

EPO – High Option A

Rx \$10/\$20/\$40

Benefits-at-a-Glance

Trinity Health

Trinity Health Facilities
Does not include
professional services

In-Network
Community Blue PPO

Out-of-Network

Deductible, Copays/Coinsurance and Dollar Maximums

Deductible - per calendar year	\$200 per member \$400 per family <i>(Please note: deductible applies only to non-emergency use of the emergency room)</i>	\$200 per member \$400 per family	Not Applicable
Copays/Coinsurance • Fixed Dollar Copays	\$15 copay • Urgent care visits \$50 copay • Emergency room visits • Outpatient surgery – facility fee only	\$15 copay • Health maintenance exams • Office visits • Urgent care visit • Outpatient mental health care visits \$50 copay • Emergency room visits \$75 copay • Outpatient surgery – facility fee only \$250 copay • Inpatient admissions	\$50 copay • Emergency room visits
• Percent Coinsurance	0%	10%	Not Applicable Note: Services without a network are covered at the in-network level.
Out-of-Pocket Maximum – per calendar year • Percent Coinsurance <i>Excludes Deductible</i>	\$1,000 per member \$2,000 per family	\$1,000 per member \$2,000 per family	Not Applicable
Lifetime Maximum <i>Includes Prescription Drugs</i>	\$2 million per member		

Facility Outpatient Diagnostic Services

MRI, MRA, PET and CAT Scans and Nuclear Medicine	Covered – 100%	Covered – 90% after deductible	Not Covered
Other Diagnostic Tests, X-rays, Laboratory & Pathology	Covered – 100%	Covered – 90% after deductible	Not Covered
Radiation Therapy	Covered – 100%	Covered – 90% after deductible	Not Covered

Emergency Room Care

Hospital Emergency Room Qualified Medical Emergency & First Aid Services	Covered – 100% after \$50 copay; copay waived if admitted	Covered – 100% after \$50 copay; copay waived if admitted	Covered – 100% after \$50 copay; copay waived if admitted
Non-Emergency use of the Emergency Room	Covered - \$50 copay, then 90% after deductible	Covered – \$50 copay, then 90% after deductible	Not Covered
Facility Based Urgent Care Centers	Covered – 100% after \$15 copay	Covered – 100% after \$15 copay	Not Covered
Ambulance Services – medically necessary transport	Covered – 100%	Covered – 90% after deductible	Covered – 90% after deductible

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Inpatient Hospital Care

Semi-Private Room, General Nursing Care, Hospital Services and Supplies	Covered – 100%	Covered – \$250 copay, then 90% after deductible	Not Covered
	Unlimited days		

Alternatives to Inpatient Hospital Care

Skilled Nursing Facility	Covered – 100%	Covered – \$250 copay, then 90% after deductible	Not Covered
	120 days per calendar years		
Hospice Care	Covered – 100%	Covered – 100%	Not Covered
	Unlimited days		
Home Health Care	Covered – 100%	Covered – 90% after deductible	Not Covered
	120 visits per calendar year		

Outpatient Surgical Services (Facility Fee)

Surgery – includes related surgical services	Covered – 100% after \$50 copay	Covered – \$75 copay, then 90% after deductible	Not Covered
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Outpatient Therapy

Outpatient Physical, Speech and Occupational Therapy	Covered – 100%	Covered – 90% after deductible	Not Covered
	Limited to 60 visits each type of therapy per calendar year. Services are covered when performed in the outpatient department of the hospital, or approved freestanding facility.		
Cardiac Rehabilitation	Covered – 100%	Covered – 90% after deductible	Not Covered
	Maximum of 36 visits in a 12 week period		
Chemotherapy	Covered – 100%	Covered – 90% after deductible	Not Covered

Human Organ Transplants

Specified Organ Transplants – coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	Covered – 100%	Covered – 100%	Not Covered
	\$1 million maximum per transplant type; separate from general lifetime maximum		
Kidney, Cornea, Bone Marrow and Skin	Covered - 100%	Covered – 90% after deductible	Not Covered

Inpatient Mental Health Care and Substance Abuse Treatment

Inpatient Mental Health and Substance Abuse Care <i>Coinsurance does not contribute to the out-of-pocket maximum</i>	Covered – 100%	Covered – \$250 copay, then 90% after deductible	Not Covered
	Combined limit of 30 days per calendar year and 120 days lifetime		

Other Services

Durable Medical Equipment/Medical Supplies	Covered – 100%	Covered – 90% after deductible	Not Covered
Prosthetic and Orthotic Appliances	Covered – 100%	Covered – 90% after deductible	Not Covered
Private Duty Nursing	Covered – 100%	Covered – 90% after deductible	Not Covered

Preventive Services

Health Maintenance Exam – age 18 and over; includes related X-rays, EKG, and lab procedures performed as part of the physical exam	Covered – 100% after \$15 copay	Not Covered
Annual Gynecological Exam - one per calendar year	Covered – 100% after \$15 copay	Not Covered
Pap Smear Screening – one per calendar year; laboratory services only	Covered – 100%	Not Covered
Mammography Screening – one baseline ages 35-39 then one annually age 40+	Covered – 100%	Not Covered
Prostate Specific Antigen (PSA) Screening - one per calendar year	Covered – 100%	Not Covered
Colonoscopy Screening Exam– one every 10 years after age 50	Covered – 100%	Not Covered
Sigmoidoscopy Screening Exam – one per calendar year	Covered – 100%	Not Covered
Well-Baby and Child Care – through age 17 <ul style="list-style-type: none"> • 7 visits birth through 12 months • 3 visits 13 months through 2 years • 1 visit per year age 3 through 17 	Covered – 100% after \$15 copay	Not Covered
Immunizations - pediatric and adult	Covered – 100%	Not Covered
Routine Hearing Exam	Covered – 100%	Not Covered

Physician Office Services

Office Visits Includes: <ul style="list-style-type: none"> • Primary care and specialist physicians • Presurgical consultations • Initial visit to determine pregnancy 	Covered – 100% after \$15 copay One copay applies to the office visit exam and all services performed during the office visit (e.g., lab, x-ray, etc.)	Not Covered
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Professional Diagnostic Services

MRI, MRA, PET and CAT Scans and Nuclear Medicine	Covered – 90% after deductible	Not Covered
Other Diagnostic Tests, X-rays, Laboratory & Pathology	Covered – 90% after deductible	Not Covered
Radiation Therapy	Covered – 90% after deductible	Not Covered

Maternity Services Provided by a Physician

Pre-Natal and Post-Natal Care	Covered – 90% after deductible	Not Covered
Delivery and Nursery Care	Covered – 90% after deductible	Not Covered

Outpatient Mental Health Care and Substance Abuse Treatment

Outpatient Mental Health Care <i>Coinsurance does not contribute to the out-of-pocket maximum</i>	Covered – 100% after \$15 copay 30 visits per calendar year	Not Covered
Outpatient Substance Abuse Care <i>Coinsurance does not contribute to the out-of-pocket maximum</i>	Covered – 90% after deductible 20 visits per calendar year	Not Covered

Other Professional Services

Inpatient Medical Care (Physician visits)	Covered – 90% after deductible	Not Covered
Surgery, TSA, Anesthesia	Covered – 90% after deductible	Not Covered
Allergy Testing and Therapy	Covered – 90% after deductible	Not Covered
Chiropractic Care – Includes x-rays, spinal manipulation, physical therapy and office visits	Covered – 90% after deductible 20 visits per calendar year	Not Covered
Physical Therapy (Independent Physical Therapist)	Covered – 90% after deductible Limited to 60 visits per calendar year combined with outpatient physical therapy	Not Covered

Prescription Drugs – Administered directly by Medco Health

Retail – 34-day supply <ul style="list-style-type: none"> • Generic • Formulary Brand Name • Non-Formulary Brand Name 	100% after \$10 copay 100% after \$20 copay 100% after \$40 copay
Mail Order – 90 day supply <ul style="list-style-type: none"> • Generic • Formulary Brand Name • Non-Formulary Brand Name 	100% after \$20 copay 100% after \$40 copay 100% after \$80 copay
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.	
Note: Infertility drugs are covered at 50%	

Non-Surgical Weight Loss and Smoking Cessation

Non-Surgical Weight Loss Therapy

Along with the existing benefits for bariatric surgery, the plan will cover additional services for non-surgical weight loss treatment. Benefits are payable 80% up to an annual benefit maximum of \$500 and include:

- Outpatient counseling or therapy,
- Office visits rendered by a licensed physician for the treatment of weight loss
- Lab services performed during a course of treatment, and
- Services for weight loss rendered by a Trinity Health Ministry Organization or national recognized programs such as Jenny Craig, Weight Watchers and LA Weight Loss.

Weight-loss expenses that are not covered are:

- Services administered exclusively through an Internet-based forum,
- Medication or injection expenses for weight loss, unless otherwise covered for an unrelated medical condition
- Charges for food or nutritional supplements, unless included in the initial program fee,
- Charges for over-the counter diet aids,
- Health clubs or exercise equipment,
- Services or programs that are not approved in the United States, and
- Charges in connection with acupuncture, hypnotism or biofeedback training.

Smoking Cessation Therapy

Covered benefits for smoking cessation treatment are payable 80% up to an annual benefit maximum of \$500 and include:

- Outpatient counseling or therapy,
- Office visits rendered by a licensed physician for the treatment of smoking cessation, and
- Lab services performed during a course of treatment.

Smoking cessation expenses that are not covered are:

- Services administered exclusively through an Internet-based forum,
- Medication or injection expenses for smoking cessation, unless otherwise covered for an unrelated medical condition,
- Charges for over-the counter smoking cessation aids,
- Services or programs that are not approved in the United States, and
- Charges in connection with acupuncture, hypnotism, or biofeedback training.

Selecting a Provider

Out-of-Network but Participating Providers

When using an out-of-network provider, try to use a BCBS participating provider. Out-of-network but participating providers have signed agreements with BCBS to accept the BCBS approved amount as payment in full for covered services. However, because these providers are not a part of the PPO network, you must pay any required copayments and a higher deductible and coinsurance for your care.

When you go to out-of-network but participating providers, you usually don't have to submit claims. These providers, like network providers, submit claims to BCBS for you and the providers are paid directly by BCBS.

Nonparticipating 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.

You are usually required to pay nonparticipating providers directly and then submit a claim to BCBS for reimbursement. If you receive services from a nonparticipating provider, you may have to pay the difference between the BCBS approved amount and what the provider charges.

This is intended as an easy-to-read guide. It is not a contract. An official description of benefits is contained in applicable Blue Cross Blue Shield of Michigan coverage documents.