

Pennsylvania Public School  
Employees' Retirement System (PSERS)

# Health Options Program



North  
& Central  
PENNSYLVANIA

2010

Medicare<sup>Rx</sup>  
Prescription Drug Coverage



Regional Guide to  
Cost and Coverage

**HOP**  
HEALTH OPTIONS PROGRAM  
  
WWW.HOPBENEFITS.COM®

## Counties in North & Central Pennsylvania

Adams • Armstrong • Beaver • Bedford • Berks • Blair • Bradford • Butler  
Cambria • Cameron • Carbon • Centre • Clarion • Clearfield • Clinton  
Columbia • Crawford • Cumberland • Dauphin • Elk • Erie • Forest • Franklin  
Fulton • Huntingdon • Jefferson • Juniata • Lackawanna • Lancaster • Lawrence  
Lebanon • Lehigh • Luzerne • Lycoming • McKean • Mercer • Mifflin • Monroe  
Montour • Northampton • Northumberland • Perry • Pike • Potter • Schuylkill  
Snyder • Somerset • Sullivan • Susquehanna • Tioga • Union • Venango  
Warren • Wayne • Wyoming • York

# About This Guide

This booklet provides side-by-side comparisons of the cost and coverage for the HOP plans that are available where you live. It covers the counties listed on the page to the left.

Since HOP offers programs for both Medicare-eligible and non-Medicare-eligible participants, this booklet is divided into two sections:

- The options available to **Medicare-eligible participants** are covered on pages 2-3. These include the HOP Medical Plan and the Basic or Enhanced Medicare Rx Option (all of which *supplement* Original Medicare) and the HOP Managed Care Plan/Highmark FreedomBlue (which *replaces* Original Medicare).
- The options available to **non-Medicare-eligible participants** are covered on pages 4-5. These include the HOP Pre-65 Medical Plan and the HOP Pre-65 Managed Care Plan/Highmark PPOBlue.

This booklet is intended to be used in conjunction with ***Welcome to HOP***, a more detailed booklet that explains the advantages of joining HOP, eligibility requirements, coverage options, enrollment instructions and other resources available to participants. If you do not have a copy of ***Welcome to HOP***, you can find it online at [www.HOPbenefits.com](http://www.HOPbenefits.com) (click on “Resources”) or request a copy from the HOP Administration Unit (1-800-773-7725).

# If You Are Eligible for Medicare



Your Options	Your Monthly Cost	
	Single Coverage	2-Person Coverage*
HOP Medical Plan Only	\$157	\$306
HOP Medical Plan and Basic Medicare Rx Option	\$183	\$358
HOP Medical Plan and Enhanced Medicare Rx Option	\$245	\$482
Basic Medicare Rx Option Only	\$26	\$52
Enhanced Medicare Rx Option Only	\$88	\$176
HOP Managed Care Plan/Highmark FreedomBlue	\$225	\$441

\* These rates assume both individuals are eligible for Medicare. Call the HOP Administration Unit for the rates that apply if only one individual is Medicare-eligible or if you want to cover more than two individuals.

If you enroll in the HOP Medical Plan within 180 days after your 65<sup>th</sup> birthday, you may be eligible for **special discounted rates**. These rates are included in the Personalized Statement you receive from HOP before your 65<sup>th</sup> birthday.

Also, if you are eligible for **Premium Assistance** (refer to *Welcome to HOP* for the eligibility requirements), your monthly rates (except for the standalone Medicare Rx Options) will be up to \$100 less than those shown here.

## Coverage Comparison

On the next page, you will find a side-by-side comparison of benefits under the HOP Medical Plan, the Basic and Enhanced Medicare Rx Options, and the HOP Managed Care Plan/Highmark FreedomBlue. Keep in mind, this comparison provides only a summary of benefits. For more details, call the HOP Administration Unit (1-800-773-7725).

How Much You Will Pay in 2010	HOP Medical Plan		HOP Managed Care Plan/ Highmark FreedomBlue In- and Out-of-Network	
	Basic Medicare Rx Option	Enhanced Medicare Rx Option	Retail Pharmacy	Mail Order (90-day supply)
Annual Deductible	\$0		\$0	
Annual Out-of-Pocket Maximum	\$750 (applies to Major Medical only—see below)		\$3,400	
Physician Visits	\$10/visit		\$15/visit	
Outpatient Surgery	\$0		\$0	
Emergency Room	\$0		\$50 (waived if admitted)	
Diagnostic Testing	\$0		\$0	
Outpatient Therapy	\$0		\$15/visit	
Durable Medical Equipment	\$0		15% to \$500 maximum	
Outpatient Mental Health	30%		\$15/visit	
Hospitalization	\$0		\$0	
Inpatient Mental Health	\$0		\$0	
Physical Exams	Not covered (unless approved by Medicare)		\$15/visit	
Ob/Gyn Exams	\$10/exam		\$15/visit	
Mammograms	\$0		\$0	
Vision Exam/Hearing Exams	Not covered		\$15/visit	
Prescription Lenses	Not covered		Davis Vision-\$0 for standard eyewear; Others-100% after \$100 allowance	
Hearing Aids	Not covered		100% after \$500 allowance	
Dental Care	Not covered		30% for routine care	
Major Medical ( After Medicare Benefits Are Exhausted)	\$250 deductible, then 20% \$750 annual out-of-pocket maximum \$1,000,000 lifetime maximum		Not applicable	
<b>Initial Coverage up to a Total Drug Cost of \$2,830</b>				
Generic drugs	\$7 for up to a 33-day supply \$21 for a 34- to 90-day supply		\$15	\$30
Preferred brand name	30% (to a maximum of \$75 for an 84- to 90-day supply)		\$30	\$60
Non-preferred brand name			\$60	\$120
Specialty drugs	33%		33%	Not available
<b>Coverage Gap to TrOOP Maximum of \$4,550</b>				
Generic drugs	Not covered	For up to an 83-day supply: 50% of the first \$200; afterwards 100%	\$15	\$30
Preferred brand name			50%	
Non-preferred brand name		50%		
Specialty drugs		33%	Not available	
<b>Catastrophic Coverage</b>				
Generic drugs	The greater of 5% or \$2.50 to a maximum of \$100		The greater of 5% or \$2.50	
Brand-name drugs	The greater of 5% or \$6.30 to a maximum of \$100		The greater of 5% or \$6.30	



# If You Are Not Eligible for Medicare

Your Options	Your Monthly Cost	
	Single Coverage	2-Person Coverage*
HOP Pre-65 Medical Plan	\$569	\$1,253
HOP Pre-65 Medical Plan with prescription drug coverage	\$686	\$1,509
HOP Pre-65 Managed Care Plan/Highmark PPOBlue	\$918	\$2,373

\* These rates assume neither individual is eligible for Medicare. Call the HOP Administration Unit for the rates that apply if one individual is Medicare-eligible or if you want to cover more than two individuals.

If you are eligible for **Premium Assistance** (refer to *Welcome to HOP* for the eligibility requirements), your monthly rates will be up to \$100 less than those shown here.

## Coverage Comparison

On the next page, you will find a side-by-side comparison of benefits under the HOP Pre-65 Medical Plan (including optional prescription drug coverage) and the HOP Pre-65 Managed Care Plan/Highmark PPOBlue. Keep in mind, this comparison provides only a summary of benefits. For more details, call the HOP Administration Unit (1-800-773-7725).

How Much You Will Pay in 2010	HOP Pre-65 Medical Plan		HOP Pre-65 Managed Care Plan/ Highmark PPOBlue	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible	\$1,500		\$100/individual \$300/family	\$500/individual \$1,500/family
Annual Out-of-Pocket Maximum	\$5,000		\$10,000	No maximum
Annual Benefit Maximum	\$200,000		No maximum	
Physician Visits	25%	40%	\$20/PCP visit \$40/specialist visit	30%
Outpatient Surgery	25%	40%	20%	30%
Emergency Room	25%	40%	\$100 (waived if admitted)	\$100 (waived if admitted)
Diagnostic Testing	25%	40%	20%	30%
Outpatient Therapy	25%	40%	\$40/visit (60-visit maximum/year*)	30% (60-visit maximum/year*)
Durable Medical Equipment	25%	40%	20%	30%
Outpatient Mental Health	25%	40%	\$40/visit	30%
Hospitalization	25%	40%	20%	30%
Inpatient Mental Health	25%	40%	20%	30%
Physical Exams	\$0**	40%**	\$20/visit	Not covered
Ob/Gyn Exams	\$0**	40%**	\$20/visit	30%
Mammograms	\$0**	40%**	20%	30%
Vision Exam/Hearing Exams	Not covered	Not covered	Not covered	Not covered
Prescription Lenses	Not covered	Not covered	Not covered	Not covered
Hearing Aids	Not covered	Not covered	Not covered	Not covered
Dental Care	Not covered	Not covered	Not covered	Not covered
	Prescription Drugs		Prescription Drugs	
Annual Deductible	\$350		\$0	Not covered
Annual Maximum	After plan pays \$3,000 for all prescription drugs, you pay 100% for non-Critical Care brand-name drugs		No maximum	Not covered
Retail Pharmacy				
Generic drugs	50%	50% of cost at a network pharmacy + 100% of excess	30%	Not covered
Brand-name drugs	50% Critical Care-\$100 maximum/prescription	50% of cost at a network pharmacy + 100% of excess	50%	Not covered
Mail Order (90-day supply)				
Generic drugs	50%	Not covered	30%	Not covered
Brand-name drugs	50% Critical Care-\$300 maximum/prescription	Not covered	50%	Not covered

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

\*\* For specific services and subject to a \$300 total annual maximum benefit



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