



**FACULTY ADMIN HOURLY BLUE
A1LUP6
007013084
Community BlueSM 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	<ul style="list-style-type: none"> € 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	<ul style="list-style-type: none"> € \$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 	<ul style="list-style-type: none"> € \$250 copay for emergency room visits € \$50 copay for ambulance services
Coinsurance amounts (percent copays)	<ul style="list-style-type: none"> € 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 	<ul style="list-style-type: none"> € 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
Note: Coinsurance amounts apply once the deductible has been met.		

ADM PLANYR JUL;ASC MOD10638;CB ASC;CB-AMB ASC;CB-ECMP-ASC;CB-ET \$250 ASC;CB-MTC \$40 ASC;CB-OPMIN 3K ASC;CB-OPMON 6K ASC;CB-OV \$25 ASC;CBC 20%-IN ASC;CBC 40%-ON ASC;CBD \$1K-ON ASC;CBD \$500-IN ASC;CBOLV 10 ASC;CCB ASC;DC 26-ME ASC;EHB-VCO-CRMK AS;JULY ASC;NFX-2 ASC;Rewards-ASC;XVA ASC

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association. 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	

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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
<p>Outpatient Diabetes Management Program (ODMP)</p> <p>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.</p> <p>Note: When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.</p>	<p>€ 80% after in-network deductible for diabetes medical supplies</p> <p>€ 100% (no deductible or copay/coinsurance) for diabetes self-management training</p>	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		
<p>Outpatient physical, speech and occupational therapy - provided for rehabilitation</p> <p>Note: Benefits are payable for professional and facility physical therapy for chronic conditions and pain management.</p>	80% after in-network deductible	60% after out-of-network deductible
Limited to a combined 60-visit maximum per member, per benefit year		
<p>Durable medical equipment</p> <p>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.</p>	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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