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: 01/01/2026
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.	$1,250 per member $2,500 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	$4,000 per member $8,000 per family *Includes deductible, coinsurance and copays for all covered services including prescription drugs*	Not Covered
Lifetime dollar maximum	Unlimited	Not Applicable

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.

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

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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*	Not Covered
Urgent Care Services	Covered - 80% after deductible	Not Covered
Ambulance Services - Medically Necessary Transport	Covered - 100% after $100 copay	Covered - 100% after $100 copay

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.**

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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

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

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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
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.

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 - Rehabilitative	Covered - 80% after deductible Rehabilitative Services - PT/OT/ST limited to a 60-visit maximum per therapy per calendar year. Covered services for Behavioral Health or Substance Use Disorder do not contribute to the maximum 60-visit per therapy per calendar year	Not Covered
Physical, Occupational and Speech Therapy - Habilitative	Covered - 80% after deductible Habilitative Services - PT/OT/ST limited to a combined 60-visit maximum per calendar year. Covered services for Behavioral Health or Substance Use Disorder do not contribute to the combined 60-visit maximum per calendar year.	Not Covered

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Selecting a Provider

In-Network: Participating Providers

In-Network PPO providers and hospitals are part of the Blue Cross' PPO network. These providers have signed an agreement with Blue Cross to accept our approved amount as payment for the services covered.

Ask your provider if he or she participates with the Blue Cross PPO network. If you need help locating a Blue Cross In-Network PPO provider, please visit Find a Doctor | bcbsm.com or call the phone number on the back of your ID card.

When you go to Blue Cross In-Network PPO providers, you do not have to send a claim to us, the claim will be sent to Blue Cross for you, and providers are paid directly by Blue Cross.

Note:
Services provided at any location of Cancer Treatment Centers of America (CTCA), now part of City of Hope, and Mayo Clinic are only covered with an approved Network Deficiency, with the exception of the City of Hope National Medical Center, general acute care hospitals.

Out-of-Network and Nonparticipating Providers

Out-of-Network providers do not participate with Blue Cross PPO. Non-participating providers have no contractual agreement with Blue Cross. Services provided by these providers are not covered. This means that if you receive services from an out-of-network or non-participating 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.

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		Current State
34-day supply	Generic	TH retail: $8 All other: $10
	Brand Formulary	TH retail: 20% ($24 min/$80 max) All other: 25% ($30 min/$100 max)
	Brand Non-Formulary	TH retail: 40% ($48 min/$136 max) All other: 50% ($60 min/$170 max)
90-day supply	Generic	TH retail: $24 All other: $25
	Brand Formulary	TH retail: 20% ($72 min/$240 max) All other: 25% ($75 min/$250 max)
	Brand Non-Formulary	TH retail: 40% ($144 min/$408 max) All other: 50% ($150 min/$425 max)

Notes:

Out-of-Pocket Maximum (OOPM)*: $4,000 single/$8,000 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 generic tenofovir disoproxil fumarate and tenofovir. Brand Truvada, Descovy, and Apretude 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)

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Drugs requiring Prior Authorization (PA)

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

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Drugs that have Quantity Limits (QL) imposed

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

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GLP-1 medications for diabetes and obesity

GLP-1 medications to treat diabetes or obesity are limited to be filled at a 30-day supply only.

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.

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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.