Pennsylvania Public School
Employees' Retirement System (PSERS)

Health Options Program

2021

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

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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

HOW MUCH YOU WILL PAY IN 2021	HIGHMARK SECURITY BLUE HMO POINT-OF-SERVICE	
MEDICAL PLAN	**In-Network**	**Out-of-Network**
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

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

HOW MUCH YOU WILL PAY IN 2021	HIGHMARK SECURITY BLUE HMO POINT-OF-SERVICE	
PRESCRIPTION DRUGS	**Retail Pharmacy (31-day supply)**	**Mail Order (90-day supply)***
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)

* Capital BlueCross BlueJourney PPO is not available in Delaware or Maryland.

HOW MUCH YOU WILL PAY IN 2021	CAPITAL BLUECROSS BLUEJOURNEY PPO*	
MEDICAL PLAN	**In-Network**	**Out-of-Network**
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

* 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	CAPITAL BLUECROSS BLUEJOURNEY PPO*	
PRESCRIPTION DRUGS	**Retail Pharmacy (30-day supply)**	**Mail Order (90-day supply)**
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.

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

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

HOW MUCH YOU WILL PAY IN 2021	UPMC PSERS HOP CUSTOM HMO*	
MEDICAL PLAN	**In-Network**	
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

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

HOW MUCH YOU WILL PAY IN 2021	UPMC PSERS HOP CUSTOM HMO*	
PRESCRIPTION DRUGS	**Retail Pharmacy (30-day supply)**	**Mail Order (90-day supply)**
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%

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

HOW MUCH YOU WILL PAY IN 2021	AETNA MEDICARE V02 PPO*	
MEDICAL PLAN	**In-Network**	**Out-of-Network**
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)

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HOW MUCH YOU WILL PAY IN 2021	AETNA MEDICARE V02 PPO*	
PRESCRIPTION DRUGS	**Retail Pharmacy (30-day supply)**	**Mail Order (90-day 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	

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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%

* Combined in- and out-of-network maximum

HOW MUCH YOU WILL PAY IN 2021	HIGHMARK PPOBLUE (80-70 PLAN)	
MEDICAL	**In-Network**	**Out-of-Network**
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

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

HOW MUCH YOU WILL PAY IN 2021	CAPITAL BLUECROSS PPO	
MEDICAL	**In-Network**	**Out-of-Network**
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

* UPMC is not available in all counties.

HOW MUCH YOU WILL PAY IN 2021	UPMC BUSINESS ADVANTAGE*
MEDICAL	**In-Network Only**
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%

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HOW MUCH YOU WILL PAY IN 2021	AETNA PREMIER OPEN CHOICE PPO*	
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

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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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