PSERS HEALTH OPTIONS PROGRAM
2025 CHANGE FORM

HOP Administration Unit
P.O. Box 1764 • Lancaster, PA 17608-1764
Phone: 1-800-773-7725 • Fax: 1-877-411-4921 •TTY Phone: 1-800-498-5428
Representatives are available 8:00 a.m. to 8:00 p.m., Monday to Friday.
Email: HOPAdminUnithb@luminarehealth.com

HOP
HEALTH OPTIONS PROGRAM
WWW.HOPBENEFITS.COM®

IMPORTANT—PLEASE READ!

- **Only use this form if you are currently enrolled in the Health Options Program and want to change your coverage. If you do not want to change your coverage, DO NOT complete this form.**

- **YOU MUST** sign and date the Change Form where indicated in the **Statement of Authorization**.
- **YOU MUST be enrolled in *BOTH* Medicare Parts A *AND* B to enroll in the HOP or Value Medical Plan. YOU MUST** be enrolled in ***EITHER*** Medicare Part A ***OR*** B to enroll in a Medicare Rx Option **with no medical coverage**.
- A retiree and spouse or dependent **MUST** apply for the **same or comparable coverage**.
- **DO NOT** use this Change Form to enroll in a managed care organization.

I want to (check all that apply):

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

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

RETIREE INFORMATION

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

PLEASE CONTINUE TO NEXT PAGE

RETIREE INFORMATION

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

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

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

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

I want to get the following materials via email. Select one or more.

- ❍ Evidence of Coverage (EOC)
- ❍ Listing of retail network pharmacies

E-mail address:_____

Will you have other **medical** coverage (besides the Health Options Program and Medicare) when your Health Options Program coverage begins?

Retiree ❍ Yes ❍ No **Spouse**** ❍ Yes ❍ No

If yes, name of other insurance company:_____

If no, did you drop an existing policy to enroll in the Health Options Program? ❍ Yes ❍ No

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

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

PLEASE CONTINUE TO NEXT PAGE

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

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

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

I want to get the following materials via email. Select one or more.

❍ Evidence of Coverage (EOC)

❍ Listing of retail network pharmacies

E-mail address:_____

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

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

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

PLEASE CONTINUE TO NEXT PAGE

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

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

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

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

REASON FOR COVERAGE CHANGE REQUEST (CHECK ONE):

❍ I want to change my current election during the Option Selection Period (OSP; only early October through mid-November). Changes made during OSP will be effective January 1, 2025.
❍ Moved out of service area
❍ Death of retiree or dependent
❍ Loss of COBRA or State Continuation: start date _____ stop date _____
❍ Loss of group coverage (i.e., under your spouse's employer plan)
❍ Marriage or divorce
❍ Disabled dependent
❍ Adding dependent due to Qualifying Event
❍ Other: _____

Please indicate whether you need language assistance services for plan information in one of the languages listed on the Multi-Language Interpreter Services notice or in another accessible format.*

- Other language: _____
- Other accessible formats: ❍ Braille ❍ Audio CD ❍ Large print ❍ Data CD

If you need information in another accessible format, contact the HOP Administration Unit (see page 1).

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

PLEASE CONTINUE TO NEXT PAGE

OPTION CHANGES

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

My current Health Options Program coverage is...	I want to add or change my Health Options Program coverage to...
Check all that apply.	Check all that apply.
Medical Coverage	**Medical Coverage**
❍ HOP Medical	❍ HOP Medical
❍ Value Medical	❍ Value Medical
❍ Medicare Advantage plan	❍ No medical coverage
❍ No medical coverage	**Prescription Drug Coverage (CMS Contract: E3014)**
Prescription Drug Coverage	❍ Medicare Plus Rx
❍ Medicare Plus Rx	❍ Medicare Standard Rx
❍ Medicare Standard Rx	❍ No prescription drug coverage
❍ Medicare Advantage plan	**Dental and Vision Coverage**
❍ No prescription drug coverage	❍ Enroll in dental and vision coverage (must also enroll in HOP Medical or Value Medical)
Dental and Vision Coverage	❍ No dental and vision coverage
❍ Dental and vision coverage (must also enroll in HOP Medical or Value Medical)	**HOP Pre-65 Medical Plan**
❍ No dental and vision coverage	❍ With prescription drug coverage
HOP Pre-65 Medical Plan	❍ Without prescription drug coverage
❍ With prescription drug coverage	❍ No pre-65 medical coverage
❍ Without prescription drug coverage	If you want to enroll in a Health Options Program Medicare Advantage plan, contact the HOP Administration Unit.
❍ No pre-65 medical coverage	

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

Please do not submit your application for medical coverage until you are enrolled in BOTH Medicare Part A and Part B.

PLEASE CONTINUE TO NEXT PAGE

STATEMENT OF AUTHORIZATION

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

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

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

Signature

Name

Address

Phone # ( )	Relationship to Applicant

National Producer Number (Agents/Brokers only):

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

PLEASE CONTINUE TO NEXT PAGE

PLEASE READ THIS IMPORTANT INFORMATION

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

By completing this change form, I agree to the following about the Medicare Plus Rx and Medicare Standard Rx Options (the "plan"):

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

PLEASE CONTINUE TO NEXT PAGE

PLEASE READ THIS IMPORTANT INFORMATION *continued*

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

Release of Information

By joining this Medicare prescription drug plan, I acknowledge that the Health Options Program will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by federal law that authorizes the collection of this information. My response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

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

Form Approved
OMB# 0938-1421

Pennsylvania Public School Employees' Retirement System (PSERS)

Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-773-7725. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-773-7725. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-800-773-7725。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-800-773-7725。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-773-7725. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-773-7725. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-800-773-7725 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-773-7725. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Updated: July 2024
Form CMS-10802
(Expires 12/31/25)

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-773-7725 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-773-7725. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-800-773-7725. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-773-7725 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-773-7725. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-773-7725. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-773-7725. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-773-7725. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、1-800-773-7725 にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサービスです。