



**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): 092
Essential Plan and Essential Assist Plan with
HRA (Modified 3)
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 authorization**.

| Member's responsibility (deductibles, copays, coinsurance and dollar maximums) | | | |
|---|--|---|---|
| Benefits | Tier 1 Trinity Health Facilities & Specified Trinity Health Professional Providers | Tier 2 PPO Network Facility and Professional Providers | Out of Network Facility and Professional Providers |
| Deductibles - per calendar year | \$1,250 per member \$2,500 per family | \$2,750 per member \$5,500 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 | \$100 copay for : • Ambulance services • Outpatient surgery - facility fee only \$200 copay for : • Emergency room \$500 copay for : • Inpatient admissions | Not Covered |
| Coinsurance • Percent Coinsurance | 20% | 30%* | Not Covered |
| Annual out-of-pocket maximums | \$4,000 per member \$8,000 per family <i>Includes deductible, coinsurance and copays for all covered services including prescription drugs</i> | \$6,000 per member \$12,000 per family <i>Includes deductible, coinsurance and copays for all covered services including prescription drugs</i> | Not Covered |
| Lifetime dollar maximum | | Unlimited | Not Covered |
| Tier 2 Cost-Share for Professional Providers | All covered services rendered by Tier 2 PROFESSIONAL providers will apply Tier 1 copays, deductible, coinsurance and out of pocket maximum. | | Not Applicable |

*Unless otherwise stated within the summary outline

Preventive Care Services

| Benefits | Tier 1 Trinity Health Facilities & Specified Trinity Health Professional Providers | Tier 2 PPO Network Facility and Professional Providers | Out of Network Facility and Professional Providers |
|--|---|--|---|
| Health Maintenance Exam - beginning age 4; one per calendar year | Covered - 100% | Covered - 100% | Not Covered |
| Routine Physical Related Test X-Rays, EKG and lab procedures performed as part of the health maintenance exam | Covered - 100% | Covered - 100% | Not Covered |
| Annual Gynecological Exam - two per calendar year, in addition to health maintenance exam | Covered - 100% | Covered - 100% | Not Covered |
| Pap Smear Screening - one per calendar year | Covered - 100% | Covered - 100% | Not Covered |
| Mammography Screening - beginning age 35; 1 base line age 35-39; annual age 40+ includes 3D Mammography | Covered - 100% | Covered - 100% | Not Covered |
| Contraceptive Methods and Counseling | Not Covered | Not Covered | Not Covered |
| Prostate Specific Antigen (PSA) screening - beginning 40 years of age; one per calendar year | Covered - 100% | Covered - 100% | Not Covered |
| Endoscopic Exams - one per calendar year | Covered - 100% | Covered - 100% | Not Covered |
| Well Child Care <ul style="list-style-type: none"> • 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% | Covered - 100% | Not Covered |
| Immunizations - pediatric and adult | Covered - 100% | Covered - 100% | Not Covered |
| Routine Hearing Exam- one per calendar year | Covered - 100% | Covered - 100% | Not Covered |

Physician Office Services

| Benefits | Tier 1 Trinity Health Facilities & Specified Trinity Health Professional Providers | Tier 2 PPO Network Facility and Professional Providers | Out of Network Facility and Professional Providers |
|--|---|--|---|
| Office Visits Includes: • Primary care and specialist physicians • Initial Visit to Determine Pregnancy | Covered - 80% after deductible | Covered - 80% after deductible* | Not Covered |
| Medical Telemedicine Visits Note: Virtual visits rendered by BCBS Providers | Covered - 80% after deductible | Covered - 80% after deductible* | Not Covered |
| Medical Blue Cross Online Visits Note: Online Visits rendered by Teladoc | Not Applicable | Covered - 80% after deductible* | Not Covered |
| Office Consultations | Covered - 80% after deductible | Covered - 80% after deductible* | Not Covered |
| Pre-Surgical Consultations | Covered - 80% after deductible | Covered - 80% after deductible* | Not Covered |

*Tier 1 deductible and coinsurance applies.

Emergency Medical Care

| Benefits | Tier 1 Trinity Health Facilities & Specified Trinity Health Professional Providers | Tier 2 PPO Network Facility and Professional Providers | 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 | Covered - 100% after \$200 copay; copay waived if admitted. |
| Non-Emergency use of the Emergency Room | Covered - \$200 copay; then 80% after deductible | Covered - \$200 copay; then 70% after deductible | Not Covered |
| Urgent Care Services | Covered - 80% after deductible | Covered - 80% after deductible* | Not Covered |
| Ambulance Services - Medically Necessary Transport | Covered - 100% after \$100 copay | Covered - 100% after \$100 copay | Covered - 100% after \$100 copay |

*Tier 1 deductible and coinsurance applies

Facility and Professional Diagnostic Services

| Benefits | Tier 1 Trinity Health Facilities & Specified Trinity Health Professional Providers | Tier 2 PPO Network Facility and Professional Providers | Out of Network Facility and Professional Providers |
|---|---|--|---|
| MRI, MRA, PET and CAT Scans and Nuclear Medicine * | Covered - 80% after deductible | Covered - 70% after deductible | Not Covered |
| Diagnostic Tests, X-rays, Laboratory & Pathology | Covered - 80% after deductible | Covered - 70% after deductible | Not Covered |
| Radiation Therapy and Chemotherapy | Covered - 80% after deductible | Covered - 70% after deductible | Not Covered |

*Prior authorization may be required.

Maternity Services Provided by a Physician

| Benefits | Tier 1 Trinity Health Facilities & Specified Trinity Health Professional Providers | Tier 2 PPO Network Facility and Professional Providers | 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% | Covered - 100% | Not Covered |
| Delivery and Nursery Care | Covered - 80% after deductible | Covered - 80% after deductible* | Not Covered |
| High Risk Specialist Visits | Covered - 80% after deductible | Covered - 80% after deductible* | Not Covered |
| Ultrasounds and Pregnancy Diagnostic Lab Tests | Covered - 80% after deductible | Covered - 80% after deductible* | Not Covered |
| Anemia Screening and Gestational Diabetes Screening | Covered - 100% | Covered - 100% | Not Covered |
| Amniocentesis (Professional Charges) | Covered - 80% after deductible | Covered - 80% after deductible* | Not Covered |
| Amniocentesis (Facility Charges) | Covered - \$50 copay; then 80% after deductible | Covered - \$100 copay; then 70% after deductible | Not Covered |

*Tier 1 deductible and coinsurance applies.

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 | Tier 1 Trinity Health Facilities & Specified Trinity Health Professional Providers | Tier 2 PPO Network Facility and Professional Providers | 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 | Covered - \$500 copay; then 70% after deductible** | Not Covered Unless admitted directly from the ER to the hospital* |
| Inpatient Medical Care (Professional Charges) | Covered - 80% after deductible | Covered - 80% after deductible* | Not Covered Unless admitted directly from the ER to the hospital* |

*Tier 1 deductible and coinsurance applies.

Alternatives to Hospital Care

| Benefits | Tier 1 Trinity Health Facilities & Specified Trinity Health Professional Providers | Tier 2 PPO Network Facility and Professional Providers | Out of Network Facility and Professional Providers |
|--|---|--|---|
| Hospice Care | Covered - 100% | Covered - 100% | Not Covered |
| Home Health Care Limited to a maximum of 120 visits per calendar year | Covered - 80% after deductible | Covered - 70% after deductible | Not Covered |
| Skilled Nursing Facility Limited to a maximum of 120 days per calendar year | Covered - 80% after deductible | Covered - \$500 copay; then 70% after deductible | Not Covered |

Surgical Services

| Benefits | Tier 1 Trinity Health Facilities & Specified Trinity Health Professional Providers | Tier 2 PPO Network Facility and Professional Providers | Out of Network Facility and Professional Providers |
|---|---|--|---|
| Surgery (includes related surgical services) | Covered - \$50 copay; then 80% after deductible | Covered - \$100 copay; then 70% after deductible | Not Covered |
| Bariatric Surgery Covered only if performed at a Tier 1 Trinity Health Facility -or- a Blue Distinction Center of Excellence Tier 2 Facility | Covered - 80% after deductible | Covered - 70% after deductible | Not Covered |
| Sterilization- males only; excludes reversal sterilization | Not Covered | Not Covered | Not Covered |
| Sterilization- females only; excludes reversal sterilization | Not Covered | Not Covered | Not Covered |

Human Organ Transplants

| Benefits | Tier 1 Trinity Health Facilities & Specified Trinity Health Professional Providers | Tier 2 PPO Network Facility and Professional Providers | 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 | Covered - 70% after deductible | Not Covered |
| Kidney, Cornea, Bone Marrow and Skin | Covered - 80% after deductible | Covered - 70% after deductible | Not Covered |

Behavioral Health Services (Mental Health and Substance Use Disorder)

| Benefits | Tier 1 Trinity Health Facilities & Specified Trinity Health Professional Providers | Tier 2 PPO Network Facility and Professional Providers | Out of Network Facility and Professional Providers |
|---|---|--|---|
| Inpatient Mental Health Care and Substance Use Disorder Treatment | Covered - 80% after deductible | Covered - 80% after deductible* | Not Covered |
| Outpatient Mental Health Care and Substance Use Disorder Treatment | Covered - 80% after deductible | Covered - 80% after deductible* | Not Covered |
| Mental Health Telemedicine Visits Note: Virtual visits rendered by BCBS Providers | Covered - 80% after deductible | Covered - 80% after deductible* | Not Covered |
| Mental Health Blue Cross Online Visits Note: Online Visits rendered by Teladoc | Not Applicable | 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 | Not Applicable |
| Spring Health: Substance Use Disorder - Virtual visits rendered by a Spring Health provider | Covered - 80% after deductible | Not Applicable | Not Applicable |

*Tier 1 deductible, coinsurance and out-of-pocket maximum applies.

Spring Health contracts separately with Trinity Health.

Autism Spectrum Disorders, Diagnoses and Treatment

| Benefits | Tier 1 Trinity Health Facilities & Specified Trinity Health Professional Providers | Tier 2 PPO Network Facility and Professional Providers | Out of Network Facility and Professional Providers |
|---|---|--|---|
| Applied Behavioral Analysis (ABA) | Covered - 80% after deductible | Covered – 80% after deductible* | Not Covered |
| Physical, Occupational and Speech Therapy | Covered - 80% after deductible | Covered - 70% after deductible | Not Covered |
| Nutritional Counseling | Covered - 80% after deductible | Covered - 80% after deductible* | Not Covered |

*Tier 1 deductible and coinsurance applies.

Other Covered Services

| Benefits | Tier 1 Trinity Health Facilities & Specified Trinity Health Professional Providers | Tier 2 PPO Network Facility and Professional Providers | Out of Network Facility and Professional Providers |
|--|---|--|---|
| Cardiac Rehabilitation Maximum of 36 visits in a 12-week period | Covered - 80% after deductible | Covered - 70% after deductible | Not Covered |
| Chiropractic Spinal Manipulation Limited to a maximum of 20 visits per calendar year | Covered - 80% after deductible | Covered - 80% after deductible* | Not Covered |
| Durable Medical Equipment | Covered - 80% after deductible | Covered - 80% after deductible* | Not Covered |
| Prosthetic and Orthotic Devices | Covered - 80% after deductible | Covered - 80% after deductible* | Not Covered |
| Private Duty Nursing Care Limited to 120 visits per calendar year | Covered - 80% after deductible | Covered - 80% after deductible | Not Covered |
| Allergy Testing and Therapy | Covered - 80% after deductible | Covered - 80% after deductible* | Not Covered |
| Facility Clinic Visit | Covered - 80% after deductible | Covered - 70% after deductible | Not Covered |

*Tier 1 deductible and coinsurance applies.

Therapy Services

| Benefits | Tier 1 Trinity Health Facilities & Specified Trinity Health Professional Providers | Tier 2 PPO Network Facility and Professional Providers | Out of Network Facility and Professional Providers |
|---|--|--|---|
| Physical, Occupational and Speech Therapy - Rehabilitative | Covered - 80% after deductible | Covered - 70% after deductible | Not Covered |
| | 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. | | |
| Physical, Occupational and Speech Therapy - Habilitative | Covered - 80% after deductible | Covered - 70% after deductible | Not Covered |
| | 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. | | |

Selecting a Provider

Tier 1: Trinity Health Facilities

This tier is comprised of Trinity Health facilities and aligned professional providers that are part of Blue Cross' PPO network and not in Tier 2. These providers have signed an agreement with Blue Cross to accept our approved amount as payment for the services covered. You'll have the lowest deductible, coinsurance and out-of-pocket maximum amounts when covered services are provided by a Tier 1 provider.

If you need help locating a Tier 1 provider, please visit [Find a Doctor | bcbsm.com](https://www.bcbsm.com) or call the phone number on the back of your ID card.

When you go to Tier 1 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.

Tier 2: In-Network PPO Providers not in Tier 1

This tier is comprised of providers and hospitals that are part of Blue Cross' PPO network and not in Tier 1. These providers have signed an agreement with Blue Cross to accept our approved amount as payment for the services covered. When services are performed by Tier 2 in-network PPO providers, you'll have larger deductible, coinsurance and out-of-pocket maximum amounts than Tier 1 providers, for most services.

All covered services rendered by Tier 2 professional providers will apply Tier 1 copays, deductible and coinsurance and out of pocket maximums.

Ask your provider if he or she participates with the Blue Cross PPO network. If you need help locating a Tier 2 provider, please visit [Find a Doctor | bcbsm.com](https://www.bcbsm.com) or call the phone number on the back of your ID card.

When you go to Tier 2 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 the Blue Cross PPO network. 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.

Essential and Essential Assist Prescription Plan

Prescription Drug Benefit administered by OptumRx
www.optumrx.com

1-855-540-5950

| | | 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)*: \$6,000 single/\$12,000 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 Yeztugo, Apretude, Descovy and generic tenofovir disoproxil fumarate and tenofovir. Brand Truvada and-Viread 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)

For a complete list, please reach out to OptumRx at 855-540-5950 or visit www.optumrx.com

Drugs requiring Prior Authorization (PA)

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

For a complete list, please reach out to OptumRx at 855-540-5950 or visit www.optumrx.com

Drugs that have Quantity Limits (QL) imposed

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

For a complete list, please reach out to OptumRx at 855-540-5950 or visit www.optumrx.com

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.

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract and is intended to be reviewed with the applicable summary plan description. Additional limitations and exclusions may apply. For a complete description of benefits, please review the applicable summary plan description. If there is a discrepancy between this summary and any applicable plan document, the plan document will control. 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.