FACULTY ADMIN HOURLY BLUE
A1LUP6
007013084
Community Blue℠ PPO ASC
Effective Date: On or after July 2024
Benefits-at-a-glance

This is intended as an easSC

Eligibility Information

Members	Eligibility Criteria
Dependents	¢ Subscriber's legal spouse ¢ **Dependent children:** related to you by birth, marriage, legal adoption or legal guardianship; eligible for coverage through the last day of the month the dependent turns age 26
No-fault automobile accidents, option 2	Excludes BCBSM from responsibility for any services related to an injury that is a direct or indirect result of a motor vehicle accident. This applies whether or not a member has no-fault motor vehicle insurance. However BCBSM will pay as primary on any motor vehicle accidents that occurs outside the United States.

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

Note: Member cost-sharing requirements are administered on a benefit year basis. Your benefit year begins on July 1 and ends the following year on June 30.

Benefits	In-network	Out-of-network
Deductible	$700 for one member, $1,400 for the family (when two or more members are covered under your contract) each benefit year **Note:** Deductible may be waived for covered services performed in an in-network physician's office and for covered mental health and substance use disorder services that are equivalent to an office visit and performed in an in-network physician's office.	$1,400 for one member, $2,800 for the family (when two or more members are covered under your contract) each benefit year **Note:** Out-of-network deductible amounts also count toward the in-network deductible.
Flat-dollar copays	¢ $25 copay for office visits and office consultations with a **primary care physician** ¢ $50 copay for office visits and office consultations with a **specialist** ¢ $10 copay for medical online visits ¢ $40 copay for chiropractic and osteopathic manipulative therapy ¢ $250 copay for emergency room visits ¢ $50 copay for ambulance services ¢ $50 copay for urgent care visits	¢ $250 copay for emergency room visits ¢ $50 copay for ambulance services
Coinsurance amounts (percent copays) **Note:** Coinsurance amounts apply once the deductible has been met.	¢ 30% of approved amount for private duty nursing care ¢ 20% of approved amount for mental health care and substance use disorder treatment ¢ 20% of approved amount for most other covered services (coinsurance waived for covered services performed in an in-network physician's office) ¢ 50% of approved amount for professional services for bariatric surgery	¢ 50% of approved amount for private duty nursing care ¢ 40% of approved amount for mental health care and substance use disorder treatment ¢ 40% of approved amount for most other covered services ¢ 50% of approved amount for professional services for bariatric surgery

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Services from a provider for which there is no Michigan PPO network and services from an out-of-network provider in a geographic area of Michigan deemed a "low access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.

Benefits	In-network	Out-of-network
Flexible sigmoidoscopy exam	100% (no deductible or copay/coinsurance), one per member per benefit year	

Emergency medical care

Benefits	In-network	Out-of-network
Hospital emergency room	Facility: $250 copay per visit (copay waived if admitted) Professional: 100% (no deductible or copay/coinsurance)	Facility: $250 copay per visit (copay waived if admitted) Professional: 100% (no deductible or copay/coinsurance)
Ambulance services - must be medically necessary	$50 copay per trip	$50 copay per trip

Diagnostic services

Benefits	In-network	Out-of-network
Laboratory and pathology services	80% after in-network deductible	60% after out-of-network deductible
Diagnostic tests and x-rays	80% after in-network deductible	60% after out-of-network deductible
Therapeutic radiology	80% after in-network deductible	60% after out-of-network deductible

Maternity services provided by a physician or certified nurse midwife

Benefits	In-network	Out-of-network
Prenatal care visits	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Postnatal care visit	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Delivery and nursery care	80% after in-network deductible	60% after out-of-network deductible

Hospital care

Benefits	In-network	Out-of-network
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies **Note:**		

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Other covered services

Benefits	In-network	Out-of-network
Outpatient Diabetes Management Program (ODMP) **Note:** Screening services required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. **Note:** When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.	¢ 80% after in-network deductible for diabetes medical supplies ¢ 100% (no deductible or copay/coinsurance) for diabetes self-management training	60% after out-of-network deductible
Allergy testing and therapy	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	$40 copay per visit	60% after out-of-network deductible
	Limited to a **combined** 24-visit maximum per member per benefit year	
Outpatient physical, speech and occupational therapy - provided for rehabilitation **Note:** Benefits are payable for professional and facility physical therapy for chronic conditions and pain management.	80% after in-network deductible	60% after out-of-network deductible **Note:** Services at nonparticipating outpatient physical therapy facilities are not covered.
	Limited to a **combined** 60-visit maximum per member, per benefit year	
Durable medical equipment **Note:** DME items required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. For a list of covered DME items required under PPACA, call BCBSM.	50% after in-network deductible	50% after in-network deductible
Prosthetic and orthotic appliances	50% after in-network deductible	50% after in-network deductible
Private duty nursing care	70% after in-network deductible	50% after out-of-network deductible
Prescription drugs	Not covered	Not covered

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