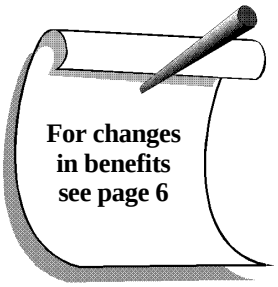
HEALTH PLAN OF NEW YORK

Health Insurance Plan (HIP/HMO)

http://www.HIPUSA.com

2002

A Health Maintenance Organization



Serving: Greater New York City Area

Enrollment in this Plan is limited. You must live in our Geographic service area to Enroll. See page 5 for requirements.

This plan has Commendable Accreditation from the NCQA. See the FEHB 2002 Guide for more information on NCQA.

Enrollment codes:

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

FEHB
Federal Employees
Health Benefits Program

RI 73-001

Table of Contents

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, 2002, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2002 and changes are summarized on page 43. Rates are shown at the end of this brochure.

Plain Language

Teams of Government and health plans' staff worked on all FEHB brochures to make them responsive, accessible, and understandable to the public. For instance,

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee or family member, "we" means HIP.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

If you have comments or suggestions about how to improve the structure of this brochure, let us know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or email us at fehbwebcomments@opm.gov. You may also write to OPM at the Office of Personnel Management, Office of Insurance Planning and Evaluation Division, 1900 E Street, NW Washington, DC 20415-3650

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 and explain the situation.
- If we do not resolve the issue, call or write

THE HEALTH CARE FRAUD HOTLINE
202/418-3300
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.

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

HIP is a mixed model plan. 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 or coinsurance.

Who provides my health care?

At the present time, approximately 15,000 professional medical providers participate in HIP/HMO and provide medical services to more than 770,000 enrollees. Our network covers 74 medical specialties ranging from family practice to urology. In addition to services from participating medical providers, you can receive paramedical services including social services, nutrition and health education at group centers.

Your Rights

OPM requires that all FEHB Plans provide certain information to their FEHB members. You may get information about us, our networks, 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.

- The HIP Health Plan of New York (HIP) was organized over 50 years ago as a non-profit corporation.
- On December 1, 1978, HIP 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.
- HIP/HMO has Commendable accreditation from the National Committee for Quality Assurance (NCQA).

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 more information, or write to The HIP Health Plan of New York, 7 West 34th Street, New York, NY 10001. You may also visit our website at http://www.hipusa.com.

Service Area

To enroll in this Plan, you must live in our Service Area. This is where our providers practice. Our service area is:
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 benefits. We will not pay for any other health care services out of our service area unless the services have prior plan approval.

If you or a covered family member move outside of our service area, you can enroll in another plan. 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 agreements with affiliates in other areas. 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 2002

Do not rely on these change descriptions; this page is not an official statement of benefits. For that, go to Section 5 Benefits. Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

Program-wide changes

- We changed the address for sending disputed claims to OPM. (Section 8)
- We changed speech therapy benefits by removing the requirement that services must be required to restore functional speech. (Section 5 (a))

Changes to this Plan

- Your share of the non-Postal premium will increase by 16.8% for Self Only or 23.1% for Self and Family.
- We no longer limit total blood cholesteral tests to certain age groups. (Section 5 (a))
- We now cover certain intestinal transplants. (Section 5 (b))
- We no longer maintain reciprocal agreements with other HMOs throughout the country.
- We have clarified the prostate cancer screening benefit. (Section 5 (a))
- Your prescription drug copays are now $10.00 generic formulary, $15.00 name brand formulary, and $35.00 non-formulary per 30-day supply. (Section 5(f))

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." 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 at 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 to get covered care

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.

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 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.

• 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 receive primary and preventative 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. When you receive a referral from your primary care physician, you must return to the primary care physician after the consultation, unless your primary care physician authorized a certain number of visits without additional referrals. The primary care physician must provide or authorize all follow-up care. Do not go to the specialist for return visits unless your primary care physician gives you a referral.

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.

The following are other services that require prior approval:

- Skilled nursing facility services
- Inpatient mental health
- Ambulatory surgery services
- Outpatient hospital services
- Home health care services
- Durable medical equipment
- Hospice care
- Inpatient hospital admissions (non-emergent)
- Inpatient physical and occupational therapies
- Inpatient substance abuse
- Organ transplants
- Growth hormone

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, facility, pharmacy, etc. 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 them. We do not have a deductible.
• **Coinsurance**	Coinsurance is the percentage of our negotiated fee that you must pay for your care. We do not have coinsurance.
Your catastrophic protection out-of-pocket maximum	We do not have an out-of-pocket maximum.

Section 5. Benefits -- OVERVIEW

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 (1-800-447-8255) or at our website at www.hipusa.com. If you are a potential member, call us at 1-888-866-7641.

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 • In an urgent care center • Office medical consultations • Second surgical opinion	$10 per office visit
• During a hospital stay • In a skilled nursing facility • 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.*	*All charges*
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 office visit

Preventive care, adult	You pay
Routine screenings, such as: • Total Blood Cholesterol – once every 3 years • Colorectal Cancer Screening, including: – Fecal occult blood test – Sigmoidoscopy, screening – every five years starting at age 50	$10 per office visit
• Standard diagnostic testing of prostate cancer, including but not limited to a digital rectal examination and a prostate-specific antigen testing for men of any age with a prior history of prostate cancer. • Annual standard diagnostic examination including but not limited to a digital rectal examination and a prostate-specific antigen testing for men age fifty and over who are asymptomatic and for men age forty and over with a family history of prostate cancer or other prostate cancer risks.	
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 64, one every calendar year • At age 65 and older, one every two consecutive calendar years	$10 per office visit
Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	*All charges*
Routine immunizations in accordance with accepted medical practice and standards such as: • Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) • Influenza/Pneumococcal vaccines, annually, age 65 and over	$10 per office visit
Not covered: • *Autogenous vaccines* • *Adult immunizations related to foreign travel*	*All charges*

Preventive care, children	You pay
• Childhood immunizations recommended by the American Academy of Pediatrics	Nothing
• Well-child care charges for routine examinations, immunizations and care • 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	Nothing
Maternity care	
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).	$10 first office visit; waived in subsequent visits.
Not covered: Routine sonograms to determine fetal age, size or sex.	*All charges*
Family planning	
A broad range of voluntary family planning services, limited to: • Voluntary sterilization • Surgically implanted contraceptives (such as Norplant) • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms NOTE: We cover oral contraceptives under the prescription drug benefit.	$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 (injectables) 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, gamete GIFT and zygote ZIFT* – *Zygote transfer* • *Services and supplies related to excluded ART procedures* • *Cost of donor sperm or sperm banking* • *Cost of donor egg*	*All charges*
Allergy care	
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	
• 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 20. • Respiratory and inhalation therapy • Dialysis – Hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) Note: Growth hormone is covered under the prescription drug benefit. Note: We will only cover GHT when we preauthorize the treatment. Growth Hormone must meet medical necessity guidelines in order for services to be approved.	$10 per office visit

Physical and occupational therapies	You pay
• Up to 2 months per condition if significant improvement can be expected for the services of each of the following: - qualified physical therapists and - occupational therapists. Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury. • Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction.	$10 per office visit Nothing per visit during covered inpatient admission
Speech therapy	
• Up to 2 months of speech therapy each calendar year for services from the following: - licensed or certified speech therapists	$10 per office visit
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)	
• 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	
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	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 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. 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 the equipment at discounted rates and will tell you more about this service when you call.	$10 per office visit
Not covered: • *Orthopedic and corrective shoes unless we determine that the Member's condition requires a corrective shoe that can only be made from a mold or cast of his or her foot.* • *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)	
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: Prior approval is required. 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.	Nothing
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.	Nothing
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family;* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative (i.e. hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication).*	*All charges*
Chiropractic	
• Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application Note: You do not need a referral from your primary care doctor.	$10 per office visit
Alternative treatments	
No benefit. We do not cover alternative treatments such as but not limited to: • *Naturopathic services* • *Hypnotherapy* • *Acupuncture* • *Biofeedback*	*All charges*
Educational classes and programs	
Coverage is limited to: • Smoking Cessation – In a HIP Free & Clean Smoking Cessation Program — Up to $100 for one smoking cessation program per member per lifetime, including all related expenses such as drugs. • 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 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 (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION OF SOME SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

IMPORTANT

Benefit Description	You pay
Surgical procedures	
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Treatment of burns • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • 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 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) Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	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	
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.	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 • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas 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	
Professional services provided in: • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	Nothing

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 Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION OF HOSPITAL STAYS**. Please refer to Section 3 to be sure which services require precertification.

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.	Nothing
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
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, 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, 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
Not covered: blood and blood derivatives not replaced by the member	*All charges*
Extended-care benefits/skilled nursing care facility benefits	
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	
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 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 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 reasonable 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. All follow-up care must be provided by participating providers.

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

Claims for emergency medical treatment must be sent to HIP/HMO within 45 days of the date you receive emergency services. The claim must include all supporting documentation.

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

Benefit Description	You pay
Emergency within our service area	
• Emergency care at a doctor's office	$10 per office visit
• Emergency care at an urgent care center	$25 per urgent care center visit
• Emergency care as an outpatient or inpatient at a hospital, including doctors' services	$25 per emergency room visits; waived if admitted
Not covered: Elective care or non-emergency care	*All charges*
Emergency outside our service area	
• Emergency care at a doctor's office	$10 per office visit
• Emergency care at an urgent care center	$25 per urgent care center visit
• Emergency care as an outpatient or inpatient at a hospital, including doctors' services	$25 per emergency room visits; waived if admitted
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	
Local ambulance service in an emergency condition or when approved in advance by the plan. See 5(c) for non-emergency service	Nothing
Not covered: air ambulance	*All charges*

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

IMPORTANT

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, about 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	
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 visit
• Diagnostic tests	Nothing
• Services provided by a hospital or other facility • 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*

Preauthorization

To be eligible to receive these benefits you must obtain a treatment plan and follow all of 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.

Limitation

We may limit your benefit if you do not obtain a 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 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. We cover non-formulary drugs prescribed by a Plan doctor subject to a $35.00 copay.
- **These are the dispensing limitations.** A participating pharmacy will provide up to a 30-day supply of your prescription. You will pay $10.00 for generic formulary drugs or $15.00 for name brand formulary drugs or $35.00 for non-formulary drugs. You may obtain up to a 90-day supply of certain formulary maintenance drugs through our mail Order Service. We will reduce your formulary copay by 50% when you use our Mail Order Service. Please contact us to see if your maintenance medication is available through our mail order service. Sexual dysfunction drugs are not available by mail-order and require prior approval. There are also limits on the number of pills that the pharmacy will fill. Please contact Customer Service Department at 1-800-HIP-TALK (1-800-447-8255)for details. For further information on using our mail order program, contact Express Scripts 1-800-224-5502.

  Plan pharmacies will dispense a generic equivalent if it is available, unless your physician specifically requires a name brand.
- **Why use generic drugs?** Generic drugs contain the same active ingredients and are equivalent in strength and dosage to the original brand name product. Generic drugs cost you and your Plan less money than a name brand drug.

- **When you have to file a claim.** Please call 1-800-HIP-TALK (1-800-447-8255 and we will send you a claim form. Under normal circumstances, you do not have to file prescription drug claims. You simply present your HIP/HMO card to the participating pharmacy and pay the appropriate copay.

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 • 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) Note: All drugs are not available by mail order	Retail Pharmacy: $10 for generic drugs per 30-day supply from a participating pharmacy or $15 for brand name drugs per 30-day supply (subject to drug formulary), $35 for non-formulary drugs per 30-day supply. Mail-order: $15.00 per 90-day supply of formulary generic drugs or $22.50 per 90-day supply of formulary name brand drugs Note: Non-formulary drugs are not available from the mail-order pharmacy.
• Implanted time-release medications • Norplant	$10 per prescription unit
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs available without a prescription or for which there is a nonprescription equivalent available* • *Drugs to enhance athletic performance* • *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies* • *Vitamins, nutrients and food supplements that can be purchased without a prescription* • *Nonprescription medicines* • *Medical supplies such as dressings and antiseptics*	*All charges*

Section 5(g). Special features

Feature	Description
Medical Case Management	We offer case management programs for members with chronic or catastrophic illnesses or injuries.
Services for deaf and hearing impaired	The telephone number for the hearing impaired is 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, about coordinating benefits with other coverage, including Medicare.

IMPORTANT

Accidental injury benefit	You pay
We cover restorative services and supplies necessary to promptly repair sound natural teeth within 12 months of the date of the accident. The need for these services must result from an accidental injury.	Nothing
Not covered: • *Dental services that you receive more than 1 year after the accidental injury* • *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 FEHB deductibles or 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 Plan covers everything that Medicare covers, plus additional benefits listed below:

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

You may still enroll in HIP VIP® Medicare if you 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 offers members discounts to fitness centers and tennis clubs in the New York metropolitan area.

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

Should you choose to seek such services, you will have access to the large OneBody 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 OneBody network provider in order to obtain the discounted rate. Call 1-888-HIP-ALMD (1-888-447-2563) for a list of OneBody 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 OneBody, this program provides HIP members with discounts for services provided by OneBody alternative medicine providers. OneBody 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 OneBody 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; or
- 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 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 (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 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 Insurance Plan of New York**
7 West 34th Street
New York, New York 10001

Prescription drugs

Under normal circumstances, you do not have to file claims for your prescription drugs. Please call 1-800-HIP-TALK for specific instructions and a claim form. Our address is:

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, 1900 E Street, NW, Washington, DC 20415-3630.

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 include 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 or from the year in which you were denied precertification or prior approval. 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 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 our allowance. 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. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (Someone who was a Federal employee on January 1, 1983 or since automatically qualifies.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.

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 (Part A or B)

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

When you are enrolled in Original Medicare along with this Plan, 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 health care services.

Claims process when you have the Original Medicare Plan – You will probably never have to file a claim form when you have both our plan and the Original Medicare Plan.

- When we are the primary payer, we process the claim first.
- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claims will be coordinated automatically and we will pay the balance of covered charges. 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-HIP-TALK (1-800-447-8255).

We do not waive costs when you have the Original Medical Plan.

(Primary payer chart begins on next page.)

The following chart illustrates whether **the Original Medicare Plan** 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, and		
a) And are an annuitant.....	✓	
b) And are an active employee		✓
c) Are a former spouse of an annuitant, or	✓	
d) Are a former spouse of an active employee		✓

• **Medicare Managed Care Plan**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from another type of Medicare+Choice plan — 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 provide all the benefits that Original Medicare covers. 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 do waive some of our copayments, coinsurance, or deductibles for your FEHB coverage. Please contact us for details.

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), but we will not waive any of our copayments under the FEHB coverage. If you enroll in a Medicare managed care plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare managed care plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in 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.

If you do not enroll in Medicare Part A or B

If you do not have one or both Parts of Medicare, you can still be covered under the FEHB Program. We will not require you to enroll in Medicare Part B and, if you can't get premium-free Part A, we will not ask you to enroll in it.

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 a similar agency pays its maximum benefits for your treatment, we will cover your care. 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.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. See page 9.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. 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.

Durable Medical Equipment, Prosthetic Devices and Orthopedic Devices

A "Covered Appliance" is one of the following items which is prescribed by a your Plan physician, dispensed by a Plan provider and approved by HIP. HIP maintains a list of Covered Appliances that contains items in each of the categories listed below. This list is prepared by HIP and periodically reviewed and modified. HIP will determine whether a Covered Appliance should be customized, rented, purchased or repaired.

1. Durable Medical Equipment, which is:

   A. Primarily and customarily used to serve a medical purpose;
   B. Generally not useful to a person in the absence of illness or injury;
   C. Appropriate for use in the home;
   D. Medically necessary for the care and treatment of the Member's illness or injury.

2. Prosthetic devices which replace all or part of an internal body organ or external limb. However, dental prosthetics needed due to an accidental injury to sound natural teeth if the service is provided within twelve (12) months of the accident and necessary in treatment due to congenital disease or anomaly will be covered.

3. Orthopedic devices which are required for the treatment of injuries or disorders of the skeletal system and associated muscles, joints and ligaments.

Experimental or investigational service

Experimental or investigational service means any evaluation, treatment, services 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:

Experimental or investigational service *(Continued)*

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, research, 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 member's 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 joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

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.

• Temporary Continuation of Coverage (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, if you lose your job, if you are a covered dependent child and you turn 22 or marry, etc.

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

Enrolling in TCC. 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. It explains what you have to do to enroll.

• 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

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group 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.

For more information, get OPM pamphlet RI 79-27, Temporary Continuation of Coverage (TCC) under the FEHB Program. See also the FEHB web site (www.opm.gov/insure/health); refer to the "TCC and HIPAA" frequently asked questions. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and have information about Federal and State agencies you can contact for more information.

Long Term Care Insurance Is Coming Later in 2002!

- Many FEHB enrollees think that their health plan and/or Medicare will cover their long-term care needs. Unfortunately, they are *WRONG*!
- How are YOU planning to pay for the future custodial or chronic care you may need?
- You should consider buying long-term care insurance.

The Office of Personnel Management (OPM) will sponsor a high-quality long term care insurance program effective in October 2002. As part of its educational effort, OPM asks you to consider these questions:

What is long term care (LTC) insurance?

- It's insurance to help pay for long term care services you may need if you can't take care of yourself because of an extended illness or injury, or an age-related disease such as Alzheimer's.
- LTC insurance can provide broad, flexible benefits for nursing home care, care in an assisted living facility, care in your home, adult day care, hospice care, and more. LTC can supplement care provided by family members, reducing the burden you place on them.

I'm healthy. I won't need long term care. Or, will I?

- Welcome to the club!
- 76% of Americans believe they will never need long term care, but the facts are that about half of them will. And it's not just the old folks. About 40% of people needing long term care are under age 65. They may need chronic care due to a serious accident, a stroke, or developing multiple sclerosis, etc.
- We hope you will never need long term care, but everyone should have a plan just in case. Many people now consider long term care insurance to be vital to their financial and retirement planing.

Is long term care expensive?

- Yes, it can be very expensive. A year in a nursing home can exceed $50,000. Home care for only three 8- hour shifts a week can exceed $20,000 a year. And that's before inflation!
- Long term care can easily exhaust your savings. Long term care insurance can protect your savings.

But won't my FEHB plan, Medicare or Medicaid cover my long term care?

- Not FEHB. Look at the "Not covered" blocks in sections 5(a) and 5(c) of your FEHB brochure. Health plans don't cover custodial care or a stay in an assisted living facility or a continuing need for a home health aide to help you get in and out of bed and with other activities of daily living. Limited stays in skilled nursing facilities can be covered in some circumstances.
- Medicare only covers skilled nursing home care (the highest level of nursing care) after a hospitalization for those who are blind, age 65 or older or fully disabled. It also has a 100 day limit.
- Medicaid covers long term care for those who meet their state's poverty guidelines, but has restrictions on covered services and where they can be received. *Long term care insurance can provide choices of care and preserve your independence.*

When will I get more information on how to apply for this new insurance coverage?

- Employees will get more information from their agencies during the LTC open enrollment period in the late summer/early fall of 2002.
- Retirees will receive information at home.

How can I find out more about the program NOW?

- Our toll-free teleservice center will begin in mid-2002. In the meantime, you can learn more about the program on our web site at www.opm.gov/insure/ltc.

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)

- **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	Office visit copay: $10 primary care or specialist	11-17
Services provided by a hospital:		
• Inpatient.....	Nothing	21
• Outpatient	Nothing	22
Emergency benefits: • In-area..... • Out-of-area	$10 urgent care center/doctor and $25 for hospital emergency room	23-24
Mental health and substance abuse treatment..... Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers	$10 per office visit	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 generic formulary/$15 name brand formulary/$35 non-formulary $15 generic formulary/$22.50 name brand formulary	26-27
Dental Care ..... Accidental injury benefit only	Nothing	28
Vision Care ..... One annual eye refraction	$10	15
Special features: Service for deaf and hearing impaired, Medical Case Management Programs, Travel benefit/services overseas		
Protection against catastrophic costs (your out-of-pocket maximum)	Nothing	9

2002 Rate Information for
Health Insurance Plan

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, 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 who are not career postal employees. 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
High Option Self Only	**511**	**$ 81.70**	**$ 27.23**	**$177.02**	**$ 59.00**	**$ 96.68**	**$ 12.25**
High Option Self and Family	**512**	**$223.41**	**$103.38**	**$484.06**	**$223.99**	**$263.75**	**$ 63.04**