Pennsylvania Public School
Employees' Retirement System (PSERS)

Health Options Program

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

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

Plan Availability

Some of the plans included in this brochure are available only in certain counties. Check the chart below to find out which are offered where you live.

County	Highmark	Geisinger	Capital BlueCross	UPMC	Aetna
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	•	•			•

County	Highmark	Geisinger	Capital BlueCross	UPMC	Aetna
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	•	•	•		•

2012 Monthly Costs if You Are Eligible for Medicare *(Excluding Premium Assistance)*

	SINGLE COVERAGE	2-PERSON COVERAGE
Highmark FreedomBlue PPO	$241	$473
Geisinger Gold Preferred PPO	$191	$373
Capital BlueCross SeniorBlue PPO	$210	$411
UPMC for Life HMO	$211	$413
Aetna Medicare 15 Special PPO	$212	$415

2012 Monthly Costs if You Are NOT Eligible for Medicare *(Excluding Premium Assistance)*

	SINGLE COVERAGE	2-PERSON COVERAGE
Highmark PPOBlue (80-70 Plan)	$1,026	$2,653
Geisinger Choice PPO	$716	$1,653
Capital BlueCross PPO	$957	$1,885
UPMC Health Plan	$1,967	$4,871
Aetna PPO Plan	$878	$1,747

2012 Plan Options if You Are Eligible for Medicare

HOW MUCH YOU WILL PAY IN 2012	HIGHMARK FREEDOMBLUE PPO		GEISINGER GOLD PREFERRED PPO*	
MEDICAL PLAN	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Annual Deductible	$0	$250	$0	$0
Annual Out-of-Pocket Maximum	$3,400		$1,995	$1,995 (combined in- and out-of-network)
Doctor Visits	$10/visit-PCP; $15/visit-Specialist	20%	$10	$15
Outpatient Surgery	$0	20%	$50	20%
Emergency Room	$50 (waived if admitted)	$50 (waived if admitted)	$50 (waived if admitted)	$50 (waived if admitted)
Diagnostic Testing	$0	20%	$0-x-rays, diagnostic procedures, lab services; $15-imaging (CT, MRI), therapeutic radiation	20%
Outpatient Therapy	$15/visit	20%	$10	$15
Durable Medical Equipment	15%	50%	15%	20%
Outpatient Mental Health	$15/visit	20%	$10	$15
Hospitalization	$0	20%	$50 day/$500 max per stay	20%/$1,000 max per stay
Inpatient Mental Health	$0	20%	$50 day/$500 max per stay	20%/$1,000 max per stay
Physical Exams	$0 (office visit copay may apply)	$0 (office visit copay may apply)	$0	$0
Ob/Gyn Exams	$0 (office visit copay may apply)	$0 (office visit copay may apply)	$0	$0
Mammograms	$0	0%	$0	$0
Vision Exam/Hearing Exams	$15/visit	20%	$10	$15
Prescription Lenses (once every 24 months)	Std lenses, frames or contacts covered in full; $100 allowance for specialty lenses	$100 allowance	100% after $200 allowance every two years for prescription eyewear	
Hearing Aids (once every 36 months)	100% after $500 allowance		100% after $800 allowance every three years	
Dental Care	30% routine care; 40% dentures	50% routine care; 50% dentures	Preventive-$20 exam; $20-$30 dental x-rays	
PRESCRIPTION DRUGS	**Retail Pharmacy**	**Mail Order (90-day supply)**	**Retail Pharmacy**	**Mail Order (90-day supply)**
Annual Deductible	$0	$0	$0	$0
Initial Coverage up to a Total Drug Cost of $2,930				
Generic drugs	$10	$25	$3 (preferred); $10 (non-preferred)	$6 (preferred); $20 (non-preferred)
Preferred brand-name drugs	$30	$75	$35	$70
Non-preferred brand drugs	$60	$150	$65	$130
Specialty drugs	33%	33%	33%	Not available
Coverage Gap to TrOOP Maximum of $4,700				
Generic drugs	$10	$25	86%	86%
Preferred brand-name drugs Non-preferred brand-name drugs Specialty drugs	Not covered, but may be subject to 50% manufacturer's discount		Not covered, but may be subject to 50% manufacturer's discount	
Catastrophic Coverage				
Generic	The greater of 5% or $2.60		The greater of 5% or $2.60	
Brand	The greater of 5% or $6.50		The greater of 5% or $6.50	

* Geisinger is not available in all counties.

2012 Plan Options if You Are Eligible for Medicare *(continued)*

HOW MUCH YOU WILL PAY IN 2012	CAPITAL BLUECROSS SENIORBLUE PPO*		UPMC FOR LIFE HMO**	
MEDICAL PLAN	**In-Network**	**Out-of-Network**	**In-Network Only**	
Annual Deductible	$0	$100	$0	
Annual Out-of-Pocket Maximum	$3,400	$5,100	$3,400	
Doctor Visits	$10/visit-PCP; $20/ visit-specialist	20%	$5 PCP/$20 Specialist	
Outpatient Surgery	$50	20%	$0	
Emergency Room	$50 (waived if admitted)	$50 (waived if admitted)	$50 (waived if admitted)	
Diagnostic Testing	$0	20%	$0 labs; $10 general x-rays; $30 advanced imaging	
Outpatient Therapy	$20	20%	$20/visit	
Durable Medical Equipment	10%	20%	15% coinsurance	
Outpatient Mental Health	$20 Indiv; $20 Group	20%	$20/visit	
Hospitalization	$0	20%	$0	
Inpatient Mental Health	$0	20%	$0	
Physical Exams	$0	20%	$0	
Ob/Gyn Exams	$0	20%	$0	
Mammograms	$0	20%	$0	
Vision Exam/Hearing Exams	$20 Vision; $20 Hearing	$20 vision; 20% coinsurance hearing	100% after $250 combined allowance for routine vision exam and eyewear every 24 months; $20/visit for hearing exams	
Prescription Lenses (once every 24 months)	Lenses: $20 copay***	Lenses: 100% after dollar limit****	100% after $250 combined allowance for routine vision exam and eyewear	
Hearing Aids (once every 36 months)	100% after $400 allowance	100% after $400 allowance	100% after $1,000 allowance	
Dental Care	$15 office visit; cleaning & X-ray covered	30%	Not covered	
PRESCRIPTION DRUGS	**Retail Pharmacy**	**Mail Order (90-day supply)**	**Retail Pharmacy**	**Mail Order (90-day supply)**
Annual Deductible	$0	$0	$0	$0
Initial Coverage up to a Total Drug Cost of $2,930				
Generic drugs	$7	$17	$5	$10
Preferred brand-name drugs	$35	$90	$30	$75
Non-preferred brand drugs	$70	$150	$70	$210
Specialty drugs	33%	Not covered	33%	Not available
Coverage Gap to TrOOP Maximum of $4,700				
Generic drugs	$7	$17	$5	$10
Preferred brand-name drugs Non-preferred brand-name drugs Specialty drugs	Not covered, but may be subject to 50% manufacturer's discount		Not covered, but may be subject to 50% manufacturer's discount	
Catastrophic Coverage				
Generic	The greater of 5% or $2.60		The greater of 5% or $2.60	
Brand	The greater of 5% or $6.50		The greater of 5% or $6.50	

* Capital BlueCross is not available in all counties.

** UPMC is not available in all counties.

*** Frames: 100% after $40 allowance.

**** Single lenses $25 limit; Bifocal lenses $35 limit; Trifocal lenses $45 limit. Frames: 100% after $28 allowance.

HOW MUCH YOU WILL PAY IN 2012	AETNA MEDICARE 15 SPECIAL PPO*	
MEDICAL PLAN	**In-Network**	**Out-of-Network**
Annual Deductible	$0	$0
Annual Out-of-Pocket Maximum	$6,700	$10,000
Doctor Visits	$15/visit-PCP	15%
Outpatient Surgery	$0	15%
Emergency Room	$50 (waived if admitted)	$50 (waived if admitted)
Diagnostic Testing	$15	15%
Outpatient Therapy	$0	15%
Durable Medical Equipment	15%	15%
Outpatient Mental Health	$15	15%
Hospitalization	$0	15%
Inpatient Mental Health	$0	15%
Physical Exams	$0	15%
Ob/Gyn Exams	$0	15%
Mammograms	$0	15%
Vision Exam/Hearing Exams	$0	15%
Prescription Lenses (once every 24 months)	100% after $100 allowance	100% after $100 allowance
Hearing Aids (once every 36 months)	100% after $500 allowance	
Dental Care	Not covered	Not covered
PRESCRIPTION DRUGS	**Retail Pharmacy**	**Mail Order (90-day supply)**
Annual Deductible	$0	$0
Initial Coverage up to a Total Drug Cost of $2,930		
Generic drugs	$5	$10
Preferred brand-name drugs	$25	$50
Non-preferred brand-name drugs	$50	$100
Specialty drugs	33%	33%
Coverage Gap to TrOOP Maximum of $4,700		
Generic drugs	$5	$10
Preferred brand-name drugs Non-preferred brand-name drugs	Not covered, but may be subject to 50% manufacturer's discount	
Specialty drugs	86% for generic drugs; brand-name drugs not covered, but may be subject to 50% manufacturer's discount	
Catastrophic Coverage		
Generic	The greater of 5% or $2.60	
Brand	The greater of 5% or $6.50	

* Aetna is not available in all counties.

2012 Plan Options if You Are NOT Eligible for Medicare

HOW MUCH YOU WILL PAY IN 2012	HIGHMARK PPOBLUE (80-70 PLAN)		GEISINGER CHOICE PPO**	
MEDICAL	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Annual Deductible	$100/individual $300/family	$500/individual $1,500/family	$1,500/individual; $4,500/family	$1,500/individual; $4,500/family
Annual Out-of-Pocket Maximum	$10,000	No maximum	$10,000/individual; $30,000/family	No maximum
Doctor Visits	$20/visit-PCP; $40/visit-specialist	30%	PCP-$20; Specialist-$40	40%
Outpatient Surgery	20%	30%	25%	40%
Emergency Room	$100 (waived if admitted)	$100 (waived if admitted)	$150 (waived if admitted)	$150 (waived if admitted)
Diagnostic Testing	20%	30%	25%	40%
Outpatient Therapy	$40/visit to 60-visit maximum*	30% to 60-visit maximum*	25%	40%
Durable Medical Equipment	20%	30%	25%	40%
Outpatient Mental Health	$0	30%	$20	40%
Hospitalization	20%	30%	25%	40%
Inpatient Mental Health	20%	30%	25%	40%
Physical Exams	PCP-$20/visit; Specialist-$40/visit	Not covered	PCP-$20; Specialist-$40	40%
Ob/Gyn Exams	$40/visit	30%-routine (deductible does not apply)	PCP-$20; Specialist-$40	40%
Mammograms	20%	30%	$0	40%
Vision Exam/Hearing Exams	Not covered	Not covered	PCP-$20; Specialist-$40 (medical conditions only for vision); refractive exams not covered	40% (medical conditions only for vision); refractive exams not covered
Prescription Lenses (once every 24 months)	Not covered	Not covered	Not covered	Not covered
Hearing Aids (once every 36 months)	Not covered	Not covered	Not covered	Not covered
Dental Care	Not covered	Not covered	Not covered	Not covered
PRESCRIPTION DRUGS				
Annual Deductible	$0	Not covered	$0	Not covered
Annual Maximum	No maximum	Not covered	No maximum	Not covered
Retail Pharmacy				
Generic drugs	30% (mandatory generic)	Not covered	50%	Not covered
Brand-name drugs	50%	Not covered	50%	Not covered
Mail Order (90-day supply)				
Generic drugs	30% (mandatory generic)	Not covered	50%	Not covered
Brand-name drugs	50%	Not covered	50%	Not covered

* Combined in- and out-of-network maximum

** Geisinger is not available in all counties.

HOW MUCH YOU WILL PAY IN 2012	CAPITAL BLUECROSS PPO*		UPMC HEALTH PLAN*
MEDICAL	**In-Network**	**Out-of-Network**	**In-Network Only**
Annual Deductible	$250/individual $750/family		$0
Annual Out-of-Pocket Maximum	$2,000/individual $6,000/family		No maximum
Doctor Visits	$10/visit	20%	$5 PCP visit/$20 Specialist visit
Outpatient Surgery	$0 after deductible	20%; 50% at certain facility providers	$0
Emergency Room	$35 (waived if admitted)	$35 (waived if admitted)	$50 copay (waived if admitted)
Diagnostic Testing	$0 after deductible	20%; 50% at certain facility providers	$0 labs and general x-rays $30 advanced imaging
Outpatient Therapy	$10/visit	20%	$20/visit
Durable Medical Equipment	$0 after deductible	20%	15%
Outpatient Mental Health	$10/visit	20%	$20/visit
Hospitalization	$0 after deductible	20%; 50% at certain facility providers	$0
Inpatient Mental Health	$0 after deductible	20%; 50% at certain facility providers	$0
Physical Exams	$10	20% (deductible waived)	$0
Ob/Gyn Exams	$10	20% (deductible waived)	$0
Mammograms	Screening-$0 (deductible waived)	20% (deductible waived)	$0
Vision Exam/Hearing Exams	Not covered	Not covered	$20/visit (vision every 2 years; hearing every year)
Prescription Lenses (once every 24 months)	Not covered	Not covered	Not covered
Hearing Aids (once every 36 months)	Not covered	Not covered	100% after $1,000 allowance
Dental Care	Not covered	Not covered	Not covered
PRESCRIPTION DRUGS			
Annual Deductible	$100/individual $300/family	Not covered	$0
Annual Maximum	$2,500 benefit period maximum on lifestyle drugs	Not covered	No maximum
Retail Pharmacy			
Generic drugs	50%	Not covered	$5
Brand-name drugs	50%	Not covered	$25/preferred; $50/non-preferred; 25%/specialty
Mail Order (90-day supply)			
Generic drugs	50%	Not covered	$15
Brand-name drugs	50%	Not covered	$75/preferred; $150/non-preferred

* Capital BlueCross and UPMC are not available in all counties.

2012 Plan Options if You Are NOT Eligible for Medicare *(continued)*

HOW MUCH YOU WILL PAY IN 2012	AETNA PPO PLAN*	
MEDICAL	**In-Network**	**Out-of-Network**
Annual Deductible	$1,500/individual $3,000/family	$1,500/individual $3,000/family
Annual Out-of-Pocket Maximum	$4,000/individual $8,000/family	$4,000/individual $8,000/family
Doctor Visits	20%; no deductible	40%
Outpatient Surgery	20%; no deductible	40%
Emergency Room	20%; no deductible	20%; no deductible
Diagnostic Testing	20%	40%
Outpatient Therapy	20%; no deductible	40%
Durable Medical Equipment	50%; $2,500 max/member/year	50%; $2,500 max/ member/year
Outpatient Mental Health	20%; no deductible	40%
Hospitalization	20%	40%
Inpatient Mental Health	20%	40%
Physical Exams	0%; no deductible	40%
Ob/Gyn Exams	0%; no deductible	40%
Mammograms	0%; no deductible	40%
Vision Exam/Hearing Exams	0%; no deductible for Vision–1 per 24 months; 20% no deductible for Hearing–1 per 24 months	40%
Prescription Lenses (once every 24 months)	Not covered	Not covered
Hearing Aids (once every 36 months)	Not covered	Not covered
Dental Care	Not covered	Not covered
PRESCRIPTION DRUGS		
Annual Deductible	$200/individual $600/family	$200/individual $600/family
Annual Maximum	No maximum	No maximum
Retail Pharmacy		
Generic drugs	30%	50% of submitted cost after in-network copay
Brand-name drugs	30% for formulary drugs; 50% for non-formulary drugs	50% of submitted cost after applicable in-network copay
Mail Order (90-day supply)		
Generic drugs	2X copay	Not covered
Brand-name drugs	2X copay	Not covered

* Aetna is not available in all counties.

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.

EFFECTIVE JANUARY 1, 2012