

Pennsylvania Public School
Employees' Retirement System (PSERS)

Health Options Program

THE HOP MEDICAL PLAN

Summary Plan Description



For Your Reference

This Summary Plan Description (SPD) describes the HOP Medical Plan in clear, easy-to-understand language. However, since certain medical terms in this SPD may be unfamiliar to you or have special meanings, we have included a **Glossary** that begins on page 44, to help you better understand how the benefits and services under your health plan work. Any words that are included in the Glossary appear throughout this document in ***bold italics***.

Important Note

The medical coverage and services described in this SPD are provided by private health care insurers and providers. Neither the Public School Employees' Retirement System (PSERS) nor the Commonwealth of Pennsylvania is an insurer. In no event shall PSERS, the Health Options Program, or the Commonwealth of Pennsylvania be responsible for any act or omission of any insurance company, third party administrator, health care provider, or other third party that performs services as part of the Health Options Program.

The Retirement Board reserves the right to determine eligibility criteria, time and options to be made available within the Health Options Program, and under what circumstances.

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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 the **Value Medical Plan**, which are available to all **Medicare**-eligible members, regardless of where they live. For more information

about the **Value Medical Plan**, see the separate **Value Medical Plan Summary Plan Description**. In addition, depending on where you live, your options may include one or more Medicare Advantage plans. These plans are provided to members of the Health Options Program by insurance companies such as Highmark and Aetna.

- **If you are NOT eligible for Medicare**, your options include the HOP Pre-65 Medical Plan, which is available to all non-**Medicare**-eligible members, regardless of where they live. In addition, depending on where you live, your options may include one or more managed care plans. These plans are provided to members of the Health Options Program by insurance companies such as Highmark and Aetna.

THE HEALTH OPTIONS PROGRAM

Options for Medicare-Eligible Members

- 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.

- **If you are Medicare-eligible** and enroll in the HOP Medical Plan, you can also enroll in one of two **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 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., 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 website at www.HOPbenefits.com or call the HOP Administration Unit at 1-800-773-7725.

For More Information about Other Options

This booklet describes only the **HOP Medical Plan** (for **Medicare**-eligible members). Separate booklets are available for other plans offered under the Health Options Program, including the Value Medical Plan, the HOP Pre-65 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.

INTRODUCTION TO THE HOP MEDICAL PLAN

The HOP Medical Plan is one of several options offered under the Health Options Program for Medicare-eligible **annuitants**, Medicare-eligible spouses of **annuitants**, Medicare-eligible survivor **annuitants**, and their Medicare-eligible **dependents**. Unlike the other options available under the Health Options Program, the HOP Medical Plan is a **Medicare Supplement Plan**, which means it pays for only things that Original **Medicare** does not pay.

The HOP Medical Plan differs from other **Medicare** Supplement Plan policies (also known as Medigap plans) because it is a *group* plan—not an individual policy. Individual **Medicare** Supplement Plan policies must conform to government standards and provide particular levels of benefits. As a group plan, the HOP Medical Plan can provide benefits not available through standard individual policies.

The HOP Medical Plan provides two types of coverage:

- **Basic Supplemental Benefits paid when Medicare** does not pay 100% of the cost of a **Medicare**-covered expense. Details about Basic Supplemental Benefits begin on page 7.
- **Major Medical Benefits** paid for certain services that are either not covered by **Medicare** or **incurred** after **Medicare** benefits are exhausted. Details about Major Medical Benefits begin on page 10.

ELIGIBILITY AND ENROLLMENT

Who Is Eligible

PSERS Medicare-eligible **annuitants**, Medicare-eligible survivor **annuitants**, and their Medicare-eligible **dependents** are eligible to participate in the HOP Medical Plan. Eligible **dependents** include:

- the **annuitant's** spouse
- the **annuitant's** unmarried children under 19 years of age, including:
 - natural children
 - stepchildren
 - legally adopted children and children legally **placed for adoption**. (Such child is eligible from the date he or she is **placed for adoption**.)
- the **annuitant's** unmarried children age 19 to 23 who are enrolled as **full-time students** in an accredited college or university or in a technical or specialized school and who are not regularly employed by one or more employers on a full-time basis, exclusive of scheduled vacation periods. It is the **annuitant's** responsibility to provide the claims processor with proof of **full-time student** status each semester. The **annuitant** must notify the HOP Administration Unit when the **dependent** is no longer a **full-time student**.
- a disabled child over age 19 who is unmarried, incapable of self-sustaining employment, and **dependent** upon the **annuitant** for support due to a mental and/or physical disability that occurred prior to age 17. Proof of incapacitation must be provided within 31 days of the child's

loss of eligibility and thereafter as requested by **PSERS** or the claims processor, but not more than once every two years. Eligibility may not be continued beyond the earliest of the following:

- cessation of the mental and/or physical disability
- failure to furnish any required proof of mental and/or physical disability or to submit to any required examination.

Every eligible **annuitant** may enroll their eligible **dependents**. However, if both spouses are **annuitants**, neither can be covered as both an **annuitant** and a **dependent**. Eligible children may be enrolled as **dependents** of one spouse, but not both.

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

When You Become Eligible

An eligible person may enroll in the HOP Medical Plan when he or she experiences one of the following **Qualifying Events**:

- You retire or lose health care coverage under your school employer's health plan. (Coverage under your school employer's health plan includes any COBRA continuation of coverage you may elect under that school employer's plan.)

- You or your spouse involuntarily loses health care coverage under a non-school employer's health plan. (Coverage under a non-school employer's health plan includes any COBRA continuation of coverage you may elect under that non-school employer's health plan.)
- You or your spouse reaches age 65 or becomes eligible for **Medicare**.
- There is a change in your family status (including, but not limited to, divorce, your spouse's death, the addition of a **dependent** through birth, adoption, or marriage, or a **dependent** loses eligibility). The death of a retiree is not a Qualifying Event unless the spouse or dependent will receive a pension from PSERS following the retiree's death.
- You become eligible for Premium Assistance due to a change in legislation.
- A plan approved for Premium Assistance terminates or you move out of an approved plan's service area.

Qualifying Events apply to a **PSERS annuitant**, a survivor **annuitant**, or the spouse or **dependent** of an **annuitant** independently. For example, if the spouse of an **annuitant** turns age 65 and becomes eligible for **Medicare**, he or she may enroll in the HOP Medical Plan regardless of whether the **annuitant** is enrolled. In addition, if one member of the **annuitant's** family has a Qualifying Event, all members may enroll.

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

Your Deadline for Enrolling

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

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

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

How to Enroll

To enroll, a **PSERS** Health Options Program Application must be submitted by the required deadline.

When Coverage Begins

Coverage generally begins the first of the month following the month the Application is received and all eligibility requirements are met, but not before the **effective date of coverage** indicated on the Application.

Coverage for New Dependents

If you acquire a new **dependent** (by birth, marriage, adoption or placement for adoption) after you are enrolled in the Health Options Program, coverage for that **dependent** will begin on or after the date of birth, marriage, adoption or placement for adoption, provided required contributions are received and the **dependent** is enrolled in the Health Options Program within a certain number of days of the Qualifying Event.

When You Can Change Your Health Option

After you enroll in the Health Options Program, you can change your health option to another option for which you are eligible during the Option Selection Period each year. You can also change your option if you experience a Qualifying Event.

- An Option Selection Period takes place each fall, generally from early October to mid-November. During that time, you can change from one option or plan to another for which you are eligible, without a Qualifying Event. You will be notified each year about your choices. If you change your option or plan, your new coverage will be effective as of January 1 following the Option Selection Period. If you take no action during the Option Selection Period, your coverage will continue with any changes in premiums and/or benefits effective January 1. If a plan offered through the Health Options Program is discontinued, you will be notified and required to change to another eligible option.
- If you experience a Qualifying Event (see the list that begins on page 4), you become eligible to change your option or plan outside of the Option Selection Period, provided you make the change within a specified time frame following the Qualifying Event. If one member of an **annuitant's** family has a Qualifying Event, all enrolled members may change plans or options. If such an event occurs, call the HOP Administration Unit at 1-800-773-7725 for details.

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

When Coverage Ends

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

- the date **PSERS** terminates the HOP Medical Plan and offers no other group health plan
- the end of the calendar month in which the **annuitant** ceases to meet the eligibility requirements of the Health Options Program
- the end of the payment period in which the **annuitant** ceases to make any required premium payments.

Coverage will terminate for a **dependent** on the earliest of the following dates:

- the date **PSERS** terminates the HOP Medical Plan and offers no other group health plan
- the end of the calendar month in which such person ceases to meet the eligibility requirements of the Health Options Program
- the end of the payment period in which the **annuitant** ceases to make any required premium payments on the **dependent's** behalf
- the end of the month in which a **dependent** age 19 or older is no longer a **full-time student**
- the end of the month in which a **dependent** marries
- the end of the calendar year in which a **full-time student** reaches age 23
- the date the **dependent** becomes a full-time, active member of the armed forces of any country
- the date the Health Options Program discontinues **dependent** coverage for any and all **dependents**.

BASIC SUPPLEMENTAL BENEFITS

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

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

If a service is covered by **Medicare**, amounts not paid by **Medicare** are then considered for payment

by the HOP Medical Plan under applicable terms for Basic Supplemental Benefits. Generally, these amounts are your deductible (the amount you must pay each year before **Medicare** pays any benefits) and **coinsurance** (your portion of the cost when **Medicare** does not pay 100%). Basic Supplemental Benefits supplement both **Medicare** Part A (hospital) and **Medicare** Part B (medical) coverage. For more information about amounts paid by **Medicare**, go online to www.medicare.gov or call 1-800-MEDICARE (1-800-633-4227) and request a copy of *Medicare & You*.

Summary Chart

The following illustrates the payments you would be required to make for select covered services after both **Medicare** and Basic Supplemental Benefits have paid their share of the cost.

BASIC SUPPLEMENTAL BENEFITS	WHAT YOU PAY
Annual Deductible	\$50 for Medicare Part B services
Doctor or Physician Visits	\$10/visit (PCP); \$20/visit (specialist)
Outpatient Surgery	\$0
Urgent Care Facility	\$15/visit
Emergency Room	\$40 (waived if admitted)
Hospitalization	\$0
Diagnostic Testing	\$0 (X-ray and laboratory) \$25 (imaging – e.g., MRI and CT scans)
Outpatient Therapy	\$0
Durable Medical Equipment	10% up to \$100 per item
Outpatient Mental Health	\$10/office visit; \$0 other services
Inpatient Mental Health	\$0
Physical Exams	Not covered (unless approved by Medicare)
Ob/gyn Exams	\$10/exam
Mammograms	\$0

Basic Supplemental Benefits may pay all or a portion of the amount not paid by Medicare for a Medicare-covered expense.

How Basic Supplemental Benefits Supplement Medicare Part A (Hospital)

With Original **Medicare** alone, you are required to pay deductibles, **copays**, and/or **coinsurance** for most covered services.

For example, if you are admitted to a **hospital**, you pay a first-day deductible (\$1,676 in 2025) and then **Medicare** pays all **Medicare**-approved expenses for the first 60 days of each benefit period. After 60 days, you pay **coinsurance**. In 2025, your **coinsurance** is \$419/day for days 61-90 and \$838/day for days 91-150 (known as your “lifetime reserve days”). Then you pay 100% of the cost.

If you are enrolled in the HOP Medical Plan, Basic Supplemental Benefits pay the Part A deductible and your **coinsurance** for all **Medicare**-approved expenses after the first 60 days until you use up all days covered by **Medicare**, including your lifetime reserve days. After that, you may be eligible for additional **hospital** benefits under the HOP Medical Plan’s Major Medical Benefits (see page 10).

As another example, if **Medicare** approves your admission to a **skilled nursing facility**, Original **Medicare** pays the full cost for the first 20 days of each benefit period. You pay a portion of the cost (**coinsurance**) for days 21-100 (\$209.50/day in 2025) and all costs after 100 days. If you are enrolled in the HOP Medical Plan, Basic Supplemental Benefits pay your **Medicare coinsurance** for days 21-100. Once you have used the 100 days covered by **Medicare**,

additional **skilled nursing facility** services may be covered under the HOP Medical Plan’s Major Medical Benefits (see page 10).

How Basic Supplemental Benefits Supplement Medicare Part B (Medical)

With Original **Medicare** alone, you must meet the Part B deductible each year before **Medicare** will pay its share of the cost for certain **covered expenses**. (In 2025, the annual deductible is \$257.) After you meet the deductible, you typically pay 20% of the **Medicare**-approved amount for a covered service, assuming your doctor or other health care provider accepts assignment. (Assignment means the provider has agreed to be paid directly by **Medicare**, to accept the payment amount approved by **Medicare**, and not to bill you for any amount that exceeds the **Medicare** deductible and **coinsurance**.)

If you are enrolled in the HOP Medical Plan, you must pay the first \$50 of the Medicare Part B deductible (the Plan will pay the balance), and your 20% of the **Medicare**-approved amount for many covered services. There are fixed dollar **copays** for doctor office visits, emergency room visits, and other services as shown in the chart on page 7. However, no payment will be made for charges not allowed by **Medicare** Part B, including but not limited to charges from a provider not participating in **Medicare**.

For **outpatient** mental health care (such as counseling or psychotherapy) not conducted in an office setting, in 2025, **Medicare** will pay 80% and you would pay 0% after Basic Supplemental Benefits. Please note, if you receive **outpatient** mental health services and your provider codes your session as an office visit, you will be subject to a \$10/visit **copay**.

Part B Covered Services and Supplies

Individuals covered under the HOP Medical Plan are entitled to supplemental payments under Basic Supplemental Benefits for all services and supplies paid by **Medicare** Part B, which may include:

1. acupuncture—up to 12 acupuncture visits are covered in a 90-day period for chronic low back pain. An additional 8 sessions are covered if you show improvement. If your doctor decides your chronic low back pain isn't improving or is getting worse, additional treatments will not be covered. You can get a maximum of 20 acupuncture treatments in a 12-month period. Acupuncture (including dry needling) for any condition other than chronic low back pain is not covered.
2. ambulance services—ground ambulance transportation to a **hospital** or **skilled nursing facility**
3. **ambulatory surgical** centers for approved surgical procedures
4. breast cancer screening—once every 12 months
5. cardiac rehabilitation
6. chemotherapy in a doctor's office or **hospital outpatient** setting for people with cancer
7. colorectal cancer screening
8. diabetes screening, self-management screening, and supplies not covered by **Medicare** Part D
9. doctor and other health care provider services
10. **durable medical equipment**—such as oxygen equipment, wheelchairs, etc. from a **Medicare**-approved supplier
11. emergency department services
12. kidney dialysis services and supplies
13. laboratory services
14. mental health care (**outpatient**)
15. **outpatient** medical and surgical services and supplies, including a visit to an urgent care **facility**
16. physical, occupational, and speech therapy
17. prosthetic/orthotic items such as braces, artificial limbs, and prosthetic devices
18. second surgical opinions
19. surgical services
20. transplants and immunosuppressive drugs
21. yearly "wellness" visit

What Is Not Covered under Basic Supplemental Benefits

In addition to General Exclusions (page 23), exclusions under the Basic Supplemental Benefits include but are not limited to:

1. blood or blood plasma in excess of three pints
2. home health care
3. medical expenses once **Medicare** benefits are exhausted, for example hospital stays beyond the lifetime reserve
4. medical expenses not covered by **Medicare**, which may include services from a **facility** or provider opting out of **Medicare**.

These medical expenses may be covered under the HOP Medical Plan's Major Medical Benefits.

MAJOR MEDICAL BENEFITS

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

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

If **Medicare** rejects your claim, Major Medical Benefits may cover **professional providers' allowable charges** for specific **medically necessary** hospitalization and medical benefits that are:

- not covered by **Medicare** and Basic Supplemental Benefits, or
- covered by **Medicare** and Basic Supplemental Benefits, but **Medicare** limits have been reached.

If **Medicare** determines that a service or product is not **medically necessary**, it will not be covered under Major Medical Benefits.

Major Medical Benefits may cover a service that is either not covered by Medicare or that is covered by Medicare but not paid because Medicare limits have been reached.

When you submit a claim that has been rejected for payment by **Medicare**, the HOP Administration Unit adjudicates the claim to determine:

- whether the service is covered under Major Medical Benefits, and if so,
- the amount eligible for payment (reimbursement).

This includes claims that are rejected by **Medicare** because you have already received **Medicare's maximum benefit**. For example, **Medicare** limits benefits for care in a **skilled nursing facility** to 100 days. Once you reach 100 days (and **Medicare** stops paying benefits), the **Health Care Management Organization** will make an independent assessment of your need to remain in the **skilled nursing facility**. Major Medical benefits may be approved or, if it is determined that the services in question are for **custodial care** (which is not covered by the HOP Medical Plan), no Major Medical Benefits will be paid.

Obtaining Certifications

Certain services require that you obtain advance certification from the **Health Care Management Organization**. In addition, if a service is certified for a specific period and, at the end of the period, an extension is required, you must request a certification of the extension. If the **Health Care Management Organization** determines that continued **confinement** is no longer **medically necessary** and/or is for **custodial care**, additional days will not be certified.

When you request a certification, the **Health Care Management Organization** will evaluate whether proposed services, supplies, or treatments are **medically necessary** and appropriate for payment under the terms and conditions of the HOP Medical Plan. However, certification of **medical necessity** and appropriateness by the **Health Care Management Organization** does not establish eligibility under the HOP Medical Plan or guarantee benefits.

Certain services require that you obtain advance certification from the Health Care Management Organization. Call 1-800-480-6658 to request a certification.

Certification by the **Health Care Management Organization** is required for the following Major Medical Benefits:

- home skilled nursing care
- acute **inpatient hospital** admissions or continued stays. Note: The Plan may NOT restrict benefits for a hospital stay in connection with childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section
- **skilled nursing facility** admissions or continued stays

The **Health Care Management Organization** can be reached by calling the number listed for authorization on the back of your HOP Medical Plan ID card (1-800-480-6658).

When you call for certification, be prepared to provide all of the following information:

- **annuitant's** name, address, phone number, and the ID number shown on the front of the HOP Medical Plan ID card
- the patient's name, address, phone number (if not the **annuitant**)
- admitting **physician's** name and phone number
- name of **facility** or **home health care agency**
- date of admission or proposed date of admission
- condition for which patient is being admitted.

Time Frames for Initial Certifications

For non-urgent care, you or your authorized representative should call the **Health Care Management Organization** at least 15 calendar days prior to initiation of services or continuation of services after **Medicare** benefits are exhausted. **For urgent care**, you or your authorized representative may call the **Health Care Management Organization** within 48 hours or the next business day, if later, after the initiation of services.

If no additional information is required, the determination of coverage will generally be completed within a reasonable period of time, but no later than 15 calendar days from receipt of the request.

In the event the HOP Medical Plan receives a communication that fails to follow the certification procedure described above but communicates at least your name, a specific medical condition or symptom, and a specific treatment, service, or product for which prior approval is requested, you (or your authorized representative) will be notified orally (and in writing, if requested) within five calendar days of the failure to follow the proper procedure.

If the **Health Care Management Organization** needs additional time to make a decision due to circumstances beyond its control, you will be notified within the 15 calendar days of the circumstances and the date by which the **Health Care Management Organization** expects to render a decision. If the circumstances include a failure by you to submit necessary information, the notice will specifically describe the needed information. You will have 45 calendar days to provide the information requested, and the **Health Care Management Organization** will complete its determination of the claim for certification no later than 15 calendar days after receiving the requested information. Failure to respond in a timely and complete manner will result in a denial of the requested certification.

Time Frames for Certification Extensions

If you request an extension of a previously approved hospitalization, **skilled nursing facility** stay, or ongoing course of treatment, and the request involves **non-urgent care**, the extension request will be processed within 15 calendar days after the request is received.

If the **inpatient** admission or ongoing course of treatment involves **urgent care** and the request is received **at least 24 hours** before the scheduled end of a hospitalization or course of treatment, the request will be ruled upon and you will be notified as soon as possible but no later than 24 hours after the request is received.

If the **inpatient** admission or ongoing course of treatment involves **urgent care** and the request is received **less than 24 hours** before the scheduled end of a hospitalization or course of treatment, the request will be ruled upon and you will be notified no later than 72 hours after the request is received.

If a Certification Changes

If the **Health Care Management Organization** determines that the **hospital** or **skilled nursing facility** 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, the HOP Administration Unit will:

- notify you of the proposed change, and
- allow you 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 a Certification Is Denied

If your request for a certification or certification extension is denied in whole or in part, the HOP Administration Unit will provide you with a written Notice of Certification Denial within the time frames indicated above. The Notice of Certification Denial will include an explanation of the denial, including:

- the specific reason(s) for the denial
- reference to the HOP Medical Plan provisions on which the denial is based
- if the denial is due to a lack of information necessary for certification, a description of any additional material or information needed and an explanation of why such material or information is necessary
- a description of the HOP Medical Plan claim review procedure and applicable time limits
- if the denial relies upon an internal rule, guideline, protocol or other similar criterion, either a copy of that criterion or a statement that such criterion was relied upon and will be supplied free of charge, upon request

- if denial was based on **custodial care, medical necessity, experimental/investigational** treatment, or similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the terms of the HOP Medical Plan to your medical circumstances, or a statement that such explanation will be supplied free of charge, upon request
- a statement that you have a right to appeal.

Appealing a Denied Certification

For information about the process for appealing a denied certification, see “Appealing a Denied Certification” on page 28.

Case Management

If your 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 Medical Plan when it is reasonable to expect a cost-effective result without sacrificing 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:

- are not **covered expenses** under the HOP Medical Plan, or
- are **covered expenses** under the HOP Medical Plan but on a basis that differs from the alternative recommended by the **Health Care Management Organization**.

The recommended alternatives will be considered **covered expenses** under Major Medical Benefits provided the expenses can be shown to be viable and **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 set any precedent or create any future liability with respect to you or any other **covered individual**.

Elder Care Program

Health Care Management Organization

Registered Nurse (RN) case managers can assist patients in obtaining **medically necessary** home skilled nursing care, a **skilled nursing facility** admission, or home intravenous infusion therapy if it is covered under the HOP Medical Plan but not covered or covered with limitations under **Medicare**. Each RN case manager is an experienced **nurse** trained to handle these special cases by helping both the patient and family members coordinate home skilled nursing care, **skilled nursing facility** care, and home intravenous infusion services. If you need assistance with this type of care, you or your doctor can call the toll-free number on the back of your medical ID card (1-800-480-6658). When you call, a representative from the **Health Care Management Organization** will answer any questions you may have about your benefits and refer you to an RN Case Manager for certification. Keep in mind, these services are available only when they are **medically necessary** and to the extent they are covered under the HOP Medical Plan.

If your care requires certification, a Registered Nurse can help you apply for certification. Call the Health Care Management Organization at 1-800-480-6658.

How Major Medical Benefits Are Paid

Unless stated otherwise, all expenses covered under Major Medical Benefits are subject to specific provisions, including but not limited to an annual deductible, **coinsurance** and **maximum benefits**. Any portion of an expense you incur for services, supplies, or treatment that is greater than the **allowable charge** will not be covered.

Annual Deductible

You must meet an annual deductible each calendar year for most **covered expenses** before any Major Medical Benefits are paid.

- The individual deductible is the amount that each **covered individual** must pay each calendar year before Major Medical Benefits pay applicable benefits.
- When two covered members of the same family each meet their individual deductible during a calendar year, the family deductible is satisfied for that calendar year for all covered family members. No further deductible will be required from any covered family member for the rest of the calendar year.
- Amounts **incurred** during October, November, and December and applied toward the individual deductible of any **covered individual** will also apply to that individual's deductible in the next calendar year.

Coinsurance

You pay a percentage of the cost of a **covered expense**, called your **coinsurance**, after you meet the annual deductible (unless no deductible is required). However, if you use a provider that charges more than the **allowable charge** (as determined by the HOP Administration Unit), you will be responsible for 100% of the amount that exceeds the **allowable charge**, in addition to the **coinsurance** amount.

Annual Out-of-Pocket Maximum

You pay **coinsurance** each calendar year until the amount you have paid, including the deductible, reaches the annual out-of-pocket maximum. After that, Major Medical Benefits pay 100% of **covered expenses** for the rest of the calendar year (or until the **lifetime maximum** paid by the **Plan** is reached). When two covered members of the same family each reach the annual out-of-pocket maximum in a calendar year, Major Medical Benefits pay 100% of **covered expenses** for all covered family members for the rest of the calendar year.

The following items do not count toward the annual out-of-pocket maximum. You will be responsible for these expenses, even if the out-of-pocket maximum has been met:

- services, supplies, and treatments not covered by Major Medical Benefits
- your **copays** under Basic Supplemental Benefits
- amounts in excess of the **allowable charge**
- services, supplies, and treatments for **mental health disorders**
- services, supplies, and treatments for **outpatient substance use disorder**.

Summary Chart

This chart summarizes how much you pay for **covered expenses** in 2025 under Major Medical Benefits.

NOTE: Major Medical Benefits apply if a service is not covered by Medicare or if you exhaust your Basic Supplemental Benefits.

MAJOR MEDICAL BENEFITS	WHAT YOU PAY
Annual deductible	\$250
Annual out-of-pocket limit	\$1,000
Maximum lifetime benefit	\$1,000,000
	% of Allowable Charge
Inpatient hospital days exceeding Medicare’s lifetime reserve for hospital care	
<ul style="list-style-type: none"> Up to lifetime maximum of 365 additional days (combination of hospital and skilled nursing facility days cannot exceed 365) 	0% (not subject to deductible)
<ul style="list-style-type: none"> After 365 additional days 	20%
Emergency room services	20%
Physician’s services	
<ul style="list-style-type: none"> Medicare excess charges 	20%
<ul style="list-style-type: none"> Physician’s services from a provider opting out of Medicare 	80%
Services from other provider opting out of Medicare	80%
Diagnostic X-rays and lab	20%
Skilled nursing facility for days exceeding 100 Medicare-covered days	
<ul style="list-style-type: none"> Up to lifetime maximum of 100 additional days (combination of skilled nursing facility and hospital days cannot exceed 365) 	0% (not subject to deductible)
<ul style="list-style-type: none"> After 100 additional days 	20%
IV therapy	20%
Durable medical equipment	20%
Routine gynecological exam (limited to one visit per calendar year in years not covered by Medicare)	20%
Mental health services	
<ul style="list-style-type: none"> Inpatient (limited to 10 days per calendar year) 	20%
<ul style="list-style-type: none"> Outpatient (limited to 30 visits per calendar year, including visits for substance use disorder) 	20%
<ul style="list-style-type: none"> All other mental health outpatient services 	20%
Outpatient substance use disorder services (limited to 30 visits per calendar year, including visit for mental health; inpatient services not covered)	20%
Physical, speech, and occupational therapy services (limited to 26 visits per calendar year in addition to Medicare maximum for physical and occupational therapy combined)	20%
Ambulance services (limited to \$150 maximum benefit per trip for advanced life support by either surface or air ambulance—see page 17 for additional details)	20%
Chiropractor services (see page 18 for additional details)	20%
Other covered services	20%

Major Medical Benefits do not cover any portion of an expense that exceeds the allowable charge as determined by the HOP Administration Unit.

Benefit Limits

The **lifetime maximum** that will be paid by Major Medical Benefits for any **covered individual** is \$1,000,000. The lifetime benefit maximum applies to the entire time you are enrolled in the HOP Medical Plan. If you terminate coverage and reenroll at a later date, all benefits paid before and after the termination(s) (including benefits paid under predecessor plans, i.e., the High and Standard Options) will count toward the **lifetime maximum** paid by the **Plan**.

Certain conditions have **separate benefit limits** (see page 15). All benefits paid by Major Medical Benefits during all periods of coverage under the HOP Medical Plan will count toward these separate benefit limits. All separate benefit limits are part of, and not in addition to, the **lifetime maximum** paid by the **Plan**.

If your Medicare benefits are exhausted, Major Medical Benefits may pay up to \$1 million in additional benefits for covered services over the course of your lifetime.

Services and Supplies That May Be Covered When Medicare Part A (Hospital) Benefits Are Exhausted

The following services covered under **Medicare** Part A may be covered by Major Medical Benefits when **Medicare** Part A benefits are exhausted:

1. **inpatient room and board**, 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 **allowable charge**. A full private room rate is covered if the private room is necessary for isolation purposes and is not for the convenience of the individual. 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**, plus \$10 per day.
2. miscellaneous services, supplies, and treatments (excluding services still covered under **Medicare** Part B) including:
 - a. **admission fees** – admission fees and other fees assessed by the **hospital** for rendering services, supplies, and treatments
 - b. **anesthesia** – anesthesia, anesthesia supplies, and its administration by an employee of the **hospital**
 - c. **blood transfusions** – 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)
 - d. **operating/other rooms** – use of operating, treatment, or delivery rooms
 - e. **oxygen** – oxygen and other gas therapy and the administration thereof
 - f. **prescription drugs** – drugs and medicines (except drugs not used or consumed in the **hospital**)

- g. **surgical dressings** – medical and surgical dressings and supplies, casts, and splints
 - h. **therapy** – therapy services
 - i. **X-ray and lab** – X-ray and diagnostic laboratory procedures and services.
3. services of **facility** providers if such services would have been covered if performed in a **hospital**
4. **skilled nursing facility** – up to 100 days of **skilled nursing facility** benefits provided you are receiving skilled nursing care and/or therapy ordered by a **physician** and your condition can be reasonably 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 **skilled nursing facility** benefits.) The HOP Administration Unit and/or **Health Care Management Organization** will evaluate the **facility** services provided once **Medicare** benefits are exhausted to determine if **skilled nursing facility** benefits are payable under Major Medical Benefits. The HOP Administration Unit will not be bound by **Medicare's** determination that services are for **skilled nursing facility** care as opposed to **custodial care**.

Skilled nursing facility services, supplies, and treatments are **covered expenses** provided the **covered individual** is under a **physician's** continuous care and the **physician** certifies that the individual must have 24-hour-per-day nursing care and the patient's condition can reasonably be expected to improve. **Covered expenses** include:

- a. **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
- b. other services, supplies, and treatment ordered by a **physician** and furnished by the **skilled nursing facility** for **inpatient** medical care (excluding services still covered under **Medicare** Part B).

The HOP 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 facility** care. While the specific services of a **physician** or skilled **nurse** that are otherwise covered by the **Plan** may be covered while you are confined for **custodial care, room and board** charges are not. If a nursing **facility** does not differentiate between skilled and non-skilled care, all care will be deemed non-skilled. See page 51 for the definition of **skilled nursing facility**.

Other Services and Supplies That May Be Covered by Major Medical Benefits

The following services may also be covered by Major Medical Benefits:

1. **ambulance** – ambulance services provided by a licensed air or ground ambulance. **Covered expenses** include:
 - a. ambulance service for air or ground transportation from the place of **injury** or serious medical incident to the nearest **hospital** where treatment can be given.
 - b. ambulance service in a non-emergency situation only to transport the patient 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.

- c. emergency services provided by an advance life support unit or paramedic intercept, even though the unit does not provide transportation, subject to the **maximum benefit** shown on page 15
 - d. wheelchair and stretcher transportation when such required treatment is certified by the attending **physician** as **medically necessary**.
2. **chiropractic – 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.
 3. **dental services resulting from an injury** – dental services for the repair of the jaw, sound natural teeth or surrounding tissue, mouth, or face provided the repair is needed as the result of an **injury** occurring on or after the individual's **effective date of coverage**. Damage to the teeth as a result of chewing or biting is not 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.
 4. **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. 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 which meets the individual's medical needs. Repair or replacement of **durable medical equipment** due to normal use will be considered a **covered expense**.
 5. **education programs – medically necessary** patient education programs, including but not limited to ostomy care.
 6. **gynecological exam** – routine gynecological examinations and papanicolaou (Pap) smears, subject to the **maximum benefit** shown on page 15.
 7. **home IV therapy** – home IV therapy that enables you 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**.
 8. **inpatient mental health** – treatment, services, and supplies related to the **inpatient** treatment of **mental health disorders**, subject to the **coinsurance** and **maximum benefit** shown on page 15. **Covered expenses** include:
 - a. biofeedback
 - b. electroconvulsive therapy (electroshock treatment) or convulsive drug therapy, including anesthesia when administered concurrently with the treatment by the same **professional provider**
 - c. group psychotherapy
 - d. individual psychotherapy

- e. **inpatient hospital confinement**
 - f. **partial confinement** in a **hospital**
 - g. psychological testing.
9. **mastectomies** – mastectomies, in accordance with the federal law known as the Women’s Health and Cancer Rights Act of 1998. **Covered expenses** include eligible charges related to a **medically necessary** mastectomy. If an individual elects breast reconstruction in connection with such mastectomy, **covered expenses** will include:
- a. reconstruction of a surgically removed breast, and
 - b. 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.
10. **orthotics** – orthotic devices and appliances (rigid or semi-rigid supportive devices that restrict or eliminate motion for a weak or diseased body part), including initial purchase, fitting, and repair. Orthopedic shoes or corrective shoes, unless they are an integral part of a leg brace, and other supportive devices for the feet are not covered. Repair or replacement of orthotics due to normal use will be considered a **covered expense**.
11. **outpatient mental health – outpatient** treatment, services, and supplies related to the treatment of **mental health disorders**, subject to the **coinsurance** and **maximum benefit** shown on page 15.
12. **physician who does not accept assignments or has opted out of Medicare – Medicare physicians** who do not accept assignments (payments directly from **Medicare**) receive a reduced payment from **Medicare** and are allowed to bill excess charges to the patient. If you choose to use a **physician** who does not accept assignments, you will pay the percentage shown on page 15 for **Medicare’s** excess charges. **Physicians** who have opted out of **Medicare** and are not **Medicare**-participating **professional providers** receive no payments from **Medicare**. If you choose to use a **physician** who has opted out of **Medicare**, you will pay the percentage shown on page 15 plus any amount over the **allowable charge**. **Covered expenses** include:
- a. medical treatment, services, and supplies, including but not limited to office visits, **inpatient** visits, and home visits
 - b. 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** include the surgical allowance for each procedure. When two or more unrelated operations or procedures are performed at the same operative session, **covered expenses** include the surgical allowance for each procedure
 - c. surgical assistance provided by a **physician** if it is determined that the condition of the individual or the type of surgical procedure requires such assistance

- d. furnishing or administering anesthetics, other than local infiltration anesthesia, by other than the surgeon or the surgeon's assistant
 - e. consultations requested by the attending **physician** during a **hospital confinement**
 - f. radiologist or pathologist services for interpretation of X-rays and laboratory tests necessary for diagnosis and treatment
 - g. radiologist or pathologist services for diagnosis or treatment, including radiation therapy and chemotherapy
 - h. second surgical opinions regarding the **medical necessity** of surgery by a board-certified specialist in the treatment of the individual's **illness** or **injury** who is not affiliated in any way with the **physician** who will be performing the actual surgery. In the event of conflicting opinions, a third opinion may be obtained. The **Plan** will consider payment for a third opinion the same as a second surgical opinion
 - i. transplant services, supplies, and treatments for the recipient in connection with human-to-human organ and tissue transplant procedures, provided the recipient is covered under this **Plan**.
13. **prosthesis** – 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. Repair or replacement of a prosthesis that is **medically necessary** due to normal use or growth of a child will be considered a **covered expense**.
14. **special supplies** – **medically necessary** special 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. 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 which 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.
15. **therapy** – therapy services ordered by a **physician** to aid restoration of normal function lost due to **illness** or **injury**. **Covered expenses** include:
- a. **cardiac** – cardiac therapy
 - b. **dialysis** – dialysis therapy or treatment
 - c. **restorative physical, occupational, and speech** – the services of a **professional provider** for physical therapy, occupational therapy, or speech therapy up to the number of visits shown on page 15
 - d. **radiation and chemo** – radiation therapy, chemotherapy, and global fees for chemotherapy treatment from an approved licensed **facility** including self-administered drugs.
16. **transsexualism** – services, supplies or treatment for transsexualism, gender dysphoria or sexual reassignment or change, including medications, implants, hormone therapy, surgery, and medical or psychiatric treatment.

What Is Not Covered under Major Medical Benefits

In addition to General Exclusions (page 23), no benefit will be provided under Major Medical Benefits for:

1. **abortion** – services provided to an individual for an elective abortion.
2. **acupuncture** – acupuncture treatment.
Note: Acupuncture is covered under **Medicare Part B**, see page 9.
3. **birth control** – services, supplies, or devices, including birth control pills, regardless of whether such pills are to be used for contraceptive or medical reasons.
4. **chiropractic services** – 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.
5. **circumcisions** – routine neonatal circumcisions.
6. **comfort items** – services, supplies, or treatment that 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, and exercise equipment.
7. **corrective vision surgery** – 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.
8. **cosmetic services** – **cosmetic surgery** or procedure and all related services.
9. **custodial care** – **custodial care**, domiciliary care, or rest cures.
10. **dental care** – except as specifically stated on page 18, services, supplies, or treatments 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.
11. **drugs for outpatient use** – drugs dispensed by a pharmacy or a **physician** for **outpatient** use.
12. **educational or vocational services** – services, supplies, or treatments that are primarily educational in nature, except as specified on page 18; 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.
13. **gene therapy** – any charges for gene therapy, which typically involves replacing a gene that causes a medical problem with one that does not, adding genes to help the body fight or treat disease, or inactivating genes that cause medical problems.
14. **hearing exam** – an examination to determine hearing loss or the fitting, purchase, repair, or replacement of a hearing aid.
15. **hypnosis** – expenses related to hypnosis.
16. **infertility treatment** – 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).
17. **inpatient diagnostic tests – inpatient room and board** in connection with a **hospital confinement** primarily for diagnostic tests, unless it is determined by the **Health Care Management Organization** that **inpatient** care is **medically necessary**.

18. **Medicare or Basic Supplemental Benefits** – services, supplies, or treatment that are payable by **Medicare** Part A or Part B or Basic Supplemental Benefits.
 19. **non-Medicare facility charges** – charges **incurred** at an **inpatient facility** that has opted out of the **Medicare** Program.
 20. **non-Medicare hospice care charges** – **hospice** care that is not covered under **Medicare**, regardless of whether it is provided at home, in an **outpatient** setting, or in a **facility** setting.
 21. **non-Medicare provider charges** – charges **incurred** by a **physician** or other medical provider that has opted out of the **Medicare** Program except as specifically provided herein.
 22. **nonprescription drugs** – vitamins, cosmetic dietary aids, nutritional supplements, etc.
 23. **not medically necessary services and supplies** – services and products that are determined by **Medicare** to be not **medically necessary**.
 24. **obesity treatment** – the treatment of obesity, except for surgical treatment of morbid obesity.
 25. **orthopedic shoes** – orthopedic shoes (except when they are an integral part of a leg brace and the cost is included in the orthotist's charge).
 26. **reversal of sterilization** – services, supplies, or treatment for the reversal of sterilization procedures.
 27. **routine foot care** – except as **medically necessary** for the treatment of metabolic or peripheral-vascular **illness**, 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.
 28. **routine physical examinations** – routine or periodic physical examinations, except as specified herein.
 29. **routine vision exams/products** – routine vision examinations and eye refractions, orthoptics, eyeglasses, or contact lenses, except when new cataract lenses are needed because of a prescription change.
 30. **services not covered** – any services, supplies, or treatment not specifically listed as covered herein.
 31. **sexual dysfunction** – treatment or surgery for sexual dysfunction unless related to organic **illness**.
 32. **substance use disorder – inpatient** treatment of **substance use disorder** or treatment, services or supplies for **confinement** or **partial confinement** in a **hospital** related to the treatment of **substance use disorder**.
 33. **surgical facility** – charges **incurred** at an **ambulatory surgical facility**.
 34. **TMJ** – treatment of temporomandibular joint dysfunction (TMJ), or any other method to alter vertical dimension.
 35. **travel** – travel or accommodations, whether or not recommended by a **physician**, except as specifically provided herein.
 36. **well-baby** – any charges for well-baby care.
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- You can call the HOP Administration Unit (1-800-773-7725) if you have a question about whether a particular service is covered under Major Medical Benefits.**
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GENERAL EXCLUSIONS

The HOP Medical Plan will not provide benefits for certain items, regardless of **medical necessity** or recommendation of a **physician** or **professional provider**. Those items include but are not limited to:

1. **criminal activity** – charges in connection with any **illness** or **injury** resulting from or occurring during commission or attempted commission of a criminal battery or felony by the **covered individual**
2. **employment or self-employment** – 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
3. **experimental/investigational** – charges for services, supplies, or treatment that are considered **experimental/investigational**
4. **government hospital** – 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
5. **hygiene items** – charges for disposable, non-reusable, hygienic items. These include but are not limited to infant/adult diapers, disposable sheets and bags, disposable underpads, and common first aid supplies
6. **late claims** – claims not submitted within the HOP Medical Plan filing deadlines as specified in the “Filing Claims” section
7. **military service injury** – charges for an **injury** sustained or **illness** contracted while on active duty in military service, unless payment is legally required
8. **missed appointments** – charges for telephone consultations, completion of claim forms, charges associated with missed appointments
9. **motor vehicle insurance** – 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
10. **not licensed providers** – 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**
11. **not medically necessary services and supplies** – services and products that are determined by **Medicare** to be not **medically necessary**

12. **not required to pay** – 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
13. **prohibited by law** – to the extent that payment under the HOP Medical Plan is prohibited by any law of any jurisdiction in which the individual resides at the time the expense is **incurred**
14. **services provided by relative** – 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**
15. **third party liability** – 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” (page 35)
16. **war** – charges for services, treatment, or supplies for treatment of **illness** or **injury** that 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
17. **while not covered** – charges for services rendered and/or supplies received prior to the **effective date of coverage** or after the termination date of a person’s coverage
18. **workers’ compensation** – 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.

FILING CLAIMS

Claims for **Basic Supplemental Benefits** should be submitted initially to **Medicare**. In most cases, providers will submit their bills directly to **Medicare**. In their submission to **Medicare**, they should identify the HOP Medical Plan as your supplemental insurance. Claims will then be sent electronically to the HOP Administration Unit. If your provider does not submit a bill to Medicare, please contact the HOP Administration Unit for assistance.

Claims for Basic Supplemental Benefits should be submitted to Medicare. Claims for Major Medical Benefits should be sent to the HOP Administration Unit.

Claims for **Major Medical Benefits** do not go to **Medicare**. Instead, they are adjudicated by the HOP Administration Unit. You may ask your health care provider to submit claims for Major Medical Benefits directly to the HOP Administration Unit, or you may submit the bill yourself with a claim form. Either way, it is your responsibility to make sure the claim for benefits is filed.

A claim for Major Medical Benefits should be submitted to the HOP Administration Unit within 90 calendar days after the occurrence or commencement of any services covered by the HOP Medical Plan, or as soon thereafter as reasonably possible.

Failure to file a Major Medical Benefits claim within the 90 days shall not invalidate or reduce a claim for benefits if:

- it was not reasonably possible to file a claim within that time, and
- such claim was furnished as soon as possible, but not later than 12 months after the loss occurred or commenced, unless the claimant is legally incapacitated.

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.

You may name a family member or anyone you want to act as your authorized representative for purposes of submitting claims or making appeals to the HOP Medical Plan.

Where to Send Claims

All claims for Major Medical Benefits and any claims for Basic Supplemental Benefits that are not submitted to **Medicare** by your health care provider should be mailed to:

HOP Administration Unit
 P.O. Box 2921
 Clinton, IA 52733-2921

The date of receipt will be the date the claim is received by the HOP Administration Unit.

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

- patient's name
- patient's date of birth
- **annuitant's** name
- **annuitant's** address
- provider's name, address, and tax identification number
- **annuitant's** ID number shown on the front of the HOP Medical Plan ID card
- date of service
- diagnosis
- description of service and procedure number
- charge for service
- the nature of the **accident, injury, or illness** being treated.

Cash register receipts, credit card copies, labels from containers, and cancelled checks are not sufficient.

Any claims not submitted within 12 months from the date the services were rendered will be denied, and no benefits will be paid. Claims for Basic Supplemental Benefits that are paid initially by **Medicare** are not subject to this time limit.

After review of the claim, the HOP Administration Unit will provide an explanation of benefits (EOB) showing the calculation of the amount payable, the charges not payable, and the reason(s) why amounts were not paid.

You must submit a claim for Major Medical within 12 months after you incur a covered expense.

Foreign Claims

In the event you incur a covered expense in a foreign country, you will be responsible for the following before any benefits are paid:

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

How Claims Are Processed

The procedure for processing a claim depends on whether it is for a Basic Supplemental Benefit or a Major Medical Benefit.

For **Basic Supplemental Benefits, Medicare** determines coverage, benefit determination, **medical necessity**, payment amount, and payment timing. The HOP Administration Unit will pay Basic Supplemental Benefits only after **Medicare** adjudicates the claim.

Claims covered by **Major Medical Benefits** are adjudicated by the HOP Administration Unit, which determines coverage, benefit determination, **medical necessity**, experimental and investigational services, reasonable and necessary, payment amount, and payment timing. The HOP Administration Unit reviews coverage requests for medical services and supplies, hospitalizations, **skilled nursing facility inpatient** stays, and home health care to determine whether the proposed services, supplies, or treatments are covered by Major Medical Benefits. The HOP Medical Plan does not cover services that are not **medically necessary** or that are experimental, investigational, or **custodial care**.

The claims procedure for Basic Supplemental Benefits is not the same as the claims procedure for Major Medical Benefits.

APPEALS

Appealing a Claim

You may request a review of a denied claim for a service or product already received by making a written request to the HOP Administration Unit within 90 calendar days after receiving notification of the denial. The HOP Administration Unit will conduct an internal review of the original adjudication or determination of the claim and explanation of benefits (EOB). This review will examine the applicable plan provisions, the nature of the claim(s), and benefit determination and payments, if applicable. Errors, if any, will be corrected, appropriate payment adjustments rendered, and a revised EOB issued. If coverage is correct and the claims have been properly determined, the HOP Administration Unit will send you a written letter indicating that the claim has been properly adjudicated. This notice of benefit denial will contain an explanation of the denial, including a statement that the decision may be appealed to the **PSERS** Health Insurance Division within 60 calendar days of receipt of the letter.

If your claim for benefits or your request for a certification is denied, you have 90 calendar days to request a review of the decision.

Appealing a Denied Certification

If your request for an initial or extended certification is denied, you have the right to appeal the decision by making a written request to the HOP Administration Unit within 90 calendar days from receipt of notification of the denial and stating the reasons you think the certification should not have been denied.

The following describes the review process and your rights when appealing a denied certification:

1. You have the right to submit documents, information, and comments.
2. You have the right to access, free of charge, information relevant to your claim for benefits.
3. The review takes into account all information you submit, even if it was not considered in the initial benefit determination.
4. The review will not afford deference to the original denial.
5. The review will not be conducted by the individual who originally denied the claim or a subordinate to the individual who originally denied the claim.
6. If the original denial was, in whole or in part, based on medical judgment:
 - a. the HOP Administration Unit will consult with a **professional provider** who has appropriate training and experience in the field involving the medical judgment

- b. the **professional provider** utilized by the HOP Administration Unit will not be an individual who was consulted in connection with the original denial of the claim or a subordinate of any other **professional provider** who was consulted in connection with the original denial.
7. If requested, the HOP Administration Unit 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.
7. if the denial was based on **medical necessity, experimental/investigational** treatment, or similar exclusion or limit, the HOP Administration Unit will supply either an explanation of the scientific or clinical judgment, applying the terms of the HOP Medical Plan to your medical circumstances, or a statement that such explanation will be supplied free of charge upon request.

Notice of Appeal Decision

The HOP Administration Unit will provide you with a written notice about the decision on your appeal as soon as possible, but not later than 30 calendar days from receipt of the appeal. If the appeal is denied, the notice will contain an explanation of the decision, including:

1. the specific reasons for the denial
2. reference to specific HOP Medical Plan provisions on which the denial is based
3. a statement that you have the right to access, free of charge, information relevant to the claim for benefits
4. a statement that you have a right to appeal
5. a statement that you have the right to access, free of charge, information about the voluntary appeal process
6. if an internal rule, guideline, protocol, or other similar criterion was relied upon, the notice will contain either a copy of that criterion or a statement that such criterion was relied upon and will be supplied free of charge upon request

If your appeal is denied, you will receive details about why it was denied, and you will have the right to request a second review by the Health Care Management Organization.

Second Level Voluntary Appeals

If your appeal is denied, you may request a secondary level of appeal by the **Health Care Management Organization**. Your appeal will be reviewed by three **professional providers** who were not consulted in connection with the original denial of certification. If you request a secondary level of appeal, it will have no effect on your rights to any other benefits under the Plan. In addition, there are no fees or costs for the voluntary appeal process.

A determination will be made within 30 business days after receiving your request for a second level voluntary appeal, and you will be notified of the outcome verbally and in writing.

With respect to certification appeals, the HOP Medical Plan agrees to both of the following:

- 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.

- 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**.

Appealing to the PSERS Health Insurance Office

You may request a review of a claim or certification denied by the HOP Administration Unit by making a written request to the **PSERS** Health Insurance Office. If the **PSERS** Health Insurance Office upholds the decision of the HOP Administration Unit, the notification from the **PSERS** Health Insurance Office will explain the reasons for the decision and contain a statement that the decision may be appealed to the Executive Staff Review Committee (ESRC).

If you choose to proceed with an appeal to the ESRC, the ESRC will process the appeal in accordance with its procedures, relying on the findings and expertise of independent professionals. If the ESRC upholds the decision of the Health Insurance Office, the notification from the ESRC will explain the reasons for the denial and contain a statement that you or your authorized representative may request an Administrative Hearing conducted by a Commonwealth Hearing Examiner.

If you choose to proceed with an Administrative Hearing, the Hearing Examiner will provide a recommendation to the Board. You have the right to file exceptions to the Hearing Examiner's recommendation. The Board will make the final decision about your appeal, and you will be notified of the decision. If your appeal is denied by the Board, you have the right to bring the matter before the Commonwealth Court.

Note: Since claims for Basic Supplemental Benefits are processed by **Medicare** A or B, decisions by **Medicare** concerning eligibility and **covered expenses** are not subject to review by the Health Insurance Office or the ESRC. Similarly, required certifications and benefits under plans provided by insurance companies under contract with **PSERS** are also not subject to review by the Health Insurance Office or ESRC. Appeals or complaints concerning benefits, eligibility, or premiums under an insurance company plan should be directed to the insurance company.

COORDINATION OF BENEFITS

The Coordination of Benefits provision is intended to prevent duplication of benefits. It applies when an individual is enrolled in more than one health benefit plan. In such a case, one plan normally pays full benefits first and is referred to as the **primary plan**. The other health benefit plan, referred to as the **secondary plan**, pays reduced benefits. When coordination of benefits occurs, the total benefit paid by all plans will not exceed 100% of the **allowable charge** for a **covered expense**. In addition, any amounts paid by other plans will not count toward the out-of-pocket maximum or other benefit maximums under the HOP Medical Plan.

This provision applies in determining the benefits for an individual for each claim determination period for the **allowable charge** for a **covered expense**.

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

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

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

Coordination with Medicare

Because the HOP Medical Plan is a supplement to **Medicare** Part A and Part B, **Medicare** is primary and the HOP Medical Plan is secondary for any individual enrolled in both. If an individual chooses to use a **facility** that is not a **Medicare-participating facility**, the HOP Medical Plan will not pay for any charges disallowed by **Medicare** due to the use of such **facility**.

If an individual chooses to use a **professional provider** who is not a **Medicare-participating professional provider**, Basic Supplemental Benefits of the HOP Medical Plan will not pay for any charges disallowed by **Medicare** due to the use of such a **professional provider**. However, Major Medical Benefits of the HOP Medical Plan may pay benefits in accordance with Plan provisions.

Medicare pays benefits before the basic supplemental benefits of the HOP Medical Plan.

Coordination with Other Health Benefit Plans

For purposes of the Coordination of Benefits provision, “other health benefit plan” means any plan, policy, or coverage providing benefits or services for medical, dental, or vision care. Such plans may include, without limitation:

1. group insurance or any other arrangement for coverage for individuals in a group, whether on an insured or uninsured basis, including but not limited to **hospital** indemnity benefits and **hospital** reimbursement-type plans
2. a **hospital** or medical service organization on a group basis, group practice, and other group prepayment plan or on an individual basis having a provision similar in effect to this provision
3. a licensed Health Maintenance Organization (HMO)
4. any coverage for students that is sponsored by, or provided through, a school or other educational institution
5. any coverage under a government program and any coverage provided by any statute
6. any plan or policy funded in whole or in part by an employer or deductions made by an employer from a person’s compensation or retirement benefits
7. labor/management trusteed, union welfare, employer organization, or employee benefit organization plans.

The Coordination of Benefits provision applies whether or not a claim is filed under the other health benefit plan(s). If another plan provides

benefits in the form of services rather than cash, the reasonable value of the service rendered shall be deemed the benefit paid.

Which Plan Is Primary (Pays First)?

The HOP Medical Plan will make its claim payment according to the following order of benefit determination:

- If the other health benefit plan contains **no provision for coordination of benefits**, then it pays benefits before the HOP Medical Plan.
- **The plan that covers the claimant as a member** (or named insured) pays as though no other health benefit plan existed. Remaining **covered expenses** are paid under a plan that covers the claimant as a **dependent**.
- **For dependent children of parents not separated or divorced**, the plan covering the parent whose birthday (month and day) occurs earlier in the year pays first, and the plan covering the parent whose birthday falls later in the year pays second. If both parents have the same birthday, the plan that covered a parent longer pays first. A parent’s year of birth is not relevant in applying this rule.
- **For dependent children of separated or divorced parents**, the birthday rule does not apply; instead:
 - If a court decree has given one parent financial responsibility for the child’s health care, the plan of that parent pays first. The plan of the stepparent married to that parent, if any, pays second. The plan of the other natural parent pays third. The plan of the spouse of the other natural parent, if any, pays fourth.

- In the absence of such a court decree, the plan of the parent with custody pays first. The plan of the stepparent married to the parent with custody, if any, pays second. The plan of the parent without custody pays third. The plan of the spouse of the parent without custody, if any, pays fourth.
- A plan covering a person as an **active (not laid off or retired)** employee or as the **dependent** of an active employee pays first. A plan covering a person as a laid-off or retired employee or as the **dependent** of a laid-off or retired employee's **dependent** pays second.
- **If none of the above rules determine the order of benefits**, the plan covering a person longer pays first.
- If the primary plan has a restricted list of health care providers and the covered person chooses not to use a provider from the primary plan's restricted list, the HOP Medical Plan will not pay for any charges disallowed by the primary plan due to the use of such provider, if shown on the primary carrier's explanation of benefits.
- If the primary plan provides coverage through the services of an HMO and the covered person chooses not to use the HMO, the HOP Medical Plan will not pay for any charges disallowed by the primary plan due to failure to utilize the HMO, if shown on the primary carrier's explanation of benefits.
- The HOP Medical Plan will not pay for any charge that has been refused by another plan covering the covered person as a penalty assessed due to non-compliance with that plan's rules and regulations, if shown on the primary carrier's explanation of benefits.
- The benefits paid under the HOP Medical Plan may be reduced so that the sum of benefits paid by all plans does not exceed 100% of the **allowable charge** for a **covered expense**.

If the HOP Medical Plan Is Secondary

If the rules set forth above make the HOP Medical Plan primary, then the benefits of the other plan will be ignored for the purposes of determining the benefits under the HOP Medical Plan. However, if the HOP Medical Plan is secondary, certain rules apply to how benefits are determined:

- The **allowable charge** for a **covered expense** will include any deductible or **coinsurance** amounts not paid by the other plan(s).
- The **allowable charge** will not include any amount that is not payable under the primary plan as a result of a contract between the primary plan and a provider of service in which such provider agrees to accept a reduced payment and not to bill the individual for the difference between the provider's contracted amount and the provider's regular billed charge.

Limitations on Payments

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

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 HOP Administration Unit may, without the consent of or notice to any person, release to or obtain from any insurance company or any other organization any information, regarding other insurance, with respect to any **covered individual**. Any person claiming benefits under the HOP Medical Plan shall furnish to the HOP Administration Unit such information as may be necessary to implement the Coordination of Benefits provision set forth in this SPD.

Facilitation of Benefit Payment

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

SUBROGATION/REIMBURSEMENT

The HOP Medical Plan maintains the right to seek reimbursement of any paid charges for an injury or illness that is the obligation of a third party on its own behalf: the right of subrogation. The HOP 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 Medical Plan reserves the right of recovery, either by subrogation or reimbursement, for **covered expenses** payable by the HOP Medical Plan that are a result of **illness** or **injury** that has been caused by a third party and who is responsible for such **illness** or **injury**. The HOP 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 Medical Plan's right to receive reimbursement from uninsured or underinsured motorist coverage and no-fault coverage.

Accepting benefits from the HOP 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 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 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 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 Medical Plan may advance payment in order to prevent any financial hardship to the individual. Acceptance of the HOP Medical Plan benefits acknowledges the obligation of the individual to:

- help the HOP Medical Plan recover benefits it has paid on behalf of the individual, and
- 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 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 Medical Plan. The HOP

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 Medical Plan's rights.

Whether the individual or the HOP 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 Medical Plan, the HOP 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 Medical Plan acknowledges and agrees upon payment to the HOP Medical Plan and releases its lien. The lien may not be for an amount greater than the amount of benefits paid under the HOP Medical Plan.

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

GENERAL PROVISIONS

Administration of the Plan

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

PSERS is the named fiduciary of the HOP Medical Plan except as noted herein. The claims processor is the named fiduciary of the HOP 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 Medical Plan. **PSERS** maintains discretionary authority to interpret the terms of the HOP Medical Plan, including but not limited to determination of eligibility for and entitlement to HOP 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 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 Medical Plan unless the claims processor is notified in writing of such assignment prior to payment pursuant to the terms of the HOP 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 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 Medical Plan that is in conflict with statutes that are applicable to the HOP 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 Medical Plan as defined by this description is January 1, 2025.

Free Choice of Hospital and Physician

Nothing contained in the HOP Medical Plan shall in any way or manner restrict or interfere with the right of any person entitled to benefits hereunder to select a **hospital** or to make a free choice of the attending **physician** or **professional provider** except as restricted by **Medicare**.

Incapacity

If, in the opinion of the **Plan sponsor**, an individual for whom a claim has been made is incapable of furnishing a valid receipt of payment due him/her and in the absence of written evidence to the HOP Administration Unit of the qualification of a guardian or personal representative for his estate, the **Plan sponsor** may on behalf of the HOP 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 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 Medical Plan shall be deemed representations and not warranties. Such statements shall not void or reduce the benefits under the HOP 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 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 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 Medical Plan shall not be liable for any obligation of the individual **incurred** in excess thereof. The liability of the HOP 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 "Filing Claims" section.

Medicaid Eligibility and Assignment of Rights

The HOP Medical Plan will not take into account whether an individual is eligible for, or is currently receiving, medical assistance under a state plan for medical assistance as provided under Title XIX of the Social Security Act (“State Medicaid Plan”) either in enrolling that individual or in determining or making any payment of benefits to that individual. The HOP 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 Medical Plan has a legal liability to make payments for the same services, supplies, or treatment, payment under the HOP 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 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 Medical Plan, or otherwise misleads the HOP Medical Plan, the HOP 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 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 Medical Plan null and void.

Physical Examinations Required by the Plan

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

Plan Is Not a Contract

The HOP 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 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 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 Medical Plan on file with the **Plan sponsor**, or a written copy thereof shall be deposited

with such master copy of the HOP Medical Plan. Appropriate filing and reporting of any such modification or amendment to individuals shall be timely made by the **Plan sponsor**.

Plan Termination

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

Prior Plan Coverage

Annuitants and **dependents** who are covered under the HOP Medical Plan as of December 31, 2024, shall be covered hereunder, provided they have not terminated coverage under the HOP Medical Plan or elected other coverage under the Health Options Program.

Amounts applied to **Plan** maximums prior to January 1, 2025, continue to count toward those maximums after December 31, 2024. For example, the Major Medical Benefits \$1,000,000 **lifetime maximum** includes payments made by the HOP Medical Plan prior to January 1, 2025.

Pronouns

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

Recovery for Overpayment

Whenever payments have been made from the HOP Medical Plan in excess of the maximum amount of benefits payable, the HOP 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 Medical Plan, should not have been made, the HOP 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 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 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 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 Medical Plan document.

Disclosure by Plan to Plan Sponsor

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

- disclose protected health information to the **Plan sponsor**
- provide for or permit the disclosure of protected health information to the **Plan sponsor** by a health insurance issuer or HMO with respect to the HOP Medical Plan pursuant to 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 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:

- to ensure that:
 - any agents (including a subcontractor) to whom it provides protected health information received from the HOP Medical Plan agree to the same restrictions and conditions that apply to **PSERS** with respect to such information, and
 - adequate separation is established between the HOP Medical Plan and **PSERS**.
- not use or further disclose protected health information received from the HOP Medical Plan, other than as permitted or required by the HOP Medical Plan documents or as required by law
- not use or disclose protected health information received from the HOP Medical Plan:
 - for employment-related actions and decisions, or
 - in connection with any other benefit or employee benefit plan of the **Plan sponsor**.
- report to the HOP Medical Plan any use or disclosure of the protected health information received from the HOP Medical Plan that is inconsistent with the use or disclosure provided for of which it becomes aware

- make available protected health information received from the HOP Medical Plan, as and to the extent required by the privacy rule:
 - for access to the individual
 - for amending and incorporating any amendments to protected health information received from the HOP Medical Plan, and
 - to provide an accounting of disclosures.
- make its internal practices, books, and records relating to the use and disclosure of protected health information received from the HOP Medical Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the HOP Medical Plan with the privacy rule
- return or destroy all protected health information received from the HOP 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 Medical Plan was made, but if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible
- provide protected health information only to those individuals under the control of **PSERS** who perform administrative functions for the HOP 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 Medical Plan administrative functions or to release protected health information to an unauthorized individual
- provide protected health information only to those entities required to receive the information in order to maintain the HOP 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 Medical Plan
- provide an effective mechanism for resolving issues of noncompliance with regard to the items mentioned in this provision
- reasonably and appropriately safeguard electronic protected health information created, received, maintained, or transmitted to or by **PSERS** on behalf of the HOP Medical Plan. Specifically, such safeguarding entails an obligation to:
 - implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that the **Plan sponsor** creates, receives, maintains, or transmits on behalf of the HOP Medical Plan
 - ensure that the adequate separation as required by 45 C.F.R. 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures
 - ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information, and
 - report to the HOP Medical Plan any security incident of which it becomes aware.
- PSERS will not use or disclose protected health information for marketing or sell protected health information

Exceptions

Notwithstanding any other provision of this “HIPAA Privacy” section, the HOP 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 Medical Plan, or
 - b. modifying, amending, or terminating the HOP Medical Plan.
2. disclose to the **Plan sponsor** information on whether the individual is participating in the HOP Medical Plan, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Health Options Program
3. use or disclose protected health information:
 - a. with (and consistent with) a valid authorization obtained in accordance with the privacy rule
 - b. to carry out treatment, payment, or health care operations in accordance with the privacy rule. However, PSERS will not use genetic information for underwriting purposes, or
 - c. as otherwise permitted or required by the privacy rule.

When the Disclosure of Your PHI is Related to Reproductive Health

The Plan will not use or disclose your information to conduct a criminal, civil, or administrative investigation into, or to impose criminal, civil, or administrative liability on any person for the

mere act of seeking, obtaining, providing, or facilitating reproductive health care, or to identify any person for the purpose of conducting such investigation or imposing such liability. Reproductive healthcare is healthcare that affects the health of an individual in all matters relating to the reproductive system and to its functions and processes.

For example, a state law might require a health plan to disclose PHI to law enforcement for an investigation. If the requested PHI involved reproductive health care that was lawful under the circumstances in which it was provided, the health plan could not disclose the PHI to law enforcement. Attestation requirement: The Plan may not use or disclose PHI potentially related to reproductive health care for the activities listed above, without obtaining a valid attestation from the person requesting the use or disclosure.

For example, if an investigator requests information from a health plan about claims for coverage of certain reproductive health care provided by a particular health care provider, the investigator must supply an attestation. The health plan must presume that the reproductive health care was lawful unless the health plan has actual knowledge that the reproductive health care was not lawful or the investigator supplied information that demonstrates a substantial factual basis to believe that the reproductive health care was not lawful under these circumstances.

Information that is disclosed by the health plan in accordance with the regulations is subject to redisclosure by the recipient and no longer protected by HIPAA.

GLOSSARY

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

accident: an unforeseen event resulting in **injury**

allowable charge: the fee for services, supplies, or treatment that does not exceed the general level of charges as determined by the HOP Administration Unit in accordance with generally accepted industry standards

ambulatory surgical facility (or center): 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:

- has permanent facilities and equipment for the purpose of performing surgical procedures on an **outpatient** basis
- provides treatment by or under the supervision of **physicians** and nursing services whenever the individual is in the **ambulatory surgical facility**
- does not provide **inpatient** accommodations, and
- 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, child, brother, sister, or parent; or the child, brother, sister, or parent of the **annuitant's** spouse

coinsurance: the percentage of **covered expenses** payable by the HOP Medical Plan (or the percentage of **covered expenses** payable by the member where so specified) for benefits that are provided under the HOP Medical 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 that is diagnosed as distinct from **pregnancy**, but is adversely affected by or caused by **pregnancy**. Some examples are:

- intra-abdominal surgery (but not elective cesarean section)
- ectopic **pregnancy**
- toxemia with convulsions (eclampsia)
- pernicious vomiting (hyperemesis gravidarum)
- nephrosis
- cardiac decompensation
- missed abortion
- 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**

copay: a cost-sharing arrangement whereby a covered person pays a set amount to a provider for a specific service at the time the service is provided

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** 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 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 rehabilitative or 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 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:

- provided during **confinement** in an institution for which coverage is available under Major Medical Benefits of the HOP Medical Plan, and
- combined with other **medically necessary** therapeutic services, under accepted medical standards, which can reasonably be expected to substantially improve the individual's medical condition.

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

dependent: see page 4

durable medical equipment: medical equipment that:

- can withstand repeated use
- is primarily and customarily used to serve a medical purpose
- is generally not used in the absence of an **illness** or **injury**
- 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, wheelchairs, and **hospital** beds, etc.

effective date of coverage: 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 or its designee must make an independent evaluation of the experimental/non-experimental standings of specific technologies. The claims processor or its designee shall be guided by a reasonable interpretation of Major Medical Benefits of the HOP Medical 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 or its designee will be guided by the following examples of experimental services and supplies:

- 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
- 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
- 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, toxicity, safety, or efficacy as compared with a standard means of treatment or diagnosis, or

- 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, toxicity, safety, or 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(s) 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 that meets all applicable federal, state, or local approval or 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**

health care management: a process of evaluating if services, supplies, or treatment are for **custodial care, medically necessary, experimental/investigational** and appropriate for benefit coverage under the HOP Medical Plan

Health Care Management Organization: the individual or organization designated by **PSERS** for the process of evaluating if a service, supply, or treatment is for **custodial care, medically necessary, experimental/investigational** and appropriate for benefit coverage under the HOP Medical Plan

home health care agency: an agency or organization that fully meets every one of the following requirements:

- 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
- 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
- It maintains a complete medical record on each patient
- It has a full-time administrator.

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:

- It has obtained any required state or governmental Certificate of Need approval
- It provides service 24 hours a day, 7 days a week
- It is under the direct supervision of a **physician**
- It has a **nurse** coordinator who is a Registered Nurse

- It has a social service coordinator who is licensed
- It is an agency that has as its primary purpose the provision of **hospice** services
- It has a full-time administrator
- It maintains written records of services provided to the individual
- It is licensed, if licensing is required
- It qualifies as a reimbursable service under **Medicare**.

hospital: an institution that meets the following conditions:

- It is licensed and operated in accordance with the laws of the jurisdiction in which it is located which pertain to **hospitals**
- It is engaged primarily in providing medical care and treatment to ill and injured persons on an **inpatient** basis at the individual's expense
- 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
- It qualifies as a **hospital** and is accredited by the Joint Commission on the Accreditation of Healthcare Organizations
- It qualifies as a reimbursable service under **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** includes a **facility** designed exclusively for physical rehabilitative services where the individual

receives 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 that 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**

incurred or incurred date: with respect to a **covered expense**, the date the service, supply, or treatment is 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 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 maintained within a **hospital** solely for the provision of **intensive care**. It must meet the following conditions:

- facilities for special nursing care not available in regular rooms and wards of the **hospital**
- special lifesaving equipment immediately available at all times
- at least two beds for the accommodation of the critically ill

- 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.

lifetime maximum: the maximum amount paid by Major Medical Benefits of the HOP Medical Plan for any one individual during the entire time he or she is covered by the HOP Medical Plan

maximum benefit: any one of the following, or any combination of the following:

- the maximum amount paid by Major Medical Benefits of the HOP Medical Plan for any one individual for a particular **covered expense** for a specified period of time, such as a calendar year
- the maximum number as outlined in Major Medical Benefits of the HOP Medical Plan as a **covered expense**. The maximum number relates to the number of:
 - treatments during a specified period of time, or
 - days of **confinement**, or
 - visits by a **home health care agency**.

medically necessary or medical necessity: service, supply, or treatment that is determined by the claims processor or its designee to be:

- 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
- supplied or performed in accordance with current standards of medical practice within the United States, and

- not primarily for the convenience of the individual or the individual's family or **professional provider**, and
- an appropriate supply or level of service that safely can be provided, and
- recommended or approved by the attending **professional provider**, and
- a qualified reimbursable service under Medicare.

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, **Plan sponsor** or its designee may request and rely upon the opinion of a **physician** or **physicians**. The determination of the claims processor, **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

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 a **hospital** as other than an **inpatient**, a **professional provider's** office, laboratory, X-ray **facility**, or **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 psychiatric services and/or treatment of **mental health disorders**. It may include day, early evening, evening, or night care or a combination of all four

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 Medical Plan

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

Plan year: January 1 through December 31

pregnancy: the physical state that results in childbirth or miscarriage

prior plan: the HOP Medical Plan in effect prior to the effective date of the **Plan** or a predecessor plan (e.g., High or Standard Option), which has been replaced by the HOP Medical Plan as of the effective date

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
- 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

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

- relied on in making the benefit determination, or
- that was submitted, considered, or generated in the course of making a benefit determination, whether or not relied upon, or
- that demonstrates compliance with the duties to make benefit decisions in accordance with Plan documents and to make consistent decisions, or
- that constitutes a statement of policy or guidance for the HOP Medical Plan concerning the denied treatment or benefit for the individual's diagnosis, even if not relied upon.

restorative therapy: a planned systematic program that focuses on restoring function lost due to an **illness** or **injury**. Treatment must be reasonable and necessary to treat the individual's **illness** or **injury** with the expectation that the individual's condition will improve significantly within a reasonable period of time

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 HOP Medical Plan that is primarily engaged in providing skilled nursing and rehabilitative 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 **custodial care**, ambulatory care, part-time care services, or 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.

PLAN FACTS

Effective Date of <i>Plan</i>:	January 1, 2025
Name of <i>Plan</i>:	HOP Medical Plan of the PSERS Health Options Program
Group Number:	503
Type of <i>Plan</i>:	Welfare Benefit Plan: voluntary health benefit program
Name, Address and Phone Number of <i>Plan</i> Sponsor:	<p>PSERS Board of Trustees 5 North 5th Street Harrisburg, PA 17101 1-888-773-7748</p> <p>Legal process may be served upon the <i>Plan sponsor</i>.</p>
<i>Plan Year</i>:	January 1 - December 31
Procedures for Filing Claims:	<p>For detailed information on how to submit a claim for benefits, or how to file an appeal on a processed claim, refer to the section entitled "Filing Claims." The designated claims processor is:</p> <p>HOP Administration Unit P.O. Box 2921 Clinton, IA 52733-2921 1-800-773-7725</p> <p>The designated <i>Health Care Management Organization</i> is:</p> <p>Luminare Health Benefits, Inc. P.O. Box 1764 Lancaster, PA 17608-1764</p>

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 panggagamot. 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 quý vị cần thông dịch viên xin gọi 1-800-773-7725 sẽ có nhân viên nói tiếng Việt giúp đỡ quý 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.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 대해 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.

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