Blue Care Network of Michigan

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

Benefit Summary for Trinity Health Muskegon Union
Effective 01/01/2023
Group Number 00107441

This is intended as an easy-to-read summary. **It is not a contract**. Additional limitations and exclusions may apply to covered services. For a complete description of benefits, please see the applicable Blue Care Network certificates and riders. Payment amounts are based on the Blue Care Network approved amount, less any applicable deductible, coinsurance and copay amounts required by the plan. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan documents, the plan document will control. **Services must be provided or arranged by member's primary care physician or health plan.**

Preauthorization for Select Services – Services listed in this BAAG are covered when provided in accordance with Certificate requirements and, when required, are preauthorized or approved by BCN except in an emergency.

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

Healthy Blue Living subscribers must complete program requirements within designated timeframes. To qualify for or maintain a lower per pay cost, the subscriber needs to complete a health assessment and BCN qualification form by March 31st, 2023 and follow their primary care physician's recommendations for a healthy lifestyle. If a tobacco user, must enroll in the BCN sponsored tobacco cessation program by June 30th, 2023. If BMI is greater than or equal to 30, must select and begin participating in a weight management program by June 30th, 2023.

Member's Responsibility: Deductible, Copays, Coinsurance and Maximums

Deductible Note: Coinsurance and select fixed dollar copays apply once the deductible has been met.	This plan has no deductible.
Fixed dollar copays	$5 for allergy injections, $20 for office visits, $50 for urgent care visits, $100 for emergency room visits, $25 copay per ambulance transport, $20 copay for online visits
Coinsurance	25% for inpatient services/outpatient surgery 50% of approved amount for select services
Annual out of pocket maximum Applies to deductibles, copays, and coinsurance amounts for all covered services including prescription drug cost sharing	$1,000 per member/$2,000 per contract per calendar year

Preventive Services

Health Maintenance Exam	Covered – 100%
Annual Gynecological Exam	Covered – 100%
Pap Smear Screening	Covered – 100%
Well-Baby and Child Care	Covered – 100%
Immunizations	Covered – 100%
Prostate Specific Antigen (PSA) Screening	Covered – 100%
Routine Colonoscopy	Covered – 100%
Mammography Screening - including 3D	Covered – 100%
Maternity Prenatal and Postnatal Care	Covered – 100%

Physician Office Services

PCP Office Visits Note: Applicable cost sharing applies when other services are received in the office.	$20 copay per visit
Medical Online Visits – from a participating provider or participating online vendor	$20 copay per visit
Retail Health Clinic	$20 copay per visit
Consulting Specialist Care – when referred for other than preventive services. Note: Applicable cost sharing applies when other services are received in the office.	$20 copay per visit

Emergency Medical Care

Hospital Emergency Room – Copay waived if admitted	$100 copay
Urgent Care Center	$50 copay
Ambulance Services	$25 copay per transport

Diagnostic Services

Laboratory and Pathology Services	Covered – 100% Office visit copay may apply
Diagnostic Tests and X-rays	Covered – 100% Office visit copay may apply
High Technology Radiology Imaging (MRI, MRA, CAT, PET)	Covered – 100% Office visit copay may apply
Radiation Therapy	Covered – 100%

Maternity Services Provided by a Physician

Non-routine prenatal and postnatal care (See Preventive Services section for routine prenatal and postnatal care)	Covered – 100%
Delivery and Nursery Care	Covered 100% for professional services; see hospital care below for facility charges

Hospital Care

General Nursing Care, Hospital Services and Supplies	25% coinsurance
Outpatient Surgery – includes all related surgical services and anesthesia- see member certificate for specific surgical copays.	25% coinsurance

Alternatives to Hospital Care

Skilled Nursing Care	Covered – 100%; limited to 45 days per calendar year
Hospice Care	Covered – 100%
Home Health Care	$20 copay

Surgical Services

Surgery – includes all related surgical services and anesthesia.	See Hospital Care for inpatient and outpatient cost sharing
Voluntary Male Sterilization – See Preventive Services section for voluntary female sterilization	Not covered
Elective Abortion	Not covered
Human Organ Transplants	Hospital and professional cost sharing applies

Surgical Services Continued

Weight Reduction Procedures – Limited to one procedure per lifetime	
Reduction Mammoplasty	50% coinsurance
Male Mastectomy	50% coinsurance
Temporomandibular Joint Syndrome	50% coinsurance
Orthognathic Surgery	50% coinsurance

Behavioral Health Services (Mental Health Care and Substance Use Disorder Treatment)

Inpatient Mental Health Care	25% coinsurance
Residential Substance Use Disorder	25% coinsurance
Outpatient Mental Health Care (includes online visits) Note: For diagnostic and therapeutic services, see the Diagnostic Services section above for applicable cost sharing.	$20 copay
Outpatient Substance Use Disorder	$20 copay

Autism Spectrum Disorders, Diagnoses and Treatment

Applied behavioral analyses (ABA) treatment	$20 copay
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder Unlimited visits for PT/OT/ST with an autism spectrum disorder diagnosis.	$20 copay
Other covered services, including mental health services, for Autism Spectrum Disorder	See your outpatient mental health benefit and medical office visit benefit

Other Services

Allergy Testing and Therapy	50% coinsurance
Allergy Injections	$5 copay
Chiropractic Spinal Manipulation – when referred	$20 copay - unlimited visits
Outpatient Physical, Speech and Occupational Therapy	$20 copay - Limited to 60 visits for each therapy per medical episode per calendar year
Habilitative Services	$20 copay - Limited to 60 visits combined for each therapy per calendar year
Infertility Counseling and Treatment (excluding In-vitro fertilization)	50% coinsurance 50% coinsurance for drugs dispensed through the pharmacy.
Durable Medical Equipment (DME) Breast pumps covered only when Medically Necessary (DME guidelines apply)	50% coinsurance
Prosthetic and Orthotic Appliances	50% coinsurance
Diabetic Supplies	50% coinsurance
Weight Management Program	Program defined by Saint Mary’s Hospital

Prescription Drugs	**Generic Tier** - $10 copay (30-day supply) **Preferred Brand Tier** – 20% coinsurance; min copay $20, max copay $70 (30-day supply) **Non-Preferred Brand Tier** – 40% coinsurance; min copay $40, max copay $90 (30-day supply • Includes health habit prescription drugs • Contraceptive drugs and drugs for the treatment of sexual dysfunction are not covered • Mail order covered at 2.5 times the applicable tiered copay up to a 90-day supply

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

Note: 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.

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