

Pennsylvania Public School  
Employees' Retirement System (PSERS)

# Health Options Program

## THE VALUE MEDICAL PLAN

Summary Plan Description





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## For Your Reference

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This Summary Plan Description (SPD) describes the Value Medical Plan in clear, easy-to-understand language. However, since certain medical terms in this SPD may be unfamiliar to you or have special meanings, we have included a **Glossary** that begins on page 22. Any words that are included in the Glossary appear throughout this document in ***bold italics***.

## Important Note

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The medical coverage and services described in this SPD are provided by private health care insurers and providers. Neither the Public School Employees' Retirement System (PSERS) nor the Commonwealth of Pennsylvania is an insurer. In no event shall PSERS, 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.



# OVERVIEW OF THE HEALTH OPTIONS PROGRAM

**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 **Value Medical Plan** and the **HOP Medical Plan**, which are available to all **Medicare**-eligible members, regardless

of where they live. 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.

## THE HEALTH OPTIONS PROGRAM

### Options for Medicare-Eligible Members

**Value Medical Plan**

**HOP Medical Plan**

**Medicare Advantage Plan “A”**

**Medicare Advantage Plan “B”**

### Options for Non-Medicare-Eligible Members

**HOP Pre-65 Medical Plan**

**Managed Care Plan “A”**

**Managed Care Plan “B”**

## Prescription Drug Coverage

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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 Value Medical Plan or 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

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

- the Value 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**. If you are enrolled but your spouse is not, consider when they might retire. At that time, under the comparable coverage rule, he/she will be enrolled in the same plan as you. Therefore, you may want to consider what options will work for both of you. Otherwise, you won't have the opportunity to change coverage (for both of you) until the Option Selection Period.

## Program Administration

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The Health Options Program is administered for **PSERS** by Luminare Health Benefits, Inc. (previously Trustmark), which provides services for 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 8 p.m. Eastern time).

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***If you have questions about the Health Options Program, you can go online to [www.HOPbenefits.com](http://www.HOPbenefits.com) or call the HOP Administration Unit at 1-800-773-7725.***

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## For More Information about Other Options

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



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# ELIGIBILITY AND ENROLLMENT

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## Who Is Eligible

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

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

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## When You Become Eligible

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An eligible person may enroll in the Value 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, but not limited to, divorce, your spouse's death, the addition of a dependent through birth, adoption or marriage, or a dependent loses eligibility). The death of a retiree is not a Qualifying Event unless the spouse or dependent will receive a pension from PSERS following the retiree's death.
- 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** and may apply to a survivor **annuitant** or the spouse or dependent of an **annuitant** independently. For example, the spouse of an **annuitant** may enroll when he or she turns age 65 and becomes eligible for **Medicare**.

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***An eligible person may enroll in the Value Medical Plan when he or she experiences a Qualifying Event.***

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### Your Deadline for Enrolling

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An eligible person must enroll in the Value Medical Plan within a limited time following a Qualifying

Event. This means, for example, that the spouse of a **PSERS annuitant** must enroll within a certain number of days following the date on which the spouse turns age 65; otherwise, he or she will not be eligible to enroll in the Health Options Program in the future without another Qualifying Event.

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***The enrollment, change or addition must be made within a specified time frame, depending on your Qualifying Event. Qualifying events cannot be made retroactively. All benefit changes are made the first of the month following the notice of the change and/or qualifying event. If such an event occurs, call the HOP Administration Unit at 1-800-773-7725.***

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### How to Enroll

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To enroll, a **PSERS** Health Options Program Application for an Enrollment/Change/Termination Request must be submitted by the required deadline.

### When Coverage Begins

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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

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If you acquire a new dependent (by birth, marriage or 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 a certain number of days of the Qualifying Event.

## When You Can Change Your Health Option

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After you enroll in the Health Options Program, you can change your health option to another option for which you are eligible, 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 option.
- If you experience a Qualifying Event (see the list that begins on page 3), you become eligible to change your option or plan outside of the Option Selection Period, provided you make the change within a specified time frame following the Qualifying Event. If one member of an **annuitant's** family has a Qualifying Event, all enrolled members may change plans or options. If such an event occurs, call the HOP Administration Unit at 1-800-773-7725 for details.

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

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## When Coverage Ends

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

- the date **PSERS** terminates the Value 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 Value 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.

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# VALUE MEDICAL PLAN BENEFITS

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***The Value Medical Plan is designed to provide financial protection in the event of unexpected high-cost hospital and medical expenses.***

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

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

For more information about amounts paid by **Medicare**, go online to [www.medicare.gov](http://www.medicare.gov) or call 1-800-MEDICARE (1-800-633-4227) and request a copy of *Medicare & You*.

If a service is covered by **Medicare**, amounts not paid by **Medicare** are then considered for payment under the Value Medical Plan. If you are admitted to the hospital, the Plan pays a portion of **Medicare's** hospital **deductible** and all of the daily **coinsurance** for a stay that exceeds 60 days. When you have medical expenses, the Plan limits your share of the cost for some services after you pay **Medicare's** Part B annual **deductible**. In addition, the Value Medical Plan has an annual out-of-pocket maximum. If your out-of-pocket payments for covered costs reach the maximum in a calendar year, the Plan will pay all of your covered expenses for the rest of that year.

## What Is Not Covered under the Value Medical Plan

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The Value Medical Plan does not cover any expenses not covered by **Medicare** or any expenses once **Medicare** benefits are exhausted, for example hospital stays beyond the lifetime reserve.

## Summary Chart

The following compares the payments you would be required to make for selected covered services if you are enrolled in Original **Medicare** only or in Original **Medicare** and the Value Medical Plan. **All amounts are based on 2024 Medicare amounts, which are subject to change in subsequent years.**

	WHAT YOU PAY IF YOU ARE ENROLLED IN	
	Original Medicare Only	Original Medicare and the Value Medical Plan
<b>Medicare Part A</b>		
First-day hospital <b>deductible</b> per admission	\$1,632	\$300
<b>Coinsurance</b> for days 1-60 of a hospital stay	\$0	\$0
<b>Coinsurance</b> for days 61-90 of a hospital stay	\$408/day	\$0
<b>Coinsurance</b> for days 91-150 of a hospital stay (lifetime reserve)	\$816/day	\$0
<b>Coinsurance</b> for days 1-20 of a stay in a skilled nursing facility	\$0	\$0
<b>Coinsurance</b> for days 21-100 of a stay in a skilled nursing facility	\$204/day	\$50/day
<b>Medicare Part B</b>		
Annual <b>deductible</b>	\$240	\$240
Physician visit	20%	20% to a maximum of \$20/visit
Outpatient mental health	20%	20% to a maximum of \$20/visit
Ob/gyn exams	20%	20% to a maximum of \$20/visit
Emergency room	20%	\$50 (waived if admitted)
Outpatient surgery	20%	20% to a maximum of \$100/procedure
Diagnostic testing	20%	20% (to a maximum of \$100/procedure for MRIs and CT scans)
Durable medical equipment	20%	20%
Other	20%	20%
<b>Annual out-of-pocket maximum (Parts A and B)</b>	<b>No maximum</b>	<b>\$5,000</b>

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# FILING CLAIMS

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Claims for benefits should be submitted initially to **Medicare**. In most cases, providers will submit their bills directly to **Medicare**. **Medicare** determines coverage, benefit determination, medical necessity, payment amount and payment timing. Claims will then be sent electronically to the HOP Administration Unit. The HOP Administration Unit will pay benefits only after **Medicare** adjudicates the claim. If your provider does not submit a bill to **Medicare**, please contact the HOP Administration Unit for assistance.

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***Claims should be submitted to Medicare.***

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## Notice of Authorized Representative

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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.

## Where to Send Claims

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All claims for 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 Value 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.

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.

## Foreign Claims

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The Value Medical Plan will cover any services provided in foreign countries that **Medicare** covers.

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# APPEALS

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## Appealing a Claim

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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.

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***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.***

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## Appealing a Denied Certification

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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.

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***Medicare makes all medical judgments leading to the acceptance or denial of a claim.***

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## 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 Value 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.

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***Medicare makes all decisions to deny a claim based on medical necessity, experimental/investigational treatment or a similar exclusion or limit.***

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# COORDINATION OF BENEFITS

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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 Value 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 Value Medical Plan.

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

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

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## Coordination with Medicare

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Because the Value Medical Plan is a supplement to **Medicare** Part A and Part B, **Medicare** is primary and the Value 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 Value 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, the Value Medical Plan will not pay for any charges disallowed by **Medicare** due to the use of such a professional provider.

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***Medicare pays benefits before the Value Medical Plan.***

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## Coordination with Other Health Benefit Plans

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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 trusteed, 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 Value 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 Value 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 none of the above rules determine the order of benefits**, the plan covering a person longer pays first.
- 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 Value 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 carrier's 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 Value 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 Value 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 Value 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.

### If the Value Medical Plan Is Secondary

If the rules set forth above make the Value Medical Plan primary, then the benefits of the other plan will be ignored for the purposes of determining the benefits under the Value Medical Plan. However, if the Value 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.

### Limitations on Payments

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

### Right to Receive and Release Necessary Information

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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 Value Medical Plan shall furnish to the HOP Administration Unit such information as may be necessary to implement the Coordination of Benefits provision for benefits and/or services under the Plan.

### Facilitation of Benefit Payment

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Whenever payments that should have been made under the Value Medical Plan in accordance with this provision have been made under any other health benefit plan, the Value 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 Value Medical Plan and, to the extent of such payments, the Value Medical Plan shall be fully discharged from liability.

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# GENERAL PROVISIONS

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## Subrogation/Reimbursement

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The Value 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 Value 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 Value Medical Plan reserves the right of recovery, either by subrogation or reimbursement, for covered expenses payable by the Value 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.

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***The Value Medical Plan will follow Medicare's subrogation and reimbursement processes to the extent permissible under state law.***

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## Administration of the Plan

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The Value 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 Value Medical Plan. **PSERS** has retained the services of an independent claims processor experienced in claims review.

**PSERS** is the named fiduciary of the Value Medical Plan except as noted herein. The claims processor is the named fiduciary of the Value 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 Value Medical Plan. **PSERS** maintains discretionary authority to interpret the terms of the Value Medical Plan, including but not limited to determination of eligibility for and entitlement to Value Medical Plan benefits in accordance with the terms of the applicable plan as set forth in this SPD; 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

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The Value 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 Value Medical Plan unless the claims processor is notified in writing of such assignment prior to payment pursuant to the terms of the applicable plan.

## Benefits Not Transferable

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

## Clerical Error

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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)

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

## Effective Date of the Plan

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The effective date of the Value Medical Plan as defined by this description is January 1, 2024.

## Free Choice of Hospital and Physician

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Nothing contained in the Value 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

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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/her 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 Value 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 Value Medical Plan's obligation to the extent of such payment.

## Incontestability

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All statements made by the **Plan sponsor** or by an individual covered under the Value Medical Plan shall be deemed representations and not warranties. Such statements shall not void or reduce the benefits under the Value 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

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No action at law or in equity shall be brought to recover on the benefits from the Value 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 Value 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

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Liability hereunder is limited to the services and benefits specified under the terms of the Plan, and the Value Medical Plan shall not be liable for any obligation of the individual incurred in excess thereof. The liability of the Value 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

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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

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The Value 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 Value 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 Value Medical Plan has a legal liability to make payments for the same services, supplies or treatment, payment under the Value 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 Value Medical Plan.

## Misrepresentation

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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 the Value Medical Plan, or otherwise misleads the Value Medical Plan, the Value Medical Plan shall be entitled to recover its damages, including legal fees, from the individual or from any other person responsible for misleading the Value 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 Value Medical Plan null and void.

## Physical Examinations Required by the Plan

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

## Plan Is Not a Contract

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

## Plan Modification and Amendment

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The **Plan sponsor** may modify or amend the Value 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 Value 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 Value Medical Plan on file with the **Plan sponsor**, or a written copy thereof shall be deposited with such master copy of the Value Medical Plan. Appropriate filing and reporting of any such modification or amendment to individuals shall be timely made by the **Plan sponsor**.

## Plan Termination

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**PSERS** reserves the right to terminate the Value 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 Value Medical Plan will be communicated to the **covered individuals**.

## Pronouns

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

## Recovery for Overpayment

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Whenever payments have been made from the Value Medical Plan in excess of the maximum amount of benefits payable, the Value Medical Plan will have the right to recover excess payments. If the claims processor makes any payment that, according to the terms of the Value Medical Plan, should not have been made, the Value 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

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The effective time with respect to any dates used in the Value 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

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The Value Medical Plan is not in lieu of, and does not affect any requirement for, coverage by workers' compensation insurance.



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# HIPAA PRIVACY

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The following provisions are intended to comply with applicable Value 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 Value Medical Plan document.

## Disclosure by Plan to Plan Sponsor

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The Value 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 Value Medical Plan, pursuant to terms set forth in the Plan document or amendment to the Plan.

## Use and Disclosure by Plan Sponsor

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

## Obligations of PSERS

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**PSERS** shall have the following obligations:

- to ensure that:
  - any agents (including a subcontractor) to whom it provides protected health information received from the Value 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 Value Medical Plan and **PSERS**.
- not use or further disclose protected health information received from the Value Medical Plan, other than as permitted or required by the Value Medical Plan documents or as required by law
- not use or disclose protected health information received from the Value 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 Value Medical Plan any use or disclosure of the protected health information received from the Value 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 Value Medical Plan, as and to the extent required by the privacy rule:
  - for access to the individual
  - for amending and incorporating any amendments to protected health information received from the Value 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 Value Medical Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the Value Medical Plan with the privacy rule
- return or destroy all protected health information received from the Value Medical Plan that **PSERS** still maintains in any form and retain no copies when no longer needed for the purpose for which the disclosure by the Value 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 Value 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 Value 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 Value 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 Value 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 Value 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 Value Medical Plan
  - ensure that the adequate separation as required by 45 C.F.R. 164.504(f)(2)(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 Value Medical Plan any security incident of which it becomes aware.
- PSERS will not use or disclose protected health information for marketing or sell protected health information

## Exceptions

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Notwithstanding any other provision of this “HIPAA Privacy” section, the Value 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 Value Medical Plan, or
  - b. modifying, amending or terminating the Value Medical Plan.
2. disclose to the **Plan sponsor** information on whether the individual is participating in the Value 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. However, PSERS will not use genetic information for underwriting purposes,
  - c. as otherwise permitted or required by the privacy rule.

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## GLOSSARY

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Certain words and terms used herein shall be defined as follows and are shown in **bold italics** throughout this SPD:

**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

**coinsurance:** the percentage of covered expenses payable by the Value Medical Plan (or the percentage of covered expenses payable by the member where so specified) for benefits that are provided under the Value Medical Plan. The **coinsurance** is applied to covered expenses after the **deductible(s)** have been met, if applicable

**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

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

**deductible:** the amount you must pay each year before Medicare or any insurance plan pays benefits

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

**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**

**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

**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 Value Medical Plan

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

**Plan year:** January 1 through December 31

**PSERS:** the Pennsylvania Public School Employees' Retirement System

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## PLAN FACTS

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<b>Effective Date of <i>Plan</i>:</b>	January 1, 2024
<b>Name of <i>Plan</i>:</b>	Value Medical Plan of the <b>PSERS</b> Health Options Program
<b>Group Number:</b>	503 or PS
<b>Type of <i>Plan</i>:</b>	Welfare Benefit Plan: voluntary health benefit program
<b>Name, Address and Phone Number of <i>Plan Sponsor</i>:</b>	<b>PSERS</b> Board of Trustees 5 North 5th Street Harrisburg, PA 17101 1-888-773-7748  Legal process may be served upon the <b><i>Plan sponsor</i></b> .
<b><i>Plan Year</i>:</b>	January 1 - December 31
<b>Procedures for Filing Claims:</b>	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





