

Pennsylvania Public School
Employees' Retirement System (PSERS)

Health Options Program



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

Allegheny • Fayette • Greene • Indiana • Washington • Westmoreland



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

	SINGLE COVERAGE	2-PERSON COVERAGE
Highmark FreedomBlue PPO	\$261	\$513
UPMC for Life HMO	\$211	\$413
Aetna Medicare 15 Special PPO	\$306	\$602

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
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		UPMC FOR LIFE HMO	
	In-Network	Out-of-Network	In-Network Only	
Annual Deductible	\$0	\$250	\$0	
Annual Out-of-Pocket Maximum	\$3,400		\$3,400	
Doctor Visits	\$10/visit-PCP; \$15/visit-Specialist	20%	\$5 PCP/\$20 Specialist	
Outpatient Surgery	\$0	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	\$15/visit	20%	\$20/visit	
Durable Medical Equipment	15%	50%	15% coinsurance	
Outpatient Mental Health	\$15/visit	20%	\$20/visit	
Hospitalization	\$0	20%	\$0	
Inpatient Mental Health	\$0	20%	\$0	
Physical Exams	\$0 (office visit copay may apply)	\$0 (office visit copay may apply)	\$0	
Ob/Gyn Exams	\$0 (office visit copay may apply)	\$0 (office visit copay may apply)	\$0	
Mammograms	\$0	0%	\$0	
Vision Exam/Hearing Exams	\$15/visit	20%	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)	Standard lenses, frames or contacts covered in full; \$100 allowance for specialty lenses	\$100 allowance	100% after \$250 combined allowance for routine vision exam and eyewear	
Hearing Aids (once every 36 months)	100% after \$500 allowance		100% after \$1,000 allowance	
Dental Care	30% routine care; 40% dentures	50% routine care; 50% dentures	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	\$10	\$25	\$5	\$10
Preferred brand-name drugs	\$30	\$75	\$30	\$75
Non-preferred brand-name drugs	\$60	\$150	\$70	\$210
Specialty drugs	33%	33%	33%	Not available
Coverage Gap to TrOOP Maximum of \$4,700				
Generic drugs	\$10	\$25	\$5	\$10
Preferred brand-name drugs	Not covered, but may be subject to 50% manufacturer's discount		Not covered, but may be subject to 50% manufacturer's discount	
Non-preferred brand-name drugs				
Specialty drugs				
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	

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	Not covered, but may be subject to 50% manufacturer's discount	
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 available in all counties except Indiana.

2012 Plan Options if You Are NOT Eligible for Medicare

HOW MUCH YOU WILL PAY IN 2012	HIGHMARK PPOBLUE (80-70 PLAN)		UPMC HEALTH PLAN
MEDICAL	In-Network	Out-of-Network	In-Network Only
Annual Deductible	\$100/individual \$300/family	\$500/individual \$1,500/family	\$0
Annual Out-of-Pocket Maximum	\$10,000	No maximum	No maximum
Doctor Visits	\$20/visit-PCP; \$40/visit-specialist	30%	\$5 PCP visit/\$20 Specialist visit
Outpatient Surgery	20%	30%	\$0
Emergency Room	\$100 (waived if admitted)	\$100 (waived if admitted)	\$50 copay (waived if admitted)
Diagnostic Testing	20%	30%	\$0 labs and general x-rays \$30 advanced imaging
Outpatient Therapy	\$40/visit to 60-visit maximum*	30% to 60-visit maximum*	\$20/visit
Durable Medical Equipment	20%	30%	15%
Outpatient Mental Health	\$0	30%	\$20/visit
Hospitalization	20%	30%	\$0
Inpatient Mental Health	20%	30%	\$0
Physical Exams	PCP-\$20/visit; Specialist-\$40/visit	Not covered	\$0
Ob/Gyn Exams	\$40/visit	30%-routine (deductible does not apply)	\$0
Mammograms	20%	30%	\$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	\$0	Not covered	\$0
Annual Maximum	No maximum	Not covered	No maximum
Retail Pharmacy			
Generic drugs	30% (mandatory generic)	Not covered	\$5
Brand-name drugs	50%	Not covered	\$25/preferred; \$50/non-preferred; 25%/specialty
Mail Order (90-day supply)			
Generic drugs	30% (mandatory generic)	Not covered	\$15
Brand-name drugs	50%	Not covered	\$75/preferred; \$150/non-preferred

* Combined in- and out-of-network maximum

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 available in all counties except Indiana.



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