Health Insurance Plan (HIP/HMO)

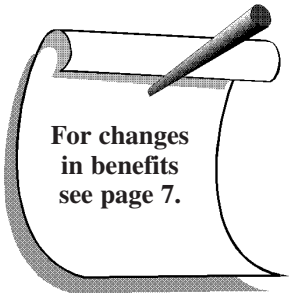
HEALTH PLAN OF NEW YORK

http://www.HIPUSA.com

2003

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 6 for requirements.

This Plan has Commendable Accreditation from the NCQA. See the 2003 Guide for more information on accreditation.

Enrollment codes for this Plan:

511 High Option Self Only
512 High Option Self and Family
514 Standard Option Self Only
515 Standard Option Self and Family

Special notice: We are offering a new plan option for the first time under the Federal Employees Health Benefits Program during the 2003 Open Season. If you were enrolled in HIP/HMO coverage during 2002, that option is now known as High Option. You will remain in the HIP/HMO High Option coverage unless you elect the Standard Option coverage or another health plan during Open Season.

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

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
WASHINGTON, DC 20415-0001

OFFICE OF THE DIRECTOR

Dear Federal Employees Health Benefits Program Participant:

I am pleased to present this Federal Employees Health Benefits (FEHB) Program plan brochure for 2003. The brochure explains all the benefits this health plan offers to its enrollees. Since benefits can vary from year to year, you should review your plan's brochure every Open Season. Fundamentally, I believe that FEHB participants are wise enough to determine the care options best suited for themselves and their families.

In keeping with the President's health care agenda, we remain committed to providing FEHB members with affordable, quality health care choices. Our strategy to maintain quality and cost this year rested on four initiatives. First, I met with FEHB carriers and challenged them to contain costs, maintain quality, and keep the FEHB Program a model of consumer choice and on the cutting edge of employer-provided health benefits. I asked the plans for their best ideas to help hold down premiums and promote quality. And, I encouraged them to explore all reasonable options to constrain premium increases while maintaining a benefits program that is highly valued by our employees and retirees, as well as attractive to prospective Federal employees. Second, I met with our own FEHB negotiating team here at OPM and I challenged them to conduct tough negotiations on your behalf. Third, OPM initiated a comprehensive outside audit to review the potential costs of federal and state mandates over the past decade, so that this agency is better prepared to tell you, the Congress and others the true cost of mandated services. Fourth, we have maintained a respectful and full engagement with the OPM Inspector General (IG) and have supported all of his efforts to investigate fraud and waste within the FEHB and other programs. Positive relations with the IG are essential and I am proud of our strong relationship.

The FEHB Program is market-driven. The health care marketplace has experienced significant increases in health care cost trends in recent years. Despite its size, the FEHB Program is not immune to such market forces. We have worked with this plan and all the other plans in the Program to provide health plan choices that maintain competitive benefit packages and yet keep health care affordable.

Now, it is your turn. We believe if you review this health plan brochure and the FEHB Guide you will have what you need to make an informed decision on health care for you and your family. We suggest you also visit our web site at www.opm.gov/insure.

Sincerely,

Kay Coles James
Director

Notice of the Office of Personnel Management's

Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

By law, the Office of Personnel Management (OPM), which administers the Federal Employees Health Benefits (FEHB) Program, is required to protect the privacy of your personal medical information. OPM is also required to give you this notice to tell you how OPM may use and give out ("disclose") your personal medical information held by OPM.

OPM **will** use and give out your personal medical information:

- To you or someone who has the legal right to act for you (your personal representative),
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected,
- To law enforcement officials when investigating and/or prosecuting alleged or civil or criminal actions, and
- Where required by law.

OPM **has the right** to use and give out your personal medical information to administer the FEHB Program. For example:

- To communicate with your FEHB health plan when you or someone you have authorized to act on your behalf asks for our assistance regarding a benefit or customer service issue.
- To review, make a decision, or litigate your disputed claim.
- For OPM and the General Accounting Office when conducting audits.

OPM **may** use or give out your personal medical information for the following purposes under limited circumstances:

- For Government healthcare oversight activities (such as fraud and abuse investigations),
- For research studies that meet all privacy law requirements (such as for medical research or education), and
- To avoid a serious and imminent threat to health or safety.

By law, OPM must have your written permission (an "authorization") to use or give out your personal medical information for any purpose that is not set out in this notice. You may take back ("revoke") your written permission at any time, except if OPM has already acted based on your permission.

By law, you **have the right** to:

- See and get a copy of your personal medical information held by OPM.
- Amend any of your personal medical information created by OPM if you believe that it is wrong or if information is missing, and OPM agrees. If OPM disagrees, you may have a statement of your disagreement added to your personal medical information.
- Get a listing of those getting your personal medical information from OPM in the past 6 years. The listing will not cover your personal medical information that was given to you or your personal representative, any information that you authorized OPM to release, or that was given out for law enforcement purposes or to pay for your health care or a disputed claim.
- Ask OPM to communicate with you in a different manner or at a different place (for example, by sending materials to a P.O. Box instead of your home address).
- Ask OPM to limit how your personal medical information is used or given out. However, OPM may not be able to agree to your request if the information is used to conduct operations in the manner described above.
- Get a separate paper copy of this notice.

For more information on exercising your rights set out in this notice, look at www.opm.gov/insure on the web. You may also call 202-606-0191 and ask for OPM's FEHB Program privacy official for this purpose.

If you believe OPM has violated your privacy rights set out in this notice, you may file a complaint with OPM at the following address:

Privacy Complaints
Office of Personnel Management
P.O. Box 707
Washington, DC 20004-0707

Filing a complaint will not affect your benefits under the FEHB Program. You also may file a complaint with the Secretary of the Department of Health and Human Services.

By law, OPM is required to follow the terms in this privacy notice. OPM has the right to change the way your personal medical information is used and given out. If OPM makes any changes, you will get a new notice by mail within 60 days of the change. The privacy practices listed in this notice will be effective April 14, 2003.

Table of Contents

Introduction

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. The address for HIP Health Plan of New York (HIP) administrative offices is:

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

This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in 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, 2003, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2003, and changes are summarized on page 52. Rates are shown at the end of this brochure.

Plain Language

FEHB brochures are written in plain language 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 OPM know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail OPM 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.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits Program (FEHB) Program premium.

OPM's Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud - Here are some things you can do to prevent fraud:

- Be wary of giving your plan identification (ID) number over the telephone or to people you do not know, except to your doctor, other provider, or authorized plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) that you receive from us.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.

- If you suspect that a provider 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 — THE HEALTH CARE FRAUD HOTLINE
202-418-3300

OR WRITE TO:

The United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, NW, Room 6400
Washington, DC 20415

- Do not maintain as a family member on your policy:
    - your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
    - your child over age 22 unless he/she is disabled and incapable of self support.
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed or with OPM if you are retired.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

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. The Plan is solely responsible for the selection of these providers in your area. Contact the Plan for a copy of their most recent provider directory.

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 18,000 professional medical providers participate in HIP/HMO and provide medical services to more than 800,000 enrollees. Our network covers 74 medical specialities 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 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 2003

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

- A Notice of the Office of Personnel Management's Privacy Practices is included.
- A section on the Children's Equity Act describes when an employee is required to maintain Self and Family coverage.
- Program information on TRICARE and CHAMPVA explains how annuitants or former spouses may suspend their FEHB Program enrollment.
- Program information on Medicare is revised.
- By law, the DoD/FEHB Demonstration project ends on December 31, 2002.

Changes to this Plan

- Your share of the non-Postal premium for High Option will increase by 23.4% for Self Only or 23.2% for Self and Family.
- We now have two benefits packages. We are now offering a High Option (511, 512) and Standard Option (514, 515) coverage package. Those enrollees who had HIP/HMO coverage during 2002 will remain in the High Option coverage unless they elect the HIP/HMO Standard Option coverage or another health plan during Open Season.
- The prescription drug copay for non-formulary drugs has increased from $35.00 to $40.00 per 30-day supply under the High Option coverage. Section 5(f).
- The High Option urgent care center or hospital emergency room copay has increased from $25.00 to $50.00. Section 5(d)

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 Web site 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 on our Web site 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. 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 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. 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 $50 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.

  Example: The Standard Option coverage has a $100 prescription drug deductible that you must meet each calendar year.

- **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 a catastrophic protection out-of-pocket maximum.

Section 5. Benefits – OVERVIEW
(See page 7 for how our benefits changed this year and page 52 for a benefits summary.)

NOTE: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claims forms, claims filing advice, or more information about our benefits, contact us at 1-800-HIP-TALK (1-800-447-8255) or at our Web site at http://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 for services described in this section.
- Providers other than your Primary Care Physician are specialists under the Standard Option coverage.
- 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

Benefit Description	You pay	
	High Option	Standard Option
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	$10 per office visit to your primary care physician or $20 per office visit to a specialist
Professional services of physicians • During a hospital stay • In a skilled nursing facility • At home	Nothing	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.*	*All charges.*

Lab, X-ray and other diagnostic tests	High Option You Pay	Standard Option You Pay
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • Cat Scans/MRI • Ultrasound • Electrocardiogram and EEG	Nothing if you receive these services during your office visit; otherwise, $10 per office visit	Nothing if you receive these services during your office visit; otherwise, $10 per office visit to your primary care physician or $20 per office visit to a specialist
Preventive care, adult		
Routine screenings, such as: • Total Blood Cholesterol – once every three years • Colorectal Cancer Screening, including: – Fecal occult blood test – Sigmoidoscopy, screening – every five years starting at age 50	$10 per office visit	$10 per office visit to your primary care physician or $20 per office visit to a specialist
Prostate Specific Antigen (PSA) test – one annually for men age 40 and older • Annual standard diagnostic testing of prostate cancer, including but not limited to a digital rectal examination and a prostate-specific antigen testing for men age 50 and over who are asymptomatic and for men age 40 and over with a family history of prostate cancer or other prostate cancer risks.	$10 per office visit	$10 per office visit to your primary care physician or $20 per office visit to a specialist
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	$10 per office visit to your primary care physician or $20 per office visit to a specialist
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	$10 per office visit to your primary care physician or $20 per office visit to a specialist
Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	*All charges.*	*All charges.*

Preventive care, adult *(continued)*	**High Option You Pay**	**Standard Option You Pay**
Routine immunizations, limited to: • Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) • Influenza vaccine, annually, age 65 and over	$10 per office visit	$10 per office visit to your primary care physician or $20 per office visit to a specialist
Not covered: *- Autgenous vaccines* *- Adult immunizations related to foreign travel*	*All charges.*	*All charges.*
Preventive care, children		
• Childhood immunizations recommended by the American Academy of Pediatrics	Nothing	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	Nothing

Maternity Care	High Option You Pay	Standard Option You Pay
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).	$10 first office visit; waived in subsequent visits.	$10 first office visit; waived in subsequent visits.
Not covered: Routine sonograms to determine fetal age, size or sex	*All charges.*	*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	$10 per office visit to your primary care physician or $20 per office visit to a specialist
Not covered: reversal of voluntary surgical sterilization, genetic counseling.	*All charges.*	*All charges.*
Infertility Services		
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	$10 per office visit to your primary care physician or $20 per office visit to a specialist

Infertility Services *(continued)*	**High Option You Pay**	**Standard Option You Pay**
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* • *Cost of donor egg*	*All charges.*	*All charges.*
Allergy Care		
Testing and treatment Allergy injection	$10 per office visit	$10 per office visit to your primary care physician or $20 per office visit to a specialist
Allergy serum	Nothing	Nothing
Not covered: Provocative food testing and sublingual allergy desensitization	*All charges.*	*All charges.*

Treatment therapies	High Option You Pay	Standard Option You Pay
• 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 24. • 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 the medical necessity guidelines in order for services to be approved.	$10 per office visit	$10 per office visit to your primary care physician or $20 per office visit to a specialist
Physical and occupational therapies		
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	$20 per office visit Included in hospital admission copay.
Not covered: • *long-term rehabilitative therapy* • *exercise programs*	*All charges.*	*All charges.*
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	$20 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	$10 per office visit to your primary care physician or $20 per office visit to a specialist
Not covered: • *all other hearing testing* • *hearing aids, testing and examinations for them*	*All charges.*	*All charges.*

Vision services (Testing, treatment and supplies)	High Option You Pay	Standard Option You Pay
• Annual eye refractions • Diagnosis and treatment of diseases of the eye • Lenses following cataract removal	$10 per office visit	$20 per office visit
Not covered: • *Eyeglasses or contact lenses* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	*All charges.*	*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	$10 per office visit to your primary care physician or $20 per office visit to a specialist
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.*	*All charges.*
Orthopedic and prosthetic devices		
• Artificial limbs and eyes; stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: We pay internal prosthetic devices as hospital benefits; see Section 5 (c) for payment information. See 5 (b) for coverage of the surgery to insert the device. • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. 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 services when you call.	$10 per office visit Nothing for the equipment	$10 per office visit to your primary care physician or $20 per office visit to a specialist Nothing for the equipment

Orthopedic and prosthetic devices *(continued)*	**High Option You Pay**	**Standard Option You Pay**
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.*	*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	Nothing
Not covered: • *Motorized and customized wheel chairs*	*All charges.*	*All charges.*
Home health services		
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide • Services include oxygen therapy, intravenous therapy and medications. Note: Standard Option coverage has a 200 visit limit per calendar year. High Option does not have a visit limit per calendar year.	Nothing	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.*	*All charges.*

Chiropractic	High Option You Pay	Standard Option You Pay
• 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	$20 per office visit
Alternative treatments		
No benefit. We do not cover treatments such as but not limited to: • *naturopathic services* • *hypnotherapy* • *acupuncture* • *biofeedback*	*All charges.*	*All charges.*
Educational classes and programs		
Coverage is limited to: • Smoking Cessation – In a HIP Free & Clear 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	$10 per office visit to your primary care physician or $20 per office visit to a specialist

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 for services described in this section.
- Providers other than your Primary Care Physician are specialists under the High Option and Standard Option coverage.
- 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	
	High Option	Standard Option
Surgical procedures		
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • 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 • Treatment of burns 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	Nothing
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care.*	*All charges.*	*All charges.*

Reconstructive surgery	High Option You Pay	Standard Option 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.	Nothing	Nothing
• 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	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.*	*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	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.*	*All charges.*

Organ/tissue transplants	High Option You Pay	Standard Option You Pay
Limited to: • Cornea • Heart • Heart/lung • Kidney • Kidney/Pancreas • Liver • Lung: Single –Double • Pancreas • 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 • 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	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.*	*All charges.*
Anesthesia		
Professional services provided in – • Hospital (inpatient)	Nothing	Nothing
Professional services provided in – • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	Nothing	Nothing

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

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- We do not have a calendar year deductible for services described in this section.
- 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	
	High Option	Standard Option
Inpatient hospital		
Room and board, such as • ward, semiprivate, or intensive care accommodations; • general nursing care; and • meals and special diets. NOTE: If you want a private room when it is not medically necessary, you pay the additional charge above the semi-private room rate.	Nothing	$500 per inpatient hospital admission
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home	Nothing	Nothing (included in the $500 inpatient hospital admission copay)
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*	*All charges.*	*All charges.*

Outpatient hospital or ambulatory surgical center	High Option You Pay	Standard Option 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	Nothing
Not covered: blood and blood derivatives not replaced by the member	*All charges.*	*All charges.*
Extended care/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	Nothing
Not covered: custodial care, rest cures, domiciliary or convalescent care	*All charges.*	*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	Nothing
Not covered: • *Independent nursing, homemaker services* • *Services or supplies not listed in the Hospice Program* • *Services for respite care* • *Nutritional supplements, non-prescription drugs or substances, vitamins and minerals*	*All charges.*	*All charges.*
Ambulance		
• Local professional ambulance service when medically appropriate	Nothing	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 for services described in this section.
- We waive your emergency room copay if you are admitted to the hospital for inpatient treatment.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

What is a medical emergency?

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

What to do in case of emergency:

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).

Emergencies outside our service area: 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.

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.

Benefit Description	You pay	
	High Option	Standard Option
Emergency within our service area		
• Emergency care at a doctor's office	$10 per office visit	$10 per office visit
• Emergency care at an urgent care center	$50 per visit	$50 per visit
• Emergency care as an outpatient or inpatient at a hospital, including doctors' services		
Not covered: Elective care or non-emergency care	*All charges.*	*All charges.*

Emergency outside our service area	High Option You Pay	Standard Option You Pay
• Emergency care at a doctor's office	$10 per office visit	$10 per office visit
• Emergency care at an urgent care center • Emergency care as an outpatient or inpatient at a hospital, including doctors' services	$50 per visit	$50 per visit
Not covered: • *Elective care or non-emergency care* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All charges.*	*All charges.*
Ambulance		
Local ambulance service in an emergency condition or when approved by the plan. See 5(c) for non-emergency service.	Nothing	Nothing
Not covered: air ambulance	*All charges.*	*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:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We do not have a calendar year benefit.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits description below.

IMPORTANT

Benefit Description	You pay	
	High Option	Standard Option
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.	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 Note: Psychiatrist, psychologists, licensed clinical social workers, etc. are specialists. The office visit copay for specialists applies to services from these professionals.	$10 per office visit or Nothing for inpatient visits	$10 per office visit to your primary care physician or $20 per office visit to a specialist or Nothing for inpatient visits
• Diagnostic tests	Nothing if you receive these services during your office visit; otherwise, $10 per office visit	Nothing if you receive these services during your office visit; otherwise, $10 per office visit to your primary care physician or $20 per office visit to a specialist
• 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	$500 per inpatient hospital admission or nothing for outpatient services.

Mental health and substance abuse benefits *(continued)*	High Option You Pay	Standard Option You Pay
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.*	*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 benefits 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.
- Under HIP/HMO Standard Option coverage, each member must satisfy a $100 calendar year prescription drug deductible. You do not have a prescription drug deductible under the High Option coverage.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

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

- **Who can write your prescription.** A licensed Plan doctor or referrral doctor must write the prescription
- **Where you can obtain them.** 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 when prescribed by a Plan doctor after you pay to a $40.00 non-formulary copay.
- **These are the dispensing limitations.** A participating pharmacy will provide up to a 30-day supply of your prescription. Under the High Option Plan, you will pay $10.00 for generic formulary drugs or $15.00 for name brand formulary drugs, or $40.00 for non-formulary drugs. Under the Standard Option plan, you pay $10.00 for generic formulary drugs, or $20.00 for name brand formulary drugs, or $40.00 for non-formulary drugs once a $100.00 deductible is met. 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. 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 1-800-HIP-TALK (1-800-447-8255) for details. For further information on using our mail order program, contact Express Scripts at 1-800-224-5502. A generic equivalent will be dispensed 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 us – less money than a brand name 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.

Benefit Description	You pay	
	High Option	Standard Option
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 those listed below • Insulin • Disposable needles and syringes for the administration of covered medications • Nutritional supplements for the treatment of phenylketonuria, branched chain ketonuria, galactosemia, and homocystinuria • Drugs for sexual dysfunction (see Prior authorization below) • Fertility drugs (oral and injectable) Note: Non-formulary drugs are not available under our mail order program.	**For up to a 30-day supply at a participating Retail Pharmacy:** $10 for generic formulary drugs; $15 for brand name formulary drugs; or $40 for non-formulary drugs **Up to a 90-day supply by Mail order:** $15.00 for generic formulary drugs or $22.50 name brand formulary drugs	**For up to a 30-day supply at a participating Retail Pharmacy:** (After the $100 calendar year deductible is met) $10 for generic formulary drugs; $20 for brand name formulary drugs; or $40 for non-formulary drugs **Up to a 90-day supply by Mail order:** (After the $100 calendar year deductible is met) $15.00 for generic formulary drugs or $30.00 name brand formulary drugs
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies* • *Vitamins, nutrients and food supplements even if a physician prescribes or administers them* • *Nonprescription medicines* • *Medical supplies*	*All charges.*	*All charges.*

Section 5 (g). Special features

Feature	Description
Services for deaf and hearing impaired	The telephone number for the hearing impaired is 1-888-HIP-4TDD (1-888-447-4833).
Medical Case Management	We offer case management for members with chronic or catastrophic illnesses or injuries.
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. See Section 5 (c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

Accidental injury benefit	High Option You Pay	Standard Option You Pay
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth within 12 months of the date of the accident. The need for these services must result from an accidental injury.	Nothing	Nothing
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

HIP VIP® Medicare Plan is our Medicare + Choice Plan. You may enroll in it if we offer it in the area where you live and you are enrolled in Medicare A and B. If you have FEHB coverage and enroll in HIP VIP® Medicare Plan, you receive the following benefits:

- 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 name 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 have suspended your FEHB Program 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.

Optical

At a participating provider members pay a $45 copay for a complete pair of eyeglasses (from a select group of frames) every 24 months.

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;
- Services, drugs, or supplies you receive without charge while in active military service.

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, coinsurance, or deductible. 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, hospital and drug benefits

In most cases, providers 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 services you receive outside of the Plan's service area — 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.

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

Other supplies or services

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

Deadline for filing your claim

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

When we need more information

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

Section 8. The disputed claims process

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

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: (a) Write to us within 6 months from the date of our decision; and (b) Send your request to us at: HIP Health Plan of New York, 7 West 34th Street, New York, NY 10001; and (c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and (d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	We have 30 days from the date we receive your request to: (a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or (b) Write to you and maintain our denial — go to step 4; or (c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request— go to step 3.
3	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
4	If you do not agree with our decision, you may ask OPM to review it.
	You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us — if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information.
	Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Health Benefits Contracts Division 3, 1900 E Street, NW, Washington, DC 20415-3630
	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 more than one claim, 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.

Step	Description
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.
	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 may 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 covered family member have coverage 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.

• 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 and Part B)

The Original Medicare Plan (Original Medicare) 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 under the FEHB Program.

Claims process when you have the Original Medicare Plan — You probably will 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 then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claims, call us at 1-800-HIP TALK

We do not waive any costs if the Original Medicare Plan is your primary payer.

Claims process when you have the Original Medicare Plan — You probably will 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 then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claims, call us at 1-800-HIP TALK

We do not waive any costs if the Original Medicare Plan is your primary payer.

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, or	✓	
b) 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) Are an annuitant, or	✓	
b) Are an active employee, or		✓
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 further 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 Part 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 and CHAMPVA

TRICARE is the health care program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPVA program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. If TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) 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 under the program.

Workers' Compensation

We do not cover services that:

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

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

Medicaid

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

Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these state programs, eliminating your FEHB 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 under the state program.

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 11.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 11.

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 11.

Durable Medical Equipment, Prosthetic Devices and Orthopedic Devices

A "Covered Appliance" is one of the following items which is prescribed by 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 services

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:

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 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 your FEHB coverage. These materials tell you:

- 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.

Children's Equity Act

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self and Family coverage in the Federal Employees Health Benefits (FEHB) Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child (ren).

If this law applies to you, you must enroll for Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self and Family coverage in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option;
- If you have a Self only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self and Family in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self and Family in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to self only, or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children. If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot make any changes after retirement. Contact your employing office for further information.

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.

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.

• Spouse equity coverage

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage. If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to supply health coverage to you. But, you may be eligible for your own FEHB coverage under the spouse equity law or Temporary Continuation of Coverage (TCC). 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. You can also download the guide from OPM's website, www.opm.gov/insure.

• 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 a non-FEHB individual policy if:

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

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

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

• Getting a Certificate of Group Health Plan Coverage

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 Still Available!

Open Season for Long Term Care Insurance

- You can protect yourself against the high cost of long term care by applying for insurance in the Federal Long Term Care Insurance Program.
- Open Season to apply for long term care insurance through LTC Partners ends on December 31, 2002.
- If you're a Federal employee, you and your spouse need only answer a few questions about your health during Open Season.
- If you apply during the Open Season, your premiums are based on your age as of July 1, 2002. After Open Season, your premiums are based on your age at the time LTC Partners receives your application.

FEHB Doesn't Cover It

- Neither FEHB plans nor Medicare cover the cost of long term care. Also called "custodial care", long term care helps you perform the activities of daily living such as bathing or dressing yourself. It can also provide help you may need due to a severe cognitive impairment such as Alzheimer's disease.

You Can Also Apply Later, But…

- Employees and their spouses can still apply for coverage after the Federal Long Term Care Insurance Program Open Season ends, but they will have to answer more health-related questions.
- For annuitants and other qualified relatives, the number of health-related questions that you need to answer is the same during and after the Open Season.

You Must Act to Receive an Application

- Unlike other benefit programs, YOU have to take action – you won't receive an application automatically. You must request one through the toll-free number or Web site listed below.
- Open Season ends December 31, 2002 – act NOW so you won't miss the abbreviated underwriting available to employees and their spouses, and the July 1 "age freeze"!

Find Out More – Contact LTC Partners by calling **1-800-LTC-FEDS (1-800-582-3337) (TDD for the hearing impaired: 1-800-843-3557)** or visiting www.ltcfeds.com to get more information and to request an application.

Index

Do not rely on this page; it is for your convenience and may not show all pages where the terms appear.

Notes

Summary of benefits for the *Health Insurance Plan (HIP/HMO)* 2003

- **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	High Option You Pay	Standard Option 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 $10 specialist	Office visit copay: $10 primary care or $20 specialist	**13**
Services provided by a hospital: • Inpatient ..... • Outpatient	 Nothing Nothing	 $500 per admission Nothing	**25**
Emergency benefits: • In-area..... • Out-of-area	 $50 per visit $50 per visit	 $50 per visit $50 per visit	**27**
Mental health and substance abuse treatment	Regular cost Sharing	Regular cost Sharing	**29**
Prescription drugs Up to 30 day supply from a participating retail pharmacy ..... Up to a 90 day supply of maintenance drugs by mail-order	 $10 per generic formulary; $15 per brand name formulary; $40 non-formulary $15 generic formulary; $22.50 brand name formulary	After $100 deductible $10 per generic formulary; $20 per brand name formulary; $40 non-formulary $15 generic formulary; $30 brand name formulary	**31**
Dental Care (Accidental Injury Only)	Nothing	Nothing	**34**
Vision Care ..... One annual eye refraction	$10 copay per visit.	$20 copay per visit.	**19**
Special features: Service for deaf and hearing impaired, Medical Case Management Programs, Travel benefit/services overseas			**33**
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum)	Nothing		**11**

2003 Rate Information for HIP Health Plan of New York

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 a special FEHB guide is published 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
Greater New York City Area							
High Option Self Only	511	$100.80	$ 33.60	$218.40	$ 72.80	$119.28	$ 15.12
High Option Self & Family	512	$249.62	$127.37	$540.84	$275.97	$294.70	$ 82.29
Standard Option Self Only	514	$ 80.63	$ 26.87	$174.69	$ 58.23	$ 95.41	$ 12.09
Standard Option Self & Family	515	$225.77	$ 75.25	$489.16	$163.05	$267.16	$ 33.86