Health Insurance Plan (HIP/HMO)

http://www.EMBLEMHEALTH.com
Customer Service 1-800-HIP-TALK (1-800-447-8255)

HIP

2013

A Health Maintenance Organization (high and standard option)

Serving: *Greater New York City Area (including Long Island and surrounding counties)*

Enrollment in this plan is limited. You must live in our geographic service area to enroll. See page 12 for requirements.

IMPORTANT
- Rates: Back Cover
- Changes for 2013: Page 13
- Summary of benefits: Page 75

This plan has Excellent Accreditation from the NCQA.

See 2013 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

Federal Employees
Health Benefits Program

Authorized for distribution by the:

United States
Office of Personnel Management

Healthcare and Insurance
http://www.opm.gov/insure

Important Notice from HIP® Health Plan of New York About

Our Prescription Drug Coverage and Medicare

OPM has determined that HIP Health Plan of New York's prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. Thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefit coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and your FEHB plan will coordinate benefits with Medicare.

Remember: If you are an annuitant and you cancel your FEHB coverage, you may not re-enroll in the FEHB Program.

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (October 15th through December 7th) to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 1-800-772-1213 (TTY 1-800-325-0778).

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit www.medicare.gov for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227), TTY 1-877-486-2048.

Table of Contents

Introduction

This brochure describes the benefits of HIP Health Plan of New York (HIP/HMO) under our contract (CS 1040) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. Customer service may be reached at 1-800-HIP-TALK (1-800-447-8255) or through our website: www.EMBLEMHEALTH.com. The address for the Health Insurance Plan (HIP/HMO) administrative offices is:

HIP Health Plan of New York
55 Water Street
New York, NY 10041

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, 2013, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2013, and changes are summarized on page 13. Rates are shown at the end of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them easy to understand. Here are some examples:

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee or family member, "we" means HIP Health Plan of New York.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States 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.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits 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 that you can do to prevent fraud:

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except to your health care providers, authorized health benefits 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.
- Periodically review your claims history for accuracy to ensure we have not been billed for services that you did not receive.
- 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

877-499-7295

OR go to www.opm.gov/oig

You can also write to:

United States Office of Personnel Management

Office of the Inspector General Fraud Hotline

1900 E Street NW Room 6400

Washington, DC 20415-1100

- 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)
- Your child age 26 or over (unless he/she was disabled and incapable of self-support prior to age 26)

- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- Fraud or intentional misrepresentation of material fact is prohibited under the plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include falsifying a claim to obtain FEHB benefits, trying to or obtaining services or coverage for yourself or for someone else who is not eligible for coverage, or enrolling in the plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

Preventing Medical Mistakes

An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That's about 3,230 preventable deaths in the FEHB Program a year. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. By asking questions, learning more and understanding your risks, you can improve the safety of your own health care, and that of your family members. Take these simple steps:

1. Ask questions if you have doubts or concerns.

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you ask questions and understand answers.

2. Keep and bring a list of all the medicines you take.

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines and dosage that you take, including non-prescription (over-the-counter) medicines and nutritional supplements.
- Tell your doctor and pharmacist about any drug allergies you have.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures.
- Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
- Call your doctor and ask for your results.
- Ask what the results mean for your care.

4. Talk to your doctor about which hospital is best for your health needs.

- Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the health care you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital.

5. Make sure you understand what will happen if you need surgery.

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, “Who will manage my care when I am in the hospital?”
- Ask your surgeon:
  - "Exactly what will you be doing?"
  - "About how long will it take?"
  - "What will happen after surgery?"
  - "How can I expect to feel during recovery?"
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications you are taking.

"Patient Safety Links"

www.ahrq.gov/consumer/pathqpack.htm. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.

www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.

www.talkaboutrx.org/consumer.html. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.

www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.

www.ahqa.gov/consumer. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

www.WhyNotTheBest.org. WhyNotTheBest was created and is maintained by The Commonwealth Fund, a private foundation working toward a high performance health system. WhyNotTheBest includes process-of-care measures, patient satisfaction measures (from the Hospital Consumer Assessment of Healthcare Providers and Systems), readmission rates, mortality rates, and average reimbursement rates.

"Never Events"

You will not be billed for inpatient services related to treatment of specific hospital acquired conditions or for inpatient services needed to correct never events, if you use HIP preferred providers. This policy helps to protect you from preventable medical errors and improve the quality of care you receive.

When you enter the hospital for treatment of one medical problem, you don't expect to leave with additional injuries, infections or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, too often patients suffer from injuries or illnesses that could have been prevented if the hospital had taken proper precautions.

We have a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores and fractures; and reduce medical errors that should never happen called "Never Events". When a Never Event occurs, neither your FEHB plan nor you will incur costs to correct the medical error.

FEHB Facts

Coverage information

No pre-existing condition limitation

We will not refuse to cover the treatment of a condition 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/health for enrollment information, as well as:

- Information on the FEHB Program and plans available to you
- A health plan comparison tool
- A list of agencies who participate in Employee Express
- A link to Employee Express
- Information on and links to other electronic enrollment systems

Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Benefits,* 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
- What happens when your enrollment ends
- 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. For information on your premium deductions, you must also contact 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 dependent children, including any foster children your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 26 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 benefits, nor will we. Please tell us immediately of changes in family member status including your marriage, divorce, annulment, or when your child reaches age 26.

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.

If you have a qualifying life event (QLE) – such as marriage, divorce, or the birth of a child – outside of the Federal Benefits Open Season, you may be eligible to enroll in the FEHB Program, change your enrollment, or cancel coverage. For a complete list of QLEs, visit the FEHB website at www.opm.gov/insure/lifeevents. If you need assistance, please contact your employing agency, personnel/payroll office, or retirement office.

Family member coverage

Family members covered under your Self and Family enrollment are your spouse (including a valid common law marriage) and children as described in the chart below.

Children	Coverage
Natural, adopted children, and stepchildren	Natural, adopted children and stepchildren are covered until their 26th birthday.
Foster Children	Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.
Children Incapable of Self-Support	Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.
Married Children	Married children (but **NOT** their spouse or their own children) are covered until their 26th birthday.
Children with or eligible for employer-provided health insurance	Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

You can find additional information at www.opm.gov/insure .

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 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 cancel your coverage, change to Self Only, or change to a plan that doesn't serve the area in which your children live as long as the court/administrative order is in effect. Contact your employing office for further information.

When benefits and premiums start

The benefits in this brochure are effective 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. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2013 benefits of your old plan or option.** However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2012 benefits until the effective date of your coverage with your new plan. 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.

If your enrollment continues after you are no longer eligible for coverage (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly from your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member are no longer eligible to use your health insurance 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.

Any person covered under the 31 day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31 day temporary extension.

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage (TCC), or a conversion policy (a non-FEHB individual policy.)

Upon divorce

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 provide health coverage for you. However, you may be eligible for your own FEHB coverage under either 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 Benefits 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 Web site, 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 Federal job, if you are a covered dependent child and you turn 26.

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 Benefits 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 at 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 information about Federal and State agencies you can contact for more information.

Section 1. How this plan works

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. We give you a choice of enrollment in a High Option or a Standard Option.

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 pay only 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.

Questions regarding what protections apply may be directed to us at 1-800-HIP-TALK (1-800-447-8255). You can also read additional information from the U.S. Department of Health and Human Services at www.healthcare.gov.

This plan is a "non-grandfathered health plan" under the Affordable Care Act. A non-grandfathered plan must meet immediate health care reforms legislated by the Act. Specifically, this plan must provide preventive services and screenings to you without any cost sharing; you may choose any available primary care provider for adult and pediatric care; visits for obstetrical or gynecological care do not require a referral; and emergency services, both in- and out-of-network, are essentially treated the same (i.e., the same cost sharing, no greater limits or requirements for one over the other; and no prior authorizations).

Questions regarding what protections apply may be directed to us at 1-800-HIP-TALK (1-800-447-8255). You can also read additional information from the U.S. Department of Health and Human Services at www.healthcare.gov.

General features of our High and Standard Options

How we pay providers

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

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 60 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 Excellent Accreditation from the National Committee for Quality Assurance (NCQA).

If you want more information about us, call 1-800-HIP-TALK (1-800-447-8255), or write to HIP Health Plan of New York, 55 Water Street, New York, NY 10041. You may also visit our website at www.emblemhealth.com.

Your medical and claims records are confidential

We will keep your medical and claims records confidential. Please note that we may disclose your medical and claims information (including your prescription drug utilization) to any of your treating physicians or dispensing pharmacies.

Service area

To enroll in this plan, you must live in or work 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. Changes for 2013

Do not rely only on these change descriptions; this Section 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

- Removed annual limits on essential health benefits as described in Section 1302 of the Affordable Care Act.
- Plans must provide coverage for routine patient costs for items and services furnished in connection with participation in an approved clinical trial.
- Coverage with no cost sharing for additional preventive care and screenings for women provided in comprehensive guidelines adopted by the Health Resources and Services Administration (HRSA).

Changes to this Plan

HMO Standard Option:

- **Specialist copayment increased to $50 per visit.**
- **Emergency room copayment increased to $150 per visit. The copay is waived if you are admitted to a hospital.**
- **Ambulatory surgery copayment increased to $150 per visit.**
- **Prescription Drug copayments for generic formulary drugs increased to $20 for up to a 30-day supply at a participating retail pharmacy with a $100 calendar year deductible. The Prescription Drug copayment will remain $30 for brand name formulary drugs and $50 for non-formulary drugs at a participating retail pharmacy with a $100 calendar year deductible. Prescription Drug copayments for generic formulary drugs increased to $30 for up to a 90-day supply by mail order with a $100 calendar year deductible. The Prescription Drug copayment will remain $45 for brand name formulary drugs for up to a 90-day supply by mail order with a $100 calendar year deductible.**

HMO High Option:

- **Primary Care Physician copayment increased to $20 per visit.**
- **Specialist copayment increased to $40 per visit.**
- **Emergency room copayment increased to $150 per visit. The copay is waived if you are admitted to a hospital.**
- **Ambulatory surgery copayment increased to $150 per visit.**
- **Prescription Drug copayments for generic formulary drugs increased to $20 for up to a 30-day supply at a participating retail pharmacy with a $100 calendar year deductible. The Prescription Drug copayment will remain $30 for brand name formulary drugs and $50 for non-formulary drugs at a participating retail pharmacy, with the addition of a $100 calendar year deductible. Prescription Drug copayments for generic formulary drugs increased to $30 for up to a 90-day supply by mail order with a $100 calendar year deductible. The Prescription Drug copayment will remain $45 for brand name formulary drugs for up to a 90-day supply by mail order with the addition of a $100 calendar year deductible.**

Changes to High Option

- Your share of the non-Postal premium will increase for Self Only and increase for Self and Family. See page 77.
- Your share of the Postal premium will increase for Self Only and increase for Self and Family. See page 77.

Changes to Standard Option

- Your share of the non-Postal premium will increase for Self Only and increase for Self and Family. See page 77.
- Your share of the Postal premium will increase for Self Only and increase for Self and Family. See page 77.

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 letter (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 1-800-HIP-TALK (1-800-447-8255) or write to us at HIP Health Plan of New York, 55 Water Street, New York, NY 10041. You may also request replacement cards through our Web site: www.emblemhealth.com.

Where you get covered care

You get care from "plan providers" and "plan facilities." You will only pay copayments, deductibles, and/or coinsurance, you can also get care from non-plan providers but it will cost you more.

- **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 national standards.

We list plan providers in the provider directory, which we update periodically. The list is also available on our website at www.emblemhealth.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 periodically. The list is also on our Web site at www.emblemhealth.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.

- **Primary care**

Your primary care physician can be a family practitioner, internist, 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 some 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. 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 and disabling condition and lose access to your specialist because we:
  - terminate our contract with your specialist for other than cause;
  - drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program 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 hospitalized when your enrollment begins**

We pay for covered services from the effective date of your enrollment. However, 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 and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

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;
- 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. If your plan terminates participation in the FEHB Program in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such cases, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

You need prior plan approval for certain services

Since your primary care physician arranges most referrals to specialists and inpatient hospitalization, the pre-service claim approval process only applies to care shown under *Other services requiring our Prior Approval.*

- **Inpatient hospital admission**

Prior Approval is the process by which - prior to your inpatient hospital admission - we evaluate the medical necessity of your proposed stay and the number of days required to treat your condition. Inpatient admissions include non emergency procedures that provide acute, rehabilitation and skilled nursing care.

- **Other 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 prior approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice.

The following are services that require prior approval:

- Inpatient non emergency procedures that provide acute, rehabilitation and skilled nursing care.
- All outpatient invasive and surgical procedures and treatments in a facility or doctor's office.
- Inpatient treatment of Mental Illness and Substance Use Disorder, Detoxification treatment of Substance Use Disorder, and Rehabilitation treatment of Substance Use Disorder.
- Non-routine outpatient treatment of Mental Illness and Substance Use Disorder, which includes:
  - partial hospitalization;
  - intensive outpatient treatment;
  - ambulatory detoxification treatment;
  - outpatient ECT (electro-convulsive treatment);
  - neuropsychological testing; and
  - psychological testing.
- Non emergent transportation.
- Home Health Care.
- Hospice Care.
- Services obtained by Non-Participating Providers with specialty expertise.
- Pre-transplant evaluation and transplant services.
- Outpatient cardiac and pulmonary rehabilitation.
- Outpatient Diagnostic Radiology Services.
- Outpatient Physical, Occupational and Speech Therapies.
- Radiation Oncology.
- Pain Management.
- Sleep Studies.
- Advanced molecular diagnostics and genetic testing.
- Hyperbaric Oxygen Therapy.
- Experimental and/or Investigational Treatments and Procedures.

How to request prior approval for an admission or get prior approval for Other services

First, your physician, your hospital, you, or your representative, must call us at 1-888-447-2884 before admission or services requiring prior approval are rendered.

Next, provide the following information:

- enrollee's name and plan identification number;
- patient's name, birth date, identification number and phone number;
- reason for hospitalization, proposed treatment, or surgery;
- name and phone number of admitting physician;
- name of hospital or facility; and
- number of planned days of confinement.

- **Non-urgent care claims**

For non-urgent care claims, we will then tell the physician and/or hospital the number of approved inpatient days, or the care that we approve for other services that must have prior approval. We will make our decision within 15 days of receipt of the pre-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you of the need for an extension of time before the end of the original 15 day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

- **Urgent care claims**

If you have an urgent care claim (i.e., when waiting for the regular time limit for your medical care or treatment could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without this care or treatment), we will expedite our review and notify you of our decision within 72 hours. If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether it is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to provide notice of the specific information we need to complete our review of the claim. We will allow you up to 48 hours from the receipt of this notice to provide the necessary information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the end of the time frame, whichever is earlier.

We may provide our decision orally within these time frames, but we will follow up with written or electronic notification within three days of oral notification.

You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at 1-800-HIP-TALK (1-800-447-8255). You may also call OPM's Health Insurance (HI) 3 at (202) 606-0737 between 8 a.m. and 5 p.m. Eastern time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, then call us at 1-800-HIP-TALK (1-800-447-8255). If it is determined that your claim is an urgent care claim, we will hasten our review (if we have not yet responded to your claim).

- **Emergency inpatient admission**

If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must telephone us within 48 hours following the day of the emergency admission, even if you have been discharged from the hospital.

- **If your treatment needs to be extended**

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.

How to request prior approval for Prescription Drugs

Prior Approval is required to obtain certain prescription drugs. These drugs include migraine medications, anti-nausea medications, anti-fungal agents, anti-inflammatory agents, appetite suppressants, hepatitis C medications, fertility medications, growth hormones, leukotriene blocker asthma medications, smoking deterrents, eczema medications, vitamin A-based medications for treatment of cystic acne and other drugs and drug classes listed below.

If your prescription is for a drug that is subject to Prior Approval, your pharmacist will inform you, and you must notify your physician. Your physician should then contact our Pharmacy Benefits Services Department (PBSD) at 1-866-447-9717. Our PBSD staff and your physician will decide, based upon our clinical guidelines, whether the prescription is Medically Necessary and Appropriate for your treatment or condition. If you elect not to contact your physician, HIP will not cover the prescription and you will be responsible for the cost of the drug.

If the prescription request is approved, the pharmacist will fill your prescription. If the prescription request is not approved, HIP will not cover the prescription.

The individual prescription drugs listed below require Prior Approval. The drug list below shows each drug by its brand name and generic name.

- Amevive / alefacept
- Enbrel / etanercept
- Humira / adalimumab
- Kineret / anakinra
- Provigil / modafinil
- Regranex / becaplermin
- Somavert / pegvisomant
- Zyvox / linezolid
- Penlac / ciclopirox solution
- Tazorac / tazarotene
- Lidoderm / lidocaine patch
- Orencia / abatacept
- Sutent / sunitinib malate
- Nexavar / sorafenib tosylate
- Xeloda / capecitabine

In addition, prescription drugs in the drug classes listed below are also subject to Prior Approval.

- Antihypertensive Agents
- Anti-Nausea Medications
- Anti-Depressant Medications
- Anti-Fungal Agents
- Anti-inflammatory Agents
- Appetite Suppressants
- Blood Pressure Medication
- Cholesterol Lowering Medications
- Diabetic Medication
- Eczema Medications
- Fertility Medications
- GI Medications that Block Acid Secretion
- Growth Hormones
- Hepatitis C Medications
- Leukotriene Blocker Asthma Medications
- Migraine Medications

- Narcotics/Opiods
- Osteo-Arthritis/Anti-Inflammatory Medications
- Smoking Deterrents
- Vitamin A Based Medications for Treatment of Cystic Acne

How to request prior approval for Specialty Pharmacy Drugs

Your physician must call the Specialty Pharmacy Program Provider at 1-800-424-4084 to obtain Prior Approval before the physician can access and administer certain Medically Necessary and Appropriate Specialty Pharmacy Drugs.

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.

If you disagree with our pre-service claim decision

If you have a **pre-service claim** and you do not agree with our decision regarding prior approval of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below.

If you have already received the service, supply, or treatment, then you have a **post-service claim** and must follow the entire disputed claims process detailed in Section 8.

To reconsider a non-urgent care claim

Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to:

1. Precertify your hospital stay, or, if applicable, arrange for the health care provider to give you the care or grant your request for prior approval for a service, drug, or supply; or

2. Ask you or your provider for more information.

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.

3. Write to you and maintain our denial.

To reconsider an urgent care claim

In the case of an appeal of a pre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

Subject to a request for additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will hasten the review process, which allows oral or written requests for appeals and the exchange of information by telephone, electronic mail, facsimile, or other expeditious methods.

To file an appeal with OPM

After we reconsider your **pre-service claim**, if you do not agree with our decision, you may ask OPM to review it by following Step 3 of the disputed claims process detailed in Section 8 of this brochure.

Section 4. Your costs for covered services

This is what you will pay out-of-pocket for covered care.

Cost-sharing	Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. Coinsurance does not begin until you have met your calendar year deductible.
Copayments	A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive certain services. Example: In the Standard Option plan, when you see your primary care physician, you pay a copayment of $20 per office visit and when you go in the hospital, you pay $500 per admission.
Deductible	A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them. Copayments do not count toward any deductible. Example: The High and Standard Option plans have a $100 prescription drug deductible that you must meet each calendar year before we apply the prescription drug copayments.
Your catastrophic protection out-of-pocket maximum	We do not have a catastrophic protection out-of-pocket maximum.
When Government facilities bill us	Facilities of the Department of Veterans Affairs, the Department of Defense and the Indian Health Services are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow. You may be responsible to pay for certain services and charges. Contact the government facility directly for more information.

Section 5. High and Standard Option Benefits

See page 13 for how our benefits changed this year. Page 75 and page 76 are a benefits summary of each option. Make sure that you review the benefits that are available under the option in which you are enrolled.

Section 5. High and Standard Option Benefits Overview

This Plan offers both a High and Standard Option. Both benefit packages are described in Section 5. Make sure that you review the benefits that are available under the option in which you are enrolled.

The High and Standard Option Section 5 is divided into subsections. Please read *Important things you should keep in mind* at the beginning of the subsections. Also read the General exclusions in Section 6, they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about High and Standard Option benefits, contact us at 1-800-HIP-TALK (1-800-447-8255) or at our Web site at www.emblemhealth.com.

Each option offers unique features.

- **High Option**
  - $20 copayment for primary care physicians.
  - $40 copayment for specialists.
  - $0 copayment for dependent children to age 26 for the following services:
    - primary care physician office visits
    - specialist physician office visits
    - home health care
    - x-rays and diagnostic & lab tests
    - outpatient treatment of mental illness
    - outpatient rehabilitation treatment of chemical abuse and dependence
    - chiropractic services
    - outpatient speech, occupational and physical therapy
- **Standard Option**
  - $20 copayment for primary care physicians.
  - $50 copayment for specialists.
  - $0 copayment for dependent children to age 26 for the following services:
    - primary care physician office visits
    - specialist physician office visits
    - home health care
    - x-rays and diagnostic & lab tests
    - outpatient treatment of mental illness
    - outpatient rehabilitation treatment of chemical abuse and dependence
    - chiropractic services
    - outpatient speech, occupational and physical therapy

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

Important things you should 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.
- A facility copay applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also, read Section 9, *Coordinating benefits with Medicare and other coverage*.

Benefit Description	You pay	
Diagnostic and treatment services	**High Option**	**Standard Option**
Professional services of physicians: • In-physician's office • In an urgent care center • Office medical consultations • Second surgical opinion	$20 per office visit to your primary care physician $40 per office visit to a specialist $0 per office visit for dependent children to age 26	$20 per office visit to your primary care physician $50 per office visit to a specialist $0 per office visit for dependent children to age 26
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**	**Standard Option**
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG	$20 per office visit to your primary care physician or $40 per office visit to a specialist $0 per office visit for dependent children to age 26	$20 per office visit to your primary care physician or $50 per office visit to a specialist $0 per office visit for dependent children to age 26

Benefit Description	You pay	
Preventive care, adult	**High Option**	**Standard Option**
Routine physical and screenings every Calendar year which includes: • Total Blood Cholesterol • Colorectal Cancer Screening , including - Fecal occult blood test - Sigmoidoscopy, screening – every five years starting at age 50 - Double contrast barium enema – every five years starting at age 50 - Colonoscopy screening – every ten years starting at age 50	Nothing	Nothing
Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older	Nothing	Nothing
Well woman – one annually; including, but not limited to: • Routine pap test • Human papillomavirus testing for women age 30 and up once every three years • Counseling for sexually transmitted infections on an annual basis • Counseling and screening for human immune-deficiency virus on an annual basis • Contraceptive methods and counseling • Screening and counseling for interpersonal and domestic violence	Nothing	Nothing
Routine mammogram - for women, as follows: • Upon recommendation of your physician, a mammogram at any age for a woman with a prior history of breast cancer or whose mother or sister has a prior history of breast cancer. • One (1) baseline mammogram for any woman between thirty-five (35) and thirty-nine (39) years of age inclusive. • One (1) mammogram every Calendar Year for any woman 40 years of age or older.	Nothing	Nothing
Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC)	Nothing	Nothing
Not covered: Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	*All charges*	*All charges*

Benefit Description	You pay	
Preventive care, children	**High Option**	**Standard Option**
• Childhood immunizations recommended by the American Academy of Pediatrics	Nothing	Nothing
• Well-child care charges for routine examinations, immunizations and care (up to age 22) • Examinations, such as: - Eye exams through age 17 to determine the need for vision correction, - Hearing exams through age 17 to determine the need for hearing correction, - Examinations done on the day of immunizations (up to age 22)	Nothing	Nothing
Maternity care	**High Option**	**Standard Option**
Complete maternity (obstetrical) care, such as: • Prenatal care • Screening for gestational diabetes for pregnant women between 24-28 weeks gestation or first prenatal visit for women at a high risk • Delivery • Postnatal care Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery. • 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. Surgical benefits, not maternity benefits, apply to circumcision. • We pay hospitalization and surgeon services (delivery) for non-maternity care the same as for illness and injury.	Nothing for prenatal care, the first postpartum care visit, screening for gestational diabetes between 24-28 weeks gestation or the first prenatal visit for women at a high risk; $20 per office visit for all postpartum care visits thereafter. Nothing for inpatient professional delivery services.	Nothing for prenatal care, the first postpartum care visit, screening for gestational diabetes between 24-28 weeks gestation or the first prenatal visit for women at a high risk; $20 per visit for all postpartum care visits thereafter. Note: There is a $500 inpatient hospital copay under the Standard Option coverage. See Section 5(c) for details.
Breastfeeding support, supplies and counseling for each birth	Nothing	Nothing

Benefit Description	You pay	
Family planning	**High Option**	**Standard Option**
Contraceptive counseling on an annual basis	Nothing	Nothing
A range of voluntary family planning services, limited to: • Voluntary sterilization (See Surgical procedures Section 5(b)) • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms	$20 per office visit to your primary care physician or $40 per office visit to a specialist	$20 per office visit to your primary care physician or $50 per office visit to a specialist
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic counseling*	*All charges*	*All charges*
Infertility services	**High Option**	**Standard Option**
Diagnosis and treatment of infertility such as: • Artificial insemination: - Intravaginal insemination (IVI) - Intracervical insemination (ICI) - Intrauterine insemination (IUI) • Fertility drugs Note: We cover injectable fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit.	$20 per office visit to your primary care physician or $40 per office visit to a specialist	$20 per office visit to your primary care physician or $50 per office visit to a specialist
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* - *In vitro fertilization (IVF)* - *Embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* • *Services and supplies related to ART procedures* • *Cost of donor sperm* • *Cost of donor egg*	*All charges*	*All charges*

Benefit Description	You pay	
Allergy care	**High Option**	**Standard Option**
• Testing and treatment • Allergy injections	$20 per office visit to your primary care physician or $40 per office visit to a specialist	$20 per office visit to your primary care physician or $50 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**	**Standard Option**
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 37. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis Note: Subject to the Prior Approval requirements, coverage is provided for a maximum of ten (10) out-of-network dialysis treatments in a calendar year. • 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 only cover GHT when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See *Other services requiring our Prior Approval* in Section 3.	$20 per office visit to your primary care physician or $40 per office visit to a specialist	$20 per office visit to your primary care physician or $50 per office visit to a specialist
Physical and occupational therapies	**High Option**	**Standard Option**
Up to 2 months per condition if significant improvement can be expected for the services of each of the following: • Qualified physical therapists • 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.	$40 per office visit $0 per office visit for dependent children to age 26 Nothing per visit during covered inpatient admission	$50 per office visit $0 per office visit for dependent children to age 26 Nothing per visit during covered inpatient admission

Physical and occupational therapies - continued on next page

Benefit Description	You pay	
Physical and occupational therapies (cont.)	**High Option**	**Standard Option**
• Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to 32 sessions	$40 per office visit $0 per office visit for dependent children to age 26 Nothing per visit during covered inpatient admission	$50 per office visit $0 per office visit for dependent children to age 26 Nothing per visit during covered inpatient admission
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs*	*All charges*	*All charges*
Speech therapy	**High Option**	**Standard Option**
Up to 2 months of speech therapy each calendar year for services from the following: • licensed or certified speech therapists	$40 per office visit $0 per office visit for dependent children to age 26 Nothing per visit during covered inpatient admission	$50 per office visit $0 per office visit for dependent children to age 26 Nothing per visit during covered inpatient admission
Hearing services (testing, treatment, and supplies)	**High Option**	**Standard Option**
• Diagnostic and treatment services for disease or medical conditions affecting hearing • For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or audiologist Note: For routine hearing screening performed during a child's preventive care visit, see Section 5(a) *Preventive care, children.* • External hearing aids • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants Note: For benefits for the devices, see Section 5(a) *Orthopedic and prosthetic devices.*	$20 per office visit to your primary care physician $40 per office visit to a specialist	$20 per office visit to your primary care physician $50 per office visit to a specialist
Not covered: • *Hearing services that are not shown as covered* • *Hearing services for age-related hearing loss*	*All charges*	*All charges*

Benefit Description	You pay	
Vision services (testing, treatment, and supplies)	**High Option**	**Standard Option**
• One pair of eyeglasses or contact lenses as standardly dispensed to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) • Annual eye refractions • Diagnosis and treatment of diseases of the eye Note: See *Preventive* care, *children* for eye exams for children.	$40 per office visit	$50 per office visit
Not covered: • *Eyeglasses or contact lenses, except as shown above* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	*All charges*	*All charges*
Foot care	**High Option**	**Standard Option**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. Note: See *Orthopedic and prosthetic devices* for information on podiatric shoe inserts.	$20 per office visit to your primary care physician or $40 per office visit to a specialist	$20 per office visit to your primary care physician or $50 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	**High Option**	**Standard Option**
• Artificial limbs and eyes • Stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome • External hearing aids • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants	$20 per office visit to your primary care physician or $40 per office visit to a specialist Nothing for the equipment	$20 per office visit to your primary care physician or $50 per office visit to a specialist Nothing for the equipment

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay	
Orthopedic and prosthetic devices (cont.)	**High Option**	**Standard Option**
• Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy Note: Call us at 1-800-HIP-TALK (1-800-447-8255) as soon as your Plan physician prescribes this equipment. We will arrange with a health care provider to rent or sell you the equipment at discounted rates and will tell you more about this service when you call. Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b) Surgical procedures. For information on the hospital and/or ambulatory surgery center benefits, see Section 5(c) Services provided by a hospital or other facility, and ambulance services	$20 per office visit to your primary care physician or $40 per office visit to a specialist Nothing for the equipment	$20 per office visit to your primary care physician or $50 per office visit to a specialist Nothing for the equipment
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)	**High Option**	**Standard Option**
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include: • Oxygen • Dialysis equipment • Hospital beds • Wheelchairs • Scooters • Crutches • Walkers • Speech generating devices 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

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay	
Durable medical equipment (DME) (cont.)	**High Option**	**Standard Option**
Not covered: Customized wheelchairs	*All charges*	*All charges*
Home health services	**High Option**	**Standard Option**
• 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 and High Option coverage 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**	**Standard Option**
• 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.	$40 per office visit $0 per office visit for dependent children to age 26	$50 per office visit $0 per office visit for dependent children to age 26
Alternative treatments	**High Option**	**Standard Option**
No benefit. *We do not cover treatments such as but not limited to:* • *Naturopathic services* • *Hypnotherapy* • *Acupuncture* • *Biofeedback*	*All charges*	*All charges*

Benefit Description	You pay	
Educational classes and programs	**High Option**	**Standard Option**
Coverage is limited to provide for: • Tobacco Cessation Program to include counseling, full coverage of over the counter (OTC) Nicotine Replacement Therapy (gum, lozenge, and patch) directly dispensed by the program vendor upon enrollment to the program and tobacco cessation prescription drugs approved by the FDA to treat tobacco dependence	Nothing for counseling for up to two quit attempts per year. Nothing for OTC and prescription drugs approved by the FDA to treat tobacco dependence.	Nothing for counseling for up to two quit attempts per year. Nothing for OTC and prescription drugs approved by the FDA to treat tobacco dependence.
• Childhood obesity education	Nothing	Nothing
Diabetes Equipment, Supplies and Education	**High Option**	**Standard Option**
The following services and supplies are covered when recommended or prescribed for the treatment of diabetes: • Blood glucose monitors and blood glucose monitors for the visually impaired • Lancets and automatic lancing devices • Test strips and control solutions for glucose monitors and visual reading and urine testing strips for glucose ketones • Data management systems • Insulin, syringes, alcohol swabs, injection aids, cartridges for the visually impaired, insulin pumps and appurtenances, and insulin infusion devices except that investigational and experimental drugs and supplies, as determined by HIP, will not be covered • Insulin pumps and equipment for the use of the pump including batteries • Insulin infusion devices • Oral agents for controlling blood sugar, treating hypoglycemia such as glucose tablets and gels and glucagon for injection to increase blood glucose concentration • Self-management education and diet information is provided by a licensed health care provider	$20 per office visit to your primary care physician $40 per office visit to a specialist	$20 per office visit to your primary care physician $50 per office visit to a specialist
Specialty Pharmacy Drugs	**High Option**	**Standard Option**
• Pharmaceutical agents that include injectables and infusion drugs • More complex to administer and monitor in comparison to traditional drugs • Specialty Pharmacy Drugs are obtained and administered only by your physician during an approved plan of treatment	Nothing (included in your primary care physician or specialist office visit copay) or Nothing (included in your Outpatient hospital or ambulatory surgical center copay)	Nothing (included in your primary care physician or specialist office visit copay) or Nothing (included in your Outpatient hospital or ambulatory surgical center copay)

Specialty Pharmacy Drugs - continued on next page

Benefit Description	You pay	
Specialty Pharmacy Drugs (cont.)	**High Option**	**Standard Option**
• Specialty Pharmacy Drugs are comprised of the following general classes of drugs: - Biologic DMARD - ESA - IVIG - Anti-Emetics - CSF - Chemotherapy - Neuromuscular Blockers - Bisphosphonates - Human Monoclonal Antibody Note: Physicians must call the Specialty Pharmacy Program Provider at 1-800-424-4084 to obtain Prior Approval before the physician can access and administer certain Medically Necessary and Appropriate Specialty Pharmacy Drugs. Failure to obtain Prior Approval may result in the denial of Covered Services or financial responsibility to you.	Nothing (included in your primary care physician or specialist office visit copay) or Nothing (included in your Outpatient hospital or ambulatory surgical center copay)	Nothing (included in your primary care physician or specialist office visit copay) or Nothing (included in your Outpatient hospital or ambulatory surgical center copay)

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

Important things you should 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.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9, *Coordinating benefits with Medicare and other coverage*.
- 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 PRIOR APPROVAL FOR SOME SURGICAL PROCEDURES.** Please refer to the prior approval information shown in Section 3 to be sure which services require prior approval and identify which surgeries require prior approval.

Benefit Description	You pay	
Surgical procedures	**High Option**	**Standard Option**
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 (bariatric surgery) • Insertion of internal prosthetic devices - See 5(a) *Orthopedic and prosthetic devices* for device coverage information. • Voluntary sterilization (e.g., tubal ligation, vasectomy) • 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 (included in the $500 inpatient hospital admission copay)
Not covered: • *Reversal of voluntary sterilization*	*All Charges*	*All Charges*

Surgical procedures - continued on next page

Benefit Description	You pay	
Surgical procedures (cont.)	**High Option**	**Standard Option**
• *Routine treatment of conditions of the foot; see Foot care*	*All Charges*	*All Charges*
Reconstructive surgery	**High Option**	**Standard Option**
• 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; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - surgery to produce a symmetrical appearance of breasts; - 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 (included in the $500 inpatient hospital admission copay)
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	**High Option**	**Standard Option**
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	Nothing (when part of an inpatient admission) $40 per office visit for outpatient procedures	Nothing (included in the $500 inpatient hospital admission copay) $50 per office visit for outpatient procedures

Oral and maxillofacial surgery - continued on next page

Benefit Description	You pay	
Oral and maxillofacial surgery (cont.)	**High Option**	**Standard Option**
• Other surgical procedures that do not involve the teeth or their supporting structures.	Nothing (when part of an inpatient admission) $40 per office visit for outpatient procedures	Nothing (included in the $500 inpatient hospital admission copay) $50 per office visit for outpatient procedures
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**	**Standard Option**
These **solid organ transplants** are subject to medical necessity and experimental/investigational review by the plan. Refer to Section 3 for prior authorization procedures. These **solid organ transplants** are covered and are limited to: • Cornea • Heart • Heart/Lung • Intestinal transplants - Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach and pancreas • Kidney • Liver • Lung: single/bilateral/lobar • Pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis	Nothing	Nothing (included in the $500 inpatient hospital admission copay)
These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the plan. Refer to Other Services in Section 3 for prior authorization procedures. Autologous tandem transplants for • AL Amyloidosis • Multiple myeloma (de novo and treated) • Recurrent germ cell tumors (including testicular cancer)	Nothing	Nothing (included in the $500 inpatient hospital admission copay)

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
Blood or marrow stem cell transplants limited to the stages of the following diagnoses. For the diagnoses listed below, the medical necessity limitation is considered satisfied if the patient meets the staging description. Physicians consider many features to determine how diseases will respond to different types of treatment. Some of the features measured are the presence or absence of normal and abnormal chromosomes, the extension of the disease throughout the body, and how fast the tumor cells can grow. By analyzing these and other characteristics, physicians can determine which diseases may respond to treatment without transplant and which diseases may respond to transplant. • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/ small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfillippo's syndrome, Maroteaux-Lamy syndrome variants) - Myelodysplasia/ Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/ Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Sickle cell anemia - X-linked lymphoproliferative syndrome • Autologous transplants for	Nothing	Nothing (included in the $500 inpatient hospital admission copay)

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
- Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Amyloidosis - Breast Cancer - Ependymoblastoma - Epithelial ovarian cancer - Ewing's sarcoma - Multiple myeloma - Medulloblastoma - Pineoblastoma - Neuroblastoma - Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors	Nothing	Nothing (included in the $500 inpatient hospital admission copay)
Mini-transplants performed in a clinical trial setting (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the plan. Refer to Other services in Section 3 for prior authorization procedures: • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e. myelogenous) leukemia - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPD's) - Amyloidosis - Chronic lymphocytic leukemia/ small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's PNH, Pure Red Cell Aplasia - Myelodysplasia/ Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplactic anemia	Nothing	Nothing (included in the $500 inpatient hospital admission copay)

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
• Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Amyloidosis - Neuroblastoma	Nothing	Nothing (included in the $500 inpatient hospital admission copay)
These blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institutes of health approved clinical trial or a plan-designed center of excellence and if approved by the plan's medical director in accordance with the plan's protocols. If you are a participant in a clinical trial, the plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, x-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the plan to discuss specific services if you participate in a clinical trial. • Allogeneic transplants for - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Beta Thalassemia Major - Chronic inflammatory demyelination polyneuropathy (CIDP) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Sickle Cell anemia • Mini-transplants (non-myeloablative allogeneic, reduced intensity conditioning or RIC) for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Breast cancer - Chronic lymphocytic leukemia - Chronic myelogenoue leukemia	Nothing	Nothing (included in the $500 inpatient hospital admission copay)

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
- Colon cancer - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Myeloproliferative disorders (MDDs) - Myelodysplasia/Myelodysplastic Syndromes - Non-small cell lung cancer - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Sarcomas - Sickle cell anemia • Autologous Transplants for - Advanced Childhood kidney cancers - Advanced Ewing sarcoma - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Breast cancer - Childhood rhabdomyosarcoma - Chronic myelogenous leukemia - Chronic lymphocytic lymphoma/ small lymphocytic lymphoma (CLL/SLL) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Epithelial Ovarian Cancer - Mantle Cell (Non-Hodgkin lymphoma) - Multiple sclerosis - Small cell lung cancer - Systemic lupus erythematosus - Systemic sclerosis	Nothing	Nothing (included in the $500 inpatient hospital admission copay)
National Transplant Program (NTP) United Network of Transplant Sharing (UNOS) Organ Procurement and Transplant Network (OPTN)		
Notes:		

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
• We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor screening tests for the actual solid organ donor or up to four bone marrow/ stem cell transplant donors in addition to the testing of family members. • Expenses for transportation, lodging and meals for the transplant recipient and his or her companion are reimbursable up to a maximum of $10,000 per transplant episode.		
Not covered: • *Donor screening tests and donor search expenses, except as shown above* • *Implants of artificial organs* • *Transplants not listed as covered.*	*All Charges*	*All Charges*
Anesthesia	**High Option**	**Standard Option**
Professional services provided in - • Hospital (inpatient)	Nothing	Nothing (included in the $500 inpatient hospital admission copay)
Professional services provided in – • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	$40 per office visit for outpatient procedures	$50 per office visit for outpatient procedures

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

Important things you should 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, *Coordinating benefits with Medicare and other coverage*.
- 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 in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRIOR APPROVAL OF HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require prior approval.

Benefit Description	You pay	
Inpatient hospital	**High Option**	**Standard Option**
Room and board, such as: • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	Nothing	$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 • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen	Nothing	Nothing (included in the $500 inpatient hospital admission copay)
• Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home (Note: calendar year deductible applies.)	Nothing	Nothing (included in the $500 inpatient hospital admission copay)
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, schools*	*All Charges*	*All Charges*

Inpatient hospital - continued on next page

Benefit Description	You pay	
Inpatient hospital (cont.)	**High Option**	**Standard Option**
• *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care, except when medically necessary*	*All Charges*	*All Charges*
Outpatient hospital or ambulatory surgical center	**High Option**	**Standard Option**
• 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 • 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.	$150 per visit	$150 per visit
Extended care benefits/Skilled nursing care facility benefits	**High Option**	**Standard Option**
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	**High Option**	**Standard Option**
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

Hospice care - continued on next page

Benefit Description	You pay	
Hospice care (cont.)	**High Option**	**Standard Option**
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	**High Option**	**Standard Option**
Local professional ambulance service when medically appropriate	Nothing	Nothing

Section 5(d). Emergency services/accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We do not have a calendar year deductible 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, *Coordinating benefits with Medicare and other coverage*.

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:

Emergencies within our service area: 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	
Emergency within our service area	**High Option**	**Standard Option**
• Emergency care at a doctor's office	$20 per office visit	$20 per office visit
• Emergency care at an urgent care center	$20 per office visit	$20 per office visit
• Emergency care as an outpatient at a hospital, including doctors' services Note: We waive the ER copay if you are admitted to the hospital.	$150 per visit	$150 per visit
Not covered: Elective care or non-emergency care	*All Charges*	*All Charges*

Benefit Description	You pay	
Emergency outside our service area	**High Option**	**Standard Option**
• Emergency care at a doctor's office	$20 per office visit	$20 per office visit
• Emergency care at an urgent care center	$20 per office visit	$20 per office visit
• Emergency care as an outpatient or inpatient at a hospital, including doctors' services Note: We waive the ER copay if you are admitted to the hospital.	$150 per visit	$150 per visit
Not covered: • *Elective care or non-emergency care and follow-up care recommended by non-plan providers that has not been approved by the plan or provided by plan providers* • *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	**High Option**	**Standard Option**
Local ambulance service in an emergency condition or when approved by the plan. Note: See 5(c) for non-emergency service.	Nothing	Nothing
Not covered: Air ambulance	*All Charges*	*All Charges*

Section 5(e). Mental health and substance use disorder benefits

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We do not have a calendar year deductible 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, *Coordinating benefits with Medicare and other coverage*.
- **YOU MUST GET PRIOR APPROVAL OF THESE SERVICES.** See the instructions after the benefits description below.

Benefit Description	You pay	
Professional Services	**High Option**	**Standard Option**
When part of a treatment plan we approve, we cover professional services by licensed professional mental health and substance use disorder practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits) • Diagnosis and treatment of alcoholism and drug abuse, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy	$20 per office visit to your primary care physician or $40 per office visit to a specialist $0 per office visit for dependent children to age 26 Nothing for inpatient visits	$20 per office visit to your primary care physician or $50 per office visit to a specialist $0 per office visit for dependent children to age 26 Nothing for inpatient visits

Benefit Description	You pay	
Diagnostics	**High Option**	**Standard Option**
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance use disorder practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility • Inpatient diagnostic tests provided and billed by a hospital or other covered facility	$20 per office visit to your primary care physician or $40 per office visit to a specialist $0 per office visit for dependent children to age 26	$20 per office visit to your primary care physician or $50 per office visit to a specialist $0 per office visit for dependent children to age 26
Inpatient hospital or other covered facility	**High Option**	**Standard Option**
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semi-private or intensive accommodations, general nursing care, meals and special diets, and other hospital services	Nothing	$500 per inpatient hospital admission
Outpatient hospital or other covered facility	**High Option**	**Standard Option**
Outpatient services provided and billed by a hospital or other covered facility • Services in approved treatment programs, such as a partial hospitalization, half-way house, residential treatment, full-day hospitalization, or facility based intensive outpatient treatment	$20 per office visit to your primary care physician or $25 per office visit to a specialist $0 per office visit for dependent children to age 26	$20 per office visit to your primary care physician or $25 per office visit to a specialist $0 per office visit for dependent children to age 26
Not covered	**High Option**	**Standard Option**
Not covered • *Services that are not part of a prior approved treatment plan*	*All Charges*	*All Charges*

Prior Approval

To be eligible to receive these benefits you must obtain a treatment plan and follow all of the following network authorization processes:

For mental health or substance abuse treatment, call 1-888-447-2526 for authorization and help in selecting a provider. A trained professional will assess your treatment needs and assist you in obtaining treatment with a participating provider. You do not need a referral from your primary care physician for mental health and substance abuse services.

Section 5(f). Prescription drug benefits

Important things you should 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 High and Standard Option coverage, each member must satisfy a $100 calendar year prescription drug deductible.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also, read Section 9, *Coordinating benefits with Medicare and other coverage*.

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

- **Who can write your prescription.** A licensed plan physician or referral doctor must write the prescription.
- **Where you can obtain them.** You may fill the prescription at a participating pharmacy. You may obtain certain generic maintenance drugs or brand name formulary maintenance drugs by mail order.
- **We use a formulary.** We cover non-formulary drugs prescribed by a plan doctor.

  We have an open formulary. If your physician believes a brand name product is necessary or there is no generic available, your physician may prescribe a brand name drug from a formulary list. This list of brand name drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. To order a prescription drug brochure, call 1-800-HIP-TALK (1-800-447-8255).
- **These are the dispensing limitations.** A participating pharmacy will provide up to a 30-day supply of your prescription. You will pay $20.00 for generic formulary drugs, or $30.00 for brand name formulary drugs, or $50 for non-formulary drugs after a $100.00 annual prescription drug 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 Home Delivery Service at 1-877-866-5828.
- **A generic equivalent will be dispensed if it is available**, unless your physician specifically requires a brand name. If you receive a brand name drug when a Federally-approved generic drug is available, and your physician has not specified Dispense as Written for the brand name drug, you have to pay the difference in cost between the brand name drug and the generic.
- **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	
Covered medications and supplies	**High Option**	**Standard Option**
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 (covered under Diabetes Equipment, Supplies and Education, page 33) • Nutritional supplements for the treatment of phenylketonuria, branched chain ketonuria, galactosemia, and homocystinuria • Drugs for sexual dysfunction (with Prior authorization) • Fertility drugs (oral and injectable)	For up to a 30-day supply at a participating Retail Pharmacy: **(After the $100 calendar year deductible)** $20 for generic formulary drugs; $30 for brand name formulary drugs; or $50 for non-formulary drugs Up to a 90-day supply by Mail order: $30 for generic formulary drugs or $45 for brand name formulary drugs Non-formulary drugs are not available through mail order. Note: If there is no generic equivalent available, you will still have to pay the brand name copay.	For up to a 30-day supply at a participating Retail Pharmacy: **(After the $100 calendar year deductible)** $20 for generic formulary drugs; $30 for brand name formulary drugs; or $50 for non-formulary drugs Up to a 90-day supply by Mail order: $30 for generic formulary drugs or $45 for brand name formulary drugs Non-formulary drugs are not available through mail order. Note: If there is no generic equivalent available, you will still have to pay the brand name copay.
Women's contraceptive drugs and devices Note: Over-the counter contraceptive drugs and devices approved by the FDA require a written prescription by an approved provider.	Nothing	Nothing
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* Note: Over-the-counter or prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco cessation benefit. (See page 33).	*All Charges*	*All Charges*

Section 5(g). Dental benefits

Important things you should 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.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9, *Coordinating benefits with Medicare and other coverage*.
- 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 non-dental 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, *Coordinating benefits with Medicare and other coverage*.

Benefit Description	You Pay	
Accidental injury benefit	**High Option**	**Standard Option**
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	Nothing	Nothing

Dental Benefits	You Pay	
Service	**High Option**	**Standard Option**
We have no other dental benefits.	*All charges*	*All charges*

Section 5(h). Special features

Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claim process (see Section 8).
24-Hour Nurse Advice Line	For any of your health concerns, 24 hours a day, 7 days a week, you may call 1-877-736-2229 and talk with a registered nurse who will discuss treatment options and answer your health questions.
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 illness or injuries.
Travel benefit/services overseas	Please refer to the HIP Member Handbook.

Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium, and you cannot file an FEHB disputed claim about them. Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums. These programs and materials are the responsibility of the Plan, and all appeals must follow their guidelines. For additional information contact the Plan at 1-800-HIP-TALK (1-800-447-8255) or visit their website at www.emblemhealth.com.

VIP (HMO) Medicare HMO Benefits - VIP (HMO) Medicare Plan is our Medicare Advantage 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 VIP (HMO) 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.

You may still enroll in VIP (HMO) 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 VIP (HMO) Medicare benefits by calling 1-800-511-4187.

Fitness Program - HIP offers members discounts to fitness centers 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 American Specialty Health, a leading national alternative medicine services organization.*

Should you choose to seek such services, you will have access to the large American Specialty Health 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 American Specialty Health network provider in order to obtain the discounted rate. Call 1-877-327-2746 for a list of American Specialty Health 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 and, 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 $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, 55 Water Street, New York, NY 10041. 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 www.emblemhealth.com or call us at 1-800-HIP-TALK (1-800-447-8255).

** Through HIP's agreement with American Specialty Health, this program provides HIP members with discounts for services provided by American Specialty Health alternative medicine providers. American Specialty Health 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 American Specialty Health alternative medicine provider.*

Section 6. General exclusions – services, drugs and supplies we do not cover

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **Although we may list a specific service as a benefit, we will not cover it unless it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition. For information on obtaining prior approval for specific services, such as transplants, see Section 3 *When you need prior Plan approval for certain services.***

We do not cover the following:

- Care by non-plan providers except for authorized referrals or emergencies (see *Emergency services /accidents*).
- Services, drugs, or supplies you receive while you are not enrolled in this Plan.
- Services, drugs, or supplies 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 (see specifics regarding transplants).
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest.
- Services, drugs, or supplies related to sex transformations.
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.
- Services, drugs, or supplies you receive without charge while in active military service.
- Applied Behavior Analysis (ABA).

Section 7. Filing a claim for covered services

This Section primarily deals with post-service claims (claims for services, drugs or supplies you have already received). See Section 3 for information on pre-service claims procedures (services, drugs or supplies requiring prior Plan approval), including urgent care claims procedures. 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 and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file form CMS-1500, Health Insurance Claim Form. Your facility will file the UB-04 form. For claims questions and assistance, contact us at 1-800-HIP-TALK (1-800-447-8255), or at our Web site at www.emblemhealth.com.

When you must file a claim – such as for services you received outside the Plan's service area – submit it on the CMS-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member's name, date of birth, address, phone number 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 payor – such as the Medicare Summary Notice (MSN)
- Receipts, if you paid for your services

Note: Canceled checks, cash register receipts, or balance due statements are not acceptable substitutes for itemized bills.

Submit your claims to: HIP Health Insurance Plan of New York
55 Water Street
New York, New York 10041

Prescription drugs

Under normal circumstances, you do not have to file claims for your prescription drugs. Please call 1-800-HIP-TALK (1-800-447-8255) for specific instructions and a claim form.

Submit your claims to: HIP Health Insurance Plan of New York
55 Water Street
New York, New York 10041

Other supplies or services

Submit your claims to: HIP Health Insurance Plan of New York
55 Water Street
New York, New York 10041

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.

Post-service claims procedures

We will notify you of our decision within 30 days after we receive your post-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

If you do not agree with our initial decision, you may ask us to review it by following the disputed claims process detailed in Section 8 of this brochure.

Authorized Representative

You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, we will permit a health care professional with knowledge of your medical condition to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.

Notice Requirements

If you live in a county where at least 10 percent of the population is literate only in a non-English language (as determined by the Secretary of Health and Human Services), we will provide language assistance in that non-English language. You can request a copy of your Explanation of Benefits (EOB) statement, related correspondence, oral language services (such as telephone customer assistance), and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language.

Any notice of an adverse benefit determination or correspondence from us confirming an adverse benefit determination will include information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis and procedure codes.

Section 8. The disputed claims process

You may be able to appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please visit www.emblemhealth.com.

Please follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your post-service claim (a claim where services, drugs or supplies have already been provided). In Section 3 *If you disagree with our pre-service claim decision,* we describe the process you need to follow if you have a claim for services, referrals, drugs or supplies that must have prior plan approval, such as inpatient hospital admissions.

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Customer Service Department by writing HIP Health Insurance Plan of New York, 55 Water Street, New York, New York 10041 or calling 1-800-HIP-TALK (1-800-447-8255).

Our reconsideration will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

When our initial decision is based (in whole or in part) on a medical judgment (i.e., medical necessity, experimental/investigational), we will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not involved in making the initial decision.

Our reconsideration decision will not afford deference to the initial decision and will be conducted by a plan representative who is neither the individual who made the initial decision that is the subject of the reconsideration, nor the subordinate of that individual.

We will not make our decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) based upon the likelihood that the individual will support the denial of benefits.

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, 55 Water Street, New York, NY 10041; 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.

e) Include your email address, if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly.

We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.

2 In the case of a post-service claim, we have 30 days from the date we receive your request to:

a) Pay the claim or

b) Write to you and maintain our denial, or

c) Ask you or your provider for more information

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.

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

3

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: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, Health Insurance (HI) 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.
- Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly.

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. However, for urgent care claims, a health care professional with knowledge of your medical condition may act as your authorized representative without your express consent.

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

4

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 preauthorization 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 you did not indicate that your claim was a claim for urgent care, then call us at 1-800-HIP-TALK (1-800-447-8255). We will hasten our review (if we not yet responded to your claim) or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's Health Insurance (HI) 3 at (202) 606-0737 between 8 am and 5 pm Eastern time.

Please remember that we do not make decisions about plan eligibility issues. For example, we do not determine whether you or a dependent is covered under this plan. You must raise eligibility issues with your Agency personnel/payroll office if you are an employee, your retirement system if you are an annuitant or the Office of Worker's Compensation programs if you are receiving Worker's Compensation benefits.

Section 9. Coordinating benefits with Medicare and other coverage

When you have other health coverage

You must tell us if you or a covered family member has coverage under any other health plan or has 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 payor and the other plan pays a reduced benefit as the secondary payor. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' (NAIC) guidelines. For more information on NAIC rules regarding the coordinating of benefits, visit the NAIC website at http://www.NAIC.org.

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

When we are the secondary payor, 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.

When you have Medicare

What is Medicare?

Medicare is a Health Insurance Program for:

- People 65 years of age or 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 four 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. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048) 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.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare's Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778). Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

- **Should I enroll in Medicare?**

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It's easy. Just call the Social Security Administration toll-free number 1-800-772-1213, (TTY 1-800-325-0778) to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**. When you don't have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage. It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage. If you do not sign up for Medicare Part B when you are first eligible, you may be charged a Medicare Part B late enrollment penalty of a 10% increase in premium for every 12 months you are not enrolled. If you didn't take Part B at age 65 because you were covered under FEHB as an active employee or you were covered under your spouse's group health insurance plan, and he or she was an active employee, you may sign up for Part B (generally without an increased premium) within 8 months from the time you or your spouse stop working or are no longer covered by the group plan. You also can sign up at any time while you are covered by the group plan.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage is the term used to describe the various private health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on whether you are in the Original Medicare Plan or a private Medicare Advantage plan.

- **The Original Medicare Plan (Part A or 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.

All physicians and other providers are required by law to file claims directly to Medicare for members with Medicare Part B, when Medicare is primary. This is true whether or not they accept Medicare.

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.

Claims process when you have the Original Medicare Plan – You will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

When we are the primary payor, we process the claim first.

When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us at 1-800-HIP-TALK (1-800-447-8255) or see our Web site at www.emblemhealth.com.

We waive some costs if the Original Medicare Plan is your primary payor - We will waive some out-of-pocket costs as follows:

- Medical services and supplies provided by physicians and other health care professionals.

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

You can find more information about how our plan coordinates benefits with Medicare in "Medicare And Other Health Benefits: Your Guide To Who Pays First" at www.Medicare.gov.

- **Tell us about your Medicare coverage**

You must tell us if you or a covered family member has Medicare coverage, and let us obtain information about services denied or paid under Medicare if we ask. You must also tell us about other coverage you or your covered family members may have as this coverage may affect the primary/secondary status of this Plan and Medicare.

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048), or at www.medicare.gov.

If you enroll in a Medicare Advantage plan, the following options are available to you:

This plan and our Medicare Advantage plan: You may enroll in our Medicare Advantage plan and also remain enrolled in our FEHB plan. In this case, we do waive some cost-sharing for your FEHB coverage.

This plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers), but we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium (OPM does not contribute to your Medicare Advantage 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 Advantage plan's service area.

- **Medicare prescription drug coverage (Part D)**

When we are the primary payor, we process the claim first. If you enroll in Medicare Part D and we are the secondary payor, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

Medicare always makes the final determination as to whether they are the primary payor. The following chart illustrates whether Medicare or this Plan should be the primary payor 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. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

Primary Payor Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	**The primary payor for the individual with Medicare is...**	
	Medicare	**This Plan**
1) Have FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and...		
• You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
6) 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) and you are not covered under FEHB through your spouse under #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation disability benefits for six months or more	✓*	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and...		
• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD **(30-month coordination period)**		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and...		
• This Plan was the primary payor before eligibility due to ESRD **(for 30 month coordination period)**		✓
• Medicare was the primary payor before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD **(for the 30 month coordination period)**		✓
• Medicare based on ESRD **(after the 30 month coordination period)**	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse	✓	

*Workers' Compensation is primary for claims related to your condition under Workers' Compensation.

TRICARE and CHAMPVA

TRICARE is the health care program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS 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 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 TRICARE or CHAMPVA.

Workers' Compensation

We do not cover services that:

- You (or a covered family member) 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.

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.

When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP) coverage

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com, you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

Clinical Trials

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

Clinical Trials (continued)

This health plan covers care for clinical trials according to the definitions listed below and as stated on specific pages of this brochure:

- Routine care costs - costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's cancer, whether the patient is in a clinical trial or is receiving standard therapy. This plan covers costs for routine care.
- Extra care costs - Costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care. This plan does not cover these costs.
- Research costs - Costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. This plan does not cover these costs.

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.

Clinical trials cost categories

- Routine care costs - costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy.
- Extra care costs - costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care.
- Research care costs - costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 20.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 20.

Cost-sharing

Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive. See page 20.

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 20.

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, 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;
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;
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.

Health care professional

A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

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.

Post-service claims

Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.

Pre-service claims

Those claims (1) that require precertification, prior approval, or a referral and (2) where failure to obtain precertification, prior approval, or a referral results in a reduction of benefits.

Urgent care claims

A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts:

- Waiting could seriously jeopardize your life or health;
- Waiting could seriously jeopardize your ability to regain maximum function; or
- In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent care claims usually involve Pre-service claims and not Post-service claims. We will judge whether a claim is an urgent care claim by applying the judgement of a prudent layperson who possesses an average knowledge of health and medicine.

If you believe your claim qualifies as an urgent care claim, please contact our Customer Service Department at 1-800-HIP-TALK (1-800-447-8255). You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.

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. Other Federal Programs

Please note, the following programs are not part of your FEHB benefits. They are separate Federal programs that complement your FEHB benefits and can potentially reduce your annual out-of-pocket expenses. These programs are offered independent of the FEHB Program and require you to enroll separately with no government contribution.

Important information about three Federal programs that complement the FEHB Program

First, the **Federal Flexible Spending Account Program**, also known as FSAFEDS, lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care and/or health care expenses. You pay less in taxes so you save money. The result can be a discount of 20% to more than 40% on services/products you routinely pay for out-of-pocket.

Second, the **Federal Employees Dental and Vision Insurance Program (FEDVIP)** provides comprehensive dental and vision insurance at competitive group rates. There are several plans from which to choose. Under **FEDVIP** you may choose self only, self plus one, or self and family coverage for yourself and any eligible dependents.

Third, the **Federal Long Term Care Insurance Program (FLTCIP)** can help cover long term care costs, which are not covered under the FEHB Program.

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

It is an account where you contribute money from your salary **BEFORE** taxes are withheld, then incur eligible expenses and get reimbursed. You pay less in taxes so you save money. **Annuitants are not eligible to enroll.**

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of $250. The maximum annual election for a health care flexible spending account (HCFSA) or a limited expense health care spending account (LEX HCFSA) is $2,500.

- **Health Care FSA (HCFSA)** –Reimburses you for eligible health care expenses (such as copayments, deductibles, insulin, products, **physician prescribed** over-the-counter drugs and medications, vision and dental expenses, and much more) for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26) which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.

FSAFEDS offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or your provider file claims with your FEHB or FEDVIP plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan.

- **Limited Expense Health Care FSA (LEX HCFSA**) – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to dental and vision care expenses for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26) which are not covered or reimbursed, by FEHBP or FEDVIP coverage or other insurance.
- **Dependent Care FSA (DCFSA)** – Reimburses you for eligible **non-medical** day care expenses for your child(ren) under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA.
- If you are a new or newly eligible employee you have 60 days from your hire date to enroll in an HCFSA or LEX HCFSA and/or DCFSA, but you must enroll before October 1. If you are hired or become eligible on or after October 1 you must wait and enroll during the Federal Benefits Open Season held each fall.

Where can I get more information about FSAFEDS?	Visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, 9 a.m. until 9 p.m., Eastern Time. TTY: 1-800-952-0450.

The Federal Empolyees Dental and Vision Insurance Program – *FEDVIP*

Important Information	The Federal Employees Dental and Vision Insurance Program (FEDVIP) is separate and different from the FEHB Program and was established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004. This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations for enrollment. FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Employee premiums are withheld from salary on a pre-tax basis.
Dental Insurance	All dental plans provide a comprehensive range of services, including: • Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays. • Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments. • Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures. • Class D (Orthodontic) services with up to a 24-month waiting period for dependent children up to age 19.
Vision Insurance	All vision plans provide comprehensive eye examinations and coverage for lenses, frames and contact lenses. Other benefits such as discounts on LASIK surgery may also be available.
Additional Information	You can find a comparison of the plans available and their premiums on the OPM website at www.opm.gov/insure/vision and www.opm.gov/insure/dental. These sites also provide links to each plan's website, where you can view detailed information about benefits and preferred providers.
How do I enroll?	You enroll on the Internet at www.BENEFEDS.com. For those without access to a computer, call 1-877-888-3337 (TTY 1-877-889-5680).

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection	The Federal Long Term Care Insurance Program (FLTCIP) can help pay for the potentially high cost of long term care services, which are not covered by FEHB plans. Long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment, such as Alzheimer's disease. For example, long term care can be received in your home from a home health aide, in a nursing home, in an assisted living facility or in adult day care. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Federal and U.S. Postal Service employees and annuitants, active and retired members of the uniformed services, and qualified relatives are eligible to apply. Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. You must apply to know if you will be approved for enrollment. For more Information call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557), or visit www.ltcfeds.com.

Pre-existing Condition Insurance Program (PCIP)

Do you know someone who needs health insurance but can't get it? The Pre-existing Condition Insurance Plan (PCIP) may help.

An individual is eligible to buy coverage in PCIP if:

- He or she has a pre-existing medical condition or has been denied coverage because of the health condition;
- He or she has been without health coverage for at least the last six months. (If the individual currently has insurance coverage that does not cover the pre-existing condition or is enrolled in a state high risk pool then that person is not eligible for PCIP.);
- He or she is a citizen or national of the United States or resides in the U.S. legally.

The Federal government administers PCIP in the following states: Alabama, Arizona, District of Columbia, Delaware, Florida, Georgia, Hawaii, Idaho, Indiana, Kentucky, Louisiana, Massachusetts, Minnesota, Mississippi, North Dakota, Nebraska, Nevada, South Carolina, Tennessee, Texas, Vermont, Virginia, West Virginia, and Wyoming. To find out about eligibility, visit www.pcip.gov and/or www.healthcare.gov or call 1-866-717-5826 (TTY): 1-866-561-1604.

Index

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

Summary of benefits for the High Option of HIP/HMO - 2013

- **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.
- Below, an asterisk (*) means the item is subject to a calendar year deductible.

High Option Benefits	You pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	Office visit copay: $20 primary care; $40 specialist; $0 dependent children to age 26	24
Services provided by a hospital:		
• **Inpatient**	Nothing	43
• **Outpatient**	$150 per visit	44
Emergency benefits:		
• **In-area**	$150 per visit	46
• **Out-of-area**	$150 per visit	47
Mental health and substance use disorder treatment:	Regular cost-sharing	48
Prescription drugs:		
• Retail pharmacy (up to a 30-day supply)	*** After the $100 calendar year deductible** $20 for generic formulary drugs; $30 for brand name formulary drugs; or $50 for non-formulary drugs	51
• Mail order (up to a 90-day supply)	$30 for generic formulary drugs or $45 for brand name formulary drugs	51
Dental care:	No benefit	52
Vision care:	$40 per visit	30
Special features: Flexible benefits option, 24-Hour Nurse Advice Line, Services for deaf and hearing impaired, Medical Case Management, Travel benefit /services overseas.		53
Protection against catastrophic costs (out-of-pocket maximum)**:**	Nothing	20

Summary of benefits for the Standard Option of HIP/HMO - 2013

- **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.
- Below, an asterisk (*) means the item is subject to a calendar year deductible.

Standard Option Benefits	You Pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	Office visit copay: $20 primary care; $50 specialist; $0 dependent children to age 26	24
Services provided by a hospital:		
• Inpatient	$500 per admission copay	43
• Outpatient	$150 per visit	44
Emergency benefits:		
• In-area	$150 per visit	46
• Out-of-area	$150 per visit	47
Mental health and substance use disorder treatment:	Regular cost-sharing	48
Prescription drugs:		
• Retail pharmacy (up to a 30-day supply)	*** After the $100 calendar year deductible** $20 for generic formulary drugs; $30 for brand name formulary drugs; or $50 for non-formulary drugs	51
• Mail order (up to a 90-day supply)	$30 for generic formulary drugs or $45 for brand name formulary drugs	51
Dental care:	No benefit	52
Vision care:	$50 per visit	30
Special features: Flexible benefits option, 24-Hour Nurse Advice Line, Services for deaf and hearing impaired, Medical Case Management, Travel benefit /services overseas.		53
Protection against catastrophic costs (out-of-pocket maximum)**:**	Nothing	20

2013 Rate Information for Health Insurance Plan (HIP/HMO)

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

Postal Category 1 rates apply to career employees covered by the National Postal Mail Handlers Union (NPMHU), National Association of Letter Carriers (NALC) and Postal Police bargaining units.

Postal Category 2 rates apply to other non-APWU, non-PCES, non-law enforcement Postal Service career employees, including management employees, and employees covered by the National Rural Letter Carriers' Association bargaining unit.

Special Guides to Benefits are published for American Postal Workers Union (APWU) employees (see RI 70-2A) including Material Distribution Center, Operating Services and Information Technology/Accounting Services employees and Nurses; Postal Service Inspectors and Office of Inspector General (OIG) law enforcement employees (see RI 70-2IN), Postal Career Executive Service (PCES) employees (see RI 70-2EX), and noncareer employees (see RI 70-8PS).

Career APWU employees hired before May 23, 2011, will have the same rates as the Category 2 rates shown below. In the Guide to Benefits for APWU Employees (RI 70-2A) this will be referred to as the "Current" rate; otherwise, "New" rates apply.

For further assistance, Postal Service employees should call:
Human Resources Shared Service Center
1-877-477-3273, option 5
TTY: 1-866-260-7507

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 *Guide to Federal Benefits.*

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	Category 1 Your Share	Category 2 Your Share
High Option Self Only	511	$190.84	$103.58	$413.49	$224.42	$82.38	$87.68
High Option Self and Family	512	$424.95	$355.28	$920.73	$769.77	$308.06	$319.87
Standard Option Self Only	514	$190.84	$72.08	$413.49	$156.17	$50.88	$56.18
Standard Option Self and Family	515	$424.95	$271.79	$920.73	$588.87	$224.57	$236.38