PriorityHealth

Summary of Benefits

PriorityMedicare Value[SM] (HMO-POS)

PriorityMedicare[SM] (HMO-POS)

January 1, 2013 - December 31, 2013

H2320_1000_1098_1 CMS-approved 05142013

Thank you for your interest in **Priority**Medicare Value (HMO-POS) and **Priority**Medicare (HMO-POS).

Our plans are offered by Priority Health/Priority Health Medicare, a Medicare Advantage Health Maintenance Organization (HMO), with a point-of-service option (POS) that contracts with the Federal government. This Summary of Benefits tells you some features of our plans. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of our benefits, please call **Priority**Medicare Value (HMO-POS) and **Priority**Medicare (HMO-POS) and ask for the "Evidence of Coverage".

You have choices in your health care.

As a Medicare beneficiary, you can choose from different Medicare options. One option is the Original (fee-for-service) Medicare Plan. Another option is a Medicare health plan, like **Priority**Medicare Value (HMO-POS) and **Priority**Medicare (HMO-POS). You may have other options too. You make the choice. No matter what you decide, you are still in the Medicare Program.

You may join or leave a plan only at certain times. Please call **Priority**Medicare Value (HMO-POS) and **Priority**Medicare (HMO-POS) at the number listed at the end of this introduction or 1-800-MEDICARE (1-800-633-4227) for more information. TTY/TDD users should call 1-877-486-2048. You can call this number 24 hours a day, 7 days a week.

How can I compare my options?

You can compare **Priority**Medicare Value (HMO-POS) and **Priority**Medicare (HMO-POS) and the Original Medicare Plan using this Summary of Benefits. The charts in this booklet list some important health benefits. For each benefit, you can see what our plan covers and what the Original Medicare Plan covers.

Our members receive all of the benefits that the Original Medicare Plan offers. We also offer more benefits, which may change from year to year.

Where are Priority Medicare Value (HMO-POS) **and Priority**Medicare (HMO-POS) **available?**
There is more than one plan listed in this Summary of Benefits.
The service area for this plan includes: Allegan, Antrim, Arenac, Barry, Bay, Benzie, Branch, Calhoun, Charlevoix, Cheboygan, Clare, Clinton, Crawford, Eaton, Emmet, Genesee, Gladwin, Grand Traverse, Gratiot, Hillsdale, Ingham, Ionia, Isabella, Jackson, Kalamazoo, Kalkaska, Kent, Lake, Leelanau, Lenawee, Livingston, Macomb, Manistee, Mason, Mecosta, Midland, Missaukee, Monroe, Montcalm, Muskegon, Newaygo, Oakland, Oceana, Ogemaw, Osceola, Otsego, Ottawa, Roscommon, Saginaw, Sanilac, Shiawassee, St. Clair, St. Joseph, Tuscola, Washtenaw, Wayne and Wexford counties, MI. You must live in one of these areas to join the plan. If you move out of the state or county where you currently live to a state listed above, you must call Customer Service to update your information. If you don't, you may be disenrolled from **Priority**Medicare Value (HMO-POS) or **Priority**Medicare (HMO-POS). If you move to a state not listed above, please call Customer Service to find out if Priority Health Medicare has a plan in your new state or county.

Who is eligible to join Priority Medicare Value (HMO-POS) **or Priority**Medicare (HMO-POS)**?**
You can join **Priority**Medicare Value (HMO-POS) or **Priority**Medicare (HMO-POS) if you are entitled to Medicare Part A and enrolled in Medicare Part B and live in the service area. However, individuals with End-Stage Renal Disease are generally not eligible to enroll in **Priority**Medicare Value (HMO-POS) or **Priority**Medicare (HMO-POS) unless they are members of our organization and have been since their dialysis began.

Can I choose my doctors?
PriorityMedicare Value (HMO-POS) and **Priority**Medicare (HMO-POS) have formed a network of doctors, specialists, and hospitals. You can use any doctor who is part of our network. In some cases, you may also go to doctors outside of our network. The health providers in our network can change at any time.

You can ask for a current provider directory. For an updated list, visit us at *www.prioritymedicare.com*. Our customer service number is listed at the end of this introduction.

What happens if I go to a doctor who's not in your network?
Generally, you are restricted to a doctor who is part of your network. However, we will cover your care from any provider for emergency or urgently needed care. Also, our point of service benefit allows you to get care from providers not in your network under certain conditions. For more information, please call the customer service number listed at the end of this introduction.

Where can I get my prescriptions if I join this plan?
PriorityMedicare Value (HMO-POS) and **Priority**Medicare (HMO-POS) has formed a network of pharmacies. You must use a network pharmacy to receive plan benefits. We may not pay for your prescriptions if you use an out-of-network pharmacy, except in certain cases. The pharmacies in our network can change at any time. You can ask for a pharmacy directory or visit us at *www.prioritymedicare.com*. Our customer service number is listed at the end of this introduction.

Does my plan cover Medicare Part B or Part D drugs?
PriorityMedicare Value (HMO-POS) and **Priority**Medicare (HMO-POS) do cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs.

What is a prescription drug formulary?
PriorityMedicare Value (HMO-POS) and **Priority**Medicare (HMO-POS) use a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, or make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits our members' ability to fill their prescriptions, we will notify the affected members before the change is made. We will send a formulary to you and you can see our complete formulary on our website at *www.prioritymedicare.com.*

If you are currently taking a drug that is not on our formulary or subject to additional requirements or limits, you may be able to get a temporary supply of the drug. You can contact us to request an exception or switch to an alternative drug listed on our formulary with your physician's help. Call us to see if you can get a temporary supply of the drug or for more details about our drug transition policy.

How can I get extra help with my prescription drug plan costs or get extra help with other Medicare costs?
You may be able to get extra help to pay for your prescription drug premiums and costs as well as get help with other Medicare costs. To see if you qualify for getting extra help, call:

- 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048, 24 hours a day/7 days a week and see *www.medicare.gov* "*Programs for People with Limited Income and Resources*" in the publication *Medicare & You*.

- The Social Security Administration at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY/TDD users should call 1-800-325-0778; or
- Your State Medicaid Office.

What are my protections in this plan?

All Medicare Advantage Plans agree to stay in the program for a full calendar year at a time. Plan benefits and cost-sharing may change from calendar year to calendar year. Each year, plans can decide whether to continue to participate with Medicare Advantage. A plan may continue in their entire service area (geographic area where the plan accepts members) or choose to continue only in certain areas. Also, Medicare may decide to end a contract with a plan. Even if your Medicare Advantage Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue for an additional calendar year, it must send you a letter at least 90 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

As a member of **Priority**Medicare Value (HMO-POS) or **Priority**Medicare (HMO-POS), you have the right to request an organization determination, which includes the right to file an appeal if we deny coverage for an item or service, and the right to file a grievance. You have the right to request an organization determination if you want us to provide or pay for an item or service that you believe should be covered. If we deny coverage for your requested item or service, you have the right to appeal and ask us to review our decision. You may ask us for an expedited (fast) coverage determination or appeal if you believe that waiting for a decision could seriously put your life or health at risk, or affect your ability to regain maximum function. If your doctor makes or supports the expedited request, we must expedite our decision. Finally, you have the right to file a grievance with us if you have any type of problem with us or one of our network providers that does not involve coverage for an item or service. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state. Please refer to the Evidence of Coverage (EOC) for the QIO contact information.

As a member of **Priority**Medicare Value (HMO-POS) or **Priority**Medicare (HMO-POS), you have the right to request a coverage determination, which includes the right to request an exception, the right to file an appeal if we deny coverage for a prescription drug, and the right to file a grievance. You have the right to request a coverage determination if you want us to cover a Part D drug that you believe should be covered. An exception is a type of coverage determination. You may ask us for an exception

if you believe you need a drug that is not on our list of covered drugs or believe you should get a non-preferred drug at a lower out-of-pocket cost. You can also ask for an exception to cost utilization rules, such as a limit on the quantity of a drug. If you think you need an exception, you should contact us before you try to fill your prescription at a pharmacy. Your doctor must provide a statement to support your exception request. If we deny coverage for your prescription drug(s), you have the right to appeal and ask us to review our decision. Finally, you have the right to file a grievance if you have any type of problem with us or one of our network pharmacies that does not involve coverage for a prescription drug. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state. Please refer to the Evidence of Coverage (EOC) for the QIO contact information.

What is a Medication Therapy Management (MTM) program?

A Medication Therapy Management (MTM) Program is a free service we offer. You may be invited to participate in a program designed for your specific health and pharmacy needs. You may decide not to participate but it is recommended that you take full advantage of this covered service if you are selected. Contact **Priority**Medicare Value (HMO-POS) and **Priority**Medicare (HMO-POS) for more details.

What types of drugs may be covered under Medicare Part B?

Some outpatient prescription drugs may be covered under Medicare Part B. These may include, but are not limited to, the following types of drugs. Contact **Priority**Medicare Value (HMO-POS) and **Priority**Medicare (HMO-POS) for more details.

- **Some Antigens:** If they are prepared by a doctor and administered by a properly instructed person (who could be the patient) under doctor supervision.
- **Osteoporosis Drugs:** Injectable osteoporosis drugs for some women.
- **Erythropoietin (Epoetin Alfa or Epogen®):** By injection if you have end-stage renal disease (permanent kidney failure requiring either dialysis or transplantation) and need this drug to treat anemia.
- **Hemophilia Clotting Factors:** Self-administered clotting factors if you have hemophilia.
- **Injectable Drugs:** Most injectable drugs administered incident to a physicians service.

- **Immunosuppressive Drugs:** Immunosuppressive drug therapy for transplant patients if the transplant took place in a Medicare-certified facility and was paid for by Medicare or by a private insurance company that was the primary payer for Medicare Part A coverage.
- **Some Oral Cancer Drugs:** If the same drug is available in injectable form.
- **Oral Anti-Nausea Drugs:** If you are part of an anti-cancer chemotherapeutic regimen.
- **Inhalation and Infusion Drugs** administered through Durable Medical Equipment.

Where can I find information on plan ratings?

The Medicare program rates how well plans perform in different categories (for example, detecting and preventing illness, ratings from patients and customer service). If you have access to the web, you may use the web tools on *www.medicare.gov* and select "Health and Drug Plans" then "Compare Drug and Health Plans" to compare the plan ratings for Medicare plans in your area. You can also call us directly to obtain a copy of the plan ratings for this plan. Our customer service number is listed on page 9.

Please call Priority Health Medicare for more information about **Priority**Medicare Value (HMO-POS) and **Priority**Medicare (HMO-POS).

Visit us at *www.prioritymedicare.com* or, call us:

Customer Service hours for October 1 – February 14

Monday - Sunday, 8 a.m.- 8 p.m. (Eastern)

Customer Service hours for February 15 – September 30

Monday - Sunday, 8 a.m.- 8 p.m. (Eastern)

Important phone numbers

Current members should call toll-free 888.389.6648 for questions related to the Medicare Advantage Program and the Medicare Part D Prescription Drug Program. (TTY/TDD 711).
Prospective members should call toll-free 888.389.6676 for questions related to the Medicare Advantage Program and Medicare Part D Prescription Drug Program. (TTY/TDD 711).
Current members should call locally 616.464.8820 for questions related to the Medicare Advantage Program and Medicare Part D Prescription Drug Program. (TTY/TDD 711).
Prospective members should call locally 616.464.8850 for questions related to the Medicare Advantage Program and Medicare Part D Prescription Drug Program. (TTY/TDD 711).

For more information about Medicare, please call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week. Or, visit *www.medicare.gov* on the web.

This document may be available in other formats such as Braille, large print or other alternate formats.

This document may be available in a non-English language. For additional information, call customer service at the phone number listed above.

Benefit	Original Medicare	**Priority**Medicare Value (HMO-POS)	**Priority**Medicare (HMO-POS)
IMPORTANT INFORMATION			
1. Premium and other important information	In 2013 the monthly Part B Premium is $104.90 and the annual Part B deductible amount is $147. If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more. Most people will pay the standard monthly Part B premium. However, some people will pay a higher premium because of their yearly income (over $85,000 for singles, $170,000 for married couples). For more information about Part B premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.	**General** $0 - $55.60 monthly plan premium in addition to your monthly Medicare Part B premium.	**General** $81 - $136 monthly plan premium in addition to your monthly Medicare Part B premium.
		Please refer to the Premium Table after this section to find out the premium in your area.	
		Most people will pay the standard monthly Part B premium in addition to their MA plan premium. However, some people will pay higher Part B and Part D premiums because of their yearly income (over $85,000 for singles, $170,000 for married couples). For more information about Part B and Part D premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.	
		In-network $3,400 out-of-pocket limit. All plan services included.	**In-network** $3,400 out-of-pocket limit. All plan services included.
		Out-of-network $1,500 annual deductible. Contact the plan for services that apply.	**Out-of-network** $1,000 annual deductible. Contact the plan for services that apply.
2. Doctor and hospital choice (For more information, see Emergency Care - #15 and Urgently Needed Care - #16.)	You may go to any doctor, specialist or hospital that accepts Medicare.	**In-network** No referral required for network doctors, specialists and hospitals.	**In-network** No referral required for network doctors, specialists and hospitals.

<table>
<tr><th>Benefit</th><th>Original Medicare</th><th>PriorityMedicare Value (HMO-POS)</th><th>PriorityMedicare (HMO-POS)</th></tr>
<tr><td colspan="4">INPATIENT CARE</td></tr>
<tr><td rowspan="3">3. Inpatient hospital care
(includes substance abuse and rehabilitation services)</td><td rowspan="3">In 2013 the amounts for each benefit period are:
• Days 1 - 60: $1,184 deductible
• Days 61 - 90: $296 per day
• Days 91 - 150: $592 per lifetime reserve day

Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days.

Lifetime reserve days can only be used once.

A "benefit period" starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.</td><td colspan="2">In-network
No limit to the number of days covered by the plan each hospital stay.</td></tr>
<tr><td>$800 copay for each Medicare-covered hospital stay.</td><td>For Medicare-covered hospital stays:
• Days 1 - 5: $130 copay per day.
• Days 6 - 90: $0 copay per day.</td></tr>
<tr><td colspan="2">$0 copay for additional hospital days.

Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</td></tr>
</table>

Benefit	Original Medicare	**Priority**Medicare Value (HMO-POS)	**Priority**Medicare (HMO-POS)
4. Inpatient mental health care	In 2013 the amounts for each benefit period are: • Days 1 - 60: $1,184 deductible • Days 61 - 90: $296 per day • Days 91 - 150: $592 per lifetime reserve day You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital.	**In-network** You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital.	
		$800 copay for each Medicare-covered hospital stay.	For Medicare-covered hospital stays: • Days 1 – 5: $130 copay per day. • Days 6 – 90: $0 copay per day. Plan covers 60 lifetime reserve days. Cost per lifetime reserve day: • Days 1 – 5: $130 copay per day. • Days 6 – 60: $0 copay per day.
		Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.	

Benefit	Original Medicare	**Priority**Medicare Value (HMO-POS)	**Priority**Medicare (HMO-POS)
5. Skilled nursing facility (SNF) (in a Medicare-certified skilled nursing facility)	In 2013 the amounts for each benefit period after at least a 3-day covered hospital stay are: • Days 1 - 20: $0 per day • Days 21 - 100: $148 per day 100 days for each benefit period. A "benefit period" starts the day you go into a hospital or SNF. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.	**General** Authorization rules may apply.	
		In-network Plan covers up to 100 days each benefit period. No prior hospital stay is required. For Medicare-covered SNF stays: • Days 1 - 20: $0 copay per day. • Days 21 - 100: $120 copay per day.	
6. Home health care (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)	$0 copay.	**General** Authorization rules may apply.	
		In-network $0 copay for Medicare-covered home health visits.	
7. Hospice	You pay part of the cost for outpatient drugs and inpatient respite care. You must get care from a Medicare-certified hospice.	**General** You must get care from a Medicare-certified hospice. Your plan will pay for a consultative visit before you select hospice.	

Benefit	Original Medicare	**Priority**Medicare Value (HMO-POS)	**Priority**Medicare (HMO-POS)
OUTPATIENT CARE			
8. Doctor office visits	20% coinsurance.	**General** Authorization rules may apply.	
		In-network $20 copay for each Medicare-covered primary care doctor visit. $45 copay for each Medicare-covered specialist visit.	**In-network** $15 copay for each Medicare-covered primary care doctor visit. $40 copay for each Medicare-covered specialist visit.
9. Chiropractic services	Supplemental routine care not covered 20% coinsurance for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.	**In-network** $20 copay for each Medicare-covered visit. Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor.	
10. Podiatry services	Supplemental routine care not covered. 20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.	**In-network** $45 copay for each Medicare-covered podiatry visits.	**In-network** $40 copay for each Medicare-covered podiatry visits.
		Medicare-covered podiatry benefits are for medically-necessary foot care.	

Benefit	Original Medicare	**Priority**Medicare Value (HMO-POS)	**Priority**Medicare (HMO-POS)
11. Outpatient mental health care	35% coinsurance for most outpatient mental health services. Specified copayment for outpatient partial hospitalization program services furnished by a hospital or community mental health center (CMHC). Copay cannot exceed the Part A inpatient hospital deductible. "Partial hospitalization program" is a structured program of active outpatient psychiatric treatment that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.	**General** Authorization rules may apply.	
		In-network $40 copay for each Medicare-covered individual therapy visit. $20 copay for each Medicare-covered group therapy visit. $40 copay for each Medicare-covered individual therapy visit with a psychiatrist. $20 copay for each Medicare-covered group therapy visit with a psychiatrist. 40% of the cost for Medicare-covered partial hospitalization program services.	**In-network** $40 copay for each Medicare-covered individual therapy visit. $15 copay for each Medicare-covered group therapy visit. $40 copay for each Medicare-covered individual therapy visit with a psychiatrist. $15 copay for each Medicare-covered group therapy visit with a psychiatrist. 40% of the cost for Medicare-covered partial hospitalization program services.
12. Outpatient substance abuse care	20% coinsurance.	**General** Authorization rules may apply.	
		In-network $40 copay for Medicare-covered individual substance abuse outpatient treatment visits. $20 copay for Medicare-covered group substance abuse outpatient treatment visits.	**In-network** $40 copay for Medicare-covered individual substance abuse outpatient treatment visits. $15 copay for Medicare-covered group substance abuse outpatient treatment visits.
13. Outpatient services	20% coinsurance for the doctor's services. Specified copayment for outpatient hospital facility services copay cannot exceed the Part A inpatient hospital deductible. 20% coinsurance for ambulatory surgical center facility services.	**General** Authorization rules may apply.	
		In-network $100 copay for each Medicare-covered ambulatory surgical center visit. $225 copay for each Medicare-covered outpatient hospital facility visit.	**In-network** $75 copay for each Medicare-covered ambulatory surgical center visit. $100 copay for each Medicare-covered outpatient hospital facility visit.

Benefit	Original Medicare	**Priority**Medicare Value (HMO-POS)	**Priority**Medicare (HMO-POS)
14. Ambulance services (medically necessary ambulance services)	20% coinsurance.	**General** Authorization rules may apply.	
		In-network $100 copay for Medicare-covered ambulance benefits.	
15. Emergency care (You may go to any emergency room if you reasonably believe you need emergency care.)	20% coinsurance for the doctor's services. Specified copayment for outpatient hospital facility emergency services. Emergency services copay cannot exceed Part A inpatient hospital deductible for each service provided by the hospital. You don't have to pay the emergency room copay if you are admitted to the hospital as an inpatient for the same condition within 3 days of the emergency room visit. Not covered outside the U.S. except under limited circumstances.	**General** $65 copay for Medicare-covered emergency room visits. Worldwide coverage. If you are admitted to the hospital within 24-hour(s) for the same condition, you pay $0 for the emergency room visit.	
16. Urgently needed care (This is NOT emergency care, and in most cases, is out of the service area.)	20% coinsurance or a set copay. NOT covered outside the U.S. except under limited circumstances.	**General** $50 copay for Medicare-covered urgently-needed-care visits. If you are admitted to the hospital within 24-hour(s) for the same condition, you pay $0 for the urgently-needed-care visit.	**General** $45 copay for Medicare-covered urgently-needed-care visits. If you are admitted to the hospital within 24-hour(s) for the same condition, you pay $0 for the urgently-needed-care visit.

Benefit	Original Medicare	**Priority**Medicare Value (HMO-POS)	**Priority**Medicare (HMO-POS)
17. Outpatient rehabilitation services (occupational therapy, physical therapy, speech and language therapy)	20% coinsurance.	**In-network** There may be limits on physical therapy, occupational therapy, and speech and language pathology services. If so, there may be exceptions to these limits.	
		\$30 copay for Medicare-covered occupational therapy visits. \$30 copay for Medicare-covered physical therapy and/or speech and language pathology therapy visits.	\$20 copay for Medicare-covered occupational therapy visits. \$20 copay for Medicare-covered physical therapy and/or speech and language pathology therapy visits.
OUTPATIENT MEDICAL SERVICES AND SUPPLIES			
18. Durable medical equipment (includes wheelchairs, oxygen, etc.)	20% coinsurance.	**General** Authorization rules may apply.	
		In-network 20% of the cost for Medicare-covered durable medical equipment.	
19. Prosthetic devices (includes braces, artificial limbs and eyes, etc.)	20% coinsurance.	**General** Authorization rules may apply.	
		In-network 20% of the cost for Medicare-covered prosthetic devices.	
20. Diabetes programs and supplies	20% coinsurance for diabetes self-management training. 20% coinsurance for diabetes supplies. 20% coinsurance for diabetic therapeutic shoes or inserts.	**In-network** \$0 copay for Medicare-covered: • Diabetes self-management training. • Diabetes monitoring supplies. • Therapeutic shoes or inserts.	
		If the doctor provides you services in addition to diabetes self-management training, separate cost sharing of \$20 to \$45 may apply.	If the doctor provides you services in addition to diabetes self-management training, separate cost sharing of \$15 to \$40 may apply.

Benefit	Original Medicare	**Priority**Medicare Value (HMO-POS)	**Priority**Medicare (HMO-POS)
21. Diagnostic tests, x-rays, lab services and radiology services	20% coinsurance for diagnostic tests and x-rays. $0 copay for Medicare-covered lab services. Lab Services: Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory that participates in Medicare. Diagnostic lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare does not cover most supplemental routine screening tests, like checking your cholesterol.	**General** Authorization rules may apply.	
		In-network $0 to $25 copay for Medicare-covered lab services. $0 to $25 copay for Medicare-covered diagnostic procedures and tests. $25 copay for Medicare-covered x-rays. $175 copay for Medicare-covered diagnostic radiology services (not including x-rays). $25 copay for Medicare-covered therapeutic radiology services. If the doctor provides you services in addition to outpatient diagnostic procedures, tests and lab services, separate cost sharing of $20 to $45 may apply. If the doctor provides you services in addition to outpatient diagnostic and therapeutic radiology services, separate cost sharing of $20 to $45 may apply.	**In-network** $0 to $20 copay for Medicare-covered lab services. $0 to $20 copay for Medicare-covered diagnostic procedures and tests. $20 copay for Medicare-covered x-rays. $100 copay for Medicare-covered diagnostic radiology services (not including x-rays). $20 copay for Medicare-covered therapeutic radiology services. If the doctor provides you services in addition to outpatient diagnostic procedures, tests and lab services, separate cost sharing of $15 to $40 may apply. If the doctor provides you services in addition to outpatient diagnostic and therapeutic radiology services, separate cost sharing of $15 to $40 may apply.
22. Cardiac and pulmonary rehabilitation services	20% coinsurance for cardiac rehabilitation services 20% coinsurance for pulmonary rehabilitation services 20% coinsurance for Intensive cardiac rehabilitation services. This applies to program services provided in a doctor's office. Specified cost sharing for program services provided by hospital outpatient departments.	**In-network** $20 copay for Medicare-covered cardiac rehabilitation services. $20 copay for Medicare-covered intensive cardiac rehabilitation services. $20 copay for Medicare-covered pulmonary rehabilitation services.	**In-network** $15 copay for Medicare-covered cardiac rehabilitation services. $15 copay for Medicare-covered intensive cardiac rehabilitation services. $15 copay for Medicare-covered pulmonary rehabilitation services.

Benefit	Original Medicare	**Priority**Medicare Value (HMO-POS)	**Priority**Medicare (HMO-POS)
PREVENTIVE SERVICES, WELLNESS/EDUCATION AND OTHER SUPPLEMENTAL BENEFIT PROGRAMS			
23. Preventive services, wellness/ education and other supplemental benefit programs	No coinsurance, copayment or deductible for the following: • Abdominal aortic aneurysm screening. • Bone mass measurement Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions. • Cardiovascular screening. • Cervical and vaginal cancer screening. Covered once every 2 years. Covered once a year for women with Medicare at high risk. • Colorectal cancer screening. • Diabetes screening. • Influenza vaccine. • Hepatitis B vaccine for people with Medicare who are at risk. • HIV screening. $0 copay for the HIV screening, but you generally pay 20% of the Medicare-approved amount for the doctor's visit. HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy.	**General** $0 copay for all preventive services covered under Original Medicare at zero cost sharing. Any additional preventive services approved by Medicare mid-year will be covered by the plan or by Original Medicare. Authorization rules may apply. **In-network** $0 copay for an annual physical exam. The plan covers the following supplemental education/ wellness programs: • Health education • Nutritional education • Health club membership/fitness classes (See page 37 for additional information about Preventive services, wellness/ education and other supplemental benefit programs.) $0 copay for telemonitoring services. Contact plan for details.	

Benefit	Original Medicare	**Priority**Medicare Value (HMO-POS)	**Priority**Medicare (HMO-POS)
23. Preventive services and wellness/ education and other supplemental benefit programs *(continued)*	• Breast Cancer Screening (Mammogram). Medicare covers screening mammograms once every 12 months for all women with Medicare age 40 and older. Medicare covers one baseline mammogram for women between ages 35-39. • Medical Nutrition Therapy Services Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian and may include a nutritional assessment and counseling to help you manage your diabetes or kidney disease. • Personalized prevention plan Services (Annual Wellness Visits). • Pneumococcal vaccine. You may only need the pneumonia vaccine once in your lifetime. Call your doctor for more information. • Prostate cancer screening – Prostate Specific Antigen (PSA) test only. Covered once a year for all men with Medicare over age 50.	**General** $0 copay for all preventive services covered under Original Medicare at zero cost sharing. Any additional preventive services approved by Medicare mid-year will be covered by the plan or by Original Medicare. Authorization rules may apply. **In-network** $0 copay for an annual physical exam. The plan covers the following supplemental education/ wellness programs: • Health education • Nutritional education • Health club membership/fitness classes (See page 37 for additional information about Preventive services, wellness/ education and other supplemental benefit programs.) $0 copay for telemonitoring services. Contact plan for details.	

Benefit	Original Medicare	**Priority**Medicare Value (HMO-POS)	**Priority**Medicare (HMO-POS)
23. Preventive services and wellness/ education and other supplemental benefit programs *(continued)*	• Smoking and Tobacco Use Cessation (counseling to stop smoking and tobacco use). Covered if ordered by your doctor. Includes two counseling attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits. • Screening and behavioral counseling interventions in primary care to reduce alcohol misuse. • Screening for depression in adults. • Screening for sexually transmitted infections (STI) and high-intensity behavioral counseling to prevent STIs. • Intensive behavioral counseling for cardiovascular disease (bi-annual). • Intensive behavioral therapy for obesity. • Welcome to Medicare preventive visits (initial preventive physical exam). When you join Medicare Part B, then you are eligible as follows. During the first 12 months of your new Part B coverage, you can get either a welcome to Medicare preventive visit or an annual wellness visit. After your first 12 months, you can get one annual wellness visit every 12 months.	**General** $0 copay for all preventive services covered under Original Medicare at zero cost sharing. Any additional preventive services approved by Medicare mid-year will be covered by the plan or by Original Medicare. Authorization rules may apply. **In-network** $0 copay for an annual physical exam. The plan covers the following supplemental education/ wellness programs: • Health education • Nutritional education • Health club membership/fitness classes (See page 37 for additional information about Preventive services, wellness/ education and other supplemental benefit programs.) $0 copay for telemonitoring services. Contact plan for details.	

Benefit	Original Medicare	**Priority**Medicare Value (HMO-POS)	**Priority**Medicare (HMO-POS)
24. Kidney disease and conditions	20% coinsurance for renal dialysis. 20% coinsurance for kidney disease education services.	**In-network** $10 copay for Medicare-covered renal dialysis. $0 copay for Medicare-covered kidney disease education services.	
PRESCRIPTION DRUG BENEFITS			
25. Outpatient prescription drugs	Most drugs are not covered under Original Medicare. You can add prescription drug coverage to Original Medicare by joining a Medicare prescription drug plan, or you can get all your Medicare coverage, including prescription drug coverage, by joining a Medicare Advantage Plan or a Medicare Cost Plan that offers prescription drug coverage.	**Drugs covered under Medicare Part B** **General** 20% of the cost for Part B-covered chemotherapy drugs and other Part B-covered drugs.	
		Home infusion drugs, supplies and services $0 copay for home infusion drugs that would normally be covered under Part D. This cost-sharing amount will also cover the supplies and services associated with home infusion of these drugs.	
		Drugs covered under Medicare Part D This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at *prioritymedicare.com* on the web. Different out-of-pocket costs may apply for people who: • have limited incomes, • live in long term care facilities, or • have access to Indian/Tribal/Urban (Indian Health Service) providers. The plan offers national in-network prescription coverage (i.e., this would include 50 states and the District of Columbia). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel).	

Benefit	Original Medicare	**Priority**Medicare Value (HMO-POS)	**Priority**Medicare (HMO-POS)
25. Outpatient prescription drugs *(continued)*	Most drugs are not covered under Original Medicare. You can add prescription drug coverage to Original Medicare by joining a Medicare prescription drug plan, or you can get all your Medicare coverage, including prescription drug coverage, by joining a Medicare Advantage Plan or a Medicare Cost Plan that offers prescription drug coverage.	Total yearly drug costs are the total drug costs paid by both you and a Part D plan. The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition. Some drugs have quantity limits. Your provider must get prior authorization from Priority Health Medicare for certain drugs. You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov. If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount. You pay $0 the first time you fill a prescription for certain drugs. These drugs will be listed as "free first fill" on the plan’s website, formulary, printed materials, and on the Medicare Prescription Drug Plan Finder on Medicare.gov. If you request a formulary exception for a drug and Priority Health Medicare approves the exception, you will pay Tier 3: Non-preferred brand cost sharing for that drug.	
		In-network $0 deductible.	
		Initial coverage You pay the following until total yearly drug costs reach $2,970:	

Benefit	Original Medicare	**Priority**Medicare Value (HMO-POS)	**Priority**Medicare (HMO-POS)
25. Outpatient prescription drugs *(continued)*	Most drugs are not covered under Original Medicare. You can add prescription drug coverage to Original Medicare by joining a Medicare prescription drug plan, or you can get all your Medicare coverage, including prescription drug coverage, by joining a Medicare Advantage Plan or a Medicare Cost Plan that offers prescription drug coverage.	**Retail pharmacy**	
		Tier 1: Generic • $9 copay for a one-month (31-day) supply of drugs in this tier. • $27 copay for a three-month (90-day) supply of drugs in this tier.	**Tier 1: Generic** • $8 copay for a one-month (31-day) supply of drugs in this tier. • $24 copay for a three-month (90-day) supply of drugs in this tier.
		Tier 2: Preferred brand • $40 copay for a one-month (31-day) supply of drugs in this tier. • $120 copay for a three-month (90-day) supply of drugs in this tier.	**Tier 2: Preferred brand** • $35 copay for a one-month (31-day) supply of drugs in this tier. • $105 copay for a three-month (90-day) supply of drugs in this tier.
		Tier 3: Non-preferred brand • $90 copay for a one-month (31-day) supply of drugs in this tier. • $270 copay for a three-month (90-day) supply of drugs in this tier.	**Tier 3: Non-preferred brand** • $80 copay for a one-month (31-day) supply of drugs in this tier. • $240 copay for a three-month (90-day) supply of drugs in this tier.
		Tier 4: Specialty tier • 33% coinsurance for a one-month (31-day) supply of drugs in this tier.	**Tier 4: Specialty tier** • 33% coinsurance for a one-month (31-day) supply of drugs in this tier.
		Long-term care pharmacy	
		Tier 1: Generic • $9 copay for a one-month 31-day) supply of drugs in this tier.	**Tier 1: Generic** • $8 copay for a one-month 31-day) supply of drugs in this tier.
		Tier 2: Preferred brand • $40 copay for a one-month (31-day) supply of drugs in this tier.	**Tier 2: Preferred brand** • $35 copay for a one-month (31-day) supply of drugs in this tier.
		Tier 2: Preferred brand Please note that brand drugs must be dispensed incrementally in long-term care facilities. Generic drugs may be dispensed incrementally. Contact your plan about cost-sharing billing/ collection when less than a one-month supply is dispensed.	

Benefit	Original Medicare	**Priority**Medicare Value (HMO-POS)	**Priority**Medicare (HMO-POS)
25. Outpatient prescription drugs *(continued)*	Most drugs are not covered under Original Medicare. You can add prescription drug coverage to Original Medicare by joining a Medicare prescription drug plan, or you can get all your Medicare coverage, including prescription drug coverage, by joining a Medicare Advantage Plan or a Medicare Cost Plan that offers prescription drug coverage.	**Tier 3: Non-preferred brand** • $90 copay for a one-month (31-day) supply of drugs in this tier.	**Tier 3: Non-preferred brand** • $80 copay for a one-month (31-day) supply of drugs in this tier.
		Tier 3: Non-preferred brand Please note that brand drugs must be dispensed incrementally in long-term care facilities. Generic drugs may be dispensed incrementally. Contact your plan about cost-sharing billing/collection when less than a one-month supply is dispensed.	
		Tier 4: Specialty tier 33% coinsurance for a one-month (31-day) supply of generic drugs in this tier. Contact your plan about cost-sharing billing/collection when less than a one-month supply is dispensed.	
		Mail order	
		Tier 1: Generic • $9 copay for a one-month (31-day) supply of drugs in this tier. • $22.50 copay for a three-month (90-day) supply of drugs in this tier.	**Tier 1: Generic** • $8 copay for a one-month (31-day) supply of drugs in this tier. • $20 copay for a three-month (90-day) supply of drugs in this tier.
		Tier 2: Preferred brand • $40 copay for a one-month (31-day) supply of drugs in this tier. • $100 copay for a three-month (90-day) supply of drugs in this tier.	**Tier 2: Preferred brand** • $35 copay for a one-month (31-day) supply of drugs in this tier. • $87.50 copay for a three-month (90-day) supply of drugs in this tier.
		Tier 3: Non-preferred brand • $90 copay for a one-month (31-day) supply of drugs in this tier. • $225 copay for a three-month (90-day) supply of drugs in this tier.	**Tier 3: Non-preferred brand** • $80 copay for a one-month (31-day) supply of drugs in this tier. • $200 copay for a three-month (90-day) supply of drugs in this tier.
		Tier 4: Specialty 33% coinsurance for a one-month (31-day) supply of drugs in this tier.	

Benefit	Original Medicare	**Priority**Medicare Value (HMO-POS)	**Priority**Medicare (HMO-POS)
25. Outpatient prescription drugs *(continued)*	Most drugs are not covered under Original Medicare. You can add prescription drug coverage to Original Medicare by joining a Medicare prescription drug plan, or you can get all your Medicare coverage, including prescription drug coverage, by joining a Medicare Advantage Plan or a Medicare Cost Plan that offers prescription drug coverage.	**Coverage gap** After your total yearly drug costs reach $2,970, you receive limited coverage by the plan on certain drugs. You will also receive a discount on brand name drugs and generally pay no more than 47.5% for the plan's costs for brand drugs and 79% of the plan's costs for generic drugs until your yearly out-of-pocket drug costs reach $4,750.	
		Catastrophic coverage After your yearly out-of-pocket drug costs reach $4,750, you pay the greater of: • 5% coinsurance, or • $2.65 copay for generic (including brand drugs treated as generic) and $6.60 copay for all other drugs.	
		Out-of-network Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from Priority Health Medicare.	
		Out-of-network initial coverage You will be reimbursed up to the plan's cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach $2,970:	
		Tier 1: Generic • $9 copay for a one-month 31-day) supply of drugs in this tier.	**Tier 1: Generic** • $8 copay for a one-month 31-day) supply of drugs in this tier.
		Tier 2: Preferred brand • $40 copay for a one-month (31-day) supply of drugs in this tier.	**Tier 2: Preferred brand** • $35 copay for a one-month (31-day) supply of drugs in this tier.
		Tier 3: Non-preferred brand • $90 copay for a one-month (31-day) supply of drugs in this tier.	**Tier 3: Non-preferred brand** • $80 copay for a one-month (31-day) supply of drugs in this tier.

Benefit	Original Medicare	**Priority**Medicare Value (HMO-POS)	**Priority**Medicare (HMO-POS)
25. Outpatient prescription drugs *(continued)*	Most drugs are not covered under Original Medicare. You can add prescription drug coverage to Original Medicare by joining a Medicare prescription drug plan, or you can get all your Medicare coverage, including prescription drug coverage, by joining a Medicare Advantage Plan or a Medicare Cost Plan that offers prescription drug coverage.	**Tier 4: Specialty tier** 33% coinsurance for a one-month (31-day) supply of drugs in this tier.	**Tier 4: Specialty tier** 33% coinsurance for a one-month (31-day) supply of drugs in this tier.
		Out-of-network coverage gap You will be reimbursed up to 21% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach $4,750. Please note that the plan allowable cost may be less than the out-of-network pharmacy price paid for your drug(s). You will be reimbursed up to 52.5% of the plan allowable cost for brand name drugs purchased out-of-network until your total yearly out-of-pocket drug costs reach $4,750. Please note that the plan allowable cost may be less than the out-of-network pharmacy price paid for your drug(s).	
		Out-of-network catastrophic coverage After your yearly out-of-pocket drug costs reach $4,750, you will be reimbursed for drugs purchased out-of-network up to the plan's cost of the drug minus your cost share, which is the greater of: • 5% coinsurance, or • $2.65 copay for generic (including brand drugs treated as generic) and $6.60 copay for all other drugs.	
OUTPATIENT MEDICAL SERVICES AND SUPPLIES			
26. Dental services	Preventive dental services (such as cleaning) not covered.	**General** Authorization rules may apply.	
		In-network $0 copay for the following preventive dental benefits: • up to 1 oral exam every year. • up to 1 cleaning every year. • $45 copay for Medicare-covered dental benefits. • 50% of the cost for up to 1 dental x-ray every year.	**In-network** $0 copay for the following preventive dental benefits: • up to 1 oral exam every year. • up to 1 cleaning every year. • $40 copay for Medicare-covered dental benefits. • 50% of the cost for up to 1 dental x-ray every year.

Benefit	Original Medicare	**Priority**Medicare Value (HMO-POS)	**Priority**Medicare (HMO-POS)
27. Hearing services	Supplemental routine hearing exams and hearing aids not covered. 20% coinsurance for diagnostic hearing exams.	**In-network** In general, supplemental routine hearing exams and hearing aids not covered. $20 to $45 copay for Medicare-covered diagnostic hearing exams.	**In-network** $0 copay for up to 2 hearing aid(s) every three years. $40 copay for Medicare-covered diagnostic hearing exams. $40 copay for up to 1 supplemental routine hearing exam every year. $350 plan coverage limit for hearing aids every three years.
28. Vision services	20% coinsurance for diagnosis and treatment of diseases and conditions of the eye. Supplemental routine eye exams and glasses not covered. Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery. Annual glaucoma screenings covered for people at risk.	**In-network** This plan offers only Medicare-covered eye care and eye wear. $0 copay for one pair of Medicare-covered eyeglasses or contact lenses after cataract surgery. $0 to $45 copay for Medicare-covered exams to diagnose and treat diseases and conditions of the eye.	**In-network** This plan offers only Medicare-covered eye care and eye wear. $0 copay for one pair of Medicare-covered eyeglasses or contact lenses after cataract surgery. $0 to $40 copay for Medicare-covered exams to diagnose and treat diseases and conditions of the eye.
Over-the-counter items	Not covered.	**General** The plan does not cover over-the-counter items.	
Transportation (routine)	Not covered.	**In-network** This plan does not cover supplemental routine transportation.	
Acupuncture	Not covered.	**In-network** This plan does not cover acupuncture.	

Benefit	Original Medicare	**Priority**Medicare Value (HMO-POS)	**Priority**Medicare (HMO-POS)
Point of Service	You may go to any doctor, specialist or hospital that accepts Medicare.	**General** Authorization rules may apply.	
		Out-of-network Point of Service coverage is available for the following benefits: **Medicare covered** • Inpatient hospital acute • Inpatient hospital psychiatric • Skilled nursing facility (SNF) • Cardiac rehabilitation services • Intensive cardiac rehabilitation Services • Pulmonary rehabilitation services • Partial hospitalization • Home health services • Primary care physician services • Chiropractic services • Occupational therapy services • Physician specialist services • Mental health specialty services • Podiatry services • Other health care professional • Psychiatric services • Physical therapy and speech-language pathology services • Outpatient diagnostic procedures/tests/lab services • Diagnostic radiological services • Therapeutic radiological services • Outpatient x-rays • Outpatient hospital services • Ambulatory surgical center (ASC) services	**Out-of-network** Point of Service coverage is available for the following benefits: **Medicare covered** • Inpatient hospital acute • Inpatient hospital psychiatric • Skilled nursing facility (SNF) • Cardiac rehabilitation services • Intensive cardiac rehabilitation Services • Pulmonary rehabilitation services • Partial hospitalization • Home health services • Primary care physician services • Chiropractic services • Occupational therapy services • Physician specialist services • Mental health specialty services • Podiatry services • Other health care professional • Psychiatric services • Physical therapy and speech-language pathology services • Outpatient diagnostic procedures/tests/lab services • Diagnostic radiological services • Therapeutic radiological services • Outpatient x-rays • Outpatient hospital services • Ambulatory surgical center (ASC) services

Benefit	Original Medicare	**Priority**Medicare Value (HMO-POS)	**Priority**Medicare (HMO-POS)
Point of Service *(continued)*	You may go to any doctor, specialist or hospital that accepts Medicare.	• Outpatient substance abuse • Outpatient blood services • Durable medical equipment (DME) • Prosthetics/medical supplies • Diabetic supplies and services • End-stage renal disease • Medicare-covered preventive services • Kidney disease education services • Diabetes self-management training • Medicare Part B Rx drugs • Eye exams • Hearing exams **Supplemental** • Outpatient blood services • Telemonitoring services • Annual physical exam • Preventive dental	• Outpatient substance abuse • Outpatient blood services • Durable medical equipment (DME) • Prosthetics/medical supplies • Diabetic supplies and services • End-stage renal disease • Medicare-covered preventive services • Kidney disease education services • Diabetes self-management training • Medicare Part B Rx drugs • Eye exams • Eye wear • Hearing exams **Supplemental** • Outpatient blood services • Telemonitoring services • Annual physical exam • Preventive dental • Hearing aids
		$1,500 annual deductible for POS benefits	$1,000 annual deductible for POS benefits
		$25,000 plan coverage limit every year for the following POS benefits: **Medicare-covered** • Inpatient hospital acute • Inpatient hospital psychiatric • Skilled nursing facility (SNF) • Cardiac rehabilitation services • Intensive cardiac rehabilitation services • Pulmonary rehabilitation services • Partial hospitalization • Home health services • Primary care physician services • Chiropractic services	$25,000 plan coverage limit every year for the following POS benefits: **Medicare-covered** • Inpatient hospital acute • Inpatient hospital psychiatric • Skilled nursing facility (SNF) • Cardiac rehabilitation services • Intensive cardiac rehabilitation services • Pulmonary rehabilitation services • Partial hospitalization • Home health services • Primary care physician services • Chiropractic services

Benefit	Original Medicare	**Priority**Medicare Value (HMO-POS)	**Priority**Medicare (HMO-POS)
Point of Service *(continued)*	You may go to any doctor, specialist or hospital that accepts Medicare.	• Occupational therapy services • Physician specialist services • Mental health specialty services • Podiatry services • Other health care professional • Psychiatric services • Physical therapy and speech-language pathology services • Outpatient diagnostic procedures/tests/lab services • Diagnostic radiological services • Therapeutic radiological services • Outpatient x-rays • Outpatient hospital services • Ambulatory surgical center (ASC) services • Outpatient substance abuse • Outpatient blood services • Durable medical equipment (DME) • Prosthetics/medical supplies • Diabetic supplies & services • End-stage renal disease • Medicare-covered preventive services • Kidney disease education services • Diabetes self-management training • Medicare Part B Rx drugs • Eye exams • Hearing exams **Supplemental** • Outpatient blood services • Annual physical exam	• Occupational therapy services • Physician specialist services • Mental health specialty services • Podiatry services • Other health care professional • Psychiatric services • Physical therapy and speech-language pathology services • Outpatient diagnostic procedures/tests/lab services • Diagnostic radiological services • Therapeutic radiological services • Outpatient x-rays • Outpatient hospital services • Ambulatory surgical center (ASC) services • Outpatient substance abuse • Outpatient blood services • Durable medical equipment (DME) • Prosthetics/medical supplies • Diabetic supplies & services • End-stage renal disease • Medicare-covered preventive services • Kidney disease education services • Diabetes self-management training • Medicare Part B Rx drugs • Eye exams • Eye wear • Hearing exams **Supplemental** • Annual physical exam • Hearing aids

Benefit	Original Medicare	**Priority**Medicare Value (HMO-POS)	**Priority**Medicare (HMO-POS)
Point of Service *(continued)*	You may go to any doctor, specialist or hospital that accepts Medicare.	30% of the cost per hospital stay.	
		30% of the cost per inpatient psychiatric hospital stay.	
		30% of the cost for each SNF stay.	
		30% of the cost for Medicare-covered • Cardiac rehabilitation services • Intensive cardiac rehabilitation services • Pulmonary rehabilitation services • Primary care physician services • Chiropractic services • Occupational therapy services • Physician specialist services • Mental health specialty services • Podiatry services • Other health care professional • Psychiatric services • Physical therapy and speech-language pathology services • Outpatient diagnostic procedures/tests/lab services • Diagnostic radiological services • Therapeutic radiological services • Outpatient x-rays • Outpatient hospital services • Ambulatory surgical center (ASC) services • Outpatient substance abuse • Outpatient blood services • Durable medical equipment (DME) • Prosthetics/medical supplies • Diabetic supplies and services	**30% of the cost for Medicare-covered** • Cardiac rehabilitation services • Intensive cardiac rehabilitation services • Pulmonary rehabilitation services • Primary care physician services • Chiropractic services • Occupational therapy services • Physician specialist services • Mental health specialty services • Podiatry services • Other health care professional • Psychiatric services • Physical therapy and speech-language pathology services • Outpatient diagnostic procedures/tests/lab services • Diagnostic radiological services • Therapeutic radiological services • Outpatient x-rays • Outpatient hospital services • Ambulatory surgical center (ASC) services • Outpatient substance abuse • Outpatient blood services • Durable medical equipment (DME) • Prosthetics/medical supplies • Diabetic supplies and services

<table>
<tr><th>Benefit</th><th>Original Medicare</th><th>PriorityMedicare Value (HMO-POS)</th><th>PriorityMedicare (HMO-POS)</th></tr>
<tr><td rowspan="4">Point of Service
(continued)</td><td rowspan="4">You may go to any doctor, specialist or hospital that accepts Medicare.</td><td>• End-stage renal disease
• Medicare-covered preventive services
• Kidney disease education Services
• Diabetes self-management training
• Eye exams
• Hearing exams

Supplemental
• Annual physical exam</td><td>• End-stage renal disease
• Medicare-covered preventive services
• Kidney disease education Services
• Diabetes self-management training
• Eye exams
• Eye wear
• Hearing exams

Supplemental
• Annual physical exam</td></tr>
<tr><td colspan="2">20% of the cost for Medicare-covered
• Medicare Part B Rx drugs</td></tr>
<tr><td>$0 copay for Medicare-covered
• Home health services

Supplemental
• Outpatient blood services
• Telemonitoring services
• Preventive dental</td><td>$0 copay for Medicare-covered
• Home health services

Supplemental
• Outpatient blood services
• Telemonitoring services
• Preventive dental
• Hearing aids</td></tr>
<tr><td colspan="2">40% of the cost for Medicare-covered
• Partial hospitalization</td></tr>
</table>

Benefit	Original Medicare	**Priority**Medicare Value (HMO-POS)	**Priority**Medicare (HMO-POS)
OPTIONAL SUPPLEMENTAL PACKAGE #1			
Premium and other important information	Not covered.	**General** Package: 1 - Comprehensive Dental (see page 71 for details): $17.00 monthly premium, in addition to your $0-$55.60 monthly plan premium and the monthly Medicare Part B premium, for the following optional benefits: • Comprehensive Dental $1,000 plan coverage limit every year for these benefits.	**General** Package: 1 - Comprehensive Dental (see page 71 for details): $17.00 monthly premium, in addition to your $81 - $136 monthly plan premium and the monthly Medicare Part B premium, for the following optional benefits: • Comprehensive Dental $1,000 plan coverage limit every year for these benefits.
		See page 38 for additional information about Premium and other important information.	
Dental Services	Not covered.	**General** Plan offers additional comprehensive dental benefits. See page 38 for additional information about Dental Services.	

Premium table

Counties			**Priority**Medicare Value (HMO-POS)	**Priority**Medicare (HMO-POS)
Allegan Barry	Kent Lenawee	Newaygo Ottawa	$0	$81.00
Ionia Isabella Kalamazoo Mason	Midland Missaukee Montcalm Muskegon	Oceana Osceola Otsego St. Clair Wexford	$32.00	$89.00
Antrim Benzie Charlevoix Clare Clinton	Crawford Grand Traverse Hillsdale Ingham Lake	Leelanau Livingston Manistee Mecosta Monroe	$43.00	$107.00
Calhoun Cheboygan Eaton Emmet	Gladwin Gratiot Jackson Kalkaska	Roscommon Sanilac Shiawassee St. Joseph	$46.00	$132.00
Arenac Bay Branch Genesee	Macomb Oakland Ogemaw Saginaw	Tuscola Washtenaw Wayne	$55.60	$136.00

Benefit	Original Medicare	All Priority Health Medicare plans
Health club membership/ fitness classes	Not covered.	**About the Silver&Fit® Basic Program** The Silver&Fit Basic program includes the following: • Membership at a local participating Silver&Fit fitness facility or exercise center • The Silver&Fit Home Fitness Program for members who are unable to participate in a fitness facility or prefer to work out at home • The Silver Slate® newsletter specifically designed for Silver&Fit members • A website designed specifically for Silver&Fit members • A toll-free customer service hotline for answers to questions about the program Prior to participating in this or any other exercise or weight management program, it is important for you to seek the advice of a physician or other qualified health professional. For more information on fitness facilities, or if you prefer to participate in the Home Fitness Program, visit *SilverandFit.com* and register to use the website, then go to Find a Fitness Facility. You may also call toll-free 1-877-427-4788 (TTY/TDD 1-877-710-2746), Monday through Friday, 8 a.m. to 9 p.m. Eastern time, to begin participating in the program.

DELTA DENTAL®

Delta Dental PPO (Point-of-Service)
Summary of Dental Plan Benefits
For Group# 1179-0002
Priority Health Medical Optional Dental Plan

This Summary of Dental Plan Benefits should be read along with your Certificate. Your Certificate provides additional information about your Delta Dental plan, including information about plan exclusions and limitations. If a statement in this Summary conflicts with a statement in the Certificate, the statement in this Summary applies to you and you should ignore the conflicting statement in the Certificate. The percentages below are applied to Delta Dental's allowance for each service and it may vary due to the dentist's network participation.*

Control Plan – Delta Dental of Michigan

Benefit Year – January 1 through December 31

Available with Priority Medicare Value, **Priority**Medicare & **Priority**Medicare Select.

Covered Services –

	PPO Dentist	Premier Dentist	Non-participating Dentist
	Plan Pays	**Plan Pays**	**Plan Pays***
Diagnostic & Preventive			
Diagnostic and Preventive Services – exams and cleanings	100%	100%	100%
Bitewing Radiographs – bitewing X-rays	100%	100%	100%
Other Preventive Services – fluoride and space maintainers	0%	0%	0%
All Other Radiographs – other X-rays	0%	0%	0%
Basic Services			
Minor Restorative Services – fillings and crown repair	50%	50%	50%
Endodontic Services – root canals	50%	50%	50%

Customer Service Toll-Free Number: (800) 524-0149
www.DeltaDentalMI.com
January 1, 2013

* When you receive services from a Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's Nonparticipating Dentist Fee that will be paid for those services. The Nonparticipating Dentist Fee may be less than what your dentist charges and you are responsible for that difference.

- Oral exams (including evaluations by a specialist) are payable twice per calendar year.
- Prophylaxes (cleanings) are payable twice per calendar year. Periodontal maintenance procedures are not a Covered Service.
- Fluoride treatments are not Covered Services.
- Space maintainers are not Covered Services.
- Bitewing X-rays are payable once per calendar year. Full mouth X-rays (which include bitewing X-rays) are not a Covered Service.
- Composite resin (white) restorations are optional treatment on posterior teeth.
- Implants and related services are not Covered Services.
- Crown repair does not include new crowns, replacement of crowns or recementation of crowns.

Having Delta Dental coverage makes it easy for you to get dental care almost everywhere in the world! You can now receive expert dental care when you are outside of the United States through our Passport Dental program. This program gives you access to a worldwide network of dentists and dental clinics. English-speaking operators are available around the clock to answer questions and help you schedule care. For more information, check our Web site or contact your benefits representative to get a copy of our Passport Dental information sheet.

Maximum Payment – $1,000 per person total per benefit year on all services.

Deductible – None.

Waiting Period – Not Applicable.

Eligible People – Members enrolled in the following Priority Health Medicare Advantage plans who elect the enhanced dental plan (0002): PriorityMedicare (HMO/POS), PriorityMedicare Value (HMO/POS) and PriorityMedicare Select (PPO). The Subscriber pays the full cost of this plan.

Dependents are not eligible. If coverage is terminated after 12 months, you may not re-enroll until the next annual election period.

If you and your spouse are both eligible for coverage under this Contract, you must enroll separately. Delta Dental will not coordinate benefits if you and your spouse are both covered under this Contract.

Benefits will cease on the last day of the month in which the member is terminated.

Revising Covered Services effective January 1, 2013.

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1.888.389.6648. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1.888.389.6648. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin:
我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电1.888.389.6648。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese:
您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1.888.389.6648。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1.888.389.6648. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1.888.389.6648. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1.888.389.6648 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1.888.389.6648. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1.888.389.6648번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1.888.389.6648. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم بمساعدتك. هذه خدمة مجانية سيقوم شخص ما يتحدث العربية.8466.983.888.1. فوري، ليس عليك سوى الاتصال بنا على .

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1.888.389.6648. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1.888.389.6648. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1.888.389.6648. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1.888.389.6648. Ta usługa jest bezpłatna.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1.888.389.6648 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Japanese: 当社の健康 健康保険と薬品
処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、1. 888. 389. 6648にお電話ください。日本語を話す人 者が支援いたします。これは無料のサービスです。