Health Options Program

Enrollment Guide for Non-Medicare-Eligible Members

2026

PSERS sponsors the Health Options Program for the sole benefit of PSERS retirees and survivor annuitants, and the spouse, surviving spouse, and dependents of retirees and survivor annuitants. PSERS is an agency of the Commonwealth of Pennsylvania with primary responsibility to administer the retirement system for all public school employees in the Commonwealth.

The Health Options Program is a voluntary health benefits program funded by participant contributions. Each retiree and survivor annuitant and the spouse and dependent of the retiree or survivor annuitant must decide whether or not to participate. Private health care organizations, third-party administrators, and insurance carriers provide the health care coverage and services available through the Health Options Program. Neither PSERS nor the Commonwealth of Pennsylvania is an insurer.

In no event will PSERS or the Commonwealth of Pennsylvania be responsible for any act or omission of any insurance company, third-party administrator, health care organization, or provider that has a role in this Program. If there is a discrepancy between the information presented in this document and the actual Program provisions, the legal Plan documents will govern.

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Welcome to the Health Options Program

The Health Options Program operates for the sole benefit of participants of the Pennsylvania Public School Employees' Retirement System (PSERS), their dependents and survivors. Under the Health Options Program, members have access to comprehensive medical and prescription drug coverage before and after they become eligible for Medicare.

The information in this *Enrollment Guide* applies to PSERS members who do not qualify for Medicare.

Get to know your options

The following pre-65 medical and prescription drug benefits are available:

- The HOP Pre-65 Medical Plan (with or without prescription drug coverage)
- The Prescription Drug Option
- Pre-65 Managed Care Plans which include both medical and prescription drug coverage. Managed care plans are available through Aetna, Capital Blue Cross, Highmark, Independent Blue Cross, and UPMC.

Get to know how the plans work

Descriptions of the medical and prescription drug plans and side-by-side comparisons are provided on the following pages. When evaluating your options, consider the following:

- Monthly Premiums: The amount you pay each month for health coverage. Important reminder: Premium Assistance will pay up to $100 per month toward the monthly premium. See page 4.
- Deductibles: The amount you must pay out of pocket before your plan begins paying for covered services.
- Copayments and Coinsurance: Your share of costs for specific services, such as office visits or prescriptions.
- Out-of-Pocket Maximums: The maximum you will spend in a year before your plan covers 100% of eligible expenses.

Advantages of the Health Options Program

No Age-Related Premium Increase

Members have the security of knowing that, as they age and use benefits more, their monthly premium is not based on their age. The Health Options Program's premiums for the Medicare Supplement plans are set to a standard rate for age 70 and older. In comparison, many commercial plans increase their monthly premiums relative to a person's age.

Substantial Premium Subsidy

If you are eligible for Premium Assistance and enroll in the HOP Pre-65 Medical Plan or a Managed Care Pre-65 Plan, you can receive up to $100 per month to help you pay for your medical insurance. See Premium Assistance on page 4 for more information.

Choice of Coverage

You have the choice between a fee-for-service plan and a Managed Care Pre-65 Plan. Prescription drug coverage is also available to all participants.

Convenience

In most cases, your monthly premium will be deducted automatically from your pension (as long as your pension exceeds the premium).

Flexibility

You can change your option each year starting in early October during the Option Selection Period. You can also enroll, add dependents, or change your option at any time during the year if you or one of your dependents experiences a Qualifying Event (see page 5 for more information).

Age 65 Discount

Once you turn 65, your monthly premium for the HOP Medical Plan—one of the medical plan options for Medicare-eligible participants—will be discounted by 15% if you enroll within the three months before or after the month in which you turn 65. As long as you remain enrolled in the HOP Medical Plan, you'll receive a discount on your premium each year until your 70th birthday.

Access to Resources

You have access to health care information to help you make informed health care decisions and lead a healthier lifestyle. You will receive newsletters and booklets to help you make the most of your participation. Customer service representatives at the HOP Administration Unit are specially trained and dedicated to helping our participants.

Premium Assistance

Participating in the Health Options Program may entitle you to a special financial incentive that is not available with a commercial program such as AARP or Blue Cross Blue Shield. PSERS provides Premium Assistance to help eligible retirees pay for health coverage through the Health Options Program or a Commonwealth public school employer plan.

If you are eligible for Premium Assistance, PSERS will pay up to $100 per month toward your monthly premium. Over the course of your lifetime, on average, you could save as much as $24,000 as a participant in the Health Options Program.

You are eligible for Premium Assistance if you are a retiree who meets one of the following retirement type requirements:

For Classes T-C, T-D, T-E, T-F, T-G, and T-H:

- All classes with at least 24½ eligibility points regardless of age, or
- Classes T-C and T-D: You terminate school employment at or after reaching age 62 with at least 15 eligibility points, or
- Classes T-E and T-F: You terminate school employment at or after reaching age 65 with at least 15 eligibility points, or
- Classes T-G and T-H: You terminate school employment at or after reaching age 67 with at least 15 eligibility points, or
- You are receiving a disability retirement benefit from PSERS.

For Class DC:

- You have at least 24½ eligibility points, terminate school employment, are Medicare-eligible, and receive all or part of your distribution, or
- You have at least 15 eligibility points, terminate school employment on or after reaching age 67, and receive all or part of your distribution.

The amount of the Premium Assistance benefit is determined by the Pennsylvania legislature and is subject to change. In addition, if you are Medicare-eligible and elect stand-alone prescription drug coverage, you are not eligible for Premium Assistance.

SilverSneakers

The SilverSneakers® fitness program, administered by Tivity Health, Inc., provides access to fitness locations throughout the country, for participants enrolled in the HOP Pre-65 Medical Plan. With SilverSneakers, you can join a local gym or take part in a fitness class designed specifically for seniors at no additional cost to you. You are automatically eligible for SilverSneakers when you enroll in the HOP Pre-65 Medical Plan.

If there's no participating facility near you, the SilverSneakers FLEX® program allows you to participate in fitness classes right in your neighborhood, for example, a walking club or an aerobic dance class at your local recreation center. SilverSneakers FLEX brings the fitness to you.

You can also request that your local fitness facility join the SilverSneakers network by contacting SilverSneakers. To learn more, visit **HOPbenefits.com**.

Enrolling in the Plan

You may enroll in the HOP Pre-65 Medical Plan if you experience a Qualifying Event. However, don't wait too long. Certain time limits apply. Contact the HOP Administration Unit at 1-800-773-7725 for details.

Qualifying Events include:

- You retire or lose health care coverage under your school employer's health plan. Coverage under your school employer's health plan includes any COBRA continuation coverage you may elect under that school employer's plan.
- You involuntarily lose health care coverage under a non-school employer's health plan, including any COBRA continuation coverage you may elect under that non-school employer's health plan.
- You or your spouse reaches age 65 or becomes eligible for Medicare. (Contact the HOP Administration Unit for information about options for Medicare-eligible participants.)
- There is a change in your family status (including divorce, the death of a spouse, addition of a dependent through birth, adoption, or marriage, or a dependent loses eligibility).
- You become eligible for Premium Assistance due to a change in legislation.
- Your current plan terminates, or you move out of your current plan's service area.

Qualifying Events apply to you and may apply to your spouse and your dependents. For example, if your spouse turns age 65 and becomes eligible for Medicare, he or she may enroll in the Health Options Program.

Option Selection Period

The Option Selection Period takes place each fall, generally from early October to mid-November. During the Option Selection Period, retirees who participate in the Health Options Program can change from one option to another. The new coverage will be effective the following January 1.

Questions

If you have questions about enrolling in the Health Options Program, the HOP Pre-65 Medical Plan, or other options that may be available to you, please visit **HOPbenefits.com**, or call the HOP Administration Unit at 1-800-PSERS25 (1-800-773-7725).

The HOP Pre-65 Medical Plan

If you are a PSERS retiree, survivor annuitant, or the spouse or dependent child of a PSERS retiree or survivor annuitant, and you are not eligible for Medicare, you can enroll in the HOP Pre-65 Medical Plan. You can elect to enroll in the HOP Pre-65 Medical Plan with or without prescription drug coverage, but you cannot enroll for prescription drug coverage only. What follows is a more complete description of the Plan and how it works.

Medical Deductible

You must meet a deductible each year before the HOP Pre-65 Medical Plan pays any benefits. The medical deductible is $1,500 per person. The same deductible applies to all covered hospital, surgical, and medical expenses. If you choose optional prescription drug coverage, a separate deductible applies (see page 9).

How Much You Pay After You Meet the Deductible

Once you meet the deductible, you and the Plan share the cost of your covered health care expenses. After you meet the annual deductible, you will pay 25% of the cost, and the Plan will pay 75%, provided you use a network provider. If you use an out-of-network provider, you will pay 40%, and the Plan will pay 60%.

Free Physical Exams

Since maintaining good health is critical to managing health care costs, the Plan pays 100% of the cost of the basic services provided for an annual physical examination with an in-network provider, up to a maximum benefit of $300 a year. As long as your cost is $300 or less, you pay nothing—no deductible, no coinsurance. If you use an out-of-network provider, the Plan will pay 60% of the cost after you meet the annual deductible (subject to the same $300 annual maximum benefit).

Out-of-Pocket Maximum on Medical Spending

To protect you financially in the event of a serious illness, the HOP Pre-65 Medical Plan includes a $5,500 limit (excluding prescription drugs) on how much you will spend out of pocket in a calendar year. Once your spending (including the deductible) reaches this limit, the Plan pays 100% of your covered medical expenses for the rest of the calendar year up to the Plan's annual maximum benefit (described in the next section). See the table on page 8 for how certain hospital and medical services are covered under the Plan.

Maximum Benefits

The Plan will pay no more than $300,000 in medical benefits for each person covered under the Plan each year. This is an annual maximum toward a $1 million lifetime maximum. Prescription drug benefits are not subject to this maximum.

Medical Plan Network Providers

The HOP Pre-65 Medical Plan uses Private Healthcare Systems (PHCS), a national network of health care providers. Each time you need medical care, you can decide whether to use an in-network or out-of-network provider. While you are free to go out of network whenever and as often as you like, using a PHCS network provider is your lowest-cost option. Here's why:

- If you use a PHCS network provider, you pay only **25%** of a **discounted** fee.
- If you go out of network, you generally pay **40%** of the **customary and reasonable amount** (the amount charged by most providers in the same area for the same service).
- In addition, if your out-of-network provider charges more than what is considered customary and reasonable, you will pay 40% of the customary and reasonable amount plus 100% of the amount by which the actual cost exceeds the customary and reasonable amount, and the amount over customary and reasonable will not count toward your out-of-pocket maximum. With an in-network provider, there are never any charges in excess of the discounted fees.

Example

Let's say that after you've met your annual deductible, you plan to see a doctor for a sore throat. The customary and reasonable amount for the medical service provided is $80. You have a choice of three equally qualified physicians.

- Dr. Jones belongs to PHCS and is under contract to charge only $60 for the service you need. You would pay $15 for this visit (25% of $60).
- Dr. Smith is not in the PHCS network and charges $75 for the visit. Since her charge is less than the customary and reasonable amount, you would pay $30 for this visit (40% of $75).
- Dr. Brown is also not in the PHCS network and charges $90 for the visit. Since his charge exceeds the customary and reasonable amount, you would pay $42 for this visit (40% of $80 plus the full $10 that Dr. Brown's charge exceeds the customary and reasonable amount).

Finding PHCS network providers

With more than 800,000 providers in the PHCS network, there are likely to be many near you. You can use the internet to find out whether a provider is in the network. Simply visit **multiplan.com**, and follow this path: **Find a Provider** > **Select Network** > pick **PHCS** from the list. Once your network is selected, enter a name, specialty, facility type, or NPI number in the search box.

If you don't have a computer with access to the internet, you can also find a PHCS provider by calling the HOP Administration Unit at 1-800-PSERS25 (1-800-773-7725), TTY users: 1-800-498-5428.

In the unlikely event that you must use out-of-network providers because there is no PHCS provider within a reasonable distance of your home, you may be eligible for in-network benefits. Contact the HOP Administration Unit.

ID Cards

If you enroll in the HOP Pre-65 Medical Plan, you will receive a HOP Pre-65 Medical Plan ID card. If you elect the prescription drug option (described on page 9), it will be indicated on your card. Use the same card for both medical and prescription drug coverage.

HOP Pre-65 Medical Plan Overview

This schedule highlights the HOP Pre-65 Medical Plan and shows some of the hospital and medical services it covers. For a more detailed list, refer to the *Pre-65 Medical Plan Summary Plan Description* (SPD). See page 7 for more information on how in-network benefits work.

	Plan Highlights
Annual Deductible	$1,500 per person
Annual Out-of-Pocket Maximum	$5,500 per person
Annual Medical Benefits Maximum	$300,000 per person

	What You Pay After You Meet the Deductible	
	In-Network*	**Out-of-Network****
Physical examination ($300 max benefit per year)	0% (not subject to deductible)	40%
Doctor's services		
In-hospital and office visits	25%	40%
Surgery	25%	40%
Pathology	25%	40%
Second surgical opinion	25%	40%
Anesthesia	25%	40%
Radiology	25%	40%
Urgent care facility	25%	40%
Diagnostic X-rays and lab	25%	40%
Hospitalization (includes semiprivate room and board, general nursing, and miscellaneous services and supplies)		
Medical	25%	40%
Emergency room	25%	25% (40% if not a true emergency)
Skilled nursing facility	25%	40%
Home health care	25%	40%
Home IV therapy	25%	40%
Durable medical equipment	25%	40%
Hospice care ($12,500 max benefit; respite care limited to 10 days inpatient or 240 hours in-home)	25%	40%
Outpatient services		
Radiation and chemotherapy	25%	40%
Physical therapy	25%	40%
Mental health services		
Inpatient (30 days per calendar year)	25%	40%
Outpatient (30-visit maximum)	25%	40%
Substance abuse		
Inpatient (30 days per calendar year)	25%	40%
Outpatient (30-visit maximum)	25%	40%

* In-network benefits are based on contracted amounts.
** Out-of-network benefits are a percentage of customary and reasonable amounts (defined on page 7).

The Prescription Drug Option

Prescription drug coverage is optional. However, if you want to elect it, you must enroll in the HOP Pre-65 Medical Plan. Prescription drug coverage is not available on a stand-alone basis for non-Medicare-eligible members, as shown in the costs table below.

The prescription drug option is administered by Optum Rx. It covers prescription drugs dispensed on an outpatient basis. (Drugs you receive in a hospital are covered under the medical portion of the Plan.) You must meet a $350 deductible each year before the Plan pays benefits. This deductible is separate from the medical deductible described on page 6.

How the Plan pays benefits

The prescription drug option pays 50% of the cost of drugs purchased at a network pharmacy. Once the Plan pays $3,000 in a calendar year, the Plan pays 50% of the cost of generic drugs and Critical Care Drugs. Critical Care Drugs are typically high-cost drugs for which there is no generic equivalent in the same therapeutic category. While a drug may be critical to your health, it may not be classified as a Critical Care Drug by the Plan. A list of Critical Care Drugs is available online at **HOPbenefits.com** or by calling the HOP Administration Unit at 1-800-773-7725. If a brand-name prescription drug is not on the Critical Care Drug list, it is not covered by the Plan once the Plan has paid $3,000 in a calendar year.

How you can fill prescriptions

If you elect prescription drug coverage, you can fill a prescription at a local pharmacy that participates in the Optum Rx network. As an alternative for maintenance or longer-term medications, you can buy up to a 90-day supply using the Optum Rx mail-service pharmacy. Either way, you will pay 50% of the cost, subject to the limits shown in the chart below. Since mail-order pricing is typically less costly than retail, you'll generally save money by using the mail-order pharmacy for larger orders.

Prescription drug benefits

Annual Deductible	$350 per person
What You Pay After You Meet the Deductible	
Generic drugs Brand-name drugs Critical Care Drugs	50% 50% 50% or $100, whichever is less
Non-Critical Care brand-name drugs are not covered once the Plan pays $3,000 for all prescription drugs.	

Monthly Costs

Your Options	Your Monthly Cost	
	Single Coverage	**2-Person Coverage***
HOP Pre-65 Medical Plan	$990	$1,980
HOP Pre-65 Medical Plan with prescription drug coverage	$1,115	$2,230

* These rates assume neither individual is eligible for Medicare. Call the HOP Administration Unit for the rates that apply if one individual is Medicare-eligible or if you want to cover more than two individuals.

Pre-65 Managed Care Plans and Premiums

- Aetna Premier Open Choice PPO
- Capital Blue Cross PPO
- Highmark PPOBlue (80-70 plan)
- Independence Blue Cross POS $20-$40/$250
- UPMC Business Advantage

Pre-65 Managed Care Plans and Premiums

You can choose a Pre-65 Managed Care Plan instead of the HOP Pre-65 Medical Plan. A managed care plan combines medical and prescription drug benefits in a single program. You cannot enroll for medical coverage without prescription drug coverage and vice versa. Managed care plans available through the Health Options Program are offered by Aetna, Capital Blue Cross, Highmark, Independence Blue Cross, and UPMC.

These insurance companies have contracted with PSERS to provide benefits. Each insurance company sets its own benefits and member rates. In addition, since each managed care plan serves only certain areas, the plans available to you depend on where you live. If you enroll in a managed care plan, you must use its network of providers to receive maximum benefits.

The following pages provide an overview of each managed care plan, which plans are available where you live, and how much they cost.

HOW MUCH YOU WILL PAY IN 2026	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%; 100-day limit
Hearing Aids (once every 36 months; $1,000 maximum benefit)	100% after $1,000 allowance	30% after $1,000 allowance
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 2026	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%; no deductible
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	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 2026	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	$40/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 2026	INDEPENDENCE BLUE CROSS POS $20-$40/$250	
MEDICAL	**In-Network**	**Out-of-Network**
Annual Deductible	$0	$5,000/individual $10,000/family
Annual Out-of-Pocket Maximum	$7,900/individual $15,800/family	$30,000/individual $60,000/family
Hospitalization	$250/day to $1,250/admission maximum	50%
Doctor Visits	$20/visit PCP; $40/visit specialist	50%
Preventive Care	$0	50%; no deductible
Emergency Room	$250 (not waived if admitted)	$250 (not waived if admitted); no deductible
Urgent Care Facility	$85	50%
Outpatient Surgery	$250	50%
Diagnostic Testing	$0 outpatient lab/pathology; $40 outpatient X-ray and routine/diagnostic radiology; $80 complex radiology	50%
Outpatient Therapy	$40 (30 visits per year)	50%
Durable Medical Equipment	50%	50%
Outpatient Mental Health	$40	50%
Inpatient Mental Health	$250/day to $1,250/admission maximum	50%
Physical Exams	$20/visit PCP; $40/visit specialist	50%; no deductible
Ob/Gyn Exams	$0	50%
Mammograms	$0	50%; no deductible
Skilled Nursing Facility	$125/day maximum $625 copay; 120 days per calendar year	50%; 120 days per calendar year
Hearing Aids	Not covered	Not covered
Dental Care	Not covered	Not covered
Vision Exam/Hearing Exams	$35 for vision, once every 24 months; Hearing not covered	Not covered
Prescription Lenses	Not covered	Not covered
PRESCRIPTION DRUGS		
Annual Deductible	$0	$0
Annual Maximum	No maximum	No maximum
Retail Pharmacy		
Generic drugs	$20	70% of drug retail cost
Brand-name drugs	$40	70% of drug retail cost
Mail Order (90-day supply)		
Generic drugs	$40	70% of drug retail cost
Brand-name drugs	$80	70% of drug retail cost

HOW MUCH YOU WILL PAY IN 2026	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.

2026 Monthly Costs if You Are NOT Eligible for Medicare (Excluding Premium Assistance)

	SINGLE COVERAGE	2-PERSON COVERAGE
Aetna Premier Open Choice PPO	$2,112	$4,224
Capital Blue Cross PPO	$1,697	$3,394
Highmark PPOBlue (80-70 Plan)	$2,258	$4,516
Independence Blue Cross POS $20-$40/$250 (only available in Southeast Pennsylvania)	$4,186	$8,372
UPMC Business Advantage	$2,395	$4,790

2026 Monthly Costs Outside of Pennsylvania if You Are NOT Eligible for Medicare (Excluding Premium Assistance)

	HIGHMARK PPOBLUE (80-70 PLAN)		AETNA PREMIER OPEN CHOICE PPO		CAPITAL BLUE CROSS PPO	
	Single Coverage	2-Person Coverage	Single Coverage	2-Person Coverage	Single Coverage	2-Person Coverage
Florida						
Bradford	$2,258	$4,516	$2,112	$4,224	$1,697	$3,394
Brevard	$2,258	$4,516	$2,112	$4,224	$1,697	$3,394
Broward	$2,258	$4,516	$2,112	$4,224	$1,697	$3,394
Charlotte	$2,258	$4,516	$2,112	$4,224	$1,697	$3,394
Citrus	$2,258	$4,516	$2,112	$4,224	$1,697	$3,394
Clay	$2,258	$4,516	$2,112	$4,224	$1,697	$3,394
Collier	$2,258	$4,516	$2,112	$4,224	$1,697	$3,394
DeSoto	$2,258	$4,516	$2,112	$4,224	$1,697	$3,394
Duval	$2,258	$4,516	$2,112	$4,224	$1,697	$3,394
Hernando	$2,258	$4,516	$2,112	$4,224	$1,697	$3,394
Highlands	$2,258	$4,516	$2,112	$4,224	$1,697	$3,394
Hillsborough	$2,258	$4,516	$2,112	$4,224	$1,697	$3,394
Indian River	$2,258	$4,516	$2,112	$4,224	$1,697	$3,394
Lake	$2,258	$4,516	$2,112	$4,224	$1,697	$3,394
Lee	$2,258	$4,516	$2,112	$4,224	$1,697	$3,394
Madison	$2,258	$4,516	$2,112	$4,224	$1,697	$3,394
Manatee	$2,258	$4,516	$2,112	$4,224	$1,697	$3,394
Marion	$2,258	$4,516	$2,112	$4,224	$1,697	$3,394
Martin	$2,258	$4,516	$2,112	$4,224	$1,697	$3,394
Miami-Dade	$2,258	$4,516	$2,112	$4,224	$1,697	$3,394
Nassau	$2,258	$4,516	$2,112	$4,224	$1,697	$3,394
Orange	$2,258	$4,516	$2,112	$4,224	$1,697	$3,394
Osceola	$2,258	$4,516	$2,112	$4,224	$1,697	$3,394
Palm Beach	$2,258	$4,516	$2,112	$4,224	$1,697	$3,394
Pasco	$2,258	$4,516	$2,112	$4,224	$1,697	$3,394
Pinellas	$2,258	$4,516	$2,112	$4,224	$1,697	$3,394
Polk	$2,258	$4,516	$2,112	$4,224	$1,697	$3,394
St. Johns	$2,258	$4,516	$2,112	$4,224	$1,697	$3,394
St. Lucie	$2,258	$4,516	$2,112	$4,224	$1,697	$3,394
Sarasota	$2,258	$4,516	$2,112	$4,224	$1,697	$3,394
Seminole	$2,258	$4,516	$2,112	$4,224	$1,697	$3,394
Volusia	$2,258	$4,516	$2,112	$4,224	$1,697	$3,394
All other counties in Florida	$2,258	$4,516	Not available		$1,697	$3,394
Maryland						
Allegany	$2,258	$4,516	Not available		$1,697	$3,394
Somerset	$2,258	$4,516	Not available		$1,697	$3,394
All other counties in Maryland	$2,258	$4,516	$2,112	$4,224	$1,697	$3,394
New Jersey						
Atlantic	$2,258	$4,516	$2,112	$4,224	$1,697	$3,394
Bergen	$2,258	$4,516	$2,112	$4,224	$1,697	$3,394
Burlington	$2,258	$4,516	$2,112	$4,224	$1,697	$3,394

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2026 Monthly Costs Outside of Pennsylvania if You Are NOT Eligible for Medicare (Excluding Premium Assistance)

	HIGHMARK PPOBLUE (80-70 PLAN)		AETNA PREMIER OPEN CHOICE PPO		CAPITAL BLUE CROSS PPO	
	Single Coverage	2-Person Coverage	Single Coverage	2-Person Coverage	Single Coverage	2-Person Coverage
New Jersey						
Camden	$2,258	$4,516	$2,112	$4,224	$1,697	$3,394
Cape May	$2,258	$4,516	$2,112	$4,224	$1,697	$3,394
Cumberland	$2,258	$4,516	$2,112	$4,224	$1,697	$3,394
Essex	$2,258	$4,516	$2,112	$4,224	$1,697	$3,394
Gloucester	$2,258	$4,516	$2,112	$4,224	$1,697	$3,394
Hudson	$2,258	$4,516	$2,112	$4,224	$1,697	$3,394
Hunterdon	$2,258	$4,516	$2,112	$4,224	$1,697	$3,394
Mercer	$2,258	$4,516	$2,112	$4,224	$1,697	$3,394
Middlesex	$2,258	$4,516	$2,112	$4,224	$1,697	$3,394
Monmouth	$2,258	$4,516	$2,112	$4,224	$1,697	$3,394
Morris	$2,258	$4,516	$2,112	$4,224	$1,697	$3,394
Ocean	$2,258	$4,516	$2,112	$4,224	$1,697	$3,394
Passaic	$2,258	$4,516	$2,112	$4,224	$1,697	$3,394
Salem	$2,258	$4,516	$2,112	$4,224	$1,697	$3,394
Somerset	$2,258	$4,516	$2,112	$4,224	$1,697	$3,394
Sussex	$2,258	$4,516	$2,112	$4,224	$1,697	$3,394
Union	$2,258	$4,516	$2,112	$4,224	$1,697	$3,394
Warren	$2,258	$4,516	$2,112	$4,224	$1,697	$3,394
New York						
Allegany	$2,258	$4,516	Not available		$1,697	$3,394
Cattaraugus	$2,258	$4,516	Not available		$1,697	$3,394
Chautauqua	$2,258	$4,516	Not available		$1,697	$3,394
Clinton	$2,258	$4,516	Not available		$1,697	$3,394
Delaware	$2,258	$4,516	Not available		$1,697	$3,394
Erie	$2,258	$4,516	Not available		$1,697	$3,394
Essex	$2,258	$4,516	Not available		$1,697	$3,394
Franklin	$2,258	$4,516	Not available		$1,697	$3,394
Fulton	$2,258	$4,516	Not available		$1,697	$3,394
Genesee	$2,258	$4,516	Not available		$1,697	$3,394
Hamilton	$2,258	$4,516	Not available		$1,697	$3,394
Herkimer	$2,258	$4,516	Not available		$1,697	$3,394
Madison	$2,258	$4,516	Not available		$1,697	$3,394
Monroe	$2,258	$4,516	Not available		$1,697	$3,394
Montgomery	$2,258	$4,516	Not available		$1,697	$3,394
Niagara	$2,258	$4,516	Not available		$1,697	$3,394
Orleans	$2,258	$4,516	Not available		$1,697	$3,394
Otsego	$2,258	$4,516	Not available		$1,697	$3,394
Schoharie	$2,258	$4,516	Not available		$1,697	$3,394
Schuyler	$2,258	$4,516	Not available		$1,697	$3,394
Steuben	$2,258	$4,516	Not available		$1,697	$3,394
Tompkins	$2,258	$4,516	Not available		$1,697	$3,394
Warren	$2,258	$4,516	Not available		$1,697	$3,394

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2026 Monthly Costs Outside of Pennsylvania if You Are NOT Eligible for Medicare (Excluding Premium Assistance)

	HIGHMARK PPOBLUE (80-70 PLAN)		AETNA PREMIER OPEN CHOICE PPO		CAPITAL BLUE CROSS PPO	
	Single Coverage	2-Person Coverage	Single Coverage	2-Person Coverage	Single Coverage	2-Person Coverage
New York						
Wayne	$2,258	$4,516	Not available		$1,697	$3,394
Yates	$2,258	$4,516	Not available		$1,697	$3,394
All other counties in New York	$2,258	$4,516	$2,112	$4,224	$1,697	$3,394
All Other						
New Castle County, Delaware	$2,258	$4,516	$2,112	$4,224	$1,697	$3,394
All other counties, Delaware	$2,258	$4,516	Not available		$1,697	$3,394
Alabama • Alaska Arizona • Arkansas California Colorado Connecticut District of Columbia Georgia • Guam Hawaii • Idaho Illinois • Indiana Iowa • Kansas Kentucky • Louisiana Maine Massachusetts Michigan Minnesota Mississippi Missouri • Montana Nebraska Nevada New Hampshire New Mexico North Carolina North Dakota Ohio • Oklahoma Oregon • Puerto Rico Rhode Island South Dakota South Carolina Tennessee Texas U.S. Virgin Islands Utah • Vermont Virginia Washington West Virginia Wisconsin Wyoming	$2,258	$4,516	Not available		$1,697	$3,394

Transitioning to Medicare

When you reach age 65 and become eligible for Medicare, you will have the opportunity to enroll in the HOP Medical Plan or Value Medical Plan (or a Medicare Advantage plan, if available) and the Medicare Plus Rx Option or the Medicare Standard Rx Option, and dental and vision coverage.

The Health Options Program is here to support you through this transition, offering resources and guidance to help you understand your Medicare options, enrollment timelines, and how your current coverage may change.

You will receive information well in advance of your 65th birthday about how to make a seamless transition to Medicare. If you become eligible for Medicare prior to your 65th birthday due to disability, please contact the HOP Administration Unit at 1-800-773-7725 (TTY users: 1-800-498-5428), and request information about your options.

Dedicated members of the HOP Administration Unit are available to answer questions about enrolling in a Medicare-eligible plan.

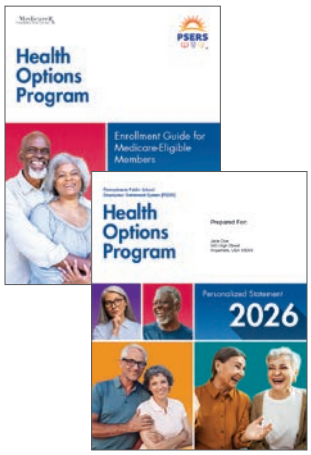
Educational seminars, webinars, and written guides are provided to help demystify the Medicare enrollment process.

Resources and Contact Information

Participant Resources

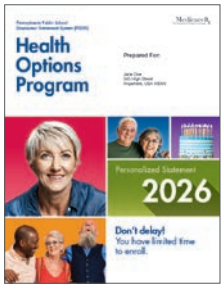
HOPbenefits.com

The Health Options Program's website, **HOPbenefits.com**, includes information, tools, and videos for both current and prospective members. It describes the health care options that are available to both Medicare-eligible and non-Medicare-eligible members and covers topics such as eligibility and Premium Assistance. Easy-to-use search tools, such as Find a Plan, Find a Drug, and Find a Pharmacy, help you make the most of your benefits. A Resources section of the site houses many useful documents, such as newsletters and patient education materials. A secure Member Area provides additional information customized for each member, including an electronic version of his or her *Personalized Statement*. Other website functionality enables members enrolled in the HOP Medical Plan, Value Medical Plan, or the Pre-65 Medical Plan to check the status of a claim or request an ID card.



Enrollment Materials for the Option Selection Period

Each fall, the Health Options Program mails a package of information to enrolled members to help them make decisions for the following year. The package includes a *Personalized Statement* that shows current coverage, and available coverage and premium rates for the next year. Note: The version you receive is for your current plan. If you want a different version to compare the benefits, you can request it from the HOP Administration Unit.



Mailing to Retirees Turning 65

Twice a year, the Health Options Program sends a package of information to PSERS retirees about to turn age 65. The package contains a description of the medical, dental, vision, and prescription drug benefits available under the Health Options Program, plus a *Personalized Statement* that has customized coverage and premium information.

Newsletters

The Health Options Program mails a newsletter to members and other PSERS retirees several times a year. Each newsletter contains news, tips, and updates about the Program, as well as general health and wellness information targeted to PSERS members. The newsletters are also available online at **HOPbenefits.com**.

Surveys

The Health Options Program is interested in what members think and periodically distributes surveys to find out if the Program is meeting their insurance and communications needs.

Contact Information

Type of Question	Please Call	Or Go Online
Pre-65 Medical Plan Health Options Program in general	HOP Administration Unit 1-800-PSERS25 (1-800-773-7725) TTY: 1-800-498-5428 8:00 a.m. to 8:00 p.m. ET, weekdays	HOPbenefits.com
Prescription Drug Coverage	Optum Rx 1-888-239-1301 TTY: 1-800-498-5428 Available 24/7	HOPbenefits.com
Premium Assistance	Premium Assistance Office 1-866-483-5509 8:00 a.m. to 8:00 p.m. ET, weekdays	HOPbenefits.com
Medicare	Medicare 1-800-MEDICARE (1-800-633-4227) TTY: 1-877-486-2048	medicare.gov

Notes

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Notice of Availability of Language Assistance Services and Auxiliary Aids and Services (45 CFR § 92.11)

English: ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-773-7725 or speak to your provider.

Spanish – Español: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-800-773-7725 o hable con su proveedor.

Chinese Simplified – 中文：注意：如果您说中文，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-800-773-7725 或咨询您的服务提供商。

Chinese Traditional – 台語：注意：如果您說台語，我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 1-800-773-7725 或與您的提供者討論。

Tagalog: PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-800-773-7725 o makipag-usap sa iyong provider.

French – Français: ATTENTION: Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-773-7725 ou parlez à votre fournisseur.

Vietnamese – Việt: LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-800-773-7725 hoặc trao đổi với người cung cấp dịch vụ của bạn.

German – Deutsch: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-800-773-7725 an oder sprechen Sie mit Ihrem Provider.

Korean – 한국어: 주의: 한국어를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-800-773-7725 번으로 전화하거나 서비스 제공업체에 문의하십시오.

Russian – РУССКИЙ: ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-800-773-7725 или обратитесь к своему поставщику услуг.

Hindi – हिंदी: ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-800-773-7725 पर कॉल करें या अपने प्रदाता से बात करें।

Italian – Italiano: ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l'1-800-773-7725 o parla con il tuo fornitore.

Portuguese – Português do Brasil: ATENÇÃO: Se você fala Português do Brasil, serviços gratuitos de assistência linguística estão disponíveis para você. Auxílios e serviços auxiliares apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 1-800-773-7725 ou fale com seu provedor.

French Creole – Kreyòl Fransè: ATANSYON: Si w pale Kreyòl Fransè, sèvis asistans lengwistik gratis yo disponib pou ou. Gen èd ak sèvis oksilyè apwopriye pou bay enfòmasyon nan fòma aksesib ki disponib tou gratis. Rele 1-800-773-7725 oswa pale ak founisè w la.

Polish – POLSKI: UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 1-800-773-7725 lub porozmawiaj ze swoim dostawcą.

Japanese – 日本語: 注：日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル（誰もが利用できるよう配慮された）な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1-800-773-7725 までお電話ください。または、ご利用の事業者にご相談ください。

Pennsylvania Dutch – Pennsilfaanisch Deitsch: UFFGEPASS! Wann du Pennsylvanisch-Deitsch schwetzscht, gebbt’s fer dich gratis Hilf mit die Schprooch. Aagmessiche Hilfsmittel un Dienscht, die Information in zugängliche Formate gebbe kenne, sin aa gratis verfügbar. Ruf aa bei 1-800-773-7725 oder schwetz mit dei Versorger.

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