HOP NEWS

Stay Cyber Safe: Spot Scams, Protect Your Accounts

Scammers often try to trick us through calls, texts, and emails. Here's how to stay vigilant and secure.

- **Watch out for suspicious requests:** Scammers may call claiming to be from a fraud department or send messages about unpaid tolls or package deliveries. Remember that companies never ask for personal info via phone, email, or text—including seemingly mundane things like your zip code or the state you live in.
- **Verify before acting:** Don't click on links or attachments in unsolicited messages. Always look up contact information on your own, and call the company directly.
- **Consider a password manager:** Tools like **LastPass**, **1Password**, and **Dashlane** can securely store and autofill your passwords.
- **Check for red flags:** Look at text numbers, email addresses, URLs, and spelling carefully—scammers often use subtle tricks to deceive you. **Be extra cautious of urgent messages pushing you to take immediate action.**
- **Use strong passwords on your online accounts:** Make them hard to guess by mixing random words, numbers, and symbols. For example, turn a catchphrase into a secure password, like:
  "To be or not to be, that is the question" becomes "Tbon2bTitQ!"
- **Enable 2FA:** Two-factor authentication adds extra security by requiring a second verification, like a code sent to your phone or email.

What's DME, and How Is It Covered?

DME stands for durable medical equipment used at home to help people with daily activities, including:

- **Mobility aids:** Walkers, manual wheelchairs, scooters, crutches, and canes
- **Home hospital equipment:** Hospital beds, commode chairs, and patient lifts
- **Respiratory equipment:** Oxygen equipment, CPAP machines, and nebulizers
- **Diabetes supplies:** Blood sugar meters and test strips
- **Other medical devices:** Infusion pumps, traction equipment, and suction pumps

How DME Is Covered

For members who are enrolled in Medicare Parts A and B and the HOP Medical Plan or the Value Medical Plan, Medicare Part B covers DME if a doctor prescribes it for home use or use in an assisted living or long-term care facility.

Members usually pay a percentage of the Medicare-approved amount after paying your Part B deductible ($50 under the HOP Medical Plan and $257 under the Value Medical Plan). For example, after the deductible, under the HOP Medical Plan, members pay 10% up to $100 per item, and 20% under the Value Medical Plan.

You should know that Medicare pays for different kinds of DME in different ways. Depending on the type of equipment, you may need to rent or buy the equipment. For example, if you need a hospital bed at home, you can often rent to own the bed through your Medicare supplier.

Other items, such as back braces and support stockings that aren't necessarily considered "DME" but enhance quality of life, can be covered with a doctor's prescription for treating specific conditions.

DME must be purchased from a Medicare supplier

If you need DME items, make sure your supplier is enrolled in Medicare and accepts payment from Medicare to ensure coverage. To search for medical equipment and suppliers, go to **medicare.gov/medical-equipment-suppliers**.

What if You're in a Medicare Advantage Plan?

They are required by law to provide at least the same benefits as Original Medicare (Part A and Part B). This means that Medicare Advantage plans cover DME in the same way as Original Medicare. However, check with the plan for coverage details, including any network restrictions, costs, and prior authorization requirements.

Are You Almost 65?

If you're a PSERS retiree about to turn age 65, we take a number of steps to make sure you understand how the Health Options Program works.

We send you a package of information from four to nine months before your 65th birthday. We mail these twice a year—in the fall for people turning age 65 during the first six months of the following year and in the spring for people turning age 65 in the second half of the year. The package contains a description of the medical, prescription drug, and dental and vision benefits available under the Health Options Program—plus a personalized statement that has information specific to you, including your monthly premiums for all your coverage options.

The Health Options Program Advantage

Here are a few things that set the Health Options Program apart from other commercial plans:

- **Substantial premium subsidy.** If you meet the requirements for Premium Assistance, you can receive up to $100 a month reimbursement (see article to the right).
- **Age 65 discount.** If you enroll in the HOP Medical Plan at age 65, you will pay a discounted premium.
- **Choice.** You can choose between Medicare Supplement plans and Medicare Advantage plans, as well as Medicare prescription drug (Part D) plans and a dental and vision option.

Premium Assistance: Annual Verification of Payments

Premium Assistance is a reimbursement of a premium paid by an eligible retiree who is enrolled in an approved health plan. It is not subject to federal or state income tax. In order to preserve this tax-favored treatment, PSERS is required to obtain verification that retirees who receive Premium Assistance actually have out-of-pocket premium expenses from approved plans.

Each year, PSERS asks school employers to verify that Premium Assistance recipients have paid premiums each month that equal or exceed the amount of the Premium Assistance benefit. If the school employer is unable to do so, PSERS must collect unverified benefits from the retiree.

PSERS sends a letter to all retirees who have received overpayments. The letter requests that overpayments be returned and explains how they can be returned, including lump-sum or monthly deductions.

Don't know if you're eligible for Premium Assistance? Call 1-866-483-5509 for help.

Remember to Call PSERS

If you are receiving Premium Assistance and your out-of-pocket premium expense changes or stops, it is your responsibility to notify PSERS. You must also notify PSERS if you have terminated your health coverage with your former school employer and have not enrolled in the Health Options Program.

If you are unsure about your eligibility for Premium Assistance, call the Premium Assistance Unit at 1-866-483-5509, and ask a customer service representative to check your retirement benefit records.

What if You Need Skilled Nursing Care?

Henry was taken to the emergency room. After beginning treatment and improving, he lost strength. The hospital suggested a skilled nursing facility (SNF) for extra support with physical therapy and nursing care.

Henry has Original Medicare, which covers the first 100 days of an SNF stay if he makes progress toward his goal of walking unassisted with his walker. Medicare must approve the stay.

Getting Medicare Approval for a Skilled Nursing Facility Stay

- **You must be hospitalized for at least three days (as an inpatient) before Medicare will cover SNF care.** In Henry's case, his first two days in the hospital did not count toward Medicare's three-day rule, because Henry's status was "observational." His status changed to "inpatient" after a focused treatment plan was implemented.
- **The SNF stay must be for medically necessary skilled care, not just custodial care.** Needing physical and occupational therapy, wound care, medication administration, or monitoring of a serious condition are considered medically necessary. Custodial care includes help with bathing, dressing, and eating. Medicare will cover the custodial care assistance you receive in an SNF, provided you also require skilled medical intervention.
- **The skilled nursing care must be continuous and begin within 30 days of discharge and be related to your hospitalization.**
- **Your doctor must certify the need for skilled care.**
- Medicare coverage for skilled nursing care resets when you haven't received **any inpatient hospital care or skilled nursing care for 60 days in a row**.

How Medicare and HOP Medical and Value Plans Cover Skilled Nursing

Days in a Skilled Nursing Facility	Original Medicare Only	Original Medicare and the HOP Medical Plan	Original Medicare and the Value Medical Plan
Days 1–20	Medicare pays the full amount	Member pays $0	Member pays $0
Days 21–100	Member pays $209.50 per day	Member pays $0	Member pays $50 per day
Days 100+	Member pays the full cost	Major medical benefits cover 80% of the allowable charge—member pays 20% of the allowable charge (after $250 deductible) with $1,000 annual out-of-pocket limit*	Member pays the full cost

** Up to lifetime maximum of 100 additional days (combination of skilled nursing facility and hospital days cannot exceed 365).*

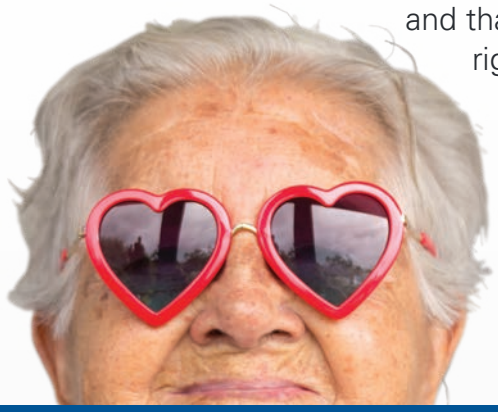
Once the Member reaches 100 days (and Medicare stops paying benefits), the Health Care Management organization will make an independent assessment of their need to remain in the skilled nursing facility.

Important! If you are in a Medicare Advantage plan, check with your plan on the details of your skilled nursing facility coverage.

The Results Are In: Members Continue to Love HOP

Thank you to the almost 5,500 members who responded to last fall's survey in the materials our members received for the Option Selection Period. The results are in and were similar to past years:

- 94% rated the materials as 7 or higher on a scale of 1 (not satisfied) to 10 (very satisfied).
- 90% said they received the right amount of information—not too much or too little—and that they had the right number of coverage options for medical, prescription drug, dental, and vision coverage.



For the question "Why do you choose the Health Options Program?," the overwhelming majority of respondents answered that it is because of the Health Option Program's reputation for quality.

Here's what else members are saying about the Health Options Program:

- *"Great job as always. Sure glad I have HOP health insurance, the BEST out there for retired educators."*
- *"Have been with HOP for many years; have studied many other health insurance policies, and I am convinced that the HOP is the best for me. Thanks for help always."*
- *"Best available—easy to contact reps. Can't beat it."*

Summer Information Sessions and Webinars

Individual Consultations

If you want to learn more about the Health Options Program, you can schedule a 30-minute telephone appointment (not a group meeting), by calling the HOP Administration Unit at 1-800-773-7725, and let the representative know that you want to schedule an individual telephone consultation.

Online Webinars

You can also attend a webinar in July or August. The schedule and registration links are posted to the **HOPbenefits.com > Eligibility and Enrolling > Information Sessions**. Or you can call the HOP Administration Unit to register. A recording will be available if you are not able to make it to a live event.

HOP
HEALTH OPTIONS PROGRAM
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Benefits Questions, ANSWERED

Have a Question?

If You Have a Question About	Please Call	Or Go Online
Enrollment in the Health Options Program or the Health Options Program in general	**HOP Administration Unit** **1-800-PSERS25 (1-800-773-7725)** TTY: **1-800-498-5428** From outside the U.S.: **+1 717-305-7388** 8:00 a.m. to 8:00 p.m. ET, weekdays	**HOPbenefits.com**
Premium Assistance	**Premium Assistance Office** **1-866-483-5509** 8:00 a.m. to 8:00 p.m. ET, weekdays	
Retirement	**PSERS** **1-888-PSERS4U (1-888-773-7748)** 8:00 a.m. to 5:00 p.m. ET, weekdays	**psers.pa.gov**
Medicare	**Medicare** **1-800-MEDICARE (1-800-633-4227)**	**medicare.gov**