Pennsylvania Public School
Employees' Retirement System (PSERS)

Health Options Program

2021

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

Southwest PENNSYLVANIA

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2021 Monthly Costs if You Are Eligible for Medicare *(Excluding Premium Assistance)*

	SINGLE COVERAGE	2-PERSON COVERAGE
Highmark Security Blue HMO Point-of-Service	$253	$506
Capital BlueCross BlueJourney PPO	$250	$500
UPMC PSERS HOP Custom HMO	$243	$486
Aetna Medicare V02 PPO	$216	$432

2021 Monthly Costs if You Are NOT Eligible for Medicare *(Excluding Premium Assistance)*

	SINGLE COVERAGE	2-PERSON COVERAGE
Highmark PPOBlue (80-70 Plan)	$1,287	$3,339
Capital BlueCross PPO	$1,371	$2,742
UPMC Business Advantage	$1,448	$2,896
Aetna Premier Open Choice PPO	$2,113	$4,226

2021 Plan Options if You Are Eligible for Medicare

HOW MUCH YOU WILL PAY IN 2021	HIGHMARK SECURITY BLUE HMO POINT-OF-SERVICE	
MEDICAL PLAN	**In-Network**	**Out-of-Network**
Annual Deductible	$0	$0
Annual Out-of-Pocket Maximum	$3,400	$10,000 (combined in- and out-of-network)
Hospitalization	$0	$0
Doctor Visits	$10 PCP; $20 specialist	$10 PCP; $20 specialist
Preventive Care	$0	$0
Emergency Room	$50 (waived if admitted)	$50 (waived if admitted)
Urgent Care Facility	$40	$40
Outpatient Surgery	$0	$0
Diagnostic Testing	$0	$0
Outpatient Therapy	$20	$20
Durable Medical Equipment	15%	Not covered
Outpatient Mental Health	$20	$20
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	$0 after annual $499 copay per aid for TruHearing Advanced; $799 per aid for TruHearing Premium	Not covered
Dental Care	$20 for exam, cleaning and X-rays every 6 months; 50% for restorative services: 50% for dentures every 5 years	Not covered
Vision Exam/Hearing Exams	$0 vision; $20 hearing	Not covered
Prescription Lenses	Standard Davis Vision eyeglass lenses and frames or contact lenses covered in full (annually); 100% after $150 benefit maximum per calendar year applies to non-standard frames and for specialty contact lenses	Not covered
PRESCRIPTION DRUGS	**Retail Pharmacy (31-day supply)**	**Mail Order (90-day supply)***
Annual Deductible	$0	$0
Initial Coverage Up to a Total Drug Cost of $4,130		
Preferred generic drugs (Tier 1)	$5 preferred pharmacy; $10 standard pharmacy	$12.50
Non-preferred generic drugs (Tier 2)	$5 preferred pharmacy; $10 standard pharmacy	$12.50
Preferred brand-name drugs (Tier 3)	$25 preferred pharmacy; $30 standard pharmacy	$62.50
Non-preferred brand-name drugs (Tier 4)	$55 preferred pharmacy; $60 standard pharmacy	$137.50
Specialty drugs (Tier 5)	33%	33% (31-day supply)
Coverage Gap to TrOOP Maximum of $6,550		
Generic drugs (Tiers 1 & 2)	$5 preferred pharmacy; $10 standard pharmacy	$12.50
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%)	20% (plan pays 10% and manufacturer discounts 70%)
Specialty drugs (Tier 5)	25% (plan pays 5% and manufacturer discounts 70%)	25% (31-day supply)
Catastrophic Coverage		
Generic drugs	The greater of 5% or $3.70	
Brand-name drugs	The greater of 5% or $9.20	

* Must obtain mail order supply using Express Scripts/ESI.

HOW MUCH YOU WILL PAY IN 2021	CAPITAL BLUECROSS BLUEJOURNEY PPO*	
MEDICAL PLAN	**In-Network**	**Out-of-Network**
Annual Deductible	$0	$0
Annual Out-of-Pocket Maximum	$3,400 combined (excludes Part D drugs and hearing)	
Hospitalization	$0	$0
Doctor Visits	$5 PCP; $0 virtual care; $15 specialist	$5 PCP; $15 specialist; virtual care N/A
Preventive Care	$0	$0
Emergency Room	$50 (waived if admitted)	$50 (waived if admitted)
Urgent Care Facility	$35 urgent care; $0 virtual care	$35 urgent care; virtual care N/A
Outpatient Surgery	$0	20%
Diagnostic Testing	$10 lab services; $25 high-tech imaging; 15% therapeutic radiology; all other $0	$10 lab services; $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 (once every 24 months)	$0 preventive screenings (once every 24 months)
Mammograms	$0 preventive screenings (once every 12 months)	$0 preventive screenings (once every 12 months)
Skilled Nursing Facility	$0 days 1-10; $25 days 11-100	20%
Hearing Aids (once every 36 months)	100% after $500 allowance (in and out-of-network combined)	100% after $500 allowance (in and out-of-network combined)
Dental Care	$15 office visit; cleaning and X-rays covered; 50% other services; $1,500 max per calendar year (in- and out-of-network combined)	50%; $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 24 months)	100% after $125 allowance for frames; $0 for one pair of standard lenses	Lenses: 100% after dollar limit** Frames: 100% after $125 limit
PRESCRIPTION DRUGS	**Retail Pharmacy (30-day supply)**	**Mail Order (90-day supply)**
Annual Deductible	$0	$0
Initial Coverage Up to a Total Drug Cost of $4,130		
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%	Not covered
Coverage Gap to TrOOP Maximum of $6,550		
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%)	Not covered
Catastrophic Coverage		
Generic drugs	The greater of 5% or $3.70	
Brand-name drugs	The greater of 5% or $9.20	

* Capital BlueCross BlueJourney PPO is not available in Delaware or Maryland.
** Single lenses $36 allowance; Bifocal lenses $48 allowance; Trifocal lenses $58 allowance.

HOW MUCH YOU WILL PAY IN 2021	UPMC PSERS HOP CUSTOM HMO*	
MEDICAL PLAN	**In-Network**	
Annual Deductible	$0	
Annual Out-of-Pocket Maximum	$3,400	
Hospitalization	$0 inpatient; $0 outpatient	
Doctor Visits	$0 PCP; $20 specialist	
Preventive Care	$0	
Emergency Room	$120 (waived if admitted within 3 days)	
Urgent Care Facility	$20	
Outpatient Surgery	$0	
Diagnostic Testing	$0 labs; $10 X-rays; $30 advanced imaging	
Outpatient Therapy	$20	
Durable Medical Equipment	15%	
Outpatient Mental Health	$20	
Inpatient Mental Health	$0	
Physical Exams	$0 routine	
Ob/Gyn Exams	$0 routine	
Mammograms	$0 routine	
Skilled Nursing Facility	$0 per day days 1-15; $50 per day days 16-100	
Hearing Aids	100% after $1,500 allowance (once every 36 months)	
Dental Care	Routine dental not covered	
Vision Exam/Hearing Exams	$0 routine vision (once every two years); $20 routine hearing (once every year)	
Prescription Lenses (once every 24 months)	100% after $250 allowance	
PRESCRIPTION DRUGS	**Retail Pharmacy (30-day supply)**	**Mail Order (90-day supply)**
Annual Deductible	$0	$0
Initial Coverage Up to a Total Drug Cost of $4,130		
Preferred generic drugs (Tier 1)	$0 preferred pharmacy; $15 standard pharmacy	$0 standard
Non-preferred generic drugs (Tier 2)	$10 preferred pharmacy; $20 standard pharmacy	$20 standard
Preferred brand-name drugs (Tier 3)	$47 preferred or standard pharmacy	$117.50
Non-preferred brand-name drugs (Tier 4)	$100 preferred or standard pharmacy	$300
Specialty drugs (Tier 5)	33% preferred or standard pharmacy	Not covered
Coverage Gap to TrOOP Maximum of $6,550		
Preferred generic drugs (Tier 1)	$0 preferred pharmacy; $15 standard pharmacy	$0 standard
Non-preferred generic drugs (Tier 2)	$10 preferred pharmacy; $20 standard pharmacy	$20 standard
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%)	Not covered
Catastrophic Coverage		
Generic drugs	The greater of 5% or $3.70	
Brand-name drugs	The greater of 5% or $9.20	

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

HOW MUCH YOU WILL PAY IN 2021	AETNA MEDICARE V02 PPO*	
MEDICAL PLAN	**In-Network**	**Out-of-Network**
Annual Deductible	$300	$500
Annual Out-of-Pocket Maximum	$6,700	$10,000
Hospitalization	$200 copay/day for days 1–7	30%
Doctor Visits	$15 PCP; $40 specialist	30%
Preventive Care	$0	30%
Emergency Room	$90 (waived if admitted)	$90 (waived if admitted)
Urgent Care Facility	$50	$50
Outpatient Surgery	$185	30%
Diagnostic Testing	$35; $200 complex imaging	30%
Outpatient Therapy	$40	30%
Durable Medical Equipment	20%	30%
Outpatient Mental Health	$40	30%
Inpatient Mental Health	$200 copay/day for days 1–7	30%
Physical Exams	$0	30%
Ob/Gyn Exams	$0	30%; no deductible
Mammograms	$0	30%; no deductible
Skilled Nursing Facility	$0 copay/day for days 1-20; $172 copay/day for days 21-100	30%
Hearing Aids (once every 36 months)	100% after $500 allowance	
Dental Care (subject to frequency limitations)	$40 (if covered by Medicare)	30% (if covered by Medicare)
Vision Exam/Hearing Exams (once every 12 months)	$0	30%
Prescription Lenses	100% after $100 allowance (once every 24 months)	
PRESCRIPTION DRUGS	**Retail Pharmacy (30-day supply)**	**Mail Order (90-day supply)**
Annual Deductible	$0	$0
Initial Coverage Up to a Total Drug Cost of $4,130		
Preferred generic drugs (Tier 1)	$2 preferred pharmacy; $15 standard pharmacy	$4 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)	$40 preferred pharmacy; $47 standard pharmacy	$80 preferred pharmacy; $94 standard pharmacy
Non-preferred brand-name drugs (Tier 4)	35% preferred pharmacy; 50% standard pharmacy	
Specialty drugs (Tier 5)	33%	33% (limited one-month supply)
Coverage Gap to TrOOP Maximum of $6,550		
Preferred generic drugs (Tier 1)	$2 preferred pharmacy; $15 standard pharmacy	$4 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%	25%
Specialty drugs (Tier 5)	25%	25%
Catastrophic Coverage		
Generic drugs	The greater of 5% or $3.70	
Brand-name drugs	The greater of 5% or $9.20	

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

2021 Plan Options if You Are NOT Eligible for Medicare

HOW MUCH YOU WILL PAY IN 2021	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	30%
Preventive Care	$20/visit	Routine physicals not covered; 30% for routine gynecological and mammograms
Emergency Room	$100 (waived if admitted)	$100 (waived if admitted)
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	Not covered
Ob/Gyn Exams	$40/visit	30% routine; no deductible
Mammograms	20%	30%
Skilled Nursing Facility	20%; 100 visits per calendar year	30%; 100 visits per calendar year
Hearing Aids (once every 36 months)	Not covered	Not covered
Dental Care	Not covered	Not covered
Vision Exam/Hearing Exams	Not covered	Not covered
Prescription Lenses (once every 24 months)	Not covered	Not covered
PRESCRIPTION DRUGS		
Annual Deductible	$0	Not covered
Annual Maximum	No maximum	Not covered
Retail Pharmacy (34-day supply)		
Generic drugs	30% (mandatory generic)	Not covered
Brand-name drugs	50%	Not covered
Mail Order (90-day supply)		
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 2021	CAPITAL BLUECROSS 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	30%; no deductible
Preventive Care	$10/visit	20%
Emergency Room	$100; no deductible (waived if admitted)	$100; no deductible (waived if admitted)
Urgent Care Facility	$40; no deductible	30%; no deductible
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
PRESCRIPTION DRUGS		
Annual Deductible	$300/individual $600/family	Not covered
Annual Maximum	$2,500 benefit period maximum on lifestyle drugs	Not covered
Retail Pharmacy		
Generic drugs	30%*	Not covered
Brand-name drugs	30%/preferred;* 50%/non-preferred	Not covered
Mail Order (90-day supply)		
Generic drugs	30%	Not covered
Brand-name drugs	30%/preferred; 50%/non-preferred	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 2021	UPMC BUSINESS ADVANTAGE*
MEDICAL	**In-Network Only**
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 (once every 36 months)	Not covered
Dental Care	Not covered
Vision Exam/Hearing Exams	Not covered
Prescription Lenses (once every 24 months)	Not covered
PRESCRIPTION DRUGS	
Annual Deductible	$0
Annual Maximum	No maximum
Retail Pharmacy	
Generic drugs	$8 (mandatory generic)
Brand-name drugs	$38/preferred; $76/non-preferred and specialty
Mail Order (90-day supply)	
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 2021	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 to $1,000/admission maximum	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	30%
Durable Medical Equipment	20%	30%
Outpatient Mental Health	$40; all other mental health $0	30%
Inpatient Mental Health	$200/day to $1,000/admission maximum	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	$100/day to $500, then $0; 100-day limit	30%
Hearing Aids (once every 36 months)	100% after $1,000 allowance	30%
Dental Care	Not covered	Not covered
Vision Exam/Hearing Exams	Vision: $0; 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
PRESCRIPTION DRUGS		
Annual Deductible	$200/individual $600/family	$200/individual $600/family
Annual Maximum	Combined with medical	Combined with medical
Retail Pharmacy		
Generic drugs	30%	50% after applicable copay
Brand-name drugs	30%-formulary 50%-non-formulary	50% after applicable copay
Mail Order (90-day supply)		
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, Maryland and New York.

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.

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