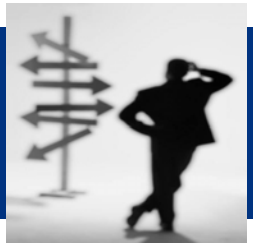
OU WB School of MEDICINE

OAKLAND UNIVERSITY WILLIAM BEAUMONT

INSURANCE GUIDE

Fall 2018

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 (Buy Up HMO) or PPO plan (Buy Up PPO).

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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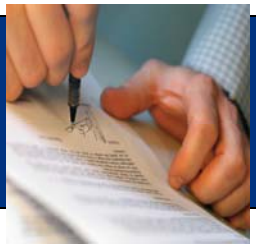
Enrollment Elections



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.

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 HMO Plan or a Buy Up PPO. This page explains the HMO plans available.

Students are also offered the option to purchase coverage for their dependents on any of the plans offered.

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

PPO Health Coverage from PriorityHealth

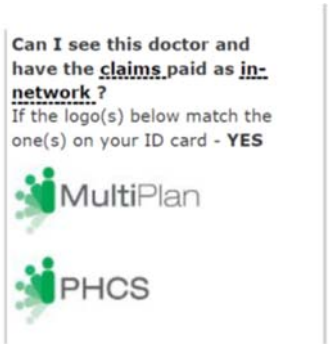
If you would like access to a bigger network of physicians and hospitals-including coverage outside the State of Michigan-OUWB School of Medicine offers students the option to Buy Up to a PPO plan.

Outside of Michigan, PHCS and Multiplan are networks Priority Health uses to provide access to members nationwide with over 900,000 providers.

You may find providers that participate with PHCS/Multiplan by accessing our Find a Doctor Tool (Select PriorityPPO in drop down box): http://priorityhealth.prismisp.com/

Once you've entered your search criteria and have the list of results, you'll need to take one additional step to confirm the provider's participation status with the PHCS/Multiplan networks.

By clicking on a provider's name, the below message will appear.



As long as your ID card contains the logos, then your claims will be paid as In-Network.

Please note, when visiting providers outside of Michigan, it is likely that they will not recognize the Priority Health name, since Priority Health is a Michigan-based insurance company.
Therefore, it is important to ask your provider if they *participate* with PHCS or Multiplan.

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Medical Insurance

PriorityHealth 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.

	HMO Core Plan	HMO Buy Up	PPO Buy Up (out of network coverage included, but not shown)
Deductible Per plan year	$500 per member $1000 per family	$250 per member $500 per family	$500 per member $1000 per family
Copays •Fixed Dollar Copay	**Office visit**: • PCP/OB: $20 • Specialist: $35 • Urgent Care: $75 • Virtual Visit: $0 • ER and High Tech Radiology: $150 after deductible	**Office visit**: • PCP/OB: $20 • Specialist: $35 • Urgent Care: $75 • Virtual Visit: $0 • ER and High Tech Radiology: $150 after deductible	**Office visit**: • PCP: $20 • Specialist: $35 • Urgent Care: $75 • Virtual Visit: $0 • ER and High Tech Radiology: $150 after deductible
Prescription Drugs	**Copays:** • $15 Generic • $50 Preferred Brand • $80 Non-Preferred Brand • 20% Specialty to a max of $150 or $300 • 2 X Mail Order	**Copays:** • $10 Generic • $40 Preferred Brand • $40 Non-Preferred Brand • $40 Specialty • 2 X Mail Order	**Copays:** • $15 Generic • $50 Preferred Brand • $80 Non-Preferred Brand • 20% Specialty to a max of $150 or $300 • 2 X Mail Order
Coinsurance Max	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**	80% coverage on most services, after deductible to a maximum of $1,500 per single $3,000 per family
Maximum Out of Pocket	$6,350 per member $12,700 per family	$6,350 per member $12,700 per family	**$7,150** per member **$14,300** per family
	Maximum Out of Pocket Cost includes copays, deductibles and prescriptions		
Preventive	100% Coverage	100% Coverage	100% Coverage
DME/ Prosthetics and Orthotics	50% Coverage after deductible	50% Coverage after deductible	50% Coverage after deductible
Network	Priority Health HMO In Michigan only	Priority Health HMO In Michigan only	Priority Health PPO Nationwide Coverage
Cost Per Student (every 6 months)	Student Only: None Student plus one dependent: $1,176.36 Student plus 2 or more dependents: $1715.40	Student only: $140.22 Student plus one dependent: $1484.70 Student plus 2 or more dependents: $2100.96	Student only: $84.00 Student plus one dependent: $1361.16 Student plus 2 or more dependents: $1946.34

Hylant 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.

Which Plan is best for you?

With three 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 HMO PLAN AND BUY UP PPO PLAN (The CORE HMO and BUY UP PPO plans have similar out of pocket expenses. However, there are network differences as outlined on previous pages)		**BUY UP HMO PLAN**	
Deductible	$500 per member $1000 per family	$_____	$250 per member $500 per family	$ _____
Copays • **Fixed Dollar Copay**	**Office visit**: • 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**: • 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:** • $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:** • $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		$250 per member $500 per family	
True Annual Out of Pocket Cost	**TOTAL:**	**$_____**	**TOTAL:**	**$_____**
Cost by enrollment (every 6 months)	**CORE PLAN**: Student Only: None Student plus one dependent: $1,176.36 Student plus 2 or more dependents: $1715.40	**PPO BUY UP:** Student only: $84.00 Student plus one dependent: $1361.16 Student plus 2 or more dependents: $1946.34	**BUY UP HMO:** Student only: $140.22 Student plus one dependent: $1484.70 Student plus 2 or more dependents: $2100.96	

Long Term Disability

All Full Time Medical Students will receive a Long Term Disability benefit.
OUWB pays 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.**

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**

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
HMO and PPO Medical Claims Questions, ID Cards and Provider Directories	**Priority Health**	1-888-389-6646 www.priorityhealth.com http://priorityhealth.prismisp.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 or pediatric dental benefits (for children enrolled) 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.

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 (Tuesdays until 6:00PM) . 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**

PriorityHealth

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, **My**Health puts you in control of your health.

Set up your My Health **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.

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****.*

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

continued >

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

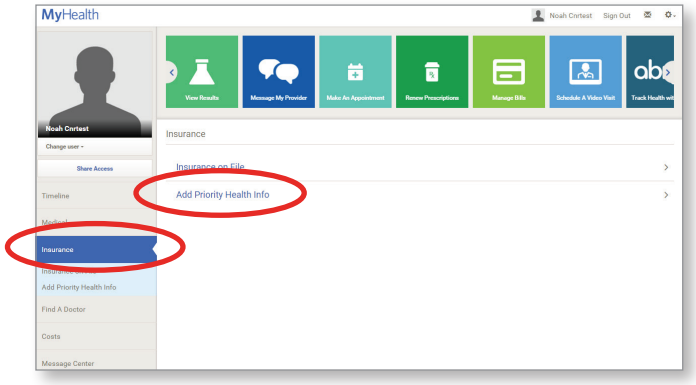
1. Go to *priorityhealth.com*, click **Login** and enter your **My**Health username and password.

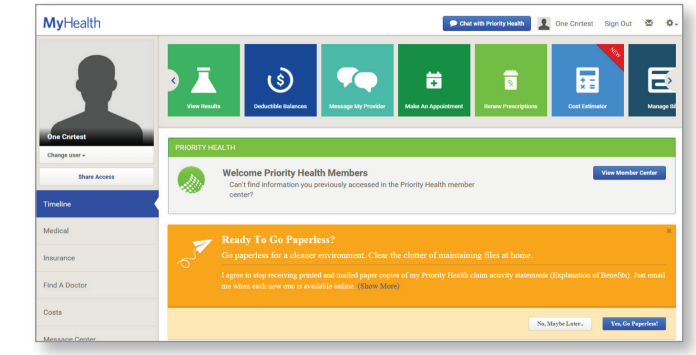
2. Choose **Insurance** from the left menu (this is where you'll find your wellness information, too).

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.

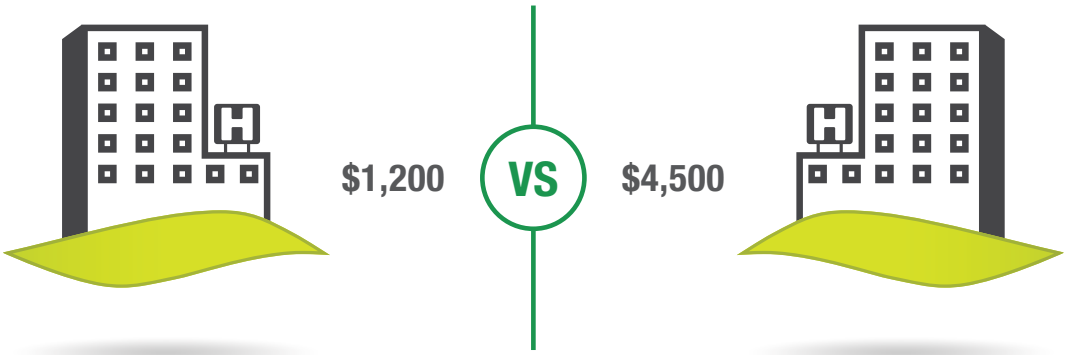




*If you have two **My**Health accounts, please call 877.308.5083 and the **My**Health Customer Support team will merge your accounts.*

PriorityHealth®
A healthier approach to health care®

PriorityHealth
A healthier approach to health care®



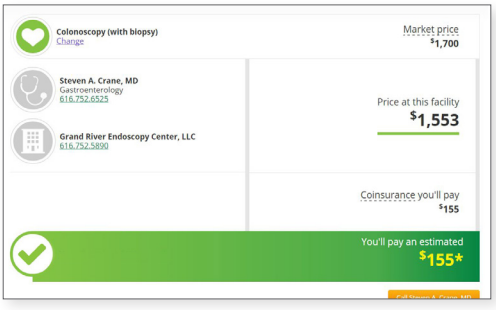
A car. A television. A vacation.

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



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.

Global emergency services

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.*

Medical consultation, evaluation and 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.

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.

Two ways to access services:

1. ***Download** the free Assist America mobile app available for iPhone and Android*
2. ***Call** Assist America's 24-hour Operations Center at 800.872.1414*

Priority Health reference number: 01-AA-PHP-12123

**Not available to Medicare, Medicaid or MIChild members.*

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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 and legal referral

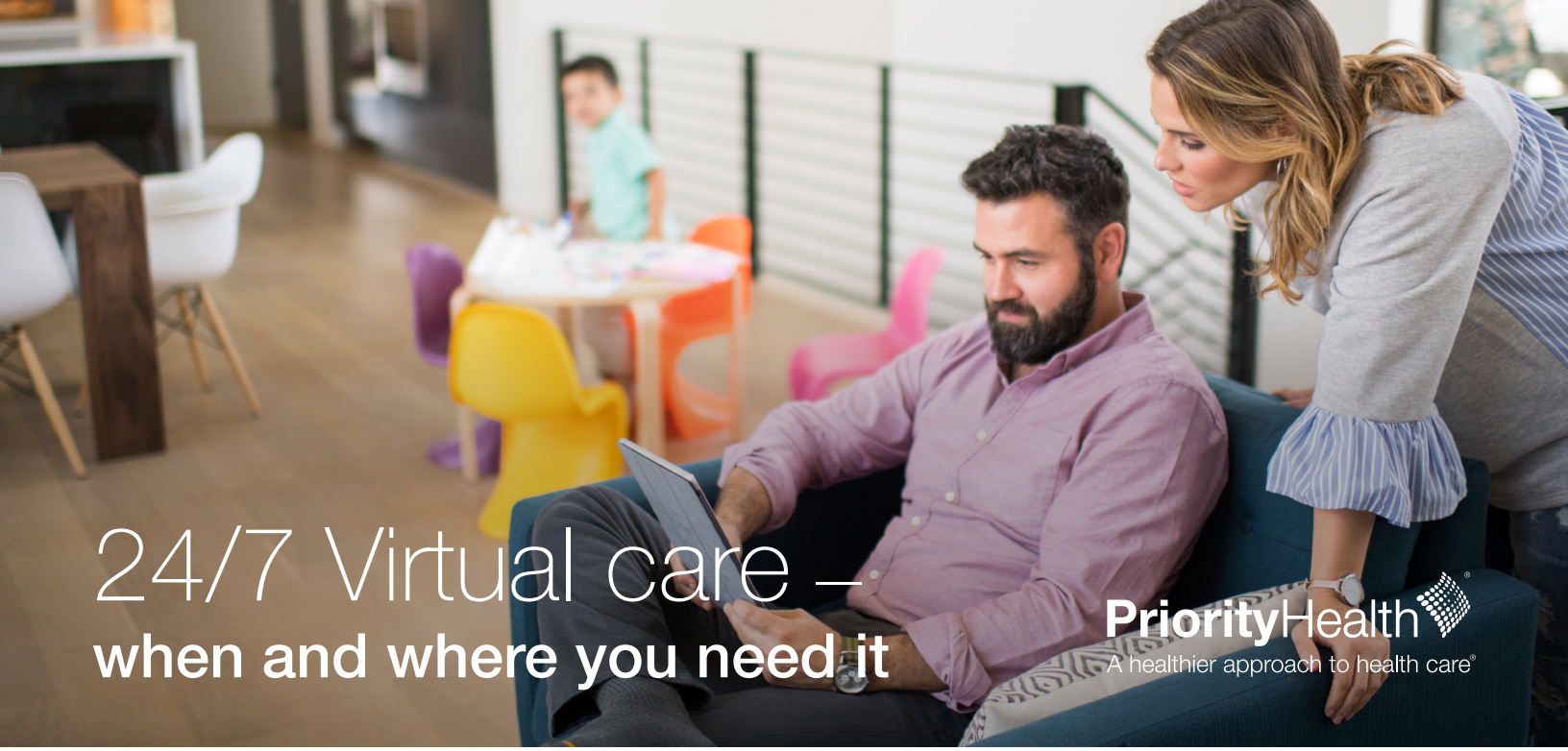
Assist America can make recommendations for trustworthy legal counsel and interpreter services in any country. Bail bonds can be coordinated in jurisdictions where they are legal.

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.



24/7 Virtual care – when and where you need it

PriorityHealth
A healthier approach to health care®

When it's not convenient to go to the doctor, bring a doctor to you.

What is virtual care?

Virtual care gives you access to board-certified doctors on nights, weekends and even holidays for health issues that aren't an emergency. Virtual care connects you with a doctor over the phone, through video, or simply by filling out an online questionnaire. Depending on your condition and the type of virtual care you choose, a doctor can:

- Prescribe a medication and send it to your preferred pharmacy
- Develop a treatment plan
- Notify your primary care doctor with current information
- Make follow-up recommendations, including referrals to see a specialist

Did you know? Members save an average of $94-649 when they use virtual care instead of the emergency room or urgent care.

What conditions can it treat?

Virtual care is great for non-emergencies, like:

- Cough, cold and flu
- Fever, nausea and vomiting
- Sinus problems
- Pink eye
- Allergies, bites and stings
- Rash, hives and more

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How much does it cost?

We offer our members 100% coverage ($0 copay) for in-network virtual care. It is included in your benefits at no cost to you.*

Talk to your doctor

Ask your doctor about what virtual care options are available to you.

Virtual care through MedNow

If your doctor doesn't offer virtual care, you can access it with MedNow℠. Download the MedNow app on your device, or login to your MyHealth account and choose the MedNow tile to get started.

Download on the App Store

GET IT ON Google Play

*Includes 100% coverage ($0 copay) for fully funded plan members and opt-in for self-funded plan members. HSA plan members must meet their deductible before 100% coverage begins, but will never pay more than an in-person doctors visit.

Priority Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia en su idioma. Consulte al número de Servicio al Cliente que está en la parte de atrás de su tarjeta de identificación de miembro. (TTY: 711).

ملاحظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. يرجى الاتصال برقم خدمة العملاء على الجانب الخلفي من بطاقة عضويتك الشخصية. (رقم هاتف الصم والبكم:711).

Benefits summary:
CORE HMO

Providing strong coverage for most commonly used benefits

PriorityHealth

Coverage period: 08.01.2018 to 07.31.2019

OAKLAND UNIVERSITY WILLIAM BEAUMONT

This document is intended to be an easy-to-read summary to provide a general overview of your benefits. It is not a contract or legal document. Additional limitations and exclusions may apply to covered services. This plan has a specific network of providers, so check the Provider Directory prior to receiving services. Prior authorizations for certain services may apply. A complete description of benefits is contained in the Certificate of Coverage, Schedule or Agreement as applicable.

Member cost-sharing	
Deductible *The amount you pay before we begin to pay.*	$500 individual/$1,000 family Deductible costs don't apply towards your coinsurance maximum. Out-of-network services not covered.
Coinsurance *Your share of the costs of a covered health care service.*	20% coinsurance for services after deductible is met, except where noted. Out-of-network services not covered.
Coinsurance maximum *The most coinsurance cost share you'll pay for covered services in a contract year. Your coinsurance cost share counts toward your out-of-pocket limit.*	$1,500 individual/$3,000 family
Out-of-pocket limit *The most you'll pay in a contract year for covered services before we begin to pay 100% of the costs.*	$6,350 individual/$12,700 family
Office visits	
Primary care provider (PCP)	$20 copayment, deductible doesn't apply
Specialists	$35 copayment, deductible doesn't apply
Urgent care	$75 copayment, deductible doesn't apply
Virtual visits *24/7 care for non-emergency conditions*	Covered in full
Allergy testing, serum and injections	Covered in full
Retail health clinic *Located in a retail center, like a supermarket or pharmacy and provides care for common illnesses and services (examples: ear aches, sore throats, flu shots)*	$75 copayment, deductible doesn't apply
Mental and behavioral health	
Inpatient hospital	20% coinsurance after deductible
Outpatient office visits	$20 copayment, deductible doesn't apply

continued	
Prescription drug coverage *Visit priorityhealth.com and search Optimized or Traditional in the **Approved Drug** list to see coverage and pricing information.*	
Formulary	Traditional
Generic	$15 copayment, deductible N/A
Brand	$50 preferred copayment, $80 non-preferred copayment, deductible N/A
Mail Order	Generic: 2x Brand: 2x; deductible N/A
Specialty	20% preferred coinsurance, $150 max, 20% non-preferred coinsurance, $300 max, deductible N/A
Preventive care	
Preventive care, immunizations	Covered in full; includes women's preventative health care services, well-child visits, flu shots and routine physical exams. Get the most up-to-date list of all the care that's recommended in our Preventative Health Care Guidelines when you login to your online account at PriorityHealth.com
Laboratory and X-ray	
Radiology	20% coinsurance after deductible
Advanced imaging (CT/ PET/MRI)	$150 copayment after deductible
Laboratory	20% coinsurance after deductible
Emergency services	
Emergency room	$150 copayment after deductible
Emergency transportation/ ambulance services	$150 copayment after deductible
Hospital care	
Inpatient hospital physician services	20% coinsurance after deductible
Surgery and/or facility fee	20% coinsurance after deductible; exceptions apply
Bariatric surgery	20% coinsurance after deductible; covered once per lifetime
Outpatient care	
Skilled nursing services and residential treatment	20% coinsurance after deductible; Up to 45 days covered per member each contract year
Outpatient surgery	20% coinsurance after deductible
In-home and hospice care	Covered in full
Rehabilitation services and devices	
Physical and occupational therapy	$20 copayment, deductible doesn't apply Combined maximum 30 visits per member per contract year
Chiropractic care	Combined with physical and occupational therapy
Speech therapy	$20 copayment, deductible doesn't apply; Combined maximum 30 visits per member per contract year
Prosthetic and orthotic support	50% coinsurance after deductible
Durable medical equipment (DME)	50% coinsurance after deductible
Family planning and maternity care	
Family planning	50% coinsurance after deductible
Routine prenatal and postpartum care	Covered in full for evaluation and management; see Preventative Health Care Guidelines for recommendations and services
Maternity delivery and nursery care	20% coinsurance after deductible
Tubal ligation	Covered in full for physicians services and outpatient facility Note: Hospital inpatient charges are subject to deductible and coinsurance when in connection with delivery or other covered inpatient surgery
Vasectomy	Covered in full when performed in physician's office or in connection with other surgery

continued	
Riders	
Domestic partners	Covers both same sex partner or different sex partner

Additional benefits:

Cost estimator: Calculates specific costs for hundreds of procedures, based on where you're at with your deductible, coinsurance, etc. If a selected procedure is above fair market price, the tool will provide a list of nearby facilities where it's offered at a lower cost.

Travel assistance: If you become ill or injured while traveling more than 100 miles from home, AssistAmerica® coverage is included in your plan. Receive help with medical care, coordinating prescriptions, assistance with lost luggage, and even arrange your travel back home.

Member perks: Earn up to 20% cash back when you purchase digital gift cards from hundreds of local and national retailers - from Amazon to Zappos. Redeem online or at checkout at the store.

Benefits summary:
BUY UP HMO

PriorityHealth

Coverage period: 08.01.2018 to 07.31.2019

Providing strong coverage for most commonly used benefits

OAKLAND UNIVERSITY WILLIAM BEAUMONT

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Member cost-sharing	
Deductible *The amount you pay before we begin to pay.*	$250 individual/$500 family Deductible costs don't apply towards your coinsurance maximum. Out-of-network services not covered.
Coinsurance *Your share of the costs of a covered health care service.*	No cost for services after deductible is met, except where noted. Out-of-network services not covered.
Coinsurance maximum *The most coinsurance cost share you'll pay for covered services in a contract year. Your coinsurance cost share counts toward your out-of-pocket limit.*	Not applicable
Out-of-pocket limit *The most you'll pay in a contract year for covered services before we begin to pay 100% of the costs.*	$6,350 individual/$12,700 family
Office visits	
Primary care provider (PCP)	$20 copayment, deductible doesn't apply
Specialists	$35 copayment, deductible doesn't apply
Urgent care	$75 copayment, deductible doesn't apply
Virtual visits *24/7 care for non-emergency conditions*	Covered in full
Allergy testing, serum and injections	Covered in full
Retail health clinic *Located in a retail center, like a supermarket or pharmacy and provides care for common illnesses and services (examples: ear aches, sore throats, flu shots)*	$75 copayment, deductible doesn't apply
Mental and behavioral health	
Inpatient hospital	Covered in full after deductible
Outpatient office visits	$20 copayment, deductible doesn't apply

continued	
Prescription drug coverage *Visit priorityhealth.com and search Optimized or Traditional in the **Approved Drug** list to see coverage and pricing information.*	
Formulary	Traditional
Generic	$10 copayment, deductible N/A
Brand	$40 copayment, deductible N/A
Mail Order	Generic: 2x Brand: 2x; deductible N/A
Specialty	$40 copayment, deductible N/A
Preventive care	
Preventive care, immunizations	Covered in full; includes women's preventative health care services, well-child visits, flu shots and routine physical exams. Get the most up-to-date list of all the care that's recommended in our Preventative Health Care Guidelines when you login to your online account at PriorityHealth.com
Laboratory and X-ray	
Radiology	Covered in full after deductible
Advanced imaging (CT/ PET/MRI)	$150 copayment after deductible
Laboratory	Covered in full after deductible
Emergency services	
Emergency room	$150 copayment after deductible
Emergency transportation/ ambulance services	$150 copayment after deductible
Hospital care	
Inpatient hospital physician services	Covered in full after deductible
Surgery and/or facility fee	Covered in full after deductible; exceptions apply
Bariatric surgery	Covered in full after deductible; covered once per lifetime
Outpatient care	
Skilled nursing services and residential treatment	Covered in full after deductible; Up to 45 days covered per member each contract year
Outpatient surgery	Covered in full after deductible
In-home and hospice care	Covered in full
Rehabilitation services and devices	
Physical and occupational therapy	$20 copayment, deductible doesn't apply Combined maximum 30 visits per member per contract year
Chiropractic care	Combined with physical and occupational therapy
Speech therapy	$20 copayment, deductible doesn't apply; Combined maximum 30 visits per member per contract year
Prosthetic and orthotic support	50% coinsurance after deductible
Durable medical equipment (DME)	50% coinsurance after deductible
Family planning and maternity care	
Family planning	50% coinsurance after deductible
Routine prenatal and postpartum care	Covered in full for evaluation and management; see Preventative Health Care Guidelines for recommendations and services
Maternity delivery and nursery care	Covered in full after deductible
Tubal ligation	Covered in full for physicians services and outpatient facility Note: Hospital inpatient charges are subject to deductible and coinsurance when in connection with delivery or other covered inpatient surgery
Vasectomy	Covered in full when performed in physician's office or in connection with other surgery

continued		
Prescription drug coverage *Visit priorityhealth.com and search Optimized or Traditional in the **Approved Drug** list to see coverage and pricing information.*		
Formulary	Traditional	
Generic	$15 copayment, deductible N/A	
Brand	$50 preferred copayment, $80 non-preferred copayment, deductible N/A	
Mail Order	Generic: 2x Brand: 2x; deductible N/A	
Specialty	20% preferred coinsurance, $150 max, 20% non-preferred coinsurance, $300 max, deductible N/A	
Preventive care	**In-network benefits**	**Out-of-network benefits**
Preventive care, immunizations	Covered in full; includes women's preventative health care services, well-child visits, flu shots and routine physical exams. Get the most up-to-date list of all the care that's recommended in our Preventative Health Care Guidelines when you login to your online account at PriorityHealth.com	40% coinsurance after deductible
Laboratory and X-ray	**In-network benefits**	**Out-of-network benefits**
Radiology	20% coinsurance after deductible	40% coinsurance after deductible
Advanced imaging (CT/ PET/MRI)	$150 copayment after deductible	40% coinsurance after deductible
Laboratory	20% coinsurance after deductible	40% coinsurance after deductible
Emergency services	**In-network benefits**	**Out-of-network benefits**
Emergency room	$150 copayment after deductible	$150 copayment after deductible
Emergency transportation/ ambulance services	$150 copayment after deductible	$150 copayment after deductible
Hospital care	**In-network benefits**	**Out-of-network benefits**
Inpatient hospital physician services	20% coinsurance after deductible	40% coinsurance after deductible
Surgery and/or facility fee	20% coinsurance after deductible; exceptions apply	40% coinsurance after deductible; exceptions apply
Bariatric surgery	20% coinsurance after deductible; covered once per lifetime	40% coinsurance after deductible; covered once per lifetime
Outpatient care	**In-network benefits**	**Out-of-network benefits**
Skilled nursing services and residential treatment	20% coinsurance after deductible; Up to 45 days covered per member each contract year	40% coinsurance after deductible; Up to 45 days covered per member each contract year
Outpatient surgery	20% coinsurance after deductible	40% coinsurance after deductible
In-home and hospice care	Covered in full	40% coinsurance after deductible
Rehabilitation services and devices	**In-network benefits**	**Out-of-network benefits**
Physical and occupational therapy	$20 copayment, deductible doesn't apply Combined maximum 30 visits per member per contract year	50% coinsurance after deductible Combined maximum 30 visits per member per contract year
Chiropractic care	Combined with physical and occupational therapy	Combined with physical and occupational therapy
Speech therapy	$20 copayment, deductible doesn't apply; Combined maximum 30 visits per member per contract year	50% coinsurance after deductible Combined maximum 30 visits per member per contract year
Prosthetic and orthotic support	50% coinsurance after deductible	50% coinsurance after deductible
Durable medical equipment (DME)	50% coinsurance after deductible	50% coinsurance after deductible

Benefits summary:
BUY UP PPO

PriorityHealth

Coverage period: 08.01.2018 to 07.31.2019

Providing strong coverage for most commonly used benefits

OAKLAND UNIVERSITY WILLIAM BEAUMONT

This document is intended to be an easy-to-read summary to provide a general overview of your benefits. It is not a contract or legal document. Additional limitations and exclusions may apply to covered services. This plan has a specific network of providers, so check the Provider Directory prior to receiving services. Prior authorizations for certain services may apply. A complete description of benefits is contained in the Certificate of Coverage, Schedule or Agreement as applicable.

Member cost-sharing	In-network benefits	Out-of-network benefits
Deductible *The amount you pay before we begin to pay.*	$500 individual/$1,000 family Deductible costs don't apply towards your coinsurance maximum	$1,000 individual/$2,000 family Deductible costs don't apply towards your coinsurance maximum
Coinsurance *Your share of the costs of a covered health care service.*	20% coinsurance for services after deductible is met, except where noted.	40% coinsurance for services after deductible is met, except where noted.
Coinsurance maximum *The most coinsurance cost share you'll pay for covered services in a contract year. Your coinsurance cost share counts toward your out-of-pocket limit.*	$1,500 individual/$3,000 family	$3,000 individual/$6,000 family
Out-of-pocket limit *The most you'll pay in a contract year for covered services before we begin to pay 100% of the costs.*	$7,150 individual/$14,300 family	$14,300 individual/$28,600 family
Office visits	**In-network benefits**	**Out-of-network benefits**
Primary care provider (PCP)	$20 copayment, deductible doesn't apply	40% coinsurance after deductible
Specialists	$35 copayment, deductible doesn't apply	40% coinsurance after deductible
Urgent care	$75 copayment, deductible doesn't apply	40% coinsurance after deductible
Virtual visits *24/7 care for non-emergency conditions*	Covered in full	Not covered
Allergy testing, serum and injections	Covered in full	40% coinsurance after deductible
Retail health clinic *Located in a retail center, like a supermarket or pharmacy and provides care for common illnesses and services (examples: ear aches, sore throats, flu shots)*	$75 copayment, deductible doesn't apply	$75 copayment after deductible
Mental and behavioral health	**In-network benefits**	**Out-of-network benefits**
Inpatient hospital	20% coinsurance after deductible	40% coinsurance after deductible
Outpatient office visits	$20 copayment, deductible doesn't apply	40% coinsurance after deductible

continued		
Family planning and maternity care	**In-network benefits**	**Out-of-network benefits**
Family planning	20% coinsurance after deductible	40% coinsurance after deductible
Routine prenatal and postpartum care	Covered in full for evaluation and management; see Preventative Health Care Guidelines for recommendations and services	40% coinsurance after deductible
Maternity delivery and nursery care	20% coinsurance after deductible	40% coinsurance after deductible
Tubal ligation	Covered in full for physicians services and outpatient facility Note: Hospital inpatient charges are subject to deductible and coinsurance when in connection with delivery or other covered inpatient surgery	40% coinsurance after deductible
Vasectomy	Covered in full when performed in physician's office or in connection with other surgery	40% coinsurance after deductible

Riders	
Domestic partners	Covers both same sex partner or different sex partner

Additional benefits:

Cost estimator: Calculates specific costs for hundreds of procedures, based on where you're at with your deductible, coinsurance, etc. If a selected procedure is above fair market price, the tool will provide a list of nearby facilities where it's offered at a lower cost.

Travel assistance: If you become ill or injured while traveling more than 100 miles from home, AssistAmerica® coverage is included in your plan. Receive help with medical care, coordinating prescriptions, assistance with lost luggage, and even arrange your travel back home.

Member perks: Earn up to 20% cash back when you purchase digital gift cards from hundreds of local and national retailers - from Amazon to Zappos. Redeem online or at checkout at the store.

continued	
Riders	
Domestic partners	Covers both same sex partner or different sex partner

Additional benefits:

Cost estimator: Calculates specific costs for hundreds of procedures, based on where you're at with your deductible, coinsurance, etc. If a selected procedure is above fair market price, the tool will provide a list of nearby facilities where it's offered at a lower cost.

Travel assistance: If you become ill or injured while traveling more than 100 miles from home, AssistAmerica® coverage is included in your plan. Receive help with medical care, coordinating prescriptions, assistance with lost luggage, and even arrange your travel back home.

Member perks: Earn up to 20% cash back when you purchase digital gift cards from hundreds of local and national retailers - from Amazon to Zappos. Redeem online or at checkout at the store.

PriorityHealth **OAKLAND UNIVERSITY WILLIAM BEAUMONT : SCHOOL OF MEDICINE -CORE HMO 2018**

Coverage for: Subscriber/Dependent | Plan Type: HMO

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 deductible do not count toward any co-insurance maximums.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes, the deductible doesn't apply to preventive care, certain services subject to flat dollar co-pays and prescription drugs. Emergency room, ambulance and advanced imaging services are subject to the deductible and a co-pay.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Yes. $6,350 person / $12,700 family Your plan also has a co-insurance maximum. $1,500 person / $3,000 family The co-insurance maximum limits the total amount of co-insurance you will pay for certain covered services during a coverage period. The co-insurance maximum is included in the out-of-pocket limit	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, health care this plan doesn't cover, services that exceed an annual day/visit limit, and any co-pays and co-insurance you pay for any non-essential health benefit.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Does this plan use a network of providers?	Yes. See PriorityHealth.com or call 1-800-446-5674 for a list of participating providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider 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 participating specialist. Yes, you do need a referral in order to receive the preferred benefit for services provided by a non-participating specialist.	You can see the in-network specialist you choose without a referral. This plan will pay some or all of the costs to see an out-of-network specialist for covered services but only if you have a referral before you see the specialist.

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	•$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	•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.

* For more information about limitations and exceptions, see the plan or policy document at PriorityHealth.com.

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	$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. Deductible does not apply.

* For more information about limitations and exceptions, see the plan or policy document at PriorityHealth.com.

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	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. Notification must be provided for all admissions following emergency room care. 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 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	No charge for first three visits with participating provider within 90 days of discharge from a participating hospital for mental health inpatient care. Including medication management visits. Deductible does not apply.
	Mental/Behavioral health inpatient services	20% co-insurance/ visit	Not covered	Including Residential Treatment and partial hospitalization. Except in an emergency, prior approval required.
	Substance use disorder outpatient services	$20 co-pay/ visit	Not covered	Prior Approval required for intensive outpatient treatment. Including medication management visits. Deductible does not apply.
	Substance use disorder inpatient services	20% co-insurance/ visit	Not covered	Including subacute Residential Treatment and partial hospitalization. Except in an emergency, prior approval required.
If you are pregnant	Routine prenatal and postnatal care	No charge	Not covered	Routine prenatal and postnatal visits are covered under your Preventive Health Care Services benefit. Appropriate office visit charge (PCP or specialist) may apply for physician office services or home visits and consultations for complications of pregnancy.
	Delivery and all inpatient services	20% co-insurance/ visit	Not covered	----------none----------

* For more information about limitations and exceptions, see the plan or policy document at PriorityHealth.com.

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. Deductible does not apply.
	Rehabilitation services *not* 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 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 ***only***	• $20 co-pay/ visit for Physical, Occupational and Speech Therapy • 20% co-insurance/ visit for Applied Behavior Analysis (ABA) services	Not covered	Prior Approval required for Applied Behavior 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	$20 co-pay/ visit	Not covered	Physical and occupational therapy limited to a combined 30 visits per contract year. Speech therapy limited to 30 visits per contract year. Deductible does not apply.
	Skilled nursing care	20% co-insurance/ visit	Not covered	Services received in a skilled nursing care facility, subacute 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	No charge	Not covered	One exam per year. Deductible does not apply.
	Child glasses	No charge	Not covered	Coverage limited to one select frame and one pair of eyeglass lenses or, in lieu of eyeglasses, contact lenses are covered up to a 6-month supply for 2-week disposable lenses, a 3-month supply of daily disposable lenses or one pair of conventional lenses. Deductible does not apply.
	Child dental check-up	Not covered	Not covered	Not covered

* For more information about limitations and exceptions, see the plan or policy document at PriorityHealth.com.

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)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- 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
- Routine eye care (Child)
- 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. 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, kwiijigo 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-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$2,000**
Specialist co-payment	**$45**
Hospital (facility) co-insurance	**20%**
Other co-insurance	**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**

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-network care of a well-controlled condition)

The plan's overall deductible	**$2,000**
Specialist co-payment	**$45**
Hospital (facility) co-insurance	**20%**
Other co-insurance	**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**

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-network emergency room visit and follow up care)

The plan's overall deductible	**$2,000**
Specialist co-payment	**$45**
Hospital (facility) co-insurance	**20%**
Other co-insurance	**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**

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.

PriorityHealth

OAKLAND UNIVERSITY WILLIAM BEAUMONT : SCHOOL OF MEDICINE - BUY UP HMO 2018

Coverage for: Subscriber/Dependent | Plan Type: HMO

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?	$250 person / $500 family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes, the deductible doesn't apply to preventive care, certain services subject to flat dollar co-pays and prescription drugs. Emergency room, ambulance and advanced imaging services are subject to the deductible and a co-pay.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Yes. $6,350 person / $12,700 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, health care this plan doesn't cover, services that exceed an annual day/visit limit, and any co-pays and co-insurance you pay for any non-essential health benefit.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Does this plan use a network of providers?	Yes. See PriorityHealth.com or call 1-800-446-5674 for a list of participating providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider 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 participating specialist. Yes, you do need a referral in order to receive the preferred benefit for services provided by a non-participating specialist.	You can see the in-network specialist you choose without a referral. This plan will pay some or all of the costs to see an out-of-network specialist for covered services but only if you have a referral before you see the specialist.

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	•$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	•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.

* For more information about limitations and exceptions, see the plan or policy document at PriorityHealth.com.

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. Deductible does not apply.

* For more information about limitations and exceptions, see the plan or policy document at PriorityHealth.com.

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	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. Notification must be provided for all admissions following emergency room care. 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 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	No charge for first three visits with participating provider within 90 days of discharge from a participating hospital for mental health inpatient care. Including medication management visits. Deductible does not apply.
	Mental/Behavioral health inpatient services	No charge	Not covered	Including Residential Treatment and partial hospitalization. Except in an emergency, prior approval required.
	Substance use disorder outpatient services	$20 co-pay/ visit	Not covered	Prior Approval required for intensive outpatient treatment. Including medication management visits. Deductible does not apply.
	Substance use disorder inpatient services	No charge	Not covered	Including subacute Residential Treatment and partial hospitalization. Except in an emergency, prior approval required.
If you are pregnant	Routine prenatal and postnatal care	No charge	Not covered	Routine prenatal and postnatal visits are covered under your Preventive Health Care Services benefit. Appropriate office visit charge (PCP or specialist) may apply for physician office services or home visits and consultations for complications of pregnancy.
	Delivery and all inpatient services	No charge	Not covered	----------none----------

* For more information about limitations and exceptions, see the plan or policy document at PriorityHealth.com.

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. Deductible does not apply.
	Rehabilitation services *not* 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 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 ***only***	• $20 co-pay/ visit for Physical, Occupational and Speech Therapy • No charge for Applied Behavior Analysis (ABA) services	Not covered	Prior Approval required for Applied Behavior 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	$20 co-pay/ visit	Not covered	Physical and occupational therapy limited to a combined 30 visits per contract year. Speech therapy limited to 30 visits per contract year. Deductible does not apply.
	Skilled nursing care	No charge	Not covered	Services received in a skilled nursing care facility, subacute 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	No charge	Not covered	One exam per year. Deductible does not apply.
	Child glasses	No charge	Not covered	Coverage limited to one select frame and one pair of eyeglass lenses or, in lieu of eyeglasses, contact lenses are covered up to a 6-month supply for 2-week disposable lenses, a 3-month supply of daily disposable lenses or one pair of conventional lenses. Deductible does not apply.
	Child dental check-up	Not covered	Not covered	Not covered

* For more information about limitations and exceptions, see the plan or policy document at PriorityHealth.com.

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)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- 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
- Routine eye care (Child)
- 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. 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.

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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.

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Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo 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-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$2,000**
Specialist co-payment	**$45**
Hospital (facility) co-insurance	**20%**
Other co-insurance	**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**

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-network care of a well-controlled condition)

The plan's overall deductible	**$2,000**
Specialist co-payment	**$45**
Hospital (facility) co-insurance	**20%**
Other co-insurance	**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**

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-network emergency room visit and follow up care)

The plan's overall deductible	**$2,000**
Specialist co-payment	**$45**
Hospital (facility) co-insurance	**20%**
Other co-insurance	**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**

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.

PriorityHealth

OAKLAND UNIVERSITY WILLIAM BEAUMONT : SCHOOL OF MEDICINE - BUY UP PPO 2018

Coverage for: Subscriber/Dependent | Plan Type: PPO

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 1-888-389-6645. 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 1-888-389-6645 to request a copy.

Important Questions	Answers	Why this Matters
What is the overall deductible?	For network providers $500 person / $1,000 family For non-network providers $1,000 person / $2,000 family The deductible for each benefit level is calculated separately. Amounts you pay toward the deductible do not count toward any co-insurance maximums.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes, the network benefits deductible doesn't apply to preventive care, services subject to flat dollar co-pays and prescription drugs. Emergency room, ambulance and advanced imaging services are subject to the deductible and a co-pay.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Yes. For network providers $7,150 person / $14,300 family For non-network providers $14,300 person / $28,600 family Your plan also has a co-insurance maximum. For network providers $1,500 person / $3,000 family For non-network providers $3,000 person / $6,000 family The co-insurance maximum limits the total amount of co-insurance you will pay for certain covered services during a coverage period. The co-insurance maximum is included in the out-of-pocket limit. The out-of-pocket limit and co-insurance maximum for each benefit level is calculated separately.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, health care this plan doesn't cover, services that exceed an annual day/visit limit, and any co-pays and co-insurance you pay for any non-essential health benefit.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Does this plan use a network of providers?	Yes. See PriorityHealth.com or call 1-888-389-6645 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do I need a referral to see a specialist?	No.	You can see the in-network specialist you choose without a referral.

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
		Network Provider (You will pay the least)	Non-Network 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	40% co-insurance/ visit	Network benefit level deductible does not apply to 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	40% co-insurance/ visit	
	Other practitioner office visit	•$75 co-pay/ visit for evaluation/ management services only at retail health clinics •20% co-insurance/ visit for family planning/ infertility services •50% co-insurance for Temporomandibular Joint Function (TMJ) treatment and Orthognathic surgery	•Evaluation/management services only at retail health clinics covered at the network benefit level •40% co-insurance/ visit for family planning/ infertility services •50% co-insurance for Temporomandibular Joint Function (TMJ) treatment and Orthognathic surgery	
	Preventive care/screening/ immunization	No charge	40% co-insurance/ visit	Preventive care services are those listed in Priority Health's Preventive Health Care Guidelines, including women's preventive health care services. Network benefit level 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	40% co-insurance	----------none----------
	Imaging (CT/PET scans, MRIs)	$150 co-pay	40% co-insurance	Prior Approval required for certain radiology examinations. Network benefits 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.

* For more information about limitations and exceptions, see the plan or policy document at PriorityHealth.com.

Common Medical Events	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider (You will pay the least)	Non-Network 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	$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	40% co-insurance/ visit	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	40% co-insurance/ visit	
If you need immediate medical attention	Emergency room services	$150 co-pay/ visit	Covered at the 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 network benefit level	----------none----------
	Urgent care	$75 co-pay/ visit	40% co-insurance/ visit	Co-pay applies to all urgent care visits. Network benefit level deductible does not apply.

Common Medical Events	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance/ visit	40% co-insurance/ visit	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. Notification must be provided for all admissions following emergency room care. 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 fee	20% co-insurance/ visit	40% co-insurance/ visit	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 co-pay/ visit	40% co-insurance/ visit	No charge for first three visits with network provider within 90 days of discharge from a network hospital for mental health inpatient care. Including medication management visits. Network benefit level deductible does not apply.
	Mental/Behavioral health inpatient services	20% co-insurance/ visit	40% co-insurance/ visit	Including Residential Treatment and partial hospitalization. Except in an emergency, prior approval required.
	Substance use disorder outpatient services	$20 co-pay/ visit	40% co-insurance/ visit	Prior Approval required for intensive outpatient treatment. Including medication management visits. Network benefit level deductible does not apply.
	Substance use disorder inpatient services	20% co-insurance/ visit	40% co-insurance/ visit	Including subacute Residential Treatment and partial hospitalization. Except in an emergency, prior approval required.
If you are pregnant	Routine prenatal and postnatal care	No charge	40% co-insurance/ visit	Routine prenatal and postnatal visits are covered under your Preventive Health Care Services benefit. Appropriate office visit charge (PCP or specialist) may apply for physician office services or home visits and consultations for complications of pregnancy.
	Delivery and all inpatient services	20% co-insurance/ visit	40% co-insurance/ visit	----------none----------

* For more information about limitations and exceptions, see the plan or policy document at PriorityHealth.com.

Common Medical Events	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No charge	40% co-insurance/ visit	Including hospice care services; excluding rehabilitation and habilitation services. Prior approval required except for hospice care services in the home. Network benefit level deductible does not apply.
	Rehabilitation services *not* for the treatment of Autism Spectrum Disorder	$20 co-pay/ visit	50% co-insurance/ visit	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. Network benefit level deductible does not apply.
	Habilitation services for treatment of Autism Spectrum Disorder ***only***	• $20 co-pay/ visit for Physical, Occupational and Speech Therapy • 20% co-insurance/ visit for Applied Behavior Analysis (ABA) services	50% co-insurance/ visit	Prior Approval required for Applied Behavior Analysis (ABA). Services are Covered for children and adolescents under age 19 only. Multiple charges may apply during one day of service. Network benefit level deductible does not apply to flat dollar co-pays.
	Habilitation services not for the treatment of Autism Spectrum Disorder	$20 co-pay/ visit	50% co-insurance/ visit	Physical and occupational therapy limited to a combined 30 visits per contract year. Speech therapy limited to 30 visits per contract year. Network benefit level deductible does not apply.
	Skilled nursing care	20% co-insurance/ visit	40% co-insurance/ visit	Services received in a skilled nursing care facility, subacute 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	50% co-insurance/ visit	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	50% co-insurance/ visit	
	Hospice service	No charge	40% co-insurance/ visit	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. Network benefit level deductible does not apply.
If your child needs dental or eye care	Child eye exam	No charge	Not covered	One exam per year. Deductible does not apply.
	Child glasses	No charge	Not covered	Coverage limited to one select frame and one pair of eyeglass lenses or, in lieu of eyeglasses, contact lenses are covered up to a 6-month supply for 2-week disposable lenses, a 3-month supply of daily disposable lenses or one pair of conventional lenses. Deductible does not apply.
	Child dental check-up	Not covered	Not covered	Not covered

* For more information about limitations and exceptions, see the plan or policy document at PriorityHealth.com.

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)
- Hearing aids
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- 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
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Child)
- 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. 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 1-888-389-6645 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 1-888-389-6645.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-389-6645.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-888-389-6645.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-389-6645.

----------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-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$2,000**
Specialist co-payment	**$45**
Hospital (facility) co-insurance	**20%**
Other co-insurance	**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**

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-network care of a well-controlled condition)

The plan's overall deductible	**$2,000**
Specialist co-payment	**$45**
Hospital (facility) co-insurance	**20%**
Other co-insurance	**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**

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-network emergency room visit and follow up care)

The plan's overall deductible	**$2,000**
Specialist co-payment	**$45**
Hospital (facility) co-insurance	**20%**
Other co-insurance	**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**

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.

Global emergency services

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.*

Medical consultation, evaluation and 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.

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.

Two ways to access services:

1. ***Download** the free Assist America mobile app available for iPhone and Android*
2. ***Call** Assist America's 24-hour Operations Center at 800.872.1414*

Priority Health reference number: 01-AA-PHP-12123

**Not available to Medicare, Medicaid or MIChild members.*

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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 and legal referral

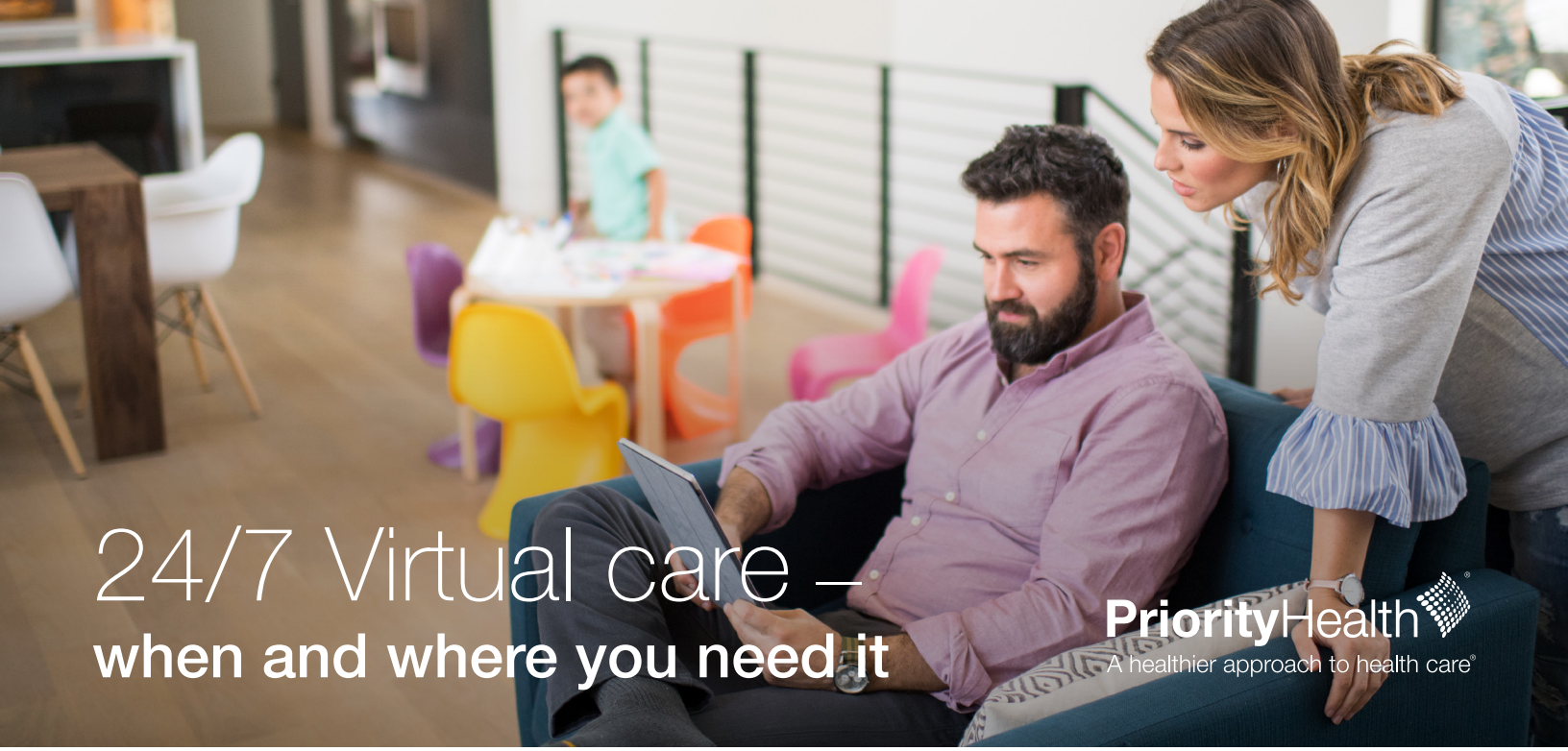
Assist America can make recommendations for trustworthy legal counsel and interpreter services in any country. Bail bonds can be coordinated in jurisdictions where they are legal.

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.



24/7 Virtual care – when and where you need it

PriorityHealth
A healthier approach to health care®

When it's not convenient to go to the doctor, bring a doctor to you.

What is virtual care?

Virtual care gives you access to board-certified doctors on nights, weekends and even holidays for health issues that aren't an emergency. Virtual care connects you with a doctor over the phone, through video, or simply by filling out an online questionnaire. Depending on your condition and the type of virtual care you choose, a doctor can:

- Prescribe a medication and send it to your preferred pharmacy
- Develop a treatment plan
- Notify your primary care doctor with current information
- Make follow-up recommendations, including referrals to see a specialist

Did you know? Members save an average of $94-649 when they use virtual care instead of the emergency room or urgent care.

What conditions can it treat?

Virtual care is great for non-emergencies, like:

- Cough, cold and flu
- Fever, nausea and vomiting
- Sinus problems
- Pink eye
- Allergies, bites and stings
- Rash, hives and more

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How much does it cost?

We offer our members 100% coverage ($0 copay) for in-network virtual care. It is included in your benefits at no cost to you.*

Talk to your doctor

Ask your doctor about what virtual care options are available to you.

Virtual care through MedNow

If your doctor doesn't offer virtual care, you can access it with MedNow℠. Download the MedNow app on your device, or login to your MyHealth account and choose the MedNow tile to get started.

Download on the App Store

GET IT ON Google Play

*Includes 100% coverage ($0 copay) for fully funded plan members and opt-in for self-funded plan members. HSA plan members must meet their deductible before 100% coverage begins, but will never pay more than an in-person doctors visit.

Priority Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia en su idioma. Consulte al número de Servicio al Cliente que está en la parte de atrás de su tarjeta de identificación de miembro. (TTY: 711).

ملاحظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. يرجى الاتصال برقم خدمة العملاء على الجانب الخلفي من بطاقة عضويتك الشخصية. (رقم هاتف الصم والبكم: 711).