HIP Health Plan of Florida 2001

http://www.hipusa.com

A Health Maintenance Organization

Serving: South Florida and Tampa Bay areas

Enrollment in this Plan is limited; see page 5 for requirements.

For changes in benefits see page 6

This Plan has commendable accreditation from the NCQA. See the *2001 Guide* for more information on NCQA.

Enrollment codes for this Plan:

South Florida
3N 1 Self Only
3N 2 Self and Family

Tampa
K7 1 Self Only
K7 2 Self and Family

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UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
RETIREMENT AND INSURANCE SERVICE
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Federal Employees Health Benefits Program

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Introduction

HIP Health Plan of Florida
300 South Park Road
Hollywood, Florida 33021

This brochure describes the benefits of HIP Health Plan of Florida under our contract (CS 2363) 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 6. 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 Health Plan of Florida.

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 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, coinsurance, and deductibles 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
We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your copayments.

Who provides my health care?
HIP Health Plan of Florida contracts with approximately 1400 primary care physicians and 1200 specialists to provide care to HIP members. When a family joins our Plan, each family member may select a different primary care physician. The primary care physician provides primary medical care, arranges lab tests, x-rays, referrals to specialists and hospital admissions for you, as medically necessary.

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 (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- We have commendable accreditation from NCQA (the National Commission for Quality Assurance).
- We are a state-licensed HMO.
- We have been in existence since 1985.

If you want more information about us, call 1-800-HIP-TALK (1-800-447-8255) or TTY 1-888-444-7352, or write to HIP Health Plan of Florida, 300 South Park Road, Hollywood, Fl. 33021. You may also contact us by fax at 954/893-6482 or visit our website at www.hipusa.com.

Service Area
To enroll in this Plan, you must live in or work in one of our Service Areas. This is where our providers practice. Our Service Areas are:

South Florida, enrollment code 3N:
Broward, Miami-Dade and Palm Beach counties

Tampa, enrollment code K7:
Hernando, Hillsborough, Pasco and Pinellas counties

You must get your care from providers who contract with us. If you receive care outside our Service Area, we will only pay for emergency care. We will not pay for any other care.

If you or a family member moves out of our Service Area, you can enroll in another FEHB plan. If you have a family member who lives outside our Service Area, for example, a child who attends college in another state, you should consider enrolling in a fee-for-service plan or an HMO that has a point-of-service benefit or an agreement with plans in other areas. We have an affiliate plan in New York which serves New York City metropolitan area. If you move to that area, you may enroll in the FEHB program offered by our affiliate plan. Contact your employing or retirement office if you move; you do not have to wait until Open Season to change plans.

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 deductibles, coinsurance, copayments, and day and visit limitations when you follow a treatment plan that we approve. Previously, we placed higher patient cost sharing and 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 customer service at 1-800-HIP-TALK (1-800-447-8255) or checking our website at www.hipusa.com. You can find out more about patient safety on the OPM website, 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 medicines you take.
  - •• Make sure you get the results of any test or procedure.
  - •• Talk with you 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 only referenced women.

Changes to this Plan

- For enrollment code 3N (South Florida), your share of the non-Postal premium will increase by 4.9% for Self Only or decrease by 5.3% for Self and Family. For enrollment code K7 (Tampa), your share of the non-Postal premium will increase by 8.7% for Self Only and 7.5% for Self and Family - see back of brochure.
- You will pay a $100 copayment for each hospital admission.
- For maintenance medications, you will pay $7.50 generic/$15 brand for a 90-day mail order supply.

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) or TTY 1-888-444-7352 or log onto www.hipusa.com.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments and you will not have to file claims.

· Plan providers

Plan providers are physicians and other health care professionals (such as chiropractors, physical therapists, nurse practitioners, nurse midwives, clinical social workers) in our service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards.

We list Plan providers in the provider directory, which we update periodically. The list is also on our website.

· 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 periodically. The list is also on our website.

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. Call us at 1-800-HIP-TALK (TTY 1-888-444-7352) or visit our website to select a primary care physician.

· Primary care

Your primary care physician can be a family practitioner, internist or pediatrician. Your primary care physician will provide most of your health care, or give you a referral to see a specialist.

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 see the following specialists without a referral:

- Obstetrician/Gynecologist for an annual well-woman examination
- Podiatrist
- Chiropractor
- Dermatology (for up to 5 visits per year)
- Mental health/substance abuse provider
- Dentist (for preventive dental services)
- Optometrist (for annual eye exam.)

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 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 (TTY 1-888-444-7352). 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 hospital benefit 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. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice.

We call this review and approval process the Member Advocacy Program (MAP). Your physician must obtain prior approval from the MAP for the following services:

- All non-emergency hospital admissions
- Outpatient surgery in a hospital setting or an ambulatory surgical center
- Skilled nursing facility stays
- Inpatient mental health or substance abuse treatment
- Home health care
- Hospice
- Durable medical equipment
- All services provided by non-participating providers, except dialysis
- Organ transplants
- Non-emergency ambulance transportation
- Growth hormone therapy treatment
- Air ambulance services

Generally, when you anticipate receiving any of these services, your participating physician will contact MAP for you. You may wish to call your physician's office to make sure this has been done

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 in the hospital, you pay $100 per admission.

- **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

After your copayments total $1,500 per person or $3,000 per family enrollment in any calendar year, you do not have to pay any more for covered services. However, copayments for prescription drugs do not count toward your out-of-pocket maximum, and you must continue to pay your prescription drug copayments.

Be sure to keep accurate records of your copayments since you are responsible for informing us when you reach the maximum.

Section 5. Benefits – OVERVIEW

(See page 6 for how our benefits changed this year and page 47 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. To obtain claims forms, claims filing advice, or more information about our benefits, contact us at 1-800-HIP-TALK (TTY 1-888-444-7352) or at our website at www.hipusa.com.

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.
- We do not have a calendar year deductible.
- Plan physicians must provide or arrange your care.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians • In physician's office • In an urgent care center • In a skilled nursing facility • Initial examination of a newborn child covered under a family enrollment • Office medical consultations • Second surgical opinion	$10 per office visit
• During a hospital stay	Nothing
• At home	Nothing
Lab, X-ray and other diagnostic tests	
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 visit

Preventive care, adult	You pay
Routine screenings, such as: • Blood lead level – One annually • Total Blood Cholesterol – once every three years, ages 19 through 64 • Colorectal Cancer Screening, including •• Fecal occult blood test •• Sigmoidoscopy, screening – every five years starting at age 50	$10 per office visit $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*, above.	$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, one every one to two calendar years • At age 50 and older, one every calendar year	$10 per office visit
Not covered: Physical exams required for obtaining or continuing employment or insurance, attending camp or travel.	*All charges*
Routine Immunizations and inoculations in accordance with accepted medical practice and standards as we establish, including: • Tetanus-diphtheria (Td) booster – once every 10 years, ages19 and over (except as provided for under Childhood immunizations) • Influenza/Pneumococcal vaccines, annually, age 65 and over	$10 per office visit
Not covered: Immunizations for travel	*All charges*
Preventive care, children	
• Childhood immunizations recommended by the American Academy of Pediatrics	Nothing
• 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)	Nothing

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 do not need to precertify your normal delivery; see page 22 for other circumstances, such as extended stays for you or your baby. • 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
Family planning	
• Voluntary sterilization • Surgically implanted contraceptives • Injectable contraceptive drugs • Intrauterine devices (IUDs)	$10 per office visit
Not covered: reversal of voluntary surgical sterilization, 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 rape or incest, sex transformation).	*All charges*
Infertility services	
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

Infertility services – Continued on next page

Infertility services *(Continued)*	**You pay**
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* ••*in vitro fertilization* ••*embryo transfer and GIFT/ZIFT* • *Drugs, services and supplies related to excluded ART procedures* • *Cost of donor sperm*	*All charges*
Allergy care	
Testing and treatment Allergy injection	$10 per office visit $10 per office visit
Allergy serum	Nothing
Not covered: provocative food testing and sublingual allergy desensitization	*All charges*
Treatment therapies	
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants on page 21. • Respiratory and inhalation therapy • Dialysis – Hemodialysis and peritoneal dialysis • Intravenous (IV) Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) Note: – We will only cover GHT when we give prior approval for the treatment. Your physician must call us for prior approval. We will ask for information that establishes that the GHT is medically necessary. Have your physician obtain approval before you begin treatment; otherwise, we will only cover GHT services from the date we approve GHT treatment. If we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See *Services requiring our prior approval* in Section 3. Growth hormone therapy is covered under the medical benefit.	$10 per office visit
Not covered: • *chelation therapy* • *any furniture, plumbing, electrical or other fixtures to perform dialysis at home*	*All charges*

Rehabilitative therapies	You pay
Physical therapy, occupational therapy and speech therapy : • Up to 2 months per condition for the services of each 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)	
• 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)	
• Annual eye refraction to provide a written lens prescription for eyeglasses • One pair of corrective eyeglasses per year from a special selection at participating provider • Contact lens eye examination, fitting and 1 pair of Daily Wear contact lenses per year in lieu of eyeglasses • Contact lens eye examination, fitting and 1 pair of Extended Wear contact lenses per year in lieu of eyeglasses	$15 per office visit Copayment depends on lenses selected $100 $140
• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts)	Copayment depends on lenses selected
• Eye exam to determine the need for vision correction for children through age 17 (see preventive care)	Nothing
Not covered: • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery; however discounts for lasik surgery are available from the Plan's participating providers – see Section 5(i)*	*All charges*

Foot care	You pay
• Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes See orthopedic and prosthetic devices for information on podiatric shoe inserts	$10 per office visit
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *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	
• 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 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 • Initial orthopedic shoes if part of a foot brace	Nothing
Not covered: • *Orthopedic shoes (if not part of a foot brace) and corrective shoes* • *Arch supports* • *Heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Prosthetic replacements provided less than 3 years after the last one we covered*	*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 • Insulin pumps Note: Call us at 1-800-HIP-TALK (TTY 1-888-444-7352) 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.	Nothing
Not covered: motorized wheel chairs	*All charges*
Home health services	
• 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	Nothing
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	
Chiropractic services	$10 per office visit
Not covered: • *naturopathic services* • *hypnotherapy* • *biofeedback* • *accupuncture*	*All charges*
Educational classes and programs	
Coverage is limited to: • Smoking Cessation – one smoking cessation program per member per calendar year, including all related expenses such as drugs • Diabetes self-management • Disease management programs for asthma, congestive heart failure, hepatitis C awareness, etc.	Nothing
• Nutritional counseling	$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 about coordinating benefits with other coverage, including with 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.).
- YOU MUST GET PRIOR APPROVAL FOR SOME SURGICAL PROCEDURES. Please refer to the prior approval information shown in Section 3 to be sure which services 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 prosthetic devices. See 5(a) – Orthopedic braces and prosthetic devices for device coverage information. Voluntary sterilization Insertion of Norplant (a surgically implanted contraceptive) and intrauterine devices (IUDs) Treatment of burns	$10 per office visit
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.	$10 per office visit
• 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.	$10 per office visit
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	
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 abscesses when done as independent procedures and • Other surgical procedures that do not involve the teeth or their supporting structures	$10 per office visit
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* • *Dental care involved in the treatment of TMJ*	*All charges*

Organ/tissue transplants	You pay
Limited to: • Cornea • Heart • Heart/lung • Kidney • Liver • Lung (Single or Double) • Pancreas/kidney • Allogeneic (donor) 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: You must receive prior approval from our Medical Director for all organ /tissue transplants. Note: We cover related medical and hospital expenses of the donor when we cover the recipient.	$10 per office visit and nothing for the actual transplant surgery Note: There is a $100 hospital admission copay
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* • *Travel expenses*	*All charges*
Anesthesia	**You pay**
Professional services provided in: • Hospital (inpatient)	Nothing
Professional services provided in: • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center	Nothing
Professional services provided in: • Office	$10 per visit

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

IMPORTANT

Here are some important things to remember 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 about coordinating benefits with other coverage, including with 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).
- **YOUR PHYSICIAN MUST GET PRIOR APPROVAL FOR HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require prior approval.

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 semiprivate room rate.	$100 per admission
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	Nothing

Inpatient hospital – Continued on next page

Inpatient hospital *(Continued)*	**You pay**
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	
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, 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
Skilled nursing care facility benefits	
Skilled nursing facility (SNF): 30 days per calendar year	Nothing
Not covered: custodial care	*All charges*
Hospice care	
Hospice care: 210 days per lifetime Supportive and palliative care for a terminally ill member with a life expectancy of 6 months or less is covered in the home or in a hospice facility	Nothing
Not covered: Independent nursing, homemaker services	*All charges*
Ambulance	
• Local professional ambulance service when medically appropriate	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 about coordinating benefits with other coverage, including with 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:

You are covered for emergency care within and outside our service area. Call your primary care physician. If you are unable to contact your physician, go to the nearest hospital emergency room or call 911. Notify us, or have a family member or the hospital notify us, within 48 hours, or as soon as reasonably possible. It is your responsibility to ensure that we are timely notified, unless it was not reasonably possible to do so. If you are hospitalized in a non-Plan facility and we believe that care can provided in a Plan hospital, we will transfer you when medically safe to do so. You must obtain all follow-up care from Plan participating providers; your primary care physician will co-ordinate your follow-up care.

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 $10 per urgent care center visit $25 per emergency room visit (waived if admitted) or $100 per hospital admission
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 $10 per urgent care center visit $25 per emergency room visit (waived if admitted) or $100 per hospital admission
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 • Air ambulance, limited to situations where ground transportation is not medically appropriate – prior approval required See 5(c) for non-emergency service.	Nothing

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 services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PRIOR APPROVAL OF THESE SERVICES.** See the instructions after the benefits description below.

IMPORTANT

Benefit Description	You pay
Mental health and substance abuse benefits	
All 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 other 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

Mental health and substance abuse benefits - Continued on next page

Mental health and substance abuse benefits *(Continued)*	**You pay**
Diagnostic tests	Nothing if you receive these services during your office visit; otherwise, $10 per office visit
Services provided by a hospital or other facility Services in approved alternative care settings such as residential treatment, partial hospitalization and facility-based intensive outpatient treatment	$100 per admission copay
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*

Prior approval

To be eligible to receive these benefits you must follow your treatment plan and all the following approval processes. You must call Psych/Care at 1-800-221-5487. You do not need a referral from your primary care physician or approval from us. Psych/Care is a managed behavioral health care firm with over 500 providers in our service area. A Psych/Care provider will evaluate you and develop a treatment plan. Once the treatment plan has been approved, you must follow it. If you need inpatient care, your Psych/Care provider will arrange it for you. Call Psych/Care for the participating providers in your area.

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

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 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

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

- **Who can write your prescription.** A Plan physician, referral physician or Plan participating dentist must write the prescription;
- **Where you can obtain them.** You must fill the prescription at a Plan pharmacy, or through our mail order program for a maintenance medication.
- **We use a formulary.** The Formulary is a list of drugs, both brand name and generic, that we approve as covered medications. Plan pharmacies will dispense a generic when a generic is available and substitution is allowed or required by law, unless the physician indicates that the brand name is medically necessary on the prescription. In that case, the physician must call our Pharmacy department to obtain an authorization. If the physician does not obtain authorization, or you request a brand name when it is not medically necessary, you will pay the brand copayment plus the difference in cost between the brand name and the generic. If there is no generic equivalent available, you will pay the brand name copayment. To obtain a copy of our formulary, call 1-800-HIP-TALK (TTY 1-888-444-7352) or visit our website at www.hipusa.com,.
- **These are the dispensing limitations.** You may obtain a 30-day supply at a Plan pharmacy or a 90-day supply via mail order. Mail order is available for maintenance medications only. A 90-day vacation supply may also be obtained from a Plan pharmacy once a year. Refills may be ordered up to 11 times or 12 months per prescription (5 refills in 6 months for controlled substances); you may obtain a refill up to 6 days before your prescription runs out.
- **When you have to file a claim.** There are no claims to file when you use a Plan pharmacy or our mail order program.

Prescription drug benefits – Continued on 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 • Disposable needles and syringes for the administration of covered medications • Contraceptive drugs and devices • Diabetic supplies, including insulin syringes, needles, glucose test tablets, test strips and solution • Nicotine patches (in connection with the Plan's smoking cessation program only)	$5 generic/$10 brand name for up to a 30-day supply per prescription or refill at a Plan pharmacy Or $7.50 generic/$15 brand name for up to a 90-day supply of maintenance medication by mail-order Note: If there is no generic equivalent available, you will pay the brand name copay
• Sexual dysfunction drugs, subject to special limits and guidelines, call plan for details Note: These drugs are not available through mail-order.	$15 per prescription or refill at a Plan pharmacy.
Not covered: • *Drugs and supplies for cosmetic purposes* • *Vitamins, nutrients and food/dietary supplements even if a physician prescribes or administers them* • *Nonprescription medicines* • *Drugs to enhance athletic performance* • *Fertility drugs except those prescribed in connection with covered artificial insemination services* • *Smoking cessation drugs and medication, including nicotine patches, unless in conjunction with participation in Psych/Care's smoking cessation program* • *Drugs given to you while you are a patient in a hospital, skilled nursing facility, convalescent hospital, hospice or other facility where drugs are ordinarily provided by the facility to its patients* • *Refills in excess of the number specified by the physician or refills dispensed more than 12 months after the original date of the prescription* • *Drugs provided to you by this Plan but which are lost, stolen, or destroyed* • *Drugs for the treatment of obesity, unless medically necessary for the treatment of morbid obesity*	*All charges*

Section 5 (g). Special features

Feature	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. • Alternative benefits are subject to our ongoing review. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
Services for deaf and hearing impaired	We have a TTY number (1-888-444-7352).
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 (TTY 1-888-444-7352).
High risk pregnancies	We have an Obstetrical program headed by a team of experienced perinatal nurses who will work with you and your physician to coordinate education and services during your pregnancy. We will provide monitoring and counseling as well as general information on breast feeding, postpartum and newborn care.
Centers of excellence for transplants	We use recognized Centers of excellence for organ transplants. We also have a transplant case manager who will work with you and your physician to coordinate your care from the pre-transplant phase until one year after your transplant, or longer if necessary.
Medical Case Management Programs	We offer case management programs for members with diabetes, congestive heart failure, asthma, HIV/AIDS and hepatitis-C. We also offer case management programs for members with chronic or catastrophic illnesses or injuries.
Social Worker Services	We have a social worker in the Case Management department who can help you with obtaining community services and education and planning for future needs
Travel benefit/ services overseas	You are covered for emergency care anywhere in the world.

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 cover hospitalization for dental procedures only when a non-dental 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 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

Accidental injury dental benefit	You pay
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury. We must receive and approve a treatment plan from your dentist.	Nothing
Not covered: Any non-accidental injury dental services not shown as covered	*All charges*

Dental Benefits	
Service	**You pay**
Preventive Services:	
• Prophylaxis or cleaning (1 every 6 months)	$5 per office visit
• Application of topical fluoride for children up to and including age 15 (1 every 6 months)	
Diagnostic Services	
• Periodic oral exam	$5 per office visit
• Bitewing X-rays (2) every 6 months	Note: the most you pay for these services is $10 per visit
Not covered: Other dental services not shown as covered	*All charges*

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

The benefits on this page 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 FEHB deductibles or out-of-pocket maximums.

- Health and Wellness Initiatives such as hepatitis C awareness intervention, smoking cessation, nutrition counseling
- Disease Management Programs for asthma, diabetes, congestive heart failure patients
- Case Management Programs for obstetrical, pediatrics, HIV/AIDS, catastrophic and transplant patients
- Fitness Club Discounts
- Lasik surgery services at preferred rates
- HIP VIP Medicare (our Medicare+Choice plan) if you live in Miami-Dade, Broward and Palm Beach counties and are entitled to Medicare Part A and enrolled in Medicare Part B. HIP VIP Medicare covers everything that Medicare covers, plus some items that Medicare does not cover, such as prescription drugs, hearing and vision screenings, routine foot care, dental services, over-the-counter vitamins and a fitness club incentive. Benefits, premiums and copayments vary by county. You may enroll at any time during the year. Call 1-800-826-1013 (TTY 1-888-444-7352 if you are hearing impaired) for more information.

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** and we agree, as discussed under *Services requiring our prior approval* on page 9.

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; or
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.
- Services provided to you without charge or that would normally be provided without charge if you were not covered under this Plan or under any other insurance, and care rendered by your immediate family members.

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 copayment.

You will only need to file a claim when you receive emergency services from non-plan providers. Sometimes these providers bill us directly. Check with the provider. If you need to file the 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 (TTY 1-888-444-7352).

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 shown below. Bills and receipts should be itemized and show:

- Covered member's name and ID number;
- Name and address of the 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 Plan of Florida
P.O. Box 819006
Hollywood, Fl. 33081-9009

Prescription drugs

You have no claims when you use Plan pharmacies or the plan's mail order service to fill your prescriptions. If you fill a prescription at a non-Plan pharmacy in an emergency, you must file a claim for reimbursement. Include your itemized receipt from the pharmacy and explain why you filled the prescription at a non-Plan pharmacy. Prescription drug claim forms may be obtained by calling our Customer Service department at 1-800-HIP-TALK (TTY 1-888-444-7352). Submit your claims to the address shown above.

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 prior approval:

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 Florida, 300 South Park Road, Hollywood, Fl. 33021; 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. The Disputed Claims Process • 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 representative, 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 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 prior approval, then call us at 1-800-HIP-TALK (TTY 1-888-444-7352) and we will expedite our review; or

(b) We denied your initial request for care or 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 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 are covered 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 our allowance. If we have already provided care to you, we are entitled to receive payment from your primary plan.

·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 + Choice 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.

·The Original Medicare Plan

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. We will not waive copayments or coinsurance for covered 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……	 …….✓ ……..	 ……✓

When Original Medicare is primary, your physician will need to file a claim with Medicare. If your Plan physician does not participate in Medicare, you will have to file the claim with Medicare.

Claims process -- You probably will not have to file a claim when you have both our Plan and Medicare.

- When we are the primary payer and you use our providers, we process the claim first.

When Original Medicare is the primary payer, Medicare processes your claim first. They will send you an Explanation of Medicare benefits. As long as you use providers that participate with both Medicare and us, your claims will be coordinated automatically. In most cases, you will not need to do anything. To find out if you need to do something about filing your claims, call us at 1-800-447-8255 (TTY 1-888-444-7352.)

· 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, and 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 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 waive some of the copayments for 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 Medicare managed care plan's network (if you use our Plan providers), but we will not waive any of our copayments. You must use our Plan providers and also follow our rules in order for us to cover your care.

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 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 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 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 page10.

Covered services

Care we provide benefits for, as described in this brochure.

Custodial care

Care which does not require the continuing attention of trained, medical personnel, including any service which can be learned and provided by an average individual who does not have medical training, for example,

- Assistance in meeting activities of daily living, such as feeding, dressing and personal hygiene; or
- Administration of oral medications, routine changing of dressing or preparation of special diets; or
- Assistance in walking or getting in or out of bed.

Experimental or Investigational services

A service, supply, drug, device, procedure or treatment if:

- There is insufficient outcomes data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or
- The Food and Drug Administration (FDA) has not granted the required approval for general use; or
- The written protocols or informed consent used by the treating facility or any other facility studying substantially the same drug, device, procedure or treatment states that it is experimental, investigational or for research purposes.

However, we will not exclude coverage for any drug prescribed for the treatment of cancer on the grounds that the drug is not approved by the FDA for a particular indication if that drug is recognized for treatment of that indication in a standard reference compendium or recommended in the medical literature.

Also, a bone marrow transplant will not be considered experimental or investigational if the particular use of the bone marrow transplant is determined to be accepted within the appropriate oncological specialty and not experimental pursuant to Florida law.

Medical Necessity

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 Member's capacity for normal activity and which cannot be omitted under generally accepted medical standards or provided in a less intensive setting.

Us/We

Us and we refer to HIP Health Plan of Florida.

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 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 www.opm.gov/insure.

Converting to individual coverage

You may convert to a non-FEHB 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 1-800-877-TELL-HIP 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.

NOTES:

Summary of benefits for HIP Health Plan of Florida – 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.....	Office visit copay: $10 primary care; $10 specialist	12
Services provided by a hospital: • Inpatient..... • Outpatient.....	 $100 per admission copay Nothing	 22 23
Emergency benefits: • In-area ..... • Out-of-area	 $25 per hospital emergency room $25 per hospital emergency room	 25 25
Mental health and substance abuse treatment.....	Regular cost sharing	26
Prescription drugs: • 30-day supply at plan pharmacy…….. • 90-day supply mail order…….	 $5 generic/ $10 brand name $7.50generic/$15 brand name	 28 28
Dental Care: • Accidental injury……. • Preventive	 Nothing $5 per service up to a $10 maximum per visit	31
Vision Care: • Annual eye refraction……..	 $15 per office visit	16
Special feautres		30
Protection against catastrophic costs (your out-of-pocket maximum)	Nothing after $1,500/Self Only or $3,000/Family enrollment per year Some costs do not count toward this protection	10

2001 Rate Information for HIP Health Plan of Florida

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
South Florida							
Self Only	3N1	$81.01	$27.00	$175.52	$58.50	$95.86	$12.15
Self and Family	3N2	$195.82	$102.78	$424.28	$222.69	$231.17	$67.43
Tampa							
Self Only	K71	$86.59	$50.14	$187.61	$108.64	$102.22	$34.51
Self and Family	K72	$195.82	$182.19	$424.28	$394.74	$231.17	$146.84