



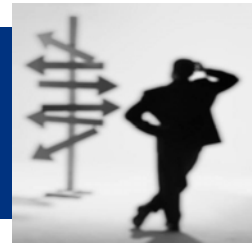
OAKLAND UNIVERSITY WILLIAM BEAUMONT

INSURANCE GUIDE



Fall 2017

Introduction



Oakland University William Beaumont School of Medicine is pleased to offer its students an excellent benefit program. These health and disability benefits are designed to protect you and your family.

It is important for you to think about your health care needs as well as the health care needs of your family during this enrollment opportunity.

All students will be provided a “core” HMO health plan insured through Priority Health. Your participation in the health insurance plan is mandatory, unless you can provide proof of other group coverage (i.e. coverage through your parents, spouse, etc).

In addition to the Core Health Plan, you are offered an option to purchase a higher level HMO plan. Enclosed are tools to help you choose your coverage carefully to fully meet your needs and minimize your out-of-pocket expenses.

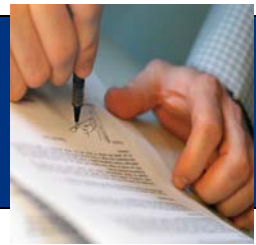
We encourage you to carefully review all of the benefit plan information, coverage, and cost information and share it with your covered dependents.

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Hylant Group Disclaimer: The abbreviated outlines of benefits used throughout this document are not intended to express any legal opinion as to the nature of coverage. They are only visuals to a basic understanding of coverages and do not detail all the contract terms nor do they alter any contract conditions. Please read your contract for specific coverages, limitations, and exclusions and call us with questions.

Enrollment Elections



Open Enrollment

Each year during the Annual Enrollment period, eligible students can enroll, dis-enroll, and add or drop dependents from the plan. It is important that you consider your elections carefully, since changes to those elections can generally only be made during a subsequent Annual Enrollment period. Exceptions will be made if you experience a qualified **Life Status Change**.

Life Status Changes

In general, the health plan prohibits change in benefit elections after the plan year begins. However, some changes are permitted when certain qualified Life Status Change events occur such as:

- * Marriage or divorce
- * Birth or adoption
- * Death of a dependent
- * Change in your spouse's employment
- * Loss of coverage by a spouse or parent
- * Eligibility for or loss of Medicare, Medicaid, or a State Child Health Insurance Plan (CHIP)

If you experience a Life Status Change and want to make a new election, you must do so within 30 days of your Life Status Change (60 days for Medicaid or CHIP related changes). Otherwise, you will have to wait until the next annual open enrollment period or your next qualifying event.

Eligible Dependents:

Eligible Dependents include your spouse, domestic partner, and children.

The information in this Benefits Summary is presented for illustrative purposes and is based on information provided by Oakland University. The text contained in this Summary was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies, or errors are always possible. In case of discrepancy between the Benefits Summary and the actual plan documents the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about this summary, contact OUWB.

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Medical Insurance



HMO Health Coverage from PriorityHealth

OUWB School of Medicine provides students with a Core HMO Medical plan insured by Priority Health. In lieu of the Core Plan, students have the option to purchase the Buy Up Plan. Students are also offered the option to purchase coverage for their dependents on either plan.

Priority Health HMO is a Michigan based plan. Your plans allow for great medical benefits with cost savings by ensuring that you get all the health care and medical services that you need.

- You get all your care from health care providers in the HMO network
- If you go to a doctor, hospital or pharmacy that is not in your plan's network, you will have to pay the full cost of your treatment.

Choose a PCP

In a Priority Health HMO plan, you'll choose a primary care physician or other primary health care provider (your "PCP") from your network. Your PCP will:

- Coordinate your care, making sure you don't receive any duplicate or unnecessary services, which helps keep your costs low
- Make sure your records are complete
- Watch for any conflicting prescriptions written by your other doctors that might cause problems
- Each family member can choose his or her own PCP

You can change your PCP once during any calendar month. The change is effective the first of the following month.

Go to any specialist in our network without a referral

Priority Health does not ask you to get a referral from your PCP to see most specialists. However, some circumstances may require a referral through your PCP.

Your global network

When you have an emergency, you can go to an Emergency Room or Urgent Care Center anywhere and you'll be covered. In addition, Priority Health has partnered with Assist America for your traveling emergencies-medical and otherwise. See brochure in the booklet for more details.

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Medical Insurance



This is intended to be an easy to read summary of some highlights of your benefit plan options. For more detailed information, please see the plan documents. A Pharmacy Quick Reference Guide is also enclosed.

	Core Plan	Buy Up
Deductible	\$500 per member \$1000 per family per calendar year	\$250 per member \$500 per family per calendar year
Copays • Fixed Dollar Copay	Office visit: <ul style="list-style-type: none"> • PCP/OB: \$20 • Specialist: \$35 • Urgent Care: \$75 • ER and High Tech Radiology: \$150 	Office visit: <ul style="list-style-type: none"> • PCP/OB: \$20 • Specialist: \$35 • Urgent Care: \$75 • ER and High Tech Radiology: \$150
Prescription Drugs	Copays: <ul style="list-style-type: none"> • \$15 Generic • \$50 Preferred Brand • \$80 Non-Preferred Brand • 20% Specialty to a max of \$150 or \$300 • 2 X Mail Order 	Copays: <ul style="list-style-type: none"> • \$10 Generic • \$40 Preferred Brand • \$40 Non-Preferred Brand • \$40 Specialty • 2 X Mail Order
Coinsurance	80% coverage on most services, after deductible to a maximum of \$1,500 per single/\$3,000 per family	100% coverage on most services, after deductible
Maximum Out of Pocket Cost (including copays, deductibles and prescriptions):	\$7,150 per member \$14,300 per family	\$7,150 per member \$14,300 per family
Preventive Services	100% Coverage	100% Coverage
Durable Medical Equipment Prosthetics and Orthotics	50% Coverage after deductible	50% Coverage after deductible
Cost Per Student (every 6 months)	Student Only: None Student plus one dependent: \$1,333.80 Student plus 2 or more dependents: \$1945.02	Student only: \$159.96 Student plus one dependent: \$1685.58 Student plus 2 or more dependents: \$2384.88

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Which Plan is best for you?



With two plan options available, you will want to determine which plan is best for you. Using the benefit summary below, based on your past medical history and foreseeable medical expenses, you can estimate your true out of pocket costs (combined expenses of the deductible, coinsurance, office visit copays, Rx copays, etc). If you have dependents, their expenses should also be considered when determining which plan is best for you.

	Core Plan	Your estimated expenses	Buy up Plan	Your estimated expenses
Deductible	\$500 per member \$1000 per family per calendar year	\$ _____	\$250 per member \$500 per family per calendar year	\$ _____
Copays • Fixed Dollar Copay	Office visit: <ul style="list-style-type: none"> PCP/OB: \$20 Specialist: \$35 Urgent Care: \$75 ER and High Tech Radiology: \$150 	# of visits X copay _____ X \$20 = \$ _____ _____ X \$35 = \$ _____ _____ X \$75 = \$ _____ _____ X \$150 = \$ _____	Office visit: <ul style="list-style-type: none"> PCP/OB: \$20 Specialist: \$35 Urgent Care: \$75 ER and High Tech Radiology: \$150 	# of visits X copay _____ X \$20 = \$ _____ _____ X \$35 = \$ _____ _____ X \$75 = \$ _____ _____ X \$150 = \$ _____
Prescription Drugs	Copays: <ul style="list-style-type: none"> \$15 Generic \$50 Preferred \$80 Non-Preferred 20% Specialty 2 X Mail Order 	# of Rx's X copay _____ X \$15 = \$ _____ _____ X \$50 = \$ _____ _____ X \$80 = \$ _____ _____ X 20% = \$ _____	Copays: <ul style="list-style-type: none"> \$10 Generic \$40 Preferred \$40 Non-Preferred \$40 Specialty 2 X Mail Order 	# of Rx's X copay _____ X \$10 = \$ _____ _____ X \$40 = \$ _____ _____ X \$40 = \$ _____ _____ X \$40 = \$ _____
Coinsurance	80% coverage on most services, after deductible	\$ _____	100% coverage on most services, after deductible	\$ _____
Maximum Deductible and Coinsurance	\$2,000 per member \$4,000 per family	See Above	\$250 per member \$500 per family	See Above
True Annual Out of Pocket Cost (to a Max of \$7,150)	TOTAL:	\$ _____	TOTAL:	\$ _____
Cost Per Student (every 6 months)	<ul style="list-style-type: none"> Student Only: None Student plus one dependent: \$1,333.80 Student plus 2 or more dependents: \$1945.02 		<ul style="list-style-type: none"> Student only: \$159.96 Student plus one dependent: \$1685.58 Student plus 2 or more dependents: \$2384.88 	

Long Term Disability



All Full Time Medical Students will receive a Long Term Disability benefit. OUWB is covering the cost of this insurance plan.

Outlined below are some of the details of the plan.

Please note that this plan will not pay for charges related to a pre-existing condition. A pre-existing condition includes pregnancy and any condition for which a Student, in the three month period prior to coverage under this plan, consults with a physician, receives treatment, takes prescribed drugs or exhibits symptoms which would cause an ordinarily prudent person to seek medical care or treatment.

Your Long Term Disability plan is insured by **Guardian**.



- **Monthly Benefit:** **Medical students in their first & second year receive \$1,000**
Medical students in their third & fourth year receive \$1,500
- **Duration of Benefit:** **Social Security Normal Retirement Age**
- **Disability Definition:** **Student-First two years; Any occupation after two years**
- **Mental and Nervous Limitation:** **24 Months**

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Contact Information



Refer to this list when you need to contact one of your benefit vendors.
For questions regarding specific benefits, limitations or claims, contact the numbers listed in this packet or on your identification card.

Plan	Company	Phone Number/Web Site
Medical Claims Questions, ID Cards and Provider Directories	Priority Health	1-888-389-6646 www.priorityhealth.com
Long Term Disability	Guardian	1-800-441-6455 www.glic.com
Payment, enrollment, eligibility	Oakland University	Katie Stotts kstotts@oakland.edu 248-370-2767
Individual Dental Plan Delta If you are interested in obtaining an individual dental plan, please visit the Delta Dental website. Visit: www.deltadentalmi.com and click on the icon to "Learn More About Individual Coverage".		
All other questions regarding the benefits, you can contact Lynn Orlowski at the Hylant. Phone: 248.822.0321 Fax: 248.498.9817 Email: Lynn.Orlowski@hylant.com		

Glossary of Frequently Used Terms



Open enrollment is the time of year reserved for you to make changes to your benefit elections. Unfamiliar terms can make this process confusing. To help you navigate your benefits options, check out these definitions of common open enrollment terms.

Coinsurance – The amount or percentage that you pay for certain covered health care services under your health plan. This is typically the amount paid after a deductible is met, and can vary based on the plan design.

Copayment– The flat fee that you pay towards the cost of covered medical services.

Covered Expenses – Health care expenses that are covered under your health plan.

Deductible – Before benefits are available through a health plan, you must pay a specific dollar amount out of pocket. Under some plans, the deductible is waived for certain services.

Dependent –Individuals who meet eligibility requirements under a health plan and are enrolled in the plan as a qualified dependent.

Health Management Organization. (HMO) – An approved and licensed organization Requires you to see only doctors or hospitals that are on a specified list of providers.

In-Network – Care received from your primary care physician or from a specialist within an outlined list of health care practitioners.

Inpatient – A person who is treated as a registered patient in a hospital or other health care facility. This person accrues room and board charges.

Medically Necessary (or medical necessity) – Services or supplies provided by a hospital, other health care facility or physician that meet the following criteria: (1) are appropriate for the symptoms and diagnosis and/or treatment of the condition, illness, disease or injury; (2) serve to provide diagnosis or direct care and/or treatment of the condition, illness, disease or injury; (3) are in accordance with standards of good medical practice; (4) are not primarily serving as convenience; and (5) are considered the most appropriate care available.

Member – You and those covered become members when you enroll in a health plan. This includes eligible students and their dependents.

Out-of-Network – Care you receive without a physician referral or services received by a non-network service provider. Out-of-network health care and plan payments are subject to deductibles and copayments.

Out-of-Pocket Expense – Amount that you must pay towards the cost of health care services. This includes deductibles, copayments and coinsurance.

Out-of-Pocket Maximum (OPM) – The top amount paid for covered services during a benefit period. Both the deductible and the coinsurance apply towards meeting the OPM, but copayments may not apply.

Premium – The amount you pay for a health plan in exchange for coverage.

Primary Care Physician (PCP) – The doctor that you select to coordinate your care under your health plan. This generally includes family practice physicians, general practitioners, internists, pediatricians, etc.

Usual, Customary and Reasonable (UCR) Allowance – The fee paid for covered services that is: (1) a similar amount to the fee charged from a health care provider to the majority of patients for the same procedure; (2) the customary fee paid to providers with similar training and expertise in a similar geographic area, and (3) reasonable in light of any unusual clinical circumstances, etc.

Frequently Asked Questions



- **Why is my health insurance policy mandatory?**

Many individual plans purchased by students provide inadequate coverage for most illness and injury situations. You are provided a comprehensive, reasonably priced, benefit package from Priority Health.

- **Could I be denied coverage?**

No, Priority Health provides coverage, regardless of medical history or current health status.

- **What is my plan year for my medical benefits?**

Your deductible will accrue starting August 1. Your health plan runs on a plan year of August 1 through July 31.

- **How do I pay for additional dependents and/or if I elect the “Buy up” plan?**

You will be required to pay the difference from the “core” plan to the “buy up” plan up front, six months at a time.

- **Am I permitted to change my plan during the year?**

No, the level of coverage (Core or buy up) is effective for the entire 12 month policy period. Changes are not allowed during the enrollment year. However, you can change the number of individuals covered if you have a Life Status Change (marriage, divorce, birth, death, adoption).

- **If I enroll in the Priority Health plan, but mid-year I become eligible for coverage elsewhere AND meet the conditions of the waiver, how do I cancel my coverage?**

You will need to fill out and submit the Student Waiver Application indicating you want to cancel your coverage. If applicable, when your health insurance is confirmed cancelled by Priority Health, you will be reimbursed accordingly.

- **If I no longer meet the waiver requirements mid-year, can I enroll mid-year?**

Yes. You will need to notify Katie Stotts within 30 days of qualifying for the coverage. Proof of loss of coverage will be required. Any additional payments, if applicable, will be due at the time of enrollment.

- **What if I get married or have a baby? Can I add these dependents to the plan?**

You can add a new spouse or baby mid-year, as long as you enroll them within 30 days of the marriage/birth. Any additional payments will be due at the time of enrollment.

- **What happens to my health insurance if I am no longer a Medical Student (i.e. academically ineligible, illness)?**

Your health coverage will terminate effective the date you are no longer a Medical Student. You will have the option to convert your coverage to an individual plan.

Graham Health Center



Graham Health Center, located on the Oakland University campus, participates in the Priority Health HMO plan. The Graham Health Center is opened from 8AM—5PM week-days. The center is staffed by Certified Nurse Practitioners and Physician Assistants. A physician visits weekly to review cases, consult, and see patients who require physician care.

Location:

The Health Center is located in the West Wing of the Graham Health Center just north of Meadow Brook Theater.

Who Can use the GHC:

All current part-time and full-time OU students can use this facility.

Contact Information:

Phone: 248.370.2341

Email:

24 hour Prescription refill

Fax: 248.370.2691

health@oakland.edu

248.370.2679

MyHealth account setup

MyHealth gives you access to your health information in one convenient place. From renewing prescriptions to scheduling a virtual doctor visit and even checking the price of health care services before you get care, **MyHealth** puts you in control of your health.

Set up your MyHealth account today.

- 1 Go to priorityhealth.com/myhealth
- 2 Click **Get an account**.
- 3 Enter your email address and a password.
- 4 Next, tell us your name and birthdate.
- 5 Select Priority Health as your primary insurance provider and add your ID number from your Priority Health membership ID card. Click **Continue**.
- 6 Answer the security questions and select the green **Accept** button.



Be sure to download the **MyHealth** app from the App Store or Google Play for health information on the go.

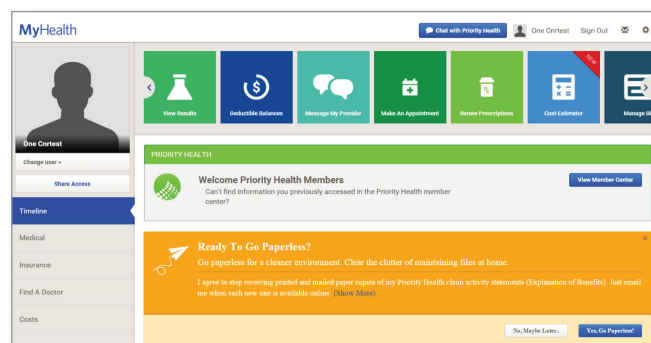
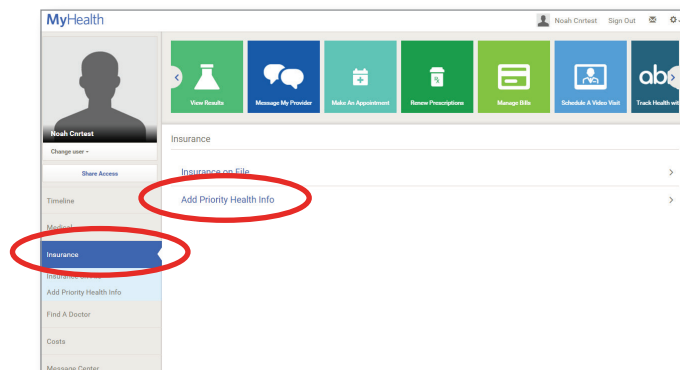
To ensure the highest level of security for our members, Priority Health uses an authentication and fraud prevention service that validates a member's identity in real time, reducing the risk of identity impersonation. **Priority Health does not use or store this information.**

continued >



If you have a **Spectrum Health MyHealth** patient account and cannot see your **Priority Health** information, follow these simple steps.

- 1 Go to *priorityhealth.com*, click **Login** and enter your **MyHealth** username and password.
- 2 Choose **Insurance** from the left menu (this is where you'll find your wellness information, too).
- 3 Select **Add Priority Health info.**
- 4 Next, add your ID number from your Priority Health membership card and click **Continue.**
- 5 Answer a few security questions to confirm your identity. You'll know you've successfully added your Priority Health information to your Spectrum Health patient account when you see the "Welcome Priority Health Members" banner.



If you have two **MyHealth** accounts, please call 877.308.5083 and the **MyHealth** Customer Support team will merge your accounts.

PriorityHealth
A healthier approach to health care®

MedNow

24/7 care when and where you need it

As a Priority Health member, you can get care from the comfort of your cabana, cubicle, college or couch.

Introducing **MedNowSM**, 24/7 virtual care delivered by care providers from one of the top 15 health systems in the country.

TWO CONVENIENT WAYS TO RECEIVE CARE WITH MEDNOW:



Video visits

Efficient, effective and ideal for things like pink eye, allergies, bites and stings, cold and flu, sinus issues and more. MedNow video visits allow the doctor to check you out head to toe, just as if you're in the exam room. Simply open up and say 'ah'.

How it works:

- 1 Call MedNow at 844.322.7374 or login to your **MyHealth** account at priorityhealth.com and select the MedNow tile.
- 2 You'll need to provide your ID number (found on the front of your membership ID card).
- 3 You'll be asked a few health questions, including a brief description of your current symptoms.
- 4 You'll be connected to a care provider who can get you on the path to better health.



eVisits*

Have a headache, cough or back pain? Describe your symptoms using an online questionnaire and a doctor will diagnose and treat the condition the same day.

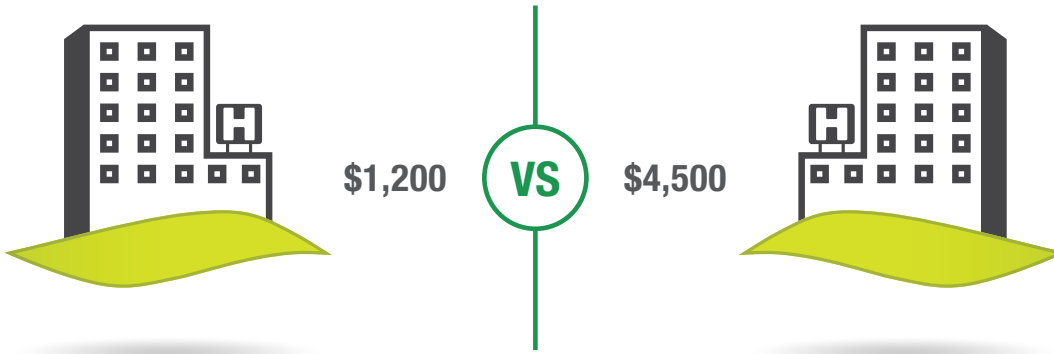
How it works:

- 1 Login to your **MyHealth** account at priorityhealth.com.
- 2 Select the MedNow tile, then **Click to Begin**.
- 3 You'll be asked a few health questions, including a brief questionnaire based on the current condition you have (*only one condition can be treated at a time*).
- 4 A care provider will reach out within one day with a diagnosis and treatment plan to get you on the path to better health.



If you need a prescription, it'll be sent to your local pharmacy. And, we'll send all the information to your primary care doctor so they have the details they need to help you be your healthiest.

Don't have a MyHealth account? Set yours up today at priorityhealth.com/myhealth. If you need assistance setting up your account, contact **MyHealth Customer Support** at 877.308.5083.



A car. A television. A vacation.

You wouldn't purchase any of these without first knowing the cost. Why should it be any different with your health care?

In Michigan, the price of a colonoscopy can vary between \$1,200 and \$4,500 depending on where you go. That's because health care facilities charge different prices for the same procedure.

Knowing the cost of care before you receive it could save you thousands of dollars.

That's why Priority Health created the **Cost Estimator**, an innovative tool that calculates a member's specific costs for hundreds of procedures like X-rays, MRI, lab tests and surgeries.

Using the Cost Estimator tool

The screenshot shows the 'Cost Estimator' tool interface. It displays the following information:

- Procedure:** Colonoscopy (with biopsy)
- Market price:** \$1,700
- Price at this facility:** \$1,553
- Coinurance you'll pay:** \$155
- You'll pay an estimated:** \$155*

At the bottom, there is a green bar with a checkmark icon and the text 'You'll pay an estimated \$155*'. Below this bar, in small orange text, it says 'Price includes all charges, taxes, and fees'.

1. Access the **Cost Estimator** on priorityhealth.com or in our mobile app.
2. Search for a procedure, doctor and preferred facility.
3. See how much the procedure will cost, based on a member's specific plan information and deductible.

If a procedure is above fair market price, the tool will provide a list of nearby facilities where the procedure is offered at a lower cost.

Leading the way

As members take on more out-of-pocket costs with high deductible plans, there's an increasing demand for price transparency. Priority Health was the first in the state to make this information available and will continue providing innovative tools to engage members in their care.

Now available to Priority Health members

You can call upon Assist America for services whenever you're 100 miles away from home or in another country for personal, vacation or business travel.*

Fully paid travel assistance services provided by assist america®

Medical consultation, evaluation & referral

Assist America's Operations Center is staffed 24/7 by medically-certified, multilingual personnel who can make immediate recommendations for any emergency situation. When a call for help comes in, they put in motion their vast English-speaking, Western-quality provider network to solve medical and non-medical emergencies anywhere in the world.

Foreign hospital admission assistance

Assist America fosters prompt hospital admission by validating your health insurance or advancing funds as needed to the hospital.

Emergency medical evacuation

If you or a covered dependant become ill or injured in an area of the globe where appropriate care is not available, Assist America will use whatever transportation, equipment and personnel are necessary to evacuate you safely to the nearest facility that meets their rigorous standards.

To activate these services, call Assist America's 24-hour Operations Center at 1.800.872.1414 or 1.609.986.1234 and provide the Priority Health reference number: 01-AA-PHP-12123.

* For conditions and exclusions, please refer to Service Certificate, available on priorityhealth.com. Not available to Medicare, Medicaid or MIChild members.

assist america® Global Emergency Services	
Reference number 01-AA-PHP-12123	Attention: This card is not a medical insurance card. All services must be provided by Assist America. No claims for reimbursement will be accepted. The holder of this card is a member of Assist America and is entitled to its medical and personal services.
If you require medical assistance and are more than 100 miles from your permanent residence, or in another country, call Assist America's Operations Center at:	
1.800.872.1414 (inside USA) +1.609.986.1234 (outside USA)	
Or email at: medservices@assistamerica.com	

Please detach card and carry with you at all times.

Medically supervised repatriation

Assist America, when deemed medically necessary, will provide transportation home or to a specified health facility with a medical or non-medical escort as required.

Prescription assistance

When a prescription is lost or left behind, Assist America works with your prescribing physician and a pharmacy in the area of travel to replace your medicine. If necessary, Assist America will arrange for you to see a local doctor for a new prescription.

Care of minor children

If children are left unattended due to an injury or illness of an accompanying parent, Assist America will arrange and pay for them to return home to a family member, or they will arrange childcare locally. They will also arrange care of children at home who are left unattended due to the parent's unexpected absence. This could include transporting children to another family member, bringing a family member to the children or whatever other solution is necessary.

Compassionate visit

Assist America realizes that having a family member or friend present during a health crisis makes everyone feel more at ease and hastens the recuperation process. That's why they will arrange and pay the transportation costs for a loved one to join you if you are traveling alone and you're expected to be hospitalized for more than seven days.

Return of mortal remains

In the unfortunate event that you pass away while traveling, Assist America will arrange and pay for the necessary paperwork, body preparations and transport to bring your mortal remains home.

Lost luggage or document assistance

Assist America works with airlines to recover and deliver lost bags, works with transportation companies to replace lost travel tickets and contacts necessary agencies to solve issues of lost passports and other documents.

Interpreter & legal referral

Assist America can make recommendations for trustworthy legal counsel and interpreter services in any country. Bail bonds can be coordinated in jurisdictions where they are legal.

Critical care monitoring

Assist America maintains regular communication with patients and attending medical staff, closely monitoring the quality and course of treatment, and Assist America stays in close touch with the patient's family.

Pre-trip information

To help you be the most informed and prepared traveler possible, Assist America offers comprehensive pre-trip insights on the Assist America website. You can review country profiles, visa requirements, immunization regulations and security advisories right from their homepage.

To learn more visit priorityhealth.com, keyword: travel



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **Note:** Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage or to get a copy of the complete terms of coverage, visit us at PriorityHealth.com or call 1-800-446-5674. For general definitions of common terms, such as allowed amount, balance billing, co-insurance, co-payment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary/> or call 1-800-446-5674 to request a copy.

Important Questions	Answers	Why this Matters
What is the overall deductible?	\$500 person / \$1,000 family Amounts you pay toward the <u>deductible</u> do not count toward any co-insurance maximums.	Generally, you must pay all of the costs from providers up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes, the <u>deductible</u> doesn't apply to <u>preventive care</u> , certain services subject to flat dollar <u>co-pays</u> and prescription drugs. Emergency room, ambulance and advanced imaging services are subject to the <u>deductible</u> and a <u>co-pay</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without cost-sharing and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	Yes. \$7,150 person / \$14,300 family Your plan also has a co-insurance maximum. \$1,500 person / \$3,000 family The co-insurance maximum limits the total amount of <u>co-insurance</u> you will pay for certain covered services during a coverage period. The co-insurance maximum is included in the <u>out-of-pocket limit</u>	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	Premiums, <u>balance-billed</u> charges, health care this <u>plan</u> doesn't cover, services that exceed an annual day/visit limit, and any <u>co-pays</u> and <u>co-insurance</u> you pay for any non-essential health benefit.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Does this plan use a participating of providers?	Yes. See PriorityHealth.com or call 1-800-446-5674 for a list of <u>participating providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do I need a referral to see a specialist?	No, you don't need a referral in order to receive the preferred benefit for services provided by a <u>participating specialist</u> . Yes, you do need a referral in order to receive the preferred benefit for services provided by a <u>non-participating specialist</u> .	You can see the in-network <u>specialist</u> you choose without a <u>referral</u> . This <u>plan</u> will pay some or all of the costs to see an out-of-network <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .



All co-payment and co-insurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20 co-pay/ visit	Not covered	Deductible does not apply to certain services subject to flat dollar co-pays. Prescription drug co-pay may also apply when selected injectable drugs are provided. Prescription drugs for infertility treatment covered only with prescription drug addendum. Retail health clinic services are covered at reasonable and customary charges.
	Specialist visit	\$35 co-pay/ visit	Not covered	
	Other practitioner office visit	<ul style="list-style-type: none"> • \$75 co-pay/ visit for evaluation/ management services only at retail health clinics • 50% co-insurance/ visit for family planning/ infertility services • 50% co-insurance for Temporomandibular Joint Function (TMJ) treatment and Orthognathic surgery 	<ul style="list-style-type: none"> • Evaluation/management services only at retail health clinics covered at the in-network benefit level • Family planning/ infertility services not covered • Temporomandibular Joint Function (TMJ) treatment and Orthognathic surgery not covered 	
	Preventive care/screening/immunization	No charge	Not covered	Preventive care services are those listed in Priority Health's Preventive Health Care Guidelines, including women's preventive health care services. Deductible does not apply. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% co-insurance	Not covered	-----none-----
	Imaging (CT/PET scans, MRIs)	\$150 co-pay	Not covered	Prior Approval required for certain radiology examinations. Co-pay waived if performed while confined in a hospital as an inpatient. Maximum of 10 co-pays per individual per contract year for imaging services.

Common Medical Events	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://www.priorityhealth.com/prog/pharmacy	Generic drugs	\$15 co-pay/ retail prescription \$30 co-pay/ mail order prescription	Not covered	Costs shown in the "Your Cost" columns apply to drugs on the approved drug list when obtained from a Participating Provider. Covers up to a 31-day supply (retail prescription); Covers up to a 90 day supply (mail order prescription) Up to a 90-day supply of medication (excluding Specialty Drugs) may be obtained at one time for three applicable Copayments at a retail Participating Pharmacy. 50% co-insurance/ prescription for infertility drugs. Deductible does not apply.
	Preferred brand drugs	\$50 co-pay/ retail prescription \$100 co-pay/ mail order prescription	Not covered	
	Non-preferred brand drugs	\$80 co-pay/ retail prescription \$160 co-pay/ mail order prescription	Not covered	
	Preferred specialty drugs	20% co-insurance/ retail prescription	Not covered	The maximum co-pay for preferred specialty drugs is \$150 per fill. The maximum co-pay for non-preferred specialty drugs is \$300 per fill. Deductible does not apply.
	Non-Preferred specialty drugs	20% co-insurance/ retail prescription	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance/ visit	Not covered	Including outpatient care, observation care and ambulatory surgery center care. Prior approval may be required. Prior approval is required for bariatric surgery. Coverage is limited to one bariatric surgery per lifetime. Unless medically necessary, a second bariatric surgery is not Covered, even if the first procedure occurred prior to joining this plan.
	Physician/surgeon fees	20% co-insurance/ visit	Not covered	
If you need immediate medical attention	Emergency room services	\$150 co-pay/ visit	Covered at the in-network benefit level	Co-pay waived if you become confined in a Hospital as an inpatient.
	Emergency medical transportation	\$150 co-pay	Covered at the in-network benefit level	-----none-----
	Urgent care	\$75 co-pay/ visit	Covered at the in-network benefit level when obtained outside of the Service Area	Urgent Care services received from a Non-Participating Provider who is located in our Service Area are not Covered. Urgent Care services received from a Non-Participating Provider who is located outside of our Service Area are Covered. Deductible does not apply.

Common Medical Events	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance/ visit	Not covered	<p>Prior Approval is required at least 5 working days in advance, except in emergencies or for Hospital stays for a mother and her Newborn of up to 48 hours following a vaginal delivery and 96 hours following a cesarean section.</p> <p>Notification must be provided for all admissions following emergency room care.</p> <p>Prior approval is required for bariatric surgery.</p> <p>Coverage is limited to one bariatric surgery per lifetime. Unless medically necessary, a second bariatric surgery is not Covered, even if the first procedure occurred prior to joining this plan.</p>
	Physician/surgeon fee	20% co-insurance/ visit	Not covered	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$20 co-pay/ visit	Not covered	<p>No charge for first three visits with participating provider within 90 days of discharge from a participating hospital for mental health inpatient care.</p> <p>Including medication management visits.</p> <p>Deductible does not apply.</p>
	Mental/Behavioral health inpatient services	20% co-insurance/ visit	Not covered	<p>Including partial hospitalization.</p> <p>Except in an emergency, prior approval required.</p> <p>Residential Treatment is subject to the skilled nursing care benefits described below.</p>
	Substance use disorder outpatient services	\$20 co-pay/ visit	Not covered	<p>Prior Approval required for intensive outpatient treatment.</p> <p>Including medication management visits.</p> <p>Deductible does not apply.</p>
	Substance use disorder inpatient services	20% co-insurance/ visit	Not covered	<p>Including partial hospitalization.</p> <p>Except in an emergency, prior approval required.</p> <p>Residential Treatment is subject to the skilled nursing care benefits described below.</p>
If you are pregnant	Routine prenatal and postnatal care	No charge	Not covered	<p>Routine prenatal and postnatal visits are covered under your Preventive Health Care Services benefit.</p> <p>Appropriate office visit charge (PCP or specialist) may apply for physician office services or home visits and consultations for complications of pregnancy.</p>
	Delivery and all inpatient services	20% co-insurance/ visit	Not covered	-----none-----

Common Medical Events	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Including hospice care services; excluding rehabilitation and habilitation services. Prior approval required except for hospice care services in the home. Rehabilitation and habilitation services provided in the home are subject to the limitations of the Rehabilitation Services and Habilitation Services benefits described below. Deductible does not apply.
	Rehabilitation services <i>not</i> for the treatment of Autism Spectrum Disorder	\$20 co-pay/ visit	Not covered	Physical and occupational therapy (Including osteopathic and chiropractic manipulation) limited to a combined 30 visits per contract year. Speech therapy limited to a combined 30 visits per contract year. Cardiac rehabilitation & pulmonary rehabilitation limited to a combined 30 visits per contract year. Deductible does not apply.
	Habilitation services for treatment of Autism Spectrum Disorder <i>only</i>	<ul style="list-style-type: none"> • \$20 co-pay/ visit for Physical, Occupational and Speech Therapy • 20% co-insurance/ visit for Applied Behavioral Analysis (ABA) services 	Not covered	Prior Approval required for Applied Behavioral Analysis (ABA). Services are Covered for children and adolescents under age 19 only. Multiple charges may apply during one day of service. Deductible does not apply to flat dollar co-pays.
	Habilitation services not for the treatment of Autism Spectrum Disorder	Not covered	Not covered	Not covered
	Skilled nursing care	20% co-insurance/ visit	Not covered	Services received in a skilled nursing care facility, subacute facility, behavioral health Residential Treatment facility, inpatient rehabilitation care facility or hospice care facility are limited to a combined 45 days per contract year. Prior approval required.
	Durable medical equipment (DME)	50% co-insurance/ visit	Not covered	Including rental, purchase or repair. Prior Approval required for equipment over \$1,000, all rentals and all shoe inserts.
	Prosthetics & orthotics	50% co-insurance/ visit	Not covered	
	Hospice service	No charge	Not covered	This benefit applies to hospice services provided in the home only. Any hospice services provided in a facility will be subject to the appropriate facility benefit. Deductible does not apply.
If your child needs dental or eye care	Child eye exam	Not covered	Not covered	Not covered
	Child glasses	Not covered	Not covered	Not covered
	Child dental check-up	Not covered	Not covered	Not covered

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan documents for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult & Child)
- Habilitation services not for the treatment of Autism Spectrum Disorder
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult & Child)
- Routine foot care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan documents.)

- Bariatric surgery
- Chiropractic care
- Emergency services provided outside the U.S.
- Infertility treatment - diagnostic, counseling and planning services for the underlying cause of infertility
- Weight loss programs

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Insurance and Financial Services (DIFS) at 1-877-999-6442 or difs-HICAP@michigan.gov; the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x61565 or www.cciio.cms.gov; or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Priority Health at 1-800-446-5674 or www.priorityhealth.com; the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; or the Department of Insurance and Financial Services (DIFS) at 1-877-999-6442 or difs-HICAP@michigan.gov. Additionally, a consumer assistance program can help you file your appeal. Contact the Michigan Health Insurance Consumer Assistance Program (HICAP) at 1-877-999-6442 or difs-HICAP@michigan.gov.

Does this plan provide Minimum Essential Coverage? Yes.

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? Yes.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-446-5674.

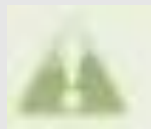
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-446-5674.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-446-5674.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-446-5674.

-----To see examples of how this plan might cover costs for a sample medical situation, see the next section-----

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, co-payments, and co-insurance) and excluded services under this plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-participating pre-natal care and a hospital delivery)

■ The <u>plan's</u> overall <u>deductible</u>	\$2,000
■ <u>Specialist co-payment</u>	\$45
■ Hospital (facility) <u>co-insurance</u>	20%
■ Other <u>co-insurance</u>	20%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

Total Example Cost	\$12,800
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$2,000
Co-payments	\$120
Co-insurance	\$2,480
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$4,660

Managing Joe's type 2 Diabetes

(a year of routine in-participating care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$2,000
■ <u>Specialist co-payment</u>	\$45
■ Hospital (facility) <u>co-insurance</u>	20%
■ Other <u>co-insurance</u>	20%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,400
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$971
Co-payments	\$1,445
Co-insurance	\$891
What isn't covered	
Limits or exclusions	\$55
The total Joe would pay is	\$3,362

Mia's Simple Fracture

(in-participating emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$2,000
■ <u>Specialist co-payment</u>	\$45
■ Hospital (facility) <u>co-insurance</u>	20%
■ Other <u>co-insurance</u>	20%

This EXAMPLE event includes services like:


Emergency room care (*including medical supplies*)
 Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost	\$1,900
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$518
Co-payments	\$705
Co-insurance	\$143
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,366

The plan would be responsible for the other costs of these EXAMPLE covered services.

	<p>The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. Note: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage or to get a copy of the complete terms of coverage, visit us at PriorityHealth.com or call 1-800-446-5674. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>co-insurance</u>, <u>co-payment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-800-446-5674 to request a copy.</p>
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Important Questions	Answers	Why this Matters
What is the overall deductible?	\$250 person / \$500 family Amounts you pay toward the <u>deductible</u> do not count toward any co-insurance maximums.	Generally, you must pay all of the costs from providers up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes, the <u>deductible</u> doesn't apply to <u>preventive care</u> , certain services subject to flat dollar <u>co-pays</u> and prescription drugs. Emergency room, ambulance and advanced imaging services are subject to the <u>deductible</u> and a <u>co-pay</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without cost-sharing and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	Yes. \$7,150 person / \$14,300 family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , <u>balance-billed</u> charges, health care this <u>plan</u> doesn't cover, services that exceed an annual day/visit limit, and any <u>co-pays</u> and <u>co-insurance</u> you pay for any non-essential health benefit.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Does this plan use a participating of providers?	Yes. See PriorityHealth.com or call 1-800-446-5674 for a list of <u>participating providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do I need a referral to see a specialist?	No, you don't need a referral in order to receive the preferred benefit for services provided by a <u>participating specialist</u> . Yes, you do need a referral in order to receive the preferred benefit for services provided by a <u>non-participating specialist</u> .	You can see the in-network <u>specialist</u> you choose without a <u>referral</u> . This <u>plan</u> will pay some or all of the costs to see an out-of-network <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .



All co-payment and co-insurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20 co-pay/ visit	Not covered	Deductible does not apply to certain services subject to flat dollar co-pays. Prescription drug co-pay may also apply when selected injectable drugs are provided. Prescription drugs for infertility treatment covered only with prescription drug addendum. Retail health clinic services are covered at reasonable and customary charges.
	Specialist visit	\$35 co-pay/ visit	Not covered	
	Other practitioner office visit	<ul style="list-style-type: none"> • \$75 co-pay/ visit for evaluation/ management services only at retail health clinics • 50% co-insurance/ visit for family planning/ infertility services • 50% co-insurance for Temporomandibular Joint Function (TMJ) treatment and Orthognathic surgery 	<ul style="list-style-type: none"> • Evaluation/management services only at retail health clinics covered at the in-network benefit level • Family planning/ infertility services not covered • Temporomandibular Joint Function (TMJ) treatment and Orthognathic surgery not covered 	
	Preventive care/screening/immunization	No charge	Not covered	Preventive care services are those listed in Priority Health's Preventive Health Care Guidelines, including women's preventive health care services. Deductible does not apply. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	-----none-----
	Imaging (CT/PET scans, MRIs)	\$150 co-pay	Not covered	Prior Approval required for certain radiology examinations. Co-pay waived if performed while confined in a hospital as an inpatient. Maximum of 10 co-pays per individual per contract year for imaging services.

Common Medical Events	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://www.priorityhealth.com/prog/pharmacy/pharmacy.cgi	Generic drugs	\$10 co-pay/ retail prescription \$20 co-pay/ mail order prescription	Not covered	Costs shown in the "Your Cost" columns apply to drugs on the approved drug list when obtained from a Participating Provider. Covers up to a 31-day supply (retail prescription); Covers up to a 90 day supply (mail order prescription) Up to a 90-day supply of medication (excluding Specialty Drugs) may be obtained at one time for three applicable Copayments at a retail Participating Pharmacy. 50% co-insurance/ prescription for infertility drugs. Deductible does not apply.
	Preferred brand drugs	\$40 co-pay/ retail prescription \$80 co-pay/ mail order prescription	Not covered	
	Non-preferred brand drugs	\$40 co-pay/ retail prescription \$80 co-pay/ mail order prescription	Not covered	
	Preferred specialty drugs	\$40 co-pay/ retail prescription	Not covered	Deductible does not apply.
	Non-Preferred specialty drugs	\$40 co-pay/ retail prescription	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	Including outpatient care, observation care and ambulatory surgery center care. Prior approval may be required. Prior approval is required for bariatric surgery. Coverage is limited to one bariatric surgery per lifetime. Unless medically necessary, a second bariatric surgery is not Covered, even if the first procedure occurred prior to joining this plan.
	Physician/surgeon fees	No charge	Not covered	
If you need immediate medical attention	Emergency room services	\$150 co-pay/ visit	Covered at the in-network benefit level	Co-pay waived if you become confined in a Hospital as an inpatient.
	Emergency medical transportation	\$150 co-pay	Covered at the in-network benefit level	-----none-----
	Urgent care	\$75 co-pay/ visit	Covered at the in-network benefit level when obtained outside of the Service Area	Urgent Care services received from a Non-Participating Provider who is located in our Service Area are not Covered. Urgent Care services received from a Non-Participating Provider who is located outside of our Service Area are Covered. Deductible does not apply.

Common Medical Events	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	<p>Prior Approval is required at least 5 working days in advance, except in emergencies or for Hospital stays for a mother and her Newborn of up to 48 hours following a vaginal delivery and 96 hours following a cesarean section.</p> <p>Notification must be provided for all admissions following emergency room care.</p> <p>Prior approval is required for bariatric surgery. Coverage is limited to one bariatric surgery per lifetime. Unless medically necessary, a second bariatric surgery is not Covered, even if the first procedure occurred prior to joining this plan.</p>
	Physician/surgeon fee	No charge	Not covered	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$20 co-pay/ visit	Not covered	<p>No charge for first three visits with participating provider within 90 days of discharge from a participating hospital for mental health inpatient care.</p> <p>Including medication management visits.</p> <p>Deductible does not apply.</p>
	Mental/Behavioral health inpatient services	No charge	Not covered	<p>Including partial hospitalization.</p> <p>Except in an emergency, prior approval required.</p> <p>Residential Treatment is subject to the skilled nursing care benefits described below.</p>
	Substance use disorder outpatient services	\$20 co-pay/ visit	Not covered	<p>Prior Approval required for intensive outpatient treatment.</p> <p>Including medication management visits.</p> <p>Deductible does not apply.</p>
	Substance use disorder inpatient services	No charge	Not covered	<p>Including partial hospitalization.</p> <p>Except in an emergency, prior approval required.</p> <p>Residential Treatment is subject to the skilled nursing care benefits described below.</p>
If you are pregnant	Routine prenatal and postnatal care	No charge	Not covered	<p>Routine prenatal and postnatal visits are covered under your Preventive Health Care Services benefit.</p> <p>Appropriate office visit charge (PCP or specialist) may apply for physician office services or home visits and consultations for complications of pregnancy.</p>
	Delivery and all inpatient services	No charge	Not covered	-----none-----

Common Medical Events	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Including hospice care services; excluding rehabilitation and habilitation services. Prior approval required except for hospice care services in the home. Rehabilitation and habilitation services provided in the home are subject to the limitations of the Rehabilitation Services and Habilitation Services benefits described below. Deductible does not apply.
	Rehabilitation services <i>not</i> for the treatment of Autism Spectrum Disorder	\$20 co-pay/ visit	Not covered	Physical and occupational therapy (Including osteopathic and chiropractic manipulation) limited to a combined 30 visits per contract year. Speech therapy limited to a combined 30 visits per contract year. Cardiac rehabilitation & pulmonary rehabilitation limited to a combined 30 visits per contract year. Deductible does not apply.
	Habilitation services for treatment of Autism Spectrum Disorder <i>only</i>	<ul style="list-style-type: none"> • \$20 co-pay/ visit for Physical, Occupational and Speech Therapy • No charge for Applied Behavioral Analysis (ABA) services 	Not covered	Prior Approval required for Applied Behavioral Analysis (ABA). Services are Covered for children and adolescents under age 19 only. Multiple charges may apply during one day of service. Deductible does not apply to flat dollar co-pays.
	Habilitation services not for the treatment of Autism Spectrum Disorder	Not covered	Not covered	Not covered
	Skilled nursing care	No charge	Not covered	Services received in a skilled nursing care facility, subacute facility, behavioral health Residential Treatment facility, inpatient rehabilitation care facility or hospice care facility are limited to a combined 45 days per contract year. Prior approval required.
	Durable medical equipment (DME)	50% co-insurance/ visit	Not covered	Including rental, purchase or repair. Prior Approval required for equipment over \$1,000, all rentals and all shoe inserts.
	Prosthetics & orthotics	50% co-insurance/ visit	Not covered	
	Hospice service	No charge	Not covered	This benefit applies to hospice services provided in the home only. Any hospice services provided in a facility will be subject to the appropriate facility benefit. Deductible does not apply.
If your child needs dental or eye care	Child eye exam	Not covered	Not covered	Not covered
	Child glasses	Not covered	Not covered	Not covered
	Child dental check-up	Not covered	Not covered	Not covered

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan documents for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult & Child)
- Habilitation services not for the treatment of Autism Spectrum Disorder
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult & Child)
- Routine foot care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan documents.)

- Bariatric surgery
- Chiropractic care
- Emergency services provided outside the U.S.
- Infertility treatment - diagnostic, counseling and planning services for the underlying cause of infertility
- Weight loss programs

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Insurance and Financial Services (DIFS) at 1-877-999-6442 or difs-HICAP@michigan.gov; the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x61565 or www.cciio.cms.gov; or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Priority Health at 1-800-446-5674 or www.priorityhealth.com; the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; or the Department of Insurance and Financial Services (DIFS) at 1-877-999-6442 or difs-HICAP@michigan.gov. Additionally, a consumer assistance program can help you file your appeal. Contact the Michigan Health Insurance Consumer Assistance Program (HICAP) at 1-877-999-6442 or difs-HICAP@michigan.gov.

Does this plan provide Minimum Essential Coverage? Yes.

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? Yes.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-446-5674.

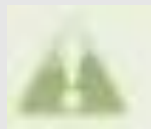
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-446-5674.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-446-5674.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-446-5674.

-----To see examples of how this plan might cover costs for a sample medical situation, see the next section-----

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, co-payments, and co-insurance) and excluded services under this plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-participating pre-natal care and a hospital delivery)

■ The <u>plan's</u> overall <u>deductible</u>	\$2,000
■ <u>Specialist co-payment</u>	\$45
■ Hospital (facility) <u>co-insurance</u>	20%
■ Other <u>co-insurance</u>	20%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

Total Example Cost	\$12,800
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$2,000
Co-payments	\$120
Co-insurance	\$2,480
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$4,660

Managing Joe's type 2 Diabetes

(a year of routine in-participating care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$2,000
■ <u>Specialist co-payment</u>	\$45
■ Hospital (facility) <u>co-insurance</u>	20%
■ Other <u>co-insurance</u>	20%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,400
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$971
Co-payments	\$1,445
Co-insurance	\$891
What isn't covered	
Limits or exclusions	\$55
The total Joe would pay is	\$3,362

Mia's Simple Fracture

(in-participating emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$2,000
■ <u>Specialist co-payment</u>	\$45
■ Hospital (facility) <u>co-insurance</u>	20%
■ Other <u>co-insurance</u>	20%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
 Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost	\$1,900
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$518
Co-payments	\$705
Co-insurance	\$143
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,366

The plan would be responsible for the other costs of these EXAMPLE covered services.