupuncture and insulin furnished through an item of durable medical equipment. **Prescription drugs (Part D):** $0	**Medical services** *In-network*: $0 *In- 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*: $5,100	*In- and out-of-network* (combined): $5,000

Monthly Premiums

Counties	PriorityMedicare (HMO-POS)	PriorityMedicare Merit (PPO)
Region 1: Allegan, Barry, Kent, Lenawee, Ottawa	$98	$100
Region 2: Berrien, Calhoun, Cass, Ionia, Isabella, Kalamazoo, Mason, Midland, Missaukee, Montcalm, Muskegon, Newaygo, Oceana, Osceola, Otsego, St. Clair, Van Buren, Wexford	$103	$119
Region 3: Alcona, Antrim, Benzie, Charlevoix, Clare, Crawford, Grand Traverse, Hillsdale, Lake, Lapeer, Leelanau, Manistee, Mecosta, Monroe	$148	$156

Counties	**Priority**Medicare (HMO-POS)	**Priority**Medicare Merit (PPO)
Region 4: Alpena, Cheboygan, Eaton, Emmet, Gladwin, Gratiot, Iosco, Jackson, Kalkaska, Montmorency, Oscoda, Presque Isle, Roscommon, Sanilac, Shiawasse, St. Joseph	$131	$163
Region 5: Arenac, Bay, Branch, Clinton, Genesee, Huron, Ingham, Livingston, Macomb, Oakland, Ogemaw, Saginaw, Tuscola, Washtenaw, Wayne	$97	$141

Part C Benefits

	PriorityMedicare (HMO-POS)	**Priority**Medicare Merit (PPO)
Hospital		
Inpatient hospital coverage* We cover an unlimited number of days for an inpatient hospital stay. *Prior authorization may be required.	*In-network*: $350 copay per day for days 1 - 6 $0 copay for additional hospital days *Out-of-network*: 30% of the total cost per stay	*In-network*: $360 copay per day for days 1 - 6 $0 copay for additional hospital days *Out-of-network*: 30% of the total cost per stay
Outpatient hospital coverage* **Outpatient hospital**	*In-network*: $0 copay for each visit at a rural health clinic $40 copay for each Medicare-covered outpatient wound care services $175 copay for each outpatient hospital visit *Out-of-network*: 30% of the total cost for each visit	*In-network*: $0 copay for each visit at a rural health clinic $45 copay for each Medicare-covered outpatient wound care services $225 copay for each outpatient hospital visit *Out-of-network*: 30% of the total cost for each visit

	PriorityMedicare (HMO-POS)	PriorityMedicare Merit (PPO)
Outpatient hospital coverage* (continued) **Observation services** *Prior authorization may be required.	*In- and out-of-network*: $130 copay per stay for each visit, including all services received	
Ambulatory surgery center* *Prior authorization may be required.	*In-network*: $175 copay for each visit *Out-of-network*: 30% of the total cost for each visit	*In-network*: $225 copay for each visit *Out-of-network*: 30% of the total cost for each visit
Doctor Visits and Preventive Care		
Doctor visits **Primary care physician (PCP)**	*In-network*: $0 copay for each office visit and simple surgical procedures done in a provider's office (i.e. mole removals/sutures) $175 copay for moderate to major surgical procedures done in a provider's office (i.e. carpal tunnel and trigger finger release surgery) *Out-of-network*: 30% of the total cost for each visit	*In-network*: $0 copay for each office visit and simple surgical procedures done in a provider's office (i.e. mole removals/sutures) $225 copay for moderate to major surgical procedures done in a provider's office (i.e. carpal tunnel and trigger finger release surgery) *Out-of-network*: 30% of the total cost for each visit
Specialist visit* *Prior authorization may be required for some specialist visits.	*In-network*: $0 copay for palliative care physician office visits $0 copay for each office visit and simple surgical procedures done in a specialist's office (i.e. mole removals/sutures) $175 copay for moderate to major surgical procedures done in a specialist's office (i.e.	*In-network*: $0 copay for palliative care physician office visits $0 copay for each office visit and simple surgical procedures done in a specialist's office (i.e. mole removals/sutures) $225 copay for moderate to major surgical procedures done in a specialist's office (i.e.

	PriorityMedicare (HMO-POS)	**Priority**Medicare Merit (PPO)
Doctor visits (continued)	carpal tunnel and trigger finger release surgery) $40 copay for all other specialty office visits *Out-of-network*: 30% of the total cost for each visit	carpal tunnel and trigger finger release surgery) $45 copay for all other specialty office visits *Out-of-network*: 30% of the total cost 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 copay for each service *Out-of-network*: 30% of the total cost 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 and Urgent Care		
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*: $130 copay 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 copay for each visit	
Outpatient Diagnostic Tests, Radiation Therapy, X-rays and Labs		
Diagnostic services/labs/imaging* **Radiology/imaging**	*In-network*: $640 copay per day, per provider for diagnostic nuclear medicine services $125 copay per day, per provider for all other diagnostic radiology services	*In-network*: $640 copay per day, per provider for diagnostic nuclear medicine services $125 copay per day, per provider for all other diagnostic radiology services

	PriorityMedicare (HMO-POS)	PriorityMedicare Merit (PPO)
Diagnostic services/labs/imaging* (continued)		
Diagnostic tests and procedures	$30 copay per day, per provider	$20 copay per day, per provider
Lab services	$0 copay for anticoagulant lab services $50 copay for genetic testing $0 copay for all other Medicare-covered lab services	$0 copay for anticoagulant lab services $50 copay for genetic testing $0 copay for all other Medicare-covered lab services
Outpatient X-rays	$35 copay per day, per provider	$35 copay per day, per provider
Radiation therapy *Prior authorization may be required for some services.	$20 copay per day, per provider *Out-of-network*: 30% of the total cost per day, per provider ($0 copay for anticoagulant lab services)	$30 copay per day, per provider *Out-of-network*: 30% of the total cost per day, per provider ($0 copay for anticoagulant lab services)
Hearing / Dental / Vision		
Hearing services		
Medicare-covered diagnostic hearing exam Medicare-covered exam performed by a primary care physician or specialist to diagnose and treat hearing and balance issues.	*In-network*: $0 - $40 copay for each office visit *Out-of-network*: 30% of the total cost for each visit	*In-network*: $0 - $45 copay for each office visit *Out-of-network*: 30% of the total cost for each visit
Routine hearing coverage and hearing aids In-network routine hearing services must be provided by a TruHearing® provider. If received by a non-TruHearing® provider (out-of-network), you must seek reimbursement. In-network and out-of-network benefits cannot be combined	*In-network* $0 copay for one routine hearing exam, per year $399 - $899 copay, per ear every year, for hearing aids from top manufacturers depending on level selected. Hearing aid cost includes a 60-day trial period, one year of	*In-network* $0 copay for one routine hearing exam, per year $399 - $899 copay, per ear every year, for hearing aids from top manufacturers depending on level selected. Hearing aid cost includes a 60-day trial period, one year of

	PriorityMedicare (HMO-POS)	**Priority**Medicare Merit (PPO)
Hearing services (continued)	post-purchase follow-up visits, 80 batteries per non-rechargeable hearing aid and a full 3-year manufacturer warranty. *Out-of-network* Not covered	post-purchase follow-up visits, 80 batteries per non-rechargeable hearing aid and a full 3-year manufacturer warranty. *Out-of-network* 30% of the total cost for one routine hearing exam every year. 50% of the total cost for hearing aids (one per ear, per year). These benefits cannot be combined with in-network benefits.
Dental services* **Medicare-covered dental services**	*In-network*: $0 - $175 copay for each visit, depending on the service performed *Out-of-network*: 30% of the total cost for each service performed	*In-network*: $0 - $225 copay for each visit, depending on the service performed *Out-of-network*: 30% of the total cost for each service performed
Additional dental services Delta Dental® is the preferred provider for additional dental services. *Prior authorization may be required for Medicare-covered dental services.	$0 copay for two cleanings (regular or periodontal maintenance) per year $0 copay for two exams per year $0 copay for one set of bitewing X-rays per year $0 copay for one brush biopsy per year $0 copay for periapical radiographs as needed $0 copay for radiographs (full-mouth or panoramic x-rays) once every 24 months $0 copay for 1 fluoride treatment every year	

	PriorityMedicare (HMO-POS)	PriorityMedicare Merit (PPO)
Vision services **Medicare-covered 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*: $40 copay for each visit $0 copay for eyeglasses or contact lenses after cataract surgery $0 copay for a yearly glaucoma screening *Out-of-network*: 30% of the total cost for each service	*In-network*: $45 copay for each visit $0 copay for eyeglasses or contact lenses after cataract surgery $0 copay for a yearly glaucoma screening *Out-of-network*: 30% of the total cost for each service
Routine Vision 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 benefits cannot be combined.	*In-network*: $0 copay for one routine exam each year (includes dilation and refraction) $0 copay 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	*In-network*: $0 copay for one routine exam each year (includes dilation and refraction) $0 copay for one retinal imaging per year $100 eyewear allowance per year *Out-of-network*: Up to $100 reimbursement for eyewear 30% of the total cost for one routine exam 30% of the total cost for retinal imaging
Mental Health Services		
Inpatient visits* We cover up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. *Prior authorization may be required.	*In-network*: $225 copay per day, days 1-6 $0 copay for additional hospital days *Out-of-network*: 30% of the total cost per stay	*In-network*: $350 copay per day, days 1-5 $0 copay for additional hospital days *Out-of-network*: 30% of the total cost per stay

	PriorityMedicare (HMO-POS)	**Priority**Medicare Merit (PPO)
Outpatient therapy (individual or group)	*In-network*: $20 copay for each visit *Out-of-network*: 30% of the total cost for each visit	*In-network*: $20 copay for each visit *Out-of-network*: 30% of the total cost for each visit
Skilled Nursing Facility (SNF)		
Skilled nursing facility* 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*: $0 copay per day, days 1 - 20 $218 copay per day, days 21 - 100 *Out-of-network*: 30% of the total cost per stay for each stay	
Outpatient Rehabilitation Services		
Physical therapy	*In-network*: $35 copay for each service *Out-of-network*: 30% of the total cost for each service	
Medical Transportation		
Ambulance* *Prior authorization may be required.	*In- and out-of-network*: $210 copay each way	*In- and out-of-network*: $270 copay each way
Transportation	Not covered	
Medicare Part B Drugs*		
Chemotherapy drugs **Other Part B drugs** **Select home infusion drugs** **Part B insulin** *Prior authorization or step therapy may be required.	*In- and out-of-network*: Up to 20% of the total cost for each drug Up to 20% of the total cost for each drug $0 copay for each drug Up to 20% of the total cost, with a maximum of $35 per month supply of insulin administered through an insulin pump.	

Prescription Drug Benefits

Important Message About What You Pay for Vaccines - Our plan covers most Part D vaccines at no cost to you, no matter what cost-sharing tier it's on.

Important Message About What You Pay for Insulin - You won't pay more than $35 for a one-month supply and no more than $105 for a three-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.

PART D OUTPATIENT PRESCRIPTION DRUGS		
	PriorityMedicare (HMO-POS)	**Priority**Medicare Merit (PPO)
Stage 1: Deductible stage	$0	$0
Stage 2: Initial coverage stage You are in this stage until your out-of-pocket Part D drug costs reach $2,400.	You pay what is listed in the chart below.	

STANDARD RETAIL PHARMACY				
	PriorityMedicare (HMO-POS)		**Priority**Medicare Merit (PPO)	
Standard Retail	**30-day supply**	**100-day supply**	**30-day supply**	**100-day supply**
Tier 1: Preferred generic	$6	$18	$7	$21
	30-day supply	**90-day supply**	**30-day supply**	**90-day supply**
Tier 2: Generic	$13	$39	$15	$45
Tier 3: Preferred brand	25%	25%	25%	25%
Tier 4: Non-preferred drug	33%	33%	34%	34%
Tier 5: Specialty*	33%	N/A	33%	N/A

PREFERRED RETAIL PHARMACY				
	PriorityMedicare (HMO-POS)		**Priority**Medicare Merit (PPO)	
Preferred Retail	**30-day supply**	**100-day supply**	**30-day supply**	**100-day supply**
Tier 1: Preferred generic	$1	$0	$2	$0
	30-day supply	**90-day supply**	**30-day supply**	**90-day supply**
Tier 2: Generic	$8	$24	$10	$30
Tier 3: Preferred brand	25%	25%	25%	25%
Tier 4: Non-preferred drug	28%	28%	29%	29%
Tier 5: Specialty*	33%	N/A	33%	N/A
Your costs will be less for your covered drugs when you use a pharmacy in our preferred network (includes Meijer, Walgreens, Walmart, Family Fare Supermarkets, Costco and more), go to ***prioritymedicare.com*** to view the list in the provider/pharmacy directory.				

PREFERRED MAIL ORDER				
	PriorityMedicare (HMO-POS)		**Priority**Medicare Merit (PPO)	
Preferred Mail Order	**30-day supply**	**100-day supply**	**30-day supply**	**100-day supply**
Tier 1: Preferred generic	$1	$0	$2	$0
	30-day supply	**90-day supply**	**30-day supply**	**90-day supply**
Tier 2: Generic	$8	$0	$10	$0
Tier 3: Preferred brand	25%	25%	25%	25%
Tier 4: Non-preferred drug	28%	28%	29%	29%
Tier 5: Specialty*	33%	N/A	33%	N/A
Your costs will be less for your covered drugs when you use a pharmacy in our preferred network (includes Express Scripts and Amazon), go to ***prioritymedicare.com*** to view the list in the provider/pharmacy directory. *Specialty drugs are limited to a 30-day supply.				

	PriorityMedicare (HMO-POS)	PriorityMedicare Merit (PPO)
Catastrophic coverage stage	Once your out-of-pocket drug costs reach $2,400, the plan pays the full cost of your covered Part D 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

Additional dental coverage, including coverage for dental services and an additional vision allowance for use on eyeglasses or contacts.

	PriorityMedicare (HMO-POS)	PriorityMedicare Merit (PPO)
Premium	**Enhanced Dental and Vision** **Option 1:** $42 per month **Option 2:** $61 per month You must keep paying your Medicare Part B premium and your $97 - $148 monthly plan premium.	**Enhanced Dental and Vision** **Option 1:** $42 per month **Option 2:** $61 per month You must keep paying your Medicare Part B premium and your $100 - $163 monthly plan premium.
Deductible	$0	
Maximum plan benefit coverage amount	$1,500 - $2,000 for comprehensive dental services, depending on the option you choose and an additional $150 for eyewear, per calendar year	
Dental services Delta Dental® is the preferred provider for additional dental services.	*In- and out-of-network* **Option 1:** $0 copay for one cleaning (regular or periodontal) per plan year $0 copay for scaling and root planing once per quadrant per 24 month period $1,500 annual maximum per year to use towards: 50% of the total cost for unlimited emergency treatment and anesthesia when used in conjunction with other services 50% of the total cost for fillings (including composite resin and amalgam) once per tooth every 24 months and crown repairs once per tooth every 12 months	

	PriorityMedicare (HMO-POS)	**Priority**Medicare Merit (PPO)
Dental services (continued)	50% of the total cost for other diagnostic services (i.e. cone beams) 50% of the total cost for surgical periodontal procedures (i.e. osseous surgery or gum grafts) once per quadrant every 36 months 50% of the total cost of onlays, crowns, and associated substructures once per tooth every 5 years 50% of the total cost of endodontics (root canals) once per tooth per lifetime 50% of the total cost of simple and surgical extractions once per tooth per lifetime 50% of the total cost of implants once per tooth, every 5 years 50% of the total cost of dentures and bridges once every 60 months, denture relines and repairs and bridge repairs once every 36 months **Option 2:** $0 copay for one cleaning (regular or periodontal) per plan year $0 copay for scaling and root planing once per quadrant per 24 month period $2,000 annual maximum per year to use towards: 25% of the total cost for unlimited emergency treatment and anesthesia when used in conjunction with other services 25% of the total cost for fillings (including composite resin and amalgam) once per tooth every 24 months and crown repairs once per tooth every 12 months 25% of the total cost for other diagnostic services (i.e. cone beams) 25% of the total cost for surgical periodontal procedures (i.e. osseous surgery or gum grafts) once per quadrant every 36 months 25% of the total cost of onlays, crowns, and associated substructures once per tooth every 5 years	

	PriorityMedicare (HMO-POS)	PriorityMedicare Merit (PPO)
Dental services (continued)	25% of the total cost of endodontics (root canals) once per tooth per lifetime 25% of the total cost of simple and surgical extractions once per tooth per lifetime 25% of the total cost of implants once per tooth, every 5 years 25% of the total cost of dentures and bridges 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 allowance/reimbursement per year for additional eyewear.	

Additional Benefits

	PriorityMedicare (HMO-POS)	PriorityMedicare Merit (PPO)
Additional Benefits		
Acupuncture	**Medicare-covered acupuncture for lower chronic back pain** *In- and out-of-network*: $20 copay per service **Non-Medicare-covered routine acupuncture for other conditions** *In- and out-of-network*: $20 copay per visit (limit 6 visits every year)	
Annual preventive physical exam	*In-network*: $0 copay for an exam *Out-of-network*: 30% of the total cost for an exam	

	PriorityMedicare (HMO-POS)	**Priority**Medicare Merit (PPO)
Annual preventive physical exam (continued)	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.	
Chiropractic services	**Medicare-covered care** *In-network*: $15 copay for each service *Out-of-network*: 30% of the total cost for each service	
Dialysis	*In-network*: 20% of the total cost for each service *Out-of-network*: 30% of the total cost for each service	
Home health services* *Prior authorization may be required.	*In- and out-of-network*: $0 copay for each Medicare-covered service	
Medical equipment and supplies* Examples include diabetic supplies (shoes/inserts, diabetic test strips), durable medical equipment (wheelchairs, oxygen, insulin pumps, continuous glucose monitors (CGM's)) and prosthetic devices (braces, artificial limbs). Diabetic test strips are limited to Contour® and Accu-Chek® Guide products when dispensed by an in-network retail or mail-order pharmacy. Continuous glucose monitors (CGM's) are limited to Dexcom® and Freestyle Libre® products when dispensed by an in-network retail or mail-order pharmacy.	**Diabetes supplies** *In-network*: $0 copay for each item *Out-of-network*: 30% of the total cost for each item **Durable medical equipment** *In-network*: 20% of the total cost for each item *Out-of-network*: 30% of the total cost for each item **Prosthetic devices** *In-network*: $0 - 20% of the total cost for each item, depending on the device *Out-of-network*: 30% of the total cost for each device	

<table>
<tr><th></th><th>PriorityMedicare (HMO-POS)</th><th>PriorityMedicare Merit (PPO)</th></tr>
<tr><td>Medical equipment and supplies* (continued)

There are no brand limitations when obtained through a durable medical equipment (DME) provider.

*Prior authorization may be required.</td><td colspan="2"></td></tr>
<tr><td>One Pass®

Fitness membership</td><td colspan="2">

$0 copay

One Pass® can help you reach your fitness goals while finding new passions along the way. Find a routine that’s right for you whether you work out at home or at the gym.

One Pass® includes:
• Access to the largest nationwide network of gyms and fitness locations
• Live, digital fitness classes and on-demand workouts
• Online brain training to improve your memory and focus
• One at home fitness kit per plan year</td></tr>
<tr><td>CogniFit®</td><td colspan="2">$0 copay

Access to the CogniFit® brain health program. Simply set up an account through One Pass® to access a collection of brain games to keep you interested, challenged, and engaged.

CogniFit® works by training over 20 cognitive skills that we use daily such as working memory, perception, attention, reasoning and coordination.</td></tr>
<tr><td></td><td>Out-of-network
<u>Not</u> covered</td><td>Out-of-network
Up to $60 reimbursement every year for comprehensive fitness benefit outside of the One Pass network (cannot combine with in-network benefit)</td></tr>
<tr><td>Podiatry services</td><td>Medicare-covered podiatry
In-network:
$40 copay for each visit</td><td>Medicare-covered podiatry
In-network:
$45 copay for each visit</td></tr>
</table>

	PriorityMedicare (HMO-POS)	**Priority**Medicare Merit (PPO)
Podiatry services (continued)	$0 copay for nail debridement and callous removal for members with specific conditions *Out-of-network*: 30% of the total cost for each visit and service	$0 copay for nail debridement and callous removal for members with specific conditions *Out-of-network*: 30% of the total cost for each visit or service
Priority Health Travel Benefit		
Out-of-area travel	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. Go to ***priorityhealth.com/provider-directory*** to find providers in our network. 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 plan's 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 and assistance while on your trip should a medical travel emergency arise, 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 rehabilitation services	*In-network*: $10 copay for each service *Out-of-network*: 30% of the total cost for each service	
Pulmonary rehabilitation and supervised exercise therapy (SET) services	*In-network*: $10 copay for each service *Out-of-network*: 30% of the total cost for each service	

	PriorityMedicare (HMO-POS)	PriorityMedicare Merit (PPO)
Rehabilitation services (continued) **Physical therapy, occupational therapy, and speech therapy services**	*In-network*: $35 copay for each service *Out-of-network*: 30% of the total cost for each service	
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 copay virtual visits with primary care, specialist, urgent care, 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	

Notes

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 888.309.5084 from 8 a.m. to 8 p.m. ET, 7 days a week (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 888.309.5084 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 may pay a higher copay to see them.
- 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/coinsurance may change on Jan. 1, 2028.
- Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for certain covered services, 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 monthly plan premium for people who get Extra Help from Medicare to help pay for their prescription drug costs

If you get extra help from Medicare to help pay for your Medicare prescription drug plan costs, your monthly plan premium will be lower than what it would be if you did not get extra help from Medicare.

If you get extra help, your monthly plan premium will be $0 for any of the plan(s) below. (This does not include any Medicare Part B premium you may have to pay.)

- **Priority**Medicare® Key (HMO-POS)
- **Priority**Medicare® Smart Savings (HMO-POS)
- **Priority**Medicare® Edge (PPO)
- **Priority**Medicare® Align (HMO-POS)

PriorityMedicare® Value (HMO-POS)

Region	Monthly premium if receiving Low Income Subsidy
Region 1: Allegan, Barry, Kent, Lenawee, Ottawa	$47
Region 2: Berrien, Calhoun, Cass, Ionia, Isabella, Kalamazoo, Mason, Midland, Missaukee, Montcalm, Muskegon, Newaygo, Oceana, Osceola, Otsego, St. Clair, Van Buren, Wexford	$70
Region 3: Alcona, Antrim, Benzie, Charlevoix, Clare, Crawford, Grand Traverse, Hillsdale, Lake, Lapeer, Leelanau, Manistee, Mecosta, Monroe	$105
Region 4: Alpena, Cheboygan, Eaton, Emmet, Gladwin, Gratiot, Iosco, Jackson, Kalkaska, Montmorency, Oscoda, Presque Isle, Roscommon, Sanilac, Shiawasse, St. Joseph	$72
Region 5: Arenac, Bay, Branch, Clinton, Genesee, Huron, Ingham, Livingston, Macomb, Oakland, Ogemaw, Saginaw, Tuscola, Washtenaw, Wayne	$70

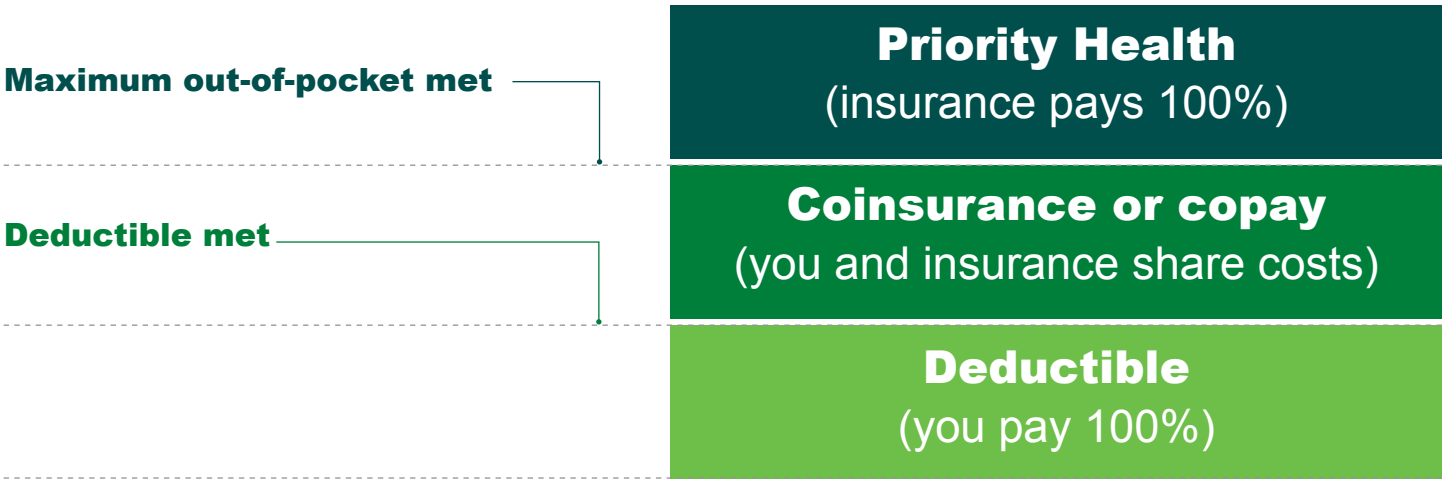
PriorityMedicare® Merit (HMO-POS)

Region	Monthly premium if receiving Low Income Subsidy
Region 1: Allegan, Barry, Kent, Lenawee, Ottawa	$98
Region 2: Berrien, Calhoun, Cass, Ionia, Isabella, Kalamazoo, Mason, Midland, Missaukee, Montcalm, Muskegon, Newaygo, Oceana, Osceola, Otsego, St. Clair, Van Buren, Wexford	$115
Region 3: Alcona, Antrim, Benzie, Charlevoix, Clare, Crawford, Grand Traverse, Hillsdale, Lake, Lapeer, Leelanau, Manistee, Mecosta, Monroe	$147
Region 4: Alpena, Cheboygan, Eaton, Emmet, Gladwin, Gratiot, Iosco, Jackson, Kalkaska, Montmorency, Oscoda, Presque Isle, Roscommon, Sanilac, Shiawasse, St. Joseph	$156
Region 5: Arenac, Bay, Branch, Clinton, Genesee, Huron, Ingham, Livingston, Macomb, Oakland, Ogemaw, Saginaw, Tuscola, Washtenaw, Wayne	$138

PriorityMedicare® (HMO-POS)

Region	Monthly premium if receiving Low Income Subsidy
Region 1: Allegan, Barry, Kent, Lenawee, Ottawa	$89
Region 2: Berrien, Calhoun, Cass, Ionia, Isabella, Kalamazoo, Mason, Midland, Missaukee, Montcalm, Muskegon, Newaygo, Oceana, Osceola, Otsego, St. Clair, Van Buren, Wexford	$94
Region 3: Alcona, Antrim, Benzie, Charlevoix, Clare, Crawford, Grand Traverse, Hillsdale, Lake, Lapeer, Leelanau, Manistee, Mecosta, Monroe	$138
Region 4: Alpena, Cheboygan, Eaton, Emmet, Gladwin, Gratiot, Iosco, Jackson, Kalkaska, Montmorency, Oscoda, Presque Isle, Roscommon, Sanilac, Shiawasse, St. Joseph	$122
Region 5: Arenac, Bay, Branch, Clinton, Genesee, Huron, Ingham, Livingston, Macomb, Oakland, Ogemaw, Saginaw, Tuscola, Washtenaw, Wayne	$88

How do health insurance costs work?

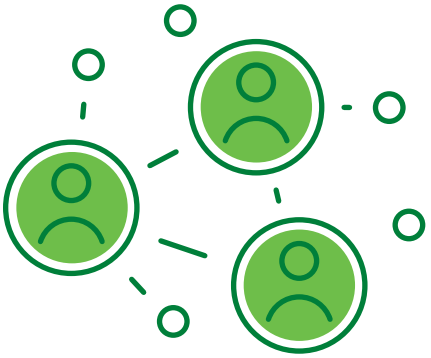


How does Original Medicare work with Medicare Advantage plans?

Original Medicare (health insurance from the federal government) may not be enough to cover all of your health care needs. 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 fitness membership*		●
Routine vision, including eyewear allowance		●
Routine hearing, including hearing aid coverage		●

Not available on **PriorityMedicare Align.*



Contact us

BY PHONE

Speak with Priority Health Medicare experts. From Oct. 1-Mar. 31, we're available seven days a week from 8 a.m.-8 p.m. and Saturday from 8 a.m.-noon ET.

Already a member?
Call 888.389.6648 (TTY 711)

Not a member yet?
Call 888.309.5084 (TTY 711)

ONLINE

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 the document. To get a complete list of services we cover including any limitations or exclusions, review the Evidence of Coverage document online at ***prioritymedicare.com***.

Priority Health was named to the America's Best Customer Service in Financial Services list by USA TODAY for 2026, and to Newsweek's America's Best Customer Service list for 2025 and 2024.

One Pass is a voluntary program. The One Pass program varies by plan/area. Information provided is not medical advice. Consult a health care professional before beginning any exercise program.

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. Y0056_100010992700_M ©2026 Priority Health MR296 PH38285-3.1 08/26