

Pennsylvania Public School  
Employees' Retirement System (PSERS)

# Health Options Program

# 2024



Managed Care Plans for  
Medicare-Eligible and  
Non-Medicare-Eligible  
Members

## Southeast

PENNSYLVANIA

Bucks • Chester • Delaware • Montgomery • Philadelphia



## 2024 Monthly Costs if You Are Eligible for Medicare *(Excluding Premium Assistance)*

	SINGLE COVERAGE	2-PERSON COVERAGE
Highmark Freedom Blue PPO	\$335	\$670
Capital Blue Cross PPO	\$257	\$514
Aetna Medicare P01 PPO	\$482	\$964
UPMC PSERS HOP Custom PPO	\$247	\$494
Independence Blue Cross Personal Choice 65 PPO	\$307	\$614

## 2024 Monthly Costs if You Are NOT Eligible for Medicare *(Excluding Premium Assistance)*

	SINGLE COVERAGE	2-PERSON COVERAGE
Highmark PPOBlue (80-70 Plan)	\$2,017	\$4,034
Capital Blue Cross PPO	\$1,697	\$3,394
Aetna Premier Open Choice PPO	\$2,112	\$4,224
UPMC Business Advantage	\$1,823	\$3,646
Independence Blue Cross POS \$20-\$40/\$250	\$3,153	\$6,306

# 2024 Plan Options if You Are Eligible for Medicare

HOW MUCH YOU WILL PAY IN 2024	HIGHMARK FREEDOM BLUE PPO	
MEDICAL PLAN	In-Network	Out-of-Network
Annual Deductible	\$0	\$0
Annual Out-of-Pocket Maximum	\$1,000 (combined)	
Hospitalization	\$0	\$0
Doctor Visits	\$5 PCP; \$15 specialist	\$5 PCP; \$15 specialist
Preventive Care	\$0	\$0
Emergency Room	\$40 (waived if admitted)	\$40 (waived if admitted)
Urgent Care Facility	\$25	\$25
Outpatient Surgery	\$0	\$0
Diagnostic Testing	\$0	\$0
Outpatient Therapy	\$15	\$15
Durable Medical Equipment	15%	20%
Outpatient Mental Health	\$15	\$15
Inpatient Mental Health	\$0	\$0
Physical Exams	\$0 (office visit copay may apply)	\$0 (office visit copay may apply)
Ob/Gyn Exams	\$0 (office visit copay may apply)	\$0 (office visit copay may apply)
Mammograms	\$0	\$0
Skilled Nursing Facility	\$0 up to 100 days per Medicare Benefit Period	\$0 up to 100 days per Medicare Benefit Period
Hearing Aids (once every 12 months)	Per year \$499 copay per aid for TruHearing Advanced; \$799 per aid for TruHearing Premium; \$500 allowance per year for other aids through TruHearing	\$500 allowance for hearing aids every three years from any other provider or TruHearing
Dental Care (subject to frequency limitations)	\$20 for exam & cleaning and \$20 for X-rays every 6 months; 50% for restorative services and dentures	50% for periodic exams, cleanings, X-rays, fillings as needed and dentures
Vision Exam/Hearing Exams	\$0 vision; \$15 hearing	\$50 vision; \$15 hearing
Prescription Lenses (once every 12 months)	\$150 benefit maximum per calendar year for standard eyeglass frames, eyeglass lenses or contact lenses; Davis Vision Fashion Collection frames and standard lenses covered in full	\$150 benefit maximum per calendar year for standard eyeglass frames, eyeglass lenses or contact lenses; Davis Vision Fashion Collection frames and standard lenses covered in full
PRESCRIPTION DRUGS	Retail Pharmacy (31-day supply)	Mail Order*
Annual Deductible	\$0	\$0
<b>Initial Coverage Up to a Total Drug Cost of \$5,030</b>		
Preferred generic drugs (Tier 1)	\$5 preferred pharmacy; \$10 standard pharmacy	\$12.50 preferred pharmacy; \$25 standard pharmacy
Non-preferred generic drugs (Tier 2)	\$5 preferred pharmacy; \$10 standard pharmacy	\$12.50 preferred pharmacy; \$25 standard pharmacy
Preferred brand-name drugs (Tier 3)	\$25 preferred pharmacy; \$30 standard pharmacy	\$62.50 preferred pharmacy; \$75 standard pharmacy
Non-preferred brand-name drugs (Tier 4)	\$55 preferred pharmacy; \$60 standard pharmacy	\$137.50 preferred pharmacy; \$150 standard pharmacy
Specialty drugs (Tier 5)	33%	33% (31-day supply)
<b>Coverage Gap to TrOOP Maximum of \$8,000</b>		
Generic drugs (Tiers 1 & 2)	\$5 preferred pharmacy; \$10 standard pharmacy	\$12.50 preferred pharmacy; \$25 standard pharmacy
Brand-name drugs (Tiers 3 & 4)	Preferred Pharmacy: 20% (plan pays 10% and manufacturer discounts 70%) Standard Pharmacy: 25% (plan pays 5% and manufacturer discounts 70%)	Preferred Pharmacy: 20% (plan pays 10% and manufacturer discounts 70%) Standard Pharmacy: 25% (plan pays 5% and manufacturer discounts 70%)
Specialty drugs (Tier 5)	25% (plan pays 5% and manufacturer discounts 70%)	25% (31-day supply)
<b>Catastrophic Coverage</b>		
Generic drugs		\$0
Brand-name drugs		\$0

\* Must obtain mail order supply using Express Scripts/ESI. In Initial Coverage and the Coverage Gap: 100-day supply for Tier 1 and Tier 2 drugs; 90-day supply for Tier 3 and Tier 4 drugs.

HOW MUCH YOU WILL PAY IN 2024	CAPITAL BLUE CROSS PPO	
MEDICAL PLAN	In-Network	Out-of-Network
Annual Deductible	\$0	\$0
Annual Out-of-Pocket Maximum	\$3,400 combined	
Hospitalization	\$0	\$0
Doctor Visits	\$5 PCP; \$15 specialist	\$5 PCP; \$15 specialist
Preventive Care	\$0	\$0
Emergency Room	\$50 (waived if admitted)	\$50 (waived if admitted)
Urgent Care Facility	\$35	\$35
Outpatient Surgery	\$0	20%
Diagnostic Testing	\$0 - \$10 lab services; \$0 - \$25 high-tech imaging; 15% therapeutic radiology; all other \$0	\$0 - \$10 lab services; \$0 - \$25 high-tech imaging; 15% therapeutic radiology, \$0 all other
Outpatient Therapy	\$15	\$15
Durable Medical Equipment	20%	20%
Outpatient Mental Health	\$15	\$15
Inpatient Mental Health	\$0	\$0
Physical Exams	\$0 (annual wellness exam)	\$0 (annual wellness exam)
Ob/Gyn Exams	\$0 preventive screenings	\$0 preventive screenings
Mammograms	\$0 preventive screenings	\$0 preventive screenings
Skilled Nursing Facility	\$0 days 1-20; \$25 days 21-100	20% days 1-100
Hearing Aids (once every 12 months)	\$150 allowance for OTC hearing aids; 100% after \$500 allowance (in and out-of-network combined)	\$150 allowance for OTC hearing aids; 100% after \$500 allowance (in and out-of-network combined)
Dental Care	\$15 office visit, cleaning and X-rays covered twice per year; \$1,500 max per calendar year (in- and out-of-network combined)	50% office visit, cleaning and X-rays covered twice per year; \$1,500 max per calendar year (in- and out-of-network combined)
Vision Exam/Hearing Exams (once every calendar year)	Vision: \$20 for routine vision exam Hearing: \$0 for routine hearing exam	50%
Prescription Lenses (once every 12 months)	100% after \$150 allowance for frames and lenses or contacts	
PRESCRIPTION DRUGS	Retail Pharmacy (30-day supply)	Mail Order (90-day supply)
Annual Deductible	\$0	\$0
<b>Initial Coverage Up to a Total Drug Cost of \$5,030</b>		
Preferred generic drugs (Tier 1)	\$4	\$12
Non-preferred generic drugs (Tier 2)	\$4	\$12
Preferred brand-name drugs (Tier 3)	\$30	\$90
Non-preferred brand-name drugs (Tier 4)	\$75	\$225
Specialty drugs (Tier 5)	33%	33% (30-day supply)
<b>Coverage Gap to TrOOP Maximum of \$8,000</b>		
Generic drugs (Tiers 1 & 2)	25%	25%
Brand-name drugs (Tiers 3 & 4)	25% (plan pays 5% and manufacturer discounts 70%)	
Specialty drugs (Tier 5)	25% (plan pays 5% and manufacturer discounts 70%); limited to a 30-day supply	
<b>Catastrophic Coverage</b>		
Generic drugs	\$0	
Brand-name drugs	\$0	

HOW MUCH YOU WILL PAY IN 2024	AETNA MEDICARE P01 PPO*	
MEDICAL PLAN	In-Network	Out-of-Network
Annual Deductible	\$0	\$0
Annual Out-of-Pocket Maximum	\$3,500	\$5,000
Hospitalization	\$0	15%
Doctor Visits	\$15	15%
Preventive Care	\$0	15%
Emergency Room	\$50 (waived if admitted)	\$50 (waived if admitted)
Urgent Care Facility	\$15	\$15
Outpatient Surgery	\$0	15%
Diagnostic Testing	\$15	15%
Outpatient Therapy	\$15	15%
Durable Medical Equipment	15%	15%
Outpatient Mental Health	\$15	15%
Inpatient Mental Health	\$0	15%
Physical Exams	\$0	15%
Ob/Gyn Exams	\$0	15%
Mammograms	\$0	15%
Skilled Nursing Facility	\$0 copay per day, day(s) 1-20; \$75 per day, day(s) 21-100	15%
Hearing Aids	\$500 allowance once every 36 months	
Dental Care	\$15 (if covered by Medicare)	15% (if covered by Medicare)
Vision Exam/Hearing Exams	\$0 (once every 12 months)	15% (once every 12 months)
Prescription Lenses (once every 24 months)	\$100 allowance	
PRESCRIPTION DRUGS	Retail Pharmacy (30-day supply)	Mail Order (90-day supply)
Annual Deductible	\$0	\$0
<b>Initial Coverage Up to a Total Drug Cost of \$5,030</b>		
Generic drugs (Tier 1)	\$4 preferred pharmacy; \$5 standard pharmacy	\$8 preferred pharmacy; \$10 standard pharmacy
Preferred brand-name drugs (Tier 2)	\$25**	\$50**
Non-preferred brand-name drugs (Tier 3)	\$50**	\$100**
Specialty drugs (Tier 4)	33%**	33%** (limited to one-month supply)
<b>Coverage Gap to TrOOP Maximum of \$8,000</b>		
Generic drugs (Tier 1)	\$4 preferred pharmacy; \$5 standard pharmacy	\$8 preferred pharmacy; \$10 standard pharmacy
Brand-name drugs (Tiers 2 & 3)	25%** (plan pays 5% and manufacturer discounts 70%)	
Specialty drugs (Tier 4)	25%** (limited to one-month supply; plan pays 5% and manufacturer discounts 70%)	
Catastrophic Coverage		
Generic drugs	\$0	
Brand-name drugs	\$0	

\* Aetna is only available in Pennsylvania, New Jersey, and some counties in Florida, Maryland, New York, and Delaware.

\*\* Includes some high-cost generics.

HOW MUCH YOU WILL PAY IN 2024	UPMC PSERS HOP CUSTOM PPO*	
MEDICAL PLAN	In-Network	Out-of-Network
Annual Deductible	\$0	\$500
Annual Out-of-Pocket Maximum	\$3,400	\$5,100
Hospitalization	\$0	20%
Doctor Visits	\$0 PCP; \$20 specialist	20%
Preventive Care	\$0	20%, no deductible
Emergency Room	\$120 (waived if admitted within 3 days)	\$120 (waived if admitted within 3 days), no deductible
Urgent Care Facility	\$20	\$20 copay, no deductible
Outpatient Surgery	\$0	20%
Diagnostic Testing	\$0 labs; \$10 X-rays; \$30 advanced imaging	20%
Outpatient Therapy	\$20	20%
Durable Medical Equipment	15%	50%
Outpatient Mental Health	\$20	20%
Inpatient Mental Health	\$0	20%
Physical Exams	\$0 Annual Wellness Exams; Annual physical exams - not covered	20% Annual Wellness Exams, no deductible; Annual physical exams - not covered
Ob/Gyn Exams	\$0 routine	20%, no deductible
Mammograms	\$0 routine	20%, no deductible
Skilled Nursing Facility	\$0 per day days 1-15; \$50 per day days 16-100	20%
Hearing Aids (once every 12 months)	\$690 - \$1,890	\$690 - \$1,890, no deductible
Dental Care	Dental exams: \$20	Dental exams: 50%, no deductible
Vision Exam/Hearing Exams (once every year)	\$0 routine vision; \$20 routine hearing	\$50 routine vision, no deductible; 50% routine hearing, no deductible
Prescription Lenses (once every 12 months)	\$175 allowance (combined in- and out-of-network)	
PRESCRIPTION DRUGS	Retail Pharmacy (30-day supply)	Retail/Mail Order (100-day supply)
Annual Deductible	\$0	\$0
<b>Initial Coverage Up to a Total Drug Cost of \$5,030</b>		
Preferred generic drugs (Tier 1)	\$0 preferred pharmacy; \$15 standard pharmacy	\$0 preferred pharmacy; \$30 standard pharmacy
Non-preferred generic drugs (Tier 2)	\$10 preferred pharmacy; \$20 standard pharmacy	\$20 preferred pharmacy; \$40 standard pharmacy
Preferred brand-name drugs (Tier 3)	\$47 preferred or standard pharmacy	\$117.50 preferred pharmacy; \$141 standard pharmacy
Non-preferred drugs (Tier 4)	\$100 preferred or standard pharmacy	\$300 preferred or standard pharmacy
Specialty drugs (Tier 5)	33% preferred or standard pharmacy	33% preferred or standard pharmacy (limited to a 30-day supply)
<b>Coverage Gap to TrOOP Maximum of \$8,000</b>		
Preferred generic drugs (Tier 1)	\$0 preferred pharmacy; \$15 standard pharmacy	\$0 preferred pharmacy; \$30 standard pharmacy
Non-preferred generic drugs (Tier 2)	\$10 preferred pharmacy; \$20 standard pharmacy	\$20 preferred pharmacy; \$40 standard pharmacy
Brand-name drugs (Tiers 3 & 4)	25% (plan pays 5% and manufacturer discounts 70%)	
Specialty drugs (Tier 5)	25% (plan pays 5% and manufacturer discounts 70%)	
Catastrophic Coverage		
Generic drugs	\$0	
Brand-name drugs	\$0	

\* UPMC is available in all South East, South West Pennsylvania counties and some North Central Pennsylvania counties.

<b>HOW MUCH YOU WILL PAY IN 2024</b>	<b>INDEPENDENCE BLUE CROSS–PERSONAL CHOICE 65 PPO</b>	
<b>MEDICAL PLAN</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Annual Deductible	\$0	\$0
Annual Out-of-Pocket Maximum	\$3,400	\$10,000 (in- and out-of-network combined)
Hospitalization	\$50/stay (days 1–6)	30%
Doctor Visits	\$0 PCP; \$15 specialist	30%
Preventive Care	\$0	30%
Emergency Room	\$90 (waived if admitted)	\$90 (waived if admitted)
Urgent Care Facility	\$40	\$40
Outpatient Surgery	\$75	30%
Diagnostic Testing	\$0	30%
Outpatient Therapy	\$15; \$5 pulmonary/cardiac rehab	30%
Durable Medical Equipment	20%; \$0 diabetic supplies	30%
Outpatient Mental Health	\$15	30%
Inpatient Mental Health (190-day combined lifetime max)	\$50/stay (days 1-6); 190-day lifetime max in a Medicare-approved facility	30%
Physical Exams	\$0	30%
Ob/Gyn Exams	\$0 (routine every two years)	30%
Mammograms	\$0	30%
Skilled Nursing Facility	\$0 days 1-20; \$188 days 21-100	30%
Hearing Aids (once every 12 months)	\$0 after annual \$499 copay per aid for TruHearing Advanced; \$799 per aid for TruHearing Premium	\$0 after annual \$499 copay per aid for TruHearing Advanced; \$799 per aid for TruHearing Premium
Dental Care	Not covered	Not covered
Vision Exam/Hearing Exams	\$15	30%
Prescription Lenses (once every 24 months)	\$0 for standard lenses and frames or contacts; 100% after \$100 allowance for nonstandard frames and specialty contacts	30%
<b>PRESCRIPTION DRUGS</b>	<b>Retail Pharmacy (30-day supply)</b>	<b>Mail Order (90-day supply)</b>
Annual Deductible	\$0	\$0
<b>Initial Coverage Up to a Total Drug Cost of \$5,030</b>		
Preferred generic drugs (Tier 1)	\$2 preferred pharmacy; \$10 standard pharmacy	\$4 preferred pharmacy
Non-preferred generic drugs (Tier 2)	\$10 preferred pharmacy; \$20 standard pharmacy	\$20 preferred pharmacy
Preferred brand-name drugs (Tier 3)	\$30	\$60 preferred pharmacy
Non-preferred brand-name drugs (Tier 4)	\$60	\$120 preferred pharmacy
Specialty drugs (Tier 5)	33%	33% preferred pharmacy
<b>Coverage Gap to TrOOP Maximum of \$8,000</b>		
Preferred generic drugs (Tier 1)	\$2 preferred pharmacy; \$10 standard pharmacy	\$4 preferred pharmacy
Non-preferred generic drugs (Tier 2)	\$10 preferred pharmacy; \$20 standard pharmacy	\$20 preferred pharmacy
Brand-name drugs (Tiers 3 & 4)	25%	25% preferred pharmacy
Specialty drugs (Tier 5)	33%	33% preferred pharmacy
<b>Catastrophic Coverage</b>		
Generic drugs		\$0
Brand-name drugs		\$0

# 2024 Plan Options if You Are NOT Eligible for Medicare

HOW MUCH YOU WILL PAY IN 2024	HIGHMARK PPOBLUE (80-70 PLAN)	
MEDICAL	In-Network	Out-of-Network
Annual Deductible	\$100/individual \$300/family	\$500/individual \$1,500/family
Annual Out-of-Pocket Maximum	\$10,000	No maximum
Hospitalization	20%	30%
Doctor Visits	\$20/visit PCP; \$40/visit specialist; no deductible	30%
Preventive Care	\$20/visit; no deductible	Routine physicals not covered; 30% for routine gynecological and mammograms
Emergency Room	\$100 (waived if admitted); no deductible	\$100 (waived if admitted); no deductible
Urgent Care Facility	\$40; no deductible	30%
Outpatient Surgery	20%	30%
Diagnostic Testing	20%	30%
Outpatient Therapy	\$40/visit; 60-visit maximum*; no deductible	30%; 60-visit maximum*
Durable Medical Equipment	20%	30%
Outpatient Mental Health	0%; no deductible	30%
Inpatient Mental Health	20%	30%
Physical Exams	\$20/visit PCP; \$40/visit specialist; no deductible	Not covered
Ob/Gyn Exams	\$20/visit; no deductible	30% routine; no deductible
Mammograms	20%	30%
Skilled Nursing Facility	20%; 100 visits per calendar year	30%; 100 visits per calendar year
Hearing Aids	Not covered	Not covered
Dental Care	Not covered	Not covered
Vision Exam/Hearing Exams	Not covered	Not covered
Prescription Lenses	Not covered	Not covered
<b>PRESCRIPTION DRUGS</b>		
Annual Deductible	\$0	Not covered
Annual Maximum	No maximum	Not covered
<b>Retail Pharmacy (34-day supply)</b>		
Generic drugs	30% (mandatory generic)	Not covered
Brand-name drugs	50%	Not covered
<b>Mail Order (90-day supply)</b>		
Generic drugs	30% (mandatory generic)	Not covered
Brand-name drugs	50%	Not covered

\* Combined in- and out-of-network maximum

HOW MUCH YOU WILL PAY IN 2024	CAPITAL BLUE CROSS PPO	
MEDICAL	In-Network	Out-of-Network
Annual Deductible	\$100/individual \$300/family	\$500/individual \$1,500/family
Annual Out-of-Pocket Maximum	\$3,000/individual \$6,000/family	No maximum
Hospitalization	20%; no deductible	30%; no deductible
Doctor Visits	\$10/PCP visit; \$25/specialist visit; no deductible	30%; no deductible
Preventive Care	\$10/visit; no deductible	20%
Emergency Room	\$100; no deductible (waived if admitted)	\$100; no deductible (waived if admitted)
Urgent Care Facility	\$40; no deductible	30%
Outpatient Surgery	20%	30%
Diagnostic Testing	20%	30%
Outpatient Therapy	\$40/visit; no deductible	30%
Durable Medical Equipment	20%	30%
Outpatient Mental Health	\$40/visit; no deductible	30%; no deductible
Inpatient Mental Health	20%	30%
Physical Exams	\$10/PCP visit; \$25/specialist visit; no deductible	20%; no deductible
Ob/Gyn Exams	\$0; no deductible	30%; no deductible
Mammograms	\$0; no deductible	30%; no deductible
Skilled Nursing Facility	\$0; limit 100 days	50%; limit 100 days
Hearing Aids	Not covered	Not covered
Dental Care	Not covered	Not covered
Vision Exam/Hearing Exams	Not covered	Not covered
Prescription Lenses	Not covered	Not covered
<b>PRESCRIPTION DRUGS</b>		
Annual Deductible	\$300/individual \$600/family	Not covered
Annual Maximum	\$2,500 benefit period maximum on lifestyle drugs	Not covered
<b>Retail Pharmacy</b>		
Generic drugs	30%*	Not covered
Brand-name drugs	30%/preferred,* 50%/non-preferred	Not covered
<b>Mail Order (90-day supply)</b>		
Generic drugs	50%	Not covered
Brand-name drugs	50%	Not covered

\* Specialty generic drugs and brand preferred drugs are covered at 50%, and Specialty brand non-preferred drugs are not covered.

HOW MUCH YOU WILL PAY IN 2024	AETNA PREMIER OPEN CHOICE PPO*	
MEDICAL	In-Network	Out-of-Network
Annual Deductible	\$300/individual \$600/family	\$500/individual \$1,000/family
Annual Out-of-Pocket Maximum	\$6,600/individual \$13,200/family	\$10,000/individual \$20,000/family
Hospitalization	\$200/day for 5 days; then \$0	30%
Doctor Visits	\$15/visit PCP; \$40/visit specialist	30%
Preventive Care	\$0; no deductible	30%
Emergency Room	\$75; no deductible (waived if admitted)	\$75; no deductible (waived if admitted)
Urgent Care Facility	\$50; no deductible	30%
Outpatient Surgery	\$150	30%
Diagnostic Testing	\$35 X-ray/lab; \$150 complex imaging	30%
Outpatient Therapy	\$40; coverage is subject to change based on type of therapy received	30%
Durable Medical Equipment	20%	30%
Outpatient Mental Health	\$40; all other mental health \$0	30%
Inpatient Mental Health	\$200/day for 5 days; then \$0	30%
Physical Exams	0%; no deductible; routine	30%
Ob/Gyn Exams	0%; no deductible; routine	30%
Mammograms	0%; no deductible; routine	30%
Skilled Nursing Facility	\$200/day for 5 days; then \$0; 100-day limit	30%
Hearing Aids (once every 36 months; \$1,000 maximum benefit)	100% after \$1,000 allowance	30%
Dental Care	Not covered	Not covered
Vision Exam/Hearing Exams	Vision: \$0; no deductible; 1 exam/12 months; Hearing: \$40; 1 exam/24 months	30%
Prescription Lenses (once every 24 months)	100% after \$100 allowance	100% after \$100 allowance
<b>PRESCRIPTION DRUGS</b>		
Annual Deductible	\$200/individual \$600/family	\$200/individual \$600/family
Annual Maximum	Combined with medical	Combined with medical
<b>Retail Pharmacy</b>		
Generic drugs	30%	50% after applicable copay
Brand-name drugs	30%-formulary 50%-non-formulary	50% after applicable copay
<b>Mail Order (90-day supply)</b>		
Generic drugs	30%	Not covered
Brand-name drugs	30%-formulary 50%-non-formulary	Not covered

\* Aetna is available only in New Jersey, Pennsylvania and some counties in Florida, Delaware, Maryland and New York.

HOW MUCH YOU WILL PAY IN 2024	UPMC BUSINESS ADVANTAGE*
<b>MEDICAL</b>	<b>In-Network Only</b>
Annual Deductible	\$500/individual \$1,000/family
Annual Out-of-Pocket Maximum	\$4,000/individual \$8,000/family
Hospitalization	20%
Doctor Visits	\$20/visit PCP; \$40/visit specialist; no deductible
Preventive Care	\$0; no deductible
Emergency Room	\$100 copay (waived if admitted); no deductible
Urgent Care Facility	\$40; no deductible
Outpatient Surgery	20%
Diagnostic Testing	20%
Outpatient Therapy	\$40/visit; 30-visit maximum; no deductible
Durable Medical Equipment	20%
Outpatient Mental Health	\$20/visit; no deductible
Inpatient Mental Health	20%
Physical Exams	\$0 routine; no deductible
Ob/Gyn Exams	\$0 routine; no deductible
Mammograms	\$0 routine; no deductible
Skilled Nursing Facility	20%; 120 days per benefit period
Hearing Aids	Not covered
Dental Care	Not covered
Vision Exam/Hearing Exams	Not covered
Prescription Lenses	Not covered
<b>PRESCRIPTION DRUGS</b>	
Annual Deductible	\$0
Annual Maximum	No maximum
<b>Retail Pharmacy</b>	
Generic drugs	\$8 (mandatory generic)
Brand-name drugs	\$38/preferred; \$76/non-preferred and specialty
<b>Mail Order (90-day supply)</b>	
Generic drugs	\$16 (mandatory generic)
Brand-name drugs	\$76/preferred; \$152/non-preferred

\* UPMC is not available in all counties.

HOW MUCH YOU WILL PAY IN 2024	INDEPENDENCE BLUE CROSS POS \$20-\$40/\$250	
MEDICAL	In-Network	Out-of-Network
Annual Deductible	\$0	\$5,000/individual \$10,000/family
Annual Out-of-Pocket Maximum	\$7,900/individual \$15,800/family	\$30,000/individual \$60,000/family
Hospitalization	\$250/day to \$1,250/admission maximum	50%
Doctor Visits	\$20/visit PCP; \$40/visit specialist	50%
Preventive Care	\$0	50%; no deductible
Emergency Room	\$250 (not waived if admitted)	\$250 (not waived if admitted); no deductible
Urgent Care Facility	\$85	50%
Outpatient Surgery	\$250	50%
Diagnostic Testing	\$0 outpatient lab/pathology; \$40 outpatient X-ray and routine/diagnostic radiology; \$80 complex radiology	50%
Outpatient Therapy	\$40	50%
Durable Medical Equipment	50%	50%
Outpatient Mental Health	\$40	50%
Inpatient Mental Health	\$250/day to \$1,250/admission maximum	50%
Physical Exams	\$20/visit PCP; \$40/visit specialist	50%; no deductible
Ob/Gyn Exams	\$0	50%
Mammograms	\$0	50%; no deductible
Skilled Nursing Facility	\$125/day maximum \$625 copay; 120 days per calendar year	50%; 120 days per calendar year
Hearing Aids	Not covered	Not covered
Dental Care	Not covered	Not covered
Vision Exam/Hearing Exams	\$35 for vision, once every 24 months; Hearing not covered	Not covered
Prescription Lenses	Not covered	Not covered
<b>PRESCRIPTION DRUGS</b>		
Annual Deductible	\$0	\$0
Annual Maximum	No maximum	No maximum
<b>Retail Pharmacy</b>		
Generic drugs	\$5-low cost generic \$20-generic	70% of drug retail cost
Brand-name drugs	\$40-preferred \$60-non-preferred	70% of drug retail cost
<b>Mail Order (90-day supply)</b>		
Generic drugs	\$10-low cost generic \$40-generic	70% of drug retail cost
Brand-name drugs	\$80-preferred \$120-non-preferred	70% of drug retail cost





This brochure provides only a summary of benefits under these plans. It does not provide details about what is covered or limitations that may apply. More information is included in the Evidence of Coverage (for a Medicare Advantage plan) or the Benefit Description (for a plan for non-Medicare-eligible members). In addition, you can call the HOP Administration Unit at 1-800-773-7725 and request an information packet for any of these plans.