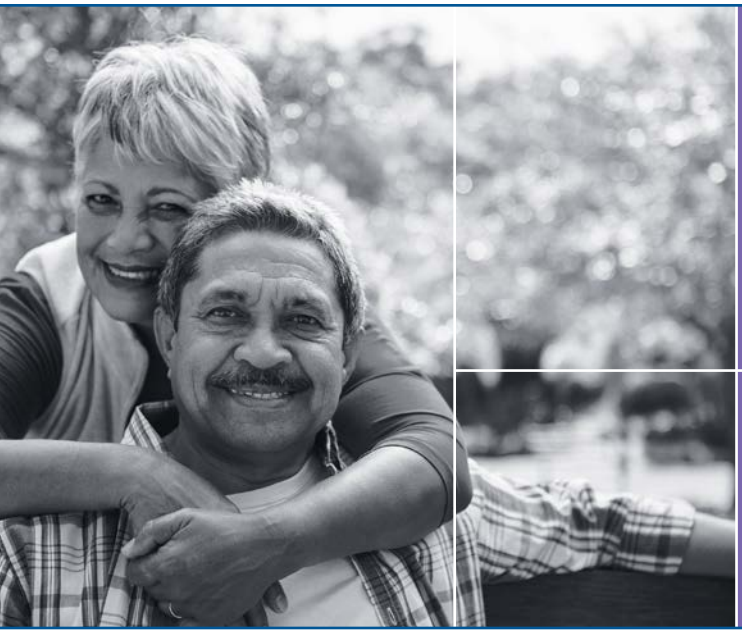
Pennsylvania Public School
Employees' Retirement System (PSERS)

Health Options Program

2020



Managed Care Plans for Medicare-Eligible and Non-Medicare-Eligible Members

North & Central PENNSYLVANIA

Adams • Armstrong • Beaver • Bedford • Berks • Blair
Bradford • Butler • Cambria • Cameron • Carbon • Centre
Clarion • Clearfield • Clinton • Columbia • Crawford
Cumberland • Dauphin • Elk • Erie • Forest • Franklin
Fulton • Huntingdon • Jefferson • Juniata • Lackawanna
Lancaster • Lawrence • Lebanon • Lehigh • Luzerne
Lycoming • McKean • Mercer • Mifflin • Monroe
Montour • Northampton • Northumberland • Perry
Pike • Potter • Schuylkill • Snyder • Somerset • Sullivan
Susquehanna • Tioga • Union • Venango • Warren
Wayne • Wyoming • York

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Plan Availability

Some of the plans included in this brochure are available only in certain counties. Check the chart below to find out which are offered where you live.

County	Highmark	Capital BlueCross	UPMC	Aetna
Adams	•	•		•
Armstrong	•	•	•	•
Beaver	•	•	•	•
Bedford	•	•	•	•
Berks	•	•	•	•
Blair	•	•	•	•
Bradford	•	•	•	•
Butler	•	•	•	•
Cambria	•	•	•	•
Cameron	•	•	•	•
Carbon	•	•		•
Centre	•	•		•
Clarion	•	•	•	•
Clearfield	•	•	•	•
Clinton	•	•	•	•
Columbia	•	•		•
Crawford	•	•	•	•
Cumberland	•	•	•	•
Dauphin	•	•	•	•
Elk	•	•	•	•
Erie	•	•	•	•
Forest	•	•	•	•
Franklin	•	•		•
Fulton	•	•	•	•
Huntingdon	•	•	•	•
Jefferson	•	•	•	•
Juniata	•	•	•	•
Lackawanna	•	•	•	•

Plan Availability *(continued)*

County	Highmark	Capital BlueCross	UPMC	Aetna
Lancaster	●	●	●	●
Lawrence	●	●	●	●
Lebanon	●	●	●	●
Lehigh	●	●	●	●
Luzerne	●	●	●	●
Lycoming	●	●	●	●
McKean	●	●	●	●
Mercer	●	●	●	●
Mifflin	●	●	●	●
Monroe	●	●		●
Montour	●	●		●
Northampton	●	●	●	●
Northumberland	●	●		●
Perry	●	●	●	●
Pike	●	●		●
Potter	●	●	●	●
Schuylkill	●	●		●
Snyder	●	●	●	●
Somerset	●	●	●	●
Sullivan	●	●	●	●
Susquehanna	●	●	●	●
Tioga	●	●	●	●
Union	●	●	●	●
Venango	●	●	●	●
Warren	●	●	●	●
Wayne	●	●	●	●
Wyoming	●	●	●	●
York	●	●	●	●

2020 Monthly Costs if You Are Eligible for Medicare *(Excluding Premium Assistance)*

	SINGLE COVERAGE	2-PERSON COVERAGE
Highmark Freedom Blue PPO	$243	$486
Capital BlueCross BlueJourney PPO	$246	$492
Aetna Medicare V02 PPO	$177	$354
UPMC for Life HMO	$257	$514

2020 Monthly Costs if You Are NOT Eligible for Medicare *(Excluding Premium Assistance)*

	SINGLE COVERAGE	2-PERSON COVERAGE
Highmark PPOBlue (80-70 Plan)	$1,754	$4,551
Capital BlueCross PPO	$1,264	$2,528
Aetna Premier Open Choice PPO	$1,682	$3,256
UPMC Health Plan EPO	$1,383	$2,766

2020 Plan Options if You Are Eligible for Medicare

HOW MUCH YOU WILL PAY IN 2020	HIGHMARK FREEDOM BLUE PPO	
MEDICAL PLAN	**In-Network**	**Out-of-Network**
Annual Deductible	$0	$0
Annual Out-of-Pocket Maximum	$3,400 (combined)	
Hospitalization	$0	$0
Doctor Visits	$10 PCP; $15 specialist	$10 PCP; $15 specialist
Preventive Care	$0	$0
Emergency Room	$50 (waived if admitted)	$50 (waived if admitted)
Urgent Care Facility	$40	$40
Outpatient Surgery	$0	$0
Diagnostic Testing	$0	$0
Outpatient Therapy	$15	$15
Durable Medical Equipment	15%	20%
Outpatient Mental Health	$15	$15
Inpatient Mental Health	$0	$0
Physical Exams	$0 (office visit copay may apply)	$0 (office visit copay may apply)
Ob/Gyn Exams	$0 (office visit copay may apply)	$0 (office visit copay may apply)
Mammograms	$0	$0
Skilled Nursing Facility	$0 up to 100 days per Medicare Benefit Period	$0 up to 100 days per Medicare Benefit Period
Hearing Aids	$0 after annual $499 copay per aid for TruHearing Advanced; $799 per aid for TruHearing Premium; $500 allowance per year for other aids through TruHearing	100% after a $500 allowance for hearing aids every three years from any other provider or TruHearing
Dental Care (subject to frequency limitations)	$20 for exam & cleaning and $20 for X-rays every 6 months; 50% for restorative services and dentures	50% for periodic exams, cleanings, X-rays, fillings as needed and dentures
Vision Exam/Hearing Exams	$0 vision; $15 hearing	$50 vision; 20% hearing
Prescription Lenses	100% after a $100 benefit maximum per calendar year for standard eyeglass lenses or contact lenses; Davis Vision Fashion Collection frames and standard lenses covered in full (annually)	100% after a $100 benefit maximum per calendar year for standard eyeglass frames, eyeglass lenses, or contact lenses
PRESCRIPTION DRUGS	**Retail Pharmacy (31-day supply)**	**Mail Order (90-day supply)***
Annual Deductible	$0	$0
Initial Coverage Up to a Total Drug Cost of $4,020		
Preferred generic drugs (Tier 1)	$5 preferred pharmacy; $10 standard pharmacy	$12.50 preferred pharmacy only
Non-preferred generic drugs (Tier 2)	$5 preferred pharmacy; $10 standard pharmacy	$12.50 preferred pharmacy only
Preferred brand-name drugs (Tier 3)	$25 preferred pharmacy; $30 standard pharmacy	$62.50
Non-preferred brand-name drugs (Tier 4)	$55 preferred pharmacy; $60 standard pharmacy	$137.50
Specialty drugs (Tier 5)	33%	Not covered
Coverage Gap to TrOOP Maximum of $6,350		
Generic drugs (Tiers 1 & 2)	$5 preferred pharmacy; $10 standard pharmacy	$12.50 preferred pharmacy only
Brand-name drugs (Tiers 3 & 4)	Preferred Pharmacy: 20% (plan pays 10% and manufacturer discounts 70%) Standard Pharmacy: 25% (plan pays 5% and manufacturer discounts 70%)	20% (plan pays 10% and manufacturer discounts 70%)
Specialty drugs (Tier 5)	25% (plan pays 5% and manufacturer discounts 70%)	Not covered
Catastrophic Coverage		
Generic drugs	The greater of 5% or $3.60	
Brand-name drugs	The greater of 5% or $8.95	

* Must obtain mail order supply using Express Scripts/ESI.

HOW MUCH YOU WILL PAY IN 2020	CAPITAL BLUECROSS BLUEJOURNEY PPO*	
MEDICAL PLAN	**In-Network**	**Out-of-Network**
Annual Deductible	$0	$0
Annual Out-of-Pocket Maximum	$3,400 (excludes Part D drugs and hearing)	$3,400 (excludes Part D drugs and hearing)
Hospitalization	$0	20%
Doctor Visits	$5 PCP; $0 virtual care; $15 specialist	$5 PCP; $15 specialist; virtual care not covered
Preventive Care	$0	20%
Emergency Room	$50 (waived if admitted)	$50 (waived if admitted)
Urgent Care Facility	$35 urgent care; $0 virtual care	$35 virtual care not covered
Outpatient Surgery	$0	20%
Diagnostic Testing	$10 lab services; $25 high-tech imaging; 15% therapeutic radiology; all other $0	$10 lab services; $25 high-tech imaging; 15% therapeutic radiology, $0 all other
Outpatient Therapy	$15	$15
Durable Medical Equipment	15%	15%
Outpatient Mental Health	$15	$15
Inpatient Mental Health	$0	20%
Physical Exams	$0 (annual wellness exam)	20%
Ob/Gyn Exams	$0 preventive screenings (once every 24 months)	20%
Mammograms	$0 preventive screenings (once every 12 months)	20%
Skilled Nursing Facility	$0 days 1-10; $25 days 11-100	20%
Hearing Aids (once every 36 months)	100% after $500 allowance	100% after $500 allowance
Dental Care	$15 office visit; cleaning and X-rays covered; 50% other services; $1,500 max per calendar year (in- and out-of-network combined)	50%; $1,500 max per calendar year (in- and out-of-network combined)
Vision Exam/Hearing Exams	$15 copay for Medicare-covered hearing service	$15 copay for Medicare-covered services
Prescription Lenses (once every 24 months)	100% after $40 allowance for frames	Lenses: 100% after dollar limit** Frames: 100% after $40 limit
PRESCRIPTION DRUGS	**Retail Pharmacy (30-day supply)**	**Mail Order (90-day supply)**
Annual Deductible	$0	$0
Initial Coverage Up to a Total Drug Cost of $4,020		
Preferred generic drugs (Tier 1)	$4 preferred pharmacy; $12 standard pharmacy	$12 preferred pharmacy; $36 standard pharmacy
Non-preferred generic drugs (Tier 2)	$4 preferred pharmacy; $12 standard pharmacy	$12 preferred pharmacy; $36 standard pharmacy
Preferred brand-name drugs (Tier 3)	$38	$114
Non-preferred brand-name drugs (Tier 4)	$90	$270
Specialty drugs (Tier 5)	33%	Not covered
Coverage Gap to TrOOP Maximum of $6,350		
Generic drugs (Tiers 1 & 2)	25%	25%
Brand-name drugs (Tiers 3 & 4)	25% (plan pays 5% and manufacturer discounts 70%)	
Specialty drugs (Tier 5)	25% (plan pays 5% and manufacturer discounts 70%)	Not covered
Catastrophic Coverage		
Generic drugs	The greater of 5% or $3.60	
Brand-name drugs	The greater of 5% or $8.95	

* Capital BlueCross BlueJourney PPO is not available in Delaware or Maryland.

** Single lenses $36 allowance; Bifocal lenses $48 allowance; Trifocal lenses $58 allowance.

HOW MUCH YOU WILL PAY IN 2020	AETNA MEDICARE V02 PPO*	
MEDICAL PLAN	**In-Network**	**Out-of-Network**
Annual Deductible	$300	$500
Annual Out-of-Pocket Maximum	$6,700	$10,000
Hospitalization	$200 copay/day for days 1–7	30%
Doctor Visits	$15 PCP; $40 specialist	30%
Preventive Care	$0	30%
Emergency Room	$90 (waived if admitted)	$90 (waived if admitted)
Urgent Care Facility	$50	$50
Outpatient Surgery	$185	30%
Diagnostic Testing	$35; $200 complex imaging	30%
Outpatient Therapy	$40	30%
Durable Medical Equipment	20%	30%
Outpatient Mental Health	$40	30%
Inpatient Mental Health	$200 copay/day for days 1–7	30%
Physical Exams	$0	30%
Ob/Gyn Exams	$0	30%
Mammograms	$0	30%
Skilled Nursing Facility	$0 days 1-20; $172 days 21-100	30%
Hearing Aids (once every 36 months)	100% after $500 allowance	
Dental Care (subject to frequency limitations)	Not covered	Not covered
Vision Exam/Hearing Exams	$0	30%
Prescription Lenses	100% after $100 allowance (once every 24 months)	
PRESCRIPTION DRUGS	**Retail Pharmacy (30-day supply)**	**Mail Order (90-day supply)**
Annual Deductible	$0	$0
Initial Coverage Up to a Total Drug Cost of $4,020		
Preferred generic drugs (Tier 1)	$2 preferred pharmacy; $15 standard pharmacy	$4 preferred pharmacy; $30 standard pharmacy
Non-preferred generic drugs (Tier 2)	$10 preferred pharmacy; $20 standard pharmacy	$20 preferred pharmacy; $40 standard pharmacy
Preferred brand-name drugs (Tier 3)	$40 preferred pharmacy; $47 standard	$80 preferred pharmacy; $94 standard
Non-preferred brand-name drugs (Tier 4)	35% preferred pharmacy; 50% standard	
Specialty drugs (Tier 5)	33%	33% (limited one-month supply)
Coverage Gap to TrOOP Maximum of $6,350		
Preferred generic drugs (Tier 1)	$2 preferred pharmacy; $15 standard pharmacy	$4 preferred pharmacy; $30 standard pharmacy
Non-preferred generic drugs (Tier 2)	$10 preferred pharmacy; $20 standard pharmacy	$20 preferred pharmacy; $40 standard pharmacy
Brand-name drugs (Tiers 3 & 4)	25%	25%
Specialty drugs (Tier 5)	25%	25%
Catastrophic Coverage		
Generic drugs	The greater of 5% or $3.60	
Brand-name drugs	The greater of 5% or $8.95	

* Aetna is available only in Pennsylvania, New Jersey and some counties in Florida, Maryland, and New York.

HOW MUCH YOU WILL PAY IN 2020	UPMC *FOR LIFE* HMO*	
MEDICAL PLAN	**In-Network**	
Annual Deductible	$0	
Annual Out-of-Pocket Maximum	$3,400	
Hospitalization	$0 inpatient; $0 outpatient	
Doctor Visits	$5 PCP; $20 specialist	
Preventive Care	$0	
Emergency Room	$120 (waived if admitted within 3 days)	
Urgent Care Facility	$20	
Outpatient Surgery	$0	
Diagnostic Testing	$0 labs; $10 X-rays; $30 advanced imaging	
Outpatient Therapy	$20	
Durable Medical Equipment	15%	
Outpatient Mental Health	$20	
Inpatient Mental Health	$0	
Physical Exams	$0 routine	
Ob/Gyn Exams	$0 routine	
Mammograms	$0 routine	
Skilled Nursing Facility	$0 per day days 1-15; $50 per day days 16-100	
Hearing Aids	100% after $1,500 allowance (once every 36 months)	
Dental Care	Routine dental not covered	
Vision Exam/Hearing Exams	$0 routine vision (once every two years); $20 routine hearing (once every year)	
Prescription Lenses (once every 24 months)	100% after $250 allowance	
PRESCRIPTION DRUGS	**Retail Pharmacy (30-day supply)**	**Mail Order (90-day supply)**
Annual Deductible	$0	$0
Initial Coverage Up to a Total Drug Cost of $4,020		
Preferred generic drugs (Tier 1)	$0 preferred pharmacy; $15 standard pharmacy	$0 standard
Non-preferred generic drugs (Tier 2)	$10 preferred pharmacy; $20 standard pharmacy	$20 standard
Preferred brand-name drugs (Tier 3)	$47 preferred or standard pharmacy	$105 standard
Non-preferred brand-name drugs (Tier 4)	$100 preferred or standard pharmacy	$285 standard
Specialty drugs (Tier 5)	33%	Not covered
Coverage Gap to TrOOP Maximum of $6,350		
Preferred generic drugs (Tier 1)	$0 preferred pharmacy; $15 standard pharmacy	$0 standard
Non-preferred generic drugs (Tier 2)	$10 preferred pharmacy; $20 standard pharmacy	$20 standard
Brand-name drugs (Tiers 3 & 4)	25% (plan pays 5% and manufacturer discounts 70%)	
Specialty drugs (Tier 5)	25% (plan pays 5% and manufacturer discounts 70%)	Not covered
Catastrophic Coverage		
Generic drugs	The greater of 5% or $3.60	
Brand-name drugs	The greater of 5% or $8.95	

* UPMC is available in all South East, South West Pennsylvania counties and some North Central Pennsylvania counties.

2020 Plan Options if You Are NOT Eligible for Medicare

HOW MUCH YOU WILL PAY IN 2020	HIGHMARK PPOBLUE (80-70 PLAN)	
MEDICAL	**In-Network**	**Out-of-Network**
Annual Deductible	$100/individual $300/family	$500/individual $1,500/family
Annual Out-of-Pocket Maximum	$10,000	No maximum
Hospitalization	20%	30%
Doctor Visits	$20/visit PCP; $40/visit specialist	30%
Preventive Care	$20/visit	Routine physicals not covered; 70% for routine gynecological and mammograms
Emergency Room	$100 (waived if admitted)	$100 (waived if admitted)
Urgent Care Facility	$40	30%
Outpatient Surgery	20%	30%
Diagnostic Testing	20%	30%
Outpatient Therapy	$40/visit; 60-visit maximum*	30% to 60-visit maximum*
Durable Medical Equipment	20%	30%
Outpatient Mental Health	0%; no deductible	30%
Inpatient Mental Health	20%	30%
Physical Exams	$20/visit PCP; $40/visit specialist	Not covered
Ob/Gyn Exams	$40/visit	30% routine (no deductible)
Mammograms	20%	30%
Skilled Nursing Facility	20%; 100 visits per calendar year	30%; 100 visits per calendar year
Hearing Aids (once every 36 months)	Not covered	Not covered
Dental Care	Not covered	Not covered
Vision Exam/Hearing Exams	Not covered	Not covered
Prescription Lenses (once every 24 months)	Not covered	Not covered
PRESCRIPTION DRUGS		
Annual Deductible	$0	Not covered
Annual Maximum	No maximum	Not covered
Retail Pharmacy		
Generic drugs	30% (mandatory generic)**	Not covered
Brand-name drugs	50%**	Not covered
Mail Order (90-day supply)		
Generic drugs	30% (mandatory generic)	Not covered
Brand-name drugs	50%	Not covered

* Combined in- and out-of-network maximum

** 34-day supply.

HOW MUCH YOU WILL PAY IN 2020	CAPITAL BLUECROSS PPO	
MEDICAL	**In-Network**	**Out-of-Network**
Annual Deductible	$100/individual $300/family	$500/individual $1,500/family
Annual Out-of-Pocket Maximum	$3,000/individual $6,000/family	No maximum
Hospitalization	20%	30%
Doctor Visits	$10/PCP visit; $25/specialist visit	30%
Preventive Care	$10/visit	20%
Emergency Room	$100; no deductible (waived if admitted)	$100; no deductible (waived if admitted)
Urgent Care Facility	$40; no deductible	30%; no deductible
Outpatient Surgery	20%	30%
Diagnostic Testing	20%	30%
Outpatient Therapy	$40/visit; no deductible	30%
Durable Medical Equipment	20%	30%
Outpatient Mental Health	$40/visit; no deductible	30%
Inpatient Mental Health	20%	30%
Physical Exams	$10/PCP visit; $25/specialist visit; no deductible	20%
Ob/Gyn Exams	$0; no deductible	30%, no deductible
Mammograms	$0; no deductible	30%, no deductible
Skilled Nursing Facility	$0; limit 100 days	50%; limit 100 days
Hearing Aids (once every 36 months)	Not covered	Not covered
Dental Care	Not covered	Not covered
Vision Exam/Hearing Exams	Not covered	Not covered
Prescription Lenses (once every 24 months)	Not covered	Not covered
PRESCRIPTION DRUGS		
Annual Deductible	$300/individual $600/family	Not covered
Annual Maximum	$2,500 benefit period maximum on lifestyle drugs	Not covered
Retail Pharmacy		
Generic drugs	30%*	Not covered
Brand-name drugs	30%/preferred;* 50%/non-preferred	Not covered
Mail Order (90-day supply)		
Generic drugs	30%	Not covered
Brand-name drugs	30%/preferred; 50%/non-preferred	Not covered

* Specialty generic drugs are covered at 30%, Specialty brand preferred drugs are covered at 50%, and Specialty brand non-preferred drugs are not covered.

HOW MUCH YOU WILL PAY IN 2020	UPMC HEALTH PLAN EPO*
MEDICAL	**In-Network Only**
Annual Deductible	$500/individual $1,000/family
Annual Out-of-Pocket Maximum	$4,000/individual $8,000/family
Hospitalization	20%
Doctor Visits	$20/visit PCP; $40/visit specialist
Preventive Care	$0
Emergency Room	$100 copay (waived if admitted)
Urgent Care Facility	$40
Outpatient Surgery	20%
Diagnostic Testing	20%
Outpatient Therapy	$40/visit; 30-visit maximum
Durable Medical Equipment	20%
Outpatient Mental Health	$40/visit
Inpatient Mental Health	20%
Physical Exams	$0 routine
Ob/Gyn Exams	$0 routine
Mammograms	$0 routine
Skilled Nursing Facility	20%; 120 days per benefit period
Hearing Aids (once every 36 months)	Not covered
Dental Care	Not covered
Vision Exam/Hearing Exams	Not covered
Prescription Lenses (once every 24 months)	Not covered
PRESCRIPTION DRUGS	
Annual Deductible	$0
Annual Maximum	No maximum
Retail Pharmacy	
Generic drugs	$8 (mandatory generic)
Brand-name drugs	$38/preferred; $76/non-preferred and specialty
Mail Order (90-day supply)	
Generic drugs	$16 (mandatory generic)
Brand-name drugs	$76/preferred; $152/non-preferred

* UPMC is not available in all counties.

HOW MUCH YOU WILL PAY IN 2020	AETNA PREMIER OPEN CHOICE PPO*	
MEDICAL	**In-Network Only**	**Out-of-Network**
Annual Deductible	$300/individual $600/family	$500/individual $1,000/family
Annual Out-of-Pocket Maximum	$6,600/individual $13,200/family	$10,000/individual $20,000/family
Hospitalization	$200/day to $1,000/admission maximum	30%
Doctor Visits	$15/visit PCP; $40/visit specialist	30%
Preventive Care	$0; no deductible	30%
Emergency Room	$75; no deductible (waived if admitted)	$75; no deductible (waived if admitted)
Urgent Care Facility	$50; no deductible	30%
Outpatient Surgery	$150	30%
Diagnostic Testing	$35 X-ray/lab; $150 complex	40%
Outpatient Therapy	$40	30%
Durable Medical Equipment	20%	30%
Outpatient Mental Health	$40; all other mental health $0	30%
Inpatient Mental Health	$200/day to $1,000/admission maximum	30%
Physical Exams	0%; no deductible; routine	30%
Ob/Gyn Exams	0%; no deductible; routine	30%
Mammograms	0%; no deductible; routine	30%
Skilled Nursing Facility	$100/day to $500, then $0; after deductible; 100-day limit	30%
Hearing Aids (once every 36 months)	100% after $1,000 allowance	30%
Dental Care	Not covered	Not covered
Vision Exam/Hearing Exams	Vision: $0; 1 exam/12 months; Hearing: $40; 1 exam/24 months	30%
Prescription Lenses (once every 24 months)	100% after $100 allowance	100% after $100 allowance
PRESCRIPTION DRUGS		
Annual Deductible	$200/individual $600/family	$200/individual $600/family
Annual Maximum	Combined with medical	Combined with medical
Retail Pharmacy		
Generic drugs	30%	50% after applicable copay
Brand-name drugs	30%-formulary 50%-non-formulary	50% after applicable copay
Mail Order (90-day supply)		
Generic drugs	30%	Not covered
Brand-name drugs	30%-formulary 50%-non-formulary	Not covered

* Aetna is available only in New Jersey, Pennsylvania and some counties in Florida, Maryland and New York.

Pennsylvania Public School Employees' Retirement System (PSERS) Notice of Nondiscrimination

The Pennsylvania Public School Employees' Retirement System (PSERS) Health Options Program complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Pennsylvania Public School Employees' Retirement System (PSERS) Health Options Program does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The PSERS Health Options Program:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Peter Camacci, Director, Health Insurance Office.

If you believe that the PSERS Health Options Program has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Peter Camacci, Director, Health Insurance Office
Public School Employees' Retirement System
5 N 5th Street
Harrisburg, PA 17101-1905
Phone: 1-888-773-7748; TTY use: 711; Fax: 717-772-3860; Email: pcamacci@pa.gov

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Peter Camacci is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW, Room 509F, HHH Building
Washington, DC 20201
1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

Attention: Free Language Assistance

This chart displays, in various languages, the phone number to call for free language assistance services for individuals with limited English proficiency.

Language	Message About Language Assistance
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-773-7725; TTY: 711.
Chinese	注意 ： 如果您使用繁體中文 ， 您可以免費獲得語言援助服務 。 請致電 1-800-773-7725; TTY: 711 。
French	ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-773-7725; TTY: 711.
Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-773-7725; TTY: 711.
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-773-7725; TTY: 711.
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-773-7725; TTY: 711.
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-773-7725; TTY: 711.
Arabic	ملحوظة: إذا كنت تتحدث العربية اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم TTY: 711; 1-800-773-7725.
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-773-7725; TTY: 711 번으로 전화해 주십시오.
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-773-7725; TTY: 711.
Polish	UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-773-7725; TTY: 711.
Serbo-Croatian	OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-773-7725; TTY: 711.
Gujarati	સુચના: જો તમે ગુજરાતી બોલતા હો, તો નઃશુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-773-7725; TTY: 711.
Ukrainian	УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-773-7725; TTY: 711.
Cambodian	ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-773-7725; TTY: 711។
French Creole (Haitian)	ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-773-7725; TTY: 711.
Portuguese	ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-773-7725; TTY: 711.
Greek	ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-800-773-7725; TTY: 711.
Pennsylvania Dutch	Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-773-7725; TTY: 711.

Rev. 6/19

This brochure provides only a summary of benefits under these plans. It does not provide details about what is covered or limitations that may apply. More information is included in the Evidence of Coverage (for a Medicare Advantage plan) or the Benefit Description (for a plan for non-Medicare-eligible members). In addition, you can call the HOP Administration Unit at 1-800-773-7725 and request an information packet for any of these plans.

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