

# National BlueCard PPO Matrix

**Auburn University**

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BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
<b>INPATIENT HOSPITAL FACILITY SERVICES</b>		
<b>Deductibles and Copay</b>	\$100 per admission deductible.* No copay required.	\$100 per admission deductible.*
<b>Inpatient Facility Coverage (including maternity)</b>	Covered at 100% of the allowance for semi-private room and board, intensive care units, general nursing services and usual hospital ancillaries.  Note: In Alabama, inpatient benefits for non-member hospitals are available only in cases of accidental injury.	Covered at 80% of the allowance for semi-private room and board, intensive care units, general nursing services and usual hospital ancillaries.*
<b>Preadmission Certification</b>	All hospital admissions require preadmission certification, except maternity. Emergency admissions require certification within 48 hours of admission. For preadmission certification, call 1 800 248-2342 (toll-free). If preadmission certification is not obtained, no benefits are available.	
<b>Individual Case Management</b>	A program to assist employees and their families in coordinating care in the event of a lengthy illness. This includes a Care Management program for chronic conditions such as asthma, diabetes, coronary artery disease, congestive heart failure and chronic obstructive pulmonary disease.	
<b>Baby Yourself</b>	A prenatal wellness program. For more information, call 1 800 222-4379. You can also enroll online at <a href="http://BeHealthy.com">BeHealthy.com</a> .	
<b>OUTPATIENT HOSPITAL FACILITY SERVICES</b>		
<b>Surgery</b>	Covered at 100% of the allowance subject to the \$100 facility copay.*	Covered at 80% of the allowance, subject to the calendar year deductible.*
<b>Medical Emergency</b>	Covered at 100% of the allowance subject to the \$100 facility copay.*	Covered at 80% of the allowance, subject to the calendar year deductible.*
<b>Accidental Injury</b>	Covered at 100% of the allowance with no deductible or copay required.*	Covered at 100% of the allowance with no deductible or copay within 72 hours of the accident. Thereafter, covered at 80% of the allowance, subject to the calendar year deductible.*
<b>Diagnostic Lab, X-ray, and Pathology</b>	Covered at 100% of the allowance with no deductible or copay required.	Covered at 80% of the allowance, subject to the calendar year deductible.*
<b>Hemodialysis, IV Therapy Chemotherapy and Radiation Therapy</b>	Covered at 100% of the allowance with no deductible or copay required.	Covered at 80% of the allowance, subject to the calendar year deductible.*
<b>Note:</b> In Alabama, outpatient benefits for non-member hospitals are available <b>only</b> in cases of accidental injury.		
<b>PHYSICIAN SERVICES</b>		
<b>Office Visits and Outpatient Consultations</b>	Covered at 100% of the allowance subject to the \$25 office visit copay.*	Covered at 80% of the allowance, subject to the calendar year deductible.*
<b>Emergency Room Physician Fees</b>	Covered at 100% of the allowance subject to the \$25 office visit copay.*	Covered at 80% of the allowance, subject to the calendar year deductible.*
<b>Surgery and Anesthesia</b>	Covered at 100% of the allowance with no deductible or copay.	Covered at 80% of the allowance, subject to the calendar year deductible.*
<b>Inpatient Visits, Second Surgical Opinions and Inpatient Consultations</b>	Covered at 100% of the allowance with no deductible or copay.	Covered at 80% of the allowance, subject to the calendar year deductible.*
<b>Maternity</b>	Covered at 100% of the allowance with no deductible or copay.	Covered at 80% of the allowance, subject to the calendar year deductible.*
<b>Diagnostic X-rays and Lab Exams</b>	Covered at 100% of the allowance with no deductible or copay.	Covered at 80% of the allowance, subject to the calendar year deductible.*
<b>Cancer Treatment (Facility and Physician)</b>	Covered at 100% of the allowance with no deductible or copay.	Covered at 100% of the allowance with no deductible or copay.
<b>ENHANCED PREVENTIVE CARE SERVICES</b>		
<b>Inpatient Visits for Routine Newborn Care</b>	Covered at 100% of the allowance with no deductible or copay.	Not covered.
<b>Well Child Care Exams</b>	Covered at 100% of the allowance subject to the \$25 office visit copay. Includes 9 visits during the first two years of the child's life and one visit each year thereafter through age 6.	Not covered.

<b>BENEFIT</b>	<b>IN-NETWORK (PPO)</b>	<b>OUT-OF-NETWORK (NON-PPO)</b>
<b>Routine Immunizations</b> (Age limitations apply to certain immunizations)	Covered at 100% of the allowance with no deductible or copay.	Not covered.
<b>Routine Office Visit</b> One visit every two years age 7-34; one exam annually age 35 and over	Covered at 100% of the allowance subject to the \$25 office visit copay.	Not covered.
<b>Routine Physical</b> (One visit per calendar year)	Covered at 100% of the allowance subject to the \$25 office visit copay.	Not covered.
<b>Routine Pap Smears</b>	Covered at 100% of the allowance with no deductible or copay. Limited to one per year. Subject to the \$25 office visit copay if applicable.	Not covered.
<b>Routine Human Papillomavirus (HPV) Testing</b> One routine test every three calendar years for females ages 30 and over	Covered at 100%; no copay or deductible	Not covered
<b>Routine Mammograms</b>	Covered at 100% of the allowance with no deductible or copay. Limited to one exam for females age 35 and above. Subject to the \$25 office copay if applicable.	Not covered.
<b>Routine Prostate Specific Antigen</b>	Covered at 100% of the allowance with no deductible or copay. Limited to one per year for males age 40 and over. Subject to the \$25 office visit copay if applicable.	Not covered.
<b>Other Routine Screening</b> Limited to one urinalysis, CBC and TB skin testing, cholesterol testing (once every five years)	Covered at 100% of the allowance with no deductible or copay.	Not covered.
<b>Routine Colorectal Cancer Screening</b> Ages 50 and over <ul style="list-style-type: none"> <li>Hemocult stool check/fecal occult blood test each year</li> <li>Flexible sigmoidoscopy every three years</li> <li>Double-contrast barium enema every five years</li> <li>Colonoscopy every 10 years</li> </ul>	Covered at 100% of the allowance with no deductible or copay (outpatient hospital copay for surgery/diagnostic services may apply.)	Not covered.
<b>MENTAL HEALTH AND SUBSTANCE ABUSE</b>		
<b>Inpatient Facility Services</b>	Covered at 100% of the allowance subject to the inpatient per admission deductible. Covers up to 15 days per person each 12 consecutive months. After the 15 basic hospital days are used, coverage is available under Other Covered Services and are paid at 80% of the allowance subject to the calendar year deductible.	Covered at 80% of the allowance subject to the inpatient per admission deductible. Covers up to 15 days per person each 12 consecutive months After the 15 basic hospital days are used, coverage is available under Other Covered Services and are paid at 80% of the allowance subject to the calendar year deductible.*
	Note: In Alabama, inpatient benefits for non-member hospitals are available only in cases of accidental injury.	
<b>Inpatient Physician Services</b>	Covered at 80% of the allowance with no deductible or copay. Covers up to 15 days of inpatient treatment during any 12 consecutive months.	Covered at 80% of the allowance subject to the calendar year deductible. Covers up to 15 days of inpatient treatment during any 12 consecutive months.*
<b>Outpatient Physician Services</b>	Covered at 50% of the allowance subject to the calendar year deductible.	
<b>Participating Substance Abuse Facilities: Residential/ Outpatient or Residential/Outpatient Combined</b>	Covers up to 120 days each benefit period with no deductible or copay. A benefit period begins the day you receive substance abuse benefits and last for 12 consecutive months afterward. The second benefit period begins on the day you receive any more substance abuse benefits. Benefits are limited to 2 benefit periods per member in a lifetime.	
<b>OTHER COVERED SERVICES</b>		
<b>Calendar Year Deductible</b>	\$150 per person each calendar year; 3 member family maximum.	

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
<b>Annual Out-of-Pocket Maximum</b>	\$1,000 individual annual out-of-pocket maximum plus the \$150 calendar year deductible. Other Covered Services are the only expenses applicable to the annual out-of-pocket maximum.	
<b>Lifetime Maximum</b>	\$1,000,000 lifetime maximum for each covered member. Only the following services are applicable to the lifetime maximum: Other Covered Services, non-PPO Physician Services, non-PPO outpatient facility services (excluding care rendered within 72 hours), and physician services for the treatment of mental health and substance abuse services	
<b>Participating Chiropractor Services</b>	Covered at 80% of the allowance, subject to the calendar year deductible.	Covered at 80% of the allowance, subject to the calendar year deductible.  <b>Non-Participating in Alabama:</b> Covered at 50% of the allowance subject to the calendar year deductible when services are provided by a non-Participating Chiropractor.
<b>Durable Medical Equipment</b>	Covered at 80% of the allowance, subject to the calendar year deductible.	
<b>Ambulance Services</b>	Covered at 80% of the allowance, subject to the calendar year deductible.	
<b>Allergy Testing &amp; Treatment</b>	Covered at 80% of the allowance, subject to the calendar year deductible.	
<b>HOME HEALTH AND HOSPICE</b>		
<b>Preferred Home Health and Hospice</b>	Covered at 100% of the allowance with no deductible or copay. Precertification required for services rendered outside of Alabama. Call 1 800 821-7231.	Covered at 80% of the allowance subject to the calendar year deductible. Precertification required. Call 1 800 821-7231. <b>Non-Preferred in Alabama:</b> No benefits are available if a non-Preferred provider is used.
	Covered PPO and non-PPO expenses for Preferred Home Health Care and covered non-PPO expenses for Preferred Hospice Care apply toward the annual out-of-pocket and lifetime maximums.	
<b>PRESCRIPTION DRUGS</b>		
<b>Prescription Drug Program</b>  <ul style="list-style-type: none"> <li>▪ Non-maintenance – up to 34 day supply at retail</li> <li>▪ Maintenance- first fill is limited to a 30 day supply. Subsequent fills up to 90 day supply for two copays</li> </ul>	<b>Participating Pharmacy:</b> Prescription drugs will be covered at 100% of the allowance after the following copays.  <b>Generic Drugs:</b> \$10 copay per prescription  <b>Preferred Brand Name Drugs:</b> \$25 copay per prescription  <b>Other Brand Name Drugs:</b> \$40 copay per prescription	<b>Non-Participating Pharmacy in Alabama:</b> No benefits are available for prescriptions purchased in a non-Participating Pharmacy in Alabama.  <b>Non-Participating Pharmacy Outside Alabama:</b> Covered at 100% of the allowance subject to the in-network copays. In addition, the member will be responsible for any difference between the allowance and the actual billed charge.

\*These services do not apply to the out-of-pocket maximums.

**Please note:** Providers/Specialists may be listed in a PPO directory or on the provider finder web site ([www.bcbs.com](http://www.bcbs.com)), but not covered as PPO benefits by this group health plan (i.e., DME, Ambulance, Allergists). Please check your benefit matrix or Benefit Booklet to determine coverage. **This is not a contract. Benefits are subject to the terms, limitations and conditions of the group contract.**