Blue Cross Blue Shield of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

Trinity Health
Group Number: 71349 Package Code(s): 072
Essential Plan
and
Essential Assist Plan with HRA
Effective Date: 01/01/2024
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 **services that need prior covered services.**

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

Benefits	In-Network	Out of Network Facility and Professional Providers
Deductibles - per calendar year The full family deductible must be met under a two person or family contract before benefits are paid for any person on the contract.	$1,150 per member $2,300 per family	Not Covered
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 : • Ambulance services $200 copay for : • Emergency room	Not Covered
Coinsurance • Percent Coinsurance	20%	Not Covered
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*	Not Covered
Lifetime dollar maximum	Unlimited	Not Applicable

Preventive Care Services

Benefits	In-Network	Out of Network Facility and Professional Providers
Health Maintenance Exam - beginning age 4; one per calendar year	Covered - 100%	Not Covered
Routine Physical Related Test X-Rays, EKG and lab procedures performed as part of the health maintenance exam	Covered - 100%	Not Covered
Annual Gynecological Exam - two per calendar year, in addition to health maintenance exam	Covered - 100%	Not Covered
Pap Smear Screening - one per calendar year	Covered - 100%	Not Covered
Mammography Screening - beginning age 35; 1 base line age 35-39; annual age 40+ includes 3D Mammography	Covered - 100%	Not Covered
Contraceptive Methods and Counseling	Not Covered	Not Covered
Prostate Specific Antigen (PSA) screening - beginning 40 years of age; one per calendar year	Covered - 100%	Not Covered
Endoscopic Exams - one per calendar year	Covered - 100%	Not Covered
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%	Not Covered
Immunizations - pediatric and adult	Covered - 100%	Not Covered
Routine Hearing Exam- one per calendar year	Covered - 100%	Not Covered

Physician Office Services

Benefits	In-Network	Out of Network Facility and Professional Providers
Office Visits Includes: -Primary care and specialist physicians -Initial visit to determine pregnancy	Covered - 80% after deductible	Not Covered
Medical Telemedicine Visits Note: Virtual visits rendered by BCBS Providers	Covered - 80% after deductible	Not Covered
Medical Blue Cross Online Visits Note: Online Visits rendered by Teladoc	Covered - 80% after deductible	Not Applicable
Office Consultations	Covered - 80% after deductible	Not Covered
Pre-Surgical Consultations	Covered - 80% after deductible	Not Covered

Emergency Medical Care

Benefits	In-Network	Out of Network Facility and Professional Providers
Hospital Emergency Room Qualified medical emergency	Covered - 100% after $200 copay; copay waived if admitted	Covered - 100% after $200 copay; copay waived if admitted.
Non-Emergency use of the Emergency Room	Covered - $200 copay; then 80% after deductible*	Covered - $200 copay; then 80% after deductible*
Facility Based Urgent Care Services	Covered - 80% after deductible*	Not Covered
Professional Based Urgent Care Services	Covered - 80% after deductible*	Not Covered
Ambulance Services - Medically Necessary Transport	Covered - 100% after $100 copay	Covered - 100% after $100 copay

***In-Network deductible and coinsurance applies**

Facility and Professional Diagnostic Services

Benefits	In-Network	Out of Network Facility and Professional Providers
MRI, MRA, PET and CAT Scans and Nuclear Medicine*****	Covered - 80% after deductible	Not Covered
Diagnostic Tests, X-rays, Laboratory & Pathology	Covered - 80% after deductible	Not Covered
Radiation Therapy and Chemotherapy	Covered - 80% after deductible	Not Covered

***Prior authorization may be required.**

Maternity Services Provided by a Physician

Benefits	In-Network	Out of 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%	Not Covered
Delivery and Nursery Care	Covered - 80% after deductible	Not Covered
High Risk Specialist Visits	Covered - 80% after deductible	Not Covered
Ultrasounds and Pregnancy Diagnostic Lab Tests	Covered - 80% after deductible	Not Covered
Anemia Screening and Gestational Diabetes Screening	Covered - 100%	Not Covered
Amniocentesis (Professional Charges)	Covered - 80% after deductible	Not Covered
Amniocentesis (Facility Charges)	Covered - $50 copay; then 80% after deductible	Not Covered

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	In-Network	Out of Network Facility and Professional Providers
Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies (Facility Charges)	Covered - 80% after deductible	Not Covered Unless admitted directly from the ER to the hospital**
Inpatient Medical Care (Professional Charges)	Covered - 80% after deductible	Not Covered Unless admitted directly from the ER to the hospital**

****In-Network cost-share applies if admitted directly from the ER to the Hospital.**

Services from a provider for which there is no Michigan PPO network and services from an out-of-network provider in a geographic area of Michigan deemed a "low access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.

Alternatives to Hospital Care

Benefits	In-Network	Out of Network Facility and Professional Providers
Hospice Care	Covered - 100%	Not Covered
Home Health Care Limited to a maximum of 120 visits per calendar year	Covered - 80% after deductible	Not Covered
Skilled Nursing Facility Limited to a maximum of 120 days per calendar year	Covered - 80% after deductible	Not Covered

Surgical Services

Benefits	In-Network	Out of Network Facility and Professional Providers
Surgery (includes related surgical services)	Covered Professional - 80% after deductible Facility - $50 copay; then 80% after deductible	Not Covered
Bariatric Surgery Covered only if performed at a Trinity Health Facility -or- a Blue Distinction Center of Excellence In-Network Facility	Covered - 80% after deductible	Not covered
Sterilization- males only; excludes reversal sterilization	Not Covered	Not Covered
Sterilization- females only; excludes reversal sterilization	Not Covered	Not Covered

Human Organ Transplants

Benefits	In-Network	Out of 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	Not Covered
Kidney, Cornea, Bone Marrow and Skin	Covered - 80% after deductible	Not Covered

Behavioral Health Services (Mental Health and Substance Use Disorder)

Benefits	In-Network	Out of Network Facility and Professional Providers
Inpatient Mental Health Care and Substance Use Disorder Treatment	Covered - 80% after deductible	Not Covered
Outpatient Mental Health Care and Substance Use Disorder Treatment	Covered - 80% after deductible	Not Covered
Mental Health Telemedicine Visits Note: Virtual visits rendered by BCBS Providers	Covered - 80% after deductible	Not Covered
Mental Health Blue Cross Online Visits Note: Online Visits rendered by Teladoc	Covered - 80% after deductible	Not Applicable
Spring Health: Mental Health Visits - Virtual or In-person visits rendered by a Spring Health Provider - Services after 6 Trinity Health sponsored visits	Covered - 80% after deductible	Not Applicable

Benefits	In-Network	Out of Network Facility and Professional Providers
Spring Health: Substance Use Disorder - Virtual visits rendered by a Spring Health provider	Covered - 80% after deductible	Not Applicable

Spring Health contracts separately with Trinity Health.

Autism Spectrum Disorders, Diagnoses and Treatment

Benefits	In-Network	Out of Network Facility and Professional Providers
Applied Behavioral Analysis (ABA)	Covered - 80% after deductible	Not Covered
Physical, Occupational and Speech Therapy	Covered - 80% after deductible	Not Covered
Nutritional Counseling	Covered - 80% after deductible	Not Covered

Other Covered Services

Benefits	In-Network	Out of Network Facility and Professional Providers
Cardiac Rehabilitation Maximum of 36 visits in a 12-week period	Covered - 80% after deductible	Not Covered
Chiropractic Spinal Manipulation Limited to a maximum of 20 visits per calendar year	Covered - 80% after deductible	Not Covered
Durable Medical Equipment	Covered - 80% after deductible	Not Covered
Prosthetic and Orthotic Devices	Covered - 80% after deductible	Not Covered
Private Duty Nursing Care Limited to 120 visits per calendar year	Covered - 80% after deductible	Not Covered
Allergy Testing and Therapy	Covered - 80% after deductible	Not Covered
Facility Clinic Visit	Covered - 80% after deductible	Not Covered

Therapy Services

Benefits	In-Network	Out of Network Facility and Professional Providers
Physical, Occupational and Speech Therapy	Covered - 80% after deductible	Not Covered
	Rehabilitative Services - PT/OT/ST limited to a 60-visit maximum per therapy per calendar year	
Habilitative & Rehabilitative Therapy	Covered - 80% after deductible	Not Covered
	Habilitative Services - PT/OT/ST limited to a combined 60-visit maximum per calendar year	

Selecting a Provider

In-Network: Participating 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 visit Find a Doctor | bcbsm.com or call the phone number on the back of your ID card.

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.

Out-of-Network: Nonparticipating Providers

Nonparticipating providers are not covered. This means that if you receive services from an out-of-network provider, you will pay the full cost for that service.

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) are now part of City of Hope- There is no 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, with the exception of the City of Hope National Medical Center, General Acute Care Hospital. Use Find a Doctor search tool on bcbsm.com to find a network doctor, hospital, or other health care provider.

Mayo Clinic – 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.

		Current State
34-day supply	Generic	TH retail: $8 All other: $10
	Brand Formulary	TH retail: 20% ($24 min/$64 max) All other: 25% ($30 min/$80 max)
	Brand Non-Formulary	TH retail: 40% ($48 min/$96 max) All other: 50% ($60 min/$120 max)
	Obesity Medications New Tier Eff 4/1/24	TH retail: 40% ($48 min/$320 max) All other: 50% ($60 min/$400 max)
90-day supply	Generic	TH retail: $24 All other: $25
	Brand Formulary	TH retail: 20% ($72 min/$192 max) All other: 25% ($75 min/$200 max)
	Brand Non-Formulary	TH retail: 40% ($144 min/$288 max) All other: 50% ($150 min/$300 max)
	Obesity Medications New Tier Eff 4/1/24	TH retail: 40% ($144 min/$960 max) All other: 50% ($150 min/$1,000 max)

Notes:

Pharmacy follows the Medical Tier 2 Out of Pocket Maximum

Infertility medications 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 Medications

Prescription Drugs that are taken on an ongoing basis to treat routine ailments or disorders are considered to be a maintenance medication. After three 30-day fills, the member will be required to fill the medication 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 Medications

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 and meets 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

For a complete list, please reach out to OptumRx at 855-540-5950 or visit www.optumrx.com

Excluded Medications

- Cosmetic medication: Anti-wrinkle agents, hair growth/removal, etc
- Non-sedating Antihistamine (NSA) medications
- 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 or visit www.optumrx.com

Medications 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 or visit www.optumrx.com

Medications 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 or visit www.optumrx.com

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 or categories, regardless of their appearance on this list.

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract and is intended to be reviewed with the applicable summary plan description. Additional limitations and exclusions may apply. For a complete description of benefits, please review the applicable summary plan description. 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.