PriorityHealth
A healthier approach to health care®

SUMMARY OF BENEFITS

PriorityMedicare Key℠ (HMO-POS)
PriorityMedicare Value℠ (HMO-POS)
PriorityMedicare℠ (HMO-POS)

January 1, 2017 - December 31, 2017

H2320_1000_1099_1700 CMS-accepted 08292016
Priority Health has HMO-POS and PPO plans with a Medicare contract.
Enrollment in Priority Health Medicare depends on contract renewal.

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

Please note that this is just a summary of the plans' benefits; it doesn't list every service we cover or list every limitation or exclusion. To get a complete list of services we cover, review the Evidence of Coverage document available online at ***prioritymedicare.com***, or by calling our customer service number. This document is available in other formats such as Braille and large print and may be available in a non-English language. For additional information, call us at 888.389.6648 (TTY 711).

HMO-POS stands for Health Maintenance Organization (HMO) and Point of Service (POS). These plans allow you to go outside the network for care, but you may have to pay more. 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. Priority Health Medicare also offers PPO plans.

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. You will also want to review our formulary, or the list of drugs our plans cover. You can find both of these documents on our website at *prioritymedicare.com*, or call our customer service number.

Eligibility

In order to join **Priority**Medicare Key, **Priority**Medicare Value or **Priority**Medicare, which are all HMO-POS plans, you need to be entitled to Medicare Part A, be enrolled in Medicare 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 866.210.5728.

Email us any time. Visit *prioritymedicare.com* and click on **Contact Us** to send a secure email.

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 *2017 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.

Benefit	**Priority**Medicare Key (HMO-POS)	**Priority**Medicare Value (HMO-POS)	**Priority**Medicare (HMO-POS)
MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES			
Monthly plan premium	$0 per month. In addition, you must keep paying your Medicare Part B premium. Priority Health Medicare will reduce your Medicare Part B premium by up to $5.	$12.00 - $78.00 per month. In addition, you must keep paying your Medicare Part B premium.	$90.00 - $160.00 per month. In addition, you must keep paying your Medicare Part B premium.
Deductible	This plan has deductibles for some hospital and medical services, and Part D prescription drugs. $325 per year for in-network services. $1,000 per year for out-of-network (POS) services. $400 per year for Part D prescription drugs.	This plan has deductibles for some hospital and medical services, and Part D prescription drugs. $1,500 per year for out-of-network (POS) services. $75 per year for Part D prescription drugs.	This plan has deductibles for some hospital and medical services. $100 per year for in-network services. $750 per year for out-of-network (POS) services. This plan does not have a deductible for Part D prescription drugs.
Maximum out-of-pocket responsibility *(does not include prescription drugs)* The most you pay for copays, coinsurance and other costs for medical services for the year.	Your yearly limit(s) in this plan: • $4,200 for services you receive from in-network providers.	Your yearly limit(s) in this plan: • $4,500 for services you receive from in-network providers.	Your yearly limit(s) in this plan: • $3,400 for services you receive from in-network providers.

Benefit	**Priority**Medicare Key (HMO-POS)	**Priority**Medicare Value (HMO-POS)	**Priority**Medicare (HMO-POS)
Point-of-service (POS) maximum plan benefit coverage amount Your POS benefit is a supplemental benefit offered by Priority Health Medicare that allows you to get services from out-of-network providers, including out-of-network providers in Michigan. We refer to point-of-service (or POS) as out-of-network.	No. There are no limits on how much our plan will pay for covered Part A and Part B services received from out-of-network providers.	Yes. We'll pay up to $25,000 per year for covered Part A and Part B services received from out-of-network providers. Once we have paid that amount, you will be 100% responsible for these services.	No. There are no limits on how much our plan will pay for covered Part A and Part B services received from out-of-network providers.
Inpatient hospital care Prior authorization may be required. Our plan covers an unlimited number of days for an inpatient hospital stay.	In-network: • $225 copay per day for days 1 through 6 • You pay nothing per day for days 7 and beyond Out-of-network (POS): • 50% of the cost per stay	In-network: • $250 copay per day for days 1 through 7 • You pay nothing per day for days 8 and beyond Out-of-network (POS): • 40% of the cost per stay	In-network: • $140 copay per day for days 1 through 6 • You pay nothing per day for days 7 and beyond Out-of-network (POS): • $140 copay per day for days 1 through 6 • You pay nothing per day for days 7 and beyond

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Doctor visits *(Primary and specialists)* Prior authorization may be required for some specialist visits.	**Primary care physician visit:** • In-network: $0-$20 copay, depending on the service • Out-of-network (POS): 50% of the cost **Specialist visit:** • In-network: $0-$45 copay, depending on the service • Out-of-network (POS): 50% of the cost	**Primary care physician visit:** • In-network: $0-$10 copay, depending on the service • Out-of-network (POS): 40% of the cost **Specialist visit:** • In-network: $0-$50 copay, depending on the service • Out-of-network (POS): 40% of the cost	**Primary care physician visit:** • In-network: $0-$10 copay, depending on the service • Out-of-network (POS): $0-$10 copay, depending of the service **Specialist visit:** • In-network: $0-$40 copay, depending on the service • Out-of-network (POS): $0-$40 copay, depending on the service
Preventive care Any additional preventive services approved by Medicare during the contract year will be covered. A referral from your doctor may be required for some preventive services.	In-network: You pay nothing Out-of-network (POS): 50% of the cost	In-network: You pay nothing Out-of-network (POS): 40% of the cost	In-network: You pay nothing Out-of-network (POS): 30% of the cost
Emergency care If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs.	In-network or out-of-network: $75 copay per visit	In-network or out-of-network: $75 copay per visit	In-network or out-of-network: $65 copay per visit

Benefit	**Priority**Medicare Key (HMO-POS)	**Priority**Medicare Value (HMO-POS)	**Priority**Medicare (HMO-POS)
Urgently Needed Services If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs.	In-network or out-of-network: $50 copay per visit	In-network or out-of-network: $55 copay per visit	In-network or out-of-network: $50 copay per visit
Diagnostic tests, lab and radiology services, and x-rays Prior authorization may be required for some services by your doctor or other network providers. Please contact the plan for more information.	**Diagnostic radiology services (such as MRIs, CT scans):** • In-network: $150 copay • Out-of-network (POS): 50% of the cost **Diagnostic tests and procedures:** • In-network: $10 copay • Out-of-network (POS): 50% of the cost **Lab services:** • In-network: $10 copay • Out-of-network (POS): 50% of the cost **Outpatient x-rays:** • In-network: $35 copay • Out-of-network (POS): 50% of the cost	**Diagnostic radiology services (such as MRIs, CT scans):** • In-network: $225 copay • Out-of-network (POS): 40% of the cost **Diagnostic tests and procedures:** • In-network: $35 copay • Out-of-network (POS): 40% of the cost **Lab services:** • In-network: $35 copay • Out-of-network (POS): 40% of the cost **Outpatient x-rays:** • In-network: $35 copay • Out-of-network (POS): 40% of the cost	**Diagnostic radiology services (such as MRIs, CT scans):** • In-network: $100 copay • Out-of-network (POS): 30% of the cost **Diagnostic tests and procedures**: • In-network: $35 copay • Out-of-network (POS): $35 copay **Lab services:** • In-network: $35 copay • Out-of-network (POS): $35 copay **Outpatient x-rays:** • In-network: $35 copay • Out-of-network (POS): 30% of the cost

Benefit	**Priority**Medicare Key (HMO-POS)	**Priority**Medicare Value (HMO-POS)	**Priority**Medicare (HMO-POS)
Hearing services	Exam to diagnose and treat hearing and balance issues: • In-network: $20-$45 copay, depending on the service • Out-of-network (POS): 50% of the cost	Exam to diagnose and treat hearing and balance issues: • In-network: $10-$50 copay, depending on the service • Out-of-network (POS): 40% of the cost	Exam to diagnose and treat hearing and balance issues: • In-network: $10-$40 copay, depending on the service • Out-of-network (POS): 30% of the cost
Dental services Prior authorization may be required for limited dental services.	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): • In-network: $20-$150 copay, depending on the service • Out-of-network (POS): 50% of the cost	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): • In-network: $10-$200 copay, depending on the service • Out-of-network (POS): 40% of the cost **Preventive dental services:** **Cleaning (for up to 1 every year):** • In-network: You pay nothing • Out-of-network: $0-40, depending on the service **Dental x-ray(s) (for up to 1 every year):** • In-network: 50% of the cost • Out-of-network: $0-40, depending on the service **Oral exam (for up to 1 every year):** • In-network: You pay nothing • Out-of-network: $0-40, depending on the service	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): • In-network: $10-$125 copay, depending on the service • Out-of-network (POS): 30% of the cost **Preventive dental services:** **Cleaning (for up to 1 every year):** • In-network: You pay nothing • Out-of-network: $0-40, depending on the service **Dental x-ray(s) (for up to 1 every year):** • In-network: 50% of the cost • Out-of-network: $0-40, depending on the service **Oral exam (for up to 1 every year):** • In-network: You pay nothing • Out-of-network: $0-40, depending on the service

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Vision services	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): • In-network: $0-$45 copay, depending on the service • Out-of-network (POS): 50% of the cost Eyeglasses or contact lenses after cataract surgery: • In-network: You pay nothing • Out-of-network (POS): 50% of the cost	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening) : • In-network: $0-$50 copay, depending on the service • Out-of-network (POS): 40% of the cost Eyeglasses or contact lenses after cataract surgery: • In-network: You pay nothing • Out-of-network (POS): 40% of the cost	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening) : • In-network: $0-$40 copay, depending on the service • Out-of-network (POS): 30% of the cost Eyeglasses or contact lenses after cataract surgery: • In-network: You pay nothing • Out-of-network (POS): 30% of the cost
Mental health care *(including inpatient)* Prior authorization may be required.	**Inpatient visit:** In-network: • $225 copay per day for days 1 through 6. You pay nothing per day for days 7 through 90 Out-of-network (POS): • 50% of the cost per stay **Outpatient group therapy visit:** • In-network: $40 copay • Out-of-network (POS): 50% of the cost **Outpatient individual therapy visit:** • In-network: $40 copay • Out-of-network (POS): 50% of the cost	**Inpatient visit:** In-network: • $250 copay per day for days 1 through 6. You pay nothing per day for days 7 through 90 Out-of-network (POS): • 40% of the cost per stay **Outpatient group therapy visit:** • In-network: $20 copay • Out-of-network (POS): 40% of the cost **Outpatient individual therapy visit:** • In-network: $40 copay • Out-of-network (POS): 40% of the cost	**Inpatient visit:** In-network: • $140 copay per day for days 1 through 6. You pay nothing per day for days 7 through 90 Out-of-network (POS): • $140 copay per day for days 1 through 6. You pay nothing per day for days 7 through 90 **Outpatient group therapy visit**: • In-network: $20 copay • Out-of-network (POS): 30% of the cost **Outpatient individual therapy visit:** • In-network: $40 copay • Out-of-network (POS): 30% of the cost

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Skilled nursing facility (SNF) Our plan covers up to 100 days, per benefit period, in a SNF. Prior authorization may be required.	In-network: • You pay nothing per day for days 1 through 20 • $160 copay per day for days 21 through 100 Out-of-network (POS): • 50% of the cost per stay	In-network: • You pay nothing per day for days 1 through 20 • $160 copay per day for days 21 through 100 Out-of-network (POS): • 40% of the cost per stay	In-network: • You pay nothing per day for days 1 through 20 • $160 copay per day for days 21 through 100 Out-of-network (POS): • 30% of the cost per stay
Rehabilitation services	**Occupational therapy visit:** • In-network: $30 copay • Out-of-network (POS): 50% of the cost **Physical therapy and speech and language therapy visit:** • In-network: $30 copay • Out-of-network (POS): 50% of the cost	**Occupational therapy visit:** • In-network: $40 copay • Out-of-network (POS): 40% of the cost **Physical therapy and speech and language therapy visit:** • In-network: $40 copay • Out-of-network (POS): 40% of the cost	**Occupational therapy visit:** • In-network: $35 copay • Out-of-network (POS): 30% of the cost **Physical therapy and speech and language therapy visit:** • In-network: $35 copay • Out-of-network (POS): 30% of the cost
Ambulance Prior authorization may be required.	• In-network: $100 copay • Out-of-network (POS): $100 copay	• In-network: $200 copay • Out-of-network (POS): $200 copay	• In-network: $125 copay • Out-of-network (POS): $125 copay
Transportation	Not covered	Not covered	Not covered
Foot care *(podiatry services)*	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: • In-network: $0-$45 copay, depending on the service • Out-of-network (POS): 50% of the cost	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: • In-network: $0-$50 copay, depending of the service • Out-of-network (POS): 40% of the cost	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: • In-network: $0-$40 copay, depending on the service • Out-of-network (POS): 30% of the cost

Benefit	**Priority**Medicare Key (HMO-POS)	**Priority**Medicare Value (HMO-POS)	**Priority**Medicare (HMO-POS)
Medical equipment and supplies Prior authorization may be required	**Diabetes supplies:** • In-network: You pay nothing • Out-of-network (POS): 50% of the cost **Durable medical equipment (e.g., wheelchairs, oxygen):** • In-network: 20% of the cost • Out-of-network (POS): 30% of the cost **Prosthetic devices (e.g., braces, artificial limbs):** • In-network: 0-20% of the cost, depending on the service • Out-of-network (POS): 30% of the cost	**Diabetes supplies:** • In-network: You pay nothing • Out-of-network (POS): 40% of the cost **Durable medical equipment (e.g., wheelchairs, oxygen):** • In-network: 20% of the cost • Out-of-network (POS): 30% of the cost **Prosthetic devices (e.g., braces, artificial limbs):** • In-network: 0-20% of the cost, depending on the service • Out-of-network (POS): 30% of the cost	**Diabetes supplies:** • In-network: You pay nothing • Out-of-network (POS): 30% of the cost **Durable medical equipment (e.g., wheelchairs, oxygen):** • In-network: 20% of the cost • Out-of-network (POS): 30% of the cost **Prosthetic devices (e.g., braces, artificial limbs):** • In-network: 0-20% of the cost, depending on the service • Out-of-network (POS): 30% of the cost

Benefit	**Priority**Medicare Key (HMO-POS)	**Priority**Medicare Value (HMO-POS)	**Priority**Medicare (HMO-POS)
Wellness programs *(e.g. fitness)*	Remote access technologies (e.g. virtual visits): • In-network: $20 copay • Out-of-network (POS): 100% of the cost	Remote access technologies (e.g. virtual visits): • In-network: $10 copay • Out-of-network (POS): 100% of the cost	Remote access technologies (e.g. virtual visits): • In-network: $10 copay • Out-of-network (POS): 100% of the cost
	Fitness membership with Silver&Fit® • In-network: You pay nothing for a fitness membership at a participating Silver&Fit facility or Silver&Fit home fitness kits. • Out-of-network: You pay nothing for Silver&Fit home fitness kits. You pay 100% of the cost for a fitness membership at a non-participating Silver&Fit facility or non-Silver&Fit home fitness kits. **More about Silver&Fit** Silver&Fit has locations nationwide. For more information on fitness facilities, or if you prefer to participate in the Home 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, to begin participating in the program. *The Silver&Fit program is provided by American Specialty Health Fitness, Inc., a subsidiary of American Specialty Health Incorporated (ASH). All programs and services are not available in all areas. Silver&Fit and The Silver Slate are federally registered trademarks of ASH.*		
	Other health & wellness benefits In-network & out-of-network: You pay nothing for the following: • Enhanced disease management • Health education • In-home safety assessment • Nutritional education • Post-discharge in-home medication reconciliation • Telemonitoring		

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PRESCRIPTION DRUG BENEFITS			
Medicare Part B drugs Prior authorization may be required.	**For Part B drugs such as chemotherapy drugs:** • In-network: 20% of the cost • Out-of-network (POS): 20% of the cost **Other Part B drugs:** • In-network: 20% of the cost • Out-of-network (POS): 20% of the cost Home infusion drugs are covered under the home infusion services benefit. Prior authorization is required. Please contact the plan for more information.		
PART D OUTPATIENT PRESCRIPTION DRUGS			
Deductible	$400	$75 per year for Part D prescription drugs	None
Initial coverage	After you pay your yearly deductible, you pay 25% of the cost for all drugs covered by this plan until your total yearly drug costs reach $3,700. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.	After you pay your yearly deductible, you pay the following until your total yearly drug costs reach $3,700. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.	You pay the following until your total yearly drug costs reach $3,700. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.

As part of **Priority**Medicare Value and **Priority**Medicare, your costs will be even less for your covered drugs when you use a pharmacy in our preferred network. Some of our preferred pharmacies include:

Albertsons/Safeway
Costco
Express Scripts Home Delivery (mail order)
Harris Teeter Inc
Kmart
Kroger
Meijer
Rite Aid
Shopko
Supervalu
Wal-Mart
Walgreens

For the full listing of preferred retail pharmacies see the 2017 Provider/Pharmacy Directory, go to *prioritymedicare.com* or call Customer Service for more information.

Benefit	**Priority**Medicare Key (HMO-POS)			**Priority**Medicare Value (HMO-POS)			**Priority**Medicare (HMO-POS)		
PREFERRED RETAIL PHARMACY COST-SHARING									
Initial coverage stage (after you pay your deductible, if applicable)	**One-month supply**	**Two-month supply**	**Three-month supply**	**One-month supply**	**Two-month supply**	**Three-month supply**	**One-month supply**	**Two-month supply**	**Three-month supply**
Tier 1 (preferred generic)	25% of the cost			$2 copay	$4 copay	$6 copay	$1 copay	$2 copay	$3 copay
Tier 2 (generic)				$10 copay	$20 copay	$30 copay	$8 copay	$16 copay	$24 copay
Tier 3 (preferred brand)				$42 copay	$84 copay	$126 copay	$38 copay	$76 copay	$114 copay
Tier 4 (non-preferred)				$95 copay	$190 copay	$285 copay	$83 copay	$166 copay	$249 copay
Tier 5 (specialty tier)	25% of the cost	Not offered	Not offered	31% of the cost	Not offered	Not offered	33% of the cost	Not offered	Not offered
STANDARD RETAIL PHARMACY COST-SHARING									
Initial coverage stage (after you pay your deductible, if applicable)	**One-month supply**	**Two-month supply**	**Three-month supply**	**One-month supply**	**Two-month supply**	**Three-month supply**	**One-month supply**	**Two-month supply**	**Three-month supply**
Tier 1 (preferred generic)	25% of the cost			$7 copay	$14 copay	$21 copay	$6 copay	$12 copay	$18 copay
Tier 2 (generic)				$15 copay	$30 copay	$45 copay	$13 copay	$26 copay	$39 copay
Tier 3 (preferred brand)				$47 copay	$94 copay	$141 copay	$43 copay	$86 copay	$129 copay
Tier 4 (non-preferred)				$100 copay	$200 copay	$300 copay	$88 copay	$176 copay	$264 copay
Tier 5 (specialty tier)	25% of the cost	Not offered	Not offered	31% of the cost	Not offered	Not offered	33% of the cost	Not offered	Not offered

Benefit	**Priority**Medicare Key (HMO-POS)			**Priority**Medicare Value (HMO-POS)			**Priority**Medicare (HMO-POS)		
MAIL ORDER COST-SHARING									
Initial coverage stage (after you pay your deductible, if applicable)	**One-month supply**	**Two-month supply**	**Three-month supply**	**One-month supply**	**Two-month supply**	**Three-month supply**	**One-month supply**	**Two-month supply**	**Three-month supply**
Tier 1 (preferred generic)	25% of the cost			$2 copay	$4 copay	$0 copay	$1 copay	$2 copay	$0 copay
Tier 2 (generic)				$10 copay	$20 copay	$0 copay	$8 copay	$16 copay	$0 copay
Tier 3 (preferred brand)				$42 copay	$84 copay	$105 copay	$38 copay	$76 copay	$95 copay
Tier 4 (non-preferred)				$95 copay	$190 copay	$237.50 copay	$83 copay	$166 copay	$207.50 copay
Tier 5 (specialty tier)	25% of the cost	Not offered	Not offered	31% of the cost	Not offered	Not offered	33% of the cost	Not offered	Not offered
Coverage gap	Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $3,700. After you enter the coverage gap, you pay 40% of the plan's cost for covered brand name drugs and 51% of the plan's cost for covered generic drugs until your costs total $4,950, which is the end of the coverage gap. Not everyone will enter the coverage gap.								
Catastrophic coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $4,950, you pay the greater of: • 5% of the cost, or • $3.30 copay for generic (including brand drugs treated as generic) and a $8.25 copayment 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 your Provider/Pharmacy Directory or call Customer Service if you have questions.								

Benefit	**Priority**Medicare Key (HMO-POS)	**Priority**Medicare Value (HMO-POS)	**Priority**Medicare (HMO-POS)
OPTIONAL BENEFITS			
OPTIONAL ENHANCED VISION, DENTAL AND HEARING PACKAGE			
Benefits	• Preventative dental • Comprehensive dental • Eye exams	• Eyewear • Hearing exams • Hearing aids	
Premium	Additional $29.00 per month. You must keep paying your Medicare Part B premium and your $0 monthly plan premium.	Additional $20.50 per month. You must keep paying your Medicare Part B premium and your $12.00 - $78.00 monthly plan premium.	Additional $20.50 per month. You must keep paying your Medicare Part B premium and your $90.00 - $160.00 monthly plan premium.
Deductible	None		
Maximum plan benefit coverage amount	Our plan pays up to $2,100. Our plan has additional coverage limits for certain benefits.		
Vision benefits *(with in-network providers)*	**Routine exam:** $0 copay for one exam every year **Eyewear:** $100 allowance, per year	**Routine exam:** $0 copay for one exam every year **Eyewear:** $100 allowance, per year	**Routine exam:** $0 copay for one exam every year **Eyewear:** $100 allowance, per year

Benefit	**Priority**Medicare Key (HMO-POS)	**Priority**Medicare Value (HMO-POS)	**Priority**Medicare (HMO-POS)
Dental benefits *(with in-network providers)*	**Exam & cleaning:** $0 copay for two exams & two cleanings, per year **Bitewing x-rays:** 100% of the cost for one set of bitewing x-rays, per year **Comprehensive coverage (basic):** 50% of the cost for fillings, crown repairs and root canals. $1,000 yearly limit.	**Exam & cleaning:** $0 copay for an additional exam & cleaning (one exam & cleaning are already included in your Medicare Advantage plan) **Bitewing x-rays:** 100% of the cost for one set of bitewing x-rays, per year (50% of the cost is already included in your Medicare Advantage plan and the other 50% is included as part of this optional enhanced package) **Comprehensive coverage (basic):** 50% of the cost for fillings, crown repairs and root canals. $1,000 yearly limit.	**Exam & cleaning:** $0 copay for an additional exam & cleaning (one exam & cleaning are already included in your Medicare Advantage plan) **Bitewing x-rays:** 100% of the cost for one set of bitewing x-rays, per year (50% of the cost is already included in your Medicare Advantage plan and the other 50% is included as part of this optional enhanced package) **Comprehensive coverage (basic):** 50% of the cost for fillings, crown repairs and root canals. $1,000 yearly limit.
Hearing *(with in-network providers)*	**Exam:** $0 copay for one exam, every 2 years **Hearing aids:** $500 per ear, every 5 years ($1,000 limit every 5 years)	**Exam:** $0 copay for one exam, every 2 years **Hearing aids:** $500 per ear, every 5 years ($1,000 limit every 5 years)	**Exam:** $0 copay for one exam, every 2 years **Hearing aids:** $500 per ear, every 5 years ($1,000 limit every 5 years)
Additional medical benefits covered under your plan			
Chiropractic care	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): • In-network: $20 copay • Out-of-network (POS): 50% of the cost	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): • In-network: $20 copay • Out-of-network (POS): 40% of the cost	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): • In-network: $20 copay • Out-of-network (POS): 30% of the cost

Benefit	**Priority**Medicare Key (HMO-POS)	**Priority**Medicare Value (HMO-POS)	**Priority**Medicare (HMO-POS)
Outpatient surgery	**Ambulatory surgical center:** • In-network: $150 copay • Out-of-network (POS): 50% of the cost **Outpatient hospital:** • In-network: $150 copay • Out-of-network (POS): 50% of the cost	**Ambulatory surgical center:** • In-network: $200 copay • Out-of-network (POS): 40% of the cost **Outpatient hospital:** • In-network: $200 copay • Out-of-network (POS): 40% of the cost	**Ambulatory surgical center:** • In-network: $125 copay • Out-of-network (POS): $125 copay **Outpatient hospital:** • In-network: $125 copay • Out-of-network (POS): $125 copay

2017 monthly premiums

Counties		**Priority**Medicare Key (HMO-POS)	**Priority**Medicare Value (HMO-POS)	**Priority**Medicare (HMO-POS)
Allegan Barry Kent	Lenawee Newaygo Ottawa	$0	$12.00	$90.00
Berrien Cass Ionia Isabella Kalamazoo Mason Midland Missaukee	Montcalm Muskegon Oceana Osceola Otsego St. Clair Van Buren Wexford	$0	$47.00	$122.00
Alcona Antrim Benzie Charlevoix Clare Clinton Crawford Grand Traverse	Hillsdale Ingham Lake Lapeer Leelanau Livingston Manistee Mecosta Monroe	$0	$78.00	$160.00
Alpena Calhoun Cheboygan Eaton Emmet Gladwin Gratiot Iosco Jackson	Kalkaska Montmorency Oscoda Presque Isle Roscommon St. Joseph Sanilac Shiawassee	$0	$66.00	$155.00
Arenac Bay Branch Genesee Huron Macomb	Oakland Ogemaw Saginaw Tuscola Washtenaw Wayne	$0	$66.00	$145.00

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or copayments may change on January 1 of each year. You must continue to pay your Medicare Part B premium.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

Priority Health Medicare's pharmacy network offers limited access to pharmacies with preferred cost sharing 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 pharmacies with preferred cost sharing, please call 888.389.6648, TTY users should 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. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. 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.