HIP® Health Insurance Plan (HIP/HMO) 2000

A Health Maintenance Organization

Serving: Greater New York City Area

Enrollment in this Plan is limited; see page 6 for requirements.

Enrollment code:
511 Self Only
512 Self and Family

This plan has Commendable Accreditation from the NCQA. See the FEHB 2000 Guide for more information on NCQA.

Visit the OPM Web site at http://www.opm.gov/insure
and
Visit this Plan's Web site at http://www.hipusa.com

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UNITED STATES OFFICE OF
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Introduction

Health Insurance Plan (HIP/HMO)
The Health Insurance Plan of Greater New York, 7 West 34th Street, New York, NY 10001

This brochure describes the benefits you can receive from HIP/HMO under its contract (CS 1040) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits (FEHB) law. This brochure is the official statement of benefits on which you can rely. A person enrolled in this Plan is 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.

OPM negotiates benefits and premiums with each plan annually. Benefit changes are effective January 1, 2000, and are shown on page 5. Premiums are listed at the end of this brochure.

Plain language

The President and Vice President are making the Government's communication more responsive, accessible, and understandable to the public by requiring agencies to use plain language. Health plan representatives and Office of Personnel Management staff have worked cooperatively to make portions of this brochure clearer. In it you will find common, everyday words, except for necessary technical terms; "you" and other personal pronouns; active voice; and short sentences.

We refer to HIP/HMO as "this Plan" throughout this brochure even though in other legal documents, you will see a plan referred to as a carrier.

These changes do not affect the benefits or services we provide. We have rewritten this brochure only to make it more understandable.

We have not re-written the Benefits section of this brochure. You will find new benefits language next year.

How to use this brochure

This brochure has eight sections. Each section has important information you should read. If you want to compare this Plan's benefits with benefits from other FEHB plans, you will find that the brochures have the same format and similar information to make comparisons easier.

1. Health Maintenance Organizations (HMO). This Plan is an HMO. Turn to this section for a brief description of HMOs and how they work.

2. How we change for 2000. If you are a current member and want to see how we have changed, read this section.

3. How to get benefits. Make sure you read this section; it tells you how to get services and how we operate.

4. What to do if we deny your claim or request for service. This section tells you what to do if you disagree with our decision not to pay for your claim or to deny your request for a service.

5. Benefits. Look here to see the benefits we will provide as well as specific exclusions and limitations. You will also find information about non-FEHB benefits.

6. General exclusions – Things we don't cover. Look here to see benefits that we will not provide.

7. Limitations – Rules that affect your benefits. This section describes limits that can affect your benefits.

8. FEHB FACTS. Read this for information about the Federal Employees Health Benefits (FEHB) Program.

Section 1. Health Maintenance Organizations

Health maintenance organizations (HMOs) are health plans that require you to see Plan providers: specific physicians, hospitals and other providers that contract with us. These providers coordinate your health care services. The care you receive includes preventive care such as routine office visits, physical exams, well-baby care and immunizations, as well as treatment for illness and injury.

When you receive services from our providers, you will not have to submit claim forms or pay bills. However, you must pay copayments and coinsurance listed in this brochure. When you receive emergency services 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. Our providers follow generally accepted medical practice when prescribing any course of treatment.

Section 2. How we change for 2000

Program-wide changes

To keep your premium as low as possible OPM has set a minimum copay of $10 for all primary care office visits.

This year, you have a right to more information about this Plan, care management, our networks, facilities, and providers.

If you have a chronic or disabling condition, and your provider leaves the Plan at our request, you may continue to see your specialist for up to 90 days. If your provider leaves the Plan and you are in the second or third trimester of pregnancy, you may be able to continue seeing your OB/GYN until the end of your postpartum care. You have similar rights if this Plan leaves the FEHB program. (See Section 3, How to get benefits, for more information.)

You may review and obtain copies of your medical records on request. If you want copies of your medical records, ask your health care provider for them. You may ask that a physician amend a record that is not accurate, not relevant, or incomplete. If the physician does not amend your record, you may add a brief statement to it. If they do not provide you your records, call us and we will assist you.

If you are over age 50, all FEHB plans will cover a screening sigmoidoscopy every five years. This screening is for colorectal cancer.

Changes to this Plan

Your share of the Non-Postal premium will increase by 1.9% for Self Only or 57.5% for Self and Family. See back cover.

Under Medical and Surgical Benefits, a primary care or specialty care office visit copay increased from nothing to $10. See page 11.

Under Prescription Drugs, the copay increased from $5 to $10. See page 16.

Under Prescription Drugs for mail order service, the maximum copay changed. See page 16.

Under Emergency Benefits, emergency room copay increased from nothing to $25; urgent care visits increased from nothing to $10. See page 14.

Under Medical and Surgical Benefits, chiropractic service is covered. See page 11.

The preventive dental benefit has moved from coverage under Other Benefits to the Non-FEHB page. See page 18.

The HIP VIP Medicare Plan has moved from coverage under Other Benefits to the Non-FEHB page. See page 18.

The Plan has updated language regarding its delivery system. See page 6.

Section 3. How to get benefits

What is this Plan's service area?

To enroll with us, 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, as described on page 14. We will not pay for any other health care services.

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. HIP/HMO members can receive care from HIP Health Plan of Florida's participating providers within their respective FEHB approved service areas. HIP/HMO also participates in two reciprocity programs. The first is with 37 other HMOs through the American Association of Health Plans (AAHP); the second is with 23 other plans through TravelCare. In this manner, HIP ensures that members can obtain emergency, urgent, or even routine care in some cases, while they are outside the Plan's service area. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

How much do I pay for services?

You must share the cost of some services. This is called a copayment (a set dollar amount). Please remember you must pay this amount when you receive services. Your out-of-pocket expenses for benefits under this Plan are limited to the stated copayments required for a few benefits.

Do I have to submit claims?

You normally won't have to submit claims to us unless you receive emergency services from a provider who doesn't contract with us. If you file a claim, please send us all of the documents for your claim as soon as possible. You must submit claims by December 31 of the year after the year you received the service. Either OPM or we can extend this deadline if you show that circumstances beyond your control prevented you from filing on time.

Who provides my health care?

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

HIP/HMO is a Mixed Model plan, with doctors in both independent and group practice. HIP/HMO Participating Physicians practice in independent offices throughout the greater metropolitan area. Some HIP participating physicians also practice in over 40 multi-specialty medical centers. Members may choose any of the independent practice or group practice physicians as their source of primary care, regardless of where they live. Family members may choose a different primary care doctor and medical group.

At the present time there are approximately 12,000 doctors participating in HIP/HMO and providing medical services to more than 750,000 enrollees. They provide services in 14 medical specialties ranging from family practice to urology. "Super-specialty" care, such as open heart surgery, beyond the capacity of the medical groups, is provided by non-participating HIP/HMO physicians. In addition, paramedical services are provided at the group centers, including social services, nutrition, and health education.

New members are asked to select a primary care physician (PCP) when they join HIP/HMO. The PCP provides primary medical care and, when medically necessary, provides referrals for specialty care and ancillary services such as lab tests and x-rays. Female members do not need a referral for primary and preventive obstetric and gynecologic care. HIP/HMO encourages new members to schedule an appointment with their PCP for a baseline physical after enrollment becomes effective.

Section 3. How to get benefits *continued*

Who provides my health care? *(continued)*

During the hours when the medical groups and participating physician offices are closed, members can call HIP's Nurse Advice Line at 1-800/HIP-HELP (1-800/446-4357) 7 days a week, 24 hours a day. (This line was previously known as the Emergency Services Program or ESP.)

The first and most important decision each member must make is the selection of a primary care doctor. The decision is important since it is through this doctor that all other health services, particularly those of specialists, are obtained. It is the responsibility of your primary care doctor to obtain any necessary authorizations from the Plan before referring you to a specialist or making arrangements for hospitalization. Services of other providers are covered only when you have been referred by your primary care doctor, with the following exceptions: primary and preventive obstetric and gynecologic care (female members have direct access to a qualified Plan participating provider of obstetric and gynecological care for at least two primary and preventive care visits annually, for services required as a result of these visits and for services related to pregnancies and acute gynecological conditions), chiropractic care (unlimited as medically necessary, subject to review), routine foot care (limited to 4 visits/calendar year) and routine eye care visits.

The Plan's provider directory lists primary care doctors (family practitioners, pediatricians and internists), with their locations and phone numbers, and notes whether or not the doctor is accepting new patients. Directories are updated a regular basis and are available at the time of enrollment or upon request by calling the Customer Service Department at 1-800/HIP-TALK; you can also find out if your doctor participates with this Plan by calling this number. If you are interested in receiving care from a specific provider who is listed in the directory, call the provider to verify that he or she still participates with the Plan and is accepting new patients. Important note: When you enroll in this Plan, services (except for emergency benefits) are provided through the Plan's delivery system; the continued availability and/or participation of any one doctor, hospital, or other provider cannot be guaranteed.

What do I do if my primary care physician leaves the Plan?

Call us. We will help you select a new one.

What do I do if I need to go into the hospital?

Talk to your Plan physician. If you need to be hospitalized, your primary care physician or specialist will make the necessary hospital arrangements and supervise your care.

What do I do if I'm in the hospital when I join this Plan?

First, call our Customer Service Department 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 are currently in the FEHB Program and are switching 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 became a member of this Plan; whichever happens first.

These provisions only apply to the person who is hospitalized.

How do I get specialty care?

Your primary care physician will arrange your referral to a specialist. Except in a medical emergency, or when a primary care doctor has designated another doctor to see his or her patients, you must receive a referral from your primary care doctor before seeing any other doctor or obtaining special services. Referral to a participating specialist is given at the primary care doctor's discretion; if non-Plan specialists or consultants are required, the primary care doctor will arrange appropriate referrals.

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

If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your

Section 3. How to get benefits *continued*

How do I get specialty care? *(continued)*

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.

What do I do if I am seeing a specialist when I enroll?

Your primary care physician will decide what treatment you need. If they decide 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.

What do I do if my 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.

But, what if I have a serious illness and my provider leaves the Plan or this Plan leaves the Program?

Please contact us if you believe your condition is chronic or disabling. You may be able to continue seeing your provider for up to 90 days after we notify you that we are terminating our contract with the provider (unless the termination is for cause). If you are in the second or third trimester of pregnancy, you may continue to see your OB/GYN until the end of your postpartum care.

You may also be able to continue seeing your provider if your plan drops out of the FEHB Program and you enroll in a new FEHB plan. Contact the new plan and explain that you have a serious or chronic condition, or are in your second or third trimester. Your new plan will pay for or provide your care for up to 90 days after you receive notice that your prior plan is leaving the FEHB Program. If you are in your second or third trimester, your new plan will pay for the OB/GYN care you receive from your current provider until the end of your postpartum care.

How do you authorize medical services?

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 medically necessary, and if it follows generally accepted medical practice.

How do you decide if a service is experimental or investigational?

EXPERIMENTAL AND INVESTIGATIONAL TREATMENT means any evaluation, treatment, therapy, or device which involves the application, administration or use, of procedures, techniques, equipment, supplies, products, remedies, vaccines, biological products, drugs, pharmaceuticals, or chemical compounds if, as determined solely by the Plan:

1) Such evaluation, treatment, therapy, or device cannot be lawfully marketed without approval of the United States Food and Drug Administration or the New York Department of Health and Rehabilitative Services, and approval for marketing has not, in fact, been given at the time such is furnished to the covered person; or 2) Reliable evidence, as determined by the Plan, shows that such evaluation, treatment, therapy, or device (a) is the subject of an ongoing Phase I, or II clinical investigation, or experimental or research arm of a Phase III clinical investigation, or under study to determine: maximum tolerated dosage(s), toxicity, safety, efficacy, or efficacy as compared with the standard means for treatment or diagnosis of the condition in question; or (b) has not been proven safe and effective for the treatment of the condition in question, as evidenced in the most recently published medical literature in the United States, Canada, or Great Britain, using generally accepted scientific, medical, or public health methodologies or statistical practices; or (c) is not the standard evaluation, treatment, therapy or device utilized by practicing physicians in treating other patients with the same or similar condition; or (3) There is no consensus among practicing physicians that the evaluation, treatment, therapy or device is safe or effective for the treatment in question; or (4) The consensus of opinion among experts is that further studies, reach, or clinical investigations are necessary to determine maximum tolerated dosage(s), toxicity, safety, efficacy or efficacy as compared with the standard means for treatment or diagnosis of the condition in question.

Section 4. What to do if we deny your claim or request for service

If we deny services or won't pay your claim, you may ask us to reconsider our decision. Your request must:

1. Be in writing,
2. Refer to specific brochure wording explaining why you believe our decision is wrong; and
3. Be made within six months from the date of our initial denial or refusal. We may extend this time limit if you show that you were unable to make a timely request due to reasons beyond your control.

We have 30 days from the date we receive your reconsideration request to:

1. Maintain our denial in writing;
2. Pay the claim;
3. Arrange for a health care provider to give you the service; or
4. Ask for more information.

If we ask your medical provider for more information, we will send you a copy of our request. We must make a decision within 30 days after we receive the additional information. If we do not receive the requested information within 60 days, we will make our decision based on the information we already have.

When may I ask OPM to review a denial?

You may ask OPM to review the denial after you ask us to reconsider our initial denial or refusal. OPM will determine if we correctly applied the terms of our contract when we denied your claim or request for service.

What if I have a serious or life threatening condition and you haven't responded to my request for service?

Call us 1-800/HIP-TALK (1-800/447-8255) and we will expedite our review.

What if you have denied my request for care and my condition is serious or life threatening?

If we expedite your review due to serious medical condition and deny your claim, we will inform OPM so that they can give your claim expedited treatment too. Alternatively, you may call OPM's health benefit Contracts Division III at 1-202/606-0755 between 8 a.m. and 5 p.m. Serious or life-threatening conditions are ones that may cause permanent loss of bodily functions or death if they are not treated as soon as possible.

Are there other time limits?

You must write to OPM and ask them to review our decision within 90 days after we uphold our initial denial or refusal of service. You may also ask OPM to review your claim if:

1. We do not answer your request within 30 days. In this case, OPM must receive your request within 120 days of the date you asked us to reconsider your claim.

2. You provided us with additional information we asked for, and we did not answer within 30 days. In this case, OPM must receive your request within 120 days of the date we asked you for additional information.

What do I send to OPM?

Your request must be complete, or OPM will return it to you. You must send the following information:

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

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

Section 4. What to do if we deny your claim or request for service *continued*

Who can make the request?

Those who have a legal right to file a disputed claim with OPM are:

1. Anyone enrolled in the Plan;
2. The estate of a person once enrolled in the Plan; and
3. Medical providers, legal counsel, and other interested parties who are acting as the enrolled person's representative. They must send a copy of the person's specific written consent with the review request.

Where should I mail my disputed claim?

Send your request for review to: Office of Personnel Management, Office of Insurance Programs, Contract Division III, P. O. Box 436, Washington, D.C. 20044.

What if OPM upholds the Plan's denial?

OPM's decision is final. There are no other administrative appeals. If OPM agrees with our decision, your only recourse is to sue.

If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services or supplies.

What laws apply if I file a lawsuit?

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 made its decision on your claim. You may recover only the amount of benefits in dispute.

You (or a person acting on your behalf) may not sue to recover benefits on a claim for treatment, services, supplies, or drugs covered by us until you have completed the OPM review procedure described above.

Your records and the Privacy Act

Chapter 89 of title 5, United States Code allows OPM to use the information it collects from you and us to determine if our denial of your claim is correct. The information OPM collects during the review process becomes a permanent part of your disputed claims file, and is subject to the provisions of the Freedom of Information Act and the Privacy Act. OPM may disclose this information to support the disputed claim decision. If you file a lawsuit, this information will become part of the court record.

Section 5. Benefits

Medical and Surgical Benefits

What is covered

A comprehensive range of preventive, diagnostic and treatment services is provided by Plan doctors and other Plan providers. This includes all necessary office visits*;* **you pay $10.** Within the service area, house calls will be provided if, in the judgment of the Plan doctor, such care is necessary and appropriate; **you pay $10** for a doctor's house call and **you pay nothing** for home visits by nurses and health aides.

The following services are included:

Preventive care, including well-baby care and periodic check-ups

Mammograms are covered as follows: for women age 35 through age 39, one mammogram during these five years; for women age 40 through 49, one mammogram every one or two years; for women age 50 through 64, one mammogram every year; and for women age 65 and above, one mammogram every two years. In addition to routine screening, mammograms are covered when prescribed by the doctor as medically necessary to diagnose or treat your illness.

Routine immunizations and boosters

Consultations by specialists

Diagnostic procedures, such as laboratory tests and X-rays

Complete obstetrical (maternity) care for all covered females, including prenatal, delivery and postnatal care by a Plan doctor. **Copays are waived for maternity care.** The mother, at her option, may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a caesarean delivery. Inpatient stays will be extended if medically necessary. If enrollment in the Plan is terminated during pregnancy, benefits will not be provided after coverage under the Plan has ended. Ordinary nursery care of the newborn child during the covered portion of the mother's hospital confinement for maternity will be covered under either a Self Only or Self and Family enrollment; other care of an infant who requires definitive treatment will be covered only if the infant is covered under a Self and Family enrollment.

Voluntary sterilization and family planning services

Diagnosis and treatment of diseases of the eye

Allergy testing and treatment, including testing and treatment materials (such as allergy serum)

The insertion of internal prosthetic devices, such as pacemakers and artificial joints

Nonexperimental transplants including heart, heart/lung, kidney, liver, lung (single or double), pancreas and corneal transplants; allogeneic (donor) bone marrow transplants; autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphoma, advanced neuroblastoma, breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors and aplastic anemia. Related medical and hospital expenses of the donor are covered when the recipient is covered by this Plan.

Women who undergo mastectomies may, at their option, have this procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.

Dialysis

Chemotherapy, radiation therapy, and inhalation therapy

Chiropractic Services

Surgical treatment of morbid obesity

Orthopedic devices, such as braces; foot orthotics

Section 5. Benefits *continued*

What is covered *(continued)*

Prosthetic devices, such as artificial limbs, breast prostheses or surgical bras and their replacements and lenses following cataract removal

Durable medical equipment, such as wheelchairs and hospital beds

All necessary medical or surgical care in a hospital or extended care facility from Plan doctors and other Plan providers

Home health services of nurses and health aides, including intravenous fluids and medications, when prescribed by your Plan doctor, who will periodically review the program for continuing appropriateness as needed

Insulin

Diabetic supplies, including glucose test tablets and test tape, acetone test tablets

Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction

Blood and blood derivatives; charges in connection with storing your own blood in advance of an elective surgical procedure

All necessary medical or surgical care in a hospital or extended care facility from Plan doctors and other Plan providers

Limited benefits

Oral and maxillofacial surgery is provided for non-dental surgical and hospitalization procedures for congenital defects, such as cleft lip and cleft palate, and for medical or surgical procedures occurring within or adjacent to the oral cavity or sinuses including, but not limited to, treatment of fractures and excision of tumors and cysts. All other procedures involving the teeth or intra-oral areas surrounding the teeth are not covered, including shortening of the mandible or maxillae for cosmetic purposes, correction of malocclusion, and any dental care involved in the treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.

Reconstructive surgery will be provided to correct a condition resulting from a functional defect or from an injury or surgery that has produced a major effect on the member's appearance and if the condition can reasonably be expected to be corrected by such surgery. A patient and her attending physician will decide whether or not to have breast reconstruction surgery following a mastectomy, including whether or not to have surgery on the other breast in order to produce a symmetrical appearance.

Short-term rehabilitative therapy (physical, speech and occupational) is provided on an inpatient or outpatient basis for up to two months per condition if significant improvement can be expected within two months; you pay nothing per outpatient session. Speech therapy is limited to treatment of certain speech impairments of organic origin. Occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living.

Diagnosis and treatment of infertility is covered; **you pay $10**. The following types of artificial insemination are covered: intravaginal insemination (IVI); intracervical insemination (ICI) and intrauterine insemination (IUI); **you pay $10;** cost of donor sperm is not covered. Oral and injectable fertility drugs are covered; **you pay a $10 copay** per prescription unit or refill. In vitro fertilization and embryo transfer, are not covered.

Podiatric services are provided for four (4) visits per calendar year for routine foot care; **you pay $10 copay.** However, this limit does not apply if foot care services are required due to a medical condition, such as diabetes.

Section 5. Benefits *continued*

What is not covered

Physical examinations that are not necessary for medical reasons, such as those required for obtaining or continuing employment or insurance, attending school or camp, or travel

Reversal of voluntary, surgically-induced sterility

Surgery primarily for cosmetic purposes

Hearing aids

Long-term rehabilitative therapy

Homemaker services

Hospital/Extended Care Benefits

What is covered
Hospital care

The Plan provides a comprehensive range of benefits with no dollar or day limit when you are hospitalized under the care of a Plan doctor. **You pay nothing.** All necessary services are covered, including:

Semiprivate room accommodations; when a Plan doctor determines it is medically necessary, the doctor may prescribe private accommodations or private duty nursing care

Specialized care units, such as intensive care or cardiac care units

Extended care

The Plan provides a comprehensive range of benefits with no dollar or day limit when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan. **You pay nothing**. All necessary services are covered, including:

Bed, board and general nursing care

Drugs, biologicals, supplies, and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor

Hospice care

Supportive and palliative care for a terminally ill member is covered in the home or hospice facility for a total of up to 210 days. Services include inpatient and outpatient care, and family counseling; these services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less.

Ambulance service

Benefits are provided for ambulance transportation ordered or authorized by a Plan doctor

Limited benefits

Inpatient dental procedures

Hospitalization for certain dental procedures is covered when a Plan doctor determines there is a need for hospitalization for reasons totally unrelated to the dental procedure; the Plan will cover the hospitalization, but not the cost of the professional dental services. Conditions for which hospitalization would be covered include hemophilia and heart disease; the need for anesthesia, by itself, is not such a condition.

Acute inpatient detoxification

Hospitalization for medical treatment of substance abuse is limited to emergency care, diagnosis, treatment of medical conditions, and medical management of withdrawal symptoms (acute detoxification) if the Plan doctor determines that outpatient management is not medically appropriate. See page 16 for non-medical substance abuse benefits.

What is not covered

Personal comfort items, such as telephone and television

Custodial care, rest cures, domiciliary or convalescent care

Section 5. Benefits *continued*

Emergency Benefits

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 the Plan may determine are medical emergencies — what they all have in common is the need for quick action.

Emergencies within the service area

If you are in an emergency situation, please call your primary care doctor. In extreme emergencies, if you are unable to contact your doctor, contact the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify the Plan. You or a family member should notify the Plan within 48 hours. It is your responsibility to ensure that the Plan has been timely notified.

If you need to be hospitalized in a non-Plan facility, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If you are hospitalized in non-Plan facilities and a Plan doctor believes care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

Benefits are available for care from non-Plan providers in a medical emergency only if delay in reaching a Plan provider would result in death, disability or significant jeopardy to your condition. Plan doctors are available 24 hours a day, 7 days a week. After regular hours call the toll-free number located on the back of your HIP ID Card. If you are not sure who to contact you may call 1-800/HIP-HELP (447-4357) or 1-888/HIP-4TDD (447-4833), the telephone number for the hearing impaired.

To be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers.

Plan pays...

Reasonable charges for emergency services to the extent the services would have been covered if received from Plan providers.

You pay...

$25 per hospital emergency room visit; **you pay $10** per urgent care center visit for emergency services that are covered benefits of this Plan.

Emergencies outside the service area

Benefits are available for any medically necessary health service that is immediately required because of injury or unforeseen illness.

If you need to be hospitalized, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If a Plan doctor believes care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

To be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers.

Plan pays...

Reasonable charges for emergency services to the extent the services would have been covered if received from Plan providers.

You pay...

$25 per hospital emergency room visit; **you pay $10** per urgent care center visit for emergency services that are covered benefits of this Plan.

Section 5. Benefits *continued*

Emergency Benefits *continued*

What is covered

Emergency care at a doctor's office or an urgent care center
Emergency care as an outpatient or inpatient at a hospital, including doctors' services
Ambulance service approved by the Plan

What is 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

Filing claims for non-Plan providers

With your authorization, the Plan will pay benefits directly to the providers of your emergency care upon receipt of their claims. Physician claims should be submitted on the HCFA 1500 claim form. If you are required to pay for the services, submit itemized bills and your receipts to the Plan along with an explanation of the services and the identification information from your ID card.

Payment will be sent to you (or the provider if you did not pay the bill), unless the claim is denied. If it is denied, you will receive notice of the decision, including the reasons for the denial and the provisions of the contract on which denial was based. If you disagree with the Plan's decision, you may request reconsideration in accordance with the disputed claims procedure described on pages 9 and 10.

Mental Conditions/Substance Abuse Benefits

Mental Conditions

What is covered

To the extent shown below, the Plan provides the following services necessary for the diagnosis and treatment of acute psychiatric conditions, including the treatment of mental illness or disorders:

Diagnostic evaluation

Psychological testing

Psychiatric treatment (including individual and group therapy)

Hospitalization (including inpatient professional services)

Outpatient care

All necessary visits to Plan mental health facilities. **You pay nothing.**

Inpatient care

Up to 30 days to hospitalization each calendar year; **you pay nothing** for the first 30 days - all charges thereafter

What is not covered

Care for psychiatric conditions that in the professional judgment of Plan doctors are not subject to significant improvement through relatively short-term treatment

Psychiatric evaluation or therapy on court order or as a condition of parole or probation, unless determined by a Plan doctor to be necessary and appropriate Psychological testing that is not medically necessary to determine the appropriate treatment of a short-term psychiatric condition

Section 5. Benefits *continued*

Substance Abuse

What is covered This Plan provides medical and hospital services such as acute detoxification services for the medical, non-psychiatric aspects of substance abuse, including alcoholism and drug addiction, the same as for any other illness or condition and, to the extent shown below, the services necessary for diagnosis and treatment

Outpatient care All necessary visits to Plan providers for treatment each calendar year. **You pay nothing**.

Inpatient care Up to 30 days per calendar year in a substance abuse rehabilitation (intermediate care) program in an alcohol or drug rehabilitation center approved by the Plan; **you pay nothing** during the benefit period -- all charges thereafter

What is not covered Treatment that is not authorized by a Plan doctor

Prescription Drug Benefits

What is covered

Prescription drugs prescribed by a Plan or referral doctor and obtained at a Plan local pharmacy will be dispensed for up to a 30-day supply. **You pay a $10 copay** per prescription unit or refill.

HIP Mail Order Service.
Members may obtain generic drugs through the Mail Order Service**. You pay $5 copay** per prescription unit or refill up to a 90 day-supply. For further information, contact ValueRX, the Plan's Mail Order vendor, at 1-800/224-5502 or Customer Service Department at 1-800/HIP TALK (1-800/447-8255).

Drugs are prescribed by Plan doctors and dispensed in accordance with the Plan's drug formulary. Non-formulary drugs will be covered when prescribed by a Plan doctor.

Covered medications and accessories include:

Drugs for which a prescription is required by law

Implanted time-release medications, such as Norplant; you pay 10% of the cost of the prescription per prescription. For other internally implanted time-release medications, you pay 10% of the cost of the prescription per prescription. There is no charge when the device is implanted during a covered hospitalization.

Oral and injectable contraceptive drugs and devices

Smoking cessation drugs and medication, including nicotine patches

Insulin; a copay charge applies to each vial

Disposable needles and syringes needed to inject covered prescribed medication

Nutritional supplements for the treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria

Fertility drugs (oral and injectable)

Intravenous fluids and medication for home use, implantable drugs, and some injectable drugs are covered under Medical and Surgical Benefits.

Section 5. Benefits *continued*

Limited Benefits

Sexual dysfunction drugs have dispensing limitations. Contact the Plan for details.

What is not covered

Drugs available without a prescription or for which there is a nonprescription equivalent available

Drugs obtained at a non-Plan pharmacy except for out-of-area emergencies

Vitamins and nutritional substances that can be purchased without a prescription

Medical supplies such as dressings and antiseptics

Drugs for cosmetic purposes

Drugs to enhance athletic performance

Other Benefits

Accidental injury benefit

Restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury; **you pay nothing**.

What is not covered

Other dental services not shown as covered

Vision care

What is covered

In addition to the medical and surgical benefits provided for diagnosis and treatment of diseases of the eye, annual eye refractions (to provide a written lens prescription for eyeglasses) may be obtained from Plan providers. **You pay nothing**.

What is not covered

Corrective eyeglasses and frames or contact lenses (including the fitting of the lenses)

Eye exercises

Section 5. Benefits *continued*

Non-FEHB Benefits Available to Plan Members

The benefits described on this page are neither offered nor guaranteed under the contract with the FEHB Program, but are made available to all enrollees and family members of this Plan. The cost of the benefits described on this page is not included in the FEHB premium and any charges for these services do not count toward any FEHB deductibles, or out-of-pocket maximums. These benefits are not subject to the FEHB disputed claims procedure.

HIP VIP® Medicare HMO Benefits

Who may enroll?

You may enroll in the HIP VIP® Medicare Plan: (1)if you have FEHB coverage; (2) if you are enrolled in Medicare Parts A and B. Note: If you meet the above-mentioned criteria, you do not need to be retired to enroll in this program. If you are eligible to enroll in the HIP VIP® Medicare Plan, you will continue to remain enrolled in the FEHB Program.

The HIP VIP® Medicare Plan is available at no additional cost to you.

HIP VIP® Medicare Plan has continuous open enrollment; so you may join any time during the year. Except for emergency care or urgently needed care, HIP VIP® Medicare Plan members must use the Plan's participating providers for all their health care needs. As a member of the HIP VIP® Medicare Plan, all your medical and hospital services must be provided or authorized by HIP.

What is covered?

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

Fitness Program Discount

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

NEW for January 1, 2000

Alternative Medicine Program

We are pleased to introduce an Alternative Medicine Program, effective 1/1/2000. It provides you with access to discounted Acupuncture, Massage Therapy and Yoga Therapy services through an agreement with Consensus Health, a leading national alternative medicine services organization*.

Should you choose to seek such services, you'll have access to the large Consensus network of quality screened providers at discount rates. **You pay** no additional plan premiums. The fees you are charged will be at a discount off of the provider's usual rates. Present your HIP ID card to the Consensus network provider in order to obtain the discounted rate.

After 1/1/2000, call 1-888/HIP-ALMD (1-888/447-2563) for a list of Consensus network providers.

Dental care

What is covered?

The following diagnostic and preventive services are covered when provided by participating HIP General Dentists:

- One examination (comprehensive or periodic) every six months - $5/visit
- One prophylaxis (cleaning) every six months - $10/visit
- One topical application of fluoride (for children age 16 and under) every six months - $5/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 participating HIP Dentists. Members must use participating HIP Dentists in order to take advantage of the reduced member fee schedule. Members may select any participating HIP Dentist and may change their choice of provider at any time.

How To Obtain Benefits

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 (447-4833), is available for use by the hearing impaired. You may also contact us at our Web site at www.hipusa.com or call us at 1-800/HIP-TALK.

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

Section 6. General exclusions — Things we don't cover

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

We do not cover the following:

- Services, drugs or supplies that are not medically necessary;
- Services not required according to accepted standards of medical, dental, or psychiatric practice;
- Care by non-Plan providers except for authorized referrals or emergencies (see Emergency Benefits) or eligible self-referred services;
- Experimental or investigational procedures, treatments, drugs or devices;
- Procedures, services, drugs and 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;
- Procedures, services, drugs and supplies related to sex transformations;
- Services or supplies you receive from a provider or facility barred from the FEHB Program; and
- Expenses you incurred while you were not enrolled in this Plan.

Section 7. Limitations – Rules that affect your benefits

Medicare

Tell us if you or a family member is enrolled in Medicare Part A or B. Medicare will determine who is responsible for paying for medical services and we will coordinate the payments. On occasion, you may need to file a Medicare claim form.

If you are eligible for Medicare, you may enroll in a Medicare+Choice plan and also remain enrolled with us.

If you are an annuitant or former spouse, you can suspend your FEHB coverage and enroll in a Medicare+Choice plan when one is available in your area. For information on suspending your FEHB enrollment and changing to a Medicare+Choice plan, 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.

If you involuntarily lose coverage, or move out of the Medicare+Choice service area, you may re-enroll in the FEHB Program at any time.

If you do not have Medicare Part A or B, you can still be covered under the FEHB Program and your benefits will not be reduced. We cannot require you to enroll in Medicare.

For information on Medicare+Choice plans, contact your local Social Security Administration (SSA) office or request it from SSA at 1-800/638-6833. For information on the Medicare+Choice plan offered by this Plan, see page 18.

Other group insurance coverage

When anyone has coverage with us and with another group health plan, it is called double coverage. You must tell us if you or a family member has double coverage. You must also send us documents about other insurance if we ask for them.

When you have double coverage, one plan is the primary payer; it pays benefits first. The other plan is secondary; it pays benefits next. We decide which insurance is primary according to the National Association of Insurance Commissioners' Guidelines.

If we pay second, we will determine what the reasonable charge for the benefit should be. After the first plan pays, we will pay either what is left of the reasonable charge or our regular benefit, whichever is less. We will not pay more than the reasonable charge. If we are the secondary payer, we may be entitled to receive payment from your primary plan.

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

Section 7. Limitations – Rules that affect your benefits *continued*

Circumstances beyond our control

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

When others are responsible for injuries

When you receive money to compensate you for medical or hospital care for injuries or illness that another person caused, you must reimburse us for whatever services we paid for. 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.

TRICARE

TRICARE is the health care program for members, eligible dependents, and retirees of the military. TRICARE includes the CHAMPUS program. If both TRICARE and this Plan cover you, we are the primary payer. 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 determine they must provide;
- 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 the OWCP or similar agency has paid its maximum benefits for your treatment, we will provide your benefits.

Medicaid

We pay first if both Medicaid and this Plan cover you.

Other Government Agencies

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

Section 8. FEHB FACTS

You have a right to information about your HMO.

OPM requires that all FEHB plans comply with the Patients' Bill of Rights, which gives you the right to information about your health plan, its networks, providers and facilities. You can also find out about care management, which includes medical practice guidelines, disease management programs and how we determine if procedures are experimental or investigational. OPM's Web site (www.opm.gov) lists the specific types of information that we must make available to you.

If you want specific information about us, call 1-800/HIP-TALK (1-800/447-8255), or write to 7 West 34th Street, New York, NY 10001. You may also contact us by fax at 1-212/630-0089, or visit our Web site at www.hipusa.com.

Where do I get information about enrolling in the FEHB Program?

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
- The next Open Season for enrollment.

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.

When are my benefits and premiums effective?

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

What happens when I 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, which is described later in this section.

What types of coverage are available for my family and me?

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 or step children your employing or retirement office authorizes coverage for. Under certain circumstances, you may also get 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 you give birth or add the child to your family. The benefits and premiums for your Self and Family enrollment begin on the first day of the pay period in which the child is born or becomes an eligible family member.

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.

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

Section 8. FEHB FACTS *continued*

Are my medical and claims records 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.

Information for new members

Identification cards

We will send you an Identification (ID) card. Use your copy of the Health Benefits Election Form, SF-2809, or the OPM annuitant confirmation letter until you receive your ID card. You can also use an Employee Express confirmation letter.

What if I paid a deductible under my old plan?

Your old plan's deductible continues until our coverage begins.

Pre-existing conditions

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

When you lose benefits

What happens if my enrollment in this Plan 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 former spouse coverage or Temporary Continuation of Coverage.

What is former spouse 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 more information about your coverage choices.

What is TCC?

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 TCC. For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire. You may not elect TCC if you are fired from your Federal job due to gross misconduct. Get the RI 79-27, which describes TCC, and the RI 70-5, the Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees from your employing or retirement office.

Key points about TCC:

- You can pick a new plan;
- If you leave Federal service, you can receive TCC for up to 18 months after you separate;
- If you no longer qualify as a family member, you can receive TCC for up to 36 months;
- Your TCC enrollment starts after regular coverage ends.
- If you or your employing office delay processing your request, you still have to pay premiums from the 32nd day after your regular coverage ends, even if several months have passed.
- You pay the total premium, and generally a 2-percent administrative charge. The government does not share your costs.
- You receive another 31-day extension of coverage when your TCC enrollment ends, unless you cancel your TCC or stop paying the premium.
- You are not eligible for TCC if you can receive regular FEHB Program benefits.

Section 8. FEHB FACTS *continued*

How do I enroll in TCC?

If you leave Federal service your employing office will notify you of your right to enroll under TCC. You must enroll within 60 days of leaving, or receiving this notice, whichever is later.

Children: You must notify your employing or retirement office within 60 days after your child is no longer an eligible family member. That office will send you information about enrolling in TCC. You must enroll your child within 60 days after they become eligible for TCC, or receive this notice, whichever is later.

Former spouses: You or your former spouse must notify your employing or retirement office within 60 days of one of these qualifying events:

- Divorce
- Loss of spouse equity coverage within 36 months after the divorce.

Your employing or retirement office will then send your former spouse information about enrolling in TCC. Your former spouse must enroll within 60 days after the event, which qualifies them for coverage, or receiving the information, whichever is later.

Note: Your child or former spouse loses TCC eligibility unless you or your former spouse notify your employing or retirement office within the 60-day deadline.

How can I convert 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 if individual coverage is available. 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.

How can I get a Certificate of Group Health Plan Coverage?

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

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

Inspector General Advisory: Stop Health Care Fraud!

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

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at 1-877/TELL-HIP (1-877/835-5447) and explain the situation.
- If we do not resolve the issue, call or write:

THE HEALTH CARE FRAUD HOTLINE
202/418-3300

U.S. Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, NW, Room 6400
Washington, D.C. 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 they:

- Try to obtain services for a person who is not an eligible family member; or
- Are no longer enrolled in the Plan and try to obtain benefits.

Your agency may also take administrative action against you.

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Summary of Benefits for HIP HEALTH INSURANCE PLAN- 2000

Do not rely on this chart alone. All benefits are provided in full unless otherwise indicated subject to the limitations and exclusions set forth in the brochure. This chart merely summarizes certain important expenses covered by the Plan. If you wish to enroll or change your enrollment in this Plan, be sure to indicate the correct enrollment code on your enrollment form (codes appear on the cover of this brochure). **ALL SERVICES COVERED UNDER THIS PLAN, WITH THE EXCEPTION OF EMERGENCY CARE, ARE COVERED ONLY WHEN PROVIDED OR ARRANGED BY PLAN DOCTORS.**

	Benefits	Plan pays/provides	Page
Inpatient care	**Hospital**	Comprehensive range of medical and surgical services without dollar or day limit. Includes in-hospital doctor care, room and board, general nursing care, private room and private nursing care if medically necessary, diagnostic tests, drugs and medical supplies, use of operating room, intensive care and complete maternity care. **You pay nothing**	**13**
	Extended care	All necessary services, no dollar or day limit. **You pay nothing**	**13**
	Mental conditions	Diagnosis and treatment of acute psychiatric conditions for 30 days of inpatient care per year. **You pay nothing**	**15**
	Substance abuse	All necessary services, for up to 30 days per year in a substance abuse treatment program. **You pay nothing**	**16**
Outpatient care		Comprehensive range of services such as diagnosis and treatment of illness or injury, including specialist's care; preventive care, including well-baby care, periodic check-ups and routine immunizations; laboratory tests and X-rays; complete maternity care. **You pay $10 per office visit**; nothing per house call by a doctor; copay is waived for maternity visits	**13**
	Home health care	All necessary visits by nurses and health aides. **You pay nothing**	**12**
	Mental conditions	All necessary outpatient visits per year. **You pay nothing**	**15-16**
	Substance abuse	All necessary outpatient visits per year. **You pay nothing**	**16**
Emergency care		Reasonable charges for services and supplies required because of a medical emergency. **You pay $10** copay for urgent care visits; **you pay $25** to the hospital for each emergency room visit and any charges for services that are not covered by this Plan	**14-15**
Prescription drugs		Drugs prescribed by a Plan doctor and obtained at a Plan pharmacy. **You pay $10 copay** per prescription unit or refill for generic or brand name drugs	**16-17**
Dental care		Accidental injury benefit; **you pay nothing**	**17**
Vision care		One refraction annually. **You pay nothing**	**17**
Out-of-pocket maximum		Your out-of-pocket expenses for benefits under this Plan are limited to the stated co-payments that are required for a few benefits	**6**

2000 Rate Information for
Health Insurance Plan of Greater New York (HIP/HMO)

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

Postal rates apply to most career U.S. Postal Service employees. In 2000, two categories of contribution rates, referred to as Category A rates and Category B rates, will apply for certain career employees. If you are a career postal employee, but not a member of a special postal employment class, refer to the category definitions in "The Guide to Federal Employees Health Benefits Plans for United States Postal Service Employees," RI 70-2 to determine which rate applies to you.

Postal rates do not apply to non-career postal employees, postal retirees, certain special postal employment classes or associate members of any postal employee organization. Such persons not subject to postal rates must refer to the applicable "Guide to Federal Employees Health Benefits Plans."

		Non-Postal Premium				**Postal Premium A**		**Postal Premium B**	
		Biweekly		**Monthly**		**Biweekly**		**Biweekly**	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share	USPS Share	Your Share
Self Only	**511**	**$ 64.25**	**$21.41**	**$139.20**	**$ 46.40**	**$ 76.02**	**$ 9.64**	**$ 76.02**	**$ 9.64**
Self and Family	**512**	**$175.97**	**$81.02**	**$381.27**	**$175.54**	**$207.74**	**$49.25**	**$201.02**	**$55.97**