HIGHMARK
An Independent Licensee of the Blue Cross and Blue Shield Association

Basic PPO – Pennsylvania Employees Benefit Trust Fund
Active Members

	Network Providers	Out of Network Providers *
DEDUCTIBLE (per calendar year) Annual in-network deductible must be paid first for the following services: Imaging, hospital expenses (inpatient and outpatient) and medical/surgical expenses including physician services (except office visits), skilled nursing facility care and home health care.	$1,500 single $3,000 family	$3,000 single $6,000 family
MEDICAL OUT-OF-POCKET MAXIMUM (per calendar year)	$1,500 single $3,000 family Plus copayments	Deductible $3,000 single / $6,000 family 30% coinsurance of the next $16,079 single/ $32,158 family after which the plan pays at 100%
COMBINED OUT-OF-POCKET MAXIMUM (per calendar year) When the Out-of-Pocket Maximum is reached, the PPO pays at 100% until the end of the benefit period.	$9,200 single $18,400 family ***Includes costs for medical, mental health and substance abuse benefits and prescription drug costs (cost difference between brand and generic does not apply).*** Includes deductibles, coinsurance, copayments and any other expenditure required of an individual which is a qualified medical expense for the essential health benefits.	$9,200 single $18,400 family ***Includes costs for medical, mental health and substance abuse benefits and prescription drug costs (cost difference between brand and generic does not apply).*** Includes deductibles, coinsurance, copayments and any other expenditure required of an individual which is a qualified medical expense for the essential health benefits. This does not include balance billing amounts for out-of-network providers but it does include out-of-network cost sharing.

	Network Providers	Out-of-Network Providers *
PREVENTIVE CARE		
• See the PEBTF Summary Plan Description (SPD) for a list of preventive benefits	Covered 100%	70% plan payment; Member pays 30% If not available in-network, full cost shall be covered without any cost sharing
MATERNITY SERVICES		
• Office visits	Covered 100% including first prenatal visit	70% plan payment; Member pays 30%
• Hospital and newborn care	Covered 100% after Deductible	70% plan payment; Member pays 30%
PHYSICIAN VISITS		
• Office visits (family practice, general practice, internal medicine and pediatrics)	$20 Copayment per office visit	70% plan payment; Member pays 30%
• Specialist office visits	$45 Copayment per office visit	70% plan payment; Member pays 30%
• Diagnostic tests (imaging, X-ray, MRI, etc.), inpatient visits, surgery and anesthesia	Covered 100% after Deductible	70% plan payment; Member pays 30%
• Diagnostic tests (lab)	Covered 100% at Quest Diagnostics or Labcorp; $30 Copayment elsewhere	70% plan payment; Member pays 30%
OUTPATIENT THERAPIES		
• Outpatient physical & occupational therapy • Speech therapy (due to a medical diagnosis or for the diagnosis of Autism Spectrum Disorders, not for developmental) • Cardiac rehabilitation (18 visits per year) • Pulmonary rehabilitation (12 visits per year) • Respiratory therapy • Manipulation therapy (restorative, chiropractic – 6 Medically Necessary visits, then Treatment Plan submitted; not for maintenance of a condition)	$20 Copayment per visit	70% plan payment; Member pays 30%
OTHER PROVIDER SERVICES		
• Radiation therapy, chemotherapy, kidney dialysis (not covered at a Non-Network freestanding dialysis center) • Home Health Care • Outpatient Private Duty Nursing (240 hours per year/8 hours per day) • Skilled Nursing Facility (240 days per year)	Covered 100% after Deductible	70% plan payment; Member pays 30%
• Hospice (outpatient)	Covered 100%	70% plan payment; Member pays 30%
• Hospice (inpatient)	Covered 100% (365 days per admission)	Not covered
OUTPATIENT HOSPITAL FACILITIES		
• Professional fees & facility services, including: lab, X-rays, pre-admission tests, radiation therapy, chemotherapy, kidney dialysis (not covered if provided in a Non-Network freestanding dialysis center – is covered at a Non-Network rate if it is a Non-Network hospital), anesthesia & surgery	Covered 100% after Deductible	70% plan payment; Member pays 30%
• Outpatient Diabetic Education	Covered 100%	Not covered

	Network Providers	Out-of-Network Providers *
INPATIENT HOSPITAL SERVICES		
• Professional fees & facility services including: room & board & other Covered Services (preauthorization is required for most services)	Covered 100% after Deductible (365 days per benefit period)	70% plan payment; Member pays 30% Non-Network: 70 days per calendar year
EMERGENCY CARE		
• Urgent care	$50 Copayment	70% plan payment; Member pays 30%
• Emergency treatment for accident or medical emergency	$200 emergency room Copayment (waived if the visit leads to an inpatient admission to the hospital); Deductible waived	
• Ambulance services for emergency care	Covered 100%; Deductible waived	Covered 100%; Deductible waived
DURABLE MEDICAL EQUIPMENT		
• Rental or purchase of durable medical equipment, supplies, prosthetics & orthotics, in accordance with the medical plan's DME policy	Covered 100% if obtained by a Network supplier; Deductible waived **NOTE**: Equipment or supplies dispensed in a physician's office or emergency room setting, provided as part of Home Health Care, Skilled Nursing Facility care or Hospice services; or as part of covered dialysis and home dialysis will be paid by your PPO at 100% after Deductible, if it is billed by the Provider and not by a DME supplier. Your Provider may dispense the equipment and will bill your PPO. For example, if you receive a knee brace or crutches at the emergency room, it is paid at 100% after Deductible. If your doctor writes a prescription for a DME item, you should obtain it from a Network supplier to get the highest level of benefits.	70% plan payment; Member pays 30%; Deductible waived if obtained by an out-of-network supplier
LIFETIME MAXIMUM BENEFIT	Unlimited	Unlimited

- *In Network Providers agree to accept the PPO Plan Allowance as payment in full, often less than their normal charge. If you visit an out of network provider, you are responsible for paying the Deductible, coinsurance and the difference between the Provider's charges and the Plan Allowance. However, the following covered services when received from an out of network provider will be provided at the In Network level of benefits and you will not be responsible for such difference:*

1. Emergency care services; and
2. Ambulance services, when provided in conjunction with emergency care services or when provided by air.

Additionally, in very limited circumstances, you may not be liable for charges for non-emergency covered services received from certain professional providers or ancillary providers who are out of network. A network facility provider may have an arrangement with a professional provider or ancillary provider who is not part of the network to render certain items and professional services (such as, but not limited to, equipment, devices, anesthesiology, radiology, or pathology services) to patients of the network facility provider. The selection of such professional providers or ancillary providers may be beyond your control. In that situation, you will not be liable, except for applicable network deductible, copayment, or coinsurance obligations, for the charges of the professional provider or ancillary provider.

NOTE: All benefits are limited to Covered Services that are determined by the PPO to be Medically Necessary.

This means services or supplies that a provider, exercising prudent judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- in accordance with generally accepted standards of medical practice; and
- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
- not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

Highmark reserves the right, utilizing the criteria set forth in this definition, to render the final determination as to whether a service or supply is medically necessary and appropriate. No benefits will be provided unless Highmark determines that the service or supply is medically necessary and appropriate.

Benefits provided by the following non-participating inpatient and outpatient providers are not covered: ambulatory surgical facilities, freestanding dialysis facilities, long-term acute care hospitals, pharmacy/medical suppliers and substance abuse treatment programs.

Healthcare Management Services (HMS) is responsible for ensuring that quality care is delivered to members within the proper setting, at the appropriate cost and with the right outcome.

All authorizations are handled by health care providers working directly with Highmark Blue Shield.

The following services require preauthorization regardless of whether they are performed as inpatient or outpatient:

- All non-emergency inpatient admissions, including acute care, long-term acute care, skilled nursing facilities, and rehabilitation hospitals. Emergency admissions require notification within 48 hours.
- Non-emergency air and ground ambulance transports.

- Any reconstructive surgery for the treatment of a medical disease, injury, accident or congenital anomaly.
- Outpatient rehabilitation therapies including physical therapy, occupational therapy, speech therapy, respiratory therapy and manipulation therapy. The completion of a treatment plan is required for outpatient rehabilitation therapies to be covered beyond the initial six (6) visits.
- Home Health Care - a treatment plan must be submitted for review and preauthorization following the first two (2) Home Health Care visits.
- Home infusion therapy - requires preauthorization after the second day of service.
- Transplant evaluation and services - preauthorization will include referral assistance to the Blue Quality Centers for Transplant network if appropriate.
- Non-Emergency high technology radiology services including magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), computed tomography (CT) scanning, positron emission tomography (PET) scanning and cardiac nuclear imaging.