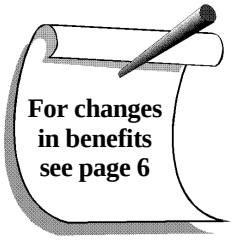
Health Insurance Plan (HIP/HMO)

http://www.HIPUSA.com

2001

A Health Maintenance Organization



Serving: Greater New York City Area

Enrollment in this Plan is limited; see page 4 for requirements.

This plan has Commendable Accreditation from the NCQA. See the FEHB 2001 Guide for more information on NCQA.

Enrollment code:

511 Self Only
512 Self and Family

Authorized for distribution by the:

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
RETIREMENT AND INSURANCE SERVICE
HTTP://WWW.OPM.GOV/INSURE

Federal Employees
Health Benefits Program

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Introduction

The Health Insurance Plan of Greater New York
7 West 34th Street
New York, NY 10001

This brochure describes the benefits of HIP/HMO under our contract (CS 1040) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled for Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2001, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2001, and are summarized on page 39. Rates are shown at the end of this brochure.

Plain Language

The President and Vice President are making the Government's communication more responsive, accessible, and understandable to the public by requiring agencies to use plain language. In response, a team of health plan representatives and OPM staff worked cooperatively to make this brochure clearer. Except for necessary technical terms, we use common words. "You" means the enrollee or family member; "we" means HIP/HMO.

The plain language team reorganized the brochure and the way we describe our benefits. When you compare this Plan with other FEHB plans, you will find that the brochures have the same format and similar information to make comparisons easier.

If you have comments or suggestions about how to improve this brochure, let us know. Visit OPM's "Rate Us" feedback area at http://www.opm.gov/insure or e-mail us at fehbwebcomments@opm.gov or write to OPM at Insurance Planning and Evaluation Division, P.O. Box 436, Washington, DC 20044-0436.

Section 1. Facts about this HMO plan

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services.

HMOs emphasize preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. Our providers follow generally accepted medical practice when prescribing any course of treatment.

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You only pay the copayments described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

You should join an HMO because you prefer the plan's benefits, not because a particular provider is available. You cannot change plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us.

How we pay providers

HIP/HMO is a Mixed Model plan. We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. Our providers accept a negotiated payment from us, and you are only responsible for your copayments for covered services.

Who provides my health care?

HIP/HMO Participating Physicians practice in independent offices throughout the greater metropolitan area. Some HIP participating physicians also practice in over 45 multi-specialty medical centers. Members may choose any of the Independent practice or group practice physicians as their source of primary care, regardless of where they live. Family members may choose a different primary care doctor and medical group.

At the present time, approximately 13,000 doctors participate in HIP/HMO and provide medical services to more than 795,000 enrollees. Our network covers 74 medical specialties ranging from family practice to urology. In addition to services from participating doctors, you may receive paramedical services including social services, nutrition, and health education at group centers.

Patients' Bill of Rights

OPM requires that all FEHB Plans comply with the Patients' Bill of Rights, recommended by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. You may get information about us, our networks, our providers and facilities. OPM's FEHB website (http://www.opm.gov/insure) lists the specific types of information that we must make available to you. We provide some of the required information in the following paragraph.

The Health Insurance Plan of Greater New York (HIP/HMO) was organized over 50 years ago as a non-profit corporation. On December 1, 1978, HIP/HMO became a New York certified health Maintenance Organization (HMO). Responsibility for HIP/HMO policy and operations is vested in an unpaid Board of Directors. This Board is composed of distinguished representatives of labor, consumers, doctors and the general public. The Board selects the principal administrative officer, the President, and holds him responsible for the enforcement of Board policy and for the operations of the Plan.

If you want more information about us and you are a current member call 1-800-HIP-TALK (1-800-447-8255). If you are a potential member, please call 1-888-866-7461 for information, or write to The Health Insurance Plan of Greater New York, 7 West 34th Street, New York, NY 10001. You may also visit our website at http://www. HIPUSA.com.

Service Area

You must live in our service area to enroll with us. The service area is where our providers practice. You must live in one of the following: New York City (the Boroughs of Manhattan, Brooklyn, Bronx, Queens, and Staten Island), all of Nassau, Orange, Rockland, Suffolk and Westchester Counties.

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care, as described on page 22. We will not pay for any other health care services.

You can enroll in another plan if you or a covered family member move outside of our service area. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a Fee-For-Service plan or an HMO that has an agreement with affiliates in other areas. HIP/HMO members can receive care from HIP Health Plan of Florida's participating providers within their respective FEHB approved service areas. HIP/HMO also participates in two reciprocity programs. The first is through the Alliance of Community Health Plans and the second is through American Association of Health Plans (AAHP). HIP has reciprocal agreements with 47 HMOs. In this manner, HIP ensures that members can obtain emergency, urgent or even routine care in some cases, while they are outside the Plan's service area. If you or a family member move, you do not have to wait until Open Season to change Plans. Contact your employing or retirement office.

Section 2. How we change for 2001

Program-wide changes

- The plain language team reorganized the brochure and the way we describe our benefits. We hope this will make it easier for you to compare plans.

- This year, the Federal Employees Health Benefits Program is implementing network mental health and substance abuse parity. This means that your coverage for mental health, substance abuse, medical, surgical, and hospital services from providers in our plan network will be the same with regard to copays, and day and visit limitations when you follow a treatment plan that we approve. Previously, we placed shorter day or visit limitations on mental health and substance abuse services than we did on services to treat physical illness, injury, or disease.

- Many healthcare organizations have turned their attention this past year to improving healthcare quality and patient safety. OPM asked all FEHB plans to join them in this effort. You can find specific information on our patient safety activities by calling Member Services at 1-800-HIP-TALK (1-800-447-8255) or checking our website, http://www.HIPUSA.com. You can find out more about patient safety on the OPM website, http://www.opm.gov/insure. To improve your healthcare, take these five steps:

  - Speak up if you have questions or concerns.
  - Keep a list of all the medicines you take.
  - Make sure you get the results of any test or procedure.
  - Talk with your doctor and health care team about your options if you need hospital care.
  - Make sure you understand what will happen if you need surgery.

- We clarified the language to show that anyone who needs a mastectomy may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure. Previously, the language referenced only women.

Changes to this Plan

- Your share of the Non-Postal premium will increase by 8.9% for Self-Only or 3.7% for Self and Family. See back cover.

- We no longer cover routine podiatry services.

Section 3. How you get care

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (for annuitants), or your Employee Express confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 1-800-HIP-TALK (1-800-447-8255).

Where you get covered care

You get care from "Plan providers" and "Plan facilities." All of your medical services are provided through our delivery system. You will only pay copayments and you will not have to file claims.

• Plan providers

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to the National Committee of Quality Assurance (NCQA) and other Industry standards.

We list Plan providers in the provider directory, which we update quarterly. For a current directory listing, members should call 1-800-HIP-TALK (1-800-447-8255). Potential members should call 1-888-866-7461. The list is also available on our website. Our website address is http://www.HIPUSA.com.

• Plan facilities

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update quarterly. The list is also available on our website at http://www.HIPUSA.com.

What you must do

It depends on the type of care you need. First, you and each family member must choose a primary care physician. This decision is important, since your primary care physician provides or arranges for most of your health care. The PCP provides primary medical care and, when medically necessary, provides referrals for specialty care and ancillary services such as lab tests and x-rays.

Our directory lists the locations and phone numbers of our primary care doctors. It also indicates whether or not a doctor is accepting new patients. After you select a specific provider from the directory, you should call the provider to verify that he or she still participates with HIP/HMO and is accepting new patients. You may also call our Customer Service Department at 1-800-HIP-TALK (1-800-447-8255) to find out if your doctor participates with HIP/HMO.

• Primary care

Your primary care physician can be a family practitioner, internist, or pediatrician. Your PCP will provide most of your health care, or give you a referral to see a specialist. We encourage our new members to schedule an appointment with their PCP for a baseline physical after coverage is effective.

If you want to change primary care physicians or if your primary care physician leaves the Plan, call us. We will help you select a new one.

• Specialty care

Your primary care physician will refer you to a specialist for needed care. However, you may receive primary and preventive obstetric and gynecologic care, chiropractic care, and routine eye care without your primary care physician's referral. Except in a medical emergency, or when a primary care doctor has designated another doctor to see his or her patients, you must receive a referral from your primary care doctor before seeing any other doctor or obtaining special services. Referral to a participating specialist is given at the primary care doctor's discretion. If non-Plan specialists or consultants are required, the primary care doctor will arrange appropriate referrals.

After you receive a referral from your primary care doctor, you must return to the primary care doctor after the consultation unless your doctor authorizes additional visits. All follow-up care must be provided or authorized by the primary care doctor. Do not go to the specialist for a second visit unless your primary care doctor has arranged for, and the Plan has issued an authorization for, the referral in advance.

Here are other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your primary care physician will use our criteria when creating your treatment plan (the physician may have to get an authorization or approval beforehand).

- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.

- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.

- If you have a chronic or disabling condition and lose access to your specialist because we:

  •• terminate our contract with your specialist for other than cause; or

  •• drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Plan; or

  •• reduce our service area and you enroll in another FEHB Plan,

  you may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us or, if we drop out of the FEHB Program, contact your new plan.

If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist until the end of your postpartum care, even if it is beyond the 90 days.

• Hospital care

Your Plan primary care physician or specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility.

If you are in the hospital when your enrollment in our Plan begins, call our Customer Service Department immediately at 1-800-HIP-TALK (1-800-447-8255). If you are new to the FEHB Program, we will arrange for you to receive care.

If you changed from another FEHB plan to us, your former plan will pay for the hospital stay until:

- You are discharged, not merely moved to an alternative care center; or
- The day your benefits from your former plan run out; or
- The 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the benefits of the hospitalized person.

Circumstances beyond our control

Under certain extraordinary circumstances, such as natural disasters, we may have to delay your services or we may be unable to provide them. In that case, we will make all reasonable efforts to provide you with the necessary care.

Services requiring our prior approval

Your primary care physician has authority to refer you for most services. For certain services, however, your physician must obtain approval from us. Your physician must get our approval before sending you to a hospital, referring you to a specialist, or recommending follow-up care. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice.

Section 4. Your costs for covered services

You must share the cost of some services. You are responsible for:

• Copayments

A copayment is a fixed amount of money you pay to the provider when you receive services.

Example: When you see your primary care physician you pay a copayment of $10 per office visit and when you go to the Emergency Room, you pay $25 per visit.

• Deductible

A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for those services. Copayments do not count toward any deductible. We do not have a deductible.

• Coinsurance

Coinsurance is the percentage of our negotiated fee that you must pay for your care. Coinsurance doesn't begin until you meet your deductible. We do not have coinsurance.

Your out-of-pocket maximum

We do not have an out-of-pocket maximum.

Section 5. Benefits -- OVERVIEW

(See page 6 for how our benefits changed this year and page 43 for a benefits summary.)

NOTE: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsections. If you are a current member and want to obtain claims forms, claims filing advice, or more information about our benefits, contact us at 1-800-HIP-TALK (1-800-447-8255). If you are a potential member, call us at 1-888-866-7461. You may also visit our website at www.HIPUSA.com for information.

Section 5(a) Medical services and supplies provided by physicians and other health care professionals

IMPORTANT

Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We do not have a calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9, *Coordinating benefits with other coverage*, including Medicare.

IMPORTANT

Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians • In physician's office	$10 per office visit
Professional services of physicians • In an urgent care center • Office medical consultations • Second surgical opinion	$10 per office visit
• During a hospital stay • In a skilled nursing facility • Initial examination of a newborn child covered under a family enrollment • At home	Nothing
Not covered: • *Physical Examinations that are not necessary for medical reasons, such as those required for obtaining or continuing employment or insurance, attending school or camp, or travel*	***All charges***
Lab, X-ray and other diagnostic tests	**You pay**
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine mammograms • Cat Scans/MRI • Ultrasound • Electrocardiogram and EEG	Nothing if you receive these services during your office visit; otherwise, $10 per office visit

Preventive care, adult	You pay
Routine screenings, such as: • Blood lead level – One annually • Total Blood Cholesterol – once every 3 years, from ages 19 - 64 • Colorectal Cancer Screening, including: •• Fecal occult blood test •• Sigmoidoscopy, screening – every five years starting at age 50	$10 per office visit
Prostate Specific Antigen (PSA test) – one annually for men age 40 and older	$10 per office visit
Routine pap test Note: The office visit is covered if pap test is received on the same day; see *Diagnosis and treatment services* on page 11	$10 per office visit
Routine mammogram – covered for women age 35 and older, as follows: • From age 35 through 39, one during this five-year period • From age 40 through 49, every 1-2 years • At age 50 and older, one every year	$10 per office visit
• Immunizations and inoculations in accordance with accepted medical practice and standards	$10 per office visit.
Not covered: • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel* • *Vaccines and immunizations for foreign travel*	***All charges***

Preventive care, children	You pay
• Childhood immunizations recommended by the American Academy of Pediatrics	$10 per office visit
• Examinations, such as: •• Eye exams through age 17 to determine the need for vision correction •• Ear exams through age 17 to determine the need for hearing correction •• Examinations done on the day of immunizations (through age 22) • Well-child care charges for routine examinations, immunizations and care (through age 22)	$10 per office visit

Maternity care	You pay
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).	Nothing
Not covered: Routine sonograms to determine fetal age, size or sex	***All charges***
Family planning	**You pay**
• Voluntary sterilization • Surgically implanted contraceptives • Injectable contraceptive drugs • Intrauterine devices (IUDs)	$10 per office visit
Not covered: reversal of voluntary surgical sterilization, genetic counseling	***All charges***
Infertility services	**You pay**
Diagnosis and treatment of infertility, such as: • Artificial insemination: •• *intravaginal insemination (IVI)* •• *intracervical insemination (ICI)* •• *intrauterine insemination (IUI)* • Fertility drugs Note: We cover injectable fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit.	$10 per office visit
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* •• *in vitro fertilization* •• *embryo transfer and GIFT* • *Services and supplies related to excluded ART procedures* • *Cost of donor sperm*	***All charges***

Allergy care	You pay
Testing and treatment Allergy injection	$10 per office visit
Allergy serum	Nothing
Not covered: provocative food testing and sublingual allergy desensitization	***All charges***

Treatment therapies	You pay
• Chemotherapy and radiation therapy Note: High-dose chemotherapy in association with autologous bone marrow transplant is limited to the Organ/Tissue Transplants list on page 19. • Respiratory and inhalation therapy • Dialysis – Hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT)	$10 per office visit

Rehabilitative therapies	You pay
Physical therapy, occupational therapy and speech therapy: • Up to two months per condition if significant improvement can be expected within two months for the services of the following: •• qualified physical therapists •• speech therapists and •• occupational therapists Note: We only cover therapy to restore bodily function or speech when there has been a total or partial loss of bodily function or functional speech due to illness or injury. • Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction	$10 per office visit
Not covered: • *long-term rehabilitative therapy* • *exercise programs*	***All charges***

Hearing services (testing, treatment, and supplies)	You pay
• First hearing aid and testing only when necessitated by accidental injury • Hearing testing for children through age 17 (see *Preventive care, children*)	$10 per office visit
Not covered: • *all other hearing testing* • *hearing aids, testing and examinations for them*	***All charges***

Vision services (testing, treatment, and supplies)	You Pay
• Diagnosis and treatment of diseases of the eye	$10 per office visit
• Annual eye refractions	$10 per office visit
• Lenses following cataract removal	$10 per office visit
Not covered: • *Eyeglasses or contact lenses* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	***All charges***

Foot care	You pay
Routine foot care only when you are receiving treatment for a metabolic or peripheral vascular disease such as diabetes Note: See orthopedic and prosthetic devices for information on podiatric shoe inserts.	$10 per office visit
Not covered: • *Simple trimming, cutting, or clipping of the distal nail plate and treatment of corns and calluses* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	***All charges***

Orthopedic and prosthetic devices	You pay
• Artificial limbs and eyes; stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy Note: We pay internal prosthetic devices as hospital benefits; see Section 5(c) for payment information. See Section 5(b) for coverage of the surgery to insert the device. • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome	$10 per office visit
Not covered: • *orthopedic and corrective shoes* • *arch supports* • *foot orthotics* • *heel pads and heel cups* • *lumbosacral supports* • *corsets, trusses, elastic stockings, support hose, and other supportive devices*	***All charges***

Durable medical equipment (DME)	You pay
Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Under this benefit, we also cover: • hospital beds • wheelchairs • crutches • walkers • blood glucose monitors and • insulin pumps Note: Call us at 1-800-HIP-TALK (1-800-447-8255) as soon as your Plan physician prescribes this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.	$10 per office visit
Not covered: • *Motorized and customized wheel chairs*	***All charges***

Home health services	You pay
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. Services include oxygen therapy, intravenous therapy and medications.	$10 per office visit
Not covered: • *nursing care requested by, or for the convenience of, the patient or the patient's family;* • *nursing care primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication.*	***All charges***

Alternative treatments	You pay
Chiropractic Care	$10 per office visit
Not coverered: • *naturopathic services* • *hypnotherapy* • *Acupuncture* • *biofeedback*	***All charges***

Educational classes and programs	You pay
Coverage is limited to: • Smoking Cessation – In a HIP Fit For Life Smoking Cessation Program • Diabetes self-management	$10 per office visit

Section 5(b). Surgical and anesthesia services provided by physicians and other health care professionals

IMPORTANT

Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We do not have a calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9, *Coordinating benefits with other coverage*, including Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility charge (i.e. hospital, surgical center, etc.).
- YOUR PHYSICIAN MUST GET PRIOR APPROVAL OF SOME SURGICAL PROCEDURES. Please refer to the prior approval information shown in Section 3 to be sure which services require precertification and identify which surgeries require prior approval.

IMPORTANT

Benefit Description	You pay
Surgical procedures	
• Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedure • Biopsy procedure • Removal of tumors and cysts • Correction of congenital anomalies (see reconstructive surgery) • Surgical treatment of morbid obesity - a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over • Insertion of internal prostethic devices. See 5(a) – Orthopedic braces and prosthetic devices for device coverage information • Voluntary sterilization • Norplant (a surgically implanted contraceptive) and intrauterine devices (IUDs) Note: Devices are covered under 5(a) • Treatment of burns	Nothing
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care*	***All charges***

Reconstructive surgery	You pay
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: •• the condition produced a major effect on the member's appearance and •• the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes. • All stages of breast reconstruction surgery following a mastectomy, such as: •• surgery to produce a symmetrical appearance on the other breast •• treatment of any physical complications, such as lymphedemas •• breast prostheses and surgical bras and replacements (see Prosthetic devices) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	Nothing
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Surgeries related to sex transformation*	***All charges***
Oral and maxillofacial surgery	**You pay**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones • Surgical correction of cleft lip, cleft palate or severe functional malocclusion • Removal of stones from salivary ducts • Excision of leukoplakia or malignancies • Excision of cysts and incision of abcesses when done as independent procedure and • Other surgical procedures that do not involve the teeth or their supporting structures	Nothing
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	***All charges***

Organ/tissue transplants	You pay
Limited to: • Cornea • Heart • Heart/lung • Kidney • Kidney/Pancreas • Liver • Lung: Single - Double • Pancreas • Allogeneic bone marrow transplants • Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors Note: We cover related medical and hospital expenses of the donor when we cover the recipient.	Nothing
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Implants of artificial organs* • *Transplants not listed as covered*	***All charges***
Anesthesia	**You pay**
Professional services provided in: • Hospital (inpatient)	$10 per office visit
Professional services provided in: • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	$10 per office visit

Section 5(c). Services provided by a hospital or other facility, and ambulance services

IMPORTANT

Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- We do not have a calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9, *Coordinating benefits with other coverage*, including Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are covered in Section 5(a) or (b).

IMPORTANT

Benefit Description	You pay
Inpatient hospital	
Room and board, such as: • ward, semiprivate, or intensive care accommodations • general nursing care and • meals and special diets NOTE: If you want a private room when it is not medically necessary, you pay the additional charge above the semi-private room rate. Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home (Note: calendar year deductible applies)	Nothing
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, extended, care facilities, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care*	***All charges***

Outpatient hospital or ambulatory surgical center	You pay
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood and blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service NOTE: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	Nothing
Not covered: blood and blood derivatives not replaced by the member	***All charges***
Extended-care benefits/skilled nursing care facility benefits	**You pay**
Skilled nursing facility (SNF): A comprehensive range of benefits with no day limit when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically necessary as determined by a Plan doctor and approved in advance by the Plan	Nothing
Not covered: *Custodial care, rest cures, domiciliary, or convalescent care*	***All charges***
Hospice care	**You pay**
Up to 210 days in an approved hospice program for a terminally ill member when a Plan doctor certifies that the member is terminal and has a life expectancy of six months or less. Covered services as follows when provided and billed by the hospice: • inpatient and outpatient care • professional services of a physician • prescription drugs and medical supplies and • bereavement counseling for immediate family members	Nothing
Not covered: • *Services or supplies not listed in the Hospice Program* • *Services for respite care* • *Nutritional supplements, non-prescription drugs or substances, vitamins and minerals* • *Independent nursing, homemaker services*	***All charges***
Ambulance	
• Local professional ambulance service in an emergency condition or when approved in advance by the Plan	Nothing

Section 5(d). Emergency services/accidents

IMPORTANT

Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure.
- We do not have a calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9, *Coordinating benefits with other coverage*, including Medicare.

IMPORTANT

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

What to do in case of emergency:

Call your Primary Care Physician. In extreme emergencies, if you are unable to contact your PCP, call 911 or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a Plan member so that they notify the Plan. You or a family member should notify the Plan within 48 hours. You can call 1-888-HIP-AUTH (1-888-447-2884).

If you are outside the service area and need to be hospitalized, you must notify us within 48 hours or on the first working day after your admission, unless it was not reasonably possible to do so. If a Plan doctor believes that care can be better provided in a Plan hospital, you will be transferred when medically feasible with any transportation charges covered in full.

We waive your emergency room copay if you are admitted to the hospital for inpatient treatment.

Section 5(d). Emergency services/accidents *(Continued)*

Benefit Description	You pay
Emergency within our service area	
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient or inpatient at a hospital, including doctors' services	$10 per office visit $25 per urgent care center visit $25 per emergency room visits
Not covered: Elective care or non-emergency care	***All charges***
Emergency outside our service area	
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient or inpatient at a hospital, including doctors' services	$10 per office visit $25 per urgent care center visit $25 per emergency room visit
Not covered: • *Elective care or non-emergency care* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	***All charges***
Ambulance	
Professional ambulance service when medically appropriate See 5(c) for non-emergency service	Nothing
Not covered: Ambulance transport when transportation other than professional ambulance service could be used without endangering the patient's medical condition	***All charges***

Section 5(e). Mental health and substance abuse benefits

IMPORTANT

Parity

Beginning in 2001, all FEHB plans' mental health and substance abuse benefits will achieve "parity" with other benefits. This means that we will provide mental health and substance abuse benefits differently than in the past.

When you get our approval for services and follow a treatment plan we approve, cost-sharing and limitations for Plan mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions.

Here are some important things to keep in mind about these benefits:

- All benefits are subject to the definitions, limitations, and exclusions in this brochure.
- We do not have a calendar year deductible.
- Be sure to read Section 4, *Your costs for covered service,* for valuable information about how cost sharing works. Also read Section 9, *Coordinating benefits with other coverage*, including Medicare.
- **YOU MUST GET PREAUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits description below.

IMPORTANT

Benefit Description	You pay
Mental health and substance abuse benefits	
Diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Your cost sharing responsibilities are no greater than for illness or conditions
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management	$10 per office visit
• Diagnostic tests • Services provided by a hospital or other facility	Nothing
• Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment	Nothing
Not covered: Services we have not approved *Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.*	***All charges***

Mental health and substance abuse benefits - Continued on next page

Preauthorization

To be eligible to receive these benefits you must follow your treatment plan and all the following authorization processes:

For mental health or substance abuse treatment, call 1-888-447-2526 for authorization and help in selecting a provider. For mental health services only, you may call a HIP mental health center directly. A trained professional will assess your treatment needs and make all necessary arrangements for you to see a participating provider at the center. You do not need a referral from your primary care physician for mental health and substance abuse services.

Special transitional benefit

If a mental health or substance abuse professional provider is treating you under our plan as of January 1, 2001, you will be eligible for continued coverage with your provider for up to 90 days under the following condition:

- If your mental health or substance abuse professional provider with whom you are currently in treatment leaves the plan at our request for other than cause.

If this condition applies to you, we will allow you reasonable time to transfer your care to a Plan mental health or substance abuse professional provider. During the transitional period, you may continue to see your treating provider and will not pay any more out-of-pocket than you did in the year 2000 for services. This transitional period will begin with our notice to you of the change in coverage and will end 90 days after you receive our notice. If we write to you before October 1, 2000, the 90-day period ends before January 1 and this transitional benefit does not apply.

Limitation

We may limit your benefits if you do not follow your treatment plan.

Section 5(f). Prescription drug benefits

IMPORTANT

Here are some important things to keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We do not have a calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9, *Coordinating benefits with other coverage*, including Medicare.

IMPORTANT

There are important features you should be aware of. These include:

- **Who can write your prescription.** A licensed Plan doctor or referral doctor must write the prescription.
- **Where you can obtain prescription drugs.** You may fill the prescription at a participating pharmacy. You may obtain generic maintenance drugs by mail order.
- **We use a formulary**. Our formulary is a list of effective medications and other items that we have approved for our members' use. A special committee of medical and pharmacy professionals reviews the formulary annually. We add or delete items on the list based on their findings. We have found that the drugs on our formulary are safe, effective, and therapeutic in the treatment of disease or illness. We also believe that our formulary improves patient outcomes while controlling drug costs. Please call 1-800-HIP-TALK (1-800-447-8255) for a copy of our formulary. Although we use a formulary, we still cover non-formulary drugs when prescribed by a Plan doctor.
- **These are the dispensing limitations.** A participating pharmacy will provide up to a 30-day supply of your prescription for $10.00. If you take generic maintenance drugs, you may also use our Mail Order Service. You pay $15.00 for up to a 90-day supply of generic drugs. Sexual dysfunction drugs require prior approval and have limits. Please contact us for details. For further information on using our mail order program, contact ValueRX at 1-800-224-5502. You may also call our Customer Service Department at 1-800-HIP-TALK (1-800-447-8255).

Prescription drug benefits begin on the next page.

Benefit Description	You pay
Covered medications and supplies	
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except as excluded below • Insulin (copay applies to each vial) • Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction (requires prior approval) • Oral and injectable contraceptive drugs and devices • Smoking cessation drugs and medication, including nicotine patches • Disposable needles and syringes needed to inject covered medication • Nutritional supplements for the treatment of phenylketonuria, branched-chain ketonuria, galactosemia, and homocystinuria • Fertility drugs (oral and injectable)	$10 per 30-day supply from a participating plan retail pharmacy or $15 for up to a 90-day supply for drugs purchased though our participating mail order pharmacy Note: All drugs are not available by mail order.
• Implanted time-release medications • Norplant	$10 per prescription unit
Here are some things to keep in mind about our prescription drug program: • A generic equivalent may be dispensed if it is available, unless your physician specifically requires a name brand. • We administer an open formulary. If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a formulary list. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. To order a prescription drug brochure, call 1-800-HIP-TALK (1-800-447-8255).	
Not covered: • *Drugs and supplies for cosmetic purposes* • *Nonprescription medicines* • *Drugs available without a prescription or for which there is a nonprescription equivalent available* • *Drugs obtained at a non-Plan pharmacy except for out-of-area emergencies* • *Vitamins and nutritional substances that can be purchased without a prescription* • *Medical supplies such as dressings and antiseptics* • *Drugs to enhance athletic performance*	***All charges***

Section 5(g). Special features

Feature	Description
Services for deaf and hearing impaired	A telephone number for the hearing impaired is 1-888-HIP-4TDD (1-888-447-4833).
Medical Case Management Programs	We offer case management programs for members with chronic or catastrophic illnesses or injuries**.**
Reciprocity benefit	HIP maintains reciprocal arrangements with other HMOs in the country. Call 1-800-223-0654 for information about other participating HMOs, or call our Customer Service Department at 1-800-HIP-TALK. If you are speech or hearing impaired, please call HIP at 1-888-HIP-4TDD (1-888-444-7352).
Travel benefit/services overseas	Please refer to the HIP Member Handbook

Section 5(h). Dental benefits

IMPORTANT

Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan dentists must provide or arrange your care.
- We do not have a calendar year deductible.
- We cover hospitalization for dental procedures only when a nondental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient; we do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9, *Coordinating benefits with other coverage*, including Medicare.

IMPORTANT

Accidental injury benefit	You pay
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. Services must be provided within 12 months of the injury. The need for dental services must result from an accidental injury.	Nothing
Not Covered: • *Dental implants* • *Orthodontic and fixed and removable prosthetics* • *Injuries to teeth that happened while eating* • *All other dental care*	***All charges***

Dental benefits

We have no other dental benefits.

Section 5(i). Non-FEHB benefits available to Plan members

The benefits on this part are not part of the FEHB contract or premium, and you cannot file an FEHB-disputed claim about them. Fees you pay for these services do not count toward out-of-pocket maximums.

HIP VIP® Medicare HMO Benefits
You may enroll in our HIP VIP® Medicare Plan: (1) if you are enrolled in Medicare Parts A and B and/or (2) if you have FEHB coverage. HIP VIP® Medicare covers everything that Medicare covers, plus additional benefits such as preventive care, hearing and eye examinations, eyeglasses, hearing aids and prescription drugs.

The HIP VIP® Medicare Plan is available at no additional cost to you and you may join any time during the year. If you are enrolled in both Medicare A & B in addition to the FEHB coverage, you receive the following benefits:

You are entitled to all benefits under the FEHB Program.	One pair of free eyeglasses every 12 months
You are entitled to coverage for everything Medicare covers	$500 towards the purchase of a hearing aid every 36 months.
You will have no copays for covered services	Worldwide emergency and urgently needed care

You may still enroll in HIP VIP® Medicare if are enrolled in Medicare Parts A and B but do not have FEHB coverage. However, your benefits will be different than those listed above. You may find out more information about HIP VIP® Medicare benefits by calling 1-888-866-7461.

Fitness Program - HIP/HMO Members receive a $100 reduction on the annual membership at all participating YMCA locations in the metropolitan New York area.

Alternative Medicine - The alternative medicine provides you with access to discounted Acupuncture, Massage Therapy and Yoga Therapy services through an agreement with Consensus Health, a leading national alternative medicine services organization.*

Should you choose to seek such services, you will have access to the large Consensus network of quality screened providers at discount rates. You pay no additional plan premiums. The fees you are charged will be at a discount off of the provider's usual rates. Present your HIP ID card to the Consensus network provider in order to obtain the discounted rate. Call 1-888-HIP-ALMD (1-888-447-2563) for a list of Consensus network providers.

Dental Care - We cover the following diagnostic and preventive services when provided by participating HIP General Dentists:
- One examination (comprehensive or periodic every six months) - $5 per visit
- One prophylaxis (cleaning) every six months - $10 per visit
- One topical fluoride (for children age 16 and under) every six months - $5 per visit

If you require other additional services, such as x-rays, fillings, crowns or dentures, your participating HIP General Dentist will provide them at a discounted rate. Please contact HIP's Dental Provider, Careington International at 1-800-290-0523 for a complete schedule of current reduced member fees. All member fees must be paid directly to the participating HIP General Dentist.

Questions?
If you have a question concerning Plan benefits or how to arrange for care, contact the Plan's Customer Service Department or you may write to the Plan at HIP/HMO, 7 West 34th Street, New York, NY 10001. A special number, 1-888-HIP-4TDD (1-888-447-4833), is available for use by the hearing impaired. You may also contact us at our Web site at http://www.HIPUSA.com or call us at 1-800-HIP-TALK (1-800-447-8255).

* *Through HIP's agreement with Consensus Health Corporation, this program provides HIP members with discounts for services provided by Consensus alternative medicine providers. Consensus is responsible for credentialing and managing all program practitioners. This program is not a covered benefit and HIP makes no representations or guarantees regarding the efficacy or appropriateness of the services made available. Use of these services is strictly the member's decision and HIP is not responsible for any acts or omissions of any Consensus alternative medicine provider.*

Section 6. General exclusions -- things we don't cover

The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition.**

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see Emergency Benefits);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies that are not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sex transformations;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program; or
- Expenses you incurred while you were not enrolled in this Plan.

Section 7. Filing a claim for covered services

When you see Plan physicians, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copay.

You will only need to file a claim when you receive services from non-plan providers. Sometimes these providers bill us directly. Check with the provider. If you need to file a claim, here is the process:

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Facilities will file on the UB-92 form. For claims questions and assistance, call us at 1-800-HIP-TALK (1-800-447-8255).

When you must file a claim -- such as for out-of-area care -- submit it on the HCFA-1500 or a claim form that includes the information below. Bills and receipts should be itemized and show:

- Covered member's name and ID number;
- Name and address of physician or facility that provided the service or supply;
- Dates you received the services or supplies;
- Diagnosis;
- Type of each service or supply;
- The charge for each service or supply;
- A copy of the explanation of benefits, payments, or denial from any primary payer --such as the Medicare Summary Notice (MSN); and
- Receipts, if you paid for your services.

Submit your claims to:
HIP Health Insurance Plan of New York
7 West 34th Street
New York, New York 10001

Prescription drugs

Call 1-800-HIP-TALK for a claim form and submit your claims to:

HIP Health Insurance Plan of New York
7 West 34th Street
New York, New York 10001

Deadline for filing your claim

Send us all of the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny your claim if you do not respond.

Section 8. The disputed claims process

Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies – including a request for preauthorization:

Step	Description

1 Ask us in writing to reconsider our initial decision. You must:

(a) Write to us within 6 months from the date of our decision; and
(b) Send your request to us at: HIP Health Plan of New York, 7 West 34th Street, New York, NY 10001; and
(c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and
(d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.

2 We have 30 days from the date we receive your request to:
(a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or
(b) Write to you and maintain our denial -- go to step 4; or
(c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.

3 You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have.

We will write to you with our decision.

4 If you do not agree with our decision, you may ask OPM to review it.

You must write to OPM within:

- 90 days after the date of our letter upholding our initial decision; or
- 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or
- 120 days after we asked for additional information.

Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division 3, P.O. Box 436, Washington, D.C. 20044-0436.

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.

Note: If you want OPM to review different claims, you must clearly identify which documents apply to which claim.

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representatives, such as medical providers, must provide a copy of your specific written consent with the review request.

Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

5 OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals.

6 If you do not agree with OPM's decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.

You may not sue until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

NOTE: If you have a serious or life threatening condition (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and

(a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 1-800-HIP-TALK (1-800-447-8255) and we will expedite our review; or

(b) We denied your initial request for care or preauthorization/prior approval, then:

- If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or

- You can call OPM's Health Benefits Contracts Division 3 at 1-202-606-0755 between 8 a.m. and 5 p.m. Eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you or a family member is covered under another group health plan or have automobile insurance that pays health care expenses without regard to fault. This is called "double coverage."

When you have double coverage, one plan normally pays its benefits in full as the primary payer and the other plan pays a reduced benefit as the secondary payer. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' guidelines.

When we are the primary payer, we will pay the benefits described in this brochure.

When we are the secondary payer, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than the reasonable charge. If we are the secondary payer, we may be entitled to receive payment from your primary plan.

We will always provide you with the benefits described in this brochure. Remember: Even if you do not file a claim with your other plan, you must still tell us that you have double coverage.

• What is Medicare?

Medicare is a Health Insurance Program for:

••People 65 years of age and older.
••Some people with disabilities, under 65 years of age.
••People with End-stage Renal Disease (permanent kidney failure requiring dialysis or a transplant)

Medicare has two parts:

••Part A (Hospital Insurance). Most people do not have to pay for Part A.
••Part B (Medical Insurance). Most people pay monthly for Part B.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare managed care plan is the term used to describe the various health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on the type of Medicare managed care plan you have.

• Original Medicare

The Original Medicare Plan is available everywhere in the United States. It is the way most people get their Medicare Part A and Part B benefits. You may go to any doctor, specialist, or hospital that accepts Medicare. Medicare pays its share and you pay your share. Some things are not covered under Original Medicare, like prescription drugs.

When you are enrolled in this Plan and Original Medicare, you still need to follow the rules in this brochure for us to cover your care. You still pay the stated copays for your covered healthcare services.

(Primary payer chart begins on next page)

The following chart illustrates whether Original Medicare or this Plan should be the primary payer for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly.

Primary Payer Chart		
A. When either you -- or your covered spouse -- are age 65 or over and …	**Then the primary payer is…**	
	Original Medicare	**This Plan**
1) Are an active employee with the Federal government (including when you or a family member are eligible for Medicare solely because of a disability)		✓
2) Are an annuitant	✓	
3) Are a reemployed annuitant with the Federal government when… a) The position is excluded from FEHB.....	✓	
b) Or, the position is not excluded from FEHB..... Ask your employing office which of these applies to you.		✓
4) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge),	✓	
5) Are enrolled in Part B only, regardless of your employment status	✓ (for Part B services)	✓ (for other services)
6) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty	✓ (except for claims related to Workers' Compensation)	
B. When you -- or a covered family member -- have Medicare based on end stage renal disease (ESRD) and…		
1) Are within the first 30 months of eligibility to receive Part A benefits solely because of ESRD		✓
2) Have completed the 30-month ESRD coordination period and are still eligible for Medicare due to ESRD	✓	
3) Become eligible for Medicare due to ESRD after Medicare became primary for you under another provision	✓	
C. When you or a covered family member have FEHB and…		
1) Are eligible for Medicare based on disability a) And are an annuitant.....	✓	
b) And are an active employee		✓

Claims process – Tell us if you or a family member is enrolled in Medicare Part A or B. Medicare will determine who is responsible for paying for medical services and we will coordinate the payments. When Original Medicare is the primary payer, Medicare processes your claim first. To find out if you need to file a claim, call Customer Service at 1-800-HIP-TALK (1-800-447-8255).

• Medicare Managed Care Plan

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare managed care plan. These are health care choices (like HMOs) in some areas of the country. In most Medicare managed care plans, you can only go to doctors, specialists, or hospitals that are part of the plan. Medicare managed care plans cover all Medicare Part A and B benefits. Some cover extras, like prescription drugs. To learn more about enrolling in a Medicare managed care plan, contact Medicare at 1-800-MEDICARE (1-800 633-4227) or at http://www.medicare.gov. If you enroll in a Medicare managed care plan, the following options are available to you:

This Plan and our Medicare managed care plan: You may enroll in our Medicare managed care plan and also remain enrolled in our FEHB plan. In this case, we reduce some of the copayments under your FEHB coverage.

This Plan and another Plan's Medicare managed care plan: You may enroll in another plan's Medicare managed care plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare managed care plan is primary, even out of the managed care plan's network and/or service area (if you use our Plan providers). However, we will not waive any of our copayments under the FEHB coverage.

Suspended FEHB coverage and a Medicare managed care plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare managed care plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare managed care plan premium.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next open season unless you involuntarily lose coverage or move out of the Medicare managed care plan's service area.

• Enrollment in Medicare Part B

Note: If you choose not to enroll in Medicare Part B, you can still be covered under the FEHB Program. We cannot require you to enroll in Medicare.

TRICARE

TRICARE is the health care program for members, eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. If both TRICARE and this Plan cover you, we pay first. See your TRICARE Health Benefits Advisor if you have questions about TRICARE coverage.

Workers' Compensation

We do not cover services that:

- you need because of a workplace-related disease or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or
- OWCP or a similar agency pays for through a third party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Once OWCP or a similar agency pays its maximum benefits for your treatment, we will cover your benefits. You must use our providers.

Medicaid

When you have this Plan and Medicaid, we pay first.

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, State, or Federal Government agency directly or indirectly pays for them.

When others are responsible for injuries

When you receive money to compensate you for medical or hospital care for injuries or illness caused by another person, you must reimburse us for any expenses we paid. However, we will cover the cost of treatment that exceeds the amount you received in the settlement.

If you do not seek damages you must agree to let us try. This is called subrogation. If you need more information, contact us for our subrogation procedures.

Section 10. Definitions of terms we use in this brochure

Calendar year	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page 9.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. See page 9.
Covered services	Care we provide benefits for, as described in this brochure.
Custodial care	Custodial care is care which does not require the continuing attention of trained medical personnel. Custodial care includes any service which can be learned and provided by an average individual who does not have medical training.
Deductible	A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 9.
Experimental or investigational services	Experimental and investigational service means any evaluation, treatment, therapy, or device which involves the application, administration or use, of procedures, techniques, equipment, supplies, products, remedies, vaccines, biological products, drugs, pharmaceuticals, or chemical compounds if, as determined solely by the Plan: 1) Such evaluation, treatment, therapy, or device cannot be lawfully marketed without approval of the United States Food and Drug Administration or the New York Department of Health and Rehabilitative Services, and approval for marketing has not, in fact been given at the time such is furnished to the covered person; or 2) Reliable evidence, as determined by the Plan, shows that such evaluation, treatment, therapy, or device (a) is the subject of an ongoing Phase I or II clinical investigation, or experimental or research arm of a Phase III clinical investigation, or under study to determine: maximum tolerated dosage(s), toxicity, safety, efficacy, or efficacy as compared without the standard means for treatment or diagnosis of the condition in question; or (b) has not been proven safe and effective for the treatment of the condition in question, as evidenced in the most recently published medical literature in the United States, Canada or Great Britain, using generally accepted scientific, medical or public health methodologies or statistical practices; or (c) is not the standard evaluation, treatment, therapy or device utilized by practicing physicians in treating other patients with the same or similar condition; or (3) There is no consensus among practicing physicians that the evaluation, treatment, therapy or device is safe or effective for the treatment in question; or (4) The consensus of opinion among experts is that further studies, reach, or clinical investigations are necessary to determine maximum tolerated dosage(s), toxicity, safety, efficacy or efficacy as compared with the standard means for treatment or diagnosis of the condition in question
Group health coverage	An organization such as your employer arranged for your coverage under this contract. The member's group has chosen to engage HIP to make arrangements through which Medical Services and Hospital Services will be delivered in accordance with the terms and conditions of the certificate of coverage.
Medically necessary and appropriate	Medically necessary and appropriate means those health care services or supplies, determined solely by HIP or its designee, that are necessary to prevent, diagnose, correct or cure conditions in the Member that cause acute suffering, endanger life, result in illness or infirmity, interfere substantially with the members capacity for normal activity or threaten some significant disability and that could not have been omitted under generally accepted medical standards or provided in a less intensive setting.
Us/We	Us and we refer to HIP Health Plan of New York.
You	You refers to the enrollee and each covered family member.

Section 11. FEHB facts

No pre-existing condition limitation

We will not refuse to cover the treatment of a condition that you had before you enrolled in this Plan solely because you had the condition before you enrolled.

Where you can get information about enrolling in the FEHB Program

See http://www.opm.gov/insure. Also, your employing or retirement office can answer your questions, and give you a Guide to Federal Employees Health Benefits Plans, brochures for other plans, and other materials you need to make an informed decision about:

- When you may change your enrollment;
- How you can cover your family members;
- What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire;
- When your enrollment ends; and
- When the next open season for enrollment begins.

We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office.

Types of coverage available for you and your family

Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your unmarried dependent children under age 22, including any foster children or stepchildren your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 22 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form. Benefits will not be available to your spouse until you marry.

Your employing or retirement office will not notify you when a family member is no longer eligible to receive health benefits, nor will we. Please tell us immediately when you add or remove family members from your coverage for any reason, including divorce, or when your child under age 22 marries or turns 22.

If you or one of your family members is enrolled in one FEHB plan, that person may not be enrolled in or covered as a family member by another FEHB plan.

When benefits and premiums start

The benefits in this brochure are effective on January 1. If you are new to this Plan, your coverage and premiums begin on the first day of your first pay period that starts on or after January 1. Annuitants' premiums begin on January 1.

Your medical and claims records are confidential

We will keep your medical and claims information confidential. Only the following will have access to it:

- OPM, this Plan, and subcontractors when they administer this contract;
- This Plan, and appropriate third parties, such as other insurance plans and the Office of Workers' Compensation Programs (OWCP), when coordinating benefit payments and subrogating claims;
- Law enforcement officials when investigating and/or prosecuting alleged civil or criminal actions;
- OPM and the General Accounting Office when conducting audits;
- Individuals involved in bona fide medical research or education that does not disclose your identity; or
- OPM, when reviewing a disputed claim or defending litigation about a claim.

When you retire

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as Temporary Continuation of Coverage (TCC).

When you lose benefits

• When FEHB coverage ends

You will receive an additional 31 days of coverage, for no additional premium, when:

- Your enrollment ends, unless you cancel your enrollment, or
- You are a family member no longer eligible for coverage.

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage.

• Spouse equity coverage

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. But, you may be eligible for your own FEHB coverage under the spouse equity law. If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees,* or other information about your coverage choices.

• TCC

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire.

You may not elect TCC if you are fired from your Federal job due to gross misconduct.

Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees,* from your employing or retirement office or from http://www.opm.gov/insure.

• Converting to individual coverage

You may convert to an individual policy if:

- Your coverage under TCC or the spouse equity law ends. (If you canceled your coverage or did not pay your premium, you cannot convert);
- You decided not to receive coverage under TCC or the spouse equity law; or
- You are not eligible for coverage under TCC or the spouse equity law.

If you leave Federal service, your employing office will notify you of your right to convert. You must apply in writing to us within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will not notify you. You must apply in writing to us within 31 days after you are no longer eligible for coverage.

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, and we will not impose a waiting period or limit your coverage due to pre-existing conditions.

Getting a certificate of group health plan coverage

If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan.

If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

Inspector General Advisory

Stop health care fraud! Fraud increases the cost of health care for everyone. If you suspect that a physician, pharmacy, or hospital has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at 1-877-TELL-HIP (1-877-835-5447) and explain the situation.
- If we do not resolve the issue, call **THE HEALTH CARE FRAUD HOTLINE 202-418-3300** or write to: The United States Office of Personnel Management, Office of the Inspector General Fraud Hotline, 1900 E Street, NW, Room 6400, Washington, DC 20415.

Penalties for Fraud

Anyone who falsifies a claim to obtain FEHB Program benefits can be prosecuted for fraud. Also, the Inspector General may investigate anyone who uses an ID card if the person tries to obtain services for someone who is not an eligible family member, or is no longer enrolled in the Plan and tries to obtain benefits. Your agency may also take administrative action against you.

Index

Do not rely on this page; it is for your convenience and does not explain your benefit coverage.

Summary of benefits for the Health Insurance Plan (HIP/HMO) - 2001

- **Do not rely on this chart alone**. All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

Benefits	You Pay	Page
Medical services provided by physicians: • Diagnostic and treatment services provided in the office ..... • Inpatient hospital visits or consultations	 $10 primary care or specialist Nothing	11-16
Services provided by a hospital:		
• Inpatient.....	Nothing	20
• Outpatient	Nothing	21
Emergency benefits: • In-area..... • Out-of-area	 $10 urgent care center/doctor and $25 for hospital emergency room	22-23
Mental health and substance abuse treatment.....	Regular cost sharing	24-25
Prescription drugs Up to a 30 day supply from a participating retail pharmacy ..... Up to a 90 day supply of generic maintenance drugs by mail-order	 $10 $15	26-27
Dental Care ..... Accidental injury benefit only	Nothing	29
Vision Care ..... One annual eye refraction	Nothing	15
Protection against catastrophic costs (your out-of-pocket maximum)	Your out-of-pocket expenses are limited to the stated copayment for a particular service	9
Special features • Service for deaf and hearing impaired • Medical Case Management Progams • Reciprocity benefit • Travel benefit/services overseas	Nothing	28

2001 Rate Information for
Health Insurance Plan of Greater New York (HIP/HMO)

Non-Postal rates apply to most non-Postal enrollees. If you are in a special enrollment category, refer to the FEHB Guide for that category or contact the agency that maintains your health benefits enrollment.

Postal rates apply to career Postal Service employees. Most employees should refer to the FEHB Guide for United States Postal Service Employees, RI 70-2. Different postal rates apply and special FEHB guides are published for Postal Service Nurses and Tool & Die employees (see RI 70-2B); and for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

Postal rates do not apply to non-career postal employees, postal retirees, or associate members of any postal employee organization. Refer to the applicable FEHB Guide.

		Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
Self Only	**511**	**$ 69.95**	**$23.32**	**$151.57**	**$ 50.52**	**$ 82.78**	**$10.49**
Self and Family	**512**	**$195.82**	**$83.99**	**$424.28**	**$181.98**	**$231.17**	**$48.64**