Benefits summary:

HMO Buy Up Plan

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.*	$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