Trinity Health
Group Number: 71349 Package Code(s): 020
PPO - Traditional Plan
Effective Date: 01/01/2022
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	$250 per member $500 per family	$750 per member $1,500 per family	$1,500 per member $3,000 per family
Copays • Fixed Dollar Copays	$20 copay for : • Primary Care Physician (PCP) office visits • Facility clinic visit • Professional based urgent care services $30 copay for : • Specialist office visits $35 copay for : • Facility based urgent care services $100 copay for : • Emergency room • Ambulance services	$30 copay for : • Primary Care Physician (PCP) office visits • Facility clinic visit • Professional based urgent care services $35 copay for : • Facility based urgent care services $40 copay for : • Specialist office visits $100 copay for : • Emergency room • Ambulance services • Outpatient surgery- facility fee only $500 copay for : • Inpatient admissions	$35 copay for : • Facility based urgent care services $100 copay for : • Emergency room • Ambulance services $200 copay for : • Outpatient surgery- facility fee only $1,000 copay for : • Inpatient admissions
Coinsurance • Percent Coinsurance	10%	20%*	40% **Note:** Services without a network are covered at the Tier 2 level.
Annual out-of-pocket maximums	$2,500 per member $5,000 per family *Includes deductible, coinsurance and copays for all covered services including prescription drugs*	$4,750 per member $9,500 per family *Includes deductible, coinsurance and copays for all covered services including prescription drugs*	$9,500 per member $19,000 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 35-40; 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

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

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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 One copay applies to the office visit exam and all services performed during the office visit (e.g. lab, x-ray, etc.)	Covered - 100% after $20 pcp copay; $30 specialist copay	Covered - 100% after $30 pcp copay; $40 specialist copay	Covered - 60% after deductible
Medical Telemedicine Visits Note: Virtual visits rendered by BCBS Providers	Covered - 100% after $20 pcp copay; $30 specialist copay	Covered - 100% after $30 pcp copay; $40 specialist copay	Covered - 60% after deductible
Medical Blue Cross Online Visits Note: Online Visits rendered by American Well	Not Applicable	Covered - 100% after $30 copay	Not Applicable
Office Consultations One copay applies all services performed during the visit (e.g. lab, x-ray, etc.)	Covered - 100% after $20 pcp copay; $30 specialist copay	Covered - 100% after $30 pcp copay; $40 specialist copay	Covered - 60% after deductible
Pre-Surgical Consultations One copay applies all services performed during the visit (e.g. lab, x-ray, etc.)	Covered - 100% after $20 pcp copay; $30 specialist copay	Covered - 100% after $30 pcp copay; $40 specialist copay	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 90% after deductible	Covered - $100 copay; then 80% after deductible	Covered - $100 copay; then 60% after deductible
Facility Based Urgent Care Services	Covered - 100% after $35 copay	Covered - 100% after $35 copay	Covered - 100% after $35 copay
Professional Based Urgent Care Services	Covered - 100% after $20 pcp copay	Covered - 100% after $30 pcp copay	Covered - 60% after deductible
Ambulance Services - Medically Necessary Transport	Covered - 100% after $100 copay	Covered - 100% after $100 copay	Covered - 100% after $100 copay

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 - 90% after deductible	Covered - 80% after deductible	Covered - 60% after deductible
Diagnostic Tests, X-rays, Laboratory & Pathology	Covered - 90% after deductible	Covered - 80% after deductible	Covered - 60% after deductible

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
Radiation Therapy and Chemotherapy	Covered - 90% after deductible	Covered - 80% 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 - 90% after deductible	Covered - 80% after deductible	Covered - 60% after deductible
High Risk Specialist Visits	Covered - 100% after $30 copay	Covered - 100% after $40 copay	Covered - 60% after deductible
Ultrasounds and Pregnancy Diagnostic Lab Tests	Covered - 90% after deductible	Covered - 80% after deductible	Covered - 60% after deductible
Anemia Screening and Gestational Diabetes Screening	Covered - 100%	Covered - 100%	Covered - 60% after deductible
Amniocentesis (Professional Charges)	Covered - 90% after deductible	Covered - 80% after deductible	Covered - 60% after deductible
Amniocentesis (Facility Charges)	Covered - $50 copay; then 90% after deductible	Covered - $100 copay; then 80% 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	Covered - 90% after deductible	Covered - $500 copay; then 80% after deductible **	Covered - $1,000 copay; then 60% after deductible **
Inpatient Medical Care	Covered - 90% after deductible	Covered - 80% 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 - 90% after deductible	Covered - 80% after deductible	Covered - 60% after deductible

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
Skilled Nursing Limited to a maximum of 120 days per calendar year	Covered - 90% after deductible	Covered - $500 copay; then 80% 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 90% after deductible	Covered - $100 copay; then 80% 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 - 90% after deductible	Covered - 80% 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 - 90% after deductible	Covered - 80% after deductible	Not covered except in designated facilities
Kidney, Cornea, Bone Marrow and Skin	Covered - 90% after deductible	Covered - 80% 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 - 90% after deductible	Covered - 90% after deductible *	Covered - $1,000 copay; then 60% after deductible
Outpatient Mental Health Care and Substance Use Disorder Treatment	Covered - 100% after $20 pcp copay	Covered - 100% after $20 pcp copay	Covered - 60% after deductible
Mental Health Telemedicine Visits Note: Virtual visits rendered by BCBS Providers	Covered - 100% after $20 pcp copay	Covered - 100% after $20 pcp copay	Covered - 60% after deductible

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
Mental Health Blue Cross Online Visits Note: Online Visits rendered by American Well	Not Applicable	Covered - 100% after $20 copay	Not Applicable

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

Autism Spectrum Disorders, Diagnoses and Treatment - Up to and including age 18

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 - 100% after $20 pcp copay	Covered - 100% after $20 pcp copay	Covered - 60% after deductible
Physical, Occupational and Speech Therapy	Covered - 90% after deductible	Covered - 80% after deductible	Covered - 60% after deductible
Nutritional Counseling	Covered - 90% after deductible	Covered - 80% after deductible	Covered - 60% after deductible

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 - 90% after deductible	Covered - 80% after deductible	Covered - 60% after deductible
Chiropractic Spinal Manipulation Limited to a maximum of 20 visits per calendar year	Covered - 90% after deductible	Covered - 80% after deductible	Covered - 60% after deductible
Durable Medical Equipment	Covered - 90% after deductible	Covered - 90% after deductible *	Covered - 60% after deductible
Prosthetic and Orthotic Devices	Covered - 90% after deductible	Covered - 90% after deductible *	Covered - 60% after deductible
Private Duty Nursing Care Limited to 120 visits per calendar year	Covered - 90% after deductible	Covered - 80% after deductible	Covered - 60% after deductible
Allergy Testing and Therapy	Covered - 90% after deductible	Covered - 80% after deductible	Covered - 60% after deductible
Facility Clinic Visit	Covered - 100% after $20 copay	Covered - 100% after $30 copay	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 - 90% after deductible	Covered - 80% 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 - 90% after deductible	Covered - 80% 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 Out-of-Network coverage for Dialysis services performed by a Tier 3 (out of network) provider.

Prescription Drugs- Administered directly by OptumRx- 1-855-540-5950

Retail – 34-day supply • Generic • Formulary Brand Name • Non-Formulary Brand Name	100% after $10 copay 20% with $30 minimum and $80 maximum 40% with $60 minimum and $100 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 16% with $24 minimum and $64 maximum 32% with $48 minimum and $80 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 16% with $72 minimum and $192 maximum 32% with $144 minimum and $240 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 20% with $75 minimum and $200 maximum 40% with $150 minimum and $250 maximum *min / max reduced by 50% for asthma and diabetes
50% coinsurance for infertility drugs dispensed through pharmacy (no maximum) Pharmacy tracks to Tier 2 Out-of-Pocket 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 drug and the generic drug.	

Specialty medications must be filled at a Trinity Health pharmacy (where available) or through the OptumRx Specialty program; prescriptions limited to a 30-day supply.

Mandatory Maintenance is required for each maintenance (90 day) medication after an initial retail prescription and two refills.

Coverage of Preventive Services Medications (under the Patient Protection and Affordable Care Act (No copay):

- Prescription required –
  - Oral Fluorides (children only)
    - generic single ingredient only
  - Aspirin
    - oral over-the-counter (OTC) aspirin products (with prescription)
    - Exclude prescription aspirin products, non-oral aspirin products, or aspirin strengths > 325 mg
  - Folic Acid
    - Includes 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

Prescription Drugs- Administered directly by OptumRx- 1-855-540-5950

- Immunizations
    - single-entity and combination vaccinations for:

Diptheria	Haemophilus influenza type B
Hepatitis A and B	Herpes zoster
Human Papillomavirus	Polio
Influenza	Measles, mumps and rubella
Meningococcal infections	Pertussis
Pneumococcal infections	Rotavirus
Tetanus	Varicella

    - Exclude vaccines not listed in the ACIP Immunization Schedules.
    - Age and/or gender limits apply in accordance with the recommendations of the ACIP to the following vaccines:
        - Haemophilus influenza type b – applies only to children < 6 years of age
        - Heplisav-B - applies only to adults ≥ 18 years of age
        - Human papillomavirus – applies to only children and adults 9 years to 26 years of age
        - Rotavirus – applies only to children < 8 months
        - Shingrix – applies only to adults ≥ 50 years of age
        - Zostavax-applies only to adults ≥ 60 years of age
- Bowel Preparation Medications
    - Selected OTC and Rx generic bowel preparation agents (with prescription)
    - Quantity limit of 1 bowel prep dispensing per year
    - Exclude branded bowel preparation products.
- Breast Cancer Drugs
    - Available at $0 cost-share 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
    - For members between ages 40-75, cover lovastatin.
    - For members between ages 40-75, having one or more cardiovascular risk factors
    - Prior authorization required for $0 copay

- Prescription required –
    - Tobacco Cessation
        - prescription and over the counter (with prescription) smoking cessation products (e.g., nicotine products, bupropion [generic only], Chantix) for adults
        - quantity limit of 2 cycles per year and max daily dose applies to each active ingredient
        - Step therapy required for some products

Exclusions:

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

Prescription Drugs- Administered directly by OptumRx- 1-855-540-5950

The following is a list of the drugs that need prior authorization to be covered (not intended to be an all-inclusive list): (Your physician must call 1-855-540-5950 to obtain approval for a period of up to one year)

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

The following is a list of most but not all of the drugs that have a quantity limit imposed:

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

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 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 those members 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 the applicable 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 add 1-855-540-5950.