

Health Insurance Plan (HIP/HMO)

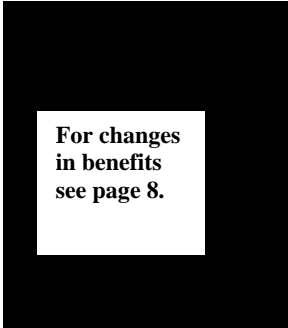
<http://www.HIPUSA.com>

2006

A Health Maintenance Organization

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 7 for requirements.



For changes
in benefits
see page 8.

*This Plan has Commendable Accreditation
from the NCQA. See the 2006 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**

Notice of the United States Office of Personnel Management's Privacy Practices

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

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

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

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

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

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

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

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

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

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

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

- For more information on exercising your rights set out in this notice, look at www.opm.gov/insure on the Web. You may also call 202-606-0745 and ask for OPM's FEHB Program privacy official for this purpose.

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

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

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

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

Important Notice from HIP Health Insurance Plan of New York About Our Prescription Drug Coverage and Medicare

OPM has determined that HIP Health Insurance Plan of New York's prescription drug coverage is, on average, comparable to Medicare Part D prescription drug coverage; thus, you do not need to enroll in Medicare Part D and pay extra for prescription drug benefits. 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 HIP Health Insurance Plan of New York will coordinate benefits with Medicare.

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

Please be advised

If you lose or drop your FEHB coverage, you will have to pay a higher Part D premium if you go without equivalent prescription drug coverage for a period of 63 days or longer. If you enroll in Medicare Part D, your premium will increase 1 percent per month for each month you did not have equivalent prescription drug 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 most other people pay. You may also have to wait until the next open enrollment period 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 coverage from these places:

Visit www.medicare.gov for personalized help,

Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Table of Contents

Introduction	3
Plain Language	3
Stop Health Care Fraud!	3
Preventing medical mistakes	4
Section 1 Facts about this HMO plan	6
General Features of our High and Standard Option	6
How we pay providers	6
Your Rights	6
Service Area	7
Section 2 How we change for 2006	8
Changes to this Plan	8
Section 3 How you get care	9
Identification cards	9
Where you get covered care	9
• Plan providers	9
• Plan facilities	9
What you must do to get covered care	9
• Primary care	9
• Specialty care	10
• Hospital care	11
Circumstances beyond our control	11
Services requiring our prior approval	11
Section 4 Your costs for covered services	12
Co-payments	12
Deductible	12
Coinsurance	12
Your catastrophic protection out-of-pocket maximum	12
Section 5 Benefits	
High and Standard Option Benefits	13
Non-FEHB benefits available to Plan members	39
Section 6 General exclusions – things we don’t cover	40
Section 7 Filing a claim for covered services	41
Section 8 The disputed claims process	42
Section 9 Coordinating benefits with other coverage	44
When you have other health coverage	44
What is Medicare?	44
Should I enroll in Medicare?	44

• The Original Medicare Plan (Part A or Part B)	45
• Medicare Advantage (Part C)	45
• Medicare prescription drug coverage (Part D).....	45
Primary Payer Chart	46
TRICARE and CHAMPVA	47
Workers' Compensation.....	47
Medicaid.....	47
When other Government agencies are responsible for your care	47
When others are responsible for injuries	47
Section 10 Definitions of terms we use in this brochure	48
Section 11 FEHB Facts	50
Coverage information.....	50
• No pre-existing condition limitation.....	50
• Where you can get information about enrolling in the FEHB Program.....	50
• Types of coverage available for you and your family	50
• Children's Equity Act.....	51
• When benefits and premiums start	51
• When you retire	51
When you lose benefits	51
• When FEHB coverage ends.....	51
• Spouse equity coverage	52
• Temporary Continuation of Coverage (TCC).....	52
• Converting to individual coverage.....	52
• Getting a Certificate of Group Health Plan Coverage	52
Section 12 Two Federal Programs complement FEHB benefits	53
The Federal Flexible Spending Account Program – <i>FSAFEDS</i>	53
The Federal Long Term Care Insurance Program	56
Index.....	57
Summary of benefits for the Health Insurance Plan (HIP/HMO) - 2006	58
2006 Rate Information for Health Insurance Plan (HIP/HMO)	59

Introduction

This brochure describes the benefits of HIP HMO under our contract (CS 1040) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. The address for 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, 2006, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2006, and changes are summarized on page 8. Rates are shown at the end of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them responsive, accessible, and understandable to the public. For instance,

- Except for necessary technical terms, we use common words. For instance, “you” means the enrollee or family member, “we” means HIP 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.

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM’s “Rate Us” feedback area at www.opm.gov/insure or e-mail OPM at fehwebcomments@opm.gov. You may also write to OPM at the U.S. Office of Personnel Management, Insurance Services Programs, Program Planning & Evaluation Group, 1900 E Street, NW, Washington, DC 20415-3650.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits Program 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:

- Be wary of giving your plan identification (ID) number over the telephone or to people you do not know, except to your doctor, other provider, or authorized plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.

- Carefully review explanations of benefits (EOBs) that you receive from us.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

Call the provider and ask for an explanation. There may be an error.

If the provider does not resolve the matter, call us at 1-877-TELL-HIP and explain the situation.

If we do not resolve the issue:

**CALL — THE HEALTH CARE FRAUD HOTLINE
202-418-3300**

OR WRITE TO:

**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); or
 - Your child over age 22 (unless he/she is disabled and incapable of self support).
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, 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.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

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 that you take, including non-prescriptive medicines. Tell them about any drug allergies you have.
- Tell them 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.

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.

Want more information on patient safety?

- 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.
- <http://www.talkaboutrx.org/>. 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.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.
- www.quic.gov/report. Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation's health care delivery system.

Section 1 Facts about this HMO plan

General Features of our High and Standard Option

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. The Plan is solely responsible for the selection of these providers in your area. Contact the Plan for a copy of their most recent provider directory.

HMOs emphasize preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. Our providers follow generally accepted medical practice when prescribing any course of treatment.

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You pay only the co-payments, coinsurance, and deductibles described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

You should join an HMO because you prefer the plan's benefits, not because a particular provider is available. You cannot change plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us.

How we pay providers

HIP is a mixed model plan that contracts with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. HIP's mixed models consist of (a) a network of medical centers that contract directly with HIP to provide health care services to HIP members; (b) IPA network providers that are private physicians or an association of physicians that contract with their member physicians and HIP to provide health care services to HIP members; and (c) fee for service providers or a fee for service health care organization that receives a payment each time a reimbursable service is provided.

HIP contracts with medical groups and premier hospital centers in the New York metropolitan area to operate multispecialty centers that provide the convenience of offering comprehensive services in State of the Art medical centers. In addition, HIP provides access to a network of physician and other providers that do not practice in multispecialty centers. HIP does not compensate health care providers in general or make specific payments intended to limit or reduce the quality or scope of medical care you receive. HIP pays health care providers on a fee-for-service basis, according to an agreed fee schedule. Some providers prefer to be compensated on a pre-payment or capitation basis, which is a fixed amount per member assigned to the provider per month. Hospital facilities are generally paid on an agreed fixed amount per day or the Diagnostic Related Group Methodology (DRG). The DRG methodology pays a fixed amount per admission according to the patient's diagnosis and general medical condition.

These Plan providers accept a negotiated payment from HIP. You will only be responsible for the applicable Plan co-payment or coinsurance amount stated in this brochure.

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

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

If you want more information about us and you are a current member, call 1-800-HIP-TALK (1-800-447-8255). If you are a potential member, please call 1-888-866-7461 for more information, or write to The HIP Health Plan of New York, 55 Water Street, New York, NY 10041. You may visit our website at www.hipusa.com.

Service Area

To enroll in this Plan, you must live in our Service Area. This is where our providers practice. Our service area is: New York City (the Boroughs of Manhattan, Brooklyn, Bronx, Queens, and Staten Island), all of Nassau, Orange, Rockland, Suffolk and Westchester Counties.

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care benefits. We will not pay for any other health care services out of our service area unless the services have prior plan approval.

If you or covered family members 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 family members move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2 How we change for 2006

Do not rely 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.

Changes to this Plan

- Your share of the non-Postal premium for High Option will increase by 10.5% for Self Only or 19.5% for Self and Family.
- Your share of the non-Postal premium for Standard Option will increase by 16.9% for Self Only or 24.4% for Self and Family.

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).

Where you get covered care

You get care from “Plan providers” and “Plan facilities.” You will only pay co-payments, deductibles, and/or coinsurance, and you will not have to file claims.

- **Plan providers**

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to the National Committee of Quality Assurance (NCQA) and other Industry standards.

We list Plan providers in the provider directory, which we update quarterly. For a current directory listing, members should call 1-800-HIP-TALK (1-800-447-8255). Potential members should call **1-888-866-7461**. The list is also available on our website at www.hipusa.com.

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. The list is also on our Web site at www.hipusa.com.

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care.

Our directory lists the locations and phone numbers of our primary care doctors. It also indicates whether or not a doctor is accepting new patients. After you select a specific provider from the directory, you should call the provider to verify that he or she still participates with HIP and is accepting new patients. You may also call our Customer Service Department at 1-800-HIP-TALK (1-800-447-8255) to find out if your doctor participates with HIP.

- **Primary care**

Your network, IPA or fee for service 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 network, IPA or fee for service primary care physician will refer you to a specialist for needed care. However, you may receive primary care and preventive obstetrical and gynecological care, chiropractic care, and routine eye care without referral from your primary care physician. 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. Your primary care physician will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic and disabling condition and lose access to your specialist because we:
 - Terminate our contract with your specialist for other than cause; or
 - Drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB 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 in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 1-800-HIP-TALK (1-800-447-8255). If you are new to the FEHB Program, we will arrange for you to receive care.

If you changed from another FEHB plan to us, your former plan will pay for the hospital stay until:

- You are discharged, not merely moved to an alternative care center; or
- The day your benefits from your former plan run out; or
- The 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the benefits of the hospitalized person. 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 case, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

Circumstances beyond our control

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

Services requiring our prior approval

Your primary care physician has authority to refer you for most services. For certain services, however, your physician must obtain approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice.

The following are other services that require prior approval:

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

Section 4 Your costs for covered services

You must share the costs of some services. You are responsible for:

Co-payments

A co-payment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive services.

Example: When you see your primary care physician you pay a co-payment of \$10 per office visit and when you go a hospital emergency room, you pay \$50 per visit.

Deductible

A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them.

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

Coinsurance

Coinsurance is the percentage of our negotiated fee that you must pay for your care. We do not have coinsurance.

Your catastrophic protection out-of-pocket maximum

We do not have a catastrophic protection out-of-pocket maximum.

Section 5 High and Standard Option Benefits

See page 8 for how our benefits changed this year and page 58 for a benefits summary. Note: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about our benefits, contact us at 1-800-HIP-TALK (1-800-447-8255) or at our website at www.hipusa.com. If you are a potential member, call us at 1-888-866-7641.

Section 5(a) Medical services and supplies provided by physicians and other health care professionals.....	15
Diagnostic and treatment services.....	15
Lab, X-ray and other diagnostic tests.....	16
Preventive care, adult.....	16
Preventive care, children.....	17
Maternity care.....	18
Family planning.....	18
Infertility services.....	19
Allergy care.....	19
Treatment therapies.....	20
Physical and occupational therapies.....	20
Speech therapy.....	20
Hearing services (testing, treatment, and supplies).....	21
Vision services (testing, treatment, and supplies).....	21
Foot care.....	21
Orthopedic and prosthetic devices.....	22
Durable medical equipment (DME).....	22
Home health services.....	23
Chiropractic.....	23
Alternative treatments.....	23
Educational classes and programs.....	23
Section 5(b) Surgical and anesthesia services provided by physicians and other health care professionals.....	24
Surgical procedures.....	24
Reconstructive surgery.....	25
Oral and maxillofacial surgery.....	26
Organ/tissue transplants.....	26
Anesthesia.....	27
Section 5(c) Services provided by a hospital or other facility, and ambulance services.....	28
Inpatient hospital.....	28
Outpatient hospital or ambulatory surgical center.....	29
Extended care benefits/Skilled nursing care facility benefits.....	29
Hospice care.....	29
Ambulance.....	30
Section 5(d) Emergency services/accidents.....	31
Emergency within our service area.....	31
Emergency outside our service area.....	32
Ambulance.....	32
Section 5(e) Mental health and substance abuse benefits.....	33
Mental health and substance abuse benefits.....	33
Section 5(f) Prescription drug benefits.....	35
Covered medications and supplies.....	36
Section (g) Special features.....	37
Services for deaf and hearing impaired.....	37
Medical Case Management.....	37
Travel benefit/services overseas.....	37

Section 5(h) Dental benefits..... 38
 Accidental injury benefit..... 38
 Dental benefits 38
Non-FEHB benefits available to Plan members 39
Summary of benefits for the Health Insurance Plan (HIP/HMO) - 2006..... 58

**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.
- We do not have a calendar year deductible for services described in this section.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including Medicare.

Benefit Description		
	High Option	Standard Option
Diagnostic and treatment services		
Professional services of physicians <ul style="list-style-type: none"> • In physician’s office • In an urgent care center • Office medical consultations • Second surgical opinion 	\$10 per office visit	\$10 per office visit to your primary care physician or \$20 per office visit to a specialist
Professional services of physicians <ul style="list-style-type: none"> • During a hospital stay • In a skilled nursing facility • At home 	Nothing	Nothing
<i>Not covered: Physical Examinations that are not necessary for medical reasons, such as those required for obtaining or continuing employment or insurance</i>	<i>All charges.</i>	<i>All charges.</i>

Lab, X-ray and other diagnostic tests	High Option	Standard Option
Tests, such as: <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG 	\$10 per office visit	\$10 per office visit to your primary care physician or \$20 per office visit to a specialist
Preventive care, adult		
Routine screenings, such as: <ul style="list-style-type: none"> • Total Blood Cholesterol • Colorectal Cancer Screening, including <ul style="list-style-type: none"> – 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 	\$10 per office visit	\$10 per office visit to your primary care physician or \$20 per office visit to a specialist
Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older <ul style="list-style-type: none"> • Annual standard diagnostic testing of prostate cancer, including but not limited to a digital rectal examination and a prostate-specific antigen testing for men age 50 and over who are asymptomatic and for men age 40 and over with a family history of prostate cancer or other prostate cancer risks. 	\$10 per office visit	\$10 per office visit to your primary care physician or \$20 per office visit to a specialist
Routine Pap test Note: You do not pay a separate office visit copay for a pap test performed during your routine annual physical.	\$10 per office visit	\$10 per office visit to your primary care physician or \$20 per office visit to a specialist

Preventive care, adult – continued on next page

Preventive care, adult <i>(continued)</i>	High Option	Standard Option
Routine mammogram – covered for women age 35 and older, as follows: <ul style="list-style-type: none"> • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years 	\$10 per office visit	\$10 per office visit to your primary care physician or \$20 per office visit to a specialist
<i>Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.</i>	All charges.	All charges.
Routine immunizations, in accordance with accepted medical practice and standards such as: <ul style="list-style-type: none"> • Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) • Influenza vaccine, annually Pneumococcal vaccine, age 65 and older	\$10 per office visit	\$10 per office visit to your primary care physician or \$20 per office visit to a specialist
<i>Not covered:</i> <ul style="list-style-type: none"> • <i>Autogenous vaccines</i> • <i>Adult immunizations related to foreign travel</i> 	All charges.	All charges.
Preventive care, children		
<ul style="list-style-type: none"> • Childhood immunizations recommended by the American Academy of Pediatrics 	Nothing	Nothing
<ul style="list-style-type: none"> • Well-child care charges for routine examinations, immunizations and care (up to age 22) • Examinations, such as: <ul style="list-style-type: none"> – Eye exams through age 17 to determine the need for vision correction – Ear exams through age 17 to determine the need for hearing correction – Examinations done on the day of immunizations (up to age 22) 	Nothing	Nothing

Maternity care	High Option You pay	Standard Option You pay
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> • Prenatal care • Delivery • Postnatal care <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother’s maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5(c)) and Surgery benefits (Section 5(b)). 	<p>\$10 first office visit; waived in subsequent visits.</p>	<p>\$10 first office visit; waived in subsequent visits.</p> <p>Note: There is a \$500 inpatient hospital copay under the Standard Option coverage. See Section 5(c) for details.</p>
<p><i>Not covered: Routine sonograms to determine fetal age, size or sex.</i></p>	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>
Family planning		
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> • Voluntary sterilization (See Surgical procedures Section 5(b)) • Surgically implanted contraceptives (such as Norplant) • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms <p>Note: We cover oral contraceptives under the prescription drug benefit.</p>	<p>\$10 per office visit</p>	<p>\$10 per office visit to your primary care physician or \$20 per office visit to a specialist</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary surgical sterilization</i> • <i>Genetic counseling.</i> 	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>

Infertility services	High Option	Standard Option
<p>Diagnosis and treatment of infertility such as:</p> <ul style="list-style-type: none"> • Artificial insemination: <ul style="list-style-type: none"> – <i>intra</i>vaginal insemination (IVI) – <i>intra</i>cervical insemination (ICI) – <i>intra</i>uterine insemination (IUI) • Fertility drugs <p>Note: We cover injectable fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit.</p>	\$10 per office visit	<p>\$10 per office visit to your primary care physician or</p> <p>\$20 per office visit to a specialist</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Assisted reproductive technology (ART) procedures, such as:</i> <ul style="list-style-type: none"> – <i>in vitro</i> fertilization – <i>embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)</i> • <i>Services and supplies related to excluded ART procedures</i> • <i>Cost of donor sperm</i> • <i>Cost of donor egg</i> 	<i>All charges.</i>	<i>All charges.</i>
Allergy care		
<ul style="list-style-type: none"> • Testing and treatment • Allergy injections 	\$10 per office visit	<p>\$10 per office visit to your primary care physician or</p> <p>\$20 per office visit to a specialist</p>
Allergy serum	Nothing	Nothing
<i>Not covered: Provocative food testing and sublingual allergy desensitization</i>	<i>All charges.</i>	<i>All charges.</i>

Treatment therapies	High Option	Standard Option
<ul style="list-style-type: none"> • Chemotherapy and radiation therapy <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 26.</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) <p>Note: Growth hormone is covered under the prescription drug benefit.</p> <p>Note: – We only cover GHT when we preauthorize the treatment. GHT must meet our medical necessity guidelines or we will not approve the treatment. See <i>Services requiring our prior approval</i> in Section 3.</p>	\$10 per office visit	\$10 per office visit to your primary care physician or \$20 per office visit to a specialist
Physical and occupational therapies		
<p>Up to 2 months per condition if significant improvement can be expected for the services of each of the following:</p> <ul style="list-style-type: none"> • qualified physical therapists and • occupational therapists <p>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.</p> <ul style="list-style-type: none"> • Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction 	\$10 per office visit Nothing per visit during covered inpatient admission	\$20 per office visit Nothing per visit during covered inpatient admission
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Long-term rehabilitative therapy</i> • <i>Exercise programs</i> 	<i>All charges.</i>	<i>All charges.</i>
Speech therapy		
<p>Up to 2 months of speech therapy each calendar year for services from the following:</p> <ul style="list-style-type: none"> • licensed or certified speech therapists 	\$10 per office visit	\$20 per office visit

Hearing services (testing, treatment, and supplies)	High Option	Standard Option
<ul style="list-style-type: none"> • First hearing aid and testing only when necessitated by accidental injury • Hearing testing for children through age 17 (see <i>Preventive care, children</i>) 	\$10 per office visit	\$10 per office visit to your primary care physician or \$20 per office visit to a specialist
<i>Not covered:</i> <ul style="list-style-type: none"> • All other hearing testing • Hearing aids, testing and examinations for them 	<i>All charges.</i>	<i>All charges.</i>
Vision services (testing, treatment, and supplies)		
<ul style="list-style-type: none"> • Annual eye refractions • Diagnosis and treatment of diseases of the eye • Lenses following cataract removal 	\$10 per office visit	\$20 per office visit
<i>Not covered:</i> <ul style="list-style-type: none"> • Eyeglasses or contact lenses • Eye exercises and orthoptics • Radial keratotomy and other refractive surgery 	<i>All charges.</i>	<i>All charges.</i>
Foot care		
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. Note: See <i>Orthopedic and prosthetic devices</i> for information on podiatric shoe inserts.	\$10 per office visit	\$10 per office visit to your primary care physician or \$20 per office visit to a specialist
<i>Not covered:</i> <ul style="list-style-type: none"> • 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) 	<i>All charges.</i>	<i>All charges.</i>

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 Standard Option coverage, each member must satisfy a \$100 calendar year prescription drug deductible. Members enrolled in the HIP/HMO High Option coverage do not have a 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 about coordinating benefits with other coverage, including with Medicare.

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 or name brand formulary maintenance drugs by mail order.
- **We use a formulary.** Our formulary is a list of effective medications and other items that we have approved for our members' use. A special committee of medical and pharmacy professionals reviews the formulary annually. We add or delete items on the list based on their findings. We have found that the drugs on our formulary are safe, effective, and therapeutic in the treatment of disease or illness. We also believe that our formulary improves patient outcomes while controlling drug costs. Please call 1-800-HIP-TALK (1-800-447-8255) for a copy of our formulary. We cover non-formulary drugs when prescribed by a Plan doctor after you pay a \$40.00 non-formulary copay.
- **These are the dispensing limitations.** A participating pharmacy will provide up to a 30-day supply of your prescription. Under the High Option Plan you will pay \$10.00 for generic formulary drugs or \$15.00 for name brand formulary drugs or \$40 for non-formulary drugs. Under the Standard Option coverage, you pay \$10.00 for generic formulary drugs, or \$20.00 for name brand formulary drugs, or \$40 for non-formulary drugs after you have satisfied a \$100.00 annual prescription drug deductible.

You may obtain up to a 90-day supply of certain formulary maintenance drugs through our mail order service. We will reduce your formulary copay by 50 % when you use our mail order service. Sexual dysfunction drugs are not available by mail-order and require prior approval. There are also limits on the number of pills that the pharmacy will fill. Please contact 1-800-HIP-TALK (1-800-447-8255) for details. For further information on using our mail order program, contact Express Scripts at 1-800-224-5502. A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand.
- **A generic equivalent will be dispensed if it is available,** unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand 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 name brand drug.
- **When you do have to file a claim.** Please call 1-800-HIP-TALK (1-800-447-8255) and we will send you a claim form. Under normal circumstances, you do not have to file prescription drug claims. You simply present your HIP/HMO card to the participating pharmacy and pay the appropriate copay.

Prescription drug benefits begin on the next page

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.

HIP VIP® Medicare HMO Benefits

HIP VIP® 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 HIP VIP® Medicare Plan, you receive the following benefits:

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

You may still enroll in HIP VIP® Medicare if you are enrolled in Medicare Parts A and B but have suspended your FEHB Program coverage. However, your benefits will be different than those listed above. You may find out more information about HIP VIP® Medicare benefits by calling 1-888-866-7461.

Fitness Program - HIP offers members discounts to fitness centers and tennis clubs in the New York metropolitan area.

Alternative Medicine - The alternative medicine provides you with access to discounted Acupuncture, Massage and Yoga Therapy services through an agreement with OneBody, a leading national alternative medicine services organization. Should you choose to seek such services, you will have access to the large OneBody network of quality screened providers at discount rates. You pay no additional plan premiums. The fees you are charged will be at a discount off of the provider's usual rates. Present your HIP ID card to the OneBody network provider in order to obtain the discounted rate. Call 1-888-HIP-ALMD (1-888-447-2563) for a list of OneBody network providers.

Dental Care - We cover the following diagnostic and preventive services when provided by participating HIP General Dentists:

- One examination (comprehensive or periodic every six months) - \$5 per visit
- One prophylaxis (cleaning) every six months - \$10 per visit
- One topical fluoride (for children age 16 and under) every six months - \$5 per visit

If you require other additional services, such as x-rays, fillings, crowns or dentures, your participating HIP General Dentist will provide them at a discounted rate. Please contact HIP's Dental Provider, Careington International, at 1-800-290-0523 for a complete schedule of current reduced member fees. All member fees must be paid directly to the participating HIP General Dentist.

Optical

At a Participating Provider members pay \$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.hipusa.com or call us at 1-800-HIP-TALK (1-800-447-8255).

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

Section 6 General exclusions – things we don't cover

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

We do not cover the following:

- Care by non-plan providers except for authorized referrals or emergencies (see *Emergency 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;
- 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;
- Expenses you incurred while not enrolled in this plan; or
- Services, drugs, or supplies you receive without charge while in active military service.

Section 10 Definitions of terms we use in this brochure

Calendar year	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 12.
Co-payment	A co-payment is a fixed amount of money you pay when you receive covered services. See page 12.
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 12.
Durable Medical Equipment, Prosthetic Devices and Orthopedic Devices	<p>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.</p> <ol style="list-style-type: none">1. Durable Medical Equipment, which is:<ol style="list-style-type: none">A. Primarily and customarily used to serve a medical purpose;B. Generally not useful to a person in the absence of illness or injury;C. Appropriate for use in the home;D. Medically necessary for the care and treatment of the Member's illness or injury.2. Prosthetic devices which replace all or part of an internal body organ or external limb. However, dental prosthetics needed due to an accidental injury to sound natural teeth if the service is provided within twelve (12) months of the accident and necessary in treatment due to congenital disease or anomaly will be covered.3. Orthopedic devices which are required for the treatment of injuries or disorders of the skeletal system and associated muscles, joints and ligaments.

Experimental or investigational services

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

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

Group health coverage

An organization such as your employer arranged for your coverage under this contract. The member's group has chosen to engage HIP to make arrangements through which Medical Services and Hospital Services will be delivered in accordance with the terms and conditions of the certificate of coverage.

Medically necessary and appropriate

Medically necessary and appropriate means those health care services or supplies, determined solely by HIP or its designee, that are necessary to prevent, diagnose, correct or cure conditions in the member that cause acute suffering, endanger life, result in illness or infirmity, interfere substantially with the member's capacity for normal activity or threaten some significant disability and that could not have been omitted under generally accepted medical standards or provided in a less intensive setting.

Morbid Obesity

Body Mass Index (BMI) of more than 40 or a BMI of 35-39.9 with documented significant co-morbid conditions.

Us/We

"Us" and "we" refer to HIP Health Plan of New York

You

"You" refers to the enrollee and each covered family member.

- **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 2006 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 2005 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.

- **When you retire**

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as Temporary Continuation of Coverage (TCC).

When you lose benefits

- **When FEHB coverage ends**

You will receive an additional 31 days of coverage, for no additional premium, when:

- Your enrollment ends, unless you cancel your enrollment, or
- You are a family member no longer eligible for coverage.

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

- **Spouse equity coverage**

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse’s enrollment. This is the case even when the court has ordered your former spouse to provide health coverage to you. But, you may be eligible for your own FEHB coverage under the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse’s employing or retirement office to get RI 70-5, the *Guide To Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices. You can also download the guide from OPM’s 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 22 or marry, etc.

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

Enrolling in TCC. Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, from your employing or retirement office or from www.opm.gov/insure. It explains what you have to do to enroll.

- **Converting to individual coverage**

You may convert to a non-FEHB individual policy if:

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

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

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

- **Getting a Certificate of Group Health Plan Coverage**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group coverage. If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan. If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

For more information, get OPM pamphlet RI 79-27, *Temporary Continuation of Coverage (TCC) under the FEHB Program*. See also the FEHB Web site 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 12 Two Federal Programs complement FEHB benefits

Important information

OPM wants to make sure you are aware of two Federal programs that complement the FEHB Program. First, the **Federal Flexible Spending Account (FSA) Program**, also known as **FSAFEDS**, lets you set aside pre-tax money to pay for health and dependent care expenses. The result can be a discount of 20% to more than 40% on services you routinely pay for out-of-pocket. Second, the **Federal Long Term Care Insurance Program (FLTCIP)** helps cover long term care costs, which are not covered under the FEHB.

The Federal Flexible Spending Account Program – *FSAFEDS*

• What is an FSA?

It is a tax-favored benefit that allows you to set aside pre-tax money from your paychecks to pay for a variety of eligible expenses. *By using an FSA, you can reduce your taxes while paying for services you would have to pay for anyway, producing a discount that can be over 40%.*

There are two types of FSAs offered by FSAFEDS:

Health Care Flexible Spending Account (HCFSA)

- Covers eligible health care expenses not reimbursed by this Plan, or any other medical, dental, or vision care plan you or your dependents may have.
- Eligible dependents for this account include anyone you claim on your Federal Income Tax return as a qualified dependent under the U.S. Internal Revenue Service (IRS) definition and/or with whom you jointly file your Federal Income Tax return, even if you don't have self and family health benefits coverage. *Note:* The IRS has a broader definition of a "family member" than is used under the FEHB Program to provide benefits by your FEHB Plan.
- The maximum annual amount that can be allotted for the HCFSA is \$5,000. *Note:* The Federal workforce includes a number of employees married to each other. If each spouse/employee is eligible for FEHB coverage, both may enroll for a HCFSA up to the maximum of \$5,000 each (\$10,000 total). Both are covered under each other's HCFSA. The minimum annual amount is \$250.

Dependent Care Flexible Spending Account (DCFSA)

- Covers eligible dependent care expenses incurred so you, and your spouse, if married, can work, look for work, or attend school full-time.
- Qualifying dependents for this account include your dependent children under age 13, or any person of any age whom you claim as a dependent on your Federal Income Tax return (and who is mentally or physically incapable of self care).
- The maximum annual amount that can be allotted for the DCFSA is \$5,000. The minimum annual amount is \$250. *Note:* The IRS limits contributions to a DCFSA. For single taxpayers and taxpayers filing a joint return, the maximum is \$5,000 per year. For taxpayers who file their taxes separately with a spouse, the maximum is \$2,500 per year.

• Enroll during Open Season

You **must make an election** to enroll in an FSA during the 2006 FEHB Open Season. Even if you enrolled during 2004, you must make a new election to continue participating in 2006. Enrollment is easy!

- **Online:** visit www.FSAFEDS.com and click on **Enroll**.
- Telephone: call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, from 9 a.m. until 9 p.m., Eastern Time. TTY: 1-800-952-0450.

What is SHPS?

SHPS is a third-party administrator hired by OPM to manage the FSAFEDS Program. SHPS is responsible for the enrollment, claims processing, customer service, and day-to-day operations of FSAFEDS.

Who is eligible to enroll?

If you are a Federal employee eligible for FEHB – even if you’re not enrolled in FEHB – you can choose to participate in either, or both, of the FSAs. *However, if you enroll in a FSA and enroll in a High Deductible Health Plan (HDHP), you are not eligible for a Health Savings Account (HSA) under your HDHP and will be enrolled in a Health Reimbursement Arrangement (HRA) are not eligible to participate in an HCFSA.*

Almost all Federal employees are eligible to enroll for a DCFSA. The only exception is intermittent (also called “when actually employed” [WAE]) employees expected to work fewer than 180 days during the year.

Note: FSAFEDS is the FSA Program established for all Executive Branch employees and Legislative Branch employees whose employers have signed on to participate. Under IRS law, FSAs are not available to annuitants. Also, the U.S. Postal Service and the Judicial Branch, among others, have their own plans with slightly different rules. However, the advantages of having an FSA are the same regardless of the agency for which you work..

• How much should I contribute to my FSA?

Plan carefully when deciding how much to contribute to an FSA. Because of the tax benefits an FSA provides, the IRS requires that you forfeit any money for which you did not incur an eligible expense under your FSA account(s) during the Plan Year. This is known as the “Use-it-or-Lose-it” rule. FSAFEDS has adopted the “grace period” permitted by the IRS. You now have an additional 2 ½ months to incur eligible expenses and reduce any potential forfeitures. In addition, you will have until May 31, following the end of the Plan Year to submit claims for your eligible expenses incurred from January 1 through March 15 of the following year. For example if you enrolled in FSAFEDS for the 2005 Plan Year, you will have from January 1, 2005 until March 15, 2006 to incur eligible expenses and, you may submit claims for those expenses through May 31, 2006.

The [FSAFEDS Calculator](#) at www.FSAFEDS.com will help you plan your FSA allocations and provide an estimate of your tax savings based on your individual situation.

• What can my HCFSA pay for?

Every FEHB plan includes cost sharing features, such as deductibles you must meet before the Plan provides benefits, coinsurance or co-payments that you pay when you and the Plan share costs, and medical services and supplies that are not covered by the Plan and for which you must pay. These out-of-pocket costs are summarized on page 58 and detailed throughout this brochure. Your HCFSA will reimburse you when those costs are for qualified medical care that you, your spouse and/or your dependents receive that is NOT covered or reimbursed by this FEHB Plan or any other coverage that you have.

The IRS governs expenses reimbursable by a HCFSA. See Publication 502 for a comprehensive list of tax-deductible medical expenses. Since Publication 502 is primarily meant to help on preparing your Federal income tax return, there are two important differences to note. **Note: While you will see insurance premiums listed in Publication 502, they are NOT a reimbursable expense for FSA purposes. In addition, over-the-counter medicines and products ARE an eligible expense under your HCFSA, and this is not included in Publication 502.** Publication 502 can be found on the IRS Web site at <http://www.irs.gov/pub/irs-pdf/p502.pdf>. The FSAFEDS Web site also has a comprehensive list of eligible expenses at www.FSAFEDS.com/fsafeds/eligibleexpenses.asp. If you do not see your service or expense listed, please call an FSAFEDS Benefits Counselor at 1-877-FSAFEDS (372-3337), who will be able to answer your specific questions.

- **Contact us**

To learn more or to enroll, please visit the **FSAFEDS Web site** at www.FSAFEDS.com, or contact SHPS directly via email or by phone. FSAFEDS Benefits Counselors are available Monday through Friday, from 9 a.m. until 9 p.m. Eastern Time.

- E-mail: FSAFEDS@shps.net
- Telephone: 1-877-FSAFEDS (1-877-372-3337)
- TTY: 1-800-952-0450

The Federal Long Term Care Insurance Program

- **It's important protection**

Why should you consider applying for coverage under the **Federal Long Term Care Insurance Program (FLTCIP)**?

- **FEHB plans do not cover the cost of long term care.** Also called “custodial care,” 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. The need for long term care can strike anyone at any age and the cost of care can be substantial.
- **The Federal Long Term Care Insurance Program can help protect you from the potentially high cost of long term care.** This coverage gives you options regarding the type of care you receive and where you receive it. With FLTCIP coverage, you won't have to worry about relying on your loved ones to provide or pay for your care.
- **It's to your advantage to apply sooner rather than later.** In order to qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. By applying while you're in good health, you could avoid the risk of having a future change in your health disqualify you from obtaining coverage. Also, the younger you are when you apply, the lower your premiums.
- **You don't have to wait for an open season to apply.** The Federal Long Term Care Insurance Program accepts applications from eligible persons at any time. You will have to complete a full underwriting application, which asks a number of questions about your health. However, if you are a new or newly eligible employee, you (and your spouse, if applicable) have a limited opportunity to apply using the abbreviated underwriting application, which asks fewer questions. Newly married spouses of employees also have a limited opportunity to apply using abbreviated underwriting.
- **Qualified relatives are also eligible to apply.** Qualified relatives include spouses and adult children of employees and annuitants, and parents, parents-in-law, and stepparents of employees.

- **To request an Information Kit and application**

Call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com.

Index

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

Accidental injury	21, 25, 38	Eyeglasses	21	Oxygen.....	22, 23, 28, 29
Allergy tests.....	19	Family planning.....	18	Pap test.....	16
Allogeneic (donor) bone marrow transplant.....	26	Fecal occult blood test.....	16	Physician.....	22, 24
Ambulance.....	28, 30, 32	Fraud.....	2, 3, 4	Precertification.....	43
Anesthesia.....	5, 24	General exclusions.....	13, 40	Prescription drugs.....	20, 41, 58
Autologous bone marrow transplant.....	20, 26	Hearing services.....	21	Preventive care, adult.....	16
Biopsy.....	24	Home health services.....	23	Preventive care, children.....	17
Blood and blood plasma.....	29	Hospital ...	4, 5, 6, 9, 11, 22, 24, 25, 26, 27, 28, 29, 31, 34, 38, 41, 45, 47, 58	Preventive services.....	6
Casts.....	28, 29	Immunizations.....	6, 17	Prior approval.....	42, 43
Catastrophic protection out-of-pocket maximum.....	39, 59	Infertility.....	19	Prosthetic devices.....	24
Changes for 2006	8	Inpatient hospital benefits.....	41	Psychologist.....	33
Chemotherapy.....	20	Insulin.....	36	Radiation therapy.....	20
Chiropractic.....	23	Magnetic Resonance Imagings (MRIs) ..	16	Room and board.....	28
Cholesterol tests.....	16	Mammograms.....	16	Second surgical opinion.....	15
Claims.....	9, 13, 41, 42, 46, 51, 53	Maternity benefits.....	18	Skilled nursing facility care..	11, 15, 27, 29
Coinsurance.....	6, 9, 12, 41, 48, 54	Medicaid.....	47	Smoking cessation.....	23
Colorectal cancer screening.....	16	Medically necessary	15, 18, 24, 28, 31, 33, 35, 38, 40	Social worker.....	33
Congenital anomalies.....	24, 25	Medicare.....	33, 44, 46	Speech therapy.....	20
Contraceptive drugs and devices.....	18	Original.....	45	Splints.....	28
Covered charges.....	45	Members.....		Subrogation.....	47
Crutches.....	22	Family.....	50	Substance abuse.....	58
Deductible.....	6, 9, 12, 39, 41, 54	Plan.....	9, 24, 39	Surgery.....	5, 18, 20, 25
Definitions ...	15, 24, 28, 31, 33, 35, 38, 48, 58	Mental Health/Substance Abuse Benefits	33	Anesthesia.....	29
Dental care.....	38, 58	Newborn care.....	18	Oral.....	26
Diagnostic services.....	15, 28, 33	Non-FEHB benefits.....	39	Outpatient.....	29
Donor expenses.....	26	Nurse.....		Reconstructive.....	24, 25
Dressings.....	28	Licensed Practical Nurse (LPN).....	23	Syringes.....	36
Durable medical equipment.....	22	Nurse Anesthetist (NA).....	28	Temporary Continuation of Coverage (TCC).....	51
Educational classes and programs.....	23	Occupational therapy.....	20	Transplants.....	20, 26
Effective date of enrollment.....	11	Office visits.....	6, 12	Treatment therapies.....	20
Emergency.....	6, 31, 32, 40, 41, 58	Oral and maxillofacial surgical.....	26	Vision care.....	58
Experimental or investigational.....	40	Out-of-pocket expenses.....	44	Wheelchairs.....	22
				Workers Compensation.....	47
				X-rays.....	16, 28, 29

