

PSERS HEALTH OPTIONS PROGRAM 2024 CHANGE FORM



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: HOPadminunit@hlthben.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.**
- **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 or 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	<input type="radio"/> Male	<input type="radio"/> 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.

RETIREE INFORMATION

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

- | | |
|--|---|
| <input type="radio"/> American Indian or Alaska Native | <input type="radio"/> Native Hawaiian |
| <input type="radio"/> Asian Indian | <input type="radio"/> Other Asian |
| <input type="radio"/> Black or African American | <input type="radio"/> Other Pacific Islander |
| <input type="radio"/> Chinese | <input type="radio"/> Samoan |
| <input type="radio"/> Filipino/a | <input type="radio"/> Vietnamese |
| <input type="radio"/> Guamanian or CHamoru | <input type="radio"/> White |
| <input type="radio"/> Japanese | <input type="radio"/> I choose not to answer. |
| <input type="radio"/> Korean | |

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 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)

Home Phone # ()	Cell Phone # ()
Sex <input type="radio"/> Male <input type="radio"/> Female	Email Address

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

- | | |
|--|--|
| <input type="radio"/> No, not of Hispanic, Latino/a, or Spanish origin | <input type="radio"/> Yes, Cuban |
| <input type="radio"/> Yes, Mexican, Mexican American, Chicano/a | <input type="radio"/> Yes, another Hispanic, Latino/a, or Spanish origin |
| <input type="radio"/> Yes, Puerto Rican | <input type="radio"/> 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.

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.)

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)

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

REASON FOR COVERAGE CHANGE REQUEST (CHECK ONE):

- I want to change my current election during the Option Selection Period (OSP; only early October through mid-November). Changes made during OSP will be effective January 1, 2024.
- Moved out of service area
- Death of retiree or dependent
- Loss of COBRA or State Continuation: start date _____ stop date _____
- Loss of group coverage (i.e., under your spouse's employer plan)
- Marriage or divorce
- Disabled dependent
- Adding dependent due to Qualifying Event
- Other: _____

OPTION CHANGES

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

My current Health Options Program coverage is...	I want to add or change my Health Options Program coverage to...	
<p>Check all that apply.</p> <p>Medical Coverage</p> <ul style="list-style-type: none"> <input type="radio"/> HOP Medical <input type="radio"/> Value Medical <input type="radio"/> Medicare Advantage plan <input type="radio"/> No medical coverage <p>Prescription Drug Coverage (CMS Contract: E3014)</p> <ul style="list-style-type: none"> <input type="radio"/> Enhanced Rx <input type="radio"/> Basic Rx <input type="radio"/> Value Rx <input type="radio"/> Medicare Advantage plan <input type="radio"/> No prescription drug coverage <p>Dental and Vision Coverage</p> <ul style="list-style-type: none"> <input type="radio"/> MetLife Dental and EyeMed Vision Option (must also enroll in HOP Medical or Value Medical) <input type="radio"/> No dental and vision coverage <p>HOP Pre-65 Medical Plan</p> <ul style="list-style-type: none"> <input type="radio"/> With prescription drug coverage <input type="radio"/> Without prescription drug coverage <input type="radio"/> No pre-65 medical coverage 	<p>Check all that apply.</p> <p>Medical Coverage</p> <ul style="list-style-type: none"> <input type="radio"/> HOP Medical <input type="radio"/> Value Medical <input type="radio"/> No medical coverage <p>Prescription Drug Coverage (CMS Contract: E3014)</p> <ul style="list-style-type: none"> <input type="radio"/> Enhanced Rx <input type="radio"/> Basic Rx <input type="radio"/> Value Rx <input type="radio"/> No prescription drug coverage <p>Dental and Vision Coverage</p> <ul style="list-style-type: none"> <input type="radio"/> MetLife Dental and EyeMed Vision Option (must also enroll in HOP Medical or Value Medical) <input type="radio"/> No dental and vision coverage <p>HOP Pre-65 Medical Plan</p> <ul style="list-style-type: none"> <input type="radio"/> With prescription drug coverage <input type="radio"/> Without prescription drug coverage <input type="radio"/> No pre-65 medical coverage <p>If you want to enroll in a Health Options Program Medicare Advantage plan, contact the HOP Administration Unit.</p>	
<p>The date(s) you want coverage or changes to begin (required)</p>	<p>Retiree (mm/dd/yy) _____/01/_____</p>	<p>Dependent (mm/dd/yy) _____/01/_____</p>

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

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 ✓ <i>(Required if newly enrolling or currently enrolled)</i>	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 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 change form, 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 mid-November), 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 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.

