

# Beaumont Health Network

Individuals and current My**Priority**<sup>®</sup> members who live in some southeast counties have the opportunity to choose a plan paired with our narrow network, Beaumont Health Network.

## Who can buy it?

Individuals who live in Wayne, Oakland and Macomb counties can purchase our Bronze, Silver and Gold plan options with the Beaumont Health Network narrow network.

## Why choose this network option?

This network option is designed to appeal to price-sensitive individuals who are willing to accept a limited network of providers in exchange for a lower monthly premium while still getting access to quality care within the Beaumont Health Network.

## Selling advantages

Unlike many competing narrow networks, all of Priority Health's narrow network products feature:

- No referrals
- Provider-specific names to make it easier for you and your client to understand which facilities are covered
- No additional limits or restrictions on care or services

## Beaumont

This plan requires members to receive care at facilities within the Beaumont Health system of doctors and affiliated providers. Care received outside of the Beaumont Health network will not be covered, and members will be required to cover the full cost for out-of-network care.

## Network details

### Network includes:

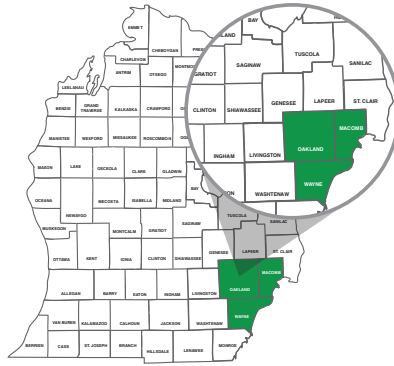
- Beaumont Health Hospitals (including former Oakwood hospitals) – Dearborn, Farmington Hills, Grosse Pointe, Royal Oak, Taylor, Trenton, Troy, Wayne

### Physician network:

- Physicians employed by Beaumont Health
- Any individual community physicians with admitting privileges at Beaumont Health that are listed as in-network in the Priority Health Beaumont Network  
Find a Doctor directory
- All in-network pharmacies

2022 MyPriority – Beaumont Health Network plan options					
	MyPriority HSA Bronze 7050	MyPriority Bronze 8700	MyPriority Silver 2500 Off-Marketplace	MyPriority Silver 2500	MyPriority HSA Silver 3000 Off-Marketplace
<b>Deductible</b> Individual / family	\$7,050 / \$14,100	\$8,700 / \$17,400	\$2,500 / \$5,000	\$2,500 / \$5,000	\$3,000 / \$6,000
<b>Out-of-pocket limit</b> Individual / family			\$8,700 / \$17,400	\$8,700 / \$17,400	\$7,050 / \$14,100
<b>Coinsurance</b>	Covered in full, after deductible	Covered in full, after deductible	30% coinsurance, after deductible	30% coinsurance, after deductible	30% coinsurance, after deductible
<b>Office visits</b> Primary doctor	Covered in full, after deductible	\$30 copay; office visits only, before deductible	\$30 copay; office visits only, before deductible	\$30 copay; office visits only, before deductible	30% coinsurance, after deductible
<b>Office visits</b> Urgent care		\$75 copay; office visits only, before deductible	\$75 copay; office visits only, before deductible	\$75 copay; office visits only, before deductible	
<b>Office visits</b> Retail health clinic		\$75 copay; office visits only, before deductible	\$75 copay; office visits only, before deductible	\$75 copay; office visits only, before deductible	
<b>Office visits</b> Specialist		Covered in full, after deductible	\$90 copay; office visits only, before deductible	\$90 copay; office visits only, before deductible	
<b>Office visits</b> Mental health		\$30 copay; office visits only, before deductible	\$30 copay; office visits only, before deductible	\$30 copay; office visits only, before deductible	
<b>Limited virtual care services</b> 24/7 access to a doctor with a Spectrum Health On-Demand Video Visit	Covered in full, after deductible	Covered in full, after deductible	Covered in full, after deductible	Covered in full, after deductible	Covered in full, after deductible
<b>Prescription Drug Coverage</b>	<i>Want to find out if your prescription drug is covered? Visit <a href="http://priorityhealth.com">priorityhealth.com</a> and click on approved drug list.</i>				
<b>Tier 1a</b>	Covered in full, after deductible	\$5 copay, before deductible	\$5 copay, before deductible	\$5 copay, before deductible	30% coinsurance, after deductible
<b>Tier 1b</b>		\$20 copay, before deductible	\$20 copay, before deductible	\$20 copay, before deductible	
<b>Tier 2</b>		Covered in full, after deductible	\$75 copay, after deductible	\$75 copay, after deductible	
<b>Tier 3</b>		Covered in full, after deductible	\$100 copay, after deductible	\$100 copay, after deductible	
<b>Tier 4 &amp; 5</b>		Covered in full, after deductible	50% coinsurance, after deductible	50% coinsurance, after deductible	
<b>Maternity</b>	Routine prenatal and postnatal care covered in full, before deductible	Routine prenatal and postnatal care covered in full, before deductible	Routine prenatal and postnatal care covered in full, before deductible	Routine prenatal and postnatal care covered in full, before deductible	Routine prenatal and postnatal care covered in full, before deductible
<b>Inpatient hospital care</b> (includes labor and delivery)	Covered in full, after deductible	Covered in full, after deductible	30% coinsurance, after deductible	30% coinsurance, after deductible	30% coinsurance, after deductible
<b>Outpatient surgery</b>	Covered in full, after deductible	Covered in full, after deductible	\$1,000 copay, 30% coinsurance, after deductible	\$1,000 copay, 30% coinsurance, after deductible	30% coinsurance, after deductible
<b>Emergency services</b>	Covered in full, after deductible	Covered in full, after deductible	\$250 copay (waived if admitted); 30% coinsurance, after deductible	\$250 copay (waived if admitted); 30% coinsurance, after deductible	30% coinsurance, after deductible

## Network county map



2022 MyPriority – Beaumont Health Network plan options					
	MyPriority Silver 3500 Off-Marketplace	MyPriority Silver 3500	MyPriority Silver 5500 Off-Marketplace	MyPriority Silver 5500	MyPriority Gold Copay+
<b>Deductible</b> Individual / family	\$3,500 / \$7,000	\$3,500 / \$7,000	\$5,500 / \$11,000	\$5,500 / \$11,000	\$0 / \$0
<b>Out-of-pocket limit</b> Individual / family	\$8,700 / \$17,400	\$8,700 / \$17,400	\$8,700 / \$17,400	\$8,700 / \$17,400	\$8,700 / \$17,400
<b>Coinsurance</b>	30% coinsurance, after deductible	30% coinsurance, after deductible	30% coinsurance, after deductible	30% coinsurance, after deductible	0% coinsurance
<b>Office visits</b> Primary doctor	\$30 copay; office visits only, before deductible	\$30 copay; office visits only, before deductible	\$30 copay; office visits only, before deductible	\$30 copay; office visits only, before deductible	\$20 copay; office visits only
<b>Office visits</b> Urgent care	\$75 copay; office visits only, before deductible	\$75 copay; office visits only, before deductible	\$75 copay; office visits only, before deductible	\$75 copay; office visits only, before deductible	\$75 copay; office visits only
<b>Office visits</b> Retail health clinic	\$75 copay; office visits only, before deductible	\$75 copay; office visits only, before deductible	\$75 copay; office visits only, before deductible	\$75 copay; office visits only, before deductible	\$75 copay; office visits only
<b>Office visits</b> Specialist	\$90 copay; office visits only, before deductible	\$90 copay; office visits only, before deductible	\$65 copay; office visits only, before deductible	\$65 copay; office visits only, before deductible	\$45 copay; office visits only
<b>Office visits</b> Mental health	\$30 copay; office visits only, before deductible	\$30 copay; office visits only, before deductible	\$30 copay; office visits only, before deductible	\$30 copay; office visits only, before deductible	\$20 copay; office visits only
<b>Limited virtual care services</b> 24/7 access to a doctor with a Spectrum Health On-Demand Video Visit	Covered in full, before deductible	Covered in full, before deductible	Covered in full, before deductible	Covered in full, before deductible	Covered in full
<b>Prescription Drug Coverage</b>	Want to find out if your prescription drug is covered? Visit <a href="https://priorityhealth.com">priorityhealth.com</a> and click on approved drug list.				
<b>Tier 1a</b>	\$5 copay, before deductible	\$5 copay, before deductible	\$5 copay, before deductible	\$5 copay, before deductible	\$5 copay
<b>Tier 1b</b>	\$20 copay, before deductible	\$20 copay, before deductible	\$20 copay, before deductible	\$20 copay, before deductible	\$20 copay
<b>Tier 2</b>	\$75 copay, after deductible	\$75 copay, after deductible	\$75 copay, before deductible	\$75 copay, before deductible	\$75 copay
<b>Tier 3</b>	\$100 copay, after deductible	\$100 copay, after deductible	\$125 copay, before deductible	\$125 copay, before deductible	\$100 copay
<b>Tier 4 &amp; 5</b>	50% coinsurance, after deductible	50% coinsurance, after deductible	50% coinsurance, after deductible	50% coinsurance, after deductible	50% coinsurance
<b>Maternity</b>	Routine prenatal and postnatal care covered in full, before deductible	Routine prenatal and postnatal care covered in full, before deductible	Routine prenatal and postnatal care covered in full, before deductible	Routine prenatal and postnatal care covered in full, before deductible	Routine prenatal and postnatal care covered in full
<b>Inpatient hospital care</b> (includes labor and delivery)	30% coinsurance, after deductible	30% coinsurance, after deductible	30% coinsurance, after deductible	30% coinsurance, after deductible	\$1,000 copay per day (maximum 5 copayments)
<b>Outpatient surgery</b>	\$1,000 copay; 30% coinsurance, after deductible	\$1,000 copay; 30% coinsurance, after deductible	\$1,000 copay; 30% coinsurance, after deductible	\$1,000 copay; 30% coinsurance, after deductible	\$1,000 copay
<b>Emergency services</b>	\$250 copay (waived if admitted); 30% coinsurance, after deductible	\$250 copay (waived if admitted); 30% coinsurance, after deductible	\$250 copay (waived if admitted); 30% coinsurance, after deductible	\$250 copay (waived if admitted); 30% coinsurance, after deductible	\$250 copay (waived if admitted)



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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).