Pennsylvania Public School
Employees' Retirement System (PSERS)

Health Options Program

The HOP Pre-65 Medical Plan

2025

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.

Contents

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 5).

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 4 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 5), 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 3 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 3).

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 2.

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.

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, up to $100 per month will be added to your pension to help you pay for your medical insurance. See Premium Assistance on page 7 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

We make paying monthly premiums easy by deducting them automatically from your pension (as long as your pension exceeds the premium).

Flexibility

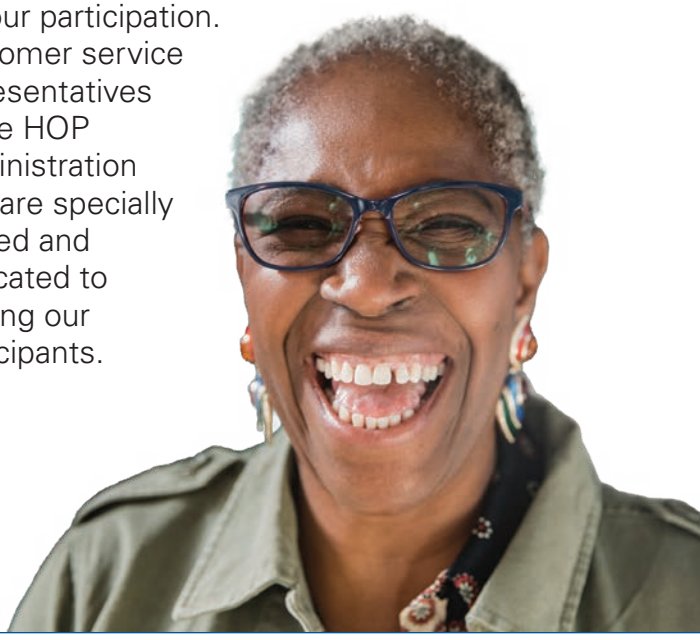
You can change your option each year starting in early October during the Option Selection Period. You can also enroll, add dependents, or change your option at any time during the year if you or one of your dependents experiences a Qualifying Event (see page 10 for more information).

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:

- All classes with at least 24½ eligibility points regardless of age, or
- Class T-C and T-D: You terminate school employment at or after reaching age 62 with at least 15 eligibility points, or
- Class T-E and T-F: You terminate school employment at or after reaching age 65 with at least 15 eligibility points, or
- Class 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.

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**.

Someone Like Me in the Health Options Program

Deciding what medical plan is right for you is not always easy. We hope these someone-like-me examples can help you in this process. The profiles are for demonstration purposes only. The plan you elect should be based on your actual health care needs.

Meet Frank

- Retired at age 55 and lost coverage with his employer
- In good health and generally only sees his doctor for wellness exams
- No prescription medications at this time
- Divorced and only needs coverage for himself
- Enjoys using technology

What Frank cares about

- **Healthy lifestyle.** Frank wants to remain healthy and active, but now that he's on a fixed income, he's worried about his gym membership fees. To keep up his health, Frank gets his annual checkups and wellness exams.
- **Easy access to resources.** Frank wants all his resources readily available. He likes the convenience of online information and tools.
- **A program with seamless transition once he's Medicare-eligible.** He wants a program that provides an easy transition to and comparable benefits in a Medicare Supplement or Medicare Advantage plan.

What plan is right for Frank?
The **HOP Pre-65 Medical Plan** without prescription drug coverage

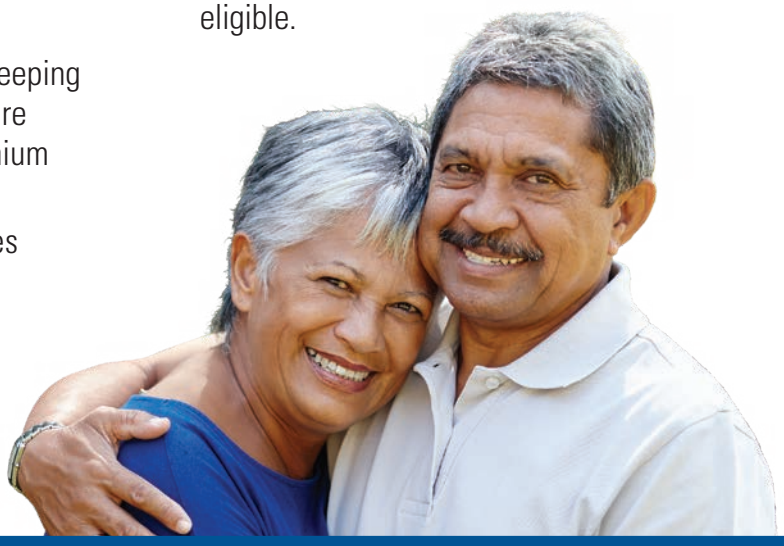
- Frank doesn't currently need prescription drug coverage; however, if that changes, he knows he can add prescription drug coverage during an Option Selection Period.
- Preventive care and wellness exams are covered 100% before the deductible.
- The SilverSneakers fitness program is included.
- The website, **HOPbenefits.com**, has a secure member portal with personalized information, general plan information, and lookup tools for network providers and covered medications.
- The Health Options Program also offers Medicare Supplement and Medicare Advantage plans for when he becomes eligible for Medicare.

Meet Mary and James

- Mary retired early and was able to remain on her school health insurance plan.
- Mary just turned 65 and is now eligible for Medicare, so she lost coverage under her school-sponsored plan.
- Mary needs to cover her husband James, who is 63 and not eligible for Medicare.
- James takes high blood pressure medication.
- Mary has prediabetes.

What Mary and James care about

- **Cost.** Mary and James are focused on keeping their expenses low and want to make sure they are in a plan that's eligible for Premium Assistance.
- **Choice and flexibility.** Mary and James worry that, over time, they might need more coverage. They want the ability to change and update their coverage as their health care needs change.
- **Prescription drug coverage.** James is only taking one prescription, but Mary may have to be put on medication to help control her blood sugar. They want financial protection against high-cost drug prices.
- **A program with options for non-Medicare-eligible dependents.** Mary is excited to enroll in the Health Options Program, because she knows it has options for James now and once he becomes Medicare-eligible.



What plan is right for Mary and James?
The **HOP Medical Plan with Rx** and the **HOP Pre-65 Medical Plan with Rx**

- For Mary, there's no premium increase based solely on age. Plus, Mary is enrolling within three months of her 65th birthday, so she'll get a discount.
- Mary is eligible for Premium Assistance, so they will save $100 on their premium each month. She also likes the convenience of having her premiums deducted automatically from her pension.
- Every year during the Option Selection Period, they have the option to change plans. They like the flexibility of being able to change coverage as their health care needs change.
- The SilverSneakers fitness program is included, which can help them with lifestyle changes to better their health conditions.
- The Health Options Program offers Medicare and non-Medicare plans.

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).

When You Reach Age 65

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 Plus and Standard Rx Options. Since the HOP Medical Plan and Value Medical Plan supplement Medicare, monthly premiums are lower than the HOP Pre-65 Medical Plan, and benefits are superior. The premiums for the Plus and Standard Rx Options are also lower than for the prescription drug coverage available with the HOP Pre-65 Medical Plan because of Medicare subsidies.

You will be notified by the HOP Administration Unit prior to your 65th birthday of the opportunity to enroll in plans for Medicare-eligible members. 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.

Notes

HOP
HEALTH OPTIONS PROGRAM
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