# Basic PPO – Pennsylvania Employees Benefit Trust Fund
# Active Members

| | Network Providers | Out of Network Providers * |
|---|---|---|
| **DEDUCTIBLE (per calendar year)**<br>Annual in-network deductible must be paid first for the following services: Diagnostic tests (labs) if not done at a Quest Diagnostics or LabCorp, imaging, hospital expenses (inpatient and outpatient) and medical/surgical expenses including physician services (except office visits), skilled nursing facility care and home health care. | $1,000 single<br>$2,000 family | $2,000 single<br>$4,000 family |
| **MEDICAL OUT-OF-POCKET MAXIMUM (per calendar year)** | $1,000 single<br>$2,000 family<br><br>Plus copayments | Deductible $2,000 single / $4,000 family<br><br>30% coinsurance of the next $10,000 single/ $20,000 family after which the plan pays at 100% |
| **COMBINED OUT-OF-POCKET MAXIMUM (per calendar year)**<br>When the Out-of-Pocket Maximum is reached, the PPO pays at 100% until the end of the benefit period. | $7,150 single<br>$14,300 family<br><br>***Includes costs for medical, mental health and substance abuse benefits and prescription drug costs (cost difference between brand and generic does not apply).***<br><br>Includes deductibles, coinsurance, copayments and any other expenditure required of an individual which is a qualified medical expense for the essential health benefits. | $7,150 single<br>$14,300 family<br><br>***Includes costs for medical, mental health and substance abuse benefits and prescription drug costs (cost difference between brand and generic does not apply).***<br><br>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 non-network providers but it does include out-of-network cost sharing. |

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| **PREVENTIVE CARE** | | |
| • See the PEBTF SPD for a list of preventive benefits | Covered 100% | 70% plan payment; Member pays 30% |
| **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 | $40 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; 100% after Deductible elsewhere | |
| **OUTPATIENT THERAPIES** | | |
| • Outpatient physical & occupational therapy<br>• Speech therapy (due to a medical diagnosis or for the diagnosis of Autism Spectrum Disorders, not for developmental)<br>• Cardiac rehabilitation (18 visits per year)<br>• Pulmonary rehabilitation (12 visits per year)<br>• Respiratory therapy<br>• 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)<br>• Home Health Care<br>• Outpatient Private Duty Nursing (240 hours per year/8 hours per day)<br>• Skilled Nursing Facility (240 days per year) | Covered 100% after Deductible | 70% plan payment; Member pays 30% |
| • Hospice | Covered 100% | 70% plan payment; Member pays 30% |
| **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 |

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|---|---|---|
| **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%<br><br>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 | $150 emergency room Copayment (waived if the visit leads to an inpatient admission to the hospital); Deductible waived | |
| • Ambulance services for emergency care | Covered 100% | Covered in full; Deductible waived |
| **INVISIBLE PROVIDERS AT A NETWORK FACILITY** | | |
| • Includes radiologists, anesthesiologists, pathologists and emergency room physicians operating in a Network facility | Covered same as Network Provider; Covered 100% after Deductible | |
| **DURABLE MEDICAL EQUIPMENT** | | |
| • Rental or purchase of durable medical equipment, supplies, prosthetics & orthotics. The Plan follows Medicare guidelines for the coverage of DME, prosthetics, orthotics and supplies | Not covered by the medical plan; covered by DMEnsion Benefit Management, in accordance with the PEBTF DME policy unless dispensed and billed by a physician's office, emergency room, home health care agency, home infusion provider, skilled nursing facility or Hospice and/or participating freestanding dialysis facility | |
| **LIFETIME MAXIMUM BENEFIT** | Unlimited | Unlimited |

* Participating Providers agree to accept the PPO Plan Allowance as payment in full, often less than their normal charge. If you visit a Non-Participating Provider, you are responsible for paying the Deductible, coinsurance and the difference between the Provider's charges and the Plan Allowance.

**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.