HOP
HEALTH OPTIONS PROGRAM
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PSERS HEALTH OPTIONS PROGRAM INITIAL ENROLLMENT APPLICATION

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 8:00 a.m. to 8:00 p.m., Monday to Friday.
Email: HOPadminunithb@hlthben.com

IMPORTANT—PLEASE READ!

- **YOU MUST** sign and date the application 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 or dependent **MUST** apply for the **same or comparable coverage**.
- **DO NOT** sign or submit this application **more than three months** before the desired effective date.
- **DO NOT** use this application to apply for coverage with a managed care organization. Contact the HOP Administration Unit for managed care organization applications.

RETIREE INFORMATION (This section must identify the PSERS retiree, whether enrolling or not.)

If the retiree is **NOT** to be covered, check here ❍		If the retiree is currently enrolled, check here ❍	
Marital Status ❍ Married ❍ Single ❍ Widowed ❍ Divorced ❍ Separated			
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)		Retirement Date (mm/dd/yy)	
Home Phone # ( )		Cell Phone # ( )	
Email Address			
Sex ❍ Male ❍ Female		Social Security Number	

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.*

❍ No, not of Hispanic, Latino/a, or Spanish origin
❍ Yes, Cuban
❍ Yes, Mexican, Mexican American, Chicano/a
❍ Yes, another Hispanic, Latino/a, or Spanish origin
❍ Yes, Puerto Rican
❍ I choose not to answer.

** Optional question: Answering this question is your choice. You can't be denied coverage because you do not complete this question.*

PLEASE CONTINUE TO NEXT PAGE

RETIREE INFORMATION (This section must identify the PSERS retiree, whether enrolling or not.)

What's your race? Select all that apply.*

- ❍ American Indian or Alaska Native
- ❍ Asian Indian
- ❍ Black or African American
- ❍ Chinese
- ❍ Filipino/a
- ❍ Guamanian or CHamoru
- ❍ Japanese
- ❍ Korean
- ❍ Native Hawaiian
- ❍ Other Asian
- ❍ Other Pacific Islander
- ❍ Samoan
- ❍ Vietnamese
- ❍ White
- ❍ I choose not to answer.

Medicare Information	Medicare Number	
	Part A Effective Date (mm/dd/yy)	Part B Effective Date (mm/dd/yy)

** Optional question: Answering this question is your choice. You can't be denied coverage because you do not complete this question.*

DEPENDENT INFORMATION (Complete this section ONLY if a dependent is enrolling. 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)				
Home Phone # ( )			Cell Phone # ( )	
Sex ❍ Male ❍ Female			Email Address	

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.*

- ❍ No, not of Hispanic, Latino/a, or Spanish origin
- ❍ Yes, Mexican, Mexican American, Chicano/a
- ❍ Yes, Puerto Rican
- ❍ Yes, Cuban
- ❍ Yes, another Hispanic, Latino/a, or Spanish origin
- ❍ I choose not to answer.

** Optional question: Answering this question is your choice. You can't be denied coverage because you do not complete this question.*

PLEASE CONTINUE TO NEXT PAGE

DEPENDENT INFORMATION (Complete this section ONLY if a dependent is enrolling. If more than one dependent is enrolling, please provide the requested information on an additional application.)

What's your race? Select all that apply.*

- ❍ American Indian or Alaska Native
- ❍ Asian Indian
- ❍ Black or African American
- ❍ Chinese
- ❍ Filipino/a
- ❍ Guamanian or CHamoru
- ❍ Japanese
- ❍ Korean
- ❍ Native Hawaiian
- ❍ Other Asian
- ❍ Other Pacific Islander
- ❍ Samoan
- ❍ Vietnamese
- ❍ White
- ❍ I choose not to answer.

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)

OPTION SELECTION

Check **ALL** boxes for the medical, prescription drug, and dental and vision coverage(s) you want.

Medical Coverage

- ❍ HOP Medical
- ❍ Value Medical
- ❍ No medical coverage

Prescription Drug Coverage (CMS Contract: E3014)

- ❍ Enhanced Rx
- ❍ Basic Rx
- ❍ Value Rx
- ❍ No prescription drug coverage

Dental and Vision Coverage

- ❍ MetLife Dental and EyeMed Vision Option (must also enroll in HOP Medical or Value Medical)
- ❍ No dental and vision coverage

HOP Pre-65 Medical Plan

- ❍ With prescription drug coverage
- ❍ Without prescription drug coverage
- ❍ No pre-65 medical coverage

The date(s) you want coverage 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.

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 first of the month after the application was received. See the "Statement of Authorization" section for a coverage-effective-date table that explains this information.

** Optional question: Answering this question is your choice. You can't be denied coverage because you do not complete this question.*

PLEASE CONTINUE TO NEXT PAGE

PLEASE ANSWER THE FOLLOWING QUESTIONS

Question	Retiree	Spouse*
1. Is this your first time enrolling in a Medicare Supplement, Medicare Advantage,** or Medicare Rx plan?	❍ Yes ❍ No	❍ Yes ❍ No
	If no: ❍ Current coverage (i.e., Medicare Supplement, Medicare Advantage, Original Medicare only): _____ ❍ Dates of coverage: (mm/dd/yy) _____ to (mm/dd/yy) _____	
2. Are you leaving employer or union coverage?	❍ Yes, on (mm/dd/yy) _____ ❍ No	❍ Yes, on (mm/dd/yy) _____ ❍ No
3. Have you recently involuntarily lost creditable prescription drug coverage (as good as Medicare's)?	❍ Yes, I lost my coverage on (mm/dd/yy) _____ ❍ No	❍ Yes, I lost my coverage on (mm/dd/yy) _____ ❍ No
4. Will you have other **medical** coverage (besides the Health Options Program and Medicare) when your Health Options Program coverage begins?	❍ Yes ❍ No	❍ Yes ❍ No
	If yes, name of other insurance company: _____	
	If no, did you drop an existing policy to enroll in the Health Options Program? ❍ Yes ❍ No	
5. Some individuals may have other drug coverage, including other private insurance, TRICARE, federal employee health benefits coverage, VA benefits, or state pharmaceutical assistance programs. Will you have other prescription drug coverage in addition to your coverage under the Health Options Program?	❍ Yes ❍ No	❍ Yes ❍ No
	If yes, list your other coverage and your identification (ID) number(s) for this coverage: Name of other coverage: _____ ID # for this coverage: _____ Group # for this coverage: _____	
	If no, did you drop an existing policy to enroll in the Health Options Program? ❍ Yes ❍ No	
Please indicate whether you need language assistance services for plan information in one of the languages listed on the Notice of Nondiscrimination or in another accessible format.***	• Other language: _____ • Other accessible formats: ❍ Braille ❍ Audio tape ❍ Large print If you need information in another accessible format, contact the HOP Administration Unit (see page 1).	

** Only complete if you are enrolling your spouse.*

*** If you are enrolling in coverage under a Health Options Program managed care organization plan, contact the HOP Administration Unit for that insurance provider's application.*

**** Optional question: Answering this question is your choice. You can't be denied coverage because you do not complete this question.*

PLEASE CONTINUE TO NEXT PAGE

STATEMENT OF AUTHORIZATION

By signing this form, you acknowledge reading and agreeing to all the terms and conditions on the back of this application. This application must be submitted prior to the desired effective date. However, your signature date(s) may NOT be more than three months prior to the desired effective date.

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

Your coverage effective date depends on when you return your application for coverage.

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

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 **ssa.gov/medicare/part-d-extra-help**.
- 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 that has provided or that 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. [If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. DON'T pay the Part D-IRMAA to the Health Options Program.]
- 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 share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by federal law that authorizes the collection of this information. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

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.