Summary of Benefits

PriorityMedicare Key℠ (HMO-POS)
PriorityMedicare Value℠ (HMO-POS)
PriorityMedicare℠ (HMO-POS)
PriorityMedicare Edge℠ (PPO)
PriorityMedicare Ideal℠ (PPO)
PriorityMedicare Merit℠ (PPO)
PriorityMedicare Select℠ (PPO)

JANUARY 1, 2020 – DECEMBER 31, 2020

PriorityHealth
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This booklet gives you a summary of the benefits you can expect when you choose a Priority Health Medicare Advantage HMO-POS or PPO plan. Inside you'll find information you can use to make a Medicare decision you'll feel good about.

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

Priority Health Medicare offers two kinds of plans – HMO-POS and PPO. Here's information to help you understand the difference.

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. You typically don't need a referral to see a specialist, but your doctor can sometimes help you get in to see one more quickly.

PPO stands for Preferred Provider Organization (PPO). With these plans, you generally don't need referrals 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.

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

Prescription coverage

All of these Medicare Advantage plans include prescription drug coverage. To make an informed decision about your Medicare plan, you'll want to review our Provider/Pharmacy Directory because 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. You will also want to review our formulary, or the list of drugs our plans cover. You can find in-network pharmacies and approved drugs on our website at ***prioritymedicare.com***, or call our customer service number.

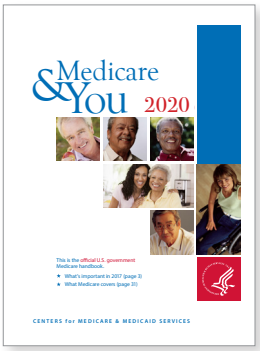
Eligibility

In order to join any of our Medicare Advantage plans, you need to be enrolled in Medicare Part A and Part B, and live in our service area—all 68 counties in the lower peninsula of Michigan.

Contact us

If you have questions, call one of our Priority Health Medicare experts from 8 a.m. to 8 p.m., seven days a week (TTY users call 711):
Already a member? Call 888.389.6648
Not a member yet? Call 877.333.0450

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



*Another resource available to you when researching your Medicare options is the **2020 Medicare & You** handbook. View it online at **medicare.gov** or get a copy by calling 800.MEDICARE (800.633.4227), 24 hours a day, seven days a week. TTY users should call 877.486.2048.*

Important health insurance terms to know

To help you better understand our plans, here are some common terms that will help you make a smart decision about your Medicare plan.

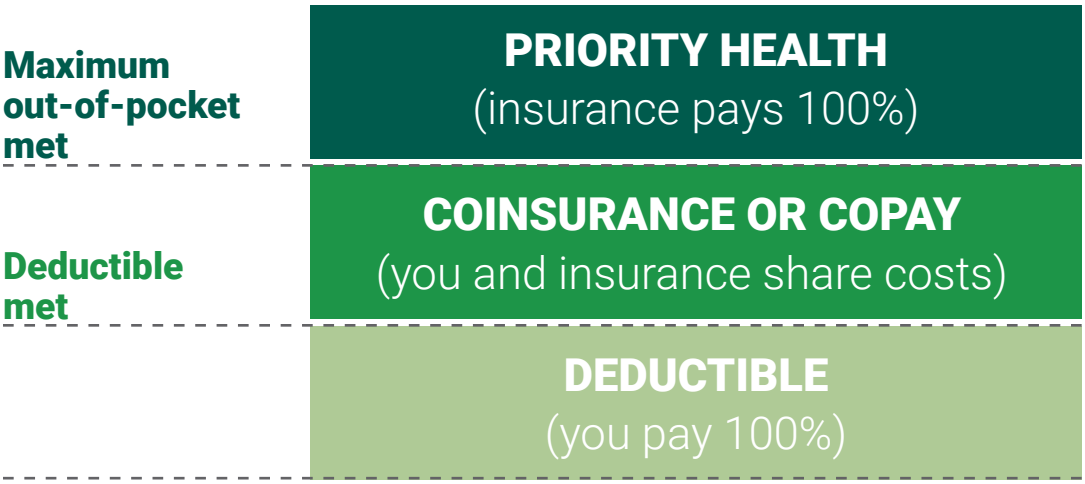
Deductible: This is the amount you pay each year before the health plan starts to pay for certain services, and you start paying a portion of the cost (copay or coinsurance). Priority Health Medicare Advantage plans do not have an in-network medical deductible, so you'll start paying only your copay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

Coinsurance: After you've paid your deductible, you may have a coinsurance as your portion of the cost for medical services or prescriptions. Coinsurance is a percentage of the cost of a medical service or prescription and is listed as a benefit in your health plan.

Copay: After you've paid your deductible, you may have a copay as your portion of the cost for medical services or prescriptions. This is a fixed amount you pay, generally at the time you receive a health care service or when you get a prescription filled.

Maximum out-of-pocket: This is the most you will pay for covered medical services for the year. Your coinsurance or copays count towards the maximum out-of-pocket; premiums and prescription costs do not.

How do health insurance costs work?



How does Original Medicare work with Medicare Advantage plans?

Original Medicare—health insurance from the federal government—may not be enough to cover all of your health care needs in retirement. Priority Health Medicare Advantage plans include everything that Original Medicare covers, plus extra benefits and services to help you save money and stay healthy.

	Original Medicare	Priority Health Medicare Advantage Plans
Covers your Medicare Part A and Part B services	✓	✓
Coverage in addition to Medicare Part A and B		✓
Predictable copays and limits to what you'll pay out-of-pocket for medical care		✓
Part D prescription drug coverage		✓
Preventive dental services		✓
Free gym membership		✓
Routine vision, including eyewear allowance		✓
Routine hearing, including hearing aid coverage		✓

Premiums and benefits

PPO PLANS

Premiums and benefits	**Priority**Medicare Edge (PPO)	**Priority**Medicare Ideal (PPO)	**Priority**Medicare Merit (PPO)	**Priority**Medicare Select (PPO)
Monthly plan premium	**$0 per month.** In addition, you must keep paying your Medicare Part B premium. **Available in Region 5 only.** See page 21 for a listing of counties in this region.	**$14 – $18 per month.** In addition, you must keep paying your Medicare Part B premium.	**$44 – $103 per month.** In addition, you must keep paying your Medicare Part B premium.	**$136 – $205 per month.** In addition, you must keep paying your Medicare Part B premium.
Deductible The amount you'll pay for most covered services before you start paying only copays or coinsurance and Priority Health pays the balance.	**Medical services** *In-network and out-of-network (combined):* $0 **Prescription drugs (Part D)** Tiers 1 – 2: $0 Tiers 3 – 5: $75	**Medical services** *In-network and out-of-network (combined):* $0 **Prescription drugs (Part D)** Tiers 1 – 5: $125	**Medical services** *In-network and out-of-network (combined):* $0 **Prescription drugs (Part D)** Tiers 1 – 5: $0	**Medical services** *In-network and out-of-network (combined):* $0 **Prescription drugs (Part D)** Tiers 1 – 5: $0
Maximum out-of-pocket responsibility This is the most you pay for covered medical services for the year, excluding Part D prescription drugs.	*In-network and out-of-network services (combined):* $5,300	*In-network and out-of-network services (combined):* $6,000	*In-network and out-of-network services (combined):* $4,100	*In-network and out-of-network services (combined):* $3,500

Premiums and benefits	**Priority**Medicare Edge (PPO)	**Priority**Medicare Ideal (PPO)	**Priority**Medicare Merit (PPO)	**Priority**Medicare Select (PPO)
MEDICAL BENEFITS COVERED UNDER YOUR PLAN				
Inpatient hospital coverage We cover an unlimited number of days for an inpatient hospital stay. Prior authorization may be required.	*In-network:* Days 1-5: $350 each day Days 6 and beyond: $0 each day *Out-of-network:* 40% for each stay	*In-network:* Days 1-6: $300 each day Days 7 and beyond: $0 each day *Out-of-network:* 45% for each stay	*In-network:* Days 1-5: $375 each day Days 6 and beyond: $0 each day *Out-of-network:* 30% for each stay	*In-network:* Days 1-6: $200 each day Days 7 and beyond: $0 each day *Out-of-network:* 30% for each stay
Outpatient hospital coverage Prior authorization may be required.	**Ambulatory surgery center** *In-network:* $325 for each visit *Out-of-network:* 40% for each visit **Outpatient hospital** *In-network:* $325 for each visit *Out-of-network:* 40% for each visit **Observation** *In-network and out-of-network:* $90 for each visit, including all services received	**Ambulatory surgery center** *In-network:* $250 for each visit *Out-of-network:* 45% for each visit **Outpatient hospital** *In-network:* $250 for each visit *Out-of-network:* 45% for each visit **Observation** *In-network and out-of-network:* $90 for each visit, including all services received	**Ambulatory surgery center** *In-network:* $225 for each visit *Out-of-network:* 30% for each visit **Outpatient hospital** *In-network:* $225 for each visit *Out-of-network:* 30% for each visit **Observation** *In-network and out-of-network:* $90 for each visit, including all services received	**Ambulatory surgery center** *In-network:* $200 for each visit *Out-of-network:* 30% for each visit **Outpatient hospital** *In-network:* $200 for each visit *Out-of-network:* 30% for each visit **Observation** *In-network and out-of-network:* $90 for each visit, including all services received

Use the out-of-state travel benefit anywhere in the U.S. when outside the state of Michigan and pay the same as when you're in-network.

Premiums and benefits

PPO PLANS

Premiums and benefits	**Priority**Medicare Edge (PPO)	**Priority**Medicare Ideal (PPO)	**Priority**Medicare Merit (PPO)	**Priority**Medicare Select (PPO)
Doctor visits Prior authorization may be required for some specialist visits.	**Primary care physician (PCP)** *In-network:* $0 for each office visit $0 for surgical procedures performed in a PCP's office *Out-of-network:* 40% for each visit **Specialist visit** *In-network:* $40 for each office visit $0 for surgical procedures performed in a specialist's office *Out-of-network:* 40% for each visit	**Primary care physician (PCP)** *In-network:* $15 for each office visit $0 for surgical procedures performed in a PCP's office *Out-of-network:* 45% for each visit **Specialist visit** *In-network:* $50 for each office visit $0 for surgical procedures performed in a specialist's office *Out-of-network:* 45% for each visit	**Primary care physician (PCP)** *In-network:* $20 for each office visit $0 for surgical procedures performed in a PCP's office *Out-of-network:* 30% for each visit **Specialist visit** *In-network:* $45 for each office visit $0 for surgical procedures performed in a specialist's office *Out-of-network:* 30% for each visit	**Primary care physician (PCP)** *In-network:* $15 for each office visit $0 for surgical procedures performed in a PCP's office *Out-of-network:* 30% for each visit **Specialist visit** *In-network:* $40 for each office visit $0 for surgical procedures performed in a specialist's office *Out-of-network:* 30% for each visit
Preventive care	*In-network:* $0 for each service *Out-of-network:* 40% for each service	*In-network:* $0 for each service *Out-of-network:* 45% for each service	*In-network:* $0 for each service *Out-of-network:* 30% for each service	*In-network:* $0 for each service *Out-of-network:* 30% for each service
	This includes mammograms, certain vaccinations, and more. See *prioritymedicare.com* for the complete listing. A referral from your doctor may be required for some preventive services.			
Emergency care This amount is waived if you are admitted as inpatient to the hospital within 24 hours from your emergency care visit.	*In-network and out-of-network:* $90 for each visit	*In-network and out-of-network:* $90 for each visit	*In-network and out-of-network:* $90 for each visit	*In-network and out-of-network:* $90 for each visit

Use the out-of-state travel benefit anywhere in the U.S. when outside the state of Michigan and pay the same as when you're in-network.

Premiums and benefits	**Priority**Medicare Edge (PPO)	**Priority**Medicare Ideal (PPO)	**Priority**Medicare Merit (PPO)	**Priority**Medicare Select (PPO)
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-network and out-of-network:* $30 for each visit	*In-network and out-of-network:* $50 for each visit	*In-network and out-of-network:* $55 for each visit	*In-network and out-of-network:* $50 for each visit
Outpatient diagnostic services Prior authorization may be required for some services.	**Radiology/imaging** *In-network:* $225 per day, per provider **Tests/procedures** *In-network:* $10 per day, per provider **Lab services** *In-network:* $10 per day, per provider **Outpatient x-rays** *In-network:* $20 per day, per provider **Radiation therapy** *In-network:* $40 per day, per provider *For all out-of-network services listed above:* 40% per day, per provider	**Radiology/imaging** *In-network:* $150 per day, per provider **Tests/procedures** *In-network:* $15 per day, per provider **Lab services** *In-network:* $15 per day, per provider **Outpatient x-rays** *In-network:* $40 per day, per provider **Radiation therapy** *In-network:* $30 per day, per provider *For all out-of-network services listed above:* 45% per day, per provider	**Radiology/imaging** *In-network:* $125 per day, per provider **Tests/procedures** *In-network:* $20 per day, per provider **Lab services** *In-network:* $20 per day, per provider **Outpatient x-rays** *In-network:* $35 per day, per provider **Radiation therapy** *In-network:* $30 per day, per provider *For all out-of-network services listed above:* 30% per day, per provider	**Radiology/imaging** *In-network:* $75 per day, per provider **Tests/procedures** *In-network:* $20 per day, per provider **Lab services** *In-network:* $20 per day, per provider **Outpatient x-rays** *In-network:* $30 per day, per provider **Radiation therapy** *In-network:* $25 per day, per provider *For all out-of-network services listed above:* 30% per day, per provider

Premiums and benefits

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Premiums and benefits	**Priority**Medicare Edge (PPO)	**Priority**Medicare Ideal (PPO)	**Priority**Medicare Merit (PPO)	**Priority**Medicare Select (PPO)
Hearing services Medicare-covered exam performed by a primary care physician or specialist to diagnose and treat hearing and balance issues. Routine hearing services must be received from a TruHearing provider.	**Medicare-covered hearing services** *In-network:* $0 – $40 for each visit *Out-of-network:* 40% for each visit **Routine hearing services** $0 for one routine hearing exam, per year $295, $695, $1,095 or $1,495 copay, per ear per year, for hearing aids from top manufacturers depending on level selected Hearing aid cost includes 3 fitting and follow-up evaluations within the first year and 48 batteries per hearing aid	**Medicare-covered hearing services** *In-network:* $15 – $50 for each visit *Out-of-network:* 45% for each visit **Routine hearing services** $0 for one routine hearing exam, per year $295, $695, $1,095 or $1,495 copay, per ear per year, for hearing aids from top manufacturers depending on level selected Hearing aid cost includes 3 fitting and follow-up evaluations within the first year and 48 batteries per hearing aid	**Medicare-covered hearing services** *In-network:* $20 – $45 for each visit *Out-of-network:* 30% for each visit **Routine hearing services** $0 for one routine hearing exam, per year $295, $695, $1,095 or $1,495 copay, per ear per year, for hearing aids from top manufacturers depending on level selected Hearing aid cost includes 3 fitting and follow-up evaluations within the first year and 48 batteries per hearing aid	**Medicare-covered hearing services** *In-network:* $15 – $40 for each visit *Out-of-network:* 30% for each visit **Routine hearing services** $0 for one routine hearing exam, per year $295, $695, $1,095 or $1,495 copay, per ear per year, for hearing aids from top manufacturers depending on level selected Hearing aid cost includes 3 fitting and follow-up evaluations within the first year and 48 batteries per hearing aid

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Premiums and benefits	**Priority**Medicare Edge (PPO)	**Priority**Medicare Ideal (PPO)	**Priority**Medicare Merit (PPO)	**Priority**Medicare Select (PPO)
Dental services Prior authorization may be required for Medicare-covered dental services. Preventive (routine) dental services provided by Delta Dental. See the Delta Dental Certificate of Coverage for details.	**Medicare-covered dental services** *In-network:* $0 – $325 for each visit, depending on the service performed *Out-of-network:* 40% for each visit **Preventive (routine) dental services** $0 for two cleanings (regular or periodontal) per year $0 for two exams per year $0 for one set of bitewing x-rays per year	**Medicare-covered dental services** *In-network:* $15 – $250 for each visit, depending on the service performed *Out-of-network:* 45% for each visit **Preventive (routine) dental services** $0 for two cleanings (regular or periodontal) per year $0 for two exams per year $0 for one set of bitewing x-rays per year	**Medicare-covered dental services** *In-network:* $20 – $225 for each visit, depending on the service performed *Out-of-network:* 30% for each visit **Preventive (routine) dental services** $0 for two cleanings (regular or periodontal) per year $0 for two exams per year $0 for one set of bitewing x-rays per year $0 for one brush biopsy per year $0 all other x-rays (one every 2 years)	**Medicare-covered dental services** *In-network:* $15 – $200 for each visit, depending on the service performed *Out-of-network:* 30% for each visit **Preventive (routine) dental services** $0 for two cleanings (regular or periodontal) per year $0 for two exams per year $0 for one set of bitewing x-rays per year $0 for one brush biopsy per year $0 all other x-rays (one every 2 years)

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Vision services Medicare-covered exam performed by a specialist to diagnose and treat diseases and conditions of the eye, and additional Medicare-covered services. Routine vision services must be provided by an EyeMed "Select" provider.	**Medicare covered services** *In-network:* $40 for each visit $0 for eyeglasses or contact lenses after cataract surgery $0 for a yearly glaucoma screening *Out-of-network:* 40% for each visit 40% for eyeglasses or contact lenses after cataract surgery 40% for a yearly glaucoma screening **Routine vision services** $0 for one routine exam each year (includes dilation and refraction) $0 for one retinal imaging per year $100 eyewear allowance per year	**Medicare-covered services** *In-network:* $50 for each visit $0 for eyeglasses or contact lenses after cataract surgery $0 for a yearly glaucoma screening *Out-of-network:* 45% for each visit 45% for eyeglasses or contact lenses after cataract surgery 45% for a yearly glaucoma screening **Routine vision services** $0 for one routine exam each year (includes dilation and refraction) $0 for one retinal imaging per year $100 eyewear allowance per year	**Medicare-covered services** *In-network:* $45 for each visit $0 for eyeglasses or contact lenses after cataract surgery $0 for a yearly glaucoma screening *Out-of-network:* 30% for each visit 30% for eyeglasses or contact lenses after cataract surgery 30% for a yearly glaucoma screening **Routine vision services** $0 for one routine exam each year (includes dilation and refraction) $0 for one retinal imaging per year $100 eyewear allowance per year	**Medicare-covered services** *In-network:* $40 for each visit $0 for eyeglasses or contact lenses after cataract surgery $0 for a yearly glaucoma screening *Out-of-network:* 30% for each visit 30% for eyeglasses or contact lenses after cataract surgery 30% for a yearly glaucoma screening **Routine vision services** $0 for one routine exam each year (includes dilation and refraction) $0 for one retinal imaging per year $100 eyewear allowance per year

Use the out-of-state travel benefit anywhere in the U.S. when outside the state of Michigan and pay the same as when you're in-network.

Premiums and benefits	**Priority**Medicare Edge (PPO)	**Priority**Medicare Ideal (PPO)	**Priority**Medicare Merit (PPO)	**Priority**Medicare Select (PPO)
Mental health care We cover up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. Prior authorization may be required.	**Inpatient visit** *In-network:* Days 1 – 5: $350 each day Days 6 – 90: $0 each day *Out-of-network:* 40% for each stay **Outpatient therapy (individual or group)** *In-network:* $20 for each visit *Out-of-network:* 40% for each visit	**Inpatient visit** *In-network:* Days 1 – 6: $290 each day Days 7 – 90: $0 each day *Out-of-network:* 45% for each stay **Outpatient therapy (individual or group)** *In-network:* $20 for each visit *Out-of-network:* 45% for each visit	**Inpatient visit** *In-network:* Days 1 – 5: $350 each day Days 6 – 90: $0 each day *Out-of-network:* 30% for each stay **Outpatient therapy (individual or group)** *In-network:* $20 for each visit *Out-of-network:* 30% for each visit	**Inpatient visit** *In-network:* Days 1 – 6: $200 each day Days 7 – 90: $0 each day *Out-of-network:* 30% for each stay **Outpatient therapy (individual or group)** *In-network:* $20 for each visit *Out-of-network:* 30% for each visit

Premiums and benefits

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Skilled Nursing Facility (SNF) Our plan covers up to 100 days each benefit period. A benefit period starts the day you go into a SNF and ends when you go for 60 days in a row without SNF care. Prior authorization may be required.	*In-network:* Days 1 – 20: $0 each day Days 21 – 100: $178 each day *Out-of-network:* 40% for each stay	*In-network:* Days 1 – 20: $0 each day Days 21 – 100: $178 each day *Out-of-network:* 45% for each stay	*In-network:* Days 1 – 20: $0 each day Days 21 – 100: $178 each day *Out-of-network:* 30% for each stay	*In-network:* Days 1 – 20: $0 each day Days 21 – 100: $178 each day *Out-of-network:* 30% for each stay
Physical therapy	*In-network:* $40 for each visit *Out-of-network:* 40% for each visit	*In-network:* $40 for each visit *Out-of-network:* 45% for each visit	*In-network:* $35 for each visit *Out-of-network:* 30% for each visit	*In-network:* $30 for each visit *Out-of-network:* 30% for each visit
Ambulance Prior authorization may be required.	*In-network or out-of-network:* $275 each way	*In-network or out-of-network:* $275 each way	*In-network or out-of-network:* $250 each way	*In-network or out-of-network:* $200 each way
Transportation	Not covered	Not covered	Not covered	Not covered

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Premiums and benefits	**Priority**Medicare Edge (PPO)	**Priority**Medicare Ideal (PPO)	**Priority**Medicare Merit (PPO)	**Priority**Medicare Select (PPO)
PRESCRIPTION DRUG BENEFITS				
Medicare Part B drugs Prior authorization may be required.	**Chemotherapy drugs** In-network or out-of-network: 20% for each drug **Other Part B drugs** In-network or out-of-network: 20% for each drug **Home infusion drugs** In-network or out-of-network: $0 for each drug			
PART D OUTPATIENT PRESCRIPTION DRUGS				
Deductible stage You'll pay this amount before you begin paying copays or coinsurance only.	Tiers 1 – 2: $0 Tiers 3 – 5: $75	Tiers 1 – 5: $125	Tiers 1 – 5: $0	Tiers 1 – 5: $0
Initial coverage stage You are in this stage until your drug total reaches $4,020, which includes what you pay out-of-pocket and what we pay for your covered drugs.	Once you have paid your deductible (only required for drugs in Tiers 3 – 5) you pay what is listed in the chart below.	Once you have paid your deductible you pay what is listed in the chart below.	You pay what is listed in the chart below.	You pay what is listed in the chart below.

PREFERRED RETAIL PHARMACY												
Initial coverage stage	30 day supply	60 day supply	90 day supply	30 day supply	60 day supply	90 day supply	30 day supply	60 day supply	90 day supply	30 day supply	60 day supply	90 day supply
Tier 1 (Preferred generic)	$2	$4	$6	$4	$8	$12	$2	$4	$6	$1	$2	$3
Tier 2 (Generic)	$8	$16	$24	$13	$26	$39	$10	$20	$30	$7	$14	$21
Tier 3 (Preferred brand)	$38	$76	$114	$42	$84	$126	$42	$84	$126	$37	$74	$111
Tier 4 (Non-preferred)	40%	40%	40%	50%	50%	50%	50%	50%	50%	45%	45%	45%
Tier 5 (Specialty tier)	31%	N/A	N/A	30%	N/A	N/A	33%	N/A	N/A	33%	N/A	N/A

Your costs will be less for your covered drugs when you use a pharmacy in our preferred network (includes Meijer, Walgreens, Walmart, Rite Aid, Kroger, Family Fare Supermarkets, Costco and more). Go to *prioritymedicare.com* to view the list in the Provider/Pharmacy Directory.

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STANDARD RETAIL PHARMACY												
Initial coverage stage	30 day supply	60 day supply	90 day supply	30 day supply	60 day supply	90 day supply	30 day supply	60 day supply	90 day supply	30 day supply	60 day supply	90 day supply
Tier 1 (Preferred generic)	$6	$12	$18	$9	$18	$27	$7	$14	$21	$6	$12	$18
Tier 2 (Generic)	$13	$26	$39	$18	$36	$54	$15	$30	$45	$12	$24	$36
Tier 3 (Preferred brand)	$43	$86	$129	$47	$94	$141	$47	$94	$141	$42	$84	$126
Tier 4 (Non-preferred)	45%	45%	45%	50%	50%	50%	50%	50%	50%	50%	50%	50%
Tier 5 (Specialty tier)	31%	N/A	N/A	30%	N/A	N/A	33%	N/A	N/A	33%	N/A	N/A
MAIL ORDER												
Initial coverage stage	30 day supply	60 day supply	90 day supply	30 day supply	60 day supply	90 day supply	30 day supply	60 day supply	90 day supply	30 day supply	60 day supply	90 day supply
Tier 1 (Preferred generic)	$2	$4	$0	$4	$8	$0	$2	$4	$0	$1	$2	$0
Tier 2 (Generic)	$8	$16	$0	$13	$26	$0	$10	$20	$0	$7	$14	$0
Tier 3 (Preferred brand)	$38	$76	$95	$42	$84	$105	$42	$84	$105	$37	$74	$92.50
Tier 4 (Non-preferred)	40%	40%	40%	50%	50%	50%	50%	50%	50%	45%	45%	45%
Tier 5 (Specialty tier)	31%	N/A	N/A	30%	N/A	N/A	33%	N/A	N/A	33%	N/A	N/A
Coverage gap stage (also known as the "donut hole")	Once the total yearly drug costs (what you've paid plus what we've paid) reach $4,020 you enter the coverage gap and then you pay a percentage of the cost we have negotiated for the drug: • 25% of what we would pay for the covered brand name drug • 25% of what we would pay for the covered generic drug When your drug costs reach $6,350, this is the end of the coverage gap stage.											
Catastrophic coverage stage	Once your drug costs reach $6,350 you will pay the larger amount, which is either: • 5% of the cost of the drug, or • $3.60 for generic, and • $8.95 for all other drugs											
Long-term care (LTC)	If you are a resident of a long-term care (LTC) facility, you may get your prescription drugs through the facility's pharmacy as long as it is part of our network. Check the Provider/Pharmacy Directory available at *prioritymedicare.com* or call Customer Service if you have questions.											

Premiums and benefits	**Priority**Medicare Edge (PPO)	**Priority**Medicare Ideal (PPO)	**Priority**Medicare Merit (PPO)	**Priority**Medicare Select (PPO)
OPTIONAL ENHANCED DENTAL AND VISION PACKAGE				
Benefits	Additional dental coverage, including coverage for advanced dental work and an additional vision allowance for use on eyeglasses or contacts.			
Premium	**Additional $33 per month.** You must keep paying your Medicare Part B premium and your $0 monthly plan premium.	**Additional $33 per month.** You must keep paying your Medicare Part B premium and your $14 – $18 monthly plan premium.	**Additional $29 per month.** You must keep paying your Medicare Part B premium and your $44 – $103 monthly plan premium.	**Additional $29 per month.** You must keep paying your Medicare Part B premium and your $136 – $205 monthly plan premium.
Deductible	$0			
Maximum plan benefit coverage amount	We pay up to $1,650 which includes $1,500 for covered dental services and $150 for eyewear, per calendar year.			
Dental services Preventive (routine) dental services provided by Delta Dental. See the Delta Dental Certificate of Coverage for details.	$0 copay for fillings, one brush biospy and anesthesia, each year. $0 copay for one other x-ray (i.e. panoramic), once every 2 years. 50% of the cost for simple extractions, films/ tests and relines and repairs to bridges and dentures, each year. 50% of the cost for crowns and root canals, each year. 30% of the cost for surgical extractions and other oral surgery, each year.		$0 copay for fillings and anesthesia, each year. 50% of the cost for simple extractions, films/ tests and relines and repairs to bridges and dentures, each year. 50% of the cost for crowns and root canals, each year. 30% of the cost for surgical extractions and other oral surgery, each year.	
Vision services Services must be provided by an EyeMed "Select" provider.	$150 additional eyewear allowance per year			

Premiums and benefits

PPO PLANS

Premiums and benefits	**Priority**Medicare Edge (PPO)	**Priority**Medicare Ideal (PPO)	**Priority**Medicare Merit (PPO)	**Priority**Medicare Select (PPO)
ADDITIONAL MEDICAL BENEFITS COVERED UNDER YOUR PLAN				
Annual preventive physical exam You're free to talk at your annual preventive exam. You will not be charged for the office visit no matter what or how much is discussed. This is an opportunity for you and your physician to discuss any concerns or questions you have.	*In-network:* $0 for an exam *Out-of-network:* 40% for an exam	*In-network:* $0 for an exam *Out-of-network:* 45% for an exam	*In-network:* $0 for an exam *Out-of-network:* 30% for an exam	*In-network:* $0 for an exam *Out-of-network:* 30% for an exam
Chiropractic care	**Medicare-covered care** *In-network:* $20 for each visit *Out-of-network:* 40% for each visit **Routine care** *In-network:* $20 for each visit (limit 12 per year) $20 for one x-ray each year *Out-of-network:* 40% for each visit 40% for one x-ray each year	**Medicare-covered care** *In-network:* $20 for each visit *Out-of-network:* 45% for each visit **Routine care** *In-network:* $20 for each visit (limit 12 per year) $40 for one x-ray each year *Out-of-network:* 45% for each visit 45% for one x-ray each year	**Medicare-covered care** *In-network:* $20 for each visit *Out-of-network:* 30% for each visit	**Medicare-covered care** *In-network:* $20 for each visit *Out-of-network:* 30% for each visit

Premiums and benefits	**Priority**Medicare Edge (PPO)	**Priority**Medicare Ideal (PPO)	**Priority**Medicare Merit (PPO)	**Priority**Medicare Select (PPO)
ADDITIONAL MEDICAL BENEFITS COVERED UNDER YOUR PLAN				
Companion care with Papa Papa connects college students ("Papa Pals") to Medicare members with specific chronic conditions who need assistance with transportation, house chores, technology lessons, companionship, and other senior services.	$0 for up to 8 hours of companion care each month if eligibility requirements are met.	$0 for up to 8 hours of companion care each month if eligibility requirements are met.	Not covered	Not covered
	An in-home health assessment with Priority Health Medicare's approved provider, Signify, is required to determine eligibility. See the Evidence of Coverage (EOC) document or visit *prioritymedicare.com* for details.			
Medical equipment and supplies Examples include diabetic supplies (shoes/inserts, diabetic test strips), durable medical equipment (wheelchairs, oxygen, insulin pumps), and prosthetic devices (braces, artificial limbs). Diabetic test strips are limited to OneTouch®(JJHCS), Breeze®(Bayer) and Contour®(Bayer) products when dispensed by a retail pharmacy or mail-order pharmacy. Prior authorization may be required.	**Diabetes supplies** *In-network:* $0 for each item *Out-of-network:* 40% for each item **Durable medical equipment** *In-network:* 20% for each item *Out-of-network:* 30% for each item **Prosthetic devices** *In-network:* 0 – 20% for each item, depending on the device *Out-of-network:* 30% for each device	**Diabetes supplies** *In-network:* $0 for each item *Out-of-network:* 45% for each item **Durable medical equipment** *In-network:* 20% for each item *Out-of-network:* 30% for each item **Prosthetic devices** *In-network:* 0 – 20% for each item, depending on the device *Out-of-network:* 30% for each device	**Diabetes supplies** *In-network:* $0 for each item *Out-of-network:* 30% for each item **Durable medical equipment** *In-network:* 20% for each item *Out-of-network:* 30% for each item **Prosthetic devices** *In-network:* 0 – 20% for each item, depending on the device *Out-of-network:* 30% for each device	**Diabetes supplies** *In-network:* $0 for each item *Out-of-network:* 30% for each item **Durable medical equipment** *In-network:* 20% for each item *Out-of-network:* 30% for each item **Prosthetic devices** *In-network:* 0 – 20% for each item, depending on the device *Out-of-network:* 30% for each device

Premiums and benefits

PPO PLANS

Premiums and benefits	**Priority**Medicare Edge (PPO)	**Priority**Medicare Ideal (PPO)	**Priority**Medicare Merit (PPO)	**Priority**Medicare Select (PPO)
ADDITIONAL MEDICAL BENEFITS COVERED UNDER YOUR PLAN				
Out-of-state travel benefit 	You'll pay in-network prices when seeking care anywhere in the U.S. outside of Michigan, when you see Medicare approved providers. You may stay enrolled in the plan when outside of the service area for up to 12 months, as long as your residency remains in the service area.			
Over-the-counter (OTC) allowance + Healthy Savings program	$25 per quarter for OTC items.	$75 per quarter for OTC items.	Not covered	Not covered
	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. Items can be purchased in participating stores (Walmart, CVS, Kroger and more). Or, over the phone or online at ***walmart.com***, with free 2-day shipping. After signing up for this benefit, you'll receive a separate OTC card in the mail. The Healthy Savings program allows members to save on healthier foods with up to $1,500 a year in discounts on healthier food options in-store at Walmart. Just scan your card at check-out to take advantage of the savings. For full details, refer to ***prioritymedicare.com*** or the Evidence of Coverage (EOC) document.			
SilverSneakers®	$0 for membership at participating SilverSneakers® fitness centers, plus access to online educational programs and SilverSneakers On-Demand™ workout videos. Even more workout options with the SilverSneakers GO™ fitness app or SilverSneakers Steps® home fitness kits. SilverSneakers® locations are nationwide. To find a participating fitness center go to ***silversneakers.com*** and search for one near you, or call toll-free 833.236.0190 (TTY 711), Monday through Friday, 8 a.m. to 8 p.m. For assistance on Saturday or Sunday, call Priority Health Medicare at 888.389.6648 (TTY 711), from 8 a.m. to 8 p.m. The SilverSneakers® program is provided by Tivity Health®. All programs and services may not be available in all areas.			
Virtual visits	$0 for each virtual visit with a PCP or specialist via phone or video, for non-emergency reasons.			
Worldwide 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. You will still pay for benefits covered by Priority Health Medicare, such as emergency, urgent care or prescription drugs.			

2020 monthly premiums

PPO PLANS

Counties	**Priority**Medicare Edge (PPO)	**Priority**Medicare Ideal (PPO)	**Priority**Medicare Merit (PPO)	**Priority**Medicare Select (PPO)
Allegan, Barry, Kent, Lenawee, Newaygo, Ottawa	**Priority**Medicare Edge plan is not available in these counties.	$18	$44	$136
Berrien, Calhoun, Cass, Ionia, Isabella, Kalamazoo, Mason, Midland, Missaukee, Montcalm, Muskegon, Oceana, Osceola, Otsego, St. Clair, Van Buren, Wexford		$14	$68	$151
Alcona, Antrim, Benzie, Charlevoix, Clare, Crawford, Grand Traverse, Hillsdale, Lake, Lapeer, Leelanau, Manistee, Mecosta, Monroe		$18	$97	$186
Alpena, Cheboygan, Eaton, Emmet, Gladwin, Gratiot, Iosco, Jackson, Kalkaska, Montmorency, Oscoda, Presque Isle, Roscommon, Sanilac, Shiawassee, St. Joseph		$18	$103	$205
Arenac, Bay, Branch, Clinton, Genesee, Huron, Ingham, Livingston, Macomb, Oakland, Ogemaw, Saginaw, Tuscola, Washtenaw, Wayne	$0	$14	$85	$196

Premiums and benefits

HMO-POS PLANS

Premiums and benefits	**Priority**Medicare Key (HMO-POS)	**Priority**Medicare Value (HMO-POS)	**Priority**Medicare (HMO-POS)
Monthly plan premium	**$0 per month.** In addition, you must keep paying your Medicare Part B premium.	**$10 – $70 per month.** In addition, you must keep paying your Medicare Part B premium.	**$78 – $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 pays the balance.	**Medical services** *In-network (HMO):* $0 *Out-of-network (POS):* $1,500 **Prescription drugs (Part D)** Tiers 1 – 2: $0 Tiers 3 – 5: $100	**Medical services** *In-network (HMO):* $0 *Out-of-network (POS):* $1,000 **Prescription drugs (Part D)** Tiers 1 – 5: $75	**Medical services** *In-network (HMO):* $0 *Out-of-network (POS):* $500 **Prescription drugs (Part D)** Tiers 1 – 5: $0
Maximum out-of-pocket responsibility This is the most you pay for covered medical services for the year, excluding Part D prescription drugs.	*In-network (HMO):* $5,500	*In-network (HMO):* $5,000	*In-network (HMO):* $4,500

Premiums and benefits	**Priority**Medicare Key (HMO-POS)	**Priority**Medicare Value (HMO-POS)	**Priority**Medicare (HMO-POS)
Inpatient hospital coverage We cover an unlimited number of days for an inpatient hospital stay. Prior authorization may be required.	*In-network (HMO):* Days 1-6: $325 each day Days 7 and beyond: $0 each day *Out-of-network (POS):* 50% for each stay	*In-network (HMO):* Days 1-5: $325 each day Days 6 and beyond: $0 each day *Out-of-network (POS):* 40% for each stay	*In-network (HMO):* Days 1-6: $225 each day Days 7 and beyond: $0 each day *Out-of-network (POS):* 30% for each stay
Outpatient hospital coverage Prior authorization may be required.	**Ambulatory surgery center** *In-network (HMO):* $250 for each visit *Out-of-network (POS):* 50% for each visit **Outpatient hospital** *In-network (HMO):* $250 for each visit *Out-of-network (POS):* 50% for each visit **Observation** *In-network (HMO) and out-of-network (POS):* $90 for each visit, including all services received	**Ambulatory surgery center** *In-network (HMO):* $225 for each visit *Out-of-network (POS):* 40% for each visit **Outpatient hospital** *In-network (HMO):* $225 for each visit *Out-of-network (POS):* 40% for each visit **Observation** *In-network (HMO) and out-of-network (POS):* $90 for each visit, including all services received	**Ambulatory surgery center** *In-network (HMO):* $175 for each visit *Out-of-network (POS):* 30% for each visit **Outpatient hospital** *In-network (HMO):* $175 for each visit *Out-of-network (POS):* 30% for each visit **Observation** *In-network (HMO) and out-of-network (POS):* $90 for each visit, including all services received

Use the out-of-state travel benefit anywhere in the U.S. when outside the state of Michigan and pay the same as when you're in-network.

Premiums and benefits

HMO-POS PLANS

Premiums and benefits	**Priority**Medicare Key (HMO-POS)	**Priority**Medicare Value (HMO-POS)	**Priority**Medicare (HMO-POS)
Doctor visits Prior authorization may be required for some specialist visits.	**Primary care physician (PCP)** *In-network (HMO):* $10 for each office visit $0 for surgical procedures performed in a PCP's office *Out-of-network (POS):* 50% for each visit **Specialist visit** *In-network (HMO):* $45 for each office visit $0 for surgical procedures performed in a specialist's office *Out-of-network (POS):* 50% for each visit	**Primary care physician (PCP)** *In-network (HMO):* $5 for each office visit $0 for surgical procedures performed in a PCP's office *Out-of-network (POS):* 40% for each visit **Specialist visit** *In-network (HMO):* $50 for each office visit $0 for surgical procedures performed in a specialist's office *Out-of-network (POS):* 40% for each visit	**Primary care physician (PCP)** *In-network (HMO):* $10 for each office visit $0 for surgical procedures performed in a PCP's office *Out-of-network (POS):* 30% for each visit **Specialist visit** *In-network (HMO):* $40 for each office visit $0 for surgical procedures performed in a specialist's office *Out-of-network (POS):* 30% for each visit
Preventive care	*In-network (HMO):* $0 for each service *Out-of-network (POS):* 50% for each service	*In-network (HMO):* $0 for each service *Out-of-network (POS):* 40% for each service	*In-network (HMO):* $0 for each service *Out-of-network (POS):* 30% for each service
	This includes mammograms, certain vaccinations, and more. See ***prioritymedicare.com*** for the complete listing. A referral from your doctor may be required for some preventive services.		
Emergency care This amount is waived if you are admitted as inpatient to the hospital within 24 hours from your emergency care visit.	*In-network (HMO) and out-of-network (POS):* $90 for each visit	*In-network (HMO) and out-of-network (POS):* $90 for each visit	*In-network (HMO) and out-of-network (POS):* $90 for each visit

Use the out-of-state travel benefit anywhere in the U.S. when outside the state of Michigan and pay the same as when you're in-network.

Premiums and benefits	**Priority**Medicare Key (HMO-POS)	**Priority**Medicare Value (HMO-POS)	**Priority**Medicare (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-network (HMO) and out-of-network (POS):* $50 for each visit	*In-network (HMO) and out-of-network (POS):* $55 for each visit	*In-network (HMO) and out-of-network (POS):* $50 for each visit
Outpatient diagnostic services Prior authorization may be required for some services.	**Radiology/imaging** *In-network (HMO):* $150 per day, per provider **Tests/procedures** *In-network (HMO):* $10 per day, per provider **Lab services** *In-network (HMO):* $10 per day, per provider **Outpatient x-rays** *In-network (HMO):* $35 per day, per provider **Radiation therapy** *In-network (HMO):* $25 per day, per provider *For all out-of-network services listed above:* 50% per day, per provider	**Radiology/imaging** *In-network (HMO):* $225 per day, per provider **Tests/procedures** *In-network (HMO):* $20 per day, per provider **Lab services** *In-network (HMO):* $20 per day, per provider **Outpatient x-rays** *In-network (HMO):* $35 per day, per provider **Radiation therapy** *In-network (HMO):* $25 per day, per provider *For all out-of-network services listed above:* 40% per day, per provider	**Radiology/imaging** *In-network (HMO):* $125 per day, per provider **Tests/procedures** *In-network (HMO):* $30 per day, per provider **Lab services** *In-network (HMO):* $30 per day, per provider **Outpatient x-rays** *In-network (HMO):* $35 per day, per provider **Radiation therapy** *In-network (HMO):* $20 per day, per provider *For all out-of-network services listed above:* 30% per day, per provider

Premiums and benefits

HMO-POS PLANS

Premiums and benefits	**Priority**Medicare Key (HMO-POS)	**Priority**Medicare Value (HMO-POS)	**Priority**Medicare (HMO-POS)
Hearing services Medicare-covered exam performed by a primary care physician or specialist to diagnose and treat hearing and balance issues. Routine hearing services must be received from a TruHearing provider.	**Medicare-covered hearing services** *In-network (HMO):* $10 – $45 for each visit *Out-of-network (POS):* 50% for each visit **Routine hearing services** $0 for one routine hearing exam, per year $295, $695, $1,095 or $1,495 copay, per ear per year, for hearing aids from top manufacturers depending on level selected Hearing aid cost includes 3 fitting and follow-up evaluations within the first year and 48 batteries per hearing aid	**Medicare-covered hearing services** *In-network (HMO):* $5 – $50 for each visit *Out-of-network (POS):* 40% for each visit **Routine hearing services** $0 for one routine hearing exam, per year $295, $695, $1,095 or $1,495 copay, per ear per year, for hearing aids from top manufacturers depending on level selected Hearing aid cost includes 3 fitting and follow-up evaluations within the first year and 48 batteries per hearing aid	**Medicare-covered hearing services** *In-network (HMO):* $10 – $40 for each visit *Out-of-network (POS):* 30% for each visit **Routine hearing services** $0 for one routine hearing exam, per year $295, $695, $1,095 or $1,495 copay, per ear per year, for hearing aids from top manufacturers depending on level selected Hearing aid cost includes 3 fitting and follow-up evaluations within the first year and 48 batteries per hearing aid

Use the out-of-state travel benefit anywhere in the U.S. when outside the state of Michigan and pay the same as when you're in-network.

Premiums and benefits	**Priority**Medicare Key (HMO-POS)	**Priority**Medicare Value (HMO-POS)	**Priority**Medicare (HMO-POS)
Dental services Prior authorization may be required for Medicare-covered dental services. Preventive (routine) dental services provided by Delta Dental. See the Delta Dental Certificate of Coverage for details.	**Medicare-covered dental services** *In-network (HMO):* $10 – $250 for each visit, depending on the service performed *Out-of-network (POS):* 50% for each visit **Preventive (routine) dental services** $0 for two cleanings (regular or periodontal) per year $0 for two exams per year $0 for one set of bitewing x-rays per year	**Medicare-covered dental services** *In-network (HMO):* $5 – $225 for each visit, depending on the service performed *Out-of-network (POS):* 40% for each visit **Preventive (routine) dental services** $0 for two cleanings (regular or periodontal) per year $0 for two exams per year $0 for one set of bitewing x-rays per year $0 for one brush biopsy per year $0 all other x-rays (one every 2 years)	**Medicare-covered dental services** *In-network (HMO):* $10 – $175 for each visit, depending on the service performed *Out-of-network (POS):* 30% for each visit **Preventive (routine) dental services** $0 for two cleanings (regular or periodontal) per year $0 for two exams per year $0 for one set of bitewing x-rays per year $0 for one brush biopsy per year $0 all other x-rays (one every 2 years)

Premiums and benefits

HMO-POS PLANS

Premiums and benefits	**Priority**Medicare Key (HMO-POS)	**Priority**Medicare Value (HMO-POS)	**Priority**Medicare (HMO-POS)
Vision services Medicare-covered exam performed by a specialist to diagnose and treat diseases and conditions of the eye, and additional Medicare-covered services. Routine vision services must be provided by an EyeMed "Select" provider.	**Medicare-covered services** *In-network (HMO):* $45 for each visit $0 for eyeglasses or contact lenses after cataract surgery $0 for a yearly glaucoma screening *Out-of-network (POS):* 50% for each visit 50% for eyeglasses or contact lenses after cataract surgery 50% for a yearly glaucoma screening **Routine vision services** $0 for one routine exam each year (includes dilation and refraction) $0 for one retinal imaging per year $100 eyewear allowance per year	**Medicare-covered services** *In-network (HMO):* $50 for each visit $0 for eyeglasses or contact lenses after cataract surgery $0 for a yearly glaucoma screening *Out-of-network (POS):* 40% for each visit 40% for eyeglasses or contact lenses after cataract surgery 40% for a yearly glaucoma screening **Routine vision services** $0 for one routine exam each year (includes dilation and refraction) $0 for one retinal imaging per year $100 eyewear allowance per year	**Medicare-covered services** *In-network (HMO):* $40 for each visit $0 for eyeglasses or contact lenses after cataract surgery $0 for a yearly glaucoma screening *Out-of-network (POS):* 30% for each visit 30% for eyeglasses or contact lenses after cataract surgery 30% for a yearly glaucoma screening **Routine vision services** $0 for one routine exam each year (includes dilation and refraction) $0 for one retinal imaging per year $100 eyewear allowance per year

Use the out-of-state travel benefit anywhere in the U.S. when outside the state of Michigan and pay the same as when you're in-network.

Premiums and benefits	**Priority**Medicare Key (HMO-POS)	**Priority**Medicare Value (HMO-POS)	**Priority**Medicare (HMO-POS)
Mental health care We cover up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. Prior authorization may be required.	**Inpatient visit** *In-network (HMO):* Days 1 – 6: $275 each day Days 7 – 90: $0 each day *Out-of-network (POS):* 50% for each stay **Outpatient therapy (individual or group)** *In-network (HMO):* $20 for each visit *Out-of-network (POS):* 50% for each visit	**Inpatient visit** *In-network (HMO):* Days 1 – 5: $325 each day Days 6 – 90: $0 each day *Out-of-network (POS):* 40% for each stay **Outpatient therapy (individual or group)** *In-network (HMO):* $20 for each visit *Out-of-network (POS):* 40% for each visit	**Inpatient visit** *In-network (HMO):* Days 1 – 6: $225 each day Days 7 – 90: $0 each day *Out-of-network (POS):* 30% for each stay **Outpatient therapy (individual or group)** *In-network (HMO):* $20 for each visit *Out-of-network (POS):* 30% for each visit

Premiums and benefits

HMO-POS PLANS

Premiums and benefits	**Priority**Medicare Key (HMO-POS)	**Priority**Medicare Value (HMO-POS)	**Priority**Medicare (HMO-POS)
Skilled Nursing Facility (SNF) Our plan covers up to 100 days each benefit period. A benefit period starts the day you go into a SNF and ends when you go for 60 days in a row without SNF care. Prior authorization may be required.	*In-network (HMO):* Days 1 – 20: $0 each day Days 21 – 100: $178 each day *Out-of-network (POS):* 50% for each stay	*In-network (HMO):* Days 1 – 20: $0 each day Days 21 – 100: $178 each day *Out-of-network (POS):* 40% for each stay	*In-network (HMO):* Days 1 – 20: $0 each day Days 21 – 100: $178 each day *Out-of-network (POS):* 30% for each stay
Physical therapy	*In-network (HMO):* $30 for each visit *Out-of-network (POS):* 50% for each visit	*In-network (HMO):* $40 for each visit *Out-of-network (POS):* 40% for each visit	*In-network (HMO):* $35 for each visit *Out-of-network (POS):* 30% for each visit
Ambulance Prior authorization may be required.	*In-network (HMO) or out-of-network (POS):* $250 each way	*In-network (HMO) or out-of-network (POS):* $250 each way	*In-network (HMO) or out-of-network (POS):* $200 each way
Transportation	Not covered	Not covered	Not covered

Premiums and benefits	**Priority**Medicare Key (HMO-POS)			**Priority**Medicare Value (HMO-POS)			**Priority**Medicare (HMO-POS)		
PRESCRIPTION DRUG BENEFITS									
Medicare Part B drugs Prior authorization may be required.	**Chemotherapy drugs** In-network (HMO) or out-of-network (POS): 20% for each drug **Other Part B drugs** In-network (HMO) or out-of-network (POS): 20% for each drug **Home infusion drugs** In-network (HMO) or out-of-network (POS): $0 for each drug								
PART D OUTPATIENT PRESCRIPTION DRUGS									
Deductible stage You'll pay this amount before you begin paying copays or coinsurance only.	Tiers 1 – 2: $0 Tiers 3 – 5: $100			Tiers 1 – 5: $75			Tiers 1 – 5: $0		
Initial coverage stage You are in this stage until your drug total reaches $4,020, which includes what you pay out-of-pocket and what we pay for your covered drugs.	Once you have paid your deductible (only required for drugs in Tiers 3 – 5) you pay what is listed in the chart below.			Once you have paid your deductible you pay what is listed in the chart below.			You pay what is listed in the chart below.		
PREFERRED RETAIL PHARMACY									
Initial coverage stage	30 day supply	60 day supply	90 day supply	30 day supply	60 day supply	90 day supply	30 day supply	60 day supply	90 day supply
Tier 1 (Preferred generic)	$4	$8	$12	$2	$4	$6	$1	$2	$3
Tier 2 (Generic)	$15	$30	$45	$10	$20	$30	$8	$16	$24
Tier 3 (Preferred brand)	$42	$84	$126	$42	$84	$126	$38	$76	$114
Tier 4 (Non-preferred)	45%	45%	45%	50%	50%	50%	45%	45%	45%
Tier 5 (Specialty tier)	31%	N/A	N/A	31%	N/A	N/A	33%	N/A	N/A
Your costs will be less for your covered drugs when you use a pharmacy in our preferred network (includes Meijer, Walgreens, Walmart, Rite Aid, Kroger, Family Fare Supermarkets, Costco and more). Go to *prioritymedicare.com* to view the list in the Provider/Pharmacy Directory.									

Premiums and benefits

HMO-POS PLANS

Premiums and benefits	**Priority**Medicare Key (HMO-POS)			**Priority**Medicare Value (HMO-POS)			**Priority**Medicare (HMO-POS)		
STANDARD RETAIL PHARMACY									
Initial coverage stage	30 day supply	60 day supply	90 day supply	30 day supply	60 day supply	90 day supply	30 day supply	60 day supply	90 day supply
Tier 1 (Preferred generic)	$10	$20	$30	$7	$14	$21	$6	$12	$18
Tier 2 (Generic)	$20	$40	$60	$15	$30	$45	$13	$26	$39
Tier 3 (Preferred brand)	$47	$94	$141	$47	$94	$141	$43	$86	$129
Tier 4 (Non-preferred)	50%	50%	50%	50%	50%	50%	45%	45%	45%
Tier 5 (Specialty tier)	31%	N/A	N/A	31%	N/A	N/A	33%	N/A	N/A
MAIL ORDER									
Initial coverage stage	30 day supply	60 day supply	90 day supply	30 day supply	60 day supply	90 day supply	30 day supply	60 day supply	90 day supply
Tier 1 (Preferred generic)	$4	$8	$0	$2	$4	$0	$1	$2	$0
Tier 2 (Generic)	$15	$30	$0	$10	$20	$0	$8	$16	$0
Tier 3 (Preferred brand)	$42	$84	$105	$42	$84	$105	$38	$76	$95
Tier 4 (Non-preferred)	45%	45%	45%	50%	50%	50%	45%	45%	45%
Tier 5 (Specialty tier)	31%	N/A	N/A	31%	N/A	N/A	33%	N/A	N/A
Coverage gap stage (also known as the "donut hole")	Once the total yearly drug costs (what you've paid plus what we've paid) reach $4,020 you enter the coverage gap and then you pay a percentage of the cost we have negotiated for the drug: • 25% of what we would pay for the covered brand name drug • 25% of what we would pay for the covered generic drug When your drug costs reach $6,350, this is the end of the coverage gap stage.								
Catastrophic coverage stage	Once your drug costs reach $6,350 you will pay the larger amount, which is either: • 5% of the cost of the drug, or • $3.60 for generic, and • $8.95 for all other drugs								
Long-term care (LTC)	If you are a resident of a long-term care (LTC) facility, you may get your prescription drugs through the facility's pharmacy as long as it is part of our network. Check the Provider/Pharmacy Directory available at *prioritymedicare.com* or call Customer Service if you have questions.								

Premiums and benefits	**Priority**Medicare Key (HMO-POS)	**Priority**Medicare Value (HMO-POS)	**Priority**Medicare (HMO-POS)
OPTIONAL ENHANCED DENTAL AND VISION PACKAGE			
Benefits	Additional dental coverage, including coverage for advanced dental work and an additional vision allowance for use on eyeglasses or contacts.		
Premium	**Additional $33 per month.** You must keep paying your Medicare Part B premium and your $0 monthly plan premium.	**Additional $29 per month.** You must keep paying your Medicare Part B premium and your $10 – $70 monthly plan premium.	**Additional $29 per month.** You must keep paying your Medicare Part B premium and your $78 – $163 monthly plan premium.
Deductible	$0		
Maximum plan benefit coverage amount	We pay up to $1,650 which includes $1,500 for covered dental services and $150 for eyewear, per calendar year.		
Dental services Preventive (routine) dental services provided by Delta Dental. See the Delta Dental Certificate of Coverage for details.	$0 copay for fillings, one brush biospy and anesthesia, each year. $0 copay for one other x-ray (i.e. panoramic), once every 2 years. 50% of the cost for simple extractions, films/tests and relines and repairs to bridges and dentures, each year. 50% of the cost for crowns and root canals, each year. 30% of the cost for surgical extractions and other oral surgery, each year.	$0 copay for fillings and anesthesia, each year. 50% of the cost for simple extractions, films/tests and relines and repairs to bridges and dentures, each year. 50% of the cost for crowns and root canals, each year. 30% of the cost for surgical extractions and other oral surgery, each year.	
Vision services Services must be provided by an EyeMed "Select" provider.	$150 additional eyewear allowance per year		

Premiums and benefits

HMO-POS PLANS

Premiums and benefits	**Priority**Medicare Key (HMO-POS)	**Priority**Medicare Value (HMO-POS)	**Priority**Medicare (HMO-POS)
ADDITIONAL MEDICAL BENEFITS COVERED UNDER YOUR PLAN			
Annual preventive physical exam You're free to talk at your annual preventive exam. You will not be charged for the office visit no matter what or how much is discussed. This is an opportunity for you and your physician to discuss any concerns or questions you may have.	*In-network (HMO):* $0 for an exam *Out-of-network (POS):* 50% for an exam	*In-network (HMO):* $0 for an exam *Out-of-network (POS):* 40% for an exam	*In-network (HMO):* $0 for an exam *Out-of-network (POS):* 30% for an exam
Chiropractic care	**Medicare-covered care** *In-network (HMO):* $20 for each visit *Out-of-network (POS):* 50% for each visit **Routine care** *In-network (HMO):* $20 for each visit (limit 12 per year) $35 for one x-ray each year *Out-of-network (POS):* Not covered	**Medicare-covered care** *In-network (HMO):* $20 for each visit *Out-of-network (POS):* 40% for each visit	**Medicare-covered care** *In-network (HMO):* $20 for each visit *Out-of-network (POS):* 30% for each visit

Premiums and benefits	**Priority**Medicare Key (HMO-POS)	**Priority**Medicare Value (HMO-POS)	**Priority**Medicare (HMO-POS)
ADDITIONAL MEDICAL BENEFITS COVERED UNDER YOUR PLAN			
Medical equipment and supplies Examples include diabetic supplies (shoes/ inserts, diabetic test strips), durable medical equipment (wheelchairs, oxygen, insulin pumps), and prosthetic devices (braces, artificial limbs). Diabetic test strips are limited to OneTouch®(JJHCS), Breeze®(Bayer) and Contour®(Bayer) products when dispensed by a retail pharmacy or mail-order pharmacy. Prior authorization may be required.	**Diabetes supplies** *In-network (HMO):* $0 for each item *Out-of-network (POS):* 50% for each item **Durable medical equipment** *In-network (HMO):* 20% for each item *Out-of-network (POS):* 30% for each item **Prosthetic devices** *In-network (HMO):* 0 – 20% for each item, depending on the device *Out-of-network (POS):* 30% for each device	**Diabetes supplies** *In-network (HMO):* $0 for each item *Out-of-network (POS):* 40% for each item **Durable medical equipment** *In-network (HMO):* 20% for each item *Out-of-network (POS):* 30% for each item **Prosthetic devices** *In-network (HMO):* 0 – 20% for each item, depending on the device *Out-of-network (POS):* 30% for each device	**Diabetes supplies** *In-network (HMO):* $0 for each item *Out-of-network (POS):* 30% for each item **Durable medical equipment** *In-network (HMO):* 20% for each item *Out-of-network (POS):* 30% for each item **Prosthetic devices** *In-network (HMO):* 0 – 20% for each item, depending on the device *Out-of-network (POS):* 30% for each device

Premiums and benefits

HMO-POS PLANS

Premiums and benefits	**Priority**Medicare Key (HMO-POS)	**Priority**Medicare Value (HMO-POS)	**Priority**Medicare (HMO-POS)
ADDITIONAL MEDICAL BENEFITS COVERED UNDER YOUR PLAN			
Out-of-state travel benefit 	You'll pay in-network prices when seeking care anywhere in the U.S. outside of Michigan, when you see Medicare-participating providers. You may stay enrolled in the plan when outside of the service area for up to 12 months, as long as your residency remains in the service area.		
Over-the-counter (OTC) allowance + Healthy Savings program	$75 per quarter for OTC items.	$25 per quarter for OTC items.	Not covered
	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. Items can be purchased in participating stores (Walmart, CVS, Kroger and more). Or, over the phone or online at ***walmart.com***, with free 2-day shipping. After signing up for this benefit, you'll receive a separate OTC card in the mail. The Healthy Savings program allows members to save on healthier foods with up to $1,500 a year in discounts on healthier food options in-store at Walmart. Just scan your OTC card at check-out to take advantage of the savings. For full details, refer to ***prioritymedicare.com*** or the Evidence of Coverage (EOC) document.		
SilverSneakers®	$0 for membership at participating SilverSneakers® fitness centers, plus access to online educational programs and SilverSneakers On-Demand™ workout videos. Even more workout options with the SilverSneakers GO™ fitness app or SilverSneakers Steps® home fitness kits. SilverSneakers® locations are nationwide. To find a participating fitness center go to ***silversneakers.com*** and search for one near you, or call toll-free 833.236.0190 (TTY 711), Monday through Friday, 8 a.m. to 8 p.m. For assistance on Saturday or Sunday, call Priority Health Medicare at 888.389.6648 (TTY 711), from 8 a.m. to 8 p.m. The SilverSneakers® program is provided by Tivity Health.® All programs and services may not be available in all areas.		
Virtual visits	$0 for each virtual visit with a PCP or specialist via phone or video, for non-emergency reasons.		
Worldwide 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. You will still pay for benefits covered by Priority Health Medicare, such as emergency, urgent care or prescription drugs.		

2020 monthly premiums

HMO-POS PLANS

Counties	**Priority**Medicare Key (HMO-POS)	**Priority**Medicare Value (HMO-POS)	**Priority**Medicare (HMO-POS)
Allegan, Barry, Kent, Lenawee, Ottawa	$0	$10	$78
Berrien, Calhoun, Cass, Ionia, Isabella, Kalamazoo, Mason, Midland, Missaukee, Montcalm, Muskegon, Newaygo, Oceana, Osceola, Otsego, St. Clair, Van Buren, Wexford	$0	$27	$98
Alcona, Antrim, Benzie, Charlevoix, Clare, Crawford, Grand Traverse, Hillsdale, Lake, Lapeer, Leelanau, Manistee, Mecosta, Monroe	$0	$70	$162
Alpena, Cheboygan, Eaton, Emmet, Gladwin, Gratiot, Iosco, Jackson, Kalkaska, Montmorency, Oscoda, Presque Isle, Roscommon, Sanilac, Shiawassee, St. Joseph	$0	$67	$163
Arenac, Bay, Branch, Clinton, Genesee, Huron, Ingham, Livingston, Macomb, Oakland, Ogemaw, Saginaw, Tuscola, Washtenaw, Wayne	$0	$42	$113

Enrollment checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. Use the checklist to help you make a smart decision about your health care. If you have any questions, you can call and speak to a customer service representative at 877.333.0450 from 8 a.m. to 8 p.m. (TTY 711).

Understanding the benefits

- Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services for which you routinely see a doctor. Visit ***prioritymedicare.com*** or call 877.333.0450 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. or you may pay more.
- 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.

Understanding important rules

- In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- Benefits, premiums and/or copayments/co-insurance may change on January 1, 2021.
- Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for certain covered services for HMO-POS plans that are provided by a non-contracted provider, the provider may not [or would need to] agree to treat you. Except in an emergency or urgent situations, non-contracted providers may deny care. In addition, you may pay a higher co-pay for services received by non-contracted providers.

Priority Health's pharmacy network includes limited lower-cost, preferred pharmacies in Michigan. The lower costs advertised in our plan materials for these pharmacies may not be available at the pharmacy you use. For up-to-date information about our network pharmacies, including whether there are any lower-cost preferred pharmacies in your area, please call 888.389.6648, TTY users call 711, or consult the online pharmacy directory at prioritymedicare.com.

Out-of-network/non-contracted providers are under no obligation to treat Priority Health members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

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