Pennsylvania Public School
Employees' Retirement System (PSERS)

Health Options Program

The HOP Pre-65 Medical Plan with Optional Prescription Drug Coverage

Plan Document and Summary Plan Description

HOP
HEALTH OPTIONS PROGRAM
WWW.HOPBENEFITS.COM®

For Your Reference

This Plan Document and Summary Plan Description (SPD) describes the HOP Pre-65 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 the **Definitions** section that begins on page 63. Any words that are included in the Definitions section appear throughout this document in ***bold italics***.

Important Note

The medical coverages 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.

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SUMMARY PLAN DESCRIPTION

(Bold, italicized terms can be located in the *Definitions* section beginning on page 64)

NAME OF PLAN:

HOP Pre-65 Medical Plan of the Health Options Program (HOP) sponsored by the Public School Employees' Retirement System (PSERS)

GROUP NUMBER:

503

TYPE OF PLAN:

Welfare Benefit Plan: voluntary health benefit program

NAME, ADDRESS AND PHONE NUMBER OF PLAN SPONSOR:

PSERS Board of Trustees
5 North Fifth Street
Harrisburg, PA 17101-1905
1-888-773-7748

Legal process may be served upon the ***Plan sponsor***.

PLAN YEAR:

January 1 – December 31

PROCEDURES FOR FILING CLAIMS:

For detailed information on how to submit a claim for benefits, or how to file an appeal on a processed claim, refer to the *Medical Claim Filing Procedures* section.

The designated claims processors are:

For Medical Claims:
HOP Administration Unit
P.O. Box 2921
Clinton, IA 52733-2921
1-800-773-7725

For Medical Claim Appeals:
HOP Administration Unit
P.O. Box 1764
Lancaster, PA 17608-1764
1-800-773-7725

For Prescription Drug Claims:
OptumRx
P.O. Box 29046
Hot Springs, AR 71903
1-888-239-1301

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 **HOP Medical Plan** and **Value Medical Plan**, which are available to all ***Medicare***-eligible members whose primary residence is in the U.S. 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 whose primary residence is in the U.S. 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

- **HOP Medical Plan and Value 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

Prescription drug coverage is available through the Health Options Program—no matter which option you choose. Prescription drug coverage is a separate election from medical coverage and there is an added premium.

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

Comparable Coverage

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

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

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

- The same Medicare Advantage plan you elect for yourself if he or she is eligible for ***Medicare***, or
- The managed care plan from the insurance company that provides your Medicare Advantage plan if he or she is NOT eligible for ***Medicare***.

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

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

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

For More Information about Other Health Options Program Options

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

THE HOP PRE-65 MEDICAL PLAN SCHEDULE OF BENEFITS

The HOP Pre-65 Medical Plan is for individuals who are not covered by ***Medicare*** (i.e., pre-Medicare retirees).

This *Schedule of Benefits* is a brief outline of some of the benefits included in the HOP Pre-65 Medical Plan.

Major Medical Benefits

Type of Expense: Major Medical	*Preferred Provider*	*Nonpreferred Provider*
Deductible Per Calendar Year:		
Individual Deductible (Per Person)	$1,500	$1,500
Family Deductible (2 Individuals)	$3,000	$3,000
Out-of-Pocket Expense Limit Per Calendar Year: (includes deductible)		
Individual (Per Person)	$5,500	$5,500
Family (2 Individuals)	$11,000	$11,000
Amounts applied toward satisfaction of the ***preferred provider*** deductible and out-of-pocket expense limit may also be applied toward satisfaction of the ***nonpreferred provider*** deductible and out-of-pocket expense limit and vice versa.		
Maximum Benefit Per Individual While Covered By This Plan For:		
Major Medical	$1,000,000	
Hospice Care	$12,500	
Respite Care	10 Days ***Inpatient*** or 240 Hours In-Home Care	
Maximum Benefit Per Individual Per Calendar Year For:		
Major Medical	$300,000	

Coinsurance:

You pay the percentage listed on the following pages for ***covered expenses incurred*** during a calendar year after the individual or family deductible has been satisfied and until the individual or family out-of-pocket expense limit has been reached. Thereafter, the ***Plan*** pays 100% of ***covered expenses*** for the remainder of the calendar year or until the ***maximum benefit*** has been reached. Refer to the section on Major Medical Benefits, Out-of-Pocket Expense Limit, for a listing of charges not applicable to the 100% ***coinsurance***.

Major Medical Benefits Description	*Preferred Provider* (% of *customary and reasonable amount you pay)*	*Nonpreferred Provider* (% of *customary and reasonable amount you pay)*
Inpatient Hospital	25%	40%
Outpatient Surgery/Ambulatory Surgical Center	25%	40%
Emergency Room Services (See page 13 for additional details)		
Emergency Care	25%	25% (40% if not a true emergency)
Non-***Emergency*** Care		
Facility Charges	Not Covered	Not Covered
All Other Charges	25%	40%
Immediate Care Center (Urgent Care)	25%	40%
Physician's Services		
Inpatient and Office Visit	25%	40%
Surgery	25%	40%
Pathology – ***Inpatient*** or ***Outpatient***	25%	40%
Anesthesiology	25%	40%
Radiology – ***Inpatient*** or ***Outpatient***	25%	40%

Major Medical Benefits Description (continued)	*Preferred Provider* (% of *customary and reasonable amount you pay)*	*Nonpreferred Provider* (% of *customary and reasonable amount you pay)*
Diagnostic X-rays & Lab *Inpatient* or *Outpatient*	25%	40%
Second Surgical Opinion	25%	40%
Skilled Nursing Facility	25%	40%
Home Health Care	25%	40%
IV Therapy	25%	40%
Hospice Care Limitation: $12,500 ***maximum benefit*** while covered under this Plan; Respite Care limited to 10 days ***inpatient*** or 240 hours in-home care ***maximum benefit*** while covered under this ***Plan***	25%	40%
Durable Medical Equipment	25%	40%
Mental Health Disorders ***Inpatient*** Services Limitation: 30 days ***maximum benefit*** per calendar year ***Outpatient*** Services Limitation: 30 visit ***maximum benefit*** per calendar year	25% 25%	40% 40%
Substance Use Disorder ***Inpatient*** Services Limitation: 30 days ***maximum benefit*** per calendar year ***Outpatient*** Services Limitation: 30 visit ***maximum benefit*** per calendar year	25% 25%	40% 40%

Major Medical Benefits Description (continued)	*Preferred Provider* (% of *customary and reasonable amount you pay)*	*Nonpreferred Provider* (% of *customary and reasonable amount you pay)*
Therapy Services (Physical, Speech, Occupational, etc.) Limitation: 26 visits per calendar year, combined for all therapy services	25%	40%
Birthing Facility	25%	40%
Ambulance Services Limitation: $150 ***maximum benefit*** per trip for advanced life support by either surface or air ambulance (See page 13 for additional details)	25%	40%
Prescription Drugs	See ***The Prescription Drug Program*** on page 26	
Diabetes Services	25%	40%
Chiropractor Services (See page 20 for additional details)	25%	40%
Physical Examination Limitation: $300 ***maximum benefit*** per calendar year (See page 22 for additional details)	0% (deductible waived)	40%
All Other Covered Expenses	25%	40%

PREFERRED PROVIDER OR NONPREFERRED PROVIDER

Covered individuals have the choice of using either a ***preferred provider*** or a ***nonpreferred provider***.

Preferred Provider

A ***preferred provider*** is a ***physician***, ***hospital*** or ancillary service provider that has an agreement in effect with the ***Preferred Provider Organization*** (PPO) to accept a reduced rate for services rendered to ***covered individuals***, and is within a 50-mile radius of the ***covered individual's*** place of residence. This is known as the ***negotiated rate***. The ***preferred provider*** cannot bill the ***covered individual*** for any amount in excess of the ***negotiated rate***.

The HOP Pre-65 Medical Plan uses the ***PHCS*** Network. With nearly 800,000 providers and over 4,000 facilities in the Network, health plan members have access to a quality network of providers wherever they may be in the United States. PHCS performs rigorous credentialing for providers in the Network to ensure that they meet its quality standards. PHCS has a high network retention rate, so members can be confident that once they select a participating ***physician***, that doctor will remain available through the HOP Pre-65 Medical Plan. To find a ***preferred provider***, visit www.multiplan.com, click "Find a Provider," and then click on the "Select Network" button and pick "PHCS" from the list. Once your network is selected, enter a name, specialty, ***facility*** type or NPI# in the search box.

Nonpreferred Provider

A ***nonpreferred provider*** does not have an agreement in effect with the ***Preferred Provider Organization***. For services provided by a nonpreferred provider, this ***Plan*** will allow only the ***customary and reasonable amount*** as a ***covered expense***. The ***Plan*** will pay its percentage of the ***customary and reasonable amount*** for the ***nonpreferred provider*** services, supplies and treatment. The individual is responsible for any remaining balance. This results in greater out-of-pocket expenses for the individual.

Referrals

Referrals to a ***nonpreferred provider*** are covered as ***nonpreferred provider*** services, supplies and treatments. It is the responsibility of the individual to ensure that services to be rendered are performed by ***preferred providers*** in order to receive the ***preferred provider*** level of benefits.

Exceptions

The following listing of exceptions represents services, supplies or treatments rendered by a ***nonpreferred provider*** where ***covered expenses*** shall be payable at the ***preferred provider*** level of benefits:

1. Emergency treatment rendered at a ***nonpreferred provider facility*** or at a ***preferred provider facility*** by a ***nonpreferred provider***. If the ***covered individual*** is admitted to the ***hospital*** on an ***emergency*** basis, ***covered expenses*** shall be payable at the ***preferred provider*** level.
2. ***Nonpreferred*** anesthesiologist when the ***facility*** where such services are rendered is a ***preferred provider***.
3. ***Nonpreferred*** assistant surgeon if the operating surgeon is a ***preferred provider***.
4. Radiologist or pathologist services for interpretation of X-rays and diagnostic laboratory and surgical pathology tests rendered by a ***nonpreferred provider*** when the ***facility*** where such services are rendered is a ***preferred provider***.
5. Diagnostic laboratory and surgical pathology tests referred to a ***nonpreferred provider*** by a ***preferred provider***.
6. While the individual is confined to a ***preferred provider hospital***, the ***preferred provider physician*** requests a consultation from a ***nonpreferred provider*** or a newborn visit is performed by a ***nonpreferred provider***.
7. ***Medically necessary*** specialty services, supplies or treatments that are not available from a provider in the ***Preferred Provider Organization*** within a 50-mile radius of the patient's place of residence.
8. Treatment rendered at a ***facility*** of the uniformed services or Indian Health Care ***facility***.

MAJOR MEDICAL BENEFITS UNDER THE HOP PRE-65 MEDICAL PLAN

This section describes the ***covered expenses*** for the Major Medical Benefits. All ***covered expenses*** are subject to specified provisions including, but not limited to: deductible, ***coinsurance*** and ***maximum benefit*** provisions as shown on the *Schedule of Benefits*, unless otherwise indicated. Any portion of an expense ***incurred*** by the ***covered individual*** for services, supplies or treatment that is greater than the ***customary and reasonable amount*** for ***nonpreferred providers*** or ***negotiated rate*** for ***preferred providers*** will not be considered a ***covered expense***. Specified preventive care expenses will be considered ***covered expenses*** for both ***preferred*** and ***nonpreferred providers***.

Deductibles

Individual Deductible

The individual deductible is the dollar amount of ***covered expense*** that each ***covered individual*** must have ***incurred*** during each calendar year before the ***Plan*** pays applicable benefits. The individual deductible amount is shown on the *Schedule of Benefits*.

Family Deductible

The family deductible amount is two times the individual deductible amount. When two covered members of the same family have each met their individual deductible amount during a calendar year, the family deductible amount shall be considered satisfied for that calendar year and no further deductible amount shall be taken from the expenses of any covered family member for the remainder of that calendar year.

Coinsurance

The ***Plan*** pays a specified percentage of ***covered expenses*** that do not exceed the ***customary and reasonable amount*** for ***nonpreferred providers***, or the percentage of the ***negotiated rate*** for ***preferred providers*** for ***covered expenses***. That percentage is listed on the *Schedule of Benefits*. The ***covered individual*** is responsible for the difference. The ***covered individual's*** portion of the ***coinsurance*** represents amounts included in the out-of-pocket expense limit.

Out-of-Pocket Expense Limit

After the ***covered individual*** has ***incurred*** an amount equal to the out-of-pocket expense limit listed on the *Schedule of Benefits* for ***covered expenses*** (after satisfaction of any applicable deductibles), the ***Plan*** will begin to pay 100% for ***covered expenses*** for the remainder of the calendar year.

The family amount is two times the individual out-of-pocket amount. After two covered family members have each ***incurred*** an amount equal to the individual out-of-pocket expense limit listed on the *Schedule of Benefits*, the ***Plan*** will pay 100% of ***covered expenses*** for all covered family members for the remainder of the calendar year.

Out-of-Pocket Expense Limit Exclusions

The following items do not apply toward satisfaction of the calendar year out-of-pocket expense limit and will not be payable at 100%, even if the out-of-pocket expense limit has been satisfied:

1. Expenses for services, supplies and treatments not covered by ***Plan***, to include charges in excess of the ***customary and reasonable amount*** or ***negotiated rate***, as applicable.
2. Expenses for services, supplies and treatments for ***mental health disorders***.
3. Expenses for services, supplies and treatments for ***substance use disorder***.

Hospital/Ambulatory Surgical Facility

All ***inpatient hospital*** admissions (emergency and scheduled) are subject to pre-certification (refer to the *Medical Claim Filing Procedures* section).

Covered expenses shall include:

1. ***Room and board*** for treatment in a ***hospital***, including ***intensive care units***, cardiac care units and similar ***medically necessary*** accommodations. ***Covered expenses*** for ***room and board*** shall be limited to the ***hospital's semiprivate rate***. ***Covered expenses*** for ***intensive care*** or cardiac care units shall be the ***customary and reasonable amount*** for ***nonpreferred providers*** and the percentage of the ***negotiated rate*** for ***preferred providers***.

   A full private room rate is covered if the private room is necessary for isolation purposes and is not for the convenience of the patient. If a private room is used for the convenience of the patient, ***covered expenses*** for ***room and board*** shall be limited to the ***hospital's semiprivate rate***.

2. Miscellaneous ***hospital*** services, supplies and treatments including, but not limited to:
   a. Admission fees and other fees assessed by the ***hospital*** for rendering services, supplies and treatments;
   b. Use of operating, treatment or delivery rooms;
   c. Anesthesia, anesthesia supplies and its administration by an employee of the ***hospital***;
   d. Medical and surgical dressings and supplies, casts and splints;
   e. Blood transfusions, including the cost of whole blood, the administration of blood, blood processing and blood derivatives (to the extent blood or blood derivatives are not donated or otherwise replaced);
   f. Drugs and medicines (except drugs not used or consumed in the ***hospital***);
   g. X-ray and diagnostic laboratory procedures and services;
   h. Oxygen and other gas therapy and the administration thereof;
   i. Therapy services.
3. Services, supplies and treatments described above furnished by an ***ambulatory surgical facility***, including follow-up care.

Facility Providers

Services of ***facility*** providers if such services would have been covered if performed in a ***hospital*** or ***ambulatory surgical facility***.

Ambulance Services

Ambulance services must be by a licensed air or ground ambulance.

Covered expenses shall include:

1. Ambulance services for air or ground transportation for the ***covered individual*** from the place of ***injury*** or serious medical incident to the nearest ***hospital*** where treatment can be given.
2. Ambulance service is covered in a non-emergency situation only to transport the ***covered individual*** to or from a ***hospital*** or between ***hospitals*** for required treatment when such transportation is certified by the attending ***physician*** as ***medically necessary***. Such transportation is covered only from the initial ***hospital*** to the nearest ***hospital*** qualified to render the special treatment.
3. Emergency services actually provided by an advance life support unit, even though the unit does not provide transportation, subject to the ***maximum benefit***, as specified on the *Schedule of Benefits*.
4. Wheelchair, stretcher transportation and paramedic intercept when such required treatment is certified by the attending ***physician*** as ***medically necessary***. Benefits subject to ***maximum benefit***, as specified on the *Schedule of Benefits*. Trip sheets will be required for all determinations.

If the ***covered individual*** is admitted to a ***nonpreferred hospital*** after emergency treatment, ambulance service is covered to transport the ***covered individual*** from the ***nonpreferred hospital*** to a ***preferred hospital*** after the patient's condition has been stabilized, provided such transport is certified by the attending ***physician*** as ***medically necessary***.

Emergency Room Services

Coverage for emergency room treatment shall be paid in accordance with the Emergency Care benefits as shown on the *Schedule of Benefits*, provided the condition meets the definition of ***accident*** or ***medical emergency*** herein.

Emergency room treatment for conditions that do not meet the definition of ***accident*** or ***medical emergency*** will be considered non-emergency use of the emergency room and shall be paid in accordance with the Non-Emergency Care benefits as shown on the *Schedule of Benefits*. ***Facility*** charges related to such treatment will not be considered a covered expense.

Immediate Care Center (Urgent Care)

Covered expenses shall include charges for treatment in an ***immediate care center***, payable as specified on the *Schedule of Benefits*.

Physician Services

Covered expenses shall include:

1. Medical treatment, services and supplies including, but not limited to: office visits, ***inpatient*** visits, home visits.
2. Surgical treatment. Separate payment will not be made for ***inpatient*** pre-operative or post-operative care normally provided by a surgeon as part of the surgical procedure. For related operations or procedures performed through the same incision or in the same operative field, ***covered expenses*** shall include the surgical

allowance for the highest paying procedure, plus 50% of the surgical allowance for the second highest paying procedure and 25% of the surgical allowance for each additional procedure. When two or more unrelated operations or procedures are performed at the same operative session, ***covered expenses*** shall include the surgical allowance for each procedure.

3. Surgical assistance provided by a ***physician*** if it is determined that the condition of the patient or the type of surgical procedure requires such assistance.
4. Furnishing or administering anesthetics, other than local infiltration anesthesia, by other than the surgeon or his assistant.
5. Consultations requested by the attending ***physician*** during a ***hospital confinement***. Consultations do not include staff consultations that are required by a ***hospital's*** rules and regulations.
6. Radiologist or pathologist services for interpretation of X-rays and laboratory tests necessary for diagnosis and treatment.
7. Radiologist or pathologist services for diagnosis or treatment, including radiation therapy and chemotherapy.

Second Surgical Opinion

Benefits for a second surgical opinion will be payable according to the *Schedule of Benefits* if an elective surgical procedure (non-emergency surgery) is recommended by the ***physician***.

The ***physician*** rendering the second opinion regarding the ***medical necessity*** of such surgery must be a board certified specialist in the treatment of the patient's ***illness*** or ***injury*** and must not be affiliated in any way with the ***physician*** who will be performing the actual surgery.

In the event of conflicting opinions, a request for a third opinion may be obtained. The ***Plan*** will consider payment for a third opinion the same as a second surgical opinion.

Diagnostic Services and Supplies

Covered expenses shall include services and supplies for diagnostic laboratory, pathology, ultrasound, nuclear medicine, magnetic imaging and X-ray and pre-admission testing.

Transplant

Services, supplies and treatments for the recipient in connection with human-to-human organ and tissue transplant procedures will be considered ***covered expenses*** when the recipient is covered under this ***Plan***.

Pregnancy

Covered expenses for ***pregnancy*** or ***complications of pregnancy*** shall be provided for covered females. Nursery care of the newborn infant will also be considered a ***covered expense***.

The ***Plan*** shall cover services, supplies and treatments for ***medically necessary*** abortions when the life of the mother would be endangered by continuation of the ***pregnancy***.

Group health plans generally may not, under federal law, restrict benefits for any ***hospital*** length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or

newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans may not, under federal law, require that a provider obtain authorization from the ***Plan*** for prescribing a length of stay not in excess of the above periods.

Birthing Center

Covered expenses shall include services, supplies and treatments rendered at a ***birthing center*** provided the ***physician*** in charge is acting within the scope of his license and the ***birthing center*** meets all legal requirements. Services of a midwife acting within the scope of his/her license or registration are a ***covered expense*** provided that the state in which such service is performed has legally recognized midwife delivery.

Sterilization

Covered expenses shall include elective sterilization procedures and reversal of sterilization for the covered ***annuitant*** or covered spouse.

Family Planning

Covered expenses shall include family planning expenses for infertility testing for ***annuitants*** and their covered spouse. ***Covered expenses*** for infertility testing are limited to the actual testing for a diagnosis of infertility. Any outside intervention procedures (e.g. artificial insemination) will not be considered a ***covered expense***.

Therapy Services

Therapy services must be ordered by a ***physician*** to aid restoration of normal function lost due to ***illness*** or ***injury***. ***Covered expenses*** shall include:

1. Services of a ***professional provider*** for physical therapy, occupational therapy, speech therapy, respiratory therapy or pulmonary therapy (subject to the limit stated on the *Schedule of Benefits*).
2. Radiation therapy and chemotherapy.
3. Dialysis therapy or treatment.
4. Cardiac therapy.

Skilled Nursing Facility

Skilled nursing facility services, supplies and treatments are subject to pre-certification and shall be a ***covered expense*** provided the ***covered individual*** is under a ***physician's*** continuous care and the ***physician*** certifies that the ***covered individual*** must have 24-hour per-day nursing care and your condition can reasonably be expected to improve. (Note that the critical nature of a non-skilled service and the frequency with which it must be performed are not factors that determine coverage for ***confinement*** in a ***skilled nursing facility***). The HOP Administration Unit will evaluate the ***facility*** services provided to determine if ***skilled nursing facility*** benefits are payable under Major Medical Benefits. The HOP Administration Unit may seek an opinion from a qualified specialist to determine that services are for ***medically necessary*** care as opposed to ***custodial care***.

Covered expenses shall include:

1. ***Room and board*** (including regular daily services, supplies and treatments furnished by the ***skilled nursing facility***) limited to the ***facility's*** average ***semiprivate*** room rate; and
2. Other services, supplies and treatment ordered by a ***physician*** and furnished by the ***skilled nursing facility*** for ***inpatient*** medical care.

The HOP Pre-65 Medical Plan does not provide coverage for ***custodial care*** (commonly referred to as long-term care) including ***confinements*** in a ***facility*** that provides skilled nursing care. If a nursing ***facility*** does not differentiate between skilled and non-skilled care, all care will be deemed non-skilled.

See page 73 for the definition of ***skilled nursing facility***.

Home Health Care

Home health care is subject to pre-certification (refer to the *Medical Claim Filing Procedures* section).

Home health care enables the ***covered individual*** to receive treatment at home for an ***illness*** or ***injury*** instead of being confined in a ***hospital*** or ***skilled nursing facility***. Charges must be ***incurred*** through and billed by a ***Home Health Care Agency***. ***Covered expenses*** shall include:

1. Part-time or intermittent nursing care by a Registered Nurse, Licensed Practical Nurse or a Licensed Vocational Nurse;
2. Physical, respiratory, occupational or speech therapy;
3. Part-time or intermittent ***home health aide services*** for a ***covered individual*** who is receiving covered nursing or therapy services;
4. Medical social service consultations.
5. IV therapy.
6. Enteral and parenteral nutrition therapy.

No ***home health care*** benefits will be provided for dietitian services, homemaker services (except as may be specifically provided herein), maintenance therapy, food or home delivered meals, rental or purchase of ***durable medical equipment*** or prescription or non-prescription drugs or biologicals.

Hospice Care

Hospice care is a health care program providing a coordinated set of services rendered at home, in ***outpatient*** settings, or in ***facility*** settings for an individual suffering from a condition that has a terminal prognosis.

Hospice benefits will be covered only if the ***covered individual's*** attending ***physician*** certifies that:

1. The individual is terminally ill, and
2. The individual has a life expectancy of six months or less.

Covered expenses shall include:

1. ***Confinement*** in a ***hospice*** to include ancillary charges and ***room and board***.
2. Services, supplies and treatment provided by a ***hospice*** to a ***covered individual*** in a home setting.
3. ***Physician*** services and/or nursing care by a Registered Nurse, Licensed Practical Nurse or a Licensed Vocational Nurse.
4. Physical therapy, occupational therapy, speech therapy or respiratory therapy.

5. Nutrition services to include nutritional advice by a registered dietitian, and nutritional supplements such as diet substitutes administered intravenously or through hyper-alimentation as determined to be ***medically necessary***.
6. Counseling services provided through the ***hospice***.
7. Respite care on an ***inpatient*** basis or by an aide who is employed by the ***hospice***, subject to the ***maximum benefit*** specified on the *Schedule of Benefits*. (Respite care provides care of the individual to allow temporary relief to family members or friends from the duties of caring for the individual.)

Hospice benefits are limited to the ***maximum benefit*** as stated on the *Schedule of Benefits*.

Charges ***incurred*** during periods of remission are not eligible under this provision of the ***Plan***. Any ***covered expense*** paid under ***hospice*** benefits will not be considered a ***covered expense*** under any other provision of this ***Plan***.

Durable Medical Equipment

Rental or purchase, whichever is less costly, of ***medically necessary durable medical equipment*** that is prescribed by a ***physician*** and required for therapeutic use by a ***covered individual*** shall be a ***covered expense***. Repair or replacement of ***durable medical equipment*** due to normal use will be considered a ***covered expense***.

Equipment containing features of an aesthetic nature or features of a medical nature that are not required by the individual's condition, or where there exists a reasonably feasible and medically appropriate alternative piece of equipment that is less costly than the equipment furnished, will be covered based on the usual charge for the equipment that meets the individual's medical needs.

Prostheses

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

Orthotics

Orthotic devices and appliances (a rigid or semi-rigid supportive device which restricts or eliminates motion for a weak or diseased body part), including initial purchase, fitting, repair, and replacement shall be a ***covered expense***. Orthopedic shoes or corrective shoes, unless they are an integral part of a leg brace, and other supportive devices for the feet shall not be covered.

Dental Services

Covered expenses shall include repair of the jaw, sound natural teeth or surrounding tissue, mouth or face provided it is the result of an ***injury*** occurring on or after the individual's date of coverage. Damage to the teeth as a result of chewing or biting shall not be considered an ***injury*** under this benefit.

Also covered is the orthodontic treatment of congenital cleft palates involving the maxillary arch, performed in conjunction with bone graft surgery to correct the bony deficits associated with extremely wide clefts affecting the alveolus.

Covered expenses shall also include:

1. Oral surgery by a ***professional provider*** for surgical removal of partial and full bony impactions.
2. Services of ***facility*** providers related to the following:
   a. Surgical removal of impacted teeth which are partially or totally covered by bone,
   b. Mandibular staple implant provided the procedure is not done in preparation of the mouth for dentures, or
   c. Maxillary or mandibular frenectomy.

Except as specifically stated above, surgical removal of teeth and maxillary or mandibular infrabony cysts and procedures performed for the preparation of the mouth for dentures are excluded under the ***Plan***, unless such procedures were for the treatment of accidental bodily ***injury***.

Special Equipment and Supplies

Covered expenses shall include ***medically necessary*** special equipment and supplies including, but not limited to: casts; splints; braces; trusses; surgical and orthopedic appliances; colostomy and ileostomy bags and supplies required for their use; catheters; crutches; electronic pacemakers; oxygen and the administration thereof; surgical dressings and other medical supplies ordered by a ***professional provider*** in connection with medical treatment, but not common first aid supplies.

Cosmetic Surgery

Cosmetic surgery or ***reconstructive surgery*** shall be a ***covered expense*** provided:

1. A ***covered individual*** receives an ***injury*** as a result of an ***accident*** and as a result requires surgery. ***Cosmetic*** or ***reconstructive surgery*** and treatment must be for the purpose of restoring the individual to his normal function immediately prior to the ***accident***.
2. It is required to correct a congenital anomaly, for example, a birth defect, for a child.

Mastectomy

(Women's Health and Cancer Rights Act of 1998)

This ***Plan*** intends to comply with the provisions of the federal law known as the Women's Health and Cancer Rights Act of 1998.

Covered expenses will include eligible charges related to ***medically necessary*** mastectomy.

For a ***covered individual*** who elects breast reconstruction in connection with such mastectomy, ***covered expenses*** will include:

1. Reconstruction of a surgically removed breast; and
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance.

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

Mental Health Disorders

Covered expenses for ***inpatient*** and ***outpatient*** treatment, services or supplies for the treatment of ***mental health disorders*** shall be subject to the ***maximum benefit*** as shown on the *Schedule of Benefits*.

Inpatient or Partial Confinement

Subject to the pre-certification provisions of the ***Plan***, the ***covered individual*** will pay the applicable ***coinsurance*** and ***maximum benefit***, as shown on the *Schedule of Benefits*, for ***confinement*** or ***partial confinement*** in a ***hospital*** for treatment, services and supplies related to the treatment of ***mental health disorders***. Three days of ***partial confinement*** will be considered as one day of ***inpatient confinement***.

Covered expenses shall include:

1. ***Inpatient hospital confinement***;
2. ***Partial confinement*** in a ***hospital***;
3. Individual psychotherapy;
4. Group psychotherapy;
5. Psychological testing;
6. Electroconvulsive therapy (electroshock treatment) or convulsive drug therapy, including anesthesia when administered concurrently with the treatment by the same ***professional provider***;
7. Biofeedback.

Outpatient

The ***covered individual*** will pay the applicable ***coinsurance*** and ***maximum benefit***, as shown on the *Schedule of Benefits*, for ***outpatient*** treatment, services and supplies related to the treatment of ***mental health disorders***.

Substance Use Disorder

Covered expenses for ***inpatient*** and ***outpatient*** treatment, services or supplies for the treatment of ***substance use disorder*** shall be subject to the ***maximum benefit*** as shown on the *Schedule of Benefits*.

Inpatient or Partial Confinement

Subject to the pre-certification provisions of the ***Plan***, the ***covered individual*** will pay the applicable ***coinsurance***, as shown on the *Schedule of Benefits*, for ***confinement*** or ***partial confinement*** in a ***hospital*** or ***treatment center*** for treatment, services and supplies related to the treatment of ***substance use disorder***. Two days of ***partial confinement*** will be considered as one day of ***inpatient confinement***.

Covered expenses shall include:

1. ***Inpatient hospital confinement***;
2. ***Partial confinement*** in a ***hospital***;
3. Individual psychotherapy;
4. Group psychotherapy;
5. Psychological testing.

Outpatient

The ***covered individual*** will pay the applicable ***coinsurance***, as shown on the *Schedule of Benefits*, for ***outpatient*** treatment, services and supplies related to the treatment of ***substance use disorder***.

Prescription Drugs

Prescription drugs shall be covered under the Prescription Drug Program only.

The application of a deductible or ***coinsurance*** under the Prescription Drug Program shall not be considered a ***covered expense*** under the Major Medical Benefits.

Podiatry Services

Covered expenses shall include surgical podiatry services, including incision and drainage of infected tissues of the foot, removal of lesions of the foot, removal or debridement of infected toenails, surgical removal of nail root, and treatment of fractures or dislocations of bones of the foot.

Diabetes Services

Covered expenses include participation in a diabetes self-management training and education program under the supervision of a licensed health care professional with expertise in diabetes. Coverage for self-management education and education relating to diet, prescribed by a licensed ***physician***, includes:

1. Visits ***medically necessary*** upon the diagnosis of diabetes; and
2. Visits when a ***physician*** identifies or diagnoses a significant change in the patient's symptoms or conditions that necessitates changes in a patient's self-management and when a new medication or therapeutic process relating to the patient's treatment and/or management of diabetes has been identified as ***medically necessary*** by a licensed ***physician***.

Limitation: For benefits to be provided, the individual must complete a diabetes education program that is 1) conducted under the supervision of a licensed health care professional with expertise in diabetes, and 2) provided in a ***hospital*** and subject to the criteria of the ***Plan***. These criteria are based on certification programs for diabetes education developed by the Department of Health and the American Diabetes Association.

Patient Education

Covered expenses shall include ***medically necessary*** patient education programs including but not limited to ostomy care.

Chiropractor Services

Covered expenses shall include ***medically necessary*** services performed by a chiropractor.

Charges related to structural imbalance or subluxation for the purpose of removing nerve interference are not covered when related to distortion, misalignment, or subluxation of or in the vertebral column.

Surcharges

Covered expenses shall include surcharges assessed under the New York Health Care Reform Act (HCRA) for services, supplies and/or treatments rendered by a ***professional provider***; ***physician***; ***hospital***; ***facility*** or any other health care provider.

Transsexualism

Transsexualism shall include services, supplies or treatment for transsexualism, gender dysphoria or sexual reassignment or change, including medications, implants, hormone therapy, surgery and medical or psychiatric treatment.

Maximum Benefit

The ***maximum benefit*** payable on behalf of a ***covered individual*** is shown on the *Schedule of Benefits*. The ***maximum benefit*** applies to the entire time the individual is covered under the ***Plan***, either as an ***annuitant*** or ***dependent***. If the individual's coverage under the ***Plan*** terminates and at a later date her or she again becomes covered under the ***Plan***, the ***maximum benefit*** will include all benefits paid by the ***Plan*** for the ***covered individual*** during any period of coverage.

The *Schedule of Benefits* contains separate ***maximum benefit*** limitations for specified conditions. Any separate ***maximum benefit*** will include all such benefits paid by the ***Plan*** for the individual during any and all periods of coverage under the ***Plan***. All separate ***maximum benefits*** are part of, and not in addition to, the ***maximum benefit***. No more than the ***maximum benefit*** will be paid for any individual while covered by the ***Plan***.

PREVENTIVE SERVICES

Physical Examination

Covered expenses for early detection care for all ***covered individuals*** shall be limited to the exams and tests on the following list, subject to the ***maximum benefit*** shown on the *Schedule of Benefits*:

One routine physical exam per calendar year to include the following:

Blood pressure check
Rectal prostate exam (digital)
Breast exam
Pelvic exam
PAP test
EKG
CBC, complete blood count
FBS, fasting blood sugar
UA, urinalysis routine
Cholesterol, serum total – Lipid panel ok
Triglycerides
Stool, occult blood
Mammography
PSA

MEDICAL EXCLUSIONS

In addition to General Exclusions (Page 33), no benefit will be provided under the ***Plan*** for medical expenses for the following:

1. Charges for services, supplies or treatment related to the treatment of infertility and artificial reproductive procedures, including, but not limited to: artificial insemination, in vitro fertilization, surrogate mother, fertility drugs, embryo implantation, or gamete intrafallopian transfer (GIFT).
2. Charges for birth control services, supplies or devices, including birth control pills, regardless of whether such pills are to be used for contraceptive or medical reasons.
3. Charges for treatment or surgery for sexual dysfunction unless related to organic ***illness***.
4. Charges for ***inpatient room and board*** in connection with a ***hospital confinement*** primarily for diagnostic tests, unless it is determined by the ***Plan*** that ***inpatient*** care is ***medically necessary***.
5. Charges for services, supplies or treatments which are primarily educational in nature; except as specified in *Major Medical Benefits*, *Patient Education*; charges for services for educational or vocational testing or training and work hardening programs regardless of diagnosis or symptoms; charges for self-help training or other forms of non-medical self-care.
6. Except as specifically stated in *Major Medical Benefits*, *Dental Services*, charges for or in connection with: treatment of ***injury*** or disease of the teeth; oral surgery; treatment of gums or structures directly supporting or attached to the teeth; removal or replacement of teeth; or dental implants.
7. Charges for routine vision examinations and eye refractions; orthoptics; eyeglasses or contact lenses, except when new cataract lenses are needed because of a prescription change.
8. Charges for any eye surgery solely for the purpose of correcting refractive defects of the eye, such as near-sightedness (myopia) and astigmatism, including radial keratotomy by whatever name called.
9. Except as ***medically necessary*** for the treatment of metabolic or peripheral-vascular illness, charges for routine, palliative or cosmetic foot care, including, but not limited to: treatment of weak, unstable, flat, strained or unbalanced feet; subluxations of the foot; treatment of corns or calluses; non-surgical care of toenails.

10. Charges for services, supplies or treatment which constitute personal comfort or beautification items, whether or not recommended by a ***physician***, such as: television, telephone, air conditioners, air purifiers, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages, non-hospital adjustable beds, exercise equipment.
11. Charges for nonprescription drugs, such as vitamins, cosmetic dietary aids, and nutritional supplements.
12. Charges for orthopedic shoes (except when they are an integral part of a leg brace and the cost is included in the orthotist's charge).
13. Expenses for a ***cosmetic surgery*** or procedure and all related services, except as specifically stated in *Major Medical Benefits, Cosmetic Surgery*.
14 Charges for services provided for an elective abortion. (See *Pregnancy* for specifics regarding the coverage of abortions.)
15. Charges for examination to determine hearing loss or the fitting, purchase, repair or replacement of a hearing aid.
16. Charges related to treatment of obesity, except for surgical treatment of morbid obesity.
17. Charges for the detection and correction by manual or mechanical means of structural imbalance or subluxation for the purpose of removing nerve interference resulting from or related to distortion, misalignment, or subluxation of or in the vertebral column.
18. Charges for well-baby care.
19. Charges for routine or periodic physical examinations, vaccinations or immunizations, except as specified herein.
20. Charges related to acupuncture treatment.
21. Charges for treatment of temporomandibular joint dysfunction (TMJ), or any other method to alter vertical dimension.
22. Charges for ***custodial care***, domiciliary care or rest cures.
23. Charges for travel or accommodations, whether or not recommended by a ***physician***, except as specified herein.
24. Charges for expenses related to hypnosis.
25. Charges for drugs dispensed by a pharmacy or a ***physician*** for the ***outpatient*** use of the individual.
26. Charges for routine neonatal circumcisions.
27. Charges for any services, supplies or treatment not specifically provided herein.

THE PRESCRIPTION DRUG PROGRAM SCHEDULE OF NETWORK BENEFITS

Prescription drug coverage is optional. However, if you want to elect it, you must enroll in the HOP Pre-65 Medical Plan. Prescription drug coverage is not available on a standalone basis. This *Schedule of Network Benefits* is a brief outline of some of the benefits for drugs purchased at a network pharmacy.

Annual Deductible Per Person Applies to both retail and mail-service pharmacies combined	$350
Supply Limitations	
Retail Pharmacies	Up to a 34-day supply per prescription order or refill
Mail-service Pharmacy	Up to a 90-day supply per prescription order or refill
Coinsurance	
Generic and Non-Critical Care Brand Name Drugs	50% after deductible
Specified Critical Care Drugs	50% after deductible or $100 (34 days) after deductible, whichever is less
Maximum Benefit Per Individual Per Calendar Year	$3,000 With some exceptions as indicated below

After an individual's $350 deductible is satisfied, the prescription benefit manager will keep track of how much the plan has paid toward the cost of your medications. The Plan cost portion of all prescriptions dispensed, both mail service and retail, for ***generic***, brand and Critical Care Drugs, paid by the Plan pursuant to the terms of the Plan, will accumulate toward the $3,000 per person annual ***maximum benefit***. Only ***generic*** drugs and Critical Care Drugs will continue to be covered at the ***coinsurance*** level shown above after an individual reaches the ***maximum benefit***.

THE PRESCRIPTION DRUG PROGRAM

If prescription drug coverage was chosen, refer to this section for a description of the benefits and limitations of the program.

Deductible

The deductible is the dollar amount of ***covered expense*** that each individual must incur each calendar year before the Plan pays applicable benefits. The deductible applies to expenses covered at all pharmacies, including retail and the mail-service pharmacy. The individual deductible amount is shown on the *Schedule of Network Benefits* on page 25. You do not have to satisfy the Major Medical deductible before prescription drug benefits are payable. The prescription drug deductible amount is not a covered expense under the Major Medical Benefits.

Participating Pharmacies

Participating pharmacies have contracted with the Plan to charge ***covered individuals*** reduced prices for both covered and non-covered prescription drugs.

Non-Participating Pharmacies

If a covered drug is purchased from a ***non-participating pharmacy***, or a ***participating pharmacy*** when the individual's ID card is not used, the individual must pay the entire cost of the prescription, then submit the receipt to OptumRx for reimbursement. The individual will be reimbursed only if the drug is covered under the program and only for the discounted network price OptumRx would have paid a ***participating pharmacy***, minus any applicable deductible and ***coinsurance***/copayment. This amount may be significantly lower than the retail price the individual actually paid. It is always best to use a network pharmacy.

Mail-Service Pharmacy

If a ***covered individual*** is taking drugs for the treatment of a chronic condition on a long-term basis, the convenience and potential savings offered by the mail-service pharmacy should be considered. Up to a 90-day supply may be obtained on a non-emergency basis through mail service. The medication can be shipped directly to the individual's home. The mail-service pharmacy may be contacted directly at 1-888-239-1301.

Coinsurance

After the deductible has been satisfied, the individual pays a specified percentage or copayment for covered prescription drugs. The Plan pays the balance of the drug cost. The percentage or copayment payable by the individual is listed in the *Schedule of Network Benefits*.

For Critical Care Drugs, the maximum copayment for any single dispensing of up to a 34-day supply is $100.

Maximum Benefit

The ***maximum benefit*** payable under the prescription drug program per calendar year on behalf of a ***covered individual*** for retail and mail service combined is shown on the *Schedule of Network Benefits*. ***Covered expenses*** for specified Critical Care Drugs and ***generic*** medications will not be subject to this ***maximum benefit***.

Discounts Available on Covered Medications after Maximum Benefit Is Reached

Individuals should continue to present their ***PSERS*** prescription program identification card after the ***maximum benefit*** is reached. In addition to continuing to receive full plan benefits on ***generic*** medications and specified Critical Care Drugs, by presenting your ID card along with your prescription order, you will receive the benefit of the ***PSERS*** plan discounted prices on brand drug prescriptions. This will reduce your out-of-pocket expenses. Also, by using your ID card for all prescription medication purchases, the prescription benefit manager can monitor your utilization and assist your pharmacist or ***physician*** in identifying potentially harmful drug interactions. This is particularly helpful when an individual sees more than one ***physician*** or uses more than one pharmacy.

Covered Prescription Drugs

1. ***Medically necessary*** drugs prescribed by a ***physician*** that require a prescription either by federal or state law, including the covered self-administered injectables listed on this page.
2. Compounded prescriptions containing at least one prescription ingredient with a therapeutic quantity.
3. Insulin, when prescribed by a ***physician***.
4. Viagra, up to four (4) dosages per month with prior approval based on appropriate medical diagnosis of non-psychological impotence.
5. Smoking cessation drug therapy, limited to a one-time 90-day lifetime maximum.
6. Any other drug which, under the applicable state law, may be dispensed only upon the written prescription of a ***qualified prescriber***.
7. Diabetic supplies, alcohol swabs, lancets, test strips and diabetic tablets.

Covered Self-Administered Injectables

Before self administered injectables on the list below can be covered, prior authorization by OptumRx is required. Authorization will be based on diagnosis and medical necessity.

1. Alferon N – interferon alfa N3
2. Brethine – terbutiline
3. Byetta – exenatide
4. Calcitonin
5. Calcitriol
6. Caverject – alprostadil
7. DDAVP – desmopressin acetate
8. Delatestryl – testosterone ethanthate
9. Edex – alprostadil
10. Enbrel – etanercept
11. EpiPen – epinephrine
12. Genotropin – somatropin
13. Gentamicin
14. Glucagon
15. Heparin – heparin sodium
16. Humatrope – somatropin
17. Hyalgan – hyaluvonate sodium

18. Imitrex – sumatriptan methotrexate
19. Miacalcin – calcitonin – salmon
20. Norditropin – somatropin
21. Nutropin – somatropin
22. Nutropin AQ – somatropin
23. Orthovisc – hyaluronate sodium
24. Saizen – somatropin
25. Supartz – hyaluronate sodium
26. Symlin – pramlintide acetate
27. Synarel – nafarelin acetate
28. Synvisc – hylan g-f 20
29. Testosterone propionate
30. Vitamin B12 – cyanocobalamin

Critical Care Drugs

The list was developed by an independent pharmacy consultant to supplement the prescription drug benefit design. Generally speaking, Critical Care Drugs are unique within a drug category and are reserved as a last option for patients with life-threatening conditions. Drugs on the list generally have few or no other medication alternatives for equivalent treatment, and no ***generic*** options. These medications are generally expensive and present the potential for severe financial hardship, so a copayment cap of $100 has been established under your benefit program and coverage for these medications continues even after the $3,000 cap is reached. The list of Critical Care Drugs will be reviewed annually and becomes effective for at least one calendar year.

Please note: Before Critical Care Drugs can be covered, prior authorization is required. Authorization will be based on diagnosis and medical necessity.

Critical Care Drug List for 2024

ABACAVIR SULFATELAMIVUDINE
ABACAVIR SULFATELAMIVUDINE-ZIDOVUDINE
ABACAVIR
ABIRATERONE
ADCIRCA
ADEMPAS
AFINITOR
AFINITOR DISPERZ
AGRYLIN
ALECENSA
ALUNBRIG
ALYQ
AMBRISENTAN
ANAGRELIDE
APRETUDE
APTIOM
APTIVUS
ARANESP
ARIMIDEX
ARIXTRA
AROMASIN
ASTAGRAF XL
ATAZANAVIR
ATRIPLA
AYVAKIT
BALVERSA
BANZEL
BENLYSTA
BETAINE POWDER
BEXAROTENE
BICALUTAMIDE
BIKTARVY
BOSENTAN
BOSULIF
BRAFTOVI
BRIVIACT
BRUKINSA
BUPHENYL
CABENUVA
CABOMETYX
CALQUENCE
CAMCEVI
CAPRELSA
CARAC
CARBAGLU
CARGLUMIC
CASODEX
CELLCEPT
CERDELGA
CHOLBAM
CIMDUO
CINQAIR
COMBIVIR
COMETRIQ
COMPLERA
COPIKTRA
COTELLIC
CREON
CRIXIVAN
CYCLOPHOSPHAMIDE
CYCLOSPORINE
CYSTADANE POWDER
CYSTAGON
DAURISMO
DELSTRIGO
DESCOVY
DIACOMIT
DICHLORPHENAMIDE
DIDANOSINE
DOPTELET
DOVATO
DUPIXENT
EDURANT
EFAVIRENZ-EMTRICITABINE-TENOFOVIR DF
EFAVIRENZ-LAMIVUDINE-TENOFOVIR DF
EFAVIRENZ
ELIGARD
EMTRICITABINE-TENOFOVIR DF
EMTRICITABINE
EMTRIVA
ENDARI
ENVARSUS XR
EPCLUSA
EPIDIOLEX
EPIVIR
EPOGEN
EPZICOM
ERIVEDGE
ERLEADA
ERLOTINIB
ETRAVIRINE
EVEROLIMUS
EVOTAZ
EXKIVITY
FARESTON
FARYDAK
FASENRA
FELBAMATE
FELBATOL
FEMARA
FINTEPLA
FIRMAGON
FLUTAMIDE
FONDAPARINUX
FOSAMPRENAVIR
FOTIVDA
FRAGMIN
FULPHILA
FUZEON
FYCOMPA
FYLNETRA
GALAFOLD
GAVRETO
GEFITINIB
GENGRAF
GENVOYA
GILOTRIF
GLEEVEC
GLEOSTINE
GRANIX
HARVONI
IBRANCE
ICLUSIG
IMBRUVICA
INLYTA
INREBIC
INTELENCE
INVIRASE
IRESSA
ISENTRESS
JAKAFI
JAVYGTOR
JAYPIRCA
JULUCA
KALETRA
KALYDECO
KEVEYIS
KISQALI
KOSELUGO
KRAZATI
KUVAN
LAMIVUDINE-ZIDOVUDINE
LAMIVUDINE
LANREOTIDE
LAPATINIB
LEDIPASVIR-SOFOSBUVIR
LENALIDOMIDE
LENVIMA
LETAIRIS
LEUCOVORIN CALCIUM
LEUKERAN
LEUKINE
LEUPROLIDE
LEXIVA
LONSURF
LOPINAVIR-RITONAVIR
LORBRENA
LUMAKRAS
LUPKYNIS
LUPRON DEPOT
LYNPARZA
LYTGOBI
MATULANE
MAVYRET
MEKINIST
MEKTOVI
MESNEX
MIGLUSTAT
MIRCERA
MULPLETA

MYCAPSSA
MYCOPHENOLAT
MYFORTIC
NEORAL
NERLYNX
NEULASTA
NEUPOGEN
NEVIRAPINE
NEXAVAR
NILANDRON
NILUTAMIDE
NINLARO
NITISINONE
NITYR
NIVESTYM
NORVIR
NUCALA
NYVEPRIA
OCTREOTIDE
ODEFSEY
ODOMZO
ONUREG
OPSUMIT
ORENITRAM
ORFADIN
ORGOVYX
ORKAMBI
ORSERDU
OXTELLAR XR
PALYNZIQ
PANCREAZE
PANRETIN
PEMAZYRE
PERTZYE
PHEBURANE
PHENYLBUTYRATE ORAL PWD
PIFELTRO
PIQRAY
POMALYST
PREZCOBIX
PREZISTA
PROCRIT
PROCYSBI
PROGRAF
PROMACTA
PULMOZYME
PURIXAN
QINLOCK
RAPAMUNE
RAVICTI
RELEUKO
RETACRIT
RETEVMO
REVATIO
REVLIMID
REYATAZ
REZLIDHIA
RIBOCICLIB-LETROZOLE
ROZLYTREK
RUBRACA
RUFINAMIDE
RUKOBIA
RYDAPT
SABRIL
SANDIMMUNE
SANDOSTATIN
SAPROPTERIN POWDER
SCEMBLIX
SELZENTRY
SIGNIFOR
SIKLOS
SIROLIMUS
SODIUM PHENYLBUTYRATE
SOFOSBUVIR-VELPATASVIR
SOLTAMOX
SOMATULINE
SOMAVERT
SORAFENIB
SOVALDI
SPRYCEL
STAVUDINE
STIVARGA
STRENSIQ
STRIBILD
SUCRAID
SUNITINIB
SUNLENCA
SUSTIVA
SUTENT
SYMDEKO
SYMFI
SYMTUZA
SYNRIBO
TABRECTA
TADALAFIL -FOR PAH
TADLIQ
TAFINLAR
TAGRISSO
TALZENNA
TARCEVA
TARGRETIN
TASIGNA
TAZVERIK
TEGSEDI
TEMIXYS
TENOFOVIR
TEZSPIRE
THALOMID
TIBSOVO
TIVICAY
TOREMIFENE
TRACLEER
TRELSTAR MIX
TRETINOIN CAP
TREXALL
TRIKAFTA
TRIPTODUR
TRIUMEQ
TRIZIVIR
TROGARZO
TRUSELTIQ
TRUVADA
TUKYSA
TURALIO
TYBOST
TYKERB
TYVASO
UDENYCA
UPTRAVI
VALCHLOR
VELCADE
VEMLIDY
VENCLEXTA
VENTAVIS
VERZENIO
VIEKIRA
VIGABATRIN
VIMPAT
VIOKACE
VIRACEPT
VIRAMUNE
VIREAD
VITRAKVI
VIZIMPRO
VOCABRIA
VONJO
VOSEVI
VOTRIENT
VYNDAQEL
WELIREG
XALKORI
XATMEP
XCOPRI
XOLAIR
XOSPATA
XPOVIO
XTANDI
XURIDEN
YONSA
ZARXIO
ZAVESCA
ZEJULA
ZELBORAF
ZENPEP
ZEPATIER
ZIAGEN
ZIDOVUDINE
ZIEXTENZO
ZILEUTON ER
ZOLINZA
ZORTRESS
ZYDELIG
ZYFLO
ZYKADIA

Limits to this Benefit

This benefit applies only when a ***covered individual incurs*** a covered prescription drug charge. The covered drug charge for any one prescription will be limited to:

1. Refills only up to the number of times specified by a ***physician***.
2. Refills up to one year from the date of order by a ***physician***.

Refills will not be dispensed before enough time has passed to allow for consumption of at least 75% of the medication dispensed for the previously covered claim.

Prior Authorization Requirements

Medications covered by this program are available only when they are appropriate for and provided for treatment of ***illness*** in accordance with normal medical practice and in accordance with FDA approved uses. On occasion, OptumRx may ask an individual to have their ***physician*** furnish a diagnosis and explanation of ***medical necessity*** prior to allowing a medication to be dispensed. This prior authorization process will be required for covered self-administered injectables, Critical Care Drugs, and other limited-use medications that are prescribed by a ***physician***. Once authorization is granted, an individual will not need to obtain additional authorizations for subsequent prescriptions and refills during the normal course of treatment. Typically a prior authorization will not exceed one year, however it can be renewed with an updated diagnosis.

Expenses Not Covered

1. A drug or medicine that can be legally purchased without a prescription order, excluding diabetic supplies. Or any drug or medicine prescribed or dispensed in a manner contrary to normal medical practices, or which are not ***medically necessary***, or any drug not prescribed in accordance with FDA-approved uses.
2. Devices of any type, even if such devices may require a prescription. These include but are not limited to: therapeutic devices, artificial appliances, braces, support garments, equipment, or any similar device.
3. Immunologicals, vaccines, allergy sera or extracts, biological products or treatment, biological or other sera, blood and blood plasma or other derivatives.
4. A drug or medicine labeled: “Caution – limited by federal law to investigational use.”
5. Experimental drugs and medicines, even though a charge is made to the individual.
6. Any charge for the administration or injection of a covered prescription drug or for special dosage packaging.
7. Any drug or medicine that is consumed or administered in the place where it is dispensed. This includes charges for prescriptions obtained by a ***covered individual*** and brought to a ***physician’s*** office for administration.
8. A drug or medicine that is to be taken by a ***covered individual***, in whole or in part, while ***hospital***-confined or under ***physician***-ordered 24-hour-per-day nursing care in a ***skilled nursing facility***. This includes being confined in any institution that has a ***facility*** for dispensing drugs.

9. The cost of any drug or medicine administered by a ***physician*** or prescriber, and those not dispensed at a pharmacy such as those an individual receives at a doctor's office, in a ***hospital***, clinic or other care ***facility***.
10. A charge for any drug or medicine that is recoverable under a program such as ***Medicare***, Department of Veterans Affairs, workers' compensation, motor vehicle insurance, or other local, state or federal program. This includes charges for prescription drugs that may be properly received without charge, whether or not an individual asserts his or her right to receive such medications without charge.
11. Drugs or medicines obtained from a federal, state or local public health agency for treatment of tuberculosis, mental disease or communicable diseases. Also, methadone maintenance and herbal maintenance, and court-ordered treatments which are not ***medically necessary***.
12. Drugs and medicines prescribed for ***injury*** or ***illness*** resulting from war or any act of war, police actions or riots; or drugs needed because an individual engaged in, or tried to engage in an illegal occupation, or committed or tried to commit a felony.
13. Contraceptive drugs, whether oral, injectable, topical or implanted, even when prescribed for other than contraceptive purposes.
14. Medications prescribed for the treatment of infertility and fertility enhancement drugs.
15. Injectable medications and IV infused medications, except those self-administered injectables previously listed, or Critical Care Drugs.
16. Injectable medications provided by home care organizations as part of infusion therapy or injection services, even if listed on the self-administered injectables lists, or a Critical Care Drug.
17. Prenatal vitamins and children's vitamins.
18. Prescription drugs utilized for cosmetic purposes such as Retin-A and Accutane, and hair regrowth medications such as Rogaine.
19. Nutritional products such as food supplements, special foods, liquid diets and supplements. Performance enhancement medications such as those used to enhance athletic performance, or lifestyle enhancement drugs or supplies.

GENERAL EXCLUSIONS

The ***Plan*** will not provide benefits for any of the items listed in this section, regardless of ***medical necessity*** or recommendation of a ***physician*** or ***professional provider***.

1. Charges for services, supplies or treatment from any ***hospital*** owned or operated by the United States government or any agency thereof or any government outside the United States, or charges for services, treatment or supplies furnished by the United States government or any agency thereof or any government outside the United States, unless payment is legally required.
2. Charges for an ***injury*** sustained or ***illness*** contracted while on active duty in military service, unless payment is legally required.
3. Charges for services, treatment or supplies for treatment of ***illness*** or ***injury*** which is caused by or attributed to by war or any act of war, participation in a riot, civil disobedience or insurrection. "War" means declared or undeclared war, whether civil or international, or any substantial armed conflict between organized forces of a military nature.
4. Any condition for which benefits of any nature are payable or are found to be eligible, either by adjudication or settlement, under any workers' compensation law, employer's liability law, or occupational disease law, even though the individual fails to claim rights to such benefits or fails to enroll or purchase such coverage.
5. Charges in connection with any ***illness*** or ***injury*** arising out of or in the course of any employment intended for wage or profit, including self-employment.
6. Charges in connection with any ***illness*** or ***injury*** of the individual resulting from or occurring during commission or attempted commission of a criminal battery or felony by the individual.
7. To the extent that payment under the ***Plan*** is prohibited by any law of any jurisdiction in which the individual resides at the time the expense is ***incurred***.
8. Charges for services rendered and/or supplies received prior to the ***effective date*** or after the termination date of a person's coverage.
9. Any services, supplies or treatment for which the individual is not legally required to pay; or for which no charge would usually be made; or for which such charge, if made, would not usually be collected if no coverage existed; or to the extent the charge for the care exceeds the charge that would have been made and collected if no coverage existed.
10. Charges for services, supplies or treatment that are considered ***experimental/ investigational***.
11. Charges for services, supplies or treatment rendered by any individual who is a ***close relative*** of the ***covered individual*** or who resides in the same household as the ***covered individual***.

12. Charges for services, supplies or treatment rendered by ***physicians*** or ***professional providers*** beyond the scope of their license; for any treatment, ***confinement*** or service which is not recommended by or performed by an appropriate ***professional provider***.
13. Charges for ***illnesses*** or ***injuries*** suffered by an individual due to the action or inaction of any party if the individual fails to provide information as specified in *Subrogation/Reimbursement*.
14. Claims not submitted within the ***Plan*** filing limit deadlines as specified in *Medical Claim Filing Procedures*.
15. Charges for telephone consultations, completion of claim forms, charges associated with missed appointments.
16. Charges for treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified self-insured plan, or payable by the Catastrophic Loss Trust Fund established under the Pennsylvania Motor Vehicle Financial Responsibility Law.
17. Any charges for disposable, non-reusable hygienic items. These include but are not limited to: infant/adult diapers, disposable sheets and bags, disposable underpads, all sizes.
18. Charges made for services, supplies and treatment which are not ***medically necessary*** for the treatment of ***illness*** or ***injury***, except as specifically stated herein, or to the extent that the charges exceed the ***customary and reasonable amount*** or exceed the ***negotiated rate***, as applicable.

ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATE

This section identifies the requirements for a person to participate in the HOP Pre-65 Medical Plan of the Health Options Program.

Annuitant Eligibility

Each ***PSERS annuitant*** not eligible for ***Medicare*** is eligible to participate in the HOP Pre-65 Medical Plan.

Annuitant Enrollment

Each ***PSERS annuitant*** must submit a ***PSERS*** Health Options Program Application by the required deadline.

Annuitant Effective Date

Benefits for each ***PSERS annuitant*** become effective on the date specified by the HOP Administration Unit.

Dependent Eligibility

Eligible ***dependents*** include:

1. The ***annuitant's*** spouse.
2. The ***annuitant's*** unmarried children under 19 years of age, including natural children, stepchildren, legally adopted children, and children legally placed for adoption.
3. 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*** for each semester. The ***annuitant*** must notify the ***PSERS*** HOP Administration Unit when the ***dependent*** is no longer a ***full-time student***.
4. Adopted children, who are less than 18 years of age at the time of adoption, shall be considered eligible from the date the child is ***placed for adoption***.
5. A child who is unmarried, incapable of self-sustaining employment, and dependent upon the ***annuitant*** for support due to a mental and/or physical disability, and who was covered under the ***Plan*** prior to reaching the maximum age limit or due to other loss of ***dependent's*** eligibility and who lives with the ***annuitant***, will remain eligible for coverage under the ***Plan*** beyond the date coverage would otherwise be lost.

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:

1. Cessation of the mental and/or physical disability;
2. Failure to furnish any required proof of mental and/or physical disability or to submit to any required examination.

Every eligible ***annuitant*** may enroll eligible ***dependents***. However, if both the husband and wife 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.

Dependent Enrollment

An ***annuitant*** must file a written application with the ***PSERS*** HOP Administration Unit for coverage hereunder for his or her eligible ***dependents*** within 31 days of becoming eligible for coverage; and within 31 days of marriage, the acquiring of children or birth of a child.

Dependent Effective Date

Eligible ***dependent(s)***, as described in the section on *Dependent Eligibility*, will become covered under the HOP Pre-65 Medical Plan on the later of the dates listed below, provided the ***annuitant*** has enrolled them in the HOP Pre-65 Medical Plan within 31 days of meeting the Health Options Program's eligibility requirements.

1. The date the ***annuitant's*** coverage becomes effective.
2. The date the ***dependent*** is acquired, provided any required contributions are made and the ***annuitant*** has applied for ***dependent*** coverage within 31 days of the date acquired.
3. Newborn children shall be covered from birth, regardless of ***confinement***, provided the ***annuitant*** has applied for ***dependent*** coverage within 31 days of birth.
4. Coverage for a newly or to be adopted child shall be effective on the date the child is adopted or ***placed for adoption***.

When You Can Change Your Health Option

An annual Option Selection Period will take place each fall, generally from early October to mid-November. For those retirees who participate in the Health Options Program, the annual Option Selection Period will allow a change from one option to another for which you are eligible, in case of a change in your health care needs or financial situation. Coverage (or a change in coverage) will be effective as of January 1.

PSERS retirees who are not currently participating in the Health Options Program may enroll only if they have experienced one of the qualifying events noted below.

You can enroll in the Health Options Program in the three months before the month and the three months after the month following one of the events listed below:

1. 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 plan.)
2. You involuntarily lose 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.)
3. You or your spouse reach age 65 or become eligible for ***Medicare***.
4. You experience a change in family status (including, but not limited to, divorce, your spouse's death, addition of a ***dependent*** through birth, adoption, or marriage or loss of a ***dependent*** through loss of eligibility).
5. You become eligible for Premium Assistance due to a change in legislation.
6. A plan approved for Premium Assistance terminates or you move out of a plan's service area.

The ***Plan sponsor*** reserves the right to determine eligibility criteria, time and options to be made available within the Health Options Program, and the circumstances under which these rights and benefits will apply.

TERMINATION OF COVERAGE

Coverage will terminate on the earliest of the following dates:

Termination of Annuitant Coverage

1. The date the ***annuitant*** becomes eligible for ***Medicare***.
2. The date ***PSERS*** terminates the Health Options Program and offers no other group health plan.
3. The end of the payment period in which the ***annuitant*** ceases to meet the eligibility requirements of the Health Options Program.
4. The end of the payment period in which the ***annuitant*** ceases to make any required contributions.

Termination of Dependent Coverage

1. The date the ***dependent*** becomes eligible for ***Medicare***.
2. The date ***PSERS*** terminates the Health Options Program and offers no other group health plan.
3. The end of the payment period in which such person ceases to meet the eligibility requirements of the Health Options Program.
4. The end of the payment period in which the ***annuitant*** ceases to make any required contributions on the ***dependent's*** behalf.
5. Cessation of ***full-time student status*** for ***dependent*** children age 19 or older shall terminate coverage on the earliest of the following dates:
   a. If under age 23, the end of the month in which the ***dependent*** is no longer a ***full-time student***.
   b. If under age 23, the end of the month in which the ***dependent*** marries.
   c. If still a ***full-time student*** at age 23, the end of the calendar year in which the ***dependent*** reaches age 23.
6. The date the ***dependent*** becomes a full-time, active member of the armed forces of any country.
7. The date the Health Options Program discontinues ***dependent*** coverage for any and all ***dependents***.

CONTINUATION OF COVERAGE

In order to comply with federal regulations, this ***Plan*** includes a continuation of coverage option for certain individuals whose coverage would otherwise terminate. The following is intended to comply with the Public Health Services Act. This continuation of coverage may be commonly referred to as "COBRA coverage" or "continuation coverage."

The coverage which may be continued under this provision consists of health (Major Medical and Prescription Drug) benefits provided under the ***Plan***. Continuation of coverage ends when an individual becomes eligible for ***Medicare***, whether or not the individual is enrolled in ***Medicare***.

Introduction

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review this Summary Plan Description or contact the HOP Administration Unit.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event."

Qualifying events are any of the following events that would cause a ***covered individual*** to lose coverage under this ***Plan*** or cause an increase in required contributions, even if such loss of coverage or increase in required contributions does not take effect immediately, and allow such person

to continue coverage beyond the date described in Termination of Coverage:

1. Divorce or legal separation from the ***annuitant***.
2. A ***dependent*** child no longer meets the eligibility requirements of the ***Plan***.
3. The ***annuitant*** becomes entitled to Medicare.
4. The ***annuitant*** dies.

After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Health Options Program, and that bankruptcy results in the loss of coverage of any retired covered individual, the retired covered individual will become a qualified beneficiary. The retired covered individual's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the HOP Administration Unit has been notified that a qualifying event has occurred. The Health Options Program must notify the HOP Administration Unit of the following qualifying events:

- Death of the covered individual;
- Commencement of a proceeding in bankruptcy with respect to the Health Options Program; or
- The covered individual becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the covered individual and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the HOP Administration Unit within 60 days after the qualifying event occurs.

How is COBRA continuation coverage provided?

Once the HOP Administration Unit receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered individuals may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the HOP Administration Unit in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the covered individual or former covered individual dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

Please contact the HOP Administration Unit for your options for enrolling in Medicare-eligible coverage.

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the

[1] *https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start.*

COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit **https://www.medicare.gov/medicare-and-you**.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

Keep your Plan informed of address changes

To protect your family's rights, let the HOP Administration Unit know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the HOP Administration Unit.

Plan contact information

Contact the HOP Administration Unit with any Plan questions, including any available continuation coverage.

MEDICAL CLAIM FILING PROCEDURES

A "pre-service claim" is a claim for a HOP Pre-65 Medical Plan benefit that is subject to the pre-certification rules, as described in the *Pre-Service Claims Procedures* section. All other claims for HOP Pre-65 Medical Plan benefits are "post-service claims" and are subject to the rules described in *Post-Service Claims Procedures*.

POST-SERVICE CLAIMS PROCEDURE

Filing a Claim

1. Claims should be submitted to the ***Preferred Provider Organization*** (PPO) at the address noted below:

   Private Healthcare Systems (PHCS)
   c/o HOP Administration Unit
   P.O. Box 2921
   Clinton, IA 52733-2921
   1-800-773-7725

   The date of receipt will be the date the claim is received by the claims processor.

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

   a. Name of patient.

   b. Patient's date of birth.

   c. Name of ***annuitant***.

   d. Address of ***annuitant***.

   e. Name, address and tax identification number of provider.

   f. ***Annuitant's*** Member Identification Number.

   g. Date of service.

   h Diagnosis.

   i. Description of service and procedure number.

   j. Charge for service.

   k. 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.

3. Any claims not submitted within 12 months from the date the services were rendered will be denied and no benefits will be paid.

The individual may ask the health care provider to submit the claim directly to the claims processor or to the ***Preferred Provider Organization*** as outlined above or may submit the bill with a claim form. Either way, it is the individual's responsibility to make sure the claim for benefits is filed.

After review of the claim, an explanation of benefits (EOB) will be provided by the claims processor showing the calculation of the total amount payable, charges not payable, and the reason.

Notice of Claim

A claim for benefits should be submitted to the claims processor within 90 calendar days after the occurrence or commencement of any services covered by the HOP Pre-65 Medical Plan, or as soon thereafter as reasonably possible.

Failure to file a claim within the time provided shall not invalidate or reduce a claim for benefits if: (1) it was not reasonably possible to file a claim within

that time; and (2) such claim was furnished as soon as possible, but no later than 12 months after the loss occurs or commences, unless the claimant is legally incapacitated.

Notice given by or on behalf of a ***covered individual*** or his beneficiary, if any, to the ***Plan sponsor*** or to any authorized agent of the Health Options Program, with information sufficient to identify the individual, shall be deemed notice of claim.

HOP Administration Unit Review Process

The HOP Administration Unit handles the Health Options Program's enrollment as well as the processing and payment of HOP Pre-65 Medical Plan Major Medical claims. The HOP Administration Unit handles complaints relating to specific claims against the Major Medical program of the HOP Pre-65 Medical Plan, including interpretation of coverage, benefit determination, medical necessity issues, payment determination and payment timing.

The HOP Administration Unit will conduct an internal review to determine if the original adjudication or determination of the claim and explanation of benefits (EOB) are consistent with the plan of benefits. This review shall 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 Health Options Program will issue a written Notice of Benefit Denial to the complaining party indicating that the claim has been properly adjudicated.

The HOP Administration Unit's 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 Office within 60 calendar days from receipt of the Notice.

PSERS Health Insurance Office Review Process

The ***PSERS*** Health Insurance Office will handle the following types of complaints:

1. Appeals of HOP Administration Unit decisions.
2. Complaints relating to overall management of the Health Options Program, e.g., whether an individual meets eligibility requirements, whether a particular product or benefit is covered under the ***Plan***, and whether there was a materially misleading or inaccurate communication regarding the Health Options Program.
3. Complaints relating to statutory processes and programs, e.g., disputes concerning the Premium Assistance Program, the definition and applicability of a qualifying event, and any matters relating to HIPAA compliance.

The ***PSERS*** Health Insurance Office shall conduct an investigation and analysis of the particular complaint and shall inform the complaining party of the decision in writing. If the claim is denied, then the denial will explain the reasons for the denial, and will contain a statement that the decision may be appealed to the Executive Staff Review Committee (ESRC). The ESRC will process the appeal in accordance with its procedures.

Complaints Directed to the Executive Staff, Board Members or Legislature

Any complaint sent directly to executive staff, a board member or to members of the Legislature will be forwarded to the ***PSERS*** Health Insurance Office for review and handling in accordance with this procedure.

Areas Not Subject to Administrative Review Process

There are three areas of complaint that are not subject to the administrative review process:

1. **Cost (pricing) of Offerings in the Health Options Program (HOP).**
   The Health Options Program is a voluntary program whose pricing is a function of actuarial determination and market dynamics. Complaints arising from the pricing levels are not subject to the administrative review process.

2. **Specific Plan Offerings or Options.**
   The products or services offered within the Health Options Program are determined solely at the discretion of the ***PSERS*** Board, considering market demand and program administrative and financial capacity. Complaints arising from the plan offerings are not subject to the administrative review process.

3. **Eligibility and Communications.**
   General complaints regarding eligibility standards or methods of communication are not subject to the administrative review process.

Foreign Claims

In the event a ***covered individual*** incurs a ***covered expense*** in a foreign country, the individual shall be responsible for providing the following information to the claims processor before payment of any benefits due are payable.

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

PRE-SERVICE CLAIMS PROCEDURES

Health Care Management

Health Care Management is the process of evaluating whether proposed services, supplies or treatments are ***medically necessary*** and appropriate to help ensure quality, cost-effective care.

Certification of ***medical necessity*** and appropriateness by the ***Health Care Management Organization*** does not establish eligibility under the Health Options Program or guarantee benefits.

Filing a Pre-Certification Claim

All ***inpatient*** admissions, partial hospitalizations, ***skilled nursing facility*** care and ***home health care*** services are to be certified by the ***Health Care Management Organization***. For non-urgent care, the individual or their authorized representative should call the ***Health Care Management Organization*** at least 15 calendar days prior to initiation of services. For ***urgent care***, the individual or their authorized representative should call the ***Health Care Management Organization*** within 48 hours or the next business day, if later, after the initiation of services.

Contact the ***Health Care Management Organization*** by calling:

1-800-480-6658

When a ***covered individual*** (or authorized representative) calls the ***Health Care Management Organization***, he or she should be prepared to provide all of the following information:

1. ***Annuitant's*** name, address, phone number and Member Identification Number.
2. If not the ***annuitant***, the patient's name, address, phone number.
3. Admitting ***physician's*** name and phone number.
4. Name of ***facility*** or ***home health care agency***.
5. Date of admission or proposed date of admission.
6. Condition for which patient is being admitted.

Group health plans generally may not, under federal law, restrict benefits for any ***hospital*** length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans may not, under federal law, require that a provider obtain authorization from the ***Plan*** for prescribing a length of stay not in excess of the above periods.

However, ***hospital*** maternity stays in excess of 48 or 96 hours as specified above should be certified.

Notice of Authorized Representative

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

Time Frame for Pre-Service Claim Determination

In the event the HOP Administration Unit receives from the ***covered individual*** (or authorized representative) a communication that fails to follow the pre-certification procedure as described above but communicates at least the name of the ***covered individual***, a specific medical condition or symptom, and a specific treatment, service or product for which prior approval is requested, the individual (or the authorized representative) will be orally notified (and in writing if requested), within five calendar days of the failure of the proper procedure to be followed.

After a completed pre-certification request for non-urgent care has been submitted to the HOP Administration Unit, and if no additional information is required, the HOP Administration Unit will generally complete its determination of the claim within a reasonable period of time, but no later than 15 calendar days from receipt of the request.

After a pre-certification request for non-urgent care has been submitted to the HOP Administration Unit, and if an extension of time to make a decision is necessary due to circumstances beyond the control of the HOP Administration Unit, the HOP Administration Unit will, within 15 calendar days

from receipt of the request, provide the ***covered individual*** (or authorized representative) with a notice detailing the circumstances and the date by which the HOP Administration Unit expects to render a decision. If the circumstances include a failure to submit necessary information, the notice will specifically describe the needed information. The individual will have 45 calendar days to provide the information requested, and the HOP Administration Unit will complete its determination of the claim no later than 15 calendar days after receipt by the HOP Administration Unit of the requested information. Failure to respond in a timely and complete manner will result in a denial.

Concurrent Care Claims

If an extension beyond the original certification is required, the ***covered individual*** (or authorized representative) shall call the ***Health Care Management Organization*** for continuation of certification.

If a ***covered individual*** (or authorized representative) requests to extend a previously approved hospitalization or an ongoing course of treatment, and:

1. The request involves non-urgent care, then the extension request must be processed within 15 calendar days after the request was received.
2. The ***inpatient*** admission or ongoing course of treatment involves ***urgent care***, and
   a. The request is received at least 24 hours before the scheduled end of a hospitalization or course of treatment, then the request must be ruled upon and the individual (or authorized representative) notified as soon as possible but no later than 24 hours after the request was received; or
   b. The request is received less than 24 hours before the scheduled end of the hospitalization or course of treatment, then the request must be ruled upon and the individual (or authorized representative) notified no later than 72 hours after the request was received.

If the ***Health Care Management Organization*** determines that the ***hospital*** stay or course of treatment should be shortened or terminated before the end of the fixed number of days and/or treatments, or the fixed time period that was previously approved, then the ***Health Care Management Organization*** shall:

1. Notify the individual of the proposed change, and
2. Allow the individual to file an appeal and obtain a decision, before the end of the fixed number of days and/or treatments, or the fixed time period that was previously approved.

If, at the end of a previously approved hospitalization or course of treatment, the ***Health Care Management Organization*** determines that continued ***confinement*** is no longer ***medically necessary***, additional days will not be certified. (Refer to the section on *Appealing a Denied Pre-Service Claim*.)

Notice of Pre-Service Denial

If a pre-certification request is denied in whole or in part, the ***Plan sponsor*** or their designee shall provide the individual (or authorized representative) with a written Notice of Pre-Service Denial within the time frames above.

The Notice of Pre-Service Denial shall include an explanation of the denial, including:

1. The specific reasons for the denial.
2. Reference to the HOP Pre-65 Medical Plan's provisions on which the denial is based.
3. A description of any additional material or information needed and an explanation of why such material or information is necessary.
4. A description of the Health Options Program claim review procedure and applicable time limits.
5. A statement that the individual has a right to appeal.
6. If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice of Benefit Denial will contain either:
    a. A copy of that criterion, or
    b. A statement that such criterion was relied upon and will be supplied free of charge, upon request.
7. If denial was based on ***medical necessity***, ***experimental/investigational*** treatment or similar exclusion or limit, the Health Options Program will supply either:
    a. An explanation of the scientific or clinical judgment, applying the terms of the HOP Pre-65 Medical Plan to the individual's medical circumstances, or
    b. A statement that such explanation will be supplied free of charge, upon request.

Appealing a Denied Pre-Service Claim

The named fiduciary for purposes of an appeal of a pre-service claim, as described in U.S. Department of Labor Regulations 2560.503-1 (issued November 21, 2000), is the claims processor.

An individual (or authorized representative) may request a review of a denied claim by making a written request to the named fiduciary within 90 calendar days from receipt of notification of the denial and stating the reasons the individual feels the claim should not have been denied. If the named fiduciary (or authorized representative) wishes to appeal the denial when the services in question have already been rendered, such an appeal will be considered as a separate post-service claim. (Refer to *Post-Service Claims Procedures*.)

The following describes the review process and rights of the eligible individual:

1. The individual has a right to submit documents, information and comments.
2. The individual has the right to access, free of charge, ***relevant information*** to the claim for benefits.
3. The review takes into account all information submitted by the individual, even if it was not considered in the initial benefit determination.
4. The review by the named fiduciary will not afford deference to the original denial.
5. The named fiduciary will not be:
    a. The individual who originally denied the claim, nor
    b. Subordinate to the individual who originally denied the claim.

6. If the original denial was, in whole or in part, based on medical judgment:
   a. The named fiduciary will consult with a ***professional provider*** who has appropriate training and experience in the field involving the medical judgment.
   b. The ***professional provide***r utilized by the named fiduciary will be neither:
      i. An individual who was consulted in connection with the original denial of the claim, nor
      ii. A subordinate of any other ***professional provider*** who was consulted in connection with the original denial.
7. If requested, the named fiduciary will identify the medical or vocational expert(s) who gave advice in connection with the original denial, whether or not the advice was relied upon.

Notice of Pre-Service Determination on Appeal

The ***Plan sponsor*** or their designee shall provide the individual (or authorized representative) with a written Notice of Appeal Decision as soon as possible, but not later than 30 calendar days from receipt of the appeal.

If the appeal is denied, the Notice of Appeal Decision will contain an explanation of the decision, including:

1. The specific reasons for the denial.
2. Reference to specific HOP Pre-65 Medical Plan's provisions on which the denial is based.
3. A statement that the individual has the right to access, free of charge, ***relevant information*** to the claim for benefits.
4. A statement that the individual has a right to appeal.
5. A statement that the individual has the right to access, free of charge, information about the voluntary appeal process.
6. If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice of Appeal Decision will contain either:
   a. A copy of that criterion, or
   b. A statement that such criterion was relied upon and will be supplied free of charge, upon request.
7. If the denial was based on ***medical necessity***, ***experimental/investigational*** treatment or similar exclusion or limit, the Health Options Program will supply either:
   a. An explanation of the scientific or clinical judgment, applying the terms of the HOP Pre-65 Medical Plan to the claimant's medical circumstances, or
   b. A statement that such explanation will be supplied free of charge, upon request.

Second Level Voluntary Appeal

The ***Health Care Management Organization***, upon request by the individual (or authorized representative) following a pre-service determination on appeal, will conduct a second level voluntary appeal. This appeal is comprised of a panel of three ***professional providers*** that were not consulted in connection with the original pre-service denial. The individual's decision as to whether to submit a previously denied appeal to the voluntary appeal process will have no effect on the individual's rights to any other benefits under the Plan. There are no fees or costs imposed as a condition to use of the voluntary appeal process.

Upon receipt of the request to conduct a voluntary appeal, a determination will be made within 30 business days. Notification of the outcome of the review will be communicated verbally and in writing.

With respect to pre-service claims, the Health Options Program agrees not to later assert a defense of failure to exhaust available administrative remedies against an individual who chooses not to make use of the voluntary appeal process.

With respect to pre-service claims, the Health Options Program agrees that any statute of limitations or other defense based on timelines is tolled while the dispute is under submission to the voluntary appeal process.

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

Case Management

In cases where an individual's condition is expected to be or is of a serious nature, the ***Health Care Management Organization*** may arrange for review and/or case management services from a professional qualified to perform such services. The ***Plan sponsor*** shall have the right to alter or waive the normal provisions of the HOP Pre-65 Medical Plan when it is reasonable to expect a cost-effective result without a sacrifice to the quality of care.

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

1. Are not ***covered expenses*** under the HOP Pre-65 Medical Plan; or
2. Are ***covered expenses*** under the HOP Pre-65 Medical Plan but on a basis that differs from the alternative recommended by the ***Health Care Management Organization***.

The recommended alternatives will be considered as ***covered expenses*** under the HOP Pre-65 Medical Plan provided the expenses can be shown to be viable, ***medically necessary***, and are included in a written case management report or treatment plan proposed by the ***Health Care Management Organization***.

Case management will be determined on the merits of each individual case, and any care or treatment provided will not be considered as setting any precedent or creating any future liability with respect to that individual or any other ***covered individual***.

COORDINATION OF BENEFITS

The Coordination of Benefits provision does not apply to benefits provided under the Prescription Drug Program.

The Coordination of Benefits provision is intended to prevent duplication of benefits. It applies when an individual is covered by two or more health plans. When the covered ***annuitant*** or ***dependent*** is covered by multiple health plans, one plan normally pays the claim for benefits or services up to the covered amount under the terms of the Plan, referred to as the primary plan. The other plan(s), referred to as the secondary plan, pays any outstanding balance on the claim as covered under the terms of the plan. When coordination of benefits occurs, the total benefit payable by all plans will not exceed 100% of "allowable expenses." Only the amount paid by the HOP Pre-65 Medical Plan will be charged against the ***maximum benefit***.

The Coordination of Benefits provision applies whether or not a claim is filed under the other applicable 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 amount paid for the benefits or services rendered.

Definitions Applicable to this Provision

"Allowable expenses" means any reasonable, necessary, and customary expenses ***incurred*** while covered under the HOP Pre-65 Medical Plan, part or all of which would be covered under the HOP Pre-65 Medical Plan. Allowable expenses do not include expenses contained in the "Exclusions" sections of the HOP Pre-65 Medical Plan.

When the HOP Pre-65 Medical Plan is secondary, "allowable expense" will include any deductible or ***coinsurance*** amounts not paid by the other plan(s).

When the HOP Pre-65 Medical Plan is secondary, "allowable expense" shall 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 ***covered individual*** for the difference between the provider's contracted amount and the provider's regular billed charge.

"Other plan" means any plan, policy or coverage providing benefits or services for, or by reason of medical, dental or vision care. Such other plan(s) 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. ***Hospital*** or medical service organization on a group basis, group practice, and other group prepayment plans 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 which 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 policies 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 HOP Pre-65 Medical Plan" shall mean that portion of the Health Options Program that provides benefits that are subject to this provision.

"Claim determination period" means a calendar year or that portion of a calendar year during which the eligible individual for whom a claim is made has been covered under the HOP Pre-65 Medical Plan.

Effect on Benefits

This provision shall apply in determining the benefits for an individual for each claim determination period for the allowable expenses. If this ***Plan*** is secondary, the benefits paid under this ***Plan*** may be reduced so that the sum of benefits paid by all plans does not exceed 100% of total allowable expense.

If the rules set forth under the *Order of Benefit Determination* section would require this ***Plan*** to determine its benefits before such other plan, then the benefits of such other plan will be ignored for the purposes of determining the benefits under this ***Plan***.

Order of Benefit Determination

Each plan will make its claim payment according to the following order of benefit determination:

1. No Coordination of Benefits Provision.
If the other plan contains no provisions for coordination of benefits, then its benefits shall be paid before all other plan(s), i.e., that plan will be primary.

2. Member/Dependent.
The plan that covers the claimant as a member (or named insured) pays as though no other plan existed, i.e., that plan is primary. Remaining ***covered expenses*** are paid under a plan that covers the claimant as a ***dependent***, i.e., that plan is secondary.

3. 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, i.e., primary. 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, i.e., primary. A parent's year of birth is not relevant in applying this rule.

4. Dependent Children of Separated or Divorced Parents.
When parents are separated or divorced, the birthday rule does not apply; instead:

a. 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.

b. 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.

5. Active/Inactive.
The plan covering a person as an active (not laid off or retired) employee or as that person's ***dependent*** pays first. The plan covering that person as a laid off or retired employee, or as that person's ***dependent*** pays second.

6. Longer/Shorter Length of Coverage.
If none of the above rules determine the order of benefits, the plan covering a person longer pays first, i.e., primary. The plan covering that person for a shorter time pays second, i.e., secondary.

Coordination With Medicare

In most cases, this ***Plan*** does not coordinate benefits with ***Medicare***. However, if an individual is covered under both this ***Plan*** and ***Medicare***, ***Medicare*** is primary (pays benefits first) and this ***Plan*** is secondary.

Limitations on Payments

In no event shall an individual recover under this ***Plan*** and all other plan(s) combined more than the total allowable expenses. Nothing contained in this section shall entitle an individual to benefits in excess of the total ***maximum benefits*** of the HOP Pre-65 Medical Plan during the claim determination period. An individual shall refund to the Health Options Program any excess it may have paid.

Right to Receive and Release Necessary Information

For the purposes of determining the applicability of and implementing the terms of this Coordination of Benefits provision, the Health Options Program may, without the consent of or notice to any person, release to or obtain from any insurance company or any other organization any information, regarding other insurance, with respect to any ***covered individual***. Any person claiming benefits under the HOP Pre-65 Medical Plan shall furnish to ***PSERS*** such information as may be necessary to implement the Coordination of Benefits provision.

Facility of Benefit Payment

Whenever payments that should have been made under the HOP Pre-65 Medical Plan in accordance with this provision have been made under any other plan, the Health Options Program shall have the right, exercisable alone and in its sole discretion, to pay over to any organization making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision. Amounts so paid shall be deemed to be benefits paid under the HOP Pre-65 Medical Plan and, to the extent of such payments, the Health Options Program shall be fully discharged from liability.

SUBROGATION/REIMBURSEMENT

The HOP Pre-65 Medical Plan maintains the right to seek reimbursement of any charges for any injury or illness that is the legal obligation of a third party. The HOP Pre-65 Medical Plan also reserves the right to reimbursement of any paid charges for an injury or illness that is the obligation of a third party upon a covered ***annuitant's*** or a covered ***dependent's*** receipt of settlement, judgment, or award: the right of reimbursement. The HOP Pre-65 Medical Plan reserves the right of recovery, either by subrogation or reimbursement, for ***covered expenses*** payable by the HOP Pre-65 Medical Plan that are a result of ***illness*** or ***injury*** that has been caused by third party and who is responsible for such ***illness*** or ***injury***. The HOP Pre-65 Medical Plan will be reimbursed from the first monies recovered as the result of judgment, settlement, or otherwise. (This is known as "pro tanto" subrogation.) This right includes the HOP Pre-65 Medical Plan's right to receive reimbursement from uninsured or underinsured motorist coverage and no-fault coverage.

Accepting benefits from the HOP Pre-65 Medical Plan automatically assigns to it any rights the individual may have to recover benefits from any party, including an insurer, or another group health program. This right of recovery allows the HOP Pre-65 Medical Plan to pursue any claim that the individual may have against any party, group health program or insurer, whether or not the individual chooses to pursue that claim. This includes a right to recover from no-fault auto insurance carriers in a situation where no third party may be liable or from any uninsured or underinsured motorist coverage where the recovery was triggered by the actions of a party that caused or contributed to the payment of benefits under the HOP Pre-65 Medical Plan. This also includes a right to recover from amounts the individual received from workers' compensation, whether by judgment or settlement, where the HOP Pre-65 Medical Plan has paid benefits prior to a determination that the medical expenses arose out of and in the course of employment. Payment by workers' compensation will be presumed to mean that such a determination has been made.

If a ***covered individual*** is involved in an automobile ***accident*** or suffers an ***illness*** or ***injury*** that was due to the action or inaction of any party, the HOP Pre-65 Medical Plan may advance payment in order to prevent any financial hardship to the individual. Acceptance of the HOP Pre-65 Medical Plan benefits acknowledges the obligation of the individual to:

1. Help the HOP Pre-65 Medical Plan recover benefits it has paid on behalf of the individual, and
2. Provide the HOP Administration Unit with information concerning any automobile insurance, any other group health program that may be obligated to pay benefits on behalf of the individual, and the insurance of any other party involved.

The ***covered individual*** is required to cooperate fully in the HOP Pre-65 Medical Plan's exercise of its right to recovery, and the individual cannot do anything to prejudice those rights. Such cooperation is required as a condition of receiving benefits under the HOP Pre-65 Medical Plan.

The HOP Pre-65 Medical Plan may refuse to pay benefits or cease to pay benefits on behalf of an eligible individual who fails to sign any document deemed by the HOP Administration Unit to be relevant to protecting its subrogation rights or fails to provide ***relevant information*** when requested. This information includes any documents, insurance policies, police reports, or any reasonable request by the claims processor or ***Plan sponsor*** to enforce the HOP Pre-65 Medical Plan's rights.

Whether the individual or the HOP Pre-65 Medical Plan makes a claim directly against any party, group health program, or insurance company for the benefit payments made on behalf of an individual by the HOP Pre-65 Medical Plan, the HOP Pre-65 Medical Plan has a lien on any amount the individual recovers or could recover from any party, insurance company, or group health program whether by judgment, settlement, or otherwise, and whether or not designated as payment for medical expenses. This lien shall remain in effect until the HOP Pre-65 Medical Plan acknowledges and agrees upon payment to the HOP Pre-65 Medical Plan and releases its lien. The lien may not be for an amount greater than the amount of benefits paid under the HOP Pre-65 Medical Plan.

The ***Plan sponsor*** has delegated to the claims processor the right to perform ministerial functions required to assert the HOP Pre-65 Medical Plan's rights; however, ***PSERS*** shall retain discretionary authority with regard to asserting the HOP Pre-65 Medical Plan's recovery rights.

GENERAL PROVISIONS

Administration of the Plan

The HOP Pre-65 Medical Plan is administered by the HOP Administration Unit. ***PSERS*** is the ***Plan sponsor.*** The ***Plan sponsor*** shall have full charge of the operation and management of the HOP Pre-65 Medical Plan. ***PSERS*** has retained the services of an independent claims processor experienced in claims review.

PSERS is the named fiduciary of the HOP Pre-65 Medical Plan except as noted herein. The claims processor is the named fiduciary of the HOP Pre-65 Medical Plan for claim adjudication and appeals. As the named fiduciary for appeals, the claims processor maintains discretionary authority to review all denied claims under appeal for benefits under the HOP Pre-65 Medical Plan. ***PSERS*** maintains discretionary authority to interpret the terms of the HOP Pre-65 Medical Plan, including but not limited to determination of eligibility for and entitlement to HOP Pre-65 Medical Plan benefits in accordance with the terms of the 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

The HOP Pre-65 Medical Plan will pay benefits to the ***annuitant*** unless payment has been assigned to a ***hospital, physician,*** or other provider of service furnishing the services for which benefits are provided herein. No assignment of benefits shall be binding on the HOP Pre-65 Medical Plan unless the claims processor is notified in writing of such assignment prior to payment pursuant to the terms of the HOP Pre-65 Medical Plan.

Benefits Not Transferable

Except as otherwise stated herein, no person other than a ***covered individual*** is entitled to receive benefits under the HOP Pre-65 Medical Plan. Such right to benefits is not transferable.

Clerical Error

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

Conformity with Statute(s)

Any provision of the HOP Pre-65 Medical Plan that is in conflict with statutes that are applicable to the HOP Pre-65 Medical Plan is hereby amended to conform to the minimum requirements of said statute(s).

Effective Date of the Plan

The effective date of the HOP Pre-65 Medical Plan as defined by this description is January 1, 2024.

Free Choice of Hospital and Physician

Nothing contained in the HOP Pre-65 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***. However, benefits will be paid in accordance with the provisions of this ***Plan***, and the ***covered individual*** will have higher out-of-pocket expenses if the ***covered individual*** uses the services of a ***nonpreferred provider***.

Incapacity

If, in the opinion of the ***Plan sponsor***, an individual for whom a claim has been made is incapable of furnishing a valid receipt of payment due him and in the absence of written evidence to the HOP Administration Unit of the qualification of a guardian or personal representative for his estate, the ***Plan sponsor*** may on behalf of the HOP Pre-65 Medical Plan, at its discretion, make any and all such payments to the provider of services or other person providing for the care and support of such person. Any payment so made will constitute a complete discharge of the HOP Pre-65 Medical Plan's obligation to the extent of such payment.

Incontestability

All statements made by the ***Plan sponsor*** or by an individual covered under the HOP Pre-65 Medical Plan shall be deemed representations and not warranties. Such statements shall not void or reduce the benefits under the HOP Pre-65 Medical Plan or be used in defense to a claim unless they are contained in writing and signed by the ***Plan sponsor*** or by the individual, as the case may be. A statement made shall not be used in any legal contest unless a copy of the instrument containing the statement is or has been furnished to the other party to such a contest.

Legal Actions

No action at law or in equity shall be brought to recover on the benefits from the HOP Pre-65 Medical Plan prior to the expiration of 60 days after all information on a claim for benefits has been filed and the appeal process has been completed in accordance with the requirements of the HOP Pre-65 Medical Plan. No such action shall be brought after the expiration of two years from the date the expense was ***incurred***, or one year from the date a completed claim was filed, whichever occurs first.

Limits on Liability

Liability hereunder is limited to the services and benefits specified under the terms of the Plan, and the HOP Pre-65 Medical Plan shall not be liable for any obligation of the individual ***incurred*** in excess thereof. The liability of the HOP Pre-65 Medical Plan shall be limited to the reasonable cost of ***covered expenses*** and shall not include any liability for suffering or general damages.

Lost Distributees

Any benefit payable hereunder shall be deemed forfeited if the ***Plan sponsor*** is unable to locate the individual to whom payment is due, provided, however, that such benefits shall be reinstated if a claim is made by the individual for the forfeited benefits within the time prescribed in the *Medical Claim Filing Procedures* section.

Medicaid Eligibility and Assignment of Rights

The HOP Pre-65 Medical Plan will not take into account whether an individual is eligible for, or is currently receiving, medical assistance under a state plan as provided under Title XIX of the Social Security Act ("State Medicaid Plan") either in enrolling that individual or in determining or making any payment of benefits to that individual. The HOP Pre-65 Medical Plan will pay benefits with respect to such individual in accordance with any assignment of rights made by or on behalf of such individual as required under a state Medicaid plan pursuant to § 1912(a)(1)(A) of the Social Security Act. To the extent payment has been made to such individual under a state Medicaid plan, and the HOP Pre-65 Medical Plan has a legal liability to make payments for the same services, supplies, or treatment, payment under the HOP Pre-65 Medical Plan will be made in accordance with any state law that provides that the state has acquired the rights with respect to such individual to payment for such services, supplies, or treatment under the terms of the HOP Pre-65 Medical Plan.

Misrepresentation

If an individual or anyone acting on behalf of an individual makes a false statement on the application for enrollment, or withholds information with intent to deceive or affect the acceptance of the enrollment application or the risks assumed by HOP Pre-65 Medical Plan, or otherwise misleads the HOP Pre-65 Medical Plan, the HOP Pre-65 Medical Plan shall be entitled to recover its damages, including legal fees, from the individual, or from any other person responsible for misleading the HOP Pre-65 Medical Plan, and from the person for whom the benefits were provided.

Any material misrepresentation on the part of the individual in making application for coverage, or any application for reclassification thereof, or for service thereunder shall render the coverage under the HOP Pre-65 Medical Plan null and void.

Physical Examinations Required by the Plan

The HOP Pre-65 Medical Plan, at its own expense, has the right to require an examination of a person covered under the HOP Pre-65 Medical Plan when and as often as it may reasonably require during the pendency of a claim.

Plan Is Not a Contract

The HOP Pre-65 Medical Plan shall not be deemed to constitute a contract between the ***Plan sponsor*** and any individual.

Plan Modification and Amendment

The ***Plan sponsor*** may modify or amend the HOP Pre-65 Medical Plan from time to time at its sole discretion, and such amendments or modifications that affect individuals will be communicated to the individuals. Any such amendments shall be in writing, setting forth the modified provisions of the HOP Pre-65 Medical Plan, the effective date of the modifications, and shall be signed by the ***Plan sponsor's*** designee.

Such modification or amendment shall be duly incorporated in writing into the master copy of the HOP Pre-65 Medical Plan on file with the ***Plan sponsor***, or a written copy thereof shall be deposited with such master copy of the HOP Pre-65 Medical Plan. Appropriate filing and reporting of any such modification or amendment to individuals shall be timely made by the ***Plan sponso***r.

Plan Termination

PSERS reserves the right to terminate the HOP Pre-65 Medical Plan at any time. Upon termination, the rights of individuals to benefits are limited to claims ***incurred*** up to the date of termination. Any termination of the HOP Pre-65 Medical Plan will be communicated to the ***covered individuals***.

Prior Plan Coverage

Annuitants and ***dependents*** who are covered under the HOP Pre-65 Medical Plan as of December 31, 2023, shall be covered hereunder, provided they have not terminated coverage under the HOP Pre-65 Medical Plan or elected other coverage under the Health Options Program.

Amounts applied to ***Plan*** maximums prior to January 1, 2024, continue to count toward those maximums after December 31, 2023. For example, the Major Medical Benefits $1,000,000 ***lifetime maximum*** includes payments made by the HOP Pre-65 Medical Plan prior to January 1, 2024.

Pronouns

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

Recovery for Overpayment

Whenever payments have been made from the HOP Pre-65 Medical Plan in excess of the maximum amount of benefits payable, the HOP Pre-65 Medical Plan will have the right to recover excess payments. If the claims processor makes any payment that, according to the terms of the HOP Pre-65 Medical Plan, should not have been made, the HOP Pre-65 Medical Plan may recover that incorrect payment, whether or not it was made due to the claims processor's own error, from the person or entity to whom it was made or from any other appropriate party.

Time Effective

The effective time with respect to any dates used in the HOP Pre-65 Medical Plan shall be 12:01 a.m. as may be legally in effect at the address of the HOP Administration Unit or ***PSERS***.

Workers' Compensation Not Affected

The HOP Pre-65 Medical Plan is not in lieu of, and does not affect any requirement for, coverage by workers' compensation insurance.

HIPAA PRIVACY

The following provisions are intended to comply with applicable HOP Pre-65 Medical Plan amendment requirements under federal regulation implementing Section 264 of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and shall be construed as a part of the HOP Pre-65 Medical Plan document.

Disclosure by Plan to Plan Sponsor

The HOP Pre-65 Medical Plan may take the following actions only upon receipt of a plan amendment certification:

1. Disclose protected health information to the ***Plan sponsor***
2. Provide for or permit the disclosure of protected health information to the ***Plan sponsor*** by a health insurance issuer or HMO with respect to the HOP Pre-65 Medical Plan pursuant to the terms set forth in the Plan Document or amendment to the Plan.

Use and Disclosure by Plan Sponsor

The ***Plan sponsor*** may use or disclose protected health information received from the HOP Pre-65 Medical Plan to the extent not inconsistent with the provisions of this *HIPAA Privacy* section or the privacy rule.

Obligations of PSERS

PSERS shall have the following obligations:

1. To ensure that:
   a. Any agents (including a subcontractor) to whom it provides protected health information received from the HOP Pre-65 Medical Plan agree to the same restrictions and conditions that apply to ***PSERS*** with respect to such information, and
   b. Adequate separation is established between the HOP Pre-65 Medical Plan and ***PSERS***.
2. Not use or further disclose protected health information received from the HOP Pre-65 Medical Plan, other than as permitted or required by the HOP Pre-65 Medical Plan documents or as required by law
3. Not use or disclose protected health information received from the HOP Pre-65 Medical Plan:
   a. For employment-related actions and decisions, or
   b. In connection with any other benefit or employee benefit plan of the ***Plan sponsor***.
4. Report to the HOP Pre-65 Medical Plan any use or disclosure of the protected health information received from the HOP Pre-65 Medical Plan that is inconsistent with the use or disclosure provided for of which it becomes aware

5. Make available protected health information received from the HOP Pre-65 Medical Plan, as and to the extent required by the privacy rule:
   a. For access to the individual
   b. For amending and incorporating any amendments to protected health information received from the HOP Pre-65 Medical Plan, and
   c. To provide an accounting of disclosures.
6. Make its internal practices, books, and records relating to the use and disclosure of protected health information received from the HOP Pre-65 Medical Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the HOP Pre-65 Medical Plan with the privacy rule
7. Return or destroy all protected health information received from the HOP Pre-65 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 HOP Pre-65 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
8. Provide protected health information only to those individuals under the control of ***PSERS*** who perform administrative functions for the HOP Pre-65 Medical Plan (i.e., eligibility, enrollment, pension deduction, benefit determination, claim reconciliation assistance), and to make clear to such individuals that they are not to use protected health information for any reason other than for HOP Pre-65 Medical Plan administrative functions or to release protected health information to an unauthorized individual
9. Provide protected health information only to those entities required to receive the information in order to maintain the HOP Pre-65 Medical Plan (i.e., claim administrator, case management vendor, pharmacy benefit manager, claim subrogation vendor, claim auditor, network manager, stop-loss insurance carrier, insurance broker/consultant) and any other entity subcontracted to assist in administering the HOP Pre-65 Medical Plan
10. Provide an effective mechanism for resolving issues of noncompliance with regard to the items mentioned in this provision
11. Reasonably and appropriately safeguard electronic protected health information created, received, maintained, or transmitted to or by ***PSERS*** on behalf of the HOP Pre-65 Medical Plan. Specifically, such safeguarding entails an obligation to:
    a. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that the ***Plan sponsor*** creates, receives, maintains, or transmits on behalf of the HOP Pre-65 Medical Plan
    b. 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
    c. 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
    d. Report to the HOP Pre-65 Medical Plan any security incident of which it becomes aware.
12. PSERS will not use or disclose protected health information for marketing or sell protected health information

Exceptions

Notwithstanding any other provision of this *HIPAA Privacy* section, the HOP Pre-65 Medical Plan may:

1. Disclose summary health information to the ***Plan sponsor*** if the ***Plan sponsor*** requests it for the purpose of:
   a. Obtaining premium bids from health plans for providing health insurance under the Health Options Program or HOP Pre-65 Medical Plan, or
   b. Modifying, amending, or terminating the HOP Pre-65 Medical Plan.
2. Disclose to the ***Plan sponsor*** information on whether the individual is participating in the HOP Pre-65 Medical Plan, or is enrolled in or has dis-enrolled 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, or
   c. As otherwise permitted or required by the privacy rule.

DEFINITIONS

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

Accident

An unforeseen event resulting in ***injury***.

Ambulatory Surgical Facility

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

1. Has permanent facilities and equipment for the purpose of performing surgical procedures on an ***outpatient*** basis;
2. Provides treatment by or under the supervision of ***physicians*** and nursing services whenever the ***individual*** is in the ***ambulatory surgical facility***;
3. Does not provide ***inpatient*** accommodations; and
4. Is not, other than incidentally, a ***facility*** used as an office or clinic for the private practice of a ***physician***.

Annuitant

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

Birthing Center

A ***facility*** that meets professionally recognized standards and complies with all licensing and other legal requirements that apply.

Close Relative

The ***annuitant's*** spouse, children, brothers, sisters, or parents; or the children, brothers, sisters or parents of the ***annuitant's*** spouse.

Coinsurance

The benefit percentage of ***covered expenses*** payable by the ***Plan*** for benefits that are provided under the ***Plan***. The ***coinsurance*** is applied to ***covered expenses*** after the deductible(s) have been met, if applicable.

Complications of Pregnancy

A disease, disorder or condition which is diagnosed as distinct from ***pregnancy***, but is adversely affected by or caused by ***pregnancy***. Some examples are:

1. Intra-abdominal surgery (but not elective cesarean section).
2. Ectopic ***pregnancy***.
3. Toxemia with convulsions (eclampsia).
4. Pernicious vomiting (hyperemesis gravidarum).
5. Nephrosis.
6. Cardiac decompensation.
7. Missed abortion.
8. Miscarriage.

These conditions are not included: false labor; occasional spotting; rest during ***pregnancy*** even

if prescribed by a ***physician***; morning sickness; or like conditions that are not medically termed as ***complications of pregnancy***.

Confinement

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

Cosmetic Surgery

Surgery for the restoration, repair, or reconstruction of body structures directed toward altering appearance.

Covered Expenses

Medically necessary services, supplies or treatments that are recommended or provided by a ***physician***, ***professional provider*** or covered ***facility*** for the treatment of an ***illness*** or ***injury*** and that are not specifically excluded from coverage herein. ***Covered expenses*** shall include specified preventive care services.

Covered Individual

An individual who is an ***annuitant*** or survivor ***annuitant***, or the spouse or ***dependent*** of an ***annuitant*** enrolled in the HOP Pre-65 Medical Plan.

Custodial Care

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

Room and board and skilled nursing services are not, however, considered ***custodial care*** if (1) provided during ***confinement*** in an institution for which coverage is available under the Plan, and (2) if combined with other ***medically necessary*** therapeutic services, under accepted medical standards, which can reasonably be expected to substantially improve the individual's medical condition.

Customary and Reasonable Amount

Any negotiated fee (where the provider has contracted to accept such fee as payment in full for ***covered expenses*** of the ***Plan***) assessed for services, supplies or treatment by a ***nonpreferred provider***, or a fee assessed by a provider of service for services, supplies or treatment which shall not exceed the general level of charges made by others rendering or furnishing such services, supplies or treatment within the area where the charge is ***incurred*** and is comparable in severity and nature to the ***illness*** or ***injury***. Due consideration shall be given to any medical complications or unusual circumstances which require additional time, skill or experience. The ***customary and reasonable amount*** is determined from a statistical review and analysis of the charges for a given procedure in a given area. The term "area" as it would apply to any particular service, supply or treatment means a county or such greater area as is necessary to obtain a representative cross-section of the level of charges. The percentage applicable to this ***Plan*** is 80% and is applied to CPT codes or HIAA Code Analysis using MDR or HIAA tables.

Dentist

A Doctor of Dental Medicine (D.M.D.), a Doctor of Dental Surgery (D.D.S.), a Doctor of Medicine (M.D.), or a Doctor of Osteopathy (D.O.), other than a ***close relative*** of the ***covered individual***, who is practicing within the scope of his license.

Dependent

See page 35.

Durable Medical Equipment

Medical equipment that:

1. Can withstand repeated use;
2. Is primarily and customarily used to serve a medical purpose;
3. Is generally not used in the absence of an ***illness*** or ***injury***;
4. Is appropriate for use in the home.

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

Effective Date

The date on which an individual's coverage commences.

Experimental/Investigational

Services, supplies, drugs and treatment that do not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered.

The claims processor, named fiduciary for post-service claims, Plan sponsor, or their designee must make an independent evaluation of the ***experimental***/non-experimental standings of specific technologies. The claims processor, named fiduciary for post-service claims, Plan sponsor or their designee shall be guided by a reasonable interpretation of the ***Plan*** provisions and information provided by qualified independent vendors who have also reviewed the information provided. The decisions shall be made in good faith and rendered following a factual background investigation of the claim and the proposed treatment. The claims processor, named fiduciary for post-service claims, Plan sponsor or their designee will be guided by the following examples of ***experimental*** services and supplies:

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

4. If "reliable evidence" shows that prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, or its efficacy as compared with standard means of treatment or diagnosis.

"Reliable evidence" shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating ***facility*** or the protocol(s) of another ***facility*** studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating ***facility*** or by another ***facility*** studying substantially the same drug, device, medical treatment or procedure.

Facility

A health care institution which meets all applicable state or local licensure requirements.

Full-time Student or Full-time Student Status

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

Generic Drug or Medication

An FDA-approved ***generic*** medication is a duplicate form of a trade name brand medication whose patent protection has expired. The ***generic*** drug is usually marketed under the chemical name of the drug and must be clearly designated by the pharmacist as ***generic***. The FDA must approve the ***generic*** version before it can be sold and requires the active ingredients to be chemically identical and have the same quality, strength, purity and safety as brand name drugs.

Health Care Management

A process of evaluating if services, supplies or treatment are ***medically necessary*** and appropriate to help ensure cost-effective care.

Health Care Management Organization

The individual or organization designated by the ***Plan sponsor*** for the process of evaluating whether the service, supply, or treatment is ***medically necessary***. The ***Health Care Management Organization*** is Luminare Health Benefits, Inc. (previously Trustmark).

Home Health Aide Services

Services which may be provided by a person, other than a Registered Nurse, which are ***medically necessary*** for the proper care and treatment of a person.

Home Health Care Agency

An agency or organization that meets fully every one of the following requirements:

1. It is primarily engaged in and duly licensed, if licensing is required, by the appropriate licensing authority, to provide skilled nursing and other therapeutic services.
2. It has a policy established by a professional group associated with the agency or organization to govern the services provided. This professional group must include at least one ***physician*** and at least one Registered Nurse. It must provide for full-time supervision of such services by a ***physician*** or Registered Nurse.
3. It maintains a complete medical record on each ***eligible individual***.
4. It has a full-time administrator.
5. It qualifies as a reimbursable service under ***Medicare***.

Hospice

An agency that provides counseling and medical services and may provide ***room and board*** to a terminally ill ***individual*** and meets all of the following tests:

1. It has obtained any required state or governmental Certificate of Need approval.
2. It provides service 24 hours per day, seven days a week.
3. It is under the direct supervision of a ***physician***.
4. It has a ***nurse*** coordinator who is a Registered Nurse.
5. It has a social service coordinator who is licensed.
6. It is an agency that has as its primary purpose the provision of ***hospice*** services.
7. It has a full-time administrator.
8. It maintains written records of services provided to the individual.
9. It is licensed, if licensing is required.

Hospital

An institution that meets the following conditions:

1. It is licensed and operates in accordance with the laws of the jurisdiction in which it is located which pertain to ***hospitals***.
2. It is engaged primarily in providing medical care and treatment to ill and injured persons on an ***inpatient*** basis at the individual's expense.
3. It maintains on its premises all the facilities necessary to provide for the diagnosis and medical and surgical treatment of an ***illness*** or ***injury***; and such treatment is provided by or under the supervision of a ***physician*** with continuous 24-hour nursing services by or under the supervision of Registered Nurses.
4. It qualifies as a ***hospital*** and is accredited by the Joint Commission on the Accreditation of Healthcare Organizations.
5. It is approved by ***Medicare***.

Under no circumstances will a ***hospital*** be, other than incidentally, a place for rest, a place for the aged, or a nursing home.

Hospital shall include a ***facility*** designed exclusively for physical rehabilitative services where the individual received treatment as a result of an ***illness*** or ***injury***.

The term ***hospital***, when used in conjunction with ***inpatient confinement*** for ***mental health disorders***, will be deemed to include an institution which is licensed as a mental ***hospital*** by the regulatory authority having responsibility for such licensing under the laws of the jurisdiction in which it is located.

Illness

A bodily disorder, disease, physical sickness, or ***pregnancy***.

Immediate Care Center (Urgent Care)

A ***facility*** that is engaged primarily in providing minor emergency and episodic medical care and has:

1. A board-certified ***physician***, a Registered Nurse (RN) and a registered X-ray technician in attendance at all times;
2. X-ray and laboratory equipment and life support systems.

An ***immediate care center*** may include a clinic located at, operated in conjunction with, or that is part of a regular ***hospital***.

Incurred or Incurred Date

With respect to a ***covered expense***, the date the services, supplies or treatment are provided.

Injury

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

Inpatient

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

Intensive Care

A service reserved for critically and seriously ill individuals requiring constant audiovisual surveillance prescribed by the attending ***physician***.

Intensive Care Unit

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

1. Facilities for special nursing care not available in regular rooms and wards of the ***hospital***;
2. Special lifesaving equipment that is immediately available at all times;
3. At least two beds for the accommodation of the critically ill; and
4. At least one Registered Nurse in continuous and constant attendance 24 hours per day.

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

Maximum Benefit

Any one of the following, or any combination of the following:

1. The maximum amount paid by the ***Plan*** for any one individual during the entire time he is covered by the ***Plan***.
2. The maximum amount paid by the ***Plan*** for any one individual for a particular ***covered expense***. The maximum amount can be for:
   a. The entire time the individual is covered under the ***Plan***, or
   b. A specified period of time, such as a calendar year.
3. The maximum number as outlined in the ***Plan*** as a ***covered expense***. The maximum number relates to the number of:
   a. Treatments during a specified period of time, or
   b. Days of ***confinement***, or
   c. Visits by a ***home health care agency***.

Medical Emergency

Medical emergency means a sudden onset of a condition with acute symptoms requiring immediate medical care and includes such conditions as heart attacks, cardiovascular ***accidents***, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions as determined to be medical emergencies by the claims processor.

Medically Necessary (or Medical Necessity)

Service, supply or treatment that is determined by the claims processor, named fiduciary for post-service claims, Plan sponsor or their designee to be:

1. Appropriate and consistent with the symptoms and provided for the diagnosis or treatment of the individual's ***illness*** or ***injury*** and which could not have been omitted without adversely affecting the individual's condition or the quality of the care rendered; and
2. Supplied or performed in accordance with current standards of medical practice within the United States; and
3. Not primarily for the convenience of the individual or the individual's family or ***professional provider***; and
4. Is an appropriate supply or level of service that safely can be provided; and
5. Is recommended or approved by the attending ***professional provider***.

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

Medicare

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

Mental Health Disorder

An emotional or mental condition characterized by abnormal functioning of the mind or emotions. Diagnosis and classifications of these conditions will be determined based on standard DSM-V (Diagnostic and Statistical Manual of Mental Disorders) or the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services.

Negotiated Rate

The rate the ***preferred providers*** have contracted to accept as payment in full for ***covered expenses*** of the ***Plan***.

Nonparticipating Pharmacy

Any pharmacy, including a ***hospital*** pharmacy, ***physician*** or other organization, licensed to dispense prescription drugs that does not fall within the definition of a ***participating pharmacy***.

Nonpreferred Provider

A ***physician***, ***hospital*** or other health care provider that does not have an agreement in effect with the ***Preferred Provider Organization*** at the time services are rendered.

Nurse

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

Outpatient

An individual who is treated at:

1. A ***hospital*** as other than an ***inpatient***;
2. A ***physician's*** office, laboratory or X-ray ***facility***; or
3. An ***ambulatory surgical facility***; and

The stay is less than 18 consecutive hours.

Partial Confinement

A period of less than 24 hours of active treatment in a ***facility*** licensed or certified by the state in which treatment is received to provide one or more of the following:

1. Psychiatric services.
2. Treatment of ***mental health disorders***.

It may include day, early evening, evening, night care, or a combination of these four.

Participating Pharmacy

Any pharmacy licensed to dispense prescription drugs that is contracted within the pharmacy organization (OptumRx).

Physician

A Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.), other than a ***close relative*** of the patient, who is practicing within the scope of his or her license.

Placed for Adoption

The date the ***annuitant*** assumes legal obligation for the total or partial financial support of a child during the adoption process.

Plan

The HOP Pre-65 Medical Plan.

Plan Sponsor

The ***Plan sponsor*** is responsible for the day-to-day functions and management of the HOP Pre-65 Medical Plan. The ***Plan sponsor*** is ***PSERS*** Board of Trustees.

Plan Year

January 1 through December 31.

Preferred Provider

A ***physician***, ***hospital*** or other health care provider who has an agreement in effect with the ***Preferred Provider Organization*** at the time services are rendered. ***Preferred providers*** agree to accept the ***negotiated rate*** as payment in full.

Preferred Provider Organization

An organization that selects and contracts with certain ***physicians***, ***hospitals*** and other health care providers to provide services, supplies and treatment to ***eligible individuals*** at a ***negotiated rate***.

Pregnancy

The physical state that results in childbirth or miscarriage.

Prior Plan

Any plan of group ***accident*** and health benefits provided by the ***Plan sponsor*** (or its predecessor) for a plan of group ***accident*** and health benefits which has been replaced by coverage under this ***Plan***.

Professional Provider

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

Audiologist

Certified Addictions Counselor (CAC)

Certified Clinical Nurse Specialist

Certified Community Health Nurse

Certified Enterostomal Therapy Nurse

Certified Psychiatric Mental Health Nurse

Certified Registered Nurse Anesthetist

Certified Registered Nurse Practitioner

Chiropractor

Clinical Laboratory

Clinical Licensed Social Worker (A.C.S.W., L.C.S.W., M.S.W., R.C.S.W., M.A., M.E.D.)

Dentist

Nurse (R.N., L.P.N., L.V.N.)

Nurse Midwife

Occupational Therapist

Optometrist

Osteopath

Physical Therapist

Physician

Podiatrist

Psychologist

Respiratory Therapist

Speech Therapist

PSERS

The Pennsylvania Public School Employees' Retirement System.

Qualified Prescriber

A ***physician***, ***dentist*** or other health care practitioner who may, in the legal scope of the license, prescribe drugs or medicines.

Reconstructive Surgery

Surgical repair of abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease.

Relevant Information

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

1. Relied on in making the benefit determination; or
2. That was submitted, considered or generated in the course of making a benefit determination, whether or not relied upon; or
3. That demonstrates compliance with the duties to make benefit decisions in accordance with plan documents and to make consistent decisions; or
4. That constitutes a statement of policy or guidance for the ***Plan*** concerning the denied treatment or benefit for the individual's diagnosis, even if not relied upon.

Room and Board

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

Semiprivate Rate

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

Skilled Nursing Facility

A ***facility*** provider approved by the ***Plan*** that is primarily engaged in providing skilled nursing and related services on an ***inpatient*** basis to patients requiring 24-hour skilled nursing services but not requiring ***confinement*** in an acute care ***hospital***. Such care is rendered by or under the supervision of ***physicians***. A ***skilled nursing facility*** is not, other than incidentally, a place that provides:

1. Minimal care, ***custodial care***, ambulatory care, or part-time care services; or
2. Care or treatment of mental ***illness***, alcoholism, drug abuse or pulmonary tuberculosis.

Substance Use Disorder

A physiological or psychological dependency, or both, on a controlled substance and/or alcoholic beverages. It is characterized by a frequent or intense pattern of pathological use to the extent the user exhibits a loss of self-control over the amount and circumstances of use; develops symptoms of tolerance or physiological and/or psychological withdrawal if the use of the controlled substance or alcoholic beverage is reduced or discontinued; and the user's health is substantially impaired or endangered or his social or economic function is substantially disrupted. Diagnosis of these conditions will be determined based on standard DSM-V (Diagnostic and Statistical Manual of Mental Disorders) criteria.

Treatment Center

1. An institution that does not qualify as a ***hospital***, but does provide a program of effective medical and therapeutic treatment for ***substance use disorder***, and
2. Where coverage of such treatment is mandated by law, has been licensed and approved by the regulatory authority having responsibility for such licensing and approval under the law, or
3. Where coverage of such treatment is not mandated by law, meets all of the following requirements:
   a. It is established and operated in accordance with the applicable laws of the jurisdiction in which it is located.
   b. It provides a program of treatment approved by a ***physician***.
   c. It has or maintains a written, specific, and detailed regimen requiring full-time residence and full-time participation by the individual.
   d. It provides at least the following basic services:
      (i.) ***Room and board***
      (ii.) Evaluation and diagnosis
      (iii.) Counseling
      (iv.) Referral and orientation to specialized community resources.

HOP
HEALTH OPTIONS PROGRAM
WWW.HOPBENEFITS.COM®

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