

PPO – Personal Care Account
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

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|---|--|--|--|
| Deductible - per calendar year | \$1,000 per member \$2,000 two person \$3,000 per family <i>(Please note: For Trinity Facilities, the deductible applies only to non-emergency use of the emergency room and urgent care visits.)</i> | | |
| Personal Care Account <i>Can be used to offset the Annual Deductible</i> | \$ 400 per member \$ 800 two person \$1,200 per family | | |
| Copays/Coinsurance • Fixed Dollar Copays | \$50 copay • Emergency room visits | \$50 copay • Emergency room visits • Outpatient surgery – facility fee only \$250 copay • Inpatient admissions | \$50 copay • Emergency room visits • Outpatient surgery – facility fee only \$250 copay • Inpatient admissions |
| • Percent Coinsurance | 0% | 20% | 40% 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> | \$1,500 per member \$2,000 two person \$2,500 per family | \$1,500 per member \$2,000 two person \$2,500 per family | \$3,000 per member \$4,500 two person \$6,000 per family |
| 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 – 80% after deductible | Covered – 60% after deductible |
| Other Diagnostic Tests, X-rays, Laboratory & Pathology | Covered – 100% | Covered – 80% after deductible | Covered – 60% after deductible |
| Radiation Therapy | Covered – 100% | Covered – 80% after deductible | Covered – 60% after deductible |

Emergency Room Care

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|---|---|---|---|
| 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 80% after deductible | Covered – \$50 copay, then 60% after deductible |
| Facility Based Urgent Care Centers | Covered – 90% after deductible | Covered – 80% after deductible | Covered – 60% after deductible |
| Ambulance Services – medically necessary transport | Covered – 100% | Covered – 80% after deductible | Covered – 80% 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 – \$250 copay, then 60% after deductible |
| | Unlimited days | | |

Alternatives to Inpatient Hospital Care

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|--------------------------|------------------------------|--|--|
| Skilled Nursing Facility | Covered – 100% | Covered – \$250 copay, then 80% after deductible | Covered – \$250 copay, then 60% after deductible |
| | 120 days per calendar years | | |
| Hospice Care | Covered – 100% | Covered – 100% | Covered – 60% after deductible |
| | Unlimited days | | |
| Home Health Care | Covered – 100% | Covered – 80% after deductible | Covered – 60% after deductible |
| | 120 visits per calendar year | | |

Outpatient Surgical Services (Facility Fee)

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|--|----------------|---|---|
| Surgery – includes related surgical services | Covered – 100% | Covered – \$50 copay, then 80% after deductible | Covered – \$50 copay, then 60% after deductible |
|--|----------------|---|---|

Outpatient Therapy

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

Human Organ Transplants

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|---|---|--------------------------------|--------------------------------|
| 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% after deductible |

Inpatient Mental Health Care and Substance Abuse Treatment

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|---|---|--|--|
| Inpatient Mental Health and Substance Abuse Care <i>Does not contribute to the out-of-pocket maximum</i> | Covered – 100% | Covered – \$250 copay, then 80% after deductible | Covered – \$250 copay, then 60% 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% after deductible |
| Prosthetic and Orthotic Appliances | Covered – 100% | Covered – 80% after deductible | Covered – 60% after deductible |
| Private Duty Nursing | Covered – 100% | Covered – 80% after deductible | Covered – 60% after deductible |

Preventive Services

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|--|----------------|----------------|
| Health Maintenance Exam – age 18 and over; includes related X-rays, EKG, and lab procedures performed as part of the physical exam | Covered – 100% | Covered – 100% |
| Annual Gynecological Exam - one per calendar year | Covered – 100% | Covered – 100% |
| Pap Smear Screening – one per calendar year; laboratory services only | Covered – 100% | Covered – 100% |
| Mammography Screening – one per calendar year; 35-39 baseline then annually | Covered – 100% | Covered – 100% |
| Prostate Specific Antigen (PSA) Screening - one per calendar year | Covered – 100% | Covered – 100% |
| Colonoscopy Screening Exam– one every 10 years after age 50 | Covered – 100% | Covered – 100% |
| Sigmoidoscopy Screening Exam – one per calendar year | Covered – 100% | Covered – 100% |
| Well-Baby and Child Care – through age 17 • 7 visits birth through 12 months • 3 visits 13 months through 2 years • 1 visit per year age 3 through 17 | Covered – 100% | Covered – 100% |
| Immunizations - pediatric and adult | Covered – 100% | Covered – 100% |
| Routine Hearing Exam – one per calendar year | Covered – 100% | Covered – 100% |

Physician Office Services

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|---|--------------------------------|--------------------------------|
| Office Visits Includes: • Primary care and specialist physicians • Presurgical consultations • Initial visit to determine pregnancy | Covered – 80% after deductible | Covered – 60% after deductible |
|---|--------------------------------|--------------------------------|

Professional Diagnostic Services

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

Maternity Services Provided by a Physician

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|-------------------------------|--------------------------------|--------------------------------|
| Pre-Natal and Post-Natal Care | Covered – 80% after deductible | Covered – 60% after deductible |
| Delivery and Nursery Care | Covered – 80% after deductible | Covered – 60% after deductible |

Outpatient Mental Health Care and Substance Abuse Treatment

| | | |
|--|--|--------------------------------|
| Outpatient Mental Health Care <i>Does not contribute to the out-of-pocket maximum</i> | Covered- 80% after deductible 30 visits per calendar year | Covered – 60% after deductible |
| Outpatient Substance Abuse Care <i>Does not contribute to the out-of-pocket maximum</i> | Covered- 80% after deductible 20 visits per calendar year | Covered – 60% after deductible |

Other Professional Services

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

Prescription Drugs – Administered directly by Medco Health

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|--|---|
| Retail – 34-day supply • 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 • 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.