Pennsylvania Public School
Employees' Retirement System (PSERS)

Health Options Program

2024

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

North & Central PENNSYLVANIA

Adams • Armstrong • Beaver • Bedford • Berks • Blair
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UPMC's plans are NOT available in Adams, Columbia, and Northumberland counties.

2024 Monthly Costs if You Are Eligible for Medicare *(Excluding Premium Assistance)*

	SINGLE COVERAGE	2-PERSON COVERAGE
Highmark Freedom Blue PPO	$241	$482
Capital Blue Cross PPO	$257	$514
Aetna Medicare P01 PPO	$309	$618
UPMC PSERS HOP Custom PPO	$247	$494

2024 Monthly Costs if You Are NOT Eligible for Medicare *(Excluding Premium Assistance)*

	SINGLE COVERAGE	2-PERSON COVERAGE
Highmark PPOBlue (80-70 Plan)	$2,017	$4,034
Capital Blue Cross PPO	$1,697	$3,394
Aetna Premier Open Choice PPO	$2,112	$4,224
UPMC Business Advantage	$1,823	$3,646

2024 Plan Options if You Are Eligible for Medicare

HOW MUCH YOU WILL PAY IN 2024	HIGHMARK FREEDOM BLUE PPO	
MEDICAL PLAN	**In-Network**	**Out-of-Network**
Annual Deductible	$0	$0
Annual Out-of-Pocket Maximum	$1,000 (combined)	
Hospitalization	$0	$0
Doctor Visits	$5 PCP; $15 specialist	$5 PCP; $15 specialist
Preventive Care	$0	$0
Emergency Room	$40 (waived if admitted)	$40 (waived if admitted)
Urgent Care Facility	$25	$25
Outpatient Surgery	$0	$0
Diagnostic Testing	$0	$0
Outpatient Therapy	$15	$15
Durable Medical Equipment	15%	20%
Outpatient Mental Health	$15	$15
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 (once every 12 months)	Per year $499 copay per aid for TruHearing Advanced; $799 per aid for TruHearing Premium; $500 allowance per year for other aids through TruHearing	$500 allowance for hearing aids every three years from any other provider or TruHearing
Dental Care (subject to frequency limitations)	$20 for exam & cleaning and $20 for X-rays every 6 months; 50% for restorative services and dentures	50% for periodic exams, cleanings, X-rays, fillings as needed and dentures
Vision Exam/Hearing Exams	$0 vision; $15 hearing	$50 vision; $15 hearing
Prescription Lenses (once every 12 months)	$150 benefit maximum per calendar year for standard eyeglass frames, eyeglass lenses or contact lenses; Davis Vision Fashion Collection frames and standard lenses covered in full	$150 benefit maximum per calendar year for standard eyeglass frames, eyeglass lenses or contact lenses; Davis Vision Fashion Collection frames and standard lenses covered in full
PRESCRIPTION DRUGS	**Retail Pharmacy (31-day supply)**	**Mail Order***
Annual Deductible	$0	$0
Initial Coverage Up to a Total Drug Cost of $5,030		
Preferred generic drugs (Tier 1)	$5 preferred pharmacy; $10 standard pharmacy	$12.50 preferred pharmacy; $25 standard pharmacy
Non-preferred generic drugs (Tier 2)	$5 preferred pharmacy; $10 standard pharmacy	$12.50 preferred pharmacy; $25 standard pharmacy
Preferred brand-name drugs (Tier 3)	$25 preferred pharmacy; $30 standard pharmacy	$62.50 preferred pharmacy; $75 standard pharmacy
Non-preferred brand-name drugs (Tier 4)	$55 preferred pharmacy; $60 standard pharmacy	$137.50 preferred pharmacy; $150 standard pharmacy
Specialty drugs (Tier 5)	33%	33% (31-day supply)
Coverage Gap to TrOOP Maximum of $8,000		
Generic drugs (Tiers 1 & 2)	$5 preferred pharmacy; $10 standard pharmacy	$12.50 preferred pharmacy; $25 standard pharmacy
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%)	Preferred Pharmacy: 20% (plan pays 10% and manufacturer discounts 70%) Standard Pharmacy: 25% (plan pays 5% and manufacturer discounts 70%)
Specialty drugs (Tier 5)	25% (plan pays 5% and manufacturer discounts 70%)	25% (31-day supply)
Catastrophic Coverage		
Generic drugs	$0	
Brand-name drugs	$0	

* Must obtain mail order supply using Express Scripts/ESI. In Initial Coverage and the Coverage Gap: 100-day supply for Tier 1 and Tier 2 drugs; 90-day supply for Tier 3 and Tier 4 drugs.

HOW MUCH YOU WILL PAY IN 2024	CAPITAL BLUE CROSS PPO	
MEDICAL PLAN	**In-Network**	**Out-of-Network**
Annual Deductible	$0	$0
Annual Out-of-Pocket Maximum	$3,400 combined	
Hospitalization	$0	$0
Doctor Visits	$5 PCP; $15 specialist	$5 PCP; $15 specialist
Preventive Care	$0	$0
Emergency Room	$50 (waived if admitted)	$50 (waived if admitted)
Urgent Care Facility	$35	$35
Outpatient Surgery	$0	20%
Diagnostic Testing	$0 - $10 lab services; $0 - $25 high-tech imaging; 15% therapeutic radiology; all other $0	$0 - $10 lab services; $0 - $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	$0 preventive screenings
Mammograms	$0 preventive screenings	$0 preventive screenings
Skilled Nursing Facility	$0 days 1-20; $25 days 21-100	20% days 1-100
Hearing Aids (once every 12 months)	$150 allowance for OTC hearing aids; 100% after $500 allowance (in and out-of-network combined)	$150 allowance for OTC hearing aids; 100% after $500 allowance (in and out-of-network combined)
Dental Care	$15 office visit, cleaning and X-rays covered twice per year; $1,500 max per calendar year (in- and out-of-network combined)	50% office visit, cleaning and X-rays covered twice per year; $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 12 months)	100% after $150 allowance for frames and lenses or contacts	
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 $5,030		
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%	33% (30-day supply)
Coverage Gap to TrOOP Maximum of $8,000		
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%); limited to a 30-day supply	
Catastrophic Coverage		
Generic drugs	$0	
Brand-name drugs	$0	

HOW MUCH YOU WILL PAY IN 2024	AETNA MEDICARE P01 PPO*	
MEDICAL PLAN	**In-Network**	**Out-of-Network**
Annual Deductible	$0	$0
Annual Out-of-Pocket Maximum	$3,500	$5,000
Hospitalization	$0	15%
Doctor Visits	$15	15%
Preventive Care	$0	15%
Emergency Room	$50 (waived if admitted)	$50 (waived if admitted)
Urgent Care Facility	$15	$15
Outpatient Surgery	$0	15%
Diagnostic Testing	$15	15%
Outpatient Therapy	$15	15%
Durable Medical Equipment	15%	15%
Outpatient Mental Health	$15	15%
Inpatient Mental Health	$0	15%
Physical Exams	$0	15%
Ob/Gyn Exams	$0	15%
Mammograms	$0	15%
Skilled Nursing Facility	$0 copay per day, day(s) 1-20; $75 per day, day(s) 21-100	15%
Hearing Aids	$500 allowance once every 36 months	
Dental Care	$15 (if covered by Medicare)	15% (if covered by Medicare)
Vision Exam/Hearing Exams	$0 (once every 12 months)	15% (once every 12 months)
Prescription Lenses (once every 24 months)	$100 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 $5,030		
Generic drugs (Tier 1)	$4 preferred pharmacy; $5 standard pharmacy	$8 preferred pharmacy; $10 standard pharmacy
Preferred brand-name drugs (Tier 2)	$25**	$50**
Non-preferred brand-name drugs (Tier 3)	$50**	$100**
Specialty drugs (Tier 4)	33%**	33%** (limited to one-month supply)
Coverage Gap to TrOOP Maximum of $8,000		
Generic drugs (Tier 1)	$4 preferred pharmacy; $5 standard pharmacy	$8 preferred pharmacy; $10 standard pharmacy
Brand-name drugs (Tiers 2 & 3)	25%** (plan pays 5% and manufacturer discounts 70%)	
Specialty drugs (Tier 4)	25%** (limited to one-month supply; plan pays 5% and manufacturer discounts 70%)	
Catastrophic Coverage		
Generic drugs	$0	
Brand-name drugs	$0	

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

** Includes some high-cost generics.

HOW MUCH YOU WILL PAY IN 2024	UPMC PSERS HOP CUSTOM PPO*	
MEDICAL PLAN	**In-Network**	**Out-of-Network**
Annual Deductible	$0	$500
Annual Out-of-Pocket Maximum	$3,400	$5,100
Hospitalization	$0	20%
Doctor Visits	$0 PCP; $20 specialist	20%
Preventive Care	$0	20%, no deductible
Emergency Room	$120 (waived if admitted within 3 days)	$120 (waived if admitted within 3 days), no deductible
Urgent Care Facility	$20	$20 copay, no deductible
Outpatient Surgery	$0	20%
Diagnostic Testing	$0 labs; $10 X-rays; $30 advanced imaging	20%
Outpatient Therapy	$20	20%
Durable Medical Equipment	15%	50%
Outpatient Mental Health	$20	20%
Inpatient Mental Health	$0	20%
Physical Exams	$0 Annual Wellness Exams; Annual physical exams - not covered	20% Annual Wellness Exams, no deductible; Annual physical exams - not covered
Ob/Gyn Exams	$0 routine	20%, no deductible
Mammograms	$0 routine	20%, no deductible
Skilled Nursing Facility	$0 per day days 1-15; $50 per day days 16-100	20%
Hearing Aids (once every 12 months)	$690 - $1,890	$690 - $1,890, no deductible
Dental Care	Dental exams: $20	Dental exams: 50%, no deductible
Vision Exam/Hearing Exams (once every year)	$0 routine vision; $20 routine hearing	$50 routine vision, no deductible; 50% routine hearing, no deductible
Prescription Lenses (once every 12 months)	$175 allowance (combined in- and out-of-network)	
PRESCRIPTION DRUGS	**Retail Pharmacy (30-day supply)**	**Retail/Mail Order (100-day supply)**
Annual Deductible	$0	$0
Initial Coverage Up to a Total Drug Cost of $5,030		
Preferred generic drugs (Tier 1)	$0 preferred pharmacy; $15 standard pharmacy	$0 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)	$47 preferred or standard pharmacy	$117.50 preferred pharmacy; $141 standard pharmacy
Non-preferred drugs (Tier 4)	$100 preferred or standard pharmacy	$300 preferred or standard pharmacy
Specialty drugs (Tier 5)	33% preferred or standard pharmacy	33% preferred or standard pharmacy (limited to a 30-day supply)
Coverage Gap to TrOOP Maximum of $8,000		
Preferred generic drugs (Tier 1)	$0 preferred pharmacy; $15 standard pharmacy	$0 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% (plan pays 5% and manufacturer discounts 70%)	
Specialty drugs (Tier 5)	25% (plan pays 5% and manufacturer discounts 70%)	
Catastrophic Coverage		
Generic drugs	$0	
Brand-name drugs	$0	

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

2024 Plan Options if You Are NOT Eligible for Medicare

HOW MUCH YOU WILL PAY IN 2024	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; no deductible	30%
Preventive Care	$20/visit; no deductible	Routine physicals not covered; 30% for routine gynecological and mammograms
Emergency Room	$100 (waived if admitted); no deductible	$100 (waived if admitted); no deductible
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; no deductible	Not covered
Ob/Gyn Exams	$20/visit; no deductible	30% routine; no deductible
Mammograms	20%	30%
Skilled Nursing Facility	20%; 100 visits per calendar year	30%; 100 visits per calendar year
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	$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 2024	CAPITAL BLUE CROSS 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; no deductible	30%; no deductible
Preventive Care	$10/visit; no deductible	20%
Emergency Room	$100; no deductible (waived if admitted)	$100; no deductible (waived if admitted)
Urgent Care Facility	$40; no deductible	30%
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	50%	Not covered
Brand-name drugs	50%	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 2024	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 for 5 days; then $0	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; coverage is subject to change based on type of therapy received	30%
Durable Medical Equipment	20%	30%
Outpatient Mental Health	$40; all other mental health $0	30%
Inpatient Mental Health	$200/day for 5 days; then $0	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	$200/day for 5 days; then $0; 100-day limit	30%
Hearing Aids (once every 36 months; $1,000 maximum benefit)	100% after $1,000 allowance	30%
Dental Care	Not covered	Not covered
Vision Exam/Hearing Exams	Vision: $0; no deductible; 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, Delaware, Maryland and New York.

HOW MUCH YOU WILL PAY IN 2024	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	Not covered
Dental Care	Not covered
Vision Exam/Hearing Exams	Not covered
Prescription Lenses	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.

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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