Blue Care Network of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

Benefits-at-a-Glance
Trinity Health Muskegon Union
Effective Date: 01/01/2026

This is intended as an easy-to-read summary. **It is not a contract.** Additional limitations and exclusions may apply to covered services. For a complete description of benefits, please see the applicable Blue Care Network certificates and riders. Payment amounts are based on the Blue Care Network approved amount, less any applicable deductible, coinsurance and copay amounts required by the plan. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan documents, the plan document will control. **Services must be provided or arranged by member's primary care physician or health plan.**

Preauthorization for Select Services - Services listed in this BAAG are covered when provided in accordance with Certificate requirements and, when required, are preauthorized or approved by BCN except in an emergency.

Note: A list of services that require approval **before** they are provided is available online at **https://bcbsm.com/priorauth**.

Note: Blue Care Network provides administrative claims services only. Your employer or plan sponsor is financially responsible for claims. You must see an individual provider, facility or other health care entity that is contracted and credentialed with BCN to provide you with covered services with the exception of emergency care.

Member's responsibility (deductibles, copays, coinsurance and dollar maximums)

Benefits	
Deductible - Coinsurance and select fixed dollar copays apply (as defined by your plan documents), once the deductible has been met. **Note:** The Deductible will apply to certain services as defined below.	$250 per member/ $500 per family per calendar year Any deductible paid during the last three months of the benefit year will not be carried over into the new benefit year.
Fixed Dollar Copays	$5 for allergy injections $20 for office visits and medical online visits $50 for urgent care $200 for emergency room visits $25 for ambulance transport
Coinsurance	25% for inpatient services/outpatient surgery 50% for select services as noted below
Out of Pocket Maximum - applies to deductibles, copays and coinsurance amounts for all covered services	$1,500 per member/$3,000 per family per calendar year

Preventive services

Benefits	
Health Maintenance Exam	100%
Annual Gynecological Exam	100%
Pap Smear Screening	100%
Well-Baby and Well-Child Visits	100%
Immunizations	100%
Prostate Specific Antigen (PSA) Screening	100%
Routine Colonoscopy	100%

Mammography Screening - including 3D	100%
Breast Pumps (DME guidelines apply.)	100%
Maternity Prenatal and Postnatal care	100%

Physician office services

Benefits	
PCP Office Visits - applicable cost-sharing applies when other services are received in the office	$20 copay
Medical Online Visits - when performed by a BCN participating provider or BCN designated online vendor **Note:** Not all services delivered virtually are considered an online visit but may be considered telemedicine. Telemedicine services will be subject to the applicable cost share associated with the service provided.	$20 copay
Referral Physician Visits - when referred for other than preventive services. Applicable cost-sharing applies when other services are received in the office	$20 copay

Emergency medical care

Benefits	
Hospital Emergency Room - copay waived if admitted as inpatient	$200 copay
Urgent Care Center	$50 copay
Retail Health Clinic	$50 copay
Ambulance Services - medically necessary	$25 copay after deductible

Diagnostic services

Benefits	
Laboratory and Pathology Tests	100%
Diagnostic Tests and X-rays	100% after deductible
High Technology Radiology Imaging (MRI, MRA, CAT, PET)	100% after deductible
Radiation Therapy	100% after deductible

Maternity services provided by a physician

Benefits	
Prenatal and Postnatal Care	100%
Delivery and Nursery Care	100% after deductible for professional services (see "Hospital Care" for facility charges)

Hospital care

Benefits	
General Nursing Care, Hospital Services and Supplies	75% after deductible
Outpatient Surgery - includes all related surgical services and anesthesia	75% after deductible

Alternatives to hospital care

Benefits	
Skilled Nursing Care	100% after deductible Limited to 45 days per member per calendar year
Hospice Care	100% after deductible
Home Health Care	$20 copay after deductible

Surgical services

Benefits	
Surgery - includes all related surgical services and anesthesia	See "Hospital Care" for inpatient and outpatient cost sharing
Adult Sterilization	Not covered
Abortion	Not covered
Human Organ Transplants	Hospital and professional cost sharing applies
Weight Reduction Procedures - Limited to one procedure per lifetime.	50% after deductible
Reduction Mammoplasty	50% after deductible
Male Mastectomy	50% after deductible
Temporomandibular Joint Syndrome	50% after deductible
Orthognathic Surgery	50% after deductible

Behavioral health services (mental health and substance use disorder treatment)

Benefits	
Inpatient Mental Health Care	75% after deductible
Residential Substance Use Disorder	75% after deductible
Outpatient Mental Health Care - includes online visits	$20 copay
Outpatient Substance Use Disorder	$20 copay
*Spring Health: Mental Health Visits Virtual or In-person visits rendered by a Spring Health Provider Services after 6 Trinity Health sponsored visits	$0 copay visits 1 -6 $20 copay per visit for visit 7 and thereafter
*Spring Health: Substance Use Disorder Virtual visits rendered by a Spring Health provider	$20 copay
Note:	*Spring Health is not a BCN provider and contracts separately with Trinity Health

Autism spectrum disorders, diagnoses and treatment

Benefits	
Applied behavioral analysis (ABA) treatment **Note:** Prior to seeking ABA treatment, the member must be evaluated by an interdisciplinary team including, but not limited to, a physician, behavioral health specialist, and a speech and language specialist for the services to be authorized. This interdisciplinary evaluation can be performed at an approved autism evaluation center (AAEC)	$20 copay
Outpatient physical therapy, speech therapy, occupational therapy, and nutritional counseling for autism spectrum disorder. Unlimited visits for PT/OT/ST with autism spectrum disorder diagnosis.	$20 copay after deductible

Other covered services, including mental health services, for autism spectrum disorder	See your outpatient mental health benefit and medical office visit benefit

Other services

Benefits	
Allergy Testing and Therapy	50% after deductible
Allergy Injections	$5 copay
Chiropractic Spinal Manipulation - when referred	$20 copay after deductible Unlimited visits
Rehabilitative Outpatient Physical, Speech and Occupational Therapy - subject to meaningful improvement within 60 days	$20 copay after deductible Limited to 60 visits for each therapy per medical episode per calendar year Note: Covered services for Behavioral Health or Substance Use Disorder do not contribute to the 60-visit maximum.
Habilitative Services	$20 copay after deductible Limited to 60 visits for each therapy per medical episode per calendar year Note: Covered services for Behavioral Health or Substance Use Disorder do not contribute to the 60-visit maximum.
Infertility Counseling and Treatment - excluding in-vitro fertilization	50% after deductible and; 50% for drugs dispensed through the pharmacy
Durable Medical Equipment - DME guidelines apply	50% Breast pumps covered 100% (when medically necessary)
Prosthetic and Orthotic Appliances	50%
Diabetic Supplies	50%

Prescription drugs

Benefits		
Retail 30-Day Supply	Generic Tier	$10 copay
	Preferred Brand Tier	20% coinsurance (min $30, max $100)
	Nonpreferred Brand Tier	40% coinsurance (min $60, max $150)
Retail 84 to 90-Day Supply	Generic Tier	$25 copay
	Preferred Brand Tier	20% coinsurance (min $75, max $250)
	Non-Preferred Brand Tier	40% coinsurance (min $150, max $375)
Mail Order 30-Day Supply	Generic Tier	$10 copay
	Preferred Brand Tier	20% coinsurance (min $30, max $100)
	Non-Preferred Brand Tier	40% coinsurance (min $60, max $150)
Mail Order 31 to 90-Day Supply	Generic Tier	$25 copay
	Non-Preferred Brand Tier	20% coinsurance (min $75, max $250)
	Preferred Brand Tier	40% coinsurance (min $150, max $375)

Custom Drug List	The list of prescription drugs that have been approved by the U.S. Food and Drug Administration and approved by the BCBSM/BCN Pharmacy and Therapeutics Committee. The list represents the clinical judgment of Michigan physicians, pharmacists and other experts in the diagnosis and treatment of disease and promotion of health. Medications are selected based on clinical effectiveness, safety and opportunity for cost savings. Some drugs included in the Custom Drug List require prior authorization and/or step therapy by BCN before they are covered. The drug list may be modified by BCN as needed to remove or add a covered drug or to modify the requirements for authorization of a covered drug. The list may be found at https://www.bcbsm.com/druglists

Note: Specialty Drugs are limited to a 30-day supply. Contraceptives and Drugs for Sexual Dysfunction are not covered.

Case Management/Disease Management

If you agree to participate, a BCN nurse case manager will administer an assessment and an individualized plan that includes condition and goals based on your assessment results.

For Internal Purposes Only
Benefits Selected - TMU25F : 1500MF,ACACCF,MOP25F,ONVPF,TRX25F,OVMPXF