Blue Cross Blue Shield of Michigan

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Trinity Health
Group Number: 71349 Package Code(s): 022
Essential Plan
and
Essential Assist Plan with HRA
Effective Date: 01/01/2023
Benefits-at-a-glance

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

BCBSM provides administrative claims services only. Your employer or plan sponsor is financially responsible for claims.

Note: A list of services that require approval **before** they are provided is available online at (https://www.bcbsm.com/importantinfo). Select **Approving covered Services**.

Member's responsibility (deductibles, copays, coinsurance and dollar maximums)

Benefits	Tier 1 Trinity Health Facilities & Specified Trinity Health Professional Providers	Tier 2 PPO Network Facility and Professional Providers	Tier 3 Non Network Facility and Professional Providers
Deductibles - per calendar year	$1,000 per member $2,000 per family	$2,500 per member $5,000 per family	$4,000 per member $8,000 per family
Health Reimbursement Account (Essential Assist Plan Only)		$1,000 Single $2,000 Family	
Copays • Fixed Dollar Copays	$50 copay for : • Outpatient surgery - facility fee only $100 copay for : • Emergency room • Ambulance services	$100 copay for : • Emergency room • Ambulance services • Outpatient surgery- facility fee only $500 copay for : • Inpatient admissions	$100 copay for : • Emergency room • Ambulance services $200 copay for : • Outpatient surgery- facility fee only $1,000 copay for : • Inpatient admissions
Coinsurance • Percent Coinsurance	20%	30%*	40%
Annual out-of-pocket maximums	$3,500 per member $7,000 per family *Includes deductible, coinsurance and copays for all covered services including prescription drugs*	$5,500 per member $11,000 per family *Includes deductible, coinsurance and copays for all covered services including prescription drugs*	$9,000 per member $18,000 per family *Includes deductible, coinsurance and copays for all covered services including prescription drugs*
Lifetime dollar maximum		Unlimited	

***Unless otherwise stated within the summary outline**

Preventive Care Services

Benefits	Tier 1 Trinity Health Facilities & Specified Trinity Health Professional Providers	Tier 2 PPO Network Facility and Professional Providers	Tier 3 Non Network Facility and Professional Providers
Health Maintenance Exam - beginning age 4; one per calendar year	Covered - 100%	Covered - 100%	Covered - 60% after deductible
Routine Physical Related Test X-Rays, EKG and lab procedures performed as part of the health maintenance exam	Covered - 100%	Covered - 100%	Covered - 60% after deductible
Annual Gynecological Exam - two per calendar year, in addition to health maintenance exam	Covered - 100%	Covered - 100%	Covered - 60% after deductible
Pap Smear Screening - one per calendar year	Covered - 100%	Covered - 100%	Covered - 60% after deductible
Mammography Screening - beginning age 35; 1 base line age 35-39; annual age 40+ includes 3D Mammography	Covered - 100%	Covered - 100%	Covered - 60% after deductible
Contraceptive Methods and Counseling	Not Covered	Not Covered	Not Covered
Prostate Specific Antigen (PSA) screening - beginning 40 years of age; one per calendar year	Covered - 100%	Covered - 100%	Covered - 60% after deductible
Endoscopic Exams - one per calendar year	Covered - 100%	Covered - 100%	Covered - 60% after deductible
Well Child Care • 8 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit	Covered - 100%	Covered - 100%	Covered - 60% after deductible
Immunizations - pediatric and adult	Covered - 100%	Covered - 100%	Covered - 60% after deductible
Routine Hearing Exam- one per calendar year	Covered - 100%	Covered - 100%	Covered - 60% after deductible

Physician Office Services

Benefits	Tier 1 Trinity Health Facilities & Specified Trinity Health Professional Providers	Tier 2 PPO Network Facility and Professional Providers	Tier 3 Non Network Facility and Professional Providers
Office Visits Includes: • Primary care and specialist physicians • Initial Visit to Determine Pregnancy	Covered - 80% after deductible	Covered - 70% after deductible	Covered - 60% after deductible
Medical Telemedicine Visits Note: Virtual visits rendered by BCBS Providers	Covered - 80% after deductible	Covered - 70% after deductible	Covered - 60% after deductible
Medical Blue Cross Online Visits Note: Online Visits rendered by American Well	Not Applicable	Covered - 70% after deductible	Not Applicable
Office Consultations	Covered - 80% after deductible	Covered - 70% after deductible	Covered - 60% after deductible
Pre-Surgical Consultations	Covered - 80% after deductible	Covered - 70% after deductible	Covered - 60% after deductible

Emergency Medical Care

Benefits	Tier 1 Trinity Health Facilities & Specified Trinity Health Professional Providers	Tier 2 PPO Network Facility and Professional Providers	Tier 3 Non Network Facility and Professional Providers
Hospital Emergency Room Qualified medical emergency	Covered - 100% after $100 copay; copay waived if admitted	Covered - 100% after $100 copay; copay waived if admitted	Covered - 100% after $100 copay; copay waived if admitted
Non-Emergency use of the Emergency Room	Covered - $100 copay; then 80% after deductible	Covered - $100 copay; then 70% after deductible	Covered - $100 copay; then 60% after deductible
Facility Based Urgent Care Services	Covered - 80% after deductible	Covered - 80% after deductible*	Covered - 80% after deductible *
Professional Based Urgent Care Services	Covered - 80% after deductible	Covered - 70% after deductible	Covered - 60% after deductible
Ambulance Services - Medically Necessary Transport	Covered - 100% after $100 copay	Covered - 100% after $100 copay	Covered - 100% after $100 copay

***Tier 1 deductible and coinsurance applies.**

Facility and Professional Diagnostic Services

Benefits	Tier 1 Trinity Health Facilities & Specified Trinity Health Professional Providers	Tier 2 PPO Network Facility and Professional Providers	Tier 3 Non Network Facility and Professional Providers
MRI, MRA, PET and CAT Scans and Nuclear Medicine *	Covered - 80% after deductible	Covered - 70% after deductible	Covered - 60% after deductible
Diagnostic Tests, X-rays, Laboratory & Pathology	Covered - 80% after deductible	Covered - 70% after deductible	Covered - 60% after deductible
Radiation Therapy and Chemotherapy	Covered - 80% after deductible	Covered - 70% after deductible	Covered - 60% after deductible

***Prior authorization may be required.**

Maternity Services Provided by a Physician

Benefits	Tier 1 Trinity Health Facilities & Specified Trinity Health Professional Providers	Tier 2 PPO Network Facility and Professional Providers	Tier 3 Non Network Facility and Professional Providers
Prenatal and Postnatal Care Visits -Physician office visits including the initial and subsequent history and physical exams of the pregnant woman (maternal weight, blood pressure, fetal heart rate check, etc.)	Covered - 100%	Covered - 100%	Covered - 60% after deductible
Delivery and Nursery Care	Covered - 80% after deductible	Covered - 70% after deductible	Covered - 60% after deductible
High Risk Specialist Visits	Covered - 80% after deductible	Covered - 70% after deductible	Covered - 60% after deductible
Ultrasounds and Pregnancy Diagnostic Lab Tests	Covered - 80% after deductible	Covered - 70% after deductible	Covered - 60% after deductible
Anemia Screening and Gestational Diabetes Screening	Covered - 100%	Covered - 100%	Covered - 60% after deductible
Amniocentesis (Professional Charges)	Covered - 80% after deductible	Covered - 70% after deductible	Covered - 60% after deductible
Amniocentesis (Facility Charges)	Covered - $50 copay; then 80% after deductible	Covered - $100 copay; then 70% after deductible	Covered - $200 copay; then 60% after deductible

Note: Mom and Baby's claims are processed separately under their own files and both may be subject to the Deductible and Out of Pocket Maximum.

Hospital Care

Benefits	Tier 1 Trinity Health Facilities & Specified Trinity Health Professional Providers	Tier 2 PPO Network Facility and Professional Providers	Tier 3 Non Network Facility and Professional Providers
Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies (Facility Charges)	Covered - 80% after deductible	Covered - $500 copay; then 70% after deductible **	Covered - $1,000 copay; then 60% after deductible **
Inpatient Medical Care (Professional Charges)	Covered - 80% after deductible	Covered - 70% after deductible**	Covered - 60% after deductible**

****Tier 1 cost-share applies if admitted directly from the ER to the Hospital.**

Alternatives to Hospital Care

Benefits	Tier 1 Trinity Health Facilities & Specified Trinity Health Professional Providers	Tier 2 PPO Network Facility and Professional Providers	Tier 3 Non Network Facility and Professional Providers
Hospice Care	Covered - 100%	Covered - 100%	Covered - 60% after deductible
Home Health Care Limited to a maximum of 120 visits per calendar year	Covered - 80% after deductible	Covered - 70% after deductible	Covered - 60% after deductible
Skilled Nursing Facility Limited to a maximum of 120 days per calendar year	Covered - 80% after deductible	Covered - $500 copay; then 70% after deductible	Covered - $1,000 copay; then 60% after deductible

Surgical Services

Benefits	Tier 1 Trinity Health Facilities & Specified Trinity Health Professional Providers	Tier 2 PPO Network Facility and Professional Providers	Tier 3 Non Network Facility and Professional Providers
Surgery (includes related surgical services)	Covered - $50 copay; then 80% after deductible	Covered - $100 copay; then 70% after deductible	Covered - $200 copay; then 60% after deductible
Bariatric Surgery Covered only if performed at a Tier 1 Trinity Health Facility -or- a Blue Distinction Center of Excellence Tier 2 Facility	Covered - 80% after deductible	Covered - 70% after deductible	Not Covered
Sterilization- males only; excludes reversal sterilization	Not Covered	Not Covered	Not Covered
Sterilization- females only; excludes reversal sterilization	Not Covered	Not Covered	Not Covered

Human Organ Transplants

Benefits	Tier 1 Trinity Health Facilities & Specified Trinity Health Professional Providers	Tier 2 PPO Network Facility and Professional Providers	Tier 3 Non Network Facility and Professional Providers
Specified Organ Transplants In designated facilities only, when coordinated through BCBSM Human Organ Transplant Program (800-242-3504)	Covered - 80% after deductible	Covered - 70% after deductible	Not covered except in designated facilities
Kidney, Cornea, Bone Marrow and Skin	Covered - 80% after deductible	Covered - 70% after deductible	Covered - 60% after deductible

Behavioral Health Services (Mental Health and Substance Use Disorder)

Benefits	Tier 1 Trinity Health Facilities & Specified Trinity Health Professional Providers	Tier 2 PPO Network Facility and Professional Providers	Tier 3 Non Network Facility and Professional Providers
Inpatient Mental Health Care and Substance Use Disorder Treatment	Covered - 80% after deductible	Covered - 80% after deductible*	Covered - $1,000 copay; then 60% after deductible
Outpatient Mental Health Care and Substance Use Disorder Treatment	Covered - 80% after deductible	Covered - 80% after deductible*	Covered - 60% after deductible
Mental Health Telemedicine Visits Note: Virtual visits rendered by BCBS Providers	Covered - 80% after deductible	Covered - 80% after deductible*	Covered - 60% after deductible
Mental Health Blue Cross Online Visits Note: Online Visits rendered by American Well	Not Applicable	Covered - 80% after deductible*	Not Applicable

***Tier 1 deductible, coinsurance and out-of-pocket maximum applies.**

Autism Spectrum Disorders, Diagnoses and Treatment

Benefits	Tier 1 Trinity Health Facilities & Specified Trinity Health Professional Providers	Tier 2 PPO Network Facility and Professional Providers	Tier 3 Non Network Facility and Professional Providers
Applied Behavioral Analysis (ABA)	Covered - 80% after deductible	Covered – 80% after deductible*	Covered - 60% after deductible
Physical, Occupational and Speech Therapy	Covered - 80% after deductible	Covered - 70% after deductible	Covered - 60% after deductible
Nutritional Counseling	Covered - 80% after deductible	Covered - 70% after deductible	Covered - 60% after deductible

***Tier 1 deductible and coinsurance applies.**

Other Covered Services

Benefits	Tier 1 Trinity Health Facilities & Specified Trinity Health Professional Providers	Tier 2 PPO Network Facility and Professional Providers	Tier 3 Non Network Facility and Professional Providers
Cardiac Rehabilitation Maximum of 36 visits in a 12-week period	Covered - 80% after deductible	Covered - 70% after deductible	Covered - 60% after deductible
Chiropractic Spinal Manipulation Limited to a maximum of 20 visits per calendar year	Covered - 80% after deductible	Covered - 70% after deductible	Covered - 60% after deductible
Durable Medical Equipment	Covered - 80% after deductible	Covered - 80% after deductible*	Covered - 60% after deductible
Prosthetic and Orthotic Devices	Covered - 80% after deductible	Covered - 80% after deductible*	Covered - 60% after deductible
Private Duty Nursing Care Limited to 120 visits per calendar year	Covered - 80% after deductible	Covered - 70% after deductible	Covered - 60% after deductible
Allergy Testing and Therapy	Covered - 80% after deductible	Covered - 70% after deductible	Covered - 60% after deductible
Facility Clinic Visit	Covered - 80% after deductible	Covered - 70% after deductible	Covered - 60% after deductible

***Tier 1 deductible and coinsurance applies.**

Therapy Services

Benefits	Tier 1 Trinity Health Facilities & Specified Trinity Health Professional Providers	Tier 2 PPO Network Facility and Professional Providers	Tier 3 Non Network Facility and Professional Providers
Physical, Occupational and Speech Therapy	Covered - 80% after deductible	Covered - 70% after deductible	Covered - 60% after deductible
	Rehabilitative Services - PT/OT/ST limited to a 60 visit maximum per therapy per calendar year		
Habilitative & Rehabilitative Therapy	Covered - 80% after deductible	Covered - 70% after deductible	Not Covered
	Habilitative Services - PT/OT/ST limited to a combined 60 visit maximum per calendar year		

Selecting a Provider

Tier 1: Trinity Health Facilities

When you use Trinity Health facilities, satellite locations and/or aligned physicians with Trinity Health, you receive the highest benefit payment level. A listing of eligible facilities is available online at bcbsm.com.

Tier 2: Network Providers

Network providers have signed agreements with BCBS, which means they agree to accept our approved payment for a covered benefit as payment in full. You will only pay for the deductibles, copayments and coinsurances required by your coverage.

Ask your physician if he or she participates with the BCBS PPO network in your plan area. If you need help locating a network provider, please call the phone number to locate a BCBS network provider or visit the Web site listed on the inside front cover of this handbook.

When you go to network providers, you do not have to send a claim to us. Network providers submit claims to BCBS for you, and they are paid directly by BCBS.

Tier 3: Nonparticipating (Out-of-Network) Providers

Nonparticipating providers have not signed agreements with BCBS. This means they may or may not choose to accept the BCBS approved amount as payment in full for your health care services. If your present providers do not participate with BCBS, ask if they will accept the amount we approve as payment in full for the services you need. This is called participating on a "per claim" basis and means that the providers will accept the approved amount as payment in full for the specific services. You are responsible for any deductibles, copayments, and coinsurances required by your plan along with charges for non-covered services.

Case Management / Disease Management Program

If you agree to participate, a BCBSM nurse case manager will administer an assessment and an individualized plan that includes your condition and goals based on your assessment results.

- The nurse will work with you via telephone to address your specific health concerns and goals.
- Once you have completed the program you will receive a case closure letter via mail and a call explaining that you have completed your program.

Notes:

Cancer Treatment Centers of America (CTCA) – There is no in-network or out-of-network coverage for both health care services provided by the facility and health care services provided by physicians and other health care professionals at any of their facilities.

Mayo Clinic – Services performed at Mayo Clinic (facility and professional) will be subject to the Tier 3 cost share.

Dialysis Services – There is no coverage for dialysis services performed by a Tier 3 (out-of-network) provider.

Prescription Drugs- Administered directly by OptumRx- 1-855-540-5950 www.optumrx.com	
Retail – 34-day supply • Generic • Formulary Brand Name • Non-Formulary Brand Name	100% after $10 copay 25% with $30 minimum and $80 maximum 50% with $60 minimum and $120 maximum *min / max reduced by 50% for asthma and diabetes
Ministry owned on-site pharmacies – 34-day supply • Generic • Formulary Brand Name • Non-Formulary Brand Name	100% after $8 copay 20% with $24 minimum and $64 maximum 40% with $48 minimum and $96 maximum *min / max reduced by 50% for asthma and diabetes
Ministry owned on-site pharmacies – 90-day supply • Generic • Formulary Brand Name • Non-Formulary Brand Name	100% after $24 copay 20% with $72 minimum and $192 maximum 40% with $144 minimum and $288 maximum *min / max reduced by 50% for asthma and diabetes
Mail Order – 90 day supply • Generic • Formulary Brand Name • Non-Formulary Brand Name	100% after $25 copay 25% with $75 minimum and $200 maximum 50% with $150 minimum and $300 maximum *min / max reduced by 50% for asthma and diabetes

Notes:

Pharmacy follows the Medical Tier 2 Out of Pocket Maximum

Infertility drugs have a 50% coinsurance (no maximum)

If the brand drug has a specific equivalent generic drug available and the plan participant receives the brand, then in addition to the copay, the plan participant must also pay the difference between the ingredient cost of the brand drugs and the generic drug

Maintenance Drugs

Prescription Drugs that are taken on an ongoing basis to treat routine ailments or disorders are considered to be a maintenance drug. After three 30-day fills, the member will be required to fill the drug as a 90-day supply through OptumRx Mail Service Pharmacy, CVS retail pharmacies (for certain Ministries) or a Trinity Health retail pharmacy, including Trinity Health Pharmacy Services in Ft. Wayne, IN.

Specialty Drugs

Specialty medications must be filled through Trinity Health Pharmacy Services in Ft. Wayne or Trinity Health retail pharmacies (certain ministries) or through the OptumRx Specialty program (certain ministries).

Preventive Service Medications (under the Patient Protection and Affordable Care Act): No Copay with Prescription

- Aspirin Products
  - Aspirin for prevention of cardiovascular disease and colorectal cancer in adults and for prevention of morbidity and mortality from preeclampsia in pregnant women at risk. Oral over-the-counter (OTC) aspirin products (with prescription). Exclude prescription aspirin products, non-oral aspirin products, or aspirin strengths > 325 mg
- Fluoride Products
  - Fluoride for prevention of dental caries in children. Prescription (generic single ingredient only) oral fluoride supplementation products. Exclude branded oral fluoride supplementation products
- Folic Acid & Prenatal Vitamins
  - Folic acid for prevention of neural tube defects. OTC folic acid supplementation products (with prescription), including prenatal vitamins containing folic acid for adults. Exclude prescription folic acid supplementation products and any product containing > 0.8mg or < 0.4mg of folic acid
- Tobacco Smoking Cessation Products
  - Prescription and OTC (with prescription) tobacco smoking cessation products (e.g., nicotine products, bupropion [generic only], varenicline) for adults. Quantity limit of 2 cycles per year and max daily dose applies to each active ingredient.
- Immunizations
  - Cover at $0 copay, single-entity and combination vaccinations for diphtheria, haemophiles influenzae type b, hepatitis A, hepatitis B, herpes zoster, human papillomavirus, polio, influenza, measles, mumps, rubella, meningococcal infections, pertussis, pneumococcal infections, rotavirus,tetanus, varicella and COVID-19 vaccines with FDA approval or emergency use approval (EUA). Exclude vaccines not listed in the ACIP Immunization Schedules. Age edits will apply in accordance with recommendations from ACIP.
- Bowel Prep Agents for Colorectal Cancer Screening
  - Selected OTC and Rx generic bowel preparation agents. Quantity limits may apply. Exclude branded bowel preparation products.
- Breast Cancer-primary preventive
  - To prevent the first occurrence of breast cancer if a Prior Authorization is obtained. Prior Authorization confirms member is using the medication for primary prevention of breast cancer andmeets the preventive parameters of the USPSTF recommendation.
- Statins
  - Low to moderate dose statins for the primary prevention of cardiovascular disease in adults.
  - For members between ages 40-75, cover lovastatin
  - For members between ages 40-75, having one or more cardiovascular risk factors
    - Risk factors such as dyslipidemia, diabetes, hypertension, or smoking, and having a calculated 10-year risk of a cardiovascular event of 10% or greater, cover atorvastatin (generic Lipitor) 10 & 20 mg and simvastatin (generic Zocor) 5, 10, 20, 40 mg.
  - Requires prior authorization for $0 cost share
- Pre-exposure Prophylaxis (PrEP)-prevention of HIV infection
  - To include Truvada, Descovy, and generic tenofovir disoproxil fumarate.
  - Requires prior authorization for $0 cost share

Excluded Drugs

- Cosmetic medication: Anti-wrinkle agents, hair growth/removal, etc
- Non-sedating Antihistamine (NSA) drugs
- Hypoactive Sexual Desire Disorder (Addyi)
- Erectile dysfunction (ED) medications
- Compound pain patches and bulk powders

For a complete list, please reach out to OptumRx at 855-540-5950

Drugs requiring Prior Authorization (PA)

- Topical Acne
- Anti-obesity agents
- Kerydin
- Narcolepsy
- Compounds $300 and greater
- Anabolic steroids
- Specialty medications
- Oral/Intranasal

For a complete list, please reach out to OptumRx at 855-540-5950

Drugs that have Quantity Limits (QL) imposed

- Flu medication
- Corticosteroid oral inhalers
- Lyrica
- Bets 2 Agonists
- Mast cell stabilizer-Anticholinergic
- Opioids

For a complete list, please reach out to OptumRx at 855-540-5950

Due to the large number of available medicines, this list is not all-inclusive. Please note that this list does not guarantee coverage and is subject to change. Your prescription benefit plan may not cover certain products orcategories, regardless of their appearance on this list.

This document is only an educational tool and should not be relied upon as legal or compliance advice. Additionally, some PPACA requirements may differ for particular members enrolled in certain programs, and thosemembers should consult with their plan administrators for specific details.

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. For a complete description of benefits, please see theapplicable summary plan descriptions. If there is a discrepancy between this summary and any applicable plan document, the plan document will control.
More information is available through optumrx.com to help you manage your prescription drug program. You will be able to locate a pharmacy, order mail service refills, track mail service orders, and ask questions. For additional information contact OptumRx at 1-855-540-5950.