For Your Reference

This Summary Plan Description (SPD) describes the HOP Medical Plan in clear, easy-to-understand language. However, since certain medical terms in this Plan Summary may be unfamiliar to you or have special meanings, we have included a Glossary that begins on page 44, to help you better understand how the benefits and services under your health plan work. Any words that are included in the Glossary appear throughout this document in bold italics.

Important Note

The medical coverage and services described in this Plan Summary are provided by private health care insurers and providers. Neither the Public School Employees’ Retirement System nor the Commonwealth of Pennsylvania is an insurer. In no event shall the Public School Employees’ Retirement System, the Health Options Program, or the Commonwealth of Pennsylvania be responsible for any act or omission of any insurance company, third party administrator, health care provider, or other third party that performs services as part of the Health Options Program.

The Retirement Board reserves the right to determine eligibility criteria, time and options to be made available within the Health Options Program, and under what circumstances.

The Pennsylvania Public School Employees’ Retirement System (PSERS) Health Options Program complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. See page 54 for our full Notice of Nondiscrimination.
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The Health Options Program is an ‘umbrella name’ for a program sponsored by the Pennsylvania Public School Employees’ Retirement System (PSERS) that includes a variety of health benefit plans. It is a voluntary health benefits program, available only to PSERS annuitants (retirees), spouses of annuitants, survivor annuitants, and their dependents. It offers health insurance plans to those eligible for Medicare and those who are not yet eligible for Medicare. Each member chooses a plan that best meets his or her health care and financial needs.

- If you are eligible for Medicare, your options include the HOP Medical Plan and the Value Medical Plan, which are available to all Medicare-eligible members, regardless of where they live. For more information about the Value Medical Plan, see the separate Value Medical Plan Summary Plan Description. In addition, depending on where you live, your options may include one or more Medicare Advantage plans. These plans are provided to members of the Health Options Program by insurance companies such as Highmark and Aetna.

- If you are NOT eligible for Medicare, your options include the HOP Pre-65 Medical Plan, which is available to all non-Medicare-eligible members, regardless of where they live. In addition, depending on where you live, your options may include one or more managed care plans. These plans are provided to members of the Health Options Program by insurance companies such as Highmark and Aetna.
Prescription Drug Coverage

Prescription drug coverage is available through the Health Options Program—no matter which option you choose.

- **If you are Medicare-eligible** and enroll in the HOP Medical Plan, you can also enroll in one of three Medicare prescription drug plans. If you enroll in a Medicare Advantage plan, you will be covered automatically by that plan for prescription drugs without a separate enrollment.

- **If you are NOT eligible for Medicare** and enroll in the HOP Pre-65 Medical Plan, you can add optional prescription drugs to your coverage. If you enroll in a managed care plan, you will be covered automatically by that plan for prescription drugs without a separate enrollment.

Comparable Coverage

As a rule, you and your dependents must enroll in comparable coverage. For example, if you elect the HOP Medical Plan, comparable coverage for your spouse is:

- the HOP Medical Plan if he or she is eligible for Medicare, or

- the HOP Pre-65 Medical Plan if he or she is NOT eligible for Medicare.

If you elect a Medicare Advantage plan from an insurance company, comparable coverage for your spouse is:

- the same Medicare Advantage plan you elect for yourself if he or she is eligible for Medicare, or

- the managed care plan from the insurance company that provides your Medicare Advantage plan if he or she is NOT eligible for Medicare.

Exception: You and your spouse do not have to elect comparable coverage if you are BOTH PSERS annuitants.

Program Administration

The Health Options Program is administered for PSERS by Trustmark, which provides services for health care management, claims processing and customer service. The customer service organization, known as the HOP Administration Unit, can be reached at 1-800-773-7725 (weekdays 8 a.m. to 7 p.m. Eastern time).

If you have questions about the Health Options Program, you can go online to the website at www.HOPbenefits.com or call the HOP Administration Unit at 1-800-773-7725.

For More Information about Other Options

This booklet describes only the HOP Medical Plan (for Medicare-eligible members). Separate booklets are available for other plans offered under the Health Options Program, including the Value Medical Plan, the HOP Pre-65 Medical Plan, the Medicare Advantage plans, the managed care plans and the prescription drug plans. For information about any of these plans, contact the HOP Administration Unit.
INTRODUCTION TO THE HOP MEDICAL PLAN

The HOP Medical Plan is one of several options offered under the Health Options Program for Medicare-eligible annuitants, spouses of annuitants, survivor annuitants, and their dependents who receive Medicare benefits (due to either age or disability). Unlike the other options available under the Health Options Program, the HOP Medical Plan is Medicare Supplement Insurance, which means it pays for only things that Original Medicare does not pay.

The HOP Medical Plan differs from other Medicare Supplement Insurance policies (also known as Medigap plans) because it is a group plan—not an individual policy. Individual Medicare Supplement Insurance policies must conform to government standards and provide particular levels of benefits. As a group plan, the HOP Medical Plan can provide benefits not available through standard individual policies.

The HOP Medical Plan provides two types of coverage:

- **Basic Supplemental Benefits** paid when Medicare does not pay 100% of the cost of a Medicare-covered expense. Details about Basic Supplemental Benefits begin on page 7.
- **Major Medical Benefits** paid for certain services that are either not covered by Medicare or incurred after Medicare benefits are exhausted. Details about Major Medical Benefits begin on page 10.
ELIGIBILITY AND ENROLLMENT

Who Is Eligible

*PSERS Medicare*-eligible *annuitants*, survivor *annuitants*, and their eligible *dependents* are eligible to participate in the HOP Medical Plan. Eligible *dependents* include:

- the *annuitant’s* spouse
- the *annuitant’s* unmarried children under 19 years of age, including:
  - natural children
  - stepchildren
  - legally adopted children and children legally *placed for adoption*. (Such child is eligible from the date he or she is *placed for adoption*.)
- the *annuitant’s* unmarried children age 19 to 23 who are enrolled as *full-time students* in an accredited college or university or in a technical or specialized school and who are not regularly employed by one or more employers on a full-time basis, exclusive of scheduled vacation periods. It is the *annuitant’s* responsibility to provide the claims processor with proof of *full-time student* status each semester. The *annuitant* must notify the HOP Administration Unit when the *dependent* is no longer a *full-time student*.
- a disabled child over age 19 who is unmarried, incapable of self-sustaining employment, and *dependent* upon the *annuitant* for support due to a mental and/or physical disability that occurred prior to age 17. Proof of incapacitation must be provided within 31 days of the child’s loss of eligibility and thereafter as requested by *PSERS* or the claims processor, but not more than once every two years. Eligibility may not be continued beyond the earliest of the following:
  - cessation of the mental and/or physical disability
  - failure to furnish any required proof of mental and/or physical disability or to submit to any required examination.

Every eligible *annuitant* may enroll their eligible *dependents*. However, if both spouses are *annuitants*, neither can be covered as both an *annuitant* and a *dependent*. Eligible children may be enrolled as *dependents* of one spouse, but not both.

*PSERS Medicare*-eligible *annuitants*, survivor *annuitants*, and their eligible *dependents* are eligible to participate in the HOP Medical Plan.

When You Become Eligible

An eligible person may enroll in the HOP Medical Plan when he or she experiences one of the following *Qualifying Events*:

- 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 of coverage you may elect under that school employer’s plan.)
• You or your spouse involuntarily loses health care coverage under a non-school employer’s health plan. (Coverage under a non-school employer’s health plan includes any COBRA continuation of coverage you may elect under that non-school employer’s health plan.)

• You or your spouse reaches age 65 or becomes eligible for Medicare.

• There is a change in your family status (including divorce, your spouse’s death, the 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.

• A plan approved for Premium Assistance terminates or you move out of an approved plan’s service area.

Qualifying Events apply to a PSERS annuitant, a survivor annuitant, or the spouse or dependent of an annuitant independently. For example, if the spouse of an annuitant turns age 65 and becomes eligible for Medicare, he or she may enroll in the HOP Medical Plan regardless of whether the annuitant is enrolled. In addition, if one member of the annuitant’s family has a Qualifying Event, all members may enroll.

Your Deadline for Enrolling

An eligible person must enroll in the HOP Medical Plan within 180 days following a Qualifying Event. This means, for example, that the spouse and/or dependents of a deceased annuitant must enroll in the Health Options Program within 180 days following the annuitant’s death; otherwise, they will not be eligible to enroll in the Health Options Program in the future.

You must enroll in the HOP Medical Plan within 180 days following a Qualifying Event.

How to Enroll

To enroll, a PSERS Health Options Program Application must be submitted by the required deadline.

When Coverage Begins

Coverage generally begins the first of the month following the month the Application is received and all eligibility requirements are met, but not before the effective date of coverage indicated on the Application.

Coverage for New Dependents

If you acquire a new dependent (by birth, marriage, adoption or placement for adoption) after you are enrolled in the Health Options Program, coverage for that dependent will begin on or after the date of birth, marriage, adoption or placement for adoption, provided required contributions are received and the dependent is enrolled in the Health Options Program within 180 days of the Qualifying Event.

An eligible person may enroll in the HOP Medical Plan when he or she experiences a Qualifying Event.
When You Can Change Your Health Option

After you enroll in the Health Options Program, you can change your health option during the Option Selection Period each year. You can also change your option if you experience a Qualifying Event.

• An Option Selection Period takes place each fall, generally from early October to mid-November. During that time, you can change from one option or plan to another for which you are eligible, without a Qualifying Event. You will be notified each year about your choices. If you change your option or plan, your new coverage will be effective as of January 1 following the Option Selection Period. If you take no action during the Option Selection Period, your coverage will continue with any changes in premiums and/or benefits effective January 1. If a plan offered through the Health Options Program is discontinued, you will be notified and required to change to another eligible option.

• If you experience a Qualifying Event (see the list that begins on page 4), you become eligible to change your option or plan outside of the Option Selection Period, provided you make the change within 180 days of the Qualifying Event. If one member of an annuitant’s family has a Qualifying Event, all enrolled members may change plans or options.

You can change your health option each year during the Option Selection Period or when you experience a Qualifying Event.

When Coverage Ends

Coverage will terminate for an annuitant on the earliest of the following dates:

• the date PSERS terminates the HOP Medical Plan and offers no other group health plan
• the end of the calendar month in which the annuitant ceases to meet the eligibility requirements of the Health Options Program
• the end of the payment period in which the annuitant ceases to make any required premium payments.

Coverage will terminate for a dependent on the earliest of the following dates:

• the date PSERS terminates the HOP Medical Plan and offers no other group health plan
• the end of the calendar month in which such person ceases to meet the eligibility requirements of the Health Options Program
• the end of the payment period in which the annuitant ceases to make any required premium payments on the dependent’s behalf
• the end of the month in which a dependent age 19 or older is no longer a full-time student
• the end of the month in which a dependent marries
• the end of the calendar year in which a full-time student reaches age 23
• the date the dependent becomes a full-time, active member of the armed forces of any country
• the date the Health Options Program discontinues dependent coverage for any and all dependents.
If you enroll in the HOP Medical Plan, Medicare is the primary payer for covered health care expenses. This means that when you incur a medical expense, Medicare intermediaries adjudicate the claim first to determine:

- whether the service is covered by Medicare, and, if so
- the amount eligible for payment (reimbursement).

If a service is covered by Medicare, amounts not paid by Medicare are then considered for payment by the HOP Medical Plan under applicable terms for Basic Supplemental Benefits. Generally, these amounts are your deductible (the amount you must pay each year before Medicare pays any benefits) and coinsurance (your portion of the cost when Medicare does not pay 100%). Basic Supplemental Benefits supplement both Medicare Part A (hospital) and Medicare Part B (medical) coverage. For more information about amounts paid by Medicare, go online to www.medicare.gov or call 1-800-MEDICARE (1-800-633-4227) and request a copy of Medicare & You.

Summary Chart

The following illustrates the payments you would be required to make for select covered services after both Medicare and Basic Supplemental Benefits have paid their share of the cost.

<table>
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<tr>
<th>BASIC SUPPLEMENTAL BENEFITS</th>
<th>WHAT YOU PAY</th>
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<tr>
<td>Annual Deductible</td>
<td>$0</td>
</tr>
<tr>
<td>Doctor or Physician Visits</td>
<td>$10/visit (PCP); $15/visit (specialist)</td>
</tr>
<tr>
<td>Outpatient Surgery</td>
<td>$0</td>
</tr>
<tr>
<td>Urgent Care Facility</td>
<td>$15/visit</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>$40 (waived if admitted)</td>
</tr>
<tr>
<td>Hospitalization</td>
<td>$0</td>
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| Diagnostic Testing                            | $0 (x-ray and laboratory)
| Durable Medical Equipment                     | 10% up to $100 per item                           |
| Outpatient Therapy                            | $0 (imaging-e.g., MRI and CT Scans)               |
| Inpatient Mental Health                        | $10/office visit; $0 (other services)             |
| Physical Exams                                | $0                                                |
| Ob/Gyn Exams                                  | Not covered (unless approved by Medicare)         |
| Mammograms                                    | $10/exam                                          |
|                                              | $0                                                |
Basic Supplemental Benefits may pay all or a portion of the amount not paid by Medicare for a Medicare-covered expense.

How Basic Supplemental Benefits Supplement Medicare Part A (Hospital)

With Original Medicare alone, you are required to pay deductibles, copays, and/or coinsurance for most covered services.

For example, if you are admitted to a hospital, you pay a first-day deductible ($1,364 in 2019) and then Medicare pays all Medicare-approved expenses for the first 60 days of each benefit period. After 60 days, you pay a copay. In 2019, your copay is $341/day for days 61 - 90 and $682/day for days 91 - 150 (known as your “lifetime reserve days”). Then you pay 100% of the cost.

If you are enrolled in the HOP Medical Plan, Basic Supplemental Benefits pay the Part A deductible and your copays for all Medicare-approved expenses after the first 60 days until you use up all days covered by Medicare, including your lifetime reserve days. After that, you may be eligible for additional hospital benefits under the HOP Medical Plan’s Major Medical Benefits (see page 10).

As another example, if Medicare approves your admission to a skilled nursing facility, Original Medicare pays the full cost for the first 20 days of each benefit period. You pay a portion of the cost (coinsurance) for days 21 - 100 ($170.50/day in 2019) and all costs after 100 days. If you are enrolled in the HOP Medical Plan, Basic Supplemental Benefits pay your Medicare coinsurance for days 21-100. Once you have used the 100 days covered by Medicare, additional skilled nursing facility services may be covered under the HOP Medical Plan’s Major Medical Benefits (see page 10).

How Basic Supplemental Benefits Supplement Medicare Part B (Medical)

With Original Medicare alone, you must meet the Part B deductible each year before Medicare will pay its share of the cost for certain covered expenses. (In 2019, the annual deductible is $185.) After you meet the deductible, you typically pay 20% of the Medicare-approved amount for a covered service, assuming your doctor or other health care provider accepts assignment. (Assignment means the provider has agreed to be paid directly by Medicare, to accept the payment amount approved by Medicare, and not to bill you for any amount that exceeds the Medicare deductible and coinsurance.)

If you are enrolled in the HOP Medical Plan, the Plan will pay your deductible and your 20% of the Medicare-approved amount for covered services. There are fixed dollar copays for doctor office visits, emergency room visits, and other services as shown in the chart on page 7. However, no payment will be made for charges not allowed by Medicare Part B, including but not limited to charges from a provider not participating in Medicare.

For outpatient mental health care (such as counseling or psychotherapy) not conducted in an office setting, in 2019, Medicare will pay 80% and you would pay 0% after Basic Supplemental Benefits. Please note, if you receive outpatient mental health services and your provider codes your session as an office visit, you will be subject to a $10/visit copay.
Part B Covered Services and Supplies

Individuals covered under the HOP Medical Plan are entitled to supplemental payments under Basic Supplemental Benefits for all services and supplies paid by Medicare Part B, which may include:

1. ambulance services—ground ambulance transportation to a hospital or skilled nursing facility
2. ambulatory surgical centers for approved surgical procedures
3. breast cancer screening—once every 12 months
4. cardiac rehabilitation
5. chemotherapy in a doctor’s office or hospital outpatient setting for people with cancer
6. colorectal cancer screening
7. diabetes screening, self-management screening, and supplies not covered by Medicare Part D
8. doctor and other health care provider services
9. durable medical equipment—such as oxygen equipment, wheelchairs, etc. from a Medicare-approved supplier
10. emergency department services
11. kidney dialysis services and supplies
12. laboratory services
13. mental health care (outpatient)
14. outpatient medical and surgical services and supplies, including a visit to an urgent care facility
15. physical, occupational, and speech therapy
16. prosthetic/orthotic items such as braces, artificial limbs, and prostheses devices
17. second surgical opinions
18. surgical services
19. transplants and immunosuppressive drugs
20. yearly “wellness” visit

What Is Not Covered under Basic Supplemental Benefits

In addition to General Exclusions (page 23), exclusions under the Basic Supplemental Benefits include but are not limited to:

1. blood or blood plasma in excess of three pints
2. home health care
3. medical expenses once Medicare benefits are exhausted
4. medical expenses not covered by Medicare, which may include services from a facility or provider opting out of Medicare.

These medical expenses may be covered under the HOP Medical Plan’s Major Medical Benefits.
MAJOR MEDICAL BENEFITS

If you enroll in the HOP Medical Plan, Medicare is the primary payer for covered health care expenses. This means that when you incur a medical expense, Medicare intermediaries adjudicate the claim first to determine:

- whether the service is covered by Medicare, and, if so
- the amount eligible for payment (reimbursement).

If Medicare rejects your claim, Major Medical Benefits may cover professional providers’ allowable charges for specific medically necessary hospitalization and medical benefits that are:

- not covered by Medicare and Basic Supplemental Benefits, or
- covered by Medicare and Basic Supplemental Benefits, but Medicare limits have been reached.

If Medicare determines that a service or product is not medically necessary, it will not be covered under Major Medical Benefits.

When you submit a claim that has been rejected for payment by Medicare, the HOP Administration Unit adjudicates the claim to determine:

- whether the service is covered under Major Medical Benefits, and if so,
- the amount eligible for payment (reimbursement).

This includes claims that are rejected by Medicare because you have already received Medicare’s maximum benefit. For example, Medicare limits benefits for care in a skilled nursing facility to 100 days. Once you reach 100 days (and Medicare stops paying benefits), the Health Care Management Organization will make an independent assessment of your need to remain in the skilled nursing facility. Major Medical benefits may be approved or, if it is determined that the services in question are for custodial care (which is not covered by the HOP Medical Plan), no Major Medical Benefits will be paid.

Obtaining Certifications

Certain services require that you obtain advance certification from the Health Care Management Organization. In addition, if a service is certified for a specific period and, at the end of the period, an extension is required, you must request a certification of the extension. If the Health Care Management Organization determines that continued confinement is no longer medically necessary and/or is for custodial care, additional days will not be certified.
When you request a certification, the Health Care Management Organization will evaluate whether proposed services, supplies, or treatments are medically necessary and appropriate for payment under the terms and conditions of the HOP Medical Plan. However, certification of medical necessity and appropriateness by the Health Care Management Organization does not establish eligibility under the HOP Medical Plan or guarantee benefits.

Certain services require that you obtain advance certification from the Health Care Management Organization. Call 1-800-480-6658 to request a certification.

Certification by the Health Care Management Organization is required for the following Major Medical Benefits:

- home intravenous infusion therapy
- home skilled nursing care
- acute inpatient hospital admissions or continued stays. Note: The Plan may NOT restrict benefits for a hospital stay in connection with childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section

- skilled nursing facility admissions or continued stays

The Health Care Management Organization can be reached by calling the number listed for authorization on the back of your HOP Medical Plan ID card (1-800-480-6658).

When you call for certification, be prepared to provide all of the following information:

- annuitant’s name, address, phone number, and the ID number shown on the front of the HOP Medical Plan ID card
- the patient’s name, address, phone number (if not the annuitant)
- admitting physician’s name and phone number
- name of facility or home health care agency
- date of admission or proposed date of admission
- condition for which patient is being admitted

Time Frames for Initial Certifications

For non-urgent care, you or your authorized representative should call the Health Care Management Organization at least 15 calendar days prior to initiation of services or continuation of services after Medicare benefits are exhausted. For urgent care, you or your authorized representative may call the Health Care Management Organization within 48 hours or the next business day, if later, after the initiation of services.

If no additional information is required, the determination of coverage will generally be completed within a reasonable period of time, but no later than 15 calendar days from receipt of the request.

In the event the HOP Medical Plan receives a communication that fails to follow the certification procedure described above but communicates at least your name, a specific medical condition or symptom, and a specific treatment, service, or product for which prior approval is requested, you (or your authorized representative) will be notified orally (and in writing, if requested) within five calendar days of the failure to follow the proper procedure.
If the **Health Care Management Organization** needs additional time to make a decision due to circumstances beyond its control, you will be notified within the 15 calendar days of the circumstances and the date by which the **Health Care Management Organization** expects to render a decision. If the circumstances include a failure by you to submit necessary information, the notice will specifically describe the needed information. You will have 45 calendar days to provide the information requested, and the **Health Care Management Organization** will complete its determination of the claim for certification no later than 15 calendar days after receiving the requested information. Failure to respond in a timely and complete manner will result in a denial of the requested certification.

**Time Frames for Certification Extensions**

If you request an extension of a previously approved hospitalization, **skilled nursing facility stay**, or ongoing course of treatment, and the request involves **non-urgent care**, the extension request will be processed within 15 calendar days after the request is received.

If the **inpatient** admission or ongoing course of treatment involves **urgent care** and the request is received at least 24 hours before the scheduled end of a hospitalization or course of treatment, the request will be ruled upon and you will be notified as soon as possible but no later than 24 hours after the request is received.

If the **inpatient** admission or ongoing course of treatment involves **urgent care** and the request is received less than 24 hours before the scheduled end of a hospitalization or course of treatment, the request will be ruled upon and you will be notified no later than 72 hours after the request is received.

**If a Certification Changes**

If the **Health Care Management Organization** determines that the **hospital** or **skilled nursing facility** stay or course of treatment should be shortened or terminated before the end of the fixed number of days and/or treatments, or the fixed time period that was previously approved, the HOP Administration Unit will:

- notify you of the proposed change, and
- allow you to file an appeal and obtain a decision before the end of the fixed number of days and/or treatments or the fixed time period that was previously approved.

**If a Certification Is Denied**

If your request for a certification or certification extension is denied in whole or in part, the HOP Administration Unit will provide you with a written Notice of Certification Denial within the time frames indicated above. The Notice of Certification Denial will include an explanation of the denial, including:

- the specific reason(s) for the denial
- reference to the HOP Medical Plan provisions on which the denial is based
- if the denial is due to a lack of information necessary for certification, a description of any additional material or information needed and an explanation of why such material or information is necessary
- a description of the HOP Medical Plan claim review procedure and applicable time limits
- if the denial relies upon an internal rule, guideline, protocol or other similar criterion, either a copy of that criterion or a statement that such criterion was relied upon and will be supplied free of charge, upon request
• if denial was based on custody care, medical necessity, experimental/investigational treatment, or similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the terms of the HOP Medical Plan to your medical circumstances, or a statement that such explanation will be supplied free of charge, upon request.

• a statement that you have a right to appeal.

**Appealing a Denied Certification**

For information about the process for appealing a denied certification, see “Appealing a Denied Certification” on page 28.

**Case Management**

If your condition is expected to be or is of a serious nature, the Health Care Management Organization may arrange for review and/or case management services from a professional qualified to perform such services. The Plan sponsor shall have the right to alter or waive the normal provisions of the HOP Medical Plan when it is reasonable to expect a cost-effective result without sacrificing the quality of care.

In addition, the Health Care Management Organization may recommend (or change) alternative methods of medical care or treatment, equipment, or supplies that:

• are not covered expenses under the HOP Medical Plan, or

• are covered expenses under the HOP Medical Plan but on a basis that differs from the alternative recommended by the Health Care Management Organization.

The recommended alternatives will be considered covered expenses under Major Medical Benefits provided the expenses can be shown to be viable and medically necessary, and are included in a written case management report or treatment plan proposed by the Health Care Management Organization.

Case management will be determined on the merits of each individual case, and any care or treatment provided will not set any precedent or create any future liability with respect to you or any other covered individual.

**Elder Care Program**

Health Care Management Organization

Registered Nurse (RN) case managers can assist patients in obtaining medically necessary home skilled nursing care, a skilled nursing facility admission, or home intravenous infusion therapy if it is covered under the HOP Medical Plan but not covered or covered with limitations under Medicare. Each RN case manager is an experienced nurse trained to handle these special cases by helping both the patient and family members coordinate home skilled nursing care, skilled nursing facility care, and home intravenous infusion services. If you need assistance with this type of care, you or your doctor can call the toll-free number on the back of your medical ID card (1-800-480-6658). When you call, a representative from the Health Care Management Organization will answer any questions you may have about your benefits and refer you to an RN Case Manager for certification. Keep in mind, these services are available only when they are medically necessary and to the extent they are covered under the HOP Medical Plan.
If your care requires certification, a Registered Nurse can help you apply for certification. Call the Health Care Management Organization at 1-800-480-6658.

How Major Medical Benefits Are Paid

Unless stated otherwise, all expenses covered under Major Medical Benefits are subject to specific provisions, including but not limited to an annual deductible, coinsurance and benefit maximums. Any portion of an expense you incur for services, supplies, or treatment that is greater than the allowable charge will not be covered.

Annual Deductible

You must meet an annual deductible each calendar year for most covered expenses before any Major Medical Benefits are paid.

- The individual deductible is the amount that each covered individual must pay each calendar year before Major Medical Benefits pay applicable benefits.
- When two covered members of the same family each meet their individual deductible during a calendar year, the family deductible is satisfied for that calendar year for all covered family members. No further deductible will be required from any covered family member for the rest of the calendar year.
- Amounts incurred during October, November, and December and applied toward the individual deductible of any covered individual will also apply to that individual’s deductible in the next calendar year.

Coinsurance

You pay a percentage of the cost of a covered expense, called your coinsurance, after you meet the annual deductible (unless no deductible is required). However, if you use a provider that charges more than the allowable charge (as determined by the HOP Administration Unit), you will be responsible for 100% of the amount that exceeds the allowable charge, in addition to the coinsurance amount.

Annual Out-of-Pocket Maximum

You pay coinsurance each calendar year until the amount you have paid, including the deductible, reaches the annual out-of-pocket maximum. After that, Major Medical Benefits pay 100% of covered expenses for the rest of the calendar year (or until the lifetime maximum paid by the Plan is reached). When two covered members of the same family each reach the annual out-of-pocket maximum in a calendar year, Major Medical Benefits pay 100% of covered expenses for all covered family members for the rest of the calendar year.

The following items do not count toward the annual out-of-pocket maximum. You will be responsible for these expenses, even if the out-of-pocket maximum has been met:

- services, supplies, and treatments not covered by Major Medical Benefits
- your copays under Basic Supplemental Benefits
- amounts in excess of the allowable charge
- services, supplies, and treatments for mental health disorders
- services, supplies, and treatments for outpatient chemical dependency.
Summary Chart

This chart summarizes how much you pay for *covered expenses* in 2019 under Major Medical Benefits. **NOTE:** Major Medical Benefits apply if a service is not covered by Medicare or if you exhaust your Basic Supplemental Benefits.

<table>
<thead>
<tr>
<th>MAJOR MEDICAL BENEFITS</th>
<th>WHAT YOU PAY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual deductible</td>
<td>$250</td>
</tr>
<tr>
<td>Annual out-of-pocket limit</td>
<td>$1,000</td>
</tr>
<tr>
<td>Maximum lifetime benefit</td>
<td>$1,000,000</td>
</tr>
<tr>
<td>Inpatient hospital days exceeding Medicare’s lifetime reserve</td>
<td>% of Allowable Charge</td>
</tr>
<tr>
<td>• Up to lifetime maximum of 365 additional days (combination of hospital and skilled nursing facility days cannot exceed 365)</td>
<td>0% (not subject to deductible)</td>
</tr>
<tr>
<td>• After 365 additional days</td>
<td>20%</td>
</tr>
<tr>
<td>Emergency room services</td>
<td>20%</td>
</tr>
<tr>
<td>Physician’s services</td>
<td></td>
</tr>
<tr>
<td>• Medicare excess charges</td>
<td>20%</td>
</tr>
<tr>
<td>• Physician’s services from a provider opting out of Medicare</td>
<td>80%</td>
</tr>
<tr>
<td>Services from other provider opting out of Medicare</td>
<td>80%</td>
</tr>
<tr>
<td>Diagnostic x-rays and lab</td>
<td>20%</td>
</tr>
<tr>
<td>Skilled nursing facility for days exceeding 100 Medicare-covered days</td>
<td>% of Allowable Charge</td>
</tr>
<tr>
<td>• Up to lifetime maximum of 100 additional days (combination of skilled nursing facility and hospital days cannot exceed 365)</td>
<td>0% (not subject to deductible)</td>
</tr>
<tr>
<td>• After 100 additional days</td>
<td>20%</td>
</tr>
<tr>
<td>IV therapy</td>
<td>20%</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>20%</td>
</tr>
<tr>
<td>Routine gynecological exam (limited to one visit per calendar year in years not covered by Medicare)</td>
<td>20%</td>
</tr>
<tr>
<td>Mental health services</td>
<td></td>
</tr>
<tr>
<td>• Inpatient (limited to 10 days per calendar year)</td>
<td>20%</td>
</tr>
<tr>
<td>• Outpatient (limited to 30 visits per calendar year, including visits for chemical dependency)</td>
<td>20%</td>
</tr>
<tr>
<td>• All other mental health outpatient services</td>
<td>20%</td>
</tr>
<tr>
<td>Outpatient chemical dependency services (limited to 30 visits per calendar year, including visit for mental health; outpatient services not covered)</td>
<td>20%</td>
</tr>
<tr>
<td>Physical, speech, and occupational therapy services (limited to 26 visits per calendar year in addition to Medicare maximum for physical and occupational therapy combined)</td>
<td>20%</td>
</tr>
<tr>
<td>Ambulance services (limited to $150 maximum benefit per trip for advanced life support by either surface or air ambulance—see page 17 for additional details)</td>
<td>20%</td>
</tr>
<tr>
<td>Chiropractor services (see page 18 for additional details)</td>
<td>20%</td>
</tr>
<tr>
<td>Other covered services</td>
<td>20%</td>
</tr>
</tbody>
</table>
Major Medical Benefits do not cover any portion of an expense that exceeds the allowable charge as determined by the HOP Administration Unit.

Benefit Limits

The lifetime maximum that will be paid by Major Medical Benefits for any covered individual is $1,000,000. The lifetime benefit maximum applies to the entire time you are enrolled in the HOP Medical Plan. If you terminate coverage and reenroll at a later date, all benefits paid before and after the termination(s) (including benefits paid under predecessor plans, i.e., the High and Standard Options) will count toward the lifetime maximum paid by the Plan.

Certain conditions have separate benefit limits (see page 15). All benefits paid by Major Medical Benefits during all periods of coverage under the HOP Medical Plan will count toward these separate benefit limits. All separate benefit limits are part of, and not in addition to, the lifetime maximum paid by the Plan.

If your Medicare benefits are exhausted, Major Medical Benefits may pay up to $1 million in additional benefits for covered services over the course of your lifetime.

Services and Supplies That May Be Covered When Medicare Part A (Hospital) Benefits Are Exhausted

The following services covered under Medicare Part A may be covered by Major Medical Benefits when Medicare Part A benefits are exhausted:

1. inpatient room and board, including intensive care units, cardiac care units, and similar medically necessary accommodations. Covered expenses for room and board shall be limited to the hospital’s semiprivate rate. Covered expenses for intensive care or cardiac care units shall be the allowable charge. A full private room rate is covered if the private room is necessary for isolation purposes and is not for the convenience of the individual. If a private room is used for the convenience of the patient, covered expenses for room and board shall be limited to the hospital’s semiprivate rate, plus $10 per day.

2. miscellaneous services, supplies, and treatments (excluding services still covered under Medicare Part B) including:
   a. admission fees – admission fees and other fees assessed by the hospital for rendering services, supplies, and treatments
   b. anesthesia – anesthesia, anesthesia supplies, and its administration by an employee of the hospital
   c. blood transfusions – blood transfusions, including the cost of whole blood, the administration of blood, blood processing, and blood derivatives (to the extent blood or blood derivatives are not donated or otherwise replaced)
   d. operating/other rooms – use of operating, treatment, or delivery rooms
   e. oxygen – oxygen and other gas therapy and the administration thereof
   f. prescription drugs – drugs and medicines (except drugs not used or consumed in the hospital)
g. surgical dressings – medical and surgical dressings and supplies, casts, and splints

h. therapy – therapy services

i. x-ray and lab – x-ray and diagnostic laboratory procedures and services.

3. services of facility providers if such services would have been covered if performed in a hospital

4. skilled nursing facility – up to 100 days of skilled nursing facility benefits provided you are receiving skilled nursing care and/or therapy ordered by a physician and your condition can be reasonably expected to improve. (Note that the critical nature of a non-skilled service and the frequency with which it must be performed are not factors that determine coverage for skilled nursing facility benefits.) The HOP Administration Unit and/or Health Care Management Organization will evaluate the facility services provided once Medicare benefits are exhausted to determine if skilled nursing facility benefits are payable under Major Medical Benefits. The HOP Administration Unit will not be bound by Medicare’s determination that services are for skilled nursing facility care as opposed to custodial care. Skilled nursing facility services, supplies, and treatments are covered expenses provided the covered individual is under a physician’s continuous care and the physician certifies that the individual must have 24-hour-per-day nursing care and the patient’s condition can reasonably be expected to improve. Covered expenses include:

a. room and board (including regular daily services, supplies, and treatments furnished by the skilled nursing facility) limited to the facility’s average semiprivate room rate

b. other services, supplies, and treatment ordered by a physician and furnished by the skilled nursing facility for inpatient medical care (excluding services still covered under Medicare Part B).

The HOP Medical Plan does not provide coverage for custodial care (commonly referred to as long-term care) including confinements in a facility that provides skilled nursing facility care. While the specific services of a physician or skilled nurse that are otherwise covered by the Plan are covered while you are confined for custodial care, room and board charges are not. If a nursing facility does not differentiate between skilled and non-skilled care, all care will be deemed non-skilled. See page 51 for the definition of skilled nursing facility.

Other Services and Supplies That May Be Covered by Major Medical Benefits

The following services may also be covered by Major Medical Benefits:

1. ambulance – ambulance services provided by a licensed air or ground ambulance. Covered expenses include:

a. ambulance service for air or ground transportation from the place of injury or serious medical incident to the nearest hospital where treatment can be given.

b. ambulance service in a non-emergency situation only to transport the patient to or from a hospital or between hospitals for required treatment when such transportation is certified by the attending physician as medically necessary. Such transportation is covered only from the initial hospital to the nearest hospital qualified to render the special treatment.
MAJOR MEDICAL BENEFITS

c. emergency services provided by an advance life support unit or paramedic intercept, even though the unit does not provide transportation, subject to the maximum benefit shown on page 15.
d. wheelchair and stretcher transportation when such required treatment is certified by the attending physician as medically necessary.

2. chiropractic – medically necessary services performed by a chiropractor. Charges related to structural imbalance or subluxation for the purpose of removing nerve interference are not covered when related to distortion, misalignment, or subluxation of or in the vertebral column.

3. dental services resulting from an injury – dental services for the repair of the jaw, sound natural teeth or surrounding tissue, mouth, or face provided the repair is needed as the result of an injury occurring on or after the individual’s effective date of coverage. Damage to the teeth as a result of chewing or biting is not considered an injury under this benefit. Also covered is the orthodontic treatment of congenital cleft palates involving the maxillary arch, performed in conjunction with bone graft surgery to correct the bony deficits associated with extremely wide clefts affecting the alveolus.

4. durable medical equipment – rental or purchase, whichever is less costly, of medically necessary durable medical equipment that is prescribed by a physician and required for therapeutic use. Equipment containing features of an aesthetic nature or features of a medical nature that are not required by the individual’s condition, or where there exists a reasonably feasible and medically appropriate alternative piece of equipment that is less costly than the equipment furnished, will be covered based on the usual charge for the equipment which meets the individual’s medical needs. Repair or replacement of durable medical equipment due to normal use will be considered a covered expense.

5. education programs – medically necessary patient education programs, including but not limited to ostomy care.

6. gynecological exam – routine gynecological examinations and papanicolaou (Pap) smears, subject to the maximum benefit shown on page 15.

7. home IV therapy – home IV therapy that enables you to receive treatment at home for an illness or injury instead of being confined in a hospital or skilled nursing facility. Charges must be incurred through and billed by a home health care agency.

8. inpatient mental health – treatment, services, and supplies related to the inpatient treatment of mental health disorders, subject to the coinsurance and maximum benefit shown on page 15. Covered expenses include:
   a. biofeedback
   b. electroconvulsivestherapy (electroshock treatment) or convulsive drug therapy, including anesthesia when administered concurrently with the treatment by the same professional provider
   c. group psychotherapy
   d. individual psychotherapy
e. **inpatient hospital confinement**

f. **partial confinement** in a **hospital**

g. psychological testing.

9. **mastectomies** – mastectomies, in accordance with the federal law known as the Women’s Health and Cancer Rights Act of 1998. **Covered expenses** include eligible charges related to a **medically necessary** mastectomy. If an individual elects breast reconstruction in connection with such mastectomy, **covered expenses** will include:

a. reconstruction of a surgically removed breast, and

b. surgery and reconstruction of the other breast to produce a symmetrical appearance.

Prostheses (and **medically necessary** replacements) and physical complications from all stages of mastectomy, including lymphedemas, will also be considered **covered expenses** following all **medically necessary** mastectomies.

10. **orthotics** – orthotic devices and appliances (rigid or semi-rigid supportive devices that restrict or eliminate motion for a weak or diseased body part), including initial purchase, fitting, and repair. Orthopedic shoes or corrective shoes, unless they are an integral part of a leg brace, and other supportive devices for the feet are not covered. Repair or replacement of orthotics due to normal use will be considered a **covered expense**.

11. **outpatient mental health** – **outpatient** treatment, services, and supplies related to the treatment of **mental health disorders**, subject to the **coinsurance** and **maximum benefit** shown on page 15.

12. **physician** who does not accept assignments or has opted out of **Medicare** – **Medicare physicians** who do not accept assignments (payments directly from **Medicare**) receive a reduced payment from **Medicare** and are allowed to bill excess charges to the patient. If you choose to use a **physician** who does not accept assignments, you will pay the percentage shown on page 15 for **Medicare’s** excess charges. **Physicians** who have opted out of **Medicare** and are not **Medicare**-participating **professional providers** receive no payments from **Medicare**. If you choose to use a **physician** who has opted out of **Medicare**, you will pay the percentage shown on page 15 plus any amount over the **allowable charge**. **Covered expenses** include:

a. medical treatment, services, and supplies, including but not limited to office visits, **inpatient visits**, and home visits

b. surgical treatment. Separate payment will not be made for **inpatient** pre-operative or post-operative care normally provided by a surgeon as part of the surgical procedure. For related operations or procedures performed through the same incision or in the same operative field, **covered expenses** include the surgical allowance for each procedure. When two or more unrelated operations or procedures are performed at the same operative session, **covered expenses** include the surgical allowance for each procedure

c. surgical assistance provided by a **physician** if it is determined that the condition of the individual or the type of surgical procedure requires such assistance
d. furnishing or administering anesthetics, other than local infiltration anesthesia, by other than the surgeon or the surgeon’s assistant

e. consultations requested by the attending physician during a hospital confinement

f. radiologist or pathologist services for interpretation of x-rays and laboratory tests necessary for diagnosis and treatment

g. radiologist or pathologist services for diagnosis or treatment, including radiation therapy and chemotherapy

h. second surgical opinions regarding the medical necessity of surgery by a board-certified specialist in the treatment of the individual’s illness or injury who is not affiliated in any way with the physician who will be performing the actual surgery. In the event of conflicting opinions, a third opinion may be obtained. The Plan will consider payment for a third opinion the same as a second surgical opinion

i. transplant services, supplies, and treatments for the recipient in connection with human-to-human organ and tissue transplant procedures, provided the recipient is covered under this Plan.

13. prosthesis – the initial purchase of a prosthesis (other than dental) provided for functional reasons when replacing all or part of a missing body part (including contiguous tissue) or to replace all or part of the function of a permanently inoperative or malfunctioning body organ. Repair or replacement of a prosthesis that is medically necessary due to normal use or growth of a child will be considered a covered expense.

14. special supplies – medically necessary special supplies, including but not limited to casts, splints, braces, trusses, surgical and orthopedic appliances, colostomy and ileostomy bags and supplies required for their use, catheters, crutches, electronic pacemakers, oxygen and the administration thereof, surgical dressings, and other medical supplies ordered by a professional provider in connection with medical treatment. Equipment containing features of an aesthetic nature or features of a medical nature that are not required by the individual’s condition, or where there exists a reasonably feasible and medically appropriate alternative piece of equipment which is less costly than the equipment furnished, will be covered based on the usual charge for the equipment that meets the individual’s medical needs.

15. therapy – therapy services ordered by a physician to aid restoration of normal function lost due to illness or injury. Covered expenses include:

a. cardiac – cardiac therapy

b. dialysis – dialysis therapy or treatment

c. restorative physical, occupational, and speech – the services of a professional provider for physical therapy, occupational therapy, or speech therapy up to the number of visits shown on page 15

d. radiation and chemo – radiation therapy, chemotherapy, and global fees for chemotherapy treatment from an approved licensed facility including self-administered drugs.
16. **transsexualism** – services, supplies or treatment for transsexualism, gender dysphoria or sexual reassignment or change, including medications, implants, hormone therapy, surgery, and medical or psychiatric treatment.

**What Is Not Covered under Major Medical Benefits**

In addition to General Exclusions (page 23), no benefit will be provided under Major Medical Benefits for:

1. **abortion** – services provided to an individual for an elective abortion
2. **acupuncture** – acupuncture treatment
3. **birth control** – services, supplies, or devices, including birth control pills, regardless of whether such pills are to be used for contraceptive or medical reasons
4. **chemical dependency** – inpatient treatment of chemical dependency or treatment, services or supplies for confinement or partial confinement in a hospital related to the treatment of chemical dependency
5. **chiropractic services** – the detection and correction by manual or mechanical means of structural imbalance or subluxation for the purpose of removing nerve interference resulting from or related to distortion, misalignment, or subluxation of or in the vertebral column
6. **circumcisions** – routine neonatal circumcisions
7. **comfort items** – services, supplies, or treatment that constitute personal comfort or beautification items, whether or not recommended by a physician, such as television, telephone, air conditioners, air purifiers, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages, non-hospital adjustable beds, and exercise equipment
8. **corrective vision surgery** – eye surgery solely for the purpose of correcting refractive defects of the eye, such as near-sightedness (myopia) and astigmatism including radial keratotomy by whatever name called
9. **cosmetic services** – cosmetic surgery or procedure and all related services
10. **custodial care** – custodial care, domiciliary care, or rest cures
11. **dental care** – except as specifically stated on page 18, services, supplies, or treatments for or in connection with treatment of injury or disease of the teeth, oral surgery, treatment of gums or structures directly supporting or attached to the teeth, removal or replacement of teeth, or dental implants
12. **drugs for outpatient use** – drugs dispensed by a pharmacy or a physician for outpatient use
13. **educational or vocational services** – services, supplies, or treatments that are primarily educational in nature, except as specified on page 18; charges for services for educational or vocational testing or training and work hardening programs regardless of diagnosis or symptoms; charges for self-help training or other forms of non-medical self-care
14. **hearing exam** – an examination to determine hearing loss or the fitting, purchase, repair, or replacement of a hearing aid
15. **hypnosis** – expenses related to hypnosis
16. **infertility treatment** – services, supplies, or treatment related to the treatment of infertility and artificial reproductive procedures, including but not limited to artificial insemination, in vitro fertilization, surrogate mother, fertility drugs, embryo implantation, or gamete intrafallopian transfer (GIFT)
17. **inpatient diagnostic tests** – **inpatient room and board** in connection with a **hospital confinement** primarily for diagnostic tests, unless it is determined by the **Health Care Management Organization** that **inpatient** care is **medically necessary**

18. **Medicare or Basic Supplemental Benefits** – services, supplies, or treatment that are payable by Medicare Part A or Part B or Basic Supplemental Benefits

19. **non-Medicare facility charges** – charges **incurred** at an **inpatient facility** that has opted out of the Medicare Program

20. **non-Medicare hospice care charges** – hospice care that is not covered under Medicare, regardless of whether it is provided at home, in an **outpatient** setting, or in a **facility** setting

21. **non-Medicare provider charges** – charges **incurred** by a **physician** or other medical provider that has opted out of the Medicare Program except as specifically provided herein

22. **nonprescription drugs** – vitamins, cosmetic dietary aids, nutritional supplements, etc.

23. **not medically necessary services and supplies** – services and products that are determined by Medicare to be not **medically necessary**

24. **obesity treatment** – the treatment of obesity, except for surgical treatment of morbid obesity

25. **orthopedic shoes** – orthopedic shoes (except when they are an integral part of a leg brace and the cost is included in the orthotist’s charge)

26. **reversal of sterilization** – services, supplies, or treatment for the reversal of sterilization procedures

27. **routine foot care** – except as **medically necessary** for the treatment of metabolic or peripheral-vascular **illness**, routine, palliative, or cosmetic foot care, including but not limited to treatment of weak, unstable, flat, strained, or unbalanced feet; subluxations of the foot; treatment of corns or calluses; non-surgical care of toenails

28. **routine physical examinations** – routine or periodic physical examinations, except as specified herein

29. **routine vision exams/products** – routine vision examinations and eye refractions, orthoptics, eyeglasses, or contact lenses, except when new cataract lenses are needed because of a prescription change

30. **services not covered** – any services, supplies, or treatment not specifically provided herein

31. **sexual dysfunction** – treatment or surgery for sexual dysfunction unless related to organic **illness**

32. **surgical facility** – charges **incurred** at an **ambulatory surgical facility**

33. **TMJ** – treatment of temporomandibular joint dysfunction (TMJ), or any other method to alter vertical dimension

34. **travel** – travel or accommodations, whether or not recommended by a **physician**, except as specifically provided herein

35. **well-baby** – any charges for well-baby care.

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**You can call the HOP Administration Unit (1-800-773-7725) if you have a question about whether a particular service is covered under Major Medical Benefits.**
GENERAL EXCLUSIONS

The HOP Medical Plan will not provide benefits for certain items, regardless of medical necessity or recommendation of a physician or professional provider. Those items include but are not limited to:

1. **criminal activity** – charges in connection with any illness or injury resulting from or occurring during commission or attempted commission of a criminal battery or felony by the covered individual

2. **employment or self-employment** – charges in connection with any illness or injury arising out of or in the course of any employment intended for wage or profit, including self-employment

3. **experimental/investigational** – charges for services, supplies, or treatment that are considered experimental/investigational

4. **government hospital** – charges for services, supplies, or treatment from any hospital owned or operated by the United States government or any agency thereof or any government outside the United States, or charges for services, treatment, or supplies furnished by the United States government or any agency thereof or any government outside the United States, unless payment is legally required

5. **hygiene items** – charges for disposable, non-reusable, hygienic items. These include but are not limited to infant/adult diapers, disposable sheets and bags, disposable underpads, and common first aid supplies

6. **late claims** – claims not submitted within the HOP Medical Plan filing deadlines as specified in the “Filing Claims” section

7. **military service injury** – charges for an injury sustained or illness contracted while on active duty in military service, unless payment is legally required

8. **missed appointments** – charges for telephone consultations, completion of claim forms, charges associated with missed appointments

9. **motor vehicle insurance** – charges for treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified self-insured plan, or payable by the Catastrophic Loss Trust Fund established under the Pennsylvania Motor Vehicle Financial Responsibility Law

10. **not licensed providers** – charges for services, supplies, or treatment rendered by physicians or professional providers beyond the scope of their license; for any treatment, confinement, or service which is not recommended by or performed by an appropriate professional provider

11. **not medically necessary services and supplies** – services and products that are determined by Medicare to be not medically necessary
12. **not required to pay** – any services, supplies, or treatment for which the individual is not legally required to pay; or for which no charge would usually be made; or for which such charge, if made, would not usually be collected if no coverage existed; or to the extent the charge for the care exceeds the charge that would have been made and collected if no coverage existed.

13. **prohibited by law** – to the extent that payment under the HOP Medical Plan is prohibited by any law of any jurisdiction in which the individual resides at the time the expense is incurred.

14. **services provided by relative** – charges for services, supplies, or treatment rendered by any individual who is a close relative of the covered individual or who resides in the same household as the covered individual.

15. **third party liability** – charges for illnesses or injuries suffered by an individual due to the action or inaction of any party if the individual fails to provide information as specified in “Subrogation/Reimbursement” (page 35).

16. **war** – charges for services, treatment, or supplies for treatment of illness or injury that is caused by or attributed to by war or any act of war, participation in a riot, civil disobedience, or insurrection. “War” means declared or undeclared war, whether civil or international, or any substantial armed conflict between organized forces of a military nature.

17. **while not covered** – charges for services rendered and/or supplies received prior to the effective date of coverage or after the termination date of a person’s coverage.

18. **Worker’s Compensation** – any condition for which benefits of any nature are payable or are found to be eligible, either by adjudication or settlement, under any Workers’ Compensation law, employer’s liability law, or occupational disease law, even though the individual fails to claim rights to such benefits or fails to enroll or purchase such coverage.
FILING CLAIMS

Claims for Basic Supplemental Benefits should be submitted initially to Medicare. In most cases, providers will submit their bills directly to Medicare. In their submission to Medicare, they should identify the HOP Medical Plan as your supplemental insurance. Claims will then be sent electronically to the HOP Administration Unit. If your provider does not submit a bill to Medicare, please contact the HOP Administration Unit for assistance.

Claims for Basic Supplemental Benefits should be submitted to Medicare. Claims for Major Medical Benefits should be sent to the HOP Administration Unit.

Claims for Major Medical Benefits do not go to Medicare. Instead, they are adjudicated by the HOP Administration Unit. You may ask your health care provider to submit claims for Major Medical Benefits directly to the HOP Administration Unit, or you may submit the bill yourself with a claim form. Either way, it is your responsibility to make sure the claim for benefits is filed.

A claim for Major Medical Benefits should be submitted to the HOP Administration Unit within 90 calendar days after the occurrence or commencement of any services covered by the HOP Medical Plan, or as soon thereafter as reasonably possible.

Failure to file a Major Medical Benefits claim within the 90 days shall not invalidate or reduce a claim for benefits if:

- it was not reasonably possible to file a claim within that time, and
- such claim was furnished as soon as possible, but not later than 12 months after the loss occurred or commenced, unless the claimant is legally incapacitated.

Notice of Authorized Representative

An individual may authorize someone else to represent him or her and act on his or her behalf and, in so doing, consent to the release of information related to himself or herself to the authorized representative with respect to a claim for benefits or an appeal. The individual must provide such authorization in writing to the HOP Administration Unit, PSERS, or their designee.

You may name a family member or anyone you want to act as your authorized representative for purposes of submitting claims or making appeals to the HOP Medical Plan.
Where to Send Claims

All claims for Major Medical Benefits and any claims for Basic Supplemental Benefits that are not submitted to Medicare by your health care provider should be mailed to:

HOP Administration Unit
P.O. Box 2921
Clinton, IA 52733-2921

The date of receipt will be the date the claim is received by the HOP Administration Unit.

All claims submitted for benefits must contain all of the following:

• patient’s name
• patient’s date of birth
• annuitant’s name
• annuitant’s address
• provider’s name, address, and tax identification number
• annuitant’s ID number shown on the front of the HOP Medical Plan ID card
• date of service
• diagnosis
• description of service and procedure number
• charge for service
• the nature of the accident, injury, or illness being treated.

Cash register receipts, credit card copies, labels from containers, and cancelled checks are not sufficient.

Any claims not submitted within 12 months from the date the services were rendered will be denied, and no benefits will be paid. Claims for Basic Supplemental Benefits that are paid initially by Medicare are not subject to this time limit.

After review of the claim, the HOP Administration Unit will provide an explanation of benefits (EOB) showing the calculation of the amount payable, the charges not payable, and the reason(s) why amounts were not paid.

You must submit a claim within 12 months after you incur a covered expense.

Foreign Claims

In the event you incur a covered expense in a foreign country, you will be responsible for the following before any benefits are paid:

• The claim form, provider invoice, and any documentation required to process the claim must be submitted to the HOP Administration Unit in English.
• The charges for services must be converted into U.S. dollars.
• A current published conversion chart, validating the conversion from the foreign country’s currency into U.S. dollars, must be submitted with the claim.

How Claims Are Processed

The procedure for processing a claim depends on whether it is for a Basic Supplemental Benefit or a Major Medical Benefit.

For Basic Supplemental Benefits, Medicare determines coverage, benefit determination, medical necessity, payment amount, and
payment timing. The HOP Administration Unit will pay Basic Supplemental Benefits only after Medicare adjudicates the claim.

Claims covered by Major Medical Benefits are adjudicated by the HOP Administration Unit, which determines coverage, benefit determination, medical necessity, experimental and investigational services, reasonable and necessary, payment amount, and payment timing. The HOP Administration Unit reviews coverage requests for medical services and supplies, hospitalizations, skilled nursing facility inpatient stays, and home health care to determine whether the proposed services, supplies, or treatments are covered by Major Medical Benefits. The HOP Medical Plan does not cover services that are not medically necessary or that are experimental, investigational, or custodial care.

The claims procedure for Basic Supplemental Benefits is not the same as the claims procedure for Major Medical Benefits.
APPEALS

Appealing a Claim

You may request a review of a denied claim for a service or product already received by making a written request to the HOP Administration Unit within 90 calendar days after receiving notification of the denial. The HOP Administration Unit will conduct an internal review of the original adjudication or determination of the claim and explanation of benefits (EOB). This review will examine the applicable plan provisions, the nature of the claim(s), and benefit determination and payments, if applicable. Errors, if any, will be corrected, appropriate payment adjustments rendered, and a revised EOB issued. If coverage is correct and the claims have been properly determined, the HOP Administration Unit will send you a written letter indicating that the claim has been properly adjudicated. This notice of benefit denial will contain an explanation of the denial, including a statement that the decision may be appealed to the PSERS Health Insurance Division within 60 calendar days of receipt of the letter.

If your claim for benefits or your request for a certification is denied, you have 90 calendar days to request a review of the decision.

Appealing a Denied Certification

If your request for an initial or extended certification is denied, you have the right to appeal the decision by making a written request to the HOP Administration Unit within 90 calendar days from receipt of notification of the denial and stating the reasons you think the certification should not have been denied.

The following describes the review process and your rights when appealing a denied certification:

1. You have the right to submit documents, information, and comments.
2. You have the right to access, free of charge, information relevant to your claim for benefits.
3. The review takes into account all information you submit, even if it was not considered in the initial benefit determination.
4. The review will not afford deference to the original denial.
5. The review will not be conducted by the individual who originally denied the claim or a subordinate to the individual who originally denied the claim.
6. If the original denial was, in whole or in part, based on medical judgment:
   a. the HOP Administration Unit will consult with a professional provider who has appropriate training and experience in the field involving the medical judgment.
b. the professional provider utilized by the HOP Administration Unit will not be an individual who was consulted in connection with the original denial of the claim or a subordinate of any other professional provider who was consulted in connection with the original denial.

7. If requested, the HOP Administration Unit will identify the medical or vocational expert(s) who gave advice in connection with the original denial, whether or not the advice was relied upon.

Notice of Appeal Decision

The HOP Administration Unit will provide you with a written notice about the decision on your appeal as soon as possible, but not later than 30 calendar days from receipt of the appeal. If the appeal is denied, the notice will contain an explanation of the decision, including:

1. the specific reasons for the denial
2. reference to specific HOP Medical Plan provisions on which the denial is based
3. a statement that you have the right to access, free of charge, information relevant to the claim for benefits
4. a statement that you have a right to appeal
5. a statement that you have the right to access, free of charge, information about the voluntary appeal process
6. if an internal rule, guideline, protocol, or other similar criterion was relied upon, the notice will contain either a copy of that criterion or a statement that such criterion was relied upon and will be supplied free of charge upon request

7. if the denial was based on medical necessity, experimental/investigational treatment, or similar exclusion or limit, the HOP Administration Unit will supply either an explanation of the scientific or clinical judgment, applying the terms of the HOP Medical Plan to your medical circumstances, or a statement that such explanation will be supplied free of charge upon request.

If your appeal is denied, you will receive details about why it was denied, and you will have the right to request a second review by the Health Care Management Organization.

Second Level Voluntary Appeals

If your appeal is denied, you may request a secondary level of appeal by the Health Care Management Organization. Your appeal will be reviewed by three professional providers who were not consulted in connection with the original denial of certification. If you request a secondary level of appeal, it will have no effect on your rights to any other benefits under the Plan. In addition, there are no fees or costs for the voluntary appeal process.

A determination will be made within 30 business days after receiving your request for a second level voluntary appeal, and you will be notified of the outcome verbally and in writing.

With respect to certification appeals, the HOP Medical Plan agrees to both of the following:

• Not to later assert a defense of failure to exhaust available administrative remedies against an individual who chooses not to make use of the voluntary appeal process.
• Any statute of limitations or other defense based on timelines is tolled while the dispute is under submission to the voluntary appeal process.

Upon written request, more information about the voluntary appeal process is available free of charge from the Health Care Management Organization.

Appealing to the PSERS Health Insurance Office

You may request a review of a claim or certification denied by the HOP Administration Unit by making a written request to the PSERS Health Insurance Office. If the PSERS Health Insurance Office upholds the decision of the HOP Administration Unit, the notification from the PSERS Health Insurance Office will explain the reasons for the decision and contain a statement that the decision may be appealed to the Executive Staff Review Committee (ESRC).

If you choose to proceed with an appeal to the ESRC, the ESRC will process the appeal in accordance with its procedures, relying on the findings and expertise of independent professionals. If the ESRC upholds the decision of the Health Insurance Office, the notification from the ESRC will explain the reasons for the denial and contain a statement that you or your authorized representative may request an Administrative Hearing conducted by a Commonwealth Hearing Examiner.

If you choose to proceed with an Administrative Hearing, the Hearing Examiner will provide a recommendation to the Board. You have the right to file exceptions to the Hearing Examiner’s recommendation. The Board will make the final decision about your appeal, and you will be notified of the decision. If your appeal is denied by the Board, you have the right to bring the matter before the Commonwealth Court.

**Note:** Since claims for Basic Supplemental Benefits are processed by Medicare A or B, decisions by Medicare concerning eligibility and covered expenses are not subject to review by the Health Insurance Office or the ESRC. Similarly, required certifications and benefits under plans provided by insurance companies under contract with PSERS are also not subject to review by the Health Insurance Office or ESRC. Appeals or complaints concerning benefits, eligibility, or premiums under an insurance company plan should be directed to the insurance company.
The Coordination of Benefits provision is intended to prevent duplication of benefits. It applies when an individual is enrolled in more than one health benefit plan. In such a case, one plan normally pays full benefits first and is referred to as the primary plan. The other health benefit plan, referred to as the secondary plan, pays reduced benefits. When coordination of benefits occurs, the total benefit paid by all plans will not exceed 100% of the allowable charge for a covered expense. In addition, any amounts paid by other plans will not count toward the out-of-pocket maximum or other benefit maximums under the HOP Medical Plan.

This provision applies in determining the benefits for an individual for each claim determination period for the allowable charge for a covered expense.

Claim determination period means a calendar year or that portion of a calendar year during which the individual for whom a claim is made has been covered under the HOP Medical Plan.

Allowable charge means any reasonable, necessary, and customary expense incurred while covered under the HOP Medical Plan, part or all of which could be covered under the HOP Medical Plan. Allowable expenses do not include expenses contained in the exclusion sections of the HOP Medical Plan.

If you are covered by the HOP Medical Plan and another health insurance program (including Medicare), Coordination of Benefits ensures that you do not receive duplicative benefits.

Coordination with Medicare

Because the HOP Medical Plan is a supplement to Medicare Part A and Part B, Medicare is primary and the HOP Medical Plan is secondary for any individual enrolled in both. If an individual chooses to use a facility that is not a Medicare-participating facility, the HOP Medical Plan will not pay for any charges disallowed by Medicare due to the use of such facility.

If an individual chooses to use a professional provider who is not a Medicare-participating professional provider, Basic Supplemental Benefits of the HOP Medical Plan will not pay for any charges disallowed by Medicare due to the use of such a professional provider. However, Major Medical Benefits of the HOP Medical Plan may pay benefits in accordance with Plan provisions.

Medicare pays benefits before the HOP Medical Plan.
Coordination with Other Health Benefit Plans

For purposes of the Coordination of Benefits provision, “other health benefit plan” means any plan, policy, or coverage providing benefits or services for medical, dental, or vision care. Such plans may include, without limitation:

1. group insurance or any other arrangement for coverage for individuals in a group, whether on an insured or uninsured basis, including but not limited to hospital indemnity benefits and hospital reimbursement-type plans
2. a hospital or medical service organization on a group basis, group practice, and other group prepayment plan or on an individual basis having a provision similar in effect to this provision
3. a licensed Health Maintenance Organization (HMO)
4. any coverage for students that is sponsored by, or provided through, a school or other educational institution
5. any coverage under a government program and any coverage provided by any statute
6. any plan or policy funded in whole or in part by an employer or deductions made by an employer from a person’s compensation or retirement benefits
7. labor/management trustee, union welfare, employer organization, or employee benefit organization plans.

The Coordination of Benefits provision applies whether or not a claim is filed under the other health benefit plan(s). If another plan provides benefits in the form of services rather than cash, the reasonable value of the service rendered shall be deemed the benefit paid.

Which Plan Is Primary (Pays First)?

The HOP Medical Plan will make its claim payment according to the following order of benefit determination:

- If the other health benefit plan contains no provision for coordination of benefits, then it pays benefits before the HOP Medical Plan.
- The plan that covers the claimant as a member (or named insured) pays as though no other health benefit plan existed. Remaining covered expenses are paid under a plan that covers the claimant as a dependent.
- For dependent children of parents not separated or divorced, the plan covering the parent whose birthday (month and day) occurs earlier in the year pays first, and the plan covering the parent whose birthday falls later in the year pays second. If both parents have the same birthday, the plan that covered a parent longer pays first. A parent’s year of birth is not relevant in applying this rule.
- For dependent children of separated or divorced parents, the birthday rule does not apply; instead:
  - If a court decree has given one parent financial responsibility for the child’s health care, the plan of that parent pays first. The plan of the stepparent married to that parent, if any, pays second. The plan of the other natural parent pays third. The plan of the spouse of the other natural parent, if any, pays fourth.
• In the absence of such a court decree, the plan of the parent with custody pays first. The plan of the stepparent married to the parent with custody, if any, pays second. The plan of the parent without custody pays third. The plan of the spouse of the parent without custody, if any, pays fourth.

• A plan covering a person as an active (not laid off or retired) employee or as the dependent of an active employee pays first. A plan covering a person as a laid-off or retired employee or as the dependent of a laid-off or retired employee’s dependent pays second.

• If a person is covered under another group health plan, but is also covered under the HOP Medical Plan for continuation of coverage due to the other health benefit plan’s limitation for pre-existing conditions or exclusions, the other health benefit plan shall be primary.

• If none of the above rules determine the order of benefits, the plan covering a person longer pays first.

**If the HOP Medical Plan Is Secondary**

If the rules set forth above make the HOP Medical Plan primary, then the benefits of the other plan will be ignored for the purposes of determining the benefits under the HOP Medical Plan. However, if the HOP Medical Plan is secondary, certain rules apply to how benefits are determined:

• The allowable charge for a covered expense will include any deductible or coinsurance amounts not paid by the other plan(s).

• The allowable charge will not include any amount that is not payable under the primary plan as a result of a contract between the primary plan and a provider of service in which such provider agrees to accept a reduced payment and not to bill the individual for the difference between the provider’s contracted amount and the provider’s regular billed charge.

• If the primary plan has a restricted list of health care providers and the covered person chooses not to use a provider from the primary plan’s restricted list, the HOP Medical Plan will not pay for any charges disallowed by the primary plan due to the use of such provider, if shown on the primary carriers’ explanation of benefits.

• If the primary plan provides coverage through the services of an HMO and the covered person chooses not to use the HMO, the HOP Medical Plan will not pay for any charges disallowed by the primary plan due to failure to utilize the HMO, if shown on the primary carrier’s explanation of benefits.

• The HOP Medical Plan will not pay for any charge that has been refused by another plan covering the covered person as a penalty assessed due to non-compliance with that plan’s rules and regulations, if shown on the primary carrier’s explanation of benefits.

• The benefits paid under the HOP Medical Plan may be reduced so that the sum of benefits paid by all plans does not exceed 100% of the allowable charge for a covered expense.

**Limitations on Payments**

In no event will an individual receive from the HOP Medical Plan and all other health benefit plan(s) combined more than the total allowable charge for an expense covered by the HOP Medical Plan and the other health benefit plan(s).
Nothing contained in this section shall entitle an individual to benefits in excess of the maximum payable under the HOP Medical Plan. An individual must refund to the HOP Medical Plan any excess payment he or she receives for benefits and/or services under the Plan.

Right to Receive and Release Necessary Information

For the purposes of determining the applicability of and implementing the terms of this Coordination of Benefits provision, the HOP Administration Unit may, without the consent of or notice to any person, release to or obtain from any insurance company or any other organization any information, regarding other insurance, with respect to any covered individual. Any person claiming benefits under the HOP Medical Plan shall furnish to the HOP Administration Unit such information as may be necessary to implement the Coordination of Benefits provision set forth in this SPD.

Facilitation of Benefit Payment

Whenever payments that should have been made under the HOP Medical Plan in accordance with this provision have been made under any other health benefit plan, the HOP Medical Plan shall have the right, exercisable alone and in its sole discretion, to pay to any organization making such other payments any amounts it determines to be warranted in order to satisfy the intent of this provision. Amounts so paid shall be deemed to be benefits paid under the HOP Medical Plan and, to the extent of such payments, the HOP Medical Plan shall be fully discharged from liability.
The HOP Medical Plan maintains the right to seek reimbursement of any paid charges for an injury or illness that is the obligation of a third party on its own behalf: the right of subrogation. The HOP Medical Plan also reserves the right to reimbursement of any paid charges for an injury or illness that is the obligation of a third party upon a covered annuitant’s or a covered dependent’s receipt of settlement, judgment, or award: the right of reimbursement. The HOP Medical Plan reserves the right of recovery, either by subrogation or reimbursement, for covered expenses payable by the HOP Medical Plan that are a result of illness or injury that has been caused by a third party and who is responsible for such illness or injury. The HOP Medical Plan will be reimbursed from the first monies recovered as the result of judgment, settlement, or otherwise. (This is known as “Pro tanto” subrogation.) This right includes the HOP Medical Plan’s right to receive reimbursement from uninsured or underinsured motorist coverage and no-fault coverage.

Accepting benefits from the HOP Medical Plan automatically assigns to it any rights the individual may have to recover benefits from any party, including an insurer, or another group health program. This right of recovery allows the HOP Medical Plan to pursue any claim that the individual may have against any party, group health program or insurer, whether or not the individual chooses to pursue that claim. This includes a right to recover from no-fault auto insurance carriers in a situation where no third party may be liable or from any uninsured or underinsured motorist coverage where the recovery was triggered by the actions of a party that caused or contributed to the payment of benefits under the HOP Medical Plan. This also includes a right to recover from amounts the individual received from Workers’ Compensation, whether by judgment or settlement, where the HOP Medical Plan has paid benefits prior to a determination that the medical expenses arose out of and in the course of employment. Payment by Workers’ Compensation will be presumed to mean that such a determination has been made.

If a covered individual is involved in an automobile accident or suffers an illness or injury that was due to the action or inaction of any party, the HOP Medical Plan may advance payment in order to prevent any financial hardship to the individual. Acceptance of the HOP Medical Plan benefits acknowledges the obligation of the individual to:

• help the HOP Medical Plan recover benefits it has paid on behalf of the individual, and
• provide the HOP Administration Unit with information concerning any automobile insurance, any other group health program that may be obligated to pay benefits on behalf of the individual, and the insurance of any other party involved.

The covered individual is required to cooperate fully in the HOP Medical Plan’s exercise of its right to recovery, and the individual cannot do anything to prejudice those rights. Such cooperation is required as a condition of receiving benefits under the HOP Medical Plan. The HOP
Medical Plan may refuse to pay benefits or cease to pay benefits on behalf of an eligible individual who fails to sign any document deemed by the HOP Administration Unit to be relevant to protecting its subrogation rights or fails to provide relevant information when requested. This information includes any documents, insurance policies, police reports, or any reasonable request by the claims processor or Plan sponsor to enforce the HOP Medical Plan’s rights.

Whether the individual or the HOP Medical Plan makes a claim directly against any party, group health program, or insurance company for the benefit payments made on behalf of an individual by the HOP Medical Plan, the HOP Medical Plan has a lien on any amount the individual recovers or could recover from any party, insurance company, or group health program whether by judgment, settlement, or otherwise, and whether or not designated as payment for medical expenses. This lien shall remain in effect until the HOP Medical Plan acknowledges and agrees upon payment to the HOP Medical Plan and releases its lien. The lien may not be for an amount greater than the amount of benefits paid under the HOP Medical Plan.

The Plan sponsor has delegated to the claims processor the right to perform ministerial functions required to assert the HOP Medical Plan’s rights; however, PSERS shall retain discretionary authority with regard to asserting the HOP Medical Plan’s recovery rights.
GENERAL PROVISIONS

Administration of the Plan

The HOP Medical Plan is administered by the HOP Administration Unit. PSERS is the Plan sponsor. The Plan sponsor shall have full charge of the operation and management of the HOP Medical Plan. PSERS has retained the services of an independent claims processor experienced in claims review. PSERS is the named fiduciary of the HOP Medical Plan except as noted herein. The claims processor is the named fiduciary of the HOP Medical Plan for claim adjudication and appeals. As the named fiduciary for appeals, the claims processor maintains discretionary authority to review all denied claims under appeal for benefits under the HOP Medical Plan. PSERS maintains discretionary authority to interpret the terms of the HOP Medical Plan, including but not limited to determination of eligibility for and entitlement to HOP Medical Plan benefits in accordance with the terms of the Plan as set forth in this Plan Summary; any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

Assignment

The HOP Medical Plan will pay benefits to the annuitant unless payment has been assigned to a hospital, physician, or other provider of service furnishing the services for which benefits are provided herein. No assignment of benefits shall be binding on the HOP Medical Plan unless the claims processor is notified in writing of such assignment prior to payment pursuant to the terms of the HOP Medical Plan.

Benefits Not Transferable

Except as otherwise stated herein, no person other than a covered individual is entitled to receive benefits under the HOP Medical Plan. Such right to benefits is not transferable.

Clerical Error

No clerical error on the part of the Plan sponsor or claims processor will operate to defeat any of the rights, privileges, services, or benefits of any annuitant or any dependent(s) hereunder, nor create or continue coverage which would not otherwise validly become effective or continue in force hereunder. An equitable adjustment of premium payments and/or benefits will be made when the error or delay is discovered. However, if more than six months have elapsed prior to discovery of any error, any adjustment of premium payments shall be waived. No party shall be liable for the failure of any other party to perform.

Conformity with Statute(s)

Any provision of the HOP Medical Plan that is in conflict with statutes that are applicable to the HOP Medical Plan is hereby amended to conform to the minimum requirements of said statute(s).
Effective Date of the Plan

The effective date of the HOP Medical Plan as defined by this description is January 1, 2019.

Free Choice of Hospital and Physician

Nothing contained in the HOP Medical Plan shall in any way or manner restrict or interfere with the right of any person entitled to benefits hereunder to select a hospital or to make a free choice of the attending physician or professional provider except as restricted by Medicare.

Incapacity

If, in the opinion of the Plan sponsor, an individual for whom a claim has been made is incapable of furnishing a valid receipt of payment due him and in the absence of written evidence to the HOP Administration Unit of the qualification of a guardian or personal representative for his estate, the Plan sponsor may on behalf of the HOP Medical Plan, at its discretion, make any and all such payments to the provider of services or other person providing for the care and support of such person. Any payment so made will constitute a complete discharge of the HOP Medical Plan’s obligation to the extent of such payment.

Incontestability

All statements made by the Plan sponsor or by an individual covered under the HOP Medical Plan shall be deemed representations and not warranties. Such statements shall not void or reduce the benefits under the HOP Medical Plan or be used in defense to a claim unless they are contained in writing and signed by the Plan sponsor or by the individual, as the case may be.

A statement made shall not be used in any legal contest unless a copy of the instrument containing the statement is or has been furnished to the other party to such a contest.

Legal Actions

No action at law or in equity shall be brought to recover on the benefits from the HOP Medical Plan prior to the expiration of 60 days after all information on a claim for benefits has been filed and the appeal process has been completed in accordance with the requirements of the HOP Medical Plan. No such action shall be brought after the expiration of two years from the date the expense was incurred, or one year from the date a completed claim was filed, whichever occurs first.

Limits on Liability

Liability hereunder is limited to the services and benefits specified under the terms of the Plan, and the HOP Medical Plan shall not be liable for any obligation of the individual incurred in excess thereof. The liability of the HOP Medical Plan shall be limited to the reasonable cost of covered expenses and shall not include any liability for suffering or general damages.

Lost Distributees

Any benefit payable hereunder shall be deemed forfeited if the Plan sponsor is unable to locate the individual to whom payment is due, provided, however, that such benefits shall be reinstated if a claim is made by the individual for the forfeited benefits within the time prescribed in the “Filing Claims” section.
Medicaid Eligibility and Assignment of Rights

The HOP Medical Plan will not take into account whether an individual is eligible for, or is currently receiving, medical assistance under a state plan for medical assistance as provided under Title XIX of the Social Security Act (“State Medicaid Plan”) either in enrolling that individual or in determining or making any payment of benefits to that individual. The HOP Medical Plan will pay benefits with respect to such individual in accordance with any assignment of rights made by or on behalf of such individual as required under a state Medicaid plan pursuant to § 1912(a)(1)(A) of the Social Security Act. To the extent payment has been made to such individual under a state Medicaid plan, and the HOP Medical Plan has a legal liability to make payments for the same services, supplies, or treatment, payment under the HOP Medical Plan will be made in accordance with any state law that provides that the state has acquired the rights with respect to such individual to payment for such services, supplies, or treatment under the terms of the HOP Medical Plan.

Misrepresentation

If an individual or anyone acting on behalf of an individual makes a false statement on the application for enrollment, or withholds information with intent to deceive or affect the acceptance of the enrollment application or the risks assumed by HOP Medical Plan, or otherwise misleads the HOP Medical Plan, the HOP Medical Plan shall be entitled to recover its damages, including legal fees, from the individual, or from any other person responsible for misleading the HOP Medical Plan, and from the person for whom the benefits were provided. Any material misrepresentation on the part of the individual in making application for coverage, or any application for reclassification thereof, or for service thereunder shall render the coverage under the HOP Medical Plan null and void.

Physical Examinations Required by the Plan

The HOP Medical Plan, at its own expense, has the right to require an examination of a person covered under the HOP Medical Plan when and as often as it may reasonably require during the pendency of a claim.

Plan Is Not a Contract

The HOP Medical Plan shall not be deemed to constitute a contract between the Plan sponsor and any individual.

Plan Modification and Amendment

The Plan sponsor may modify or amend the HOP Medical Plan from time to time at its sole discretion, and such amendments or modifications that affect individuals will be communicated to the individuals. Any such amendments shall be in writing, setting forth the modified provisions of the HOP Medical Plan, the effective date of the modifications, and shall be signed by the Plan sponsor’s designee.

Such modification or amendment shall be duly incorporated in writing into the master copy of the HOP Medical Plan on file with the Plan sponsor, or a written copy thereof shall be deposited.
with such master copy of the HOP Medical Plan. Appropriate filing and reporting of any such modification or amendment to individuals shall be timely made by the **Plan sponsor**.

**Plan Termination**

**PSERS** reserves the right to terminate the HOP Medical Plan at any time. Upon termination, the rights of individuals to benefits are limited to claims **incurred** up to the date of termination. Any termination of the HOP Medical Plan will be communicated to the **covered individuals**.

**Prior Plan Coverage**

**Annuitants** and **dependents** who are covered under the HOP Medical Plan as of December 31, 2018, shall be covered hereunder, provided they have not terminated coverage under the HOP Medical Plan or elected other coverage under the Health Options Program.

Amounts applied to **Plan** maximums prior to January 1, 2019, continue to count toward those maximums after December 31, 2018. For example, the Major Medical Benefits $1,000,000 **lifetime maximum** includes payments made by the HOP Medical Plan prior to January 1, 2019.

**Pronouns**

All personal pronouns used in this Plan Summary shall include either gender unless the context clearly indicates to the contrary.

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**Recovery for Overpayment**

Whenever payments have been made from the HOP Medical Plan in excess of the maximum amount of benefits payable, the HOP Medical Plan will have the right to recover excess payments. If the claims processor makes any payment that, according to the terms of the HOP Medical Plan, should not have been made, the HOP Medical Plan may recover that incorrect payment, whether or not it was made due to the claims processor’s own error, from the person or entity to whom it was made or from any other appropriate party.

**Time Effective**

The effective time with respect to any dates used in the HOP Medical Plan shall be 12:01 a.m. as may be legally in effect at the address of the HOP Administration Unit or **PSERS**.

**Workers’ Compensation Not Affected**

The HOP Medical Plan is not in lieu of, and does not affect any requirement for, coverage by Workers’ Compensation insurance.
HIPAA PRIVACY

The following provisions are intended to comply with applicable HOP Medical Plan amendment requirements under federal regulation implementing Section 264 of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and shall be construed as a part of the HOP Medical Plan document.

Disclosure by Plan to Plan Sponsor

The HOP Medical Plan may take the following actions only upon receipt of a plan amendment certification:

- disclose protected health information to the Plan sponsor
- provide for or permit the disclosure of protected health information to the Plan sponsor by a health insurance issuer or HMO with respect to the HOP Medical Plan pursuant to terms set forth in the Plan document or amendment to the Plan.

Use and Disclosure by Plan Sponsor

The Plan sponsor may use or disclose protected health information received from the HOP Medical Plan to the extent not inconsistent with the provisions of this “HIPAA Privacy” section or the privacy rule.

Obligations of PSERS

PSERS shall have the following obligations:

- to ensure that:
  - any agents (including a subcontractor) to whom it provides protected health information received from the HOP Medical Plan agree to the same restrictions and conditions that apply to PSERS with respect to such information, and
  - adequate separation is established between the HOP Medical Plan and PSERS.
- not use or further disclose protected health information received from the HOP Medical Plan, other than as permitted or required by the HOP Medical Plan documents or as required by law
- not use or disclose protected health information received from the HOP Medical Plan:
  - for employment-related actions and decisions, or
  - in connection with any other benefit or employee benefit plan of the Plan sponsor.
- report to the HOP Medical Plan any use or disclosure of the protected health information received from the HOP Medical Plan that is inconsistent with the use or disclosure provided for of which it becomes aware
• make available protected health information received from the HOP Medical Plan, as and to the extent required by the privacy rule:
  • for access to the individual
  • for amendment and incorporate any amendments to protected health information received from the HOP Medical Plan, and
  • to provide an accounting of disclosures.

• make its internal practices, books, and records relating to the use and disclosure of protected health information received from the HOP Medical Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the HOP Medical Plan with the privacy rule.

• return or destroy all protected health information received from the HOP Medical Plan that still maintains in any form and retain no copies when no longer needed for the purpose for which the disclosure by the HOP Medical Plan was made, but if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

• provide protected health information only to those individuals under the control of PSERS who perform administrative functions for the HOP Medical Plan (i.e., eligibility, enrollment, pension deduction, benefit determination, claim reconciliation assistance), and to make clear to such individuals that they are not to use protected health information for any reason other than for HOP Medical Plan administrative functions or to release protected health information to an unauthorized individual.

• provide protected health information only to those entities required to receive the information in order to maintain the HOP Medical Plan (i.e., claim administrator, case management vendor, pharmacy benefit manager, claim subrogation, vendor, claim auditor, network manager, stop-loss insurance carrier, insurance broker/consultant) and any other entity subcontracted to assist in administering the HOP Medical Plan.

• provide an effective mechanism for resolving issues of noncompliance with regard to the items mentioned in this provision.

• reasonably and appropriately safeguard electronic protected health information created, received, maintained, or transmitted to or by PSERS on behalf of the HOP Medical Plan. Specifically, such safeguarding entails an obligation to:

  • implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that the Plan sponsor creates, receives, maintains, or transmits on behalf of the HOP Medical Plan.

  • ensure that the adequate separation as required by 45 C.F.R. 164.504(f)(i)(iii) is supported by reasonable and appropriate security measures.

  • ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information, and

  • report to the HOP Medical Plan any security incident of which it becomes aware.
Exceptions

Notwithstanding any other provision of this “HIPAA Privacy” section, the HOP Medical Plan may:

1. disclose summary health information to the Plan sponsor if the Plan sponsor requests it for the purpose of:

   a. obtaining premium bids from health plans for providing health insurance under the Health Options Program or HOP Medical Plan, or

   b. modifying, amending, or terminating the HOP Medical Plan.

2. disclose to the Plan sponsor information on whether the individual is participating in the HOP Medical Plan, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Health Options Program

3. use or disclose protected health information:

   a. with (and consistent with) a valid authorization obtained in accordance with the privacy rule

   b. to carry out treatment, payment, or health care operations in accordance with the privacy rule, or

   c. as otherwise permitted or required by the privacy rule.
Certain words and terms used herein shall be defined as follows and are shown in **bold italics** throughout this Plan Summary:

**accident**: an unforeseen event resulting in **injury**

**allowable charge**: the fee for services, supplies, or treatment that does not exceed the general level of charges as determined by the HOP Administration Unit in accordance with generally accepted industry standards

**ambulatory surgical facility (or center)**: a **facility** provider with an organized staff of **physicians** that has been approved by the Joint Commission on the Accreditation of Healthcare Organizations, or by the Accreditation Association for Ambulatory Health, Inc., which:

- has permanent facilities and equipment for the purpose of performing surgical procedures on an **outpatient** basis
- provides treatment by or under the supervision of **physicians** and nursing services whenever the individual is in the **ambulatory surgical facility**
- does not provide **inpatient** accommodations, and
- is not, other than incidentally, a **facility** used as an office or clinic for the private practice of a **physician**

**annuitant**: any member of **PSERS** on or after the effective date of retirement until his or her annuity is terminated and who meets the Health Options Program eligibility requirements for enrollment

**birthing center**: a **facility** that meets professionally recognized standards and complies with all licensing and other legal requirements that apply

**chemical dependency**: a physiological or psychological dependency, or both, on a controlled substance and/or alcoholic beverages. It is characterized by a frequent or intense pattern of pathological use to the extent the user exhibits a loss of self-control over the amount and circumstances of use; develops symptoms of tolerance or physiological and/or psychological withdrawal if the use of the controlled substance or alcoholic beverage is reduced or discontinued; and the user’s health is substantially impaired or endangered or his social or economic function is substantially disrupted. Diagnosis of these conditions will be determined based on standard DSM-IV (diagnostic and statistical manual of mental disorders) criteria.

**close relative**: the **annuitant’s** spouse, child, brother, sister, or parent; or the child, brother, sister, or parent of the **annuitant’s** spouse

**coinsurance**: the percentage of **covered expenses** payable by the HOP Medical Plan (or the percentage of **covered expenses** payable by the member where so specified) for benefits that are provided under the HOP Medical Plan. The **coinsurance** is applied to **covered expenses** after the deductible(s) have been met, if applicable.
complications of pregnancy: a disease, disorder, or condition that is diagnosed as distinct from pregnancy, but is adversely affected by or caused by pregnancy. Some examples are:

- intra-abdominal surgery (but not elective Cesarean section)
- ectopic pregnancy
- toxemia with convulsions (eclampsia)
- pernicious vomiting (hyperemesis gravidarum)
- nephrosis
- cardiac decompensation
- missed abortion
- miscarriage.

These conditions are not included: false labor, occasional spotting, rest during pregnancy even if prescribed by a physician, morning sickness, or like conditions that are not medically termed as complications of pregnancy.

confinement: a continuous stay in a hospital, skilled nursing facility, hospice, or birthing center due to an illness or injury diagnosed by a physician.

copay: a cost-sharing arrangement whereby a covered person pays a set amount to a provider for a specific service at the time the service is provided.

cosmetic surgery: surgery for the restoration, repair, or reconstruction of body structures directed toward altering appearance.

covered expenses: medically necessary services, supplies, or treatments that are recommended or provided by a physician, professional provider or covered facility for the treatment of an illness or injury and that are not specifically excluded from coverage herein.

Covered expenses include specified preventive care services.

covered individual: an individual who is an annuitant or survivor annuitant, or the spouse or dependent of an annuitant enrolled in the HOP Medical Plan.

custodial care: care provided primarily for maintenance of the individual or which is designed essentially to assist the individual in meeting his activities of daily living and which is not primarily provided for its rehabilitative or therapeutic value in the treatment of an illness or injury. Custodial care includes but is not limited to help in walking, bathing, dressing, feeding, preparation of special diets, and supervision over administration of medications. Such services shall be considered custodial care without regard to the provider by whom or by which they are prescribed, recommended or performed. Room and board and skilled nursing services are not, however, considered custodial care if:

- provided during confinement in an institution for which coverage is available under Major Medical Benefits of the HOP Medical Plan, and
- combined with other medically necessary therapeutic services, under accepted medical standards, which can reasonably be expected to substantially improve the individual’s medical condition.

dentist: a Doctor of Dental Medicine (D.M.D.), Doctor of Dental Surgery (D.D.S.), Doctor of Medicine (M.D.), or Doctor of Osteopathy (D.O.), other than a close relative of the covered individual, who is practicing within the scope of his or her license.
**dependent:** see page 4

**durable medical equipment:** medical equipment that:

- can withstand repeated use
- is primarily and customarily used to serve a medical purpose
- is generally not used in the absence of an illness or injury
- is appropriate for use in the home.

All provisions of this definition must be met before an item can be considered **durable medical equipment.** **Durable medical equipment** includes but is not limited to crutches, wheelchairs, and **hospital** beds

**effective date of coverage:** the date on which an individual’s coverage commences

**experimental/investigational:** services, supplies, drugs, and treatment that do not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered. The claims processor or its designee must make an independent evaluation of the experimental/non-experimental standings of specific technologies. The claims processor or its designee shall be guided by a reasonable interpretation of Major Medical Benefits of the HOP Medical Plan provisions and information provided by qualified independent vendors who have also reviewed the information provided. The decisions shall be made in good faith and rendered following a factual background investigation of the claim and the proposed treatment. The claims processor or its designee will be guided by the following examples of experimental services and supplies:

- if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished, or
- if the drug, device, medical treatment, or procedure was not reviewed and approved by the treating facility’s institutional review board or other body serving a similar function, or if federal law requires such review or approval, or
- if “reliable evidence” shows that the drug, device, medical treatment, or procedure is the subject of ongoing Phase I or Phase II clinical trials, is in the research, experimental, study, or investigational arm of ongoing Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, toxicity, safety, or efficacy as compared with a standard means of treatment or diagnosis, or
- if “reliable evidence” shows that prevailing opinion among experts regarding the drug, device, medical treatment, or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety, or efficacy as compared with standard means of treatment or diagnosis.

“Reliable evidence” shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol(s) used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment, or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment, or procedure.
**facility**: a health care institution that meets all applicable federal, state, or local approval or licensure requirements

**full-time student or full-time student status**: an annuitant’s dependent child who is enrolled in and regularly attending secondary school, an accredited college, university, or institution of higher learning for the minimum number of credit hours required by that institution in order to maintain full-time student status

**health care management**: a process of evaluating if services, supplies, or treatment are for custodial care, medically necessary, experimental/investigational and appropriate for benefit coverage under the HOP Medical Plan

**Health Care Management Organization**: the individual or organization designated by PSERS for the process of evaluating if a service, supply, or treatment is for custodial care, medically necessary, experimental/investigational and appropriate for benefit coverage under the HOP Medical Plan

**home health care agency**: an agency or organization that fully meets every one of the following requirements:
- It is primarily engaged in and duly licensed, if licensing is required, by the appropriate licensing authority, to provide skilled nursing and other therapeutic services
- It has a policy established by a professional group associated with the agency or organization to govern the services provided. This professional group must include at least one physician and at least one Registered Nurse. It must provide for full-time supervision of such services by a physician or Registered Nurse
- It maintains a complete medical record on each patient
- It has a full-time administrator

**hospice**: an agency that provides counseling and medical services and may provide room and board to a terminally ill individual and meets all of the following tests:
- It has obtained any required state or governmental Certificate of Need approval
- It provides service 24 hours a day, 7 days a week
- It is under the direct supervision of a physician
- It has a nurse coordinator who is a Registered Nurse
- It has a social service coordinator who is licensed
- It is an agency that has as its primary purpose the provision of hospice services
- It has a full-time administrator
- It maintains written records of services provided to the individual
- It is licensed, if licensing is required
- It qualifies as a reimbursable service under Medicare

**hospital**: an institution that meets the following conditions:
- It is licensed and operated in accordance with the laws of the jurisdiction in which it is located which pertain to hospitals
- It is engaged primarily in providing medical care and treatment to ill and injured persons on an inpatient basis at the individual’s expense
• It maintains on its premises all the facilities necessary to provide for the diagnosis and medical and surgical treatment of an illness or injury; and such treatment is provided by or under the supervision of a physician with continuous 24-hour nursing services by or under the supervision of Registered Nurses.

• It qualifies as a hospital and is accredited by the Joint Commission on the Accreditation of Healthcare Organizations.

• It qualifies as a reimbursable service under Medicare.

Under no circumstances will a hospital be, other than incidentally, a place for rest, a place for the aged, or a nursing home. Hospital includes a facility designed exclusively for physical rehabilitative services where the individual receives treatment as a result of an illness or injury. The term hospital, when used in conjunction with inpatient confinement for mental health disorders, will be deemed to include an institution that is licensed as a mental hospital by the regulatory authority having responsibility for such licensing under the laws of the jurisdiction in which it is located.

illness: a bodily disorder, disease, physical sickness, or pregnancy

incurred or incurred date: with respect to a covered expense, the date the service, supply, or treatment is provided.

injury: a physical harm or disability that is the result of a specific incident caused by external means. The physical harm or disability must have occurred at an identifiable time and place. Injury does not include illness or infection of a cut or wound, or self-inflicted injury.

inpatient: a confinement of an individual in a hospital, hospice, or skilled nursing facility as a registered bed patient for 18 or more consecutive hours and for whom charges are made for room and board.

intensive care: a service reserved for critically and seriously ill individuals requiring constant audiovisual surveillance prescribed by the attending physician.

intensive care unit: a separate, clearly designated service area maintained within a hospital solely for the provision of intensive care. It must meet the following conditions:

• facilities for special nursing care not available in regular rooms and wards of the hospital.

• special lifesaving equipment immediately available at all times.

• at least two beds for the accommodation of the critically ill.

• at least one Registered Nurse in continuous and constant attendance 24 hours per day.

This term does not include care in a surgical recovery room, but does include a cardiac care unit or any such other similar designation.

lifetime maximum: the maximum amount paid by Major Medical Benefits of the HOP Medical Plan for any one individual during the entire time he or she is covered by the HOP Medical Plan.

maximum benefit: any one of the following, or any combination of the following:

• the maximum amount paid by Major Medical Benefits of the HOP Medical Plan for any one individual for a particular covered expense for a specified period of time, such as a calendar year.
• the maximum number as outlined in Major Medical Benefits of the HOP Medical Plan as a covered expense. The maximum number relates to the number of:
  • treatments during a specified period of time, or
  • days of confinement, or
  • visits by a home health care agency.

medically necessary or medical necessity: service, supply, or treatment that is determined by the claims processor or its designee to be:
• appropriate and consistent with the symptoms and provided for the diagnosis or treatment of the individual’s illness or injury and which could not have been omitted without adversely affecting the individual’s condition or the quality of the care rendered, and
• supplied or performed in accordance with current standards of medical practice within the United States, and
• not primarily for the convenience of the individual or the individual’s family or professional provider, and
• an appropriate supply or level of service that safely can be provided, and
• recommended or approved by the attending professional provider, and
• a qualified reimbursable service under Medicare.

The fact that a professional provider may prescribe, order, recommend, perform, or approve a service, supply, or treatment does not in and of itself make the service, supply, or treatment medically necessary and the claims processor, Plan sponsor or its designee may request and rely upon the opinion of a physician or physicians. The determination of the claims processor, Plan sponsor or its designee shall be final and binding.

Medicare: the programs established by Title XVIII known as the Health Insurance for the Aged Act, which includes: Part A, Hospital Benefits For The Aged; Part B, Supplementary Medical Insurance Benefits For The Aged; and Part C, Miscellaneous provisions regarding both programs; and including any subsequent changes or additions to those programs.

mental health disorder: an emotional or mental condition characterized by abnormal functioning of the mind or emotions. Diagnosis and classifications of these conditions will be determined based on standard DSM-IV (diagnostic and statistical manual of mental disorders) or the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services.

nurse: a licensed person holding the degree Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocational Nurse (L.V.N.) who is practicing within the scope of the license.

outpatient: an individual who is treated at a hospital as other than an inpatient, a professional provider’s office, laboratory, x-ray facility, or ambulatory surgical facility, and the stay is less than 18 consecutive hours.

partial confinement: a period of less than 24 hours of active treatment in a facility licensed or certified by the state in which treatment is received to provide psychiatric services and/or treatment of mental health disorders. It may include day, early evening, evening, or night care or a combination of all four.
physician: a Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.), other than a close relative of the patient, who is practicing within the scope of his or her license

placed for adoption: the date the annuitant assumes legal obligation for the total or partial financial support of a child during the adoption process

Plan: the HOP Medical Plan

Plan sponsor: The Plan sponsor is responsible for the management of the HOP Medical Plan. The Plan sponsor is the PSERS Board of Trustees

Plan year: January 1 through December 31

pregnancy: the physical state that results in childbirth or miscarriage

prior plan: the HOP Medical Plan in effect prior to the effective date of the Plan or a predecessor plan (e.g., High or Standard Option), which has been replaced by the HOP Medical Plan as of the effective date

professional provider: a person or other entity licensed where required and performing services within the scope of such license. The covered professional providers are:

- audiologist
- certified addictions counselor
- certified clinical nurse specialist
- certified community health nurse
- certified enterostomal therapy nurse
- certified psychiatric mental health nurse
- certified Registered Nurse anesthetist
- certified Registered Nurse practitioner
- chiropractor
- clinical laboratory
- clinical licensed social worker (A.C.S.W., L.C.S.W., M.S.W., R.C.S.W., M.A., M.E.D.)
- dentist
- nurse (R.N., L.P.N., L.V.N.)
- nurse midwife
- occupational therapist
- optometrist
- osteopath
- physical therapist
- physician
- podiatrist
- psychologist
- respiratory therapist
- speech therapist

PSERS: the Pennsylvania Public School Employees’ Retirement System

relevant information: when used in connection with a claim for benefits or a claim appeal, any document, record, or other information:

- relied on in making the benefit determination, or
- that was submitted, considered, or generated in the course of making a benefit determination, whether or not relied upon, or
- that demonstrates compliance with the duties to make benefit decisions in accordance with Plan documents and to make consistent decisions, or
- that constitutes a statement of policy or guidance for the HOP Medical Plan concerning the denied treatment or benefit for the individual’s diagnosis, even if not relied upon
restorative therapy: a planned systematic program that focuses on restoring function lost due to an illness or injury. Treatment must be reasonable and necessary to treat the individual’s illness or injury with the expectation that the individual’s condition will improve significantly within a reasonable period of time.

room and board: room and linen service, dietary service, including meals, special diets and nourishments, and general nursing service. Room and board does not include personal items.

semiprivate rate: the daily room and board charge that a facility applies to the greatest number of beds in its semiprivate rooms containing two or more beds.

skilled nursing facility: a facility provider approved by the HOP Medical Plan that is primarily engaged in providing skilled nursing and rehabilitative services on an inpatient basis to patients requiring 24-hour skilled nursing services but not requiring confinement in an acute care hospital. Such care is rendered by or under the supervision of physicians. A skilled nursing facility is not, other than incidentally, a place that provides custodial care, ambulatory care, part-time care services, or care or treatment of mental illness, alcoholism, drug abuse, or pulmonary tuberculosis.
# PLAN FACTS

<table>
<thead>
<tr>
<th><strong>Effective Date of Plan:</strong></th>
<th>January 1, 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Name of Plan:</strong></td>
<td>HOP Medical Plan of the <strong>PSERS</strong> Health Options Program</td>
</tr>
<tr>
<td><strong>Group Number:</strong></td>
<td>503</td>
</tr>
<tr>
<td><strong>Type of Plan:</strong></td>
<td>Welfare Benefit Plan: voluntary health benefit program</td>
</tr>
</tbody>
</table>
| **Name, Address and Phone Number of Plan Sponsor:** | PSERS Board of Trustees  
5 North 5th Street  
Harrisburg, PA 17101  
1-888-773-7748  
Legal process may be served upon the **Plan sponsor.** |
| **Plan Year:**              | January 1 - December 31 |
| **Procedures for Filing Claims:** | For detailed information on how to submit a claim for benefits, or how to file an appeal on a processed claim, refer to the section entitled “Filing Claims.” The designated claims processor is:  
HOP Administration Unit  
P.O. Box 2921  
Clinton, IA 52733-2921  
1-800-773-7725  
The designated **Health Care Management Organization** is:  
Trustmark  
P.O. Box 1764  
Lancaster, PA 17608-1764 |
ENNSYLVANIA PUBLIC SCHOOL EMPLOYEES’ RETIREMENT SYSTEM (PSERS) NOTICE OF NONDISCRIMINATION

The Pennsylvania Public School Employees’ Retirement System (PSERS) Health Options Program complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Pennsylvania Public School Employees’ Retirement System (PSERS) Health Options Program does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The PSERS Health Options Program:

• Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  – Qualified sign language interpreters
  – Written information in other formats (large print, audio, accessible electronic formats, other formats)
• Provides free language services to people whose primary language is not English, such as:
  – Qualified interpreters
  – Information written in other languages

If you need these services, contact Peter Camacci, Director, Health Insurance Office.

If you believe that the PSERS Health Options Program has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

  Peter Camacci, Director, Health Insurance Office
  Public School Employees’ Retirement System
  5 N 5th Street
  Harrisburg, PA 17101-1905
  Phone: (888) 773-7748; TTY use: 711; Fax: (717) 772-3860; Email: pcamacci@pa.gov

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Peter Camacci is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

  U.S. Department of Health and Human Services
  200 Independence Avenue, SW Room 509F, HHH Building
  Washington, D.C. 20201
  1-800-868-1019, 800-537-7697 (TDD).

## ATTENTION: FREE LANGUAGE ASSISTANCE

This chart displays, in various languages, the phone number to call for free language assistance services for individuals with limited English proficiency.

<table>
<thead>
<tr>
<th>Language</th>
<th>Message About Language Assistance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spanish</td>
<td>ATENCION: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-773-7725; TTY: 711.</td>
</tr>
<tr>
<td>Chinese</td>
<td>注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-800-773-7725; TTY: 711。</td>
</tr>
<tr>
<td>French</td>
<td>ATTENTION : Si vous parlez français, des services d’aide linguistique vous sont proposés gratuitement. Appelez le 1-800-773-7725; TTY: 711.</td>
</tr>
<tr>
<td>Italian</td>
<td>ATTENZIONE: In caso la lingua parlata sia l’italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-773-7725; TTY: 711.</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-773-7725; TTY: 711.</td>
</tr>
<tr>
<td>Tagalog</td>
<td>PAUNAWA: Kung nagasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-773-7725; TTY: 711.</td>
</tr>
<tr>
<td>Arabic</td>
<td>ملاحظة: إذا كنت تتحدث العربية اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجاني. اتصل برقم 1-800-773-7722.</td>
</tr>
<tr>
<td>Korean</td>
<td>주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-773-7725; TTY: 711 번으로 전화해 주십시오.</td>
</tr>
<tr>
<td>Russian</td>
<td>ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-773-7725; TTY: 711.</td>
</tr>
<tr>
<td>Polish</td>
<td>UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-773-7725; TTY: 711.</td>
</tr>
<tr>
<td>Gujarati</td>
<td>સુચના: તમે ગુજરાતી બોલતા હોવાથી તમારા માટે ભાષા સહાય સેવાઓ ઉપલબ્ધ છે. ફોન કરાય જે 1-800-773-7725; TTY: 711.</td>
</tr>
<tr>
<td>Ukrainian</td>
<td>УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-773-7725; TTY: 711.</td>
</tr>
<tr>
<td>Cambodian</td>
<td>ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយភាសាខ្មែរ, ស្រវាជំនួយផ្ន្រិតភាសាកំពុងបានសម្រាប់អ្នក។ ចូរ ទូរស័ព្ទ 1-800-773-7725; TTY: 711។</td>
</tr>
<tr>
<td>French Creole  (Haitian)</td>
<td>ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-773-7725; TTY: 711.</td>
</tr>
<tr>
<td>Portuguese</td>
<td>ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-773-7725; TTY: 711.</td>
</tr>
<tr>
<td>Greek</td>
<td>ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε το 1-800-773-7725; TTY: 711.</td>
</tr>
</tbody>
</table>