

**PPO – Muskegon Union High Plan**  
**Rx \$5/\$5/\$5**  
**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**

<b>Deductible - per calendar year</b>	\$100 per member \$200 per family <i>(Please note: deductible applies only to non-emergency use of the emergency room and urgent care visits)</i>	\$100 per member \$200 per family	\$200 per member \$400 per family
<b>Copays/Coinsurance</b> • Fixed Dollar Copays	None	\$10 copay • Well baby/well child care visits • Office visits • Outpatient mental health and substance abuse care visits	None
• Percent Coinsurance	0%	10%	25% <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>	\$ 500 per member \$1,000 per family	\$ 500 per member \$1,000 per family	\$1,000 per member \$2,000 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 – 90% after deductible	Covered – 75% after deductible
Other Diagnostic Tests, X-rays, Laboratory & Pathology	Covered – 100%	Covered – 90% after deductible	Covered – 75% after deductible
Radiation Therapy	Covered – 100%	Covered – 90% after deductible	Covered – 75% after deductible

**Emergency Room Care**

Hospital Emergency Room Qualified Medical Emergency & First Aid Services	Covered – 100%	Covered – 100%	Covered – 100%
Non-Emergency use of the Emergency Room	Covered – 90% after deductible	Covered – 90% after deductible	Covered – 75% after deductible
Facility Based Urgent Care Centers	Covered – 90% after deductible	Covered – 90% after deductible	Covered – 75% after deductible
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 – 90% after deductible	Covered – 75% after deductible
	Unlimited days		

**Alternatives to Inpatient Hospital Care**

Skilled Nursing Facility	Covered – 100%	Covered – 90% after deductible	Covered – 75% after deductible
	120 days per calendar years		
Hospice Care	Covered – 100%	Covered – 100%	Covered – 75% after deductible
	Unlimited days		
Home Health Care	Covered – 100%	Covered – 90% after deductible	Covered – 75% after deductible
	Unlimited visits		

**Outpatient Surgical Services (Facility Fee)**

Surgery – includes related surgical services	Covered – 100%	Covered – 90% after deductible	Covered – 75% after deductible
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**Outpatient Therapy**

Outpatient Physical, Speech and Occupational Therapy	Covered – 100%	Covered – 90% after deductible	Covered – 75% 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 – 90% after deductible	Covered – 75% after deductible
	Maximum of 36 visits in a 12 week period		
Chemotherapy	Covered – 100%	Covered – 90% after deductible	Covered – 75% 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
	Up to \$500,000 maximum per transplant type; included in General Lifetime Maximum		
Kidney, Cornea, Bone Marrow and Skin	Covered – 100%	Covered – 90% after deductible	Covered – 75% 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 – 90% after deductible	Covered – 75% after deductible
	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	Covered – 75% after deductible
Prosthetic and Orthotic Appliances	Covered – 100%	Covered – 90% after deductible	Covered – 75% after deductible
Private Duty Nursing	Covered – 100%	Covered – 90% after deductible	Covered – 75% after deductible

**Preventive Services**

Health Maintenance Exam – age 6 and over; includes related X-rays, EKG, and lab procedures performed as part of the physical exam	Not Covered	Not Covered
X-rays, EKG, and lab procedures performed as part of a physical exam	Not Covered	Not Covered
Annual Gynecological Exam - one per calendar year	Not Covered	Not Covered
Pap Smear Screening – one per calendar year; laboratory services only	Covered – 100%	Covered – 75% after deductible
Mammography Screening – one baseline ages 35-39 then one annually age 40+	Covered – 100%	Covered – 75% after deductible
Prostate Specific Antigen (PSA) Screening - one per calendar year	Covered – 100%	Covered – 75% after deductible
Colonoscopy Screening Exam – one every 10 years after age 50	Not Covered	Not Covered
Sigmoidoscopy Screening Exam – one per calendar year	Not Covered	Not Covered
Well-Baby and Child Care – through age 5 <ul style="list-style-type: none"> <li>• 6 visits birth through age 1</li> <li>• 2 visits per year age 2 through 3</li> <li>• 1 visit per year age 4 through 5</li> </ul>	Covered – 100% after \$10 copay	Covered – 75% after deductible
Immunizations - pediatric and adult	Covered – 100%	Covered – 75% 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 \$10 copay One copay applies to the office visit exam and all services performed during the office visit (e.g., lab, x-ray, etc.)	Covered – 75% after deductible
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**Professional Diagnostic Services**

MRI, MRA, PET and CAT Scans and Nuclear Medicine	Covered – 90% after deductible	Covered – 75% after deductible
Other Diagnostic Tests, X-rays, Laboratory & Pathology	Covered – 90% after deductible	Covered – 75% after deductible
Radiation Therapy	Covered – 90% after deductible	Covered – 75% after deductible

**Maternity Services Provided by a Physician**

Pre-Natal and Post-Natal Care	Covered – 90% after deductible	Covered – 75% after deductible
Delivery and Nursery Care	Covered – 90% after deductible	Covered – 75% after deductible

**Outpatient Mental Health Care and Substance Abuse Treatment**

Outpatient Mental Health Care <i>Coinurance does not contribute to the out-of-pocket maximum</i>	Covered- 100% after \$10 copay 30 visits per calendar year	Covered – 75% after deductible
Outpatient Substance Abuse Care <i>Coinurance does not contribute to the out-of-pocket maximum</i>	Covered- 100% after \$10 copay 20 visits per calendar year	Covered – 75% after deductible

**Other Professional Services**

Inpatient Medical Care (Physician visits)	Covered – 90% after deductible	Covered – 75% after deductible
Surgery, TSA, Anesthesia	Covered – 90% after deductible	Covered – 75% after deductible
TMJ Services	Covered – 50% after deductible Limited to a maximum of \$1,000 per calendar year; \$2,500 lifetime (excluding surgery)	Covered – 50% after deductible
Allergy Testing and Therapy	Covered – 90% after deductible	Covered – 75% after deductible
Chiropractic Care – Includes x-rays, spinal manipulation, physical therapy and office visits	Covered – 75% after deductible 20 visits per calendar year	Covered – 75% after deductible
Physical Therapy (Independent Physical Therapist)	Covered – 90% after deductible Limited to 60 visits per calendar year combined with outpatient physical therapy	Covered – 75% after deductible

**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 \$5 copay 100% after \$5 copay 100% after \$5 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 \$10 copay 100% after \$30 copay 100% after \$50 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.**