



**Blue Care
Network
of Michigan**

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

Benefits-at-a-Glance

Trinity Health Muskegon Union

Effective Date: 01/01/2027

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 <https://bcbsm.com/priorauth>.

Note: Blue Care Network provides administrative claims services only. Your employer or plan sponsor is financially responsible for claims. You must see an individual provider, facility or other health care entity that is contracted and credentialed with BCN to provide you with covered services with the exception of emergency care.

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

Benefits

Deductible - Coinsurance and select fixed dollar copays apply (as defined by your plan documents), once the deductible has been met. Note: The Deductible will apply to certain services as defined below.	\$250 per member/ \$500 per family per calendar year Any deductible paid during the last three months of the benefit year will not be carried over into the new benefit year.
Fixed Dollar Copays	\$5 for allergy injections \$20 for office visits and medical online visits \$50 for urgent care \$200 for emergency room visits \$25 for ambulance transport
Coinsurance	25% for inpatient services/outpatient surgery 50% for select services as noted below
Out of Pocket Maximum - applies to deductibles, copays and coinsurance amounts for all covered services	\$1,500 per member/\$3,000 per family per calendar year

Preventive services

Benefits

Health Maintenance Exam	100%
Annual Gynecological Exam	100%
Pap Smear Screening	100%
Well-Baby and Well-Child Visits	100%
Immunizations	100%
Prostate Specific Antigen (PSA) Screening	100%
Routine Colonoscopy	100%

Mammography Screening - including 3D	100%
Breast Pumps (DME guidelines apply.)	100%
Maternity Prenatal and Postnatal care	100%

Physician office services

Benefits	
PCP Office Visits - applicable cost-sharing applies when other services are received in the office	\$20 copay
Medical Online Visits - when performed by a BCN participating provider or Teladoc, the BCN designated online vendor Note: Not all services delivered virtually are considered an online visit but may be considered telemedicine. Telemedicine services will be subject to the applicable cost share associated with the service provided.	\$20 copay
Referral (Specialist) Physician Visits - when referred for other than preventive services. Applicable cost-sharing applies when other services are received in the office	\$20 copay

Emergency medical care

Benefits	
Hospital Emergency Room - copay waived if admitted as inpatient	\$200 copay
Urgent Care Center	\$50 copay
Ambulance Services - medically necessary	\$25 copay after deductible

Outpatient Diagnostic services

Benefits	
Laboratory and Pathology Tests	100%
Diagnostic Tests and X-rays	100% after deductible
High Technology Radiology Imaging (MRI, MRA, CAT, PET)	100% after deductible
Radiation Therapy	100% after deductible

Maternity services provided by a physician

Benefits	
Prenatal and Postnatal Care	100%
Delivery and Nursery Care	100% after deductible for professional services (see "Hospital Care" for facility charges)

Hospital care

Benefits	
General Nursing Care, Hospital Services and Supplies	75% after deductible
Outpatient Surgery - includes all related surgical services and anesthesia	75% after deductible

Alternatives to hospital care

Benefits

Skilled Nursing Care	100% after deductible Limited to 45 days per member per calendar year
Hospice Care	100% after deductible
Home Health Care	\$20 copay after deductible

Surgical services

Benefits

Surgery - includes all related surgical services and anesthesia	See "Hospital Care" for inpatient and outpatient cost sharing
Sterilization	Not covered
Abortion	Not covered
Human Organ Transplants - when performed at an approved facility	Hospital and professional cost sharing applies
Weight Reduction Procedures - Limited to one procedure per lifetime.	50% after deductible
Reduction Mammoplasty	50% after deductible
Male Mastectomy	50% after deductible
Temporomandibular Joint Syndrome	50% after deductible
Orthognathic Surgery	50% after deductible

Behavioral health services (mental health and substance use disorder treatment)

Benefits

Inpatient Mental Health Care	75% after deductible
Residential Substance Use Disorder	75% after deductible
Outpatient Mental Health Care - includes online visits	\$20 copay
Outpatient Substance Use Disorder	\$20 copay
*Spring Health: Mental Health Visits Virtual or In-person visits rendered by a Spring Health Provider Services after 6 Trinity Health sponsored visits	\$0 copay visits 1 -6 \$20 copay per visit for visit 7 and thereafter
*Spring Health: Substance Use Disorder Virtual visits rendered by a Spring Health provider	\$20 copay
Note:	*Spring Health is not a BCN provider and contracts separately with Trinity Health

Autism spectrum disorders, diagnoses and treatment

Benefits

Applied behavioral analysis (ABA) treatment Note: Prior to seeking ABA treatment, the member must be evaluated by an interdisciplinary team including, but not limited to, a physician, behavioral health specialist, and a speech and language specialist for the services to be authorized. This interdisciplinary evaluation can be performed at an approved autism evaluation center (AAEC)	\$20 copay
Outpatient physical therapy, speech therapy, occupational therapy, and nutritional counseling for autism spectrum disorder. Unlimited visits for PT/OT/ST with autism spectrum disorder diagnosis.	\$20 copay after deductible

Other covered services, including mental health services, for autism spectrum disorder

See your outpatient mental health benefit and medical office visit benefit

Other services

Benefits

Allergy Testing and Therapy	50% after deductible
Allergy Injections	\$5 copay
Chiropractic Spinal Manipulation - when referred	\$20 copay after deductible 20 visits per benefit year
Rehabilitative Outpatient Physical, Speech and Occupational Therapy - subject to meaningful improvement within 60 days	\$20 copay after deductible Limited to 60 visits for each therapy per medical episode per calendar year Note: Covered services for Behavioral Health or Substance Use Disorder do not contribute to the 60-visit maximum.
Habilitative Outpatient Physical, Speech and Occupational Therapy - subject to meaningful improvement within 60 days	\$20 copay after deductible Limited to 60 visits for each therapy per medical episode per calendar year Note: Covered services for Behavioral Health or Substance Use Disorder do not contribute to the 60-visit maximum.
Infertility Counseling and Treatment - excluding in-vitro fertilization	50% after deductible and; 50% for drugs dispensed through the pharmacy
Durable Medical Equipment - DME guidelines apply	50% Breast pumps covered 100% (when medically necessary)
Prosthetic and Orthotic Appliances	50%
Diabetic Supplies	50%

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.

For Internal Purposes Only

Benefits Selected - TMU25F : ACACCF, ONVPF, OVMPXF

BCN Prescription Plan

Prescription Drug Benefit administered by OptumRx

1-855-540-5950

www.optumrx.com

		Current State
34-day supply	Generic	Retail: \$10
	Brand Formulary	Retail: 20% (\$30 min/\$100 max)
	Brand Non-Formulary	All other: 40% (\$60 min/\$150 max)
90-day supply	Generic	All other: \$25
	Brand Formulary	All other: 20% (\$75 min/\$250 max)
	Brand Non-Formulary	All other: 40% (\$150 min/\$375 max)

Notes:

Out-of-Pocket Maximum (OOPM)*: \$1,500 single/\$3,000 family

*Combined with medical OOPM

Infertility medications have a 50% coinsurance (no maximum)

Dispense as Written (DAW): If the brand drug has a specific equivalent generic drug available and the plan participant receives the brand, the plan participant must pay the difference between the ingredient cost of the brand drugs and the generic drug along with the regular copay.

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 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 monkeypox, respiratory syncytial virus, and COVID-19 vaccines with FDA approval. 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 Yeztugo, Apretude, Descovy and generic tenofovir disoproxil fumarate and tenofovir. Brand Truvada and Viread are available if unable to take generics listed.
 - 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 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
- Medications and products available over-the-counter (OTC)
- Certain GLP-1 medications such as:
 - Saxenda
 - Wegovy (injections and oral)
 - Zepbound
 - Foundayo

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

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 or visit www.optumrx.com

Drugs that have Quantity Limits (QL) imposed

- Flu medication
- Corticosteroid oral inhalers
- Pregablin
- 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

GLP-1 medications for diabetes

- GLP-1 medications to treat diabetes are limited to be filled at a 30-day supply only. Certain GLP-1 medications for treatment other than diabetes are excluded such as:
 - Saxenda
 - Wegovy (injections and oral)
 - Zepbound
 - Foundayo

Nicotine Cessation

Nicotine cessation medications, excluding OTC products, will be filled at appropriate tier level once Healthcare Reform (HCR) \$0 benefit has been exhausted.

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.