

**PPO – High Option B**  
**Rx \$10/\$20/\$40**  
**Benefits-at-a-Glance**  
**Trinity Health**

**Group 71349**  
**Package Code 040**

**Trinity Health Facilities**  
**Does not include**  
**professional services**

**In-Network**  
**Community Blue PPO**

**Out-of-Network**

**Deductible, Copays/Coinsurance and Dollar Maximums**

<b>Deductible - per calendar year</b>	\$400 per member \$800 per family <i>(Please note: deductible applies only to non-emergency use of the emergency room)</i>	\$400 per member \$800 per family	\$ 800 per member \$1,600 per family
<b>Copays/Coinsurance</b> • Fixed Dollar Copays	\$30 copay • Urgent care visits \$75 copay • Emergency room visits \$50 Copay • Outpatient surgery – facility fee only	\$20 copay • Health Maintenance Exam • Annual Gynecological Exam • Well-Baby and Child Care • Office Visit • Outpatient mental health care visit \$30 Copay • Urgent care visit \$75 copay • Emergency room visits \$100 copay • Outpatient surgery – facility fee only \$250 copay • Inpatient admissions	\$75 copay • Emergency room visits \$200 copay • Outpatient surgery – facility fee only \$500 copay • Inpatient admissions
• Percent Coinsurance	0%	20%	40% <b>Note:</b> Services without a network are covered at the in-network level.
<b>Out-of-Pocket Maximum – per calendar year</b> • Percent Coinsurance <i>Excludes Deductible</i>	\$1,000 per member \$2,000 per family	\$2,000 per member \$4,000 per family	\$4,000 per member \$8,000 per family
<b>Lifetime Maximum</b> <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 – 80% after deductible	Covered – 60% of R&C after deductible
Other Diagnostic Tests, X-rays, Laboratory & Pathology	Covered – 100%	Covered – 80% after deductible	Covered – 60% of R&C after deductible
Radiation Therapy	Covered – 100%	Covered – 80% after deductible	Covered – 60% of R&C after deductible

**Emergency Room Care**

Hospital Emergency Room Qualified Medical Emergency & First Aid	Covered – 100% after \$75 copay; copay waived if admitted	Covered – 100% after \$75 copay; copay waived if admitted	Covered – 100% of R&C after \$75 copay; copay waived if admitted
Non-Emergency use of the Emergency Room	Covered – \$75 copay, then 80% after deductible	Covered – \$75 copay, then 80% after deductible	Covered – \$75 copay, then 60% of R&C after deductible
Facility Based Urgent Care Centers	Covered – 100% after \$30 copay	Covered – 100% after \$30 copay	Covered – 60% of R&C after deductible
Ambulance Services – medically necessary transport	Covered – 100%	Covered – 80% after deductible	Covered – 80% of R&C 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 80% after deductible	Covered – \$500 copay, then 60% of R&C after deductible
	Unlimited days		

**Alternatives to Inpatient Hospital Care**

Skilled Nursing Facility	Covered – 100%	Covered – \$250 copay, then 80% after deductible	Covered – \$500 copay, then 60% of R&C after deductible
	120 days per calendar year		
Hospice Care	Covered – 100%	Covered – 100%	Covered – 60% of R&C after deductible
	Unlimited days		
Home Health Care	Covered – 100%	Covered – 80% after deductible	Covered – 60% of R&C after deductible
	120 visits per calendar year		

**Outpatient Surgical Services (Facility Fee)**

Surgery – includes related surgical services	Covered – 100% after \$50 copay	Covered – \$100 copay, then 80% after deductible	Covered – \$200 copay, then 60% of R&C after deductible
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**Outpatient Therapy**

Outpatient Physical, Speech and Occupational Therapy	Covered – 100%	Covered – 80% after deductible	Covered – 60% of R&C after deductible
	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 – 80% after deductible	Covered – 60% of R&C after deductible
	Maximum of 36 visits in a 12 week period		
Chemotherapy	Covered – 100%	Covered – 80% after deductible	Covered – 60% of R&C after deductible

**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 – 80% after deductible	Covered – 60% of R&C after deductible

**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 80% after deductible	Covered – \$500 copay, then 60% of R&C after deductible
	Combined limit of 30 days per calendar year and 120 days lifetime		

**Other Services**

Durable Medical Equipment/Medical Supplies	Covered – 100%	Covered – 80% after deductible	Covered – 60% of R&C after deductible
Prosthetic and Orthotic Appliances	Covered – 100%	Covered – 80% after deductible	Covered – 60% of R&C after deductible
Private Duty Nursing	Covered – 100%	Covered – 80% after deductible	Covered – 60% of R&C after deductible

**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 \$20 copay	Covered – 60% of R&C after deductible
Annual Gynecological Exam - one per calendar year	Covered – 100% after \$20 copay	Covered – 60% of R&C after deductible
Pap Smear Screening – one per calendar year; laboratory services only	Covered – 100%	Covered – 60% of R&C after deductible
Mammography Screening – one baseline ages 35-39 then one annually age 40+	Covered – 100%	Covered – 60% of R&C after deductible
Prostate Specific Antigen (PSA) Screening - one per calendar year	Covered – 100%	Covered – 60% of R&C after deductible
Colonoscopy Screening Exam – one every 10 years after age 50	Covered – 100%	Covered – 60% of R&C after deductible
Sigmoidoscopy Screening Exam – one per calendar year	Covered – 100%	Covered – 60% of R&C after deductible
Well-Baby and Child Care – through age 17 <ul style="list-style-type: none"> <li>• 7 visits birth through 12 months</li> <li>• 3 visits 13 months through 2 years</li> <li>• 1 visit per year age 3 through 17</li> </ul>	Covered – 100% after \$20 copay	Covered – 60% of R&C after deductible
Immunizations - pediatric and adult	Covered – 100%	Covered – 60% of R&C after deductible
Routine Hearing Exam – one per calendar year	Covered – 100%	Covered – 60% of R&C after deductible

**Physician Office Services**

Office Visits Includes: <ul style="list-style-type: none"> <li>• Primary care and specialist physicians</li> <li>• Presurgical consultations</li> <li>• Initial visit to determine pregnancy</li> </ul>	Covered – 100% after \$20 copay One copay applies to the office visit exam and all services performed during the office visit (e.g., lab, x-ray, etc.)	Covered – 60% of R&C after deductible
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**Professional Diagnostic Services**

MRI, MRA, PET and CAT Scans and Nuclear Medicine	Covered – 80% after deductible	Covered – 60% of R&C after deductible
Other Diagnostic Tests, X-rays, Laboratory & Pathology	Covered – 80% after deductible	Covered – 60% of R&C after deductible
Radiation Therapy	Covered – 80% after deductible	Covered – 60% of R&C after deductible

**Maternity Services Provided by a Physician**

Pre-Natal and Post-Natal Care	Covered – 80% after deductible	Covered – 60% of R&C after deductible
Delivery and Nursery Care	Covered – 80% after deductible	Covered – 60% of R&C after deductible

**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 \$20 copay	Covered – 60% of R&C after deductible
	30 visits per calendar year	
Outpatient Substance Abuse Care <i>Coinsurance does not contribute to the out-of-pocket maximum</i>	Covered – 80% after deductible	Covered – 60% of R&C after deductible
	20 visits per calendar year	

**Other Professional Services**

Inpatient Medical Care (Physician visits)	Covered – 80% after deductible	Covered – 60% of R&C after deductible
Surgery, TSA, Anesthesia	Covered – 80% after deductible	Covered – 60% of R&C after deductible
Allergy Testing and Therapy	Covered – 80% after deductible	Covered – 60% of R&C after deductible
Chiropractic Care – Includes x-rays, spinal manipulation, physical therapy and office visits	Covered – 80% after deductible	Covered – 60% of R&C after deductible
	20 visits per calendar year	
Physical Therapy (Independent Physical Therapist)	Covered – 80% after deductible	Covered – 60% of R&C after deductible
	Limited to 60 visits per calendar year combined with outpatient physical therapy	

**Prescription Drugs – Administered directly by Medco Health**

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

### 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

### **Trinity Health Facilities**

When you use Trinity Health facilities and satellite locations, you receive the highest benefit payment level. A listing of eligible facilities is available online at bsbsm.com.

### **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.

### **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.**

<p><b>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.</b></p>
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