PSERS HEALTH OPTIONS PROGRAM
2021 OPTION SELECTION PERIOD CHANGE FORM

HEALTH OPTIONS PROGRAM
WWW.HOPBENEFITS.COM®

HOP Administration Unit
P.O. Box 1764 • Lancaster, PA 17608-1764
Phone: 1-800-773-7725 • Fax: 1-877-411-4921 • TTY Phone: 1-800-498-5428
Representatives are available 8 a.m. to 8 p.m., Monday to Friday.
Email: hopadminunit@trustmarkbenefits.com

IMPORTANT—PLEASE READ!

- **Only use this form if you are currently enrolled in the Health Options Program and want to change your coverage. If you do not want to change your coverage, DO NOT complete this form.**
- If you are making coverage changes for 2021, please complete this form, and return it to the HOP Administration Unit by November 16, 2020.
- **YOU MUST** sign and date the Change Form where indicated in the **Statement of Authorization**.
- **YOU MUST be enrolled in *BOTH* Medicare Parts A *AND* B to enroll in the HOP or Value Medical Plan. YOU MUST** be enrolled in ***EITHER*** Medicare Part A ***OR*** B to enroll in a Medicare Rx Option **with no medical coverage**.
- A retiree and spouse/dependent **MUST** apply for the **same or comparable coverage**.
- **DO NOT** use this Change Form to enroll in a managed care organization.

I want to (check all that apply):

Change coverage for:
- ❑ Myself
- ❑ My spouse
- ❑ My dependents

Terminate coverage for:
- ❑ Myself
- ❑ My spouse
- ❑ My dependents

RETIREE INFORMATION

Name (as it appears on your Medicare card)	Last	First	MI
Permanent Address	Street (no P.O. boxes)		City
	State	Zip	County
Mailing Address (if different from above)	Street		City
	State	Zip	County
Birth Date (mm/dd/yy)			
Home Phone # ( )		Cell Phone # ( )	
Email Address			
Sex ❑ Male ❑ Female		Social Security Number	
Medicare Information	Medicare Number		
	Part A Effective Date (mm/dd/yy)	Part B Effective Date (mm/dd/yy)	

PLEASE CONTINUE TO NEXT PAGE

DEPENDENT INFORMATION (Complete this section ONLY if you are adding a dependent to your coverage for the first time, or you are making a change to your dependent's coverage. If more than one dependent is enrolling, please provide the requested information on an additional application.)

Relationship to PSERS Retiree ❑ Spouse ❑ Child (Call the HOP Administration Unit at 1-800-773-7725 before enrolling a child.)

Name	Last		First	MI
Permanent Address	Street (no P.O. boxes)			City
	State	Zip		County
Mailing Address (if different from above)	Street			City
	State	Zip		County
Birth Date (mm/dd/yy)				
Phone # ( )		Cell Phone # ( )		
Sex ❑ Male ❑ Female		Email Address		
Medicare Information (if your dependent is Medicare-eligible)	Medicare Number			
	Social Security Number			
	Part A Effective Date (mm/dd/yy)			
	Part B Effective Date (mm/dd/yy)			

PLEASE CONTINUE TO NEXT PAGE

OPTION CHANGES

Check **ALL** boxes for the medical, prescription drug, and dental/vision coverage(s) you want. Note: If you want to keep your current coverage, do **NOT** complete this form.

My current coverage is...

Check all that apply.

Medical Coverage

- ❑ HOP Medical
- ❑ Value Medical
- ❑ Medicare Advantage plan
- ❑ None

Prescription Drug Coverage

- ❑ Enhanced Rx
- ❑ Basic Rx
- ❑ Value Rx
- ❑ Medicare Advantage plan
- ❑ None

Dental/Vision Coverage

- ❑ Dental/Vision Plan (must also enroll in HOP Medical or Value Medical)
- ❑ None

HOP Pre-65 Medical Plan

- ❑ With prescription drug coverage
- ❑ Without prescription drug coverage
- ❑ None

I want to change coverage to...

Check all that apply.

Medical Coverage

- ❑ HOP Medical
- ❑ Value Medical
- ❑ None

Prescription Drug Coverage

- ❑ Enhanced Rx
- ❑ Basic Rx
- ❑ Value Rx
- ❑ None

Dental/Vision Coverage

- ❑ Dental/Vision (must also enroll in HOP Medical or Value Medical)
- ❑ None

HOP Pre-65 Medical Plan

- ❑ With prescription drug coverage
- ❑ Without prescription drug coverage
- ❑ None

The date(s) you want coverage or changes to begin (required)	Retiree (mm/dd/yy) _____/01/_____	Dependent (mm/dd/yy)_____/01/_____

Please do not submit your application until BOTH Medicare Part A and Part B are effective.

Your coverage effective date depends on when you return your application for coverage. If you would like your effective date to be the first day of the month you turn 65, please submit this application anytime during the three months before your 65th birthday month. All other applications will be processed with an effective date of the 1st of the month after the application was received.

IF YOU JOIN	YOUR COVERAGE BEGINS
During one of the three months before you turn 65	The first day of the month you turn 65
During the month you turn 65	The first day of the month after you ask to join the plan
During one of the three months after you turn 65	The first day of the month after you ask to join the plan

PLEASE CONTINUE TO NEXT PAGE

STATEMENT OF AUTHORIZATION

By signing this form, I acknowledge reading and agreeing to all the terms and conditions on the back of this application.

Retiree's Signature ✔	**Date (mm/dd/yy)** ✔
Spouse's Signature ✔ *(Required if newly enrolling or currently enrolled)*	**Date (mm/dd/yy)** ✔

If you are an authorized representative or have power of attorney, you must sign and complete the information below.

Signature

Name

Address

Phone # ( )	Relationship to Applicant

Important! If you're enrolling because you lost employer-sponsored coverage, please include a *Loss of Coverage Letter* from the employer on company letterhead. The letter must state when and why the coverage was lost, and be signed and dated by the employer representative.

PLEASE CONTINUE TO NEXT PAGE

PLEASE READ THIS IMPORTANT INFORMATION

- People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.
- If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.
- **If you are a member of a Medicare Advantage plan** (like an HMO or PPO), you may already have prescription drug coverage from your Medicare Advantage plan that will meet your needs. By joining the Health Options Program, your membership in your Medicare Advantage plan may end. This will affect both your doctor and hospital coverage as well as your prescription drug coverage. Read the information that your Medicare Advantage plan sends you, and if you have questions, contact your Medicare Advantage plan.
- **If you currently have health coverage from an employer or union, joining the Health Options Program could affect your employer or union health benefits.** You could lose your employer or union health coverage if you join the Health Options Program. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If you don't have contact information, your benefits administrator or the office that answers questions about your coverage can help.

By completing this enrollment application, I agree to the following about the Enhanced, Basic, and Value Medicare Rx Options (the "plan"):

- The plan is a Medicare drug plan and has a contract with the federal government. I understand that this prescription drug coverage is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare Part A or Part B coverage. It is my responsibility to inform the plan of any prescription drug coverage that I have or may get in the future. I can only be in one Medicare prescription drug plan at a time—if I am currently in a Medicare prescription drug plan, my enrollment in the plan will end that enrollment.
- Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes if an enrollment period is available, generally during the Option Selection Period (early October to November 16), unless I qualify for certain special circumstances.
- The plan serves a specific service area. If I move out of the plan area, I need to notify the plan so I can disenroll and find a plan in my new area. I understand that I must use network pharmacies except in an emergency when I cannot reasonably use the plan's network pharmacies. Once I am a member of the plan, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage from the plan when I get it to know which rules I must follow to get coverage.
- I understand that if I leave this plan and don't have or get other Medicare prescription drug coverage or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty in addition to my premium for Medicare prescription drug coverage in the future.

PLEASE CONTINUE TO NEXT PAGE

PLEASE READ THIS IMPORTANT INFORMATION *continued*

- Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or prescription drug plan options, medical assistance through the state Medicaid program, and the Medicare Savings Program.
- I understand this application is subject to approval by the Health Options Program, a voluntary health benefits plan sponsored by the Pennsylvania Public School Employees' Retirement System, and any coverage provided will be subject to the terms of the applicable description of benefits and standard health insurance procedures and practices. Any person or organization having provided or who may provide health care services to me or any person named on this application, either prior to or during the period of coverage, is authorized to furnish the PSERS Health Options Program and any third-party payer any information or records relating to these services.
- I understand that premiums will be deducted from my monthly benefit from PSERS unless the amount of the monthly benefit is insufficient to cover the premium, at which time I will be billed directly.
- I understand that my election of a coverage option is for the following calendar year or the remainder of the current calendar year and cannot be changed during the year unless I have a "Qualifying Event" as defined in the communication materials.
- I verify that the information given in this application is true and correct and understand that false statements made herein or fraudulent claims made hereunder are subject to penalties under 18 PA C.S.A. §4117 relating to health insurance fraud.
- I understand that I will not be eligible for prescription drug coverage through the PSERS Health Options Program if I elect Medicare prescription drug coverage (Part D) from another provider.

Release of Information:

By joining this Medicare prescription drug plan, I acknowledge that the Health Options Program will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations. I also acknowledge that the Health Options Program will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes, which follow all applicable federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under state law where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that (1) this person is authorized under state law to complete this enrollment, and (2) documentation of this authority is available upon request by the Health Options Program or by Medicare.