Pennsylvania Public School
Employees' Retirement System (PSERS)

Health Options Program

2024

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

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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
UPMC PSERS HOP Custom PPO	$247	$494
Aetna Medicare P01 PPO	$433	$866

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
UPMC Business Advantage	$1,823	$3,646
Aetna Premier Open Choice PPO	$2,112	$4,224

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	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.

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.

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	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.

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.

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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