Health Insurance Plan (HIP/HMO)

www.EMBLEMHEALTH.com

Customer Service 800-HIP-TALK (800-447-8255)

HIP
HEALTH PLAN OF NEW YORK
an EmblemHealth Company

2024

A Health Maintenance Organization (High and Standard Option)

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 7 for details. This plan is accredited. See page 12.

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

Enrollment in this plan is limited. You must live or work in our geographic service area to enroll. See page 13 for requirements.

Enrollment codes for this Plan:

511 High Option – Self Only
513 High Option – Self Plus One
512 High Option – Self and Family

YL4 Standard Option – Self Only
YL6 Standard Option – Self Plus One
YL5 Standard Option – Self and Family

IMPORTANT

FEHB
Federal Employees
Health Benefits Program

Authorized for distribution by the:

United States
Office of Personnel Management

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

RI 73-001

Important Notice from Health Insurance Plan (HIP/HMO) About

Our Prescription Drug Coverage and Medicare

The Office of Personnel Management (OPM) has determined that Health Insurance Plan (HIP/HMO)'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. This means you do not need to enroll in Medicare Part D and pay extra for prescription drug 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 is at least as good as Medicare's prescription drug coverage, your monthly Medicare Part D premium will go up at least 1 percent 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 will 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 15 through December 7) 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 800-772-1213, TTY: 800-325-0778.

Potential Additional Premium for Medicare's High Income Members

Income-Related Monthly Adjustment Amount (IRMAA)

The Medicare Income-Related Monthly Adjustment Amount (IRMAA) is an amount you may pay in addition to your FEHB premium to enroll in and maintain Medicare prescription drug coverage. **This additional premium is assessed only to those with higher incomes and is adjusted based on the income reported on your IRS tax return**. You do not make any IRMAA payments to your FEHB plan. Refer to the Part D-IRMAA section of the Medicare website to see if you would be subject to this additional premium.

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 800-MEDICARE (1-800-633-4227), (TTY 877-486-2048).

Table of Contents

Introduction

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

HIP
55 Water Street
New York, NY 10041

This brochure is the official statement of benefits. No verbal 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 Plus One or 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, 2024, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates for each plan annually. Benefit changes are effective January 1, 2024, unless are summarized on page 28. 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 and each covered family member, "we" means Health Insurance Plan (HIP/HMO), an EmblemHealth Company.
- 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.
- 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 healthcare 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 phone or to people you do not know, except to your healthcare 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 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 877-TELL-HIP (877-835-5447) and explain the situation.
- If we do not resolve the issue:

CALL – THE HEALTHCARE FRAUD HOTLINE

(877) 499-7295

OR go to www.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse/complaint-form/

The online reporting form is the desired method of reporting fraud in order to ensure accuracy, and a quicker response time.

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 they are disabled and incapable of self-support prior to age 26).

A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

- 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 (TCC).
- 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.

Discrimination is Against the Law

The health benefits described in this brochure are consistent with applicable laws prohibiting discrimination.

Preventing Medical Mistakes

Medical mistakes continue to be a significant cause of preventable deaths within the United States. 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. Medical mistakes and their consequences also add significantly to the overall cost of healthcare. Hospitals and healthcare providers are being held accountable for the quality of care and reduction in medical mistakes by their accrediting bodies. You can also improve the quality and safety of your own health care and that of your family members by learning more about and understanding your risks. 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 take notes, ask questions and understand answers.

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

- Bring the actual medication or give your doctor and pharmacist a list of all the medication and dosage that you take, including non-prescription (over-the-counter) medication and nutritional supplements.
- Tell your doctor and pharmacist about any drug, food, and other allergies you have, such as latex.
- 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 medication 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 medication, including all warnings and instructions.
- Know how to use your medication. Especially note the times and conditions when your medication should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.
- Understand both the generic and brand names of your medication. This helps ensure you do not receive double dosing from taking both a generic and a brand. It also helps prevent you from taking a medication to which you are allergic.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures. Will it be in person, by phone, mail, through the Plan or Provider's portal?
- Don’t assume the results are fine if you do not get them when expected. Contact your healthcare provider and ask for your results.
- Ask what the results mean for your care.

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

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

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 or nutritional supplements you are taking.

Patient Safety Links

For more information on patient safety, please visit:

www.jointcommission.org/speakup.aspx. The Joint Commission’s Speak Up™ patient safety program.

www.jointcommission.org/topics/patient_safety.aspx. The Joint Commission helps healthcare organizations to improve the quality and safety of the care they deliver.

www.ahrq.gov/patients-consumers/. 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 healthcare providers and improve the quality of care you receive.

www.bemedwise.org The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medication.

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 healthcare professionals working to improve patient safety.

Preventable Healthcare Acquired Conditions ("Never Events")

When you enter the hospital for treatment of one medical problem, you do not 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, patients do suffer from injuries or illnesses that could have been prevented if doctors or the hospital had taken proper precautions. Errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients, can indicate a significant problem in the safety and credibility of a healthcare facility. These conditions and errors are sometimes call "Never Events" or "Serious Reportable Events."

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. When such an event occurs, neither you nor your FEHB plan will incur costs to correct the medical error.

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/HMO preferred providers. This policy helps to protect you from preventable medical errors and improve the quality of care you receive.

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.

- **Minimum essential coverage (MEC)**

  Coverage under this plan qualifies as minimum essential coverage. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

- **Minimum value standard**

  Our health coverage meets the minimum value standard of 60% established by the ACA. This means that we provide benefits to cover at least 60% of the total allowed costs of essential health benefits. The 60% standard is an actuarial value; your specific out-of-pocket costs are determined as explained in this brochure.

- **Where you can get information about enrolling in the FEHB Program**

  See www.opm.gov/healthcare-insurance 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 that 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, give you other plans' brochures 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 do not 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, disability leave, pensions, etc. you must also contact your employing or retirement office.

  Once enrolled in your FEHB Program Plan, you should contact your carrier directly for address updates and questions about your benefit coverage.

- **Enrollment types available for you and your family**

  Self Only coverage is only for the enrollee. Self Plus One coverage is for the enrollee and one eligible family member. Self and Family coverage is for the enrollee and one or more eligible family members. Family members include your spouse and your dependent children under age 26, including any foster children authorized for coverage by your employing agency or retirement office. 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 Plus One or 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 Plus One or 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 Plus One or 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 are married. A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

Contact your employing or retirement office if you want to change from Self Only to Self Plus One or Self and Family. If you have a Self and Family enrollment, you may contact us to add a family member.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits. Please tell us immediately of changes in family member status, including your marriage, divorce, annulment, or when your child reaches age 26. We will send written notice to you 60 days before we proactively disenroll your child on midnight of their 26th birthday unless your child is eligible for continued coverage because they are incapable of self-support due to a physical or mental disability that began before age 26.

If you or one of your family members is enrolled in one FEHB plan, you or they cannot be enrolled in or covered as a family member by another enrollee in 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/healthcare-insurance/life-events. If you need assistance, please contact your employing agency, Tribal Benefits Officer, personnel/ payroll office, or retirement office.

- **Family member coverage**

Family members covered under your Self and Family enrollment are your spouse (including your spouse by valid common-law marriage from a state that recognizes common law marriages) and children as described below. A Self Plus One enrollment covers you and your spouse, or one other eligible family member as described below.

Natural children, adopted children, and stepchildren
Coverage: Natural children, adopted children, and stepchildren are covered until their 26th birthday.

Foster children
Coverage: 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
Coverage: 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
Coverage: 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
Coverage: Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

Newborns of covered children are insured only for routine nursery care during the covered portion of the mother's maternity stay.

You can find additional information at www.opm.gov/healthcare-insurance.

- **Children's Equity Act**

OPM implements the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self Plus One or 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 in Self Plus One or 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 Plus One or Self and Family coverage, as appropriate, in the lowest-cost nationwide plan option as determined by OPM
- 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 Plus One or Self and Family, as appropriate, 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 a Self Plus One or Self and Family, as appropriate, in the lowest-cost nationwide plan option as determined by OPM.

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 does not 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 does not serve the area in which your children live as long as the court/administrative order is in effect. Similarly, you cannot change to Self Plus One if the court/administrative order identifies more than one child. 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 processed according to the 2024 benefits of your prior plan or option.** If you have met (or pay cost-sharing that results in your meeting) the out-of-pocket maximum under the prior plan or option, you will not pay cost-sharing for services covered between January 1 and the effective date of coverage under your new plan or option. However, if your prior plan left the FEHB Program at the end of the year, you are covered under that plan's 2023 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 assistance with enrolling in a conversion policy (a non-FEHB individual policy).

- **Upon divorce**

If you are an enrollee, and your divorce or annulment is final, your ex-spouse cannot remain covered as a family member under your Self Plus One or Self and Family enrollment. You must contact us to let us know the date of the divorce or annulment and have us remove your ex-spouse. We may ask for a copy of the divorce decree as proof. In order to change enrollment type, you must contact your employing or retirement office. A change will not automatically be made.

If you were married to an enrollee and your divorce or annulment is final, you may not remain covered as a family member 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 information about your coverage choices. You can also visit OPM's website at https://www.opm.gov/healthcare-insurance/life-events/memy-family/im-separated-or-im-getting-divorced/#url=Health. We may request that you verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

- **Temporary Continuation of Coverage (TCC)**

If you leave Federal service, Tribal employment, 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 or Tribal job, or if you are a covered child and you turn 26. You may not elect TCC if you are fired from your Federal or Tribal job due to gross misconduct.

Enrolling in TCC. Get the RI 79-27, which describes TCC, from your employing or retirement office or from www.opm.gov/healthcare-insurance. It explains what you have to do to enroll.

Alternatively, you can buy coverage through the Health Insurance Marketplace where, depending on your income, you could be eligible for a tax credit that lowers your monthly premiums. Visit www.HealthCare.gov to compare plans and see what your premium, deductible, and out-of-pocket costs would be before you make a decision to enroll. Finally, if you qualify for coverage under another group health plan (such as your spouse's plan), you may be able to enroll in that plan, as long as you apply within 30 days of losing FEHB Program coverage.

- **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 cancelled 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 or Tribal service, your employing office will notify you of your right to convert. You must contact us in writing 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 contact us in writing 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, a waiting period will not be imposed and your coverage will not be limited due to pre-existing conditions. When you contact us, we will assist you in obtaining information about health benefits coverage inside and outside the Affordable Care Act's Health Insurance Marketplace in your state. For assistance in finding coverage, please contact us at 800-HIP-TALK (800-447-8255) or visit our website at **www.emblemhealth.com**.

- **Health Insurance Marketplace**

If you would like to purchase health insurance through the ACA's Health Insurance Marketplace, please visit www.HealthCare.gov. This is a website provided by the U.S. Department of Health and Human Services that provides up-to-date information on the Marketplace.

Section 1. How This Plan Works

This Plan is a health maintenance organization (HMO). OPM requires that FEHB plans be accredited to validate that plan operations and/or care management meet nationally recognized standards. HIP/HMO holds the following accreditation: Utilization Review Accreditation Commission (URAC). To learn more about this plan's accreditation, please visit the following websites: URAC (www.urac.org).

We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. We are solely responsible for the selection of these providers in your area. Contact us for a copy of our most recent provider directory. We give you a choice of enrollment in a High Option or 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 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.

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 cost-sharing (copayments, deductibles, and non-covered services and supplies).

Catastrophic protection

We protect you against catastrophic out-of-pocket expenses for covered services. The annual out-of-pocket expenses for covered services, including deductibles and copayments, cannot exceed $6,850 for Self Only enrollment, and $13,700 for a Self Plus One or Self and Family for the High Option plan; or cannot exceed $8,550 for Self Only enrollment, and $17,100 for a Self Plus One or Self and Family for the Standard Option plan.

Your rights and responsibilities

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/healthcare-insurance/) lists the specific types of information that we must make available to you. Some of the required information is listed below:

- HIP/HMO was organized over 60 years ago as a non-profit organization.
- 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 accreditation from the Utilization Review Accreditation Commission (URAC).

You are also entitled to a wide range of consumer protections and have specific responsibilities as a member of this Plan. You can view the complete list of these rights and responsibilities by visiting our website, www.emblemhealth.com. You can also contact us to request that we mail a copy to you.

If you want more information about us, call 800-HIP-TALK (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.

By law, you have the right to access your protected health information (PHI). For more information regarding access to PHI, visit our website at www.emblemhealth.com to obtain our Notice of Privacy Practices. You can also contact us to request that we mail you a copy of that Notice.

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, Rockland, Suffolk, Westchester, Albany, Broome, Columbia, Delaware, Dutchess, Fulton, Greene, Montgomery, Orange, Otsego, Putnam, Rensselaer, Saratoga, Schenectady, Schoharie, Sullivan, Ulster, Warren, and Washington 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 healthcare 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 2024

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.

Changes to our High and Standard Options

Premium Rates

Your share of the premium rate will increase for Self Only, Self Plus One and Self and Family. See page 95.

Fertility Procedures

The Plan is expanding coverage for artificial insemination (AI) procedures to include coverage for intravaginal insemination (IVI); and intracervical (ICI) insemination. There are no dollar or cycle limitations on this benefit. See page 37-38. The cost share for the plan's infertility benefits is as follows:

High and Standard Options - $30 per office visit to PCP

High Option - $50 per office visit to a specialist

Standard Option - $75 per office visit to a specialist (after deductible)

Fertility Drugs

The plan will expand fertility drug coverage to include in vitro fertilization (IVF) related fertility drugs. Injectable fertility drugs are covered under the medical benefit and oral fertility drugs are covered under the prescription drug benefit. Both oral and injectable fertility drugs have no caps or lifetime maximums. See page 70. The cost share for oral fertility drugs covered under the prescription drug benefit is as follows:

High Option ($100 brand name only calendar year deductible applies)

Standard Option ($300 brand name only calendar year deductible applies)

$25 for generic formulary drugs

$50 for brand name formulary drugs

$100 for non-formulary drugs

$200 for Specialty drugs at a participating Specialty pharmacy

Gender Affirming Care Services (GACS)

Services covered will now include coverage of all medically necessary gender affirming surgeries, including breast augmentation, breast reduction mammoplasty, and facial gender affirming surgeries. Pre-authorization is required for all services. See page 52. The cost share for these services is as follows:

High Option - Member pays Nothing

Standard Option - Member pays Nothing (included in the inpatient hospital admission copay or outpatient copay, after deductible)

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 800-HIP-TALK (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 website: www.emblemhealth.com.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments and deductibles.

- **Balance Billing Protection**

FEHB Carriers must have clauses in their in-network (participating) providers agreements. These clauses provide that, for a service that is a covered benefit in the plan brochure or for services determined not medically necessary, the in-network provider agrees to hold the covered individual harmless (and may not bill) for the difference between the billed charge and the in network contracted amount. If an in-network provider bills you for covered services over your normal cost share (deductible, copay, co-insurance) contact your Carrier to enforce the terms of its provider contract.

- **Plan providers**

Plan providers are physicians and other healthcare professionals in our service area that we contract with to provide covered services to our members. Services by Plan Providers are covered when acting within the scope of their license or certification under applicable state law. We credential Plan providers according to national standards.

Benefits are provided under this Plan for the services of covered providers, in accordance with Section 2706(a) of the Public Health Service Act. Coverage of practitioners is not determined by your state's designation as a medically underserved area.

We list Plan providers in the provider directory, which we update periodically. The list is also available on our website.

This plan recognizes that transgender, non-binary, and other gender diverse members require health care delivered by healthcare providers experienced in gender affirming health. Benefits described in this brochure are available to all members meeting medical necessity guidelines regardless of race, color, national origin, age, disability, religion, sex or gender.

This plan provides Care Coordinators for complex conditions and can be reached at www.emblemhealth.com for assistance.

- **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 website 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 provider. This decision is important since your primary care provider provides or arranges for most of your health care.

- **Primary care**

Your primary care provider can be a family practitioner, internist or pediatrician. Your primary care provider will provide most of your healthcare, or give you a referral to see a specialist.

If you want to change primary care providers or if your primary care provider leaves the plan, call us. We will help you select a new one.

- **Specialty care**

Your primary care provider will refer you to a specialist for needed care. When you receive a referral from your primary care provider, you must return to the primary care provider after the consultation, unless your primary care provider authorized a certain number of visits without additional referrals. The primary care provider must provide or authorize all follow-up care. Do not go to the specialist for return visits unless your primary care provider gives you a referral. However, you may see a Plan gynecologist without 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 provider will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your primary care provider will create 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 provider. If they decide to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- If you are seeing a specialist and your specialist leaves the plan, call your primary care provider, 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 provider 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 800-HIP-TALK (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 provider 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.* You are responsible for the cost of any service received without 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.

- **Other services requiring our Prior Approval**

Your primary care provider 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.
- 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.

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 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/opioids

- Osteo-arthritis/anti-inflammatory medications
- Vitamin A based medications for treatment of cystic acne

How to request prior approval for an admission or get prior approval for Other services, Prescription drugs, and Specialty drugs

First, your physician, your hospital, you, or your representative, must call us at 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 days requested for hospital stay.

Prescription Drugs: 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.

Specialty Pharmacy: 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.

- **Non-urgent care claims**

For non-urgent care claims, we will 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 or not it is an urgent care claim by applying the judgment of a prudent layperson that 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 let you know what information we need to complete our review of the claim. You will then have up to 48 hours to provide the required 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 800-HIP-TALK (800-447-8255). You may also call OPM's FEHB 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, call us at 800-HIP-TALK (800-447-8255). If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

- **Concurrent care claims**

A concurrent care claim involves care provided over a period of time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment before the end of the approved period of time or number of treatments as an appealable decision. This does not include reduction or termination due to benefit changes or if your enrollment ends. If we believe a reduction or termination is warranted we will allow you sufficient time to apeal and obtain a decision from us before the reduction or termination takes effect.

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, we will make a decision within 24 hours after we receive the 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 phone us within 48 hours following the day of the emergency admission, even if you have been discharged from the hospital.

- **Maternity care**

You do not need precertification of a maternity admission for a routine delivery. However, if your medical condition requires you to stay more than 48 hours after a vaginal delivery or 96 hours after a cesarean section, then your physician or the hospital must contact us for precertification of additional days. Further, if your baby stays after you are discharged, your physician or the hospital must contact us for precertification of additional days for your baby.

Note: When a newborn requires definitive treatment during or after the mother's hospital stay, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.

- **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, we will make a decision within 24 hours after we receive the claim.

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 your claim is in reference to a contraceptive, call 800-HIP-Talk (800-447-8255)

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 healthcare 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.

Unless we request additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will expedite the review process, which allows oral or written requests for appeals and the exchange of information by phone, 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 and copayments) for the covered care you receive.

Copayments

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

In the High Option plan, when you see your primary care provider, you pay a copayment of $30 per office visit. When you see a specialist, you pay a copayment of $50 per office visit.

In the Standard Option plan, when you see your primary care provider, you pay a copayment of $30 per office visit. When you see a specialist, you pay a copayment of $75 per office visit.

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.

- We do not have a calendar year deductible for the High Option.
- The calendar year deductible is $3,000 per person under Standard Option. Under a Self Only enrollment, the deductible is considered satisfied and benefits are payable for you when your covered expenses applied to the calendar year deductible for your enrollment reach $3,000 under Standard Option. Under Self Plus One enrollment, the deductible is considered satisfied and benefits are payable for you and one other eligible family member when the combined covered expenses applied to the calendar year deductible for your enrollment reach $6,000 under the Standard Option. Under a Self and Family enrollment, the deductible is considered satisfied and benefits are payable for all family members when the combined covered expenses applied to the calendar year deductible for family members reach $6,000 under the Standard Option.
- There is also an annual $100 deductible for brand name prescription drugs under the High Option and an annual $300 deductible for brand name prescription drugs under the Standard Option.

Note: If you change plans during Open Season, you do not have to start a new deductible under your prior plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan.

Differences between our Plan Allowances and the bill

You should also see section Important Notice About Surprise Billing - Know Your Rights below that describes your protections against surprise billing under the No Surprises Act.

Your catastrophic protection out-of-pocket maximum

After your (in network) out-of-pocket expenses, for the High Option plan, including any applicable deductibles and copayments total $6,850 for Self Only, or $13,700 for a Self Plus One or Self and Family enrollment in any calendar year, you do not have to pay any more for covered services. ***The maximum annual limitation on cost sharing listed under Self Only of $6,850 applies to each individual, regardless of whether the individual is enrolled in Self Only, Self Plus One, or Self and Family.***

After your (in network) out-of-pocket expenses, for the Standard Option plan, including any applicable deductibles and copayments total $8,550 for Self Only, or $17,100 for a Self Plus One or Self and Family enrollment in any calendar year, you do not have to pay any more for covered services. ***The maximum annual limitation on cost sharing listed under Self Only of $8,550 applies to each individual, regardless of whether the individual is enrolled in Self Only, Self Plus One, or Self and Family.***

High Option example scenario: Your plan has a $6,850 Self Only maximum out-of-pocket limit and a $13,700 Self Plus One or Self and Family maximum out-of-pocket limit. If you or one of your eligible family members has out-of-pocket qualified medical expenses of $6,850 or more for the calendar year, any remaining qualified medical expenses for that individual will be covered fully by your health plan. With a Self and Family enrollment out-of-pocket maximum of $13,700, a second family member, or an aggregate of other eligible family members, will continue to accrue out-of-pocket qualified medical expenses up to a maximum of $6,850 for the calendar year before their qualified medical expenses will begin to be covered in full.

However, copayments if applicable for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments for these services:

- Routine foot care
- Vision care services
- Expenses for services and supplies that exceed the stated maximum dollar or day limit
- Expenses from utilizing out-of-network providers

Be sure to keep accurate records and receipt of your copayments to ensure the plan's calculation of your out-of-pocket maximum is reflected accurately.

Carryover

If you changed to this Plan during Open Season from a plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to that plan's catastrophic protection benefit during the prior year will be covered by your prior plan if they are for care you received in January before your effective date of coverage in this Plan. If you have already met your prior plan's catastrophic protection benefit level in full, it will continue to apply until the effective date of your coverage in this Plan. If you have not met this expense level in full, your prior plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date of your coverage in this Plan. Your prior plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.

If you change options in this Plan during the year, we will credit the amount of covered expenses already accumulated toward the catastrophic out-of-pocket limit of your old option to the catastrophic protection limit of your new option.

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.

Important Notice About Surprise Billing - Know Your Rights

The No Surprises Act (NSA) is a federal law that provided you with protections against "surprise billing" and "balance billing" for out-of-network emergency services; out-of-network non-emergency services provided with respect to a visit to a participating health care facility; and out-of-network air ambulance services.

A surprise bill is an unexpected bill you receive for:

- emergency care - when you have little or no say in the facility or provider from whom you receive care, or for
- non-emergency services furnished by nonparticipating providers with respect to patient visits to participating health care facilities, or for
- air ambulance services furnished by nonparticipating providers of air ambulance services.

Balance billing happens when you receive a bill from the nonparticipating provider, facility, or air ambulance service for the difference between the nonparticipating provider's charge and the amount payable by your health plan.

Your health plan must comply with the NSA protections that hold you harmless from surprise bills.

For specific information on surprise billing, the rights and protections you have, and your responsibilities go to www.emblemhealth.com or contact the health plan at 800-447-8255.

If we overpay you

We will make diligent efforts to recover benefit payments we made in error but in good faith. We may reduce subsequent benefit payments to offset overpayments.

The Federal Flexible Spending Account Program - FSAFEDS

- **Health Care FSA (HCFSA)** - Reimburses you for eligible out-of-pocket healthcare expenses (such as copayments, deductibles, 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).
- **FSAFEDS** offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or your provider files 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.

Section 5. High and Standard Option Benefits

See page 15 for how our benefit changed this year. Page 92 and 93 are benefit summaries 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. Please be sure to review the benefits that are available under the option in which you are enrolled. Each option offers unique features.

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 800-HIP-TALK (800-447-8255) or on our website at www.emblemhealth.com/federal.

- **High Option**
  - $30 copay for primary care providers.
  - $30 copay for mental health and substance abuse providers.
  - $50 copay for specialists.
  - $50 deductible for durable medical equipment (DME).
  - $50 deductible for orthopedic and prosthetic devices.
  - $100 brand name prescription drug calendar year deductible per individual.
  - $0 copay for dependent children to age 26 for the following services:
    - primary care provider office visits
    - specialist physician office visits
    - home health care
    - x-rays and diagnostic & lab tests
    - outpatient treatment of mental illness
    - outpatient rehabilitation treatment of substance use disorders
    - chiropractic services
    - outpatient speech, occupational and physical therapy
- **Standard Option**
  - $30 copay for primary care providers, not subject to deductible.
  - $30 copay for mental health and substance abuse providers, not subject to deductible.
  - $75 copay for specialists, after deductible.
  - $100 deductible for durable medical equipment (DME).
  - $300 brand name prescription deductible.
  - $3,000 calendar year deductible per individual; $6,000 calendar year deductible per family.

Section 5(a). Medical Services and Supplies Provided by Physicians and Other Healthcare 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.
- High Option - We have a $50 calendar year deductible for Durable Medical Equipment (DME) and a separate brand name prescription drug calendar year deductible of $100 per individual.
- Standard Option - The calendar year deductible is $3,000 per person; $6,000 per Self Plus One and Self and Family enrollment. The separate brand name prescription drug calendar year deductible is $300 per individual. There is a separate Durable Medical Equipment (DME) deductible of $100. We indicate when the calendar year deductible does not apply.
- 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 coverage and cost-sharing listed below are for services provided by physicians and other health care professionals for your medical care. See Section 5(c). for cost-sharing associated with the facility (i.e., hospital, surgical center, etc.)

Benefit Description	You pay	
Note: The calendar year deductible applies to almost all benefits in this section. We say "not subject to deductible" when it does not apply.		
Diagnostic and treatment services	**High Option**	**Standard Option**
Professional services of physicians: • In physician's office • Office medical consultations • Second surgical opinion • Advance care planning	$30 per office visit to your primary care provider (PCP) $50 per office visit to a specialist $0 per office visit for dependent children to age 26	$30 per office visit to your primary care provider (PCP), not subject to deductible $75 per office visit to a specialist, after deductible
Professional services of physicians: • During a hospital stay • In a skilled nursing facility • At home	Nothing	$30 per office visit to your primary care provider (PCP), not subject to deductible $75 per office visit to a specialist, after deductible
Professional services of physicians: • Urgent Care	$30 per office visit	$75 per office visit, after deductible
Not covered:	*All charges*	*All charges*

Diagnostic and treatment services - continued on next page

Benefit Description	You pay	
Diagnostic and treatment services (cont.)	**High Option**	**Standard Option**
• *Physical examinations that are not necessary for medical reasons, such as those required for obtaining or continuing employment or insurance*	*All charges*	*All charges*
Telehealth services	**High Option**	**Standard Option**
• Covered services will include the use of electronic information and communication technologies by a provider to deliver covered services (primary care, specialty care and urgent care rendered by participating providers) to you while your location is different than your providers location. • Provider consultations are for non-emergency medical conditions only for Plan providers who offer telehealth services. Note: Subject to the prescription drug section, if necessary the telehealth physician may write a prescription and send it to an in-network participating retail pharmacy. Prescriptions are subject to cost sharing where applicable. Note: Covered services are subject to the same utilization review and quality assurance requirements and other terms and conditions of this plan.	$30 for telehealth services by a PCP $50 for telehealth services by a Specialist	$30 for telehealth services by a PCP, not subject to deductible $75 for telehealth services by a Specialist, not subject to deductible
Not Covered: • *Telehealth services for consultations with nutritionists and dietitians are not covered.*	*All charges*	*All charges*

Benefit Description	You pay	
Telemedicine	**High Option**	**Standard Option**
• We cover online internet consultations between you and providers who participate in our telemedicine program for primary care, specialty care and urgent care medical conditions that are not an emergency condition. Note: Not all participating providers participate in our telemedicine program. You can check our provider directory or contact us for a listing of the providers that participate in the telemedicine program at https://www.teladoc.com/ Note: Subject to the prescription drug section, if necessary, the telemedicine physician may write a prescription and send it to an in-network participating retail pharmacy. Prescriptions are subject to cost-sharing where applicable. Note: You must create an account with our telemedicine vendor (Teladoc) before You will be given access to the list of participating telemedicine physicians. Once access is obtained, You will be able to participate in a telemedicine consultation either online or by phone with a telemedicine physician who is available. Telemedicine providers are available twenty-four (24) hours/ seven (7) days a week. Note: Covered services are subject to the same utilization review and quality assurance requirements and other terms and conditions of this plan. Note: Telemedicine services are adminstered by Teladoc.	$10 for telemedicine services per visit	$10 for telemedicine services per visit, not subject to deductible

Benefit Description	You pay	
Lab, X-ray and other diagnostic tests	**High Option**	**Standard Option**
Tests, such as: • Blood tests • Urinalysis • Non-routine pap test • Pathology • X-rays • Non-routine mammogram • CT Scans • MRI • Ultrasound • Electrocardiogram and EEG	Nothing	$30 per office visit to your primary care provider, not subject to deductible $75 per office visit to a specialist, or outpatient hospital/free standing facility, after deductible
Preventive care, adult	**High Option**	**Standard Option**
Routine physical every calendar year: The **following** preventive services are covered at the time interval recommended at each of the links below. • Immunizations such as Pneumococcal, influenza, shingles, tetanus/Tdap, and human papillomavirus (HPV). For a complete list of immunizations go to the Centers for Disease Control (CDC) website at https://www.cdc.gov/vaccines/schedules/ • Screenings such as cancer, osteoporosis, depression, diabetes, high blood pressure, total blood cholesterol, HIV, and colorectal cancer screening. For a complete list of screenings go to the U.S. Preventive Services Task Force (USPSTF) website at https://shorturl.at/hovHM • Individual counseling on prevention and reducing health risks	Nothing	Nothing

Preventive care, adult - continued on next page

Benefit Description	You pay	
Preventive care, adult (cont.)	**High Option**	**Standard Option**
• Preventive care benefits for women such as Pap smears, gonorrhea prophylactic medication to protect newborns, annual counseling for sexually transmitted infections, contraceptive methods, and screening for interpersonal and domestic violence. For a complete list of preventive care benefits for women go to the Health and Human Services (HHS) website at https://www.healthcare.gov/preventive-care-women/ • To build your personalized list of preventive services go to https://health.gov/myhealthfinder	Nothing	Nothing
• Routine mammogram	Nothing	Nothing
• Adult immunizations endorsed by the Centers for Disease Control and Prevention (CDC): based on the Advisory Committee on Immunization Practices (ACIP) schedule Note: Any procedure, injection, or diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member copay, coinsurance, and deductible.	Nothing	Nothing
• Medical Nutrition Therapy and Intensive Behavioral Therapy for the prevention of obesity related comorbidities as recommended under the U.S. Preventive Services Task Force (USPSTF) A and B recommendations.	Nothing	Nothing
Not covered:	*All charges*	*All charges*

Preventive care, adult - continued on next page

Benefit Description	You pay	
Preventive care, adult (cont.)	**High Option**	**Standard Option**
• *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel.* • *Immunizations, boosters, and medications for travel or work-related exposure.*	*All charges*	*All charges*
Preventive care, children	**High Option**	**Standard Option**
• Well-child visits, examinations, and other preventive services as described in the Bright Future Guidelines provided by the American Academy of Pediatrics. For a complete list of the American Academy of Pediatrics Bright Futures Guidelines go to https://brightfutures.aap.org • Immunizations such as DTaP/ Tdap, Polio, Measles, Mumps, and Rubella (MMR), and Varicella. For a complete list of immunizations go to the Centers for Disease Control (CDC) website at https://www.cdc.gov/vaccines/schedules/index.html • You can also find a complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) online at https://shorturl.at/hovHM Note: Any procedure, injection, or diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member copay, coinsurance, and deductible.	Nothing	Nothing

Benefit Description	You pay	
Maternity care	**High Option**	**Standard Option**
Complete maternity (obstetrical) care, such as: • Prenatal and Postpartum care • Screening for gestational diabetes • Delivery • Screening and counseling for prenatal and postpartum depression	Nothing for prenatal care, the first postpartum care visit, screening for gestational diabetes for pregnant women; $30 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 for pregnant women; $30 per office visit for all postpartum care visits thereafter, not subject to deductible. $150 inpatient hospital maternity copay, not subject to the deductible.

Maternity care - continued on next page

Benefit Description	You pay	
Maternity care (cont.)	**High Option**	**Standard Option**
Breastfeeding support, supplies and counseling for each birth Note: Here are some things to keep in mind: • You do not need to precertify your vaginal delivery. See page 20 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a vaginal 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 Plus One or 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. • Hospital services are covered under Section 5(c) and Surgical benefits under Section 5(b). Note: When a newborn requires definitive treatment during or after the mother's confinement, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.	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: • Surgically implanted contraceptive drugs and devices • Injectable contraceptive drugs (such as Depo Provera) • Intrauterine devices (IUDs) • Diaphragms • Tubal ligation Note: We cover oral contraceptives under the prescription drug benefit.	Nothing	Nothing
Voluntary sterilization (See Surgical Procedures Section 5 (b))	Nothing	Nothing
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic testing and counseling*	*All charges*	*All charges*
Infertility services	**High Option**	**Standard Option**
"Infertility" is a disease characterized by the incapacity to impregnate another person or to conceive, defined by the failure to establish a clinical pregnancy after twelve (12) months of unprotected sexual intercourse or artificial insemination, or after six (6) months of unprotected sexual intercourse or artificial insemination for an individual thirty-five (35) years of age or older. Evaluation and treatment may be warranted based on a member's medical history or diagnostic testing. Diagnostic and treatment of infertility specific to: • Artificial insemination: - Intrauterine insemination (IUI) - Intravaginal insemination (IVI)	$30 per office visit to your primary care provider $50 per office visit to a specialist	$30 per office visit to your primary care provider, not subject to deductible $75 per office visit to a specialist, after deductible

Infertility services - continued on next page

Benefit Description	You pay	
Infertility services (cont.)	**High Option**	**Standard Option**
- Intracervical insemination (ICI) • Injectable fertility drugs including IVF related drugs. See section 5(f) for orally administered fertility drugs. • We cover standard fertility preservation services for members 35 years of age or older when a medical treatment, including gender transition services, will directly or indirectly lead to iatrogenic infertility. Benefits are available for fertility preservation for medical reasons that cause irreversible infertility such as chemotherapy, radiation treatment, and bilateral oophorectomy due to cancer. Services include the collection of sperm; Cryo-preservation of sperm; Ovarian stimulation, retrieval of eggs and fertilization, Oocyte cryo-preservation; Embryo cryo-preservation. Preservation storage is limited to one year in a covered person's lifetime.	$30 per office visit to your primary care provider $50 per office visit to a specialist	$30 per office visit to your primary care provider, not subject to deductible $75 per office visit to a specialist, after deductible
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	$30 per office visit to your primary care provider $50 per office visit to a specialist	$30 per office visit to your primary care provider, not subject to deductible $75 per office visit to a specialist, after deductible
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 48. Note: Facility copay apply. See Section 5(c). Note: These services require prior approval, see page 18.	Nothing	Nothing
• Respiratory and inhalation therapy • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to 32 sessions Note: Growth hormone is covered under the prescription drug benefit.	$30 per office visit to your primary care provider or $50 per office visit to a specialist	$30 per office visit to your primary care provider, not subject to deductible or $75 per office visit to a specialist, after deductible

Treatment therapies - continued on next page

Benefit Description	You pay	
Treatment therapies (cont.)	**High Option**	**Standard Option**
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.	$30 per office visit to your primary care provider or $50 per office visit to a specialist	$30 per office visit to your primary care provider, not subject to deductible or $75 per office visit to a specialist, after deductible
• 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.	$30 per office visit to your primary care provider	$75 per office visit to a specialist, after deductible
• Applied Behavior Analysis (ABA) - See section 5(e)	$30 per office visit $0 per office visit for dependent children to age 26	$30 per office visit, not subject to deductible
Physical and occupational therapies	**High Option**	**Standard Option**
Rehabilitation 60 visits of physical or occupational therapy each calendar year for services from the following: • Qualified physical therapists • Occupational therapists **Habilitation** 60 visits of physical or occupational therapy each calendar year for services for the following: • Health care services that help a person keep, learn or improve skills and functioning for daily living including:	$50 per office visit $0 per office visit for dependent children to age 26. Nothing for physician or health professional visits during covered inpatient admission	$75 per office visit to a specialist, after deductible Nothing for physician or health professional visits 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**
- the management of limitations and disabilities - services or programs that help maintain or prevent deterioration in physical, cognitive, or behavioral function. Note: We only cover therapy when a physician: • Orders the care • Identifies the specific professional skills the patient requires and the medical necessity for skilled services and • indicates the length of time the services are needed. Note: We cover Habilitation Services in the outpatient department of a facility or in a health care professional's office. Note: These services require prior approval, see page 18.	$50 per office visit $0 per office visit for dependent children to age 26. Nothing for physician or health professional visits during covered inpatient admission	$75 per office visit to a specialist, after deductible Nothing for physician or health professional visits during covered inpatient admission
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs*	*All charges*	*All charges*
Speech therapy	**High Option**	**Standard Option**
60 visits of speech therapy each calendar year for services from the following: • Licensed or certified speech therapists **Habilitation Services** 60 visits of speech therapy each calendar year for services for the following: • Speech therapy services that help a person keep, learn or improve skills and functioning for daily living including: - the management of limitations and disabilities	$50 per office visit $0 per office visit for dependent children to age 26 Nothing per visit during covered inpatient admission	$75 per office visit to a specialist, after deductible Nothing per visit during covered inpatient admission

Speech therapy - continued on next page

Benefit Description	You pay	
Speech therapy (cont.)	**High Option**	**Standard Option**
- services or programs that help maintain or prevent deterioration in cognitive function. Note: We cover Habilitation Services in the outpatient department of a facility or in a health care professional's office. Note: These services require prior approval, see page 16.	$50 per office visit $0 per office visit for dependent children to age 26 Nothing per visit during covered inpatient admission	$75 per office visit to a specialist, after deductible Nothing per visit during covered inpatient admission
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs*	*All charges*	*All charges*
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 for children are covered up to a $2,000 annual maximum per ear. • External hearing aids for adults are covered up to a $2,000 maximum per ear every thirty-six (36) months. • 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.*	$30 per office visit to your primary care provider $50 per office visit to a specialist	$30 per office visit to your primary care provider, not subject to deductible $75 per office visit to a specialist, after deductible
Not covered:	*All charges*	*All charges*

Hearing services (testing, treatment, and supplies) - continued on next page

Benefit Description	You pay	
Hearing services (testing, treatment, and supplies) (cont.)	**High Option**	**Standard Option**
• *Hearing services and or supplies that are not shown as covered*	*All charges*	*All charges*
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.	$50 per office visit	$50 per office visit, after deductible
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.	$30 per office visit to your primary care provider $50 per office visit to a specialist	$30 per office visit to your primary care provider, not subject to deductible or $75 per office visit to a specialist, after deductible
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*	*All charges*	*All charges*

Foot care - continued on next page

Benefit Description	You pay	
Foot care (cont.)	**High Option**	**Standard Option**
• *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 • Prosthetic sleeve or sock • 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 • Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy Note: Call us at 800-HIP-TALK (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.	$30 per office visit to your primary care provider or $50 per office visit to a specialist Nothing after $50 deductible for the equipment	$30 per office visit to your primary care provider, not subject to deductible $75 per office visit to a specialist, after deductible 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**
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* • *Prosthetic replacements if the repair or replacement is the result of misuse or abuse by you*	*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 • Audible prescription reading devices • Speech generating devices • Blood glucose monitors • Insulin pumps	Nothing after $50 deductible	Nothing after $100 deductible

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay	
Durable medical equipment (DME) (cont.)	**High Option**	**Standard Option**
Note: Prior approval is required. Call us at 800-HIP-TALK (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 after $50 deductible	Nothing after $100 deductible
Not covered: • *Customized wheelchairs*	*All charges*	*All charges*
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 including for members who are 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. • 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 Note: Investigational and experimental drugs and supplies, as determined by HIP, will not be covered	$30	$30, not subject to deductible

Benefit Description	You pay	
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: High Option coverage does not have a visit limit per calendar year. Standard Option is limited to 40 visits per calendar year. Note: These services require prior approval, see page 18.	Nothing	$75 per visit, after deductible
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.	$50 per office visit $0 per office visit for dependent children to age 26	$75 per office visit, after deductible

Benefit Description	You pay	
Alternative treatments	**High Option**	**Standard Option**
No benefit.	*All charges*	*All charges*
Educational classes and programs	**High Option**	**Standard Option**
Coverage is provided 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. Members are strongly encouraged to enroll in the Tobacco Cessation Program to receive personal coaching that will help them overcome obstacles to stop. To join this program, please call 1- 877-500-2393, Monday through Friday between 8 am and 9 pm, Saturday between 9 am and 7 pm and Sunday between 9 and 5 pm. TTY/TDD users should call 711.	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.	$30 per visit to your primary care provider, not subject to deductible 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 up to a 180 day supply.

Educational classes and programs - continued on next page

Benefit Description	You pay	
Educational classes and programs (cont.)	**High Option**	**Standard Option**
• Diabetes self-management • Multicomponent, family centered programs focused on childhood obesity that are part of intensive behavioral interventions (behavior change counseling for healthy diet and physical activity)	Nothing	$30 per visit, not subject to deductible
Specialty Pharmacy Drugs	**High Option**	**Standard Option**
• Pharmaceutical agents that include injectable and infusion drugs • Specialty Pharmacy Drugs are obtained and administered only by your physician during an approved plan of treatment • 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 Service or financial responsibility to you. See section 5(f) for Specialty Pharmacy Drugs not administered in the doctor's office.	Nothing (included in your primary care provider or specialist office visit, outpatient hospital or ambulatory surgical center copay)	Nothing (included in your primary care provider or specialist office visit, outpatient hospital or ambulatory surgical center copay)

Section 5(b). Surgical and Anesthesia Services Provided by Physicians and Other Healthcare 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.
- High Option - We have a $50 calendar year deductible for Durable Medical Equipment (DME) and a separate brand name prescription drug calendar year deductible of $100 per individual.
- Standard Option - The calendar year deductible is $3,000 per person; $6,000 per Self Plus One and Self and Family enrollment. The separate brand name prescription drug calendar year deductible is $300 per individual. There is a separate Durable Medical Equipment (DME) deductible of $100. We indicate when the calendar year deductible does not apply.
- 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 services listed below are for the charges billed by a physician or other healthcare professional for your surgical care. See Section 5(c) for charges associated with a 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	
Note: The calendar year deductible applies to almost all benefits in this section. We say "not subject to deductible" when it does not apply.		
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 severe 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)	Nothing	Nothing (included in the inpatient hospital admission copay or outpatient copay, after deductible)

Surgical procedures - continued on next page

Benefit Description	You pay	
Surgical procedures (cont.)	**High Option**	**Standard Option**
• 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. Note: These services require prior approval, see page 18.	Nothing	Nothing (included in the inpatient hospital admission copay or outpatient copay, after deductible)
Not covered: • *Reversal of voluntary sterilization* • *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 • 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. • 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.	Nothing	Nothing (included in the inpatient hospital admission copay or outpatient copay, after deductible)

Reconstructive surgery - continued on next page

Benefit Description	You pay	
Reconstructive surgery (cont.)	**High Option**	**Standard Option**
• Surgeries related to gender affirmation when all Plan criteria are met. The following common medically necessary gender affirmation procedures include but are not limited to: - Breast augmentation - Breast reduction mammoplasty - Gender affirming facial surgery - Clitoroplasty - Hysterectomy - Labioplasty - Mastectomy (trial of hormone therapy not pre-requisite) - Metoidioplasty - Oophorectomy - Orchiectomy - Penectomy - Phalloplasty ± - Prostatectomy - Salpingectomy - Scrotoplasty - Testicular/penile prosthesis implantation - Urethroplasty - Vaginectomy - Vaginoplasty ± - Vulvectomy - Vulvoplasty ± Genital electrolysis is not considered a surgical procedure, but is performed in conjunction with genital surgery (i.e., when required for vaginoplasty or phalloplasty) Note: These services require prior approval, see page 18.	Nothing	Nothing (included in the inpatient hospital admission copay or outpatient copay, after deductible)
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.*	*All charges*	*All charges*

Benefit Description	You pay	
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 • Other surgical procedures that do not involve the teeth or their supporting structures.	Nothing $50 per office visit for outpatient procedures	Nothing (included in the inpatient hospital admission copay or outpatient copay, after deductible)
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 covered. Solid organ transplants are limited to: • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Cornea • Heart • Heart/Lung • Intestinal transplants - Isolated small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach and pancreas • Kidney • Kidney-pancreas • Liver • Lung: single/bilateral/lobar • Pancreas Note: These **solid organ transplants** are subject to medical necessity and experimental/ investigational review by the Plan. Refer to Section 3 for prior authorization procedures.	Nothing	Nothing (included in the inpatient hospital admission copay or outpatient copay, after deductible)

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
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 inpatient hospital admission copay or outpatient copay, after deductible)
Blood or marrow stem cell transplants (Hematopoietic stem cell transplants (HSCT or SCT)) - The Plan extends coverage for the diagnoses as indicated below. • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i. e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Advanced neuroblastoma - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Chronic lymphocytic leukemia/ small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Infantile malignant osteopetrosis - Kostmann's syndrome - Leukocyte adhesion deficiencies - Marrow failure and related disorders (i.e., Fanconi's, Paroxysmal Nocturnal Hemoglobinuria, 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	Nothing	Nothing (included in the inpatient hospital admission copay or outpatient copay, after deductible)

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
- 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 - Acute lymphocytic or nonlymphocytic (i. e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPD's) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Breast cancer - Ependymoblastoma - Epithelial ovarian cancer - Ewing's sarcoma - Medulloblastoma - Multiple myeloma - Neuroblastoma - Pineoblastoma - Testicular, Mediastinal, Retroperitoneal, and Ovarian germ cell tumors	Nothing	Nothing (included in the inpatient hospital admission copay or outpatient copay, after deductible)
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 - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) -	Nothing	Nothing (included in the inpatient hospital admission copay or outpatient copay, after deductible)

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
- 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 • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i. e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Neuroblastoma	Nothing	Nothing (included in the inpatient hospital admission copay or outpatient copay, after deductible)
These blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institute of health **approved clinical trial** or a Plan-designed center of excellence 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	Nothing	Nothing (included in the inpatient hospital admission copay or outpatient copay, after deductible)

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
- 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 lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenoue leukemia - Colon cancer - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Myelodysplasia/Myelodysplastic Syndromes - Myeloproliferative disorders (MDDs) - 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 - Aggressive non-Hodgkin lymphomas - Breast cancer - Childhood rhabdomyosarcoma	Nothing	Nothing (included in the inpatient hospital admission copay or outpatient copay, after deductible)

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
- Chronic lymphocytic lymphoma/ small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - 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 Available transplant networks: • National Transplant Program (NTP) - https://www.va.gov/health/services/transplant/ • United Network of Transplant Sharing (UNOS) - https://unos.org/ • Organ Procurement and Transplant Network (OPTN) - https://optn.transplant.hrsa.gov/ Notes: • 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 their companion are reimbursable up to a maximum of $10,000 per transplant episode.	Nothing	Nothing (included in the inpatient hospital admission copay or outpatient copay, after deductible)
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*

Benefit Description	You pay	
Anesthesia	**High Option**	**Standard Option**
Professional services provided in - • Hospital (inpatient)	Nothing	Nothing (included in the inpatient hospital admission copay or outpatient copay, after deductible)
Professional services provided in - • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	$50 per office visit for outpatient procedure	$75 per office visit for outpatient procedure, after deductible

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.
- 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.
- High Option - We have a $50 calendar year deductible for Durable Medical Equipment (DME) and a separate brand name prescription drug calendar year deductible of $100 per individual.
- Standard Option - The calendar year deductible is $3,000 per person; $6,000 per Self Plus One and Self and Family enrollment. The separate brand name prescription drug calendar year deductible is $300 per individual. There is a separate Durable Medical Equipment (DME) deductible of $100. We indicate when the calendar year deductible does not apply.
- 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	
Note: The calendar year deductible applies to almost all benefits in this section. We say "not subject to deductible" when it does not apply.		
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.	$100 per inpatient hospital admission	$250 per inpatient hospital admission, after deductible
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests and X-rays • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen	Nothing	Nothing (included in the inpatient hospital admission copay) $150 per inpatient hospital maternity admission
• Anesthetics, including nurse anesthetist services • Take-home items	Nothing	Nothing (included in the inpatient hospital admission copay)

Inpatient hospital - continued on next page

Benefit Description	You pay	
Inpatient hospital (cont.)	**High Option**	**Standard Option**
• Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home (Note: calendar year deductible applies.) Note: These services require prior approval, see page 18.	Nothing	Nothing (included in the inpatient hospital admission copay)
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as phone, 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 • 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 • Intrauterine insemination (IUI) services • Intravaginal insemination (IVI) services • Intracervical insemination (IVI) services 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, after deductible
• Diagnostic laboratory tests, X-rays, and pathology service Note: These services require prior approval, see page 18.	$150 per visit	$75 per visit, after deductible

Benefit Description	You pay	
Extended care benefits/Skilled nursing care facility benefits	**High Option**	**Standard Option**
Skilled nursing facility (SNF): A comprehensive range of benefits 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. Note: These services require prior approval, see page 18.	Nothing 90 day limit	Nothing 30 day limit
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 member Note: These services require prior approval, see page 18.	Nothing	Nothing
Not covered: • *Independent nursing, homemaker services* • *Services or supplies not shown as covered above* • *Services for respite care* • *Nutritional supplements, non-prescription drugs or substances, vitamins and minerals*	*All charges*	*All charges*
End of life care	**High Option**	**Standard Option**
Acute care provided in an accredited nursing facility or acute care facility that specializes in terminally ill patients, for members diagnosed with advanced cancer with less than sixty (60) days to live. Note: These services require prior approval, see page 18.	Nothing	Nothing
Not covered: • *Services or supplies not related to End of life care.*	*All charges*	*All charges*

Benefit Description	You pay	
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.
- Plan physicians must provide or arrange your care.
- High Option - We have a $50 calendar year deductible for Durable Medical Equipment (DME) and a separate brand name prescription drug calendar year deductible of $100 per individual.
- Standard Option - The calendar year deductible is $3,000 per person; $6,000 per Self Plus One and Self and Family enrollment. The separate brand name prescription drug calendar year deductible is $300 per individual. There is a separate Durable Medical Equipment (DME) deductible of $100. We indicate when the calendar year deductible does not apply.
- 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 Provider. 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 unless it was not reasonably possible to do so. You can call 888-HIP-AUTH (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.

Observation Care: Hospitals provide observation care for patients who are not well enough to go home but not sick enough to be admitted. The hospitalization can include short-term treatment and tests to help doctors decide whether the patient meets the medical criteria for admission. Observation Care is covered as an inpatient benefit, even without formal admission to the hospital. Providers can determine this level of care is required at any point during an Emergency Department visit. However, if a patient is in the Emergency Department for more than 24 hours, the provider should bill as observation care, which would only require the member to be responsible for the inpatient cost share and they would not have an Emergency Department cost share responsibility.

Benefit Description	You pay	
Note: The calendar year deductible applies to almost all benefits in this section. We say "not subject to deductible" when it does not apply.		
Emergency within our service area	**High Option**	**Standard Option**
• Emergency care at a doctor's office	$30 per office visit	$30 per office visit, not subject to deductible
• Emergency care at an urgent care center	$30 per office visit	$75 per office visit, after deductible
• Emergency care as an outpatient at a hospital, including doctors' services Note: We waive the ER copay if you are admitted to the hospital. Note: Observation care lasting more than 24 hours is assessed at the inpatient cost share.	$250 per visit	$250 per visit, after deductible
Not covered: Elective care or non-emergency care	*All charges*	*All charges*
Emergency outside our service area	**High Option**	**Standard Option**
• Emergency care at a doctor's office	$30 per office visit	$30 per office visit, not subject to deductible
• Emergency care at an urgent care center	$30 per office visit	$75 per office visit, after deductible
• 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. Note: Observation care lasting more than 24 hours is assessed at the inpatient cost share.	$250 per visit	$250 per visit, after deductible
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

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.
- High Option - We have a $50 calendar year deductible for Durable Medical Equipment (DME) and a separate brand name prescription drug calendar year deductible of $100 per individual.
- Standard Option - The calendar year deductible is $3,000 per person; $6,000 per Self Plus One and Self and Family enrollment. The separate brand name prescription drug calendar year deductible is $300 per individual. There is a separate Durable Medical Equipment (DME) deductible of $100. We indicate when the calendar year deductible does not apply.
- 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*.
- **YOUR PHYSICIAN MUST GET APPROVAL FOR SOME MENTAL HEALTH AND SUBSTANCE USE DISORDER PROCEDURES.** Benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. To be eligible to receive full benefits, you must follow the preauthorization process and get Plan approval of your treatment plan.
- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.
- OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.

Benefit Description	You pay	
Note: The calendar year deductible applies to almost all benefits in this section. We say "not subject to deductible" when it does not apply.		
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 treatment 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	$30 per office visit $0 per office visit for dependent children to age 26 Nothing for inpatient admission	$30 per office visit, not subject to deductible $250 per inpatient admission, after deductible

Professional Services - continued on next page

Benefit Description	You pay	
Professional Services (cont.)	**High Option**	**Standard Option**
• Treatment and counseling (including individual or group therapy visits) • Diagnosis and treatment of substance use disorders, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy	$30 per office visit $0 per office visit for dependent children to age 26 Nothing for inpatient admission	$30 per office visit, not subject to deductible $250 per inpatient admission, after deductible
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	$30 per office visit $0 per office visit for dependent children to age 26	$30 per office visit to your primary care provider, not subject to deductible or $75 per office visit to a specialist, not subject to deductible
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, residential treatment, general nursing care, meals and special diets, and other hospital services	$100 per inpatient hospital admission	$250 per inpatient hospital admission, after deductible
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	$30 per office visit $0 per office visit for dependent children to age 26	$30 per office visit, not subject to deductible
Autism Spectrum Disorders	**High Option**	**Standard Option**
Inpatient and Outpatient Coverage for the Treatment of Autism Spectrum Disorder. Coverage is provided for Medically Necessary and Appropriate services associated with the screening, diagnosis and treatment of Autism Spectrum Disorder. Treatment of Autism Spectrum Disorder includes the following care and assistive communication devices prescribed or ordered for an individual diagnosed with autism spectrum disorder by a licensed physician or a licensed psychologist: 1. Behavioral Health Treatment;	$30 per office visit $0 per office visit for dependent children to age 26 Nothing for inpatient hospital admission	$30 per office visit, not subject to deductible $250 inpatient hospital admission copay, not subject to deductible

Autism Spectrum Disorders - continued on next page

Benefit Description	You pay	
Autism Spectrum Disorders (cont.)	**High Option**	**Standard Option**
2. Psychiatric Care; 3. Psychological Care; 4. medical care provided by a licensed health care provider; 5. Therapeutic care, including therapeutic care which is deemed habilitative or nonrestorative; and 6. Pharmacy care. **Assistive Communication Devices** **Applied Behavior Analysis**	$30 per office visit $0 per office visit for dependent children to age 26 Nothing for inpatient hospital admission	$30 per office visit, not subject to deductible $250 inpatient hospital admission copay, not subject to deductible

Prior Approval

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

Routine outpatient mental health and substance use disorder services do not require prior authorization. For mental health and substance use disorder services that do require prior authorization, including those identified in Section 3, above, regarding "Other services requiring our Prior Approval," call 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 provider for mental health and substance use 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.
- 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.
- Your prescribers must obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- Federal law prevents the pharmacy from accepting unused medications.
- High Option - There is a separate prescription drug calendar year deductible of $100 per individual.
- Standard Option - The separate brand name prescription drug calendar year deductible is $300 per individual.
- Members must make sure their prescribers obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- 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 dentist, and in states allowing, licensed/certified providers with prescriptive authority prescribing within their scope of practice must prescribe your medication.
- **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 a managed 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 800-HIP-TALK (800-447-8255)
- **These are the dispensing limitations.** A participating pharmacy will provide up to a 30-day supply of your prescription. For High Option, you will pay $25 for generic formulary drugs, or $50 for brand name formulary drugs, or $100 for non-formulary drugs. A $100 brand name only calendar year deductible applies. For Standard Option, you will pay $25 for generic formulary drugs, or $50 for brand name formulary drugs, or $100 for non-formulary drugs. A $300 brand name only calendar year deductible applies.
- 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 800-HIP-TALK (800-447-8255) for details. For further information on using our mail order program, contact Express Scripts Home Delivery Service at 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 FDA 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 800-HIP-TALK (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 medications including those administered during a non-covered admission or in a non-covered facility that by Federal law of the United States require a physician's prescription for their purchase, except those listed as Not covered. • Insulin • Diabetic supplies limited to: • Disposable needles and syringes for the administration of covered medications. • Drugs for sexual dysfunction. • Growth hormone therapy (GHT). • Orally administered IVF related drugs. • Medical foods, which are specifically formulated and prescribed to treat inborn errors of metabolism (IEM) are covered without regard to age, mode of administration (oral vs. nasogastric tube), narrow arbitrary limitations to specific diseases (e.g., PKU), or whether it is the sole source of nutrition for that individual.	For up to a 30-day supply at a participating Retail Pharmacy: **(A $100 brand name only calendar year deductible applies)** $25 for generic formulary drugs; $50 for brand name formulary drugs; or $100 for non-formulary drugs For up to a 30-day supply at a participating Specialty Pharmacy: $200 for generic formulary drugs; $200 for brand formulary drugs; or $200 for non-formulary drugs Up to a 90-day supply by Mail order: $37.50 for generic formulary drugs or $75 for brand name formulary drugs Non-formulary drugs and Specialty Pharmacy 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: **(A $300 brand name only calendar year deductible applies)** $25 for generic formulary drugs; $50 for brand name formulary drugs; or $100 for non-formulary drugs For up to a 30-day supply at a participating Specialty Pharmacy: $200 for generic formulary drugs; $200 for brand formulary drugs; or $200 for non-formulary drugs Up to a 90-day supply by Mail order: $38 for generic formulary drugs or $75 for brand name formulary drugs Non-formulary drugs and Specialty Pharmacy 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.
• Contraceptive drugs and devices as listed in the ACA/HRSA site. Contraceptive coverage is available at no cost to FEHB members. The contraceptive benefit includes at least one option in all methods of contraception (as well as the screening, education, counseling, and follow-up care). Any contraceptive that is not already available without cost sharing on the formulary can be accessed through the contraceptive exceptions process described below.	Nothing	Nothing

Covered medications and supplies - continued on next page

Benefit Description	You pay	
Covered medications and supplies (cont.)	**High Option**	**Standard Option**
• Contraceptive Exception Process - If a contraceptive drug is not on our formulary, You, Your designee or Your prescribing physician may request a formulary exception for a clinically-appropriate contraceptive drug in writing, electronically or telephonically. The request should include a statement from your prescribing physician that all formulary drugs will be or have been ineffective, would not be as effective as the non-formulary drug, or would have adverse effects. • Drugs to treat gender dysphoria such as psychotherapy, cross-sex hormone therapy, puberty suppressing medications and laboratory testing to monitor the safety of hormone therapy. • Reimbursement for over-the-counter contraceptives can be submitted by completing a claim form. Claim forms are available from us by calling 800-HIP-TALK (800-447-8255) or visiting our website at www.emblemhealth.com. Completed forms can be mailed or electronically submitted. See the "Filing a Claim for Covered Services" section of this brochure for information. Note: Over-the counter contraceptive drugs and devices approved by the FDA require a written prescription by an approved provider.	Nothing	Nothing
Preventive Medications	**High Option**	**Standard Option**
The following drugs and supplements are covered without cost-share, even if over the counter, are prescribed by a healthcare professional and filled at a network pharmacy. • Pre-exposure prophylaxis (PrEP) • Aspirin (81 mg) for men age 45-79 and women age 55-79 and women of childbearing age • Folic acid supplements for women of childbearing age (400 & 800 mcg) • Liquid iron supplements for children 6 months to 1 year • Vitamin D supplements (prescription strength) (400 & 1000 units) for members 65 or older • Fluoride tablets, solution (not toothpaste, rinses) for children age 0-6 years. Note: To receive this benefit a prescription from a doctor must be presented to the pharmacy. The following are covered:	Nothing	Nothing

Preventive Medications - continued on next page

Benefit Description	You pay	
Preventive Medications (cont.)	**High Option**	**Standard Option**
• Low to moderate dose Statin for the primary prevention of Cardiovascular Disease (CVD)for adults without a history of (CVD) when all of the following criteria are met: - The member is aged forty (40) to Seventy-five (75) years; - They have one (1) or more CVD risk factors (ie: dyslipidemia, diabetes, hypertension, or smoking); and - They have a calculated ten (10)- year risk of a cardiovascular event of 10% or greater Note: Preventive medications with a USPSTF recommendation of A and B are covered without cost-share when prescribed by a health care professional and filled by a network pharmacy. These may include some over-the-counter vitamins, nicotine replacement medications, and low dose aspirin for certain patients. For current recommendations go to www.uspreventiveservicetaskforce.org/BrowseRec/Index/browse-recommendations	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 not listed as a covered benefit even if a physician prescribes or administers them* • *Nonprescription medications* unless specifically indicated elsewhere Note: Over-the-counter and appropriate prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco Cessation program benefit. (See page 45).	*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 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.
- High Option - There is a separate brand name prescription drug calendar year deductible of $100 per individual.
- Standard Option - The calendar year deductible is $3,000 per person; $6,000 per Self Plus One and Self and Family enrollment. The separate brand name prescription drug calendar year deductible is $300 per individual. We indicate when the calendar year deductible does not apply.
- 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	
Note: The calendar year deductible applies to almost all benefits in this section. We say "not subject to deductible" when it does not apply.		
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	
Note: The calendar year deductible applies to almost all benefits in this section. We say "not subject to deductible" when it does not apply.		
Pediatric Dental	**High Option**	**Standard Option**
Every six months: • One examination (comprehensive or periodic) • One prophylaxis (cleaning) • One topical fluoride Note: This benefit is administered by Healthplex at www.healthplex.com	Nothing (covered for children age 19 and under)	Nothing (covered for children age 19 and under)

Dental Benefits	You Pay	
Adult Dental	**High Option**	**Standard Option**
Every six months: • One examination (comprehensive or periodic) • One prophylaxis (cleaning) Note: This benefit is administered by Healthplex at www.healthplex.com	 $5 per visit $10 per visit	*All Charges*

Section 5(h). Wellness and Other 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 1-877-444-7988 and talk with a registered nurse who will discuss treatment options and answer your health questions.
Services for deaf and hearing impaired	The phone number for the hearing impaired is 888- HIP-4TDD (888-447-4833).
Medical Case Management	We offer case management for members with chronic or catastrophic illness or injuries.
Travel benefit/services overseas	Please contact customer service at: (800) 447-8255
Healthy Futures Program	This member journey begins through all stages of pregnancy and lasts through eight (8) weeks post-delivery. Utilizing enhanced digital outreach and education, we can proactively seek and sign up these members, especially those at high risk, so they can feel empowered as they prepare for pregnancy and know how to access the critical resources to keep themselves - and their baby - stay healthy. Members can be referred to Complex Care Management if additional needs are identified beyond the post-delivery period. This program is also integrated with our Neonatal Intensive Care Unit (NICU) program, managing newborn babies admitted to the NICU. This program provides resources and caregiver support for members and their loved ones in situations where there is a need for long term home care, durable medical equipment, or those who need to be put in an institution after discharge from the acute care setting.

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 800-HIP-TALK (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 are enrolled in Medicare A and B and the High Option. If you have FEHB High Option coverage and enroll in VIP (HMO) Medicare Plan, you receive the following benefits:

- You are entitled to all benefits under the High Option.
- You are entitled to coverage for everything Medicare covers.
- You will have no copays for the following covered services:
  - PCP and specialty care; 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 800-511-4187.

Healthy Discounts - The Healthy Discount programs are available to all Health Insurance Plan (HIP/HMO) members **but are not a covered benefit under Your plan**. We cannot guarantee the continued availability of any discount program or the continued participation of any discount program vendor. For more information, please refer to our website or call the number on the back of your ID card.

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, 888-HIP-4TDD (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 800-HIP-TALK (800-447-8255).

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 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.
- Services or supplies we are prohibited from covering under Federal Law.

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 providers, 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. Providers 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 800-HIP-TALK (800-447-8255), or at our website 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 provider 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 800-HIP-TALK (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 healthcare 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% 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 phone 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 healthcare 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 appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information or to make an inquiry 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 call your plan's customer service representative at the phone number found on your enrollment card, plan brochure, or plan website.

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 800-HIP-TALK (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 healthcare 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 will not take in account the initial decision. The review will not be conducted by the same person, or their subordinate, who made the initial decision.

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.

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: a) Write to us within 6 months from the date of our decision; and b) Send your request to us at: HIP Health Plan of New York, 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.

3

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

You must write to OPM within:

- 90 days after the date of our letter upholding our initial decision; or
- 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or
- 120 days after we asked for additional information.

Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, FEHB 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 healthcare 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.

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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 or notify you of the status of OPM's review 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 file a lawsuit, 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 file a lawsuit 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 800-HIP-TALK (800-447-8255). We will expedite 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 FEHB 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 family member 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 Workers' Compensation Programs if you are receiving Workers' 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 healthcare 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 our website at www.emblemhealth.com.

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 processes the benefit, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance.

- **TRICARE and CHAMPVA**

TRICARE is the healthcare 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 or employing 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**

Every job-related injury or illness should be reported as soon as possible to your supervisor. Injury also means any illness or disease that is caused or aggravated by the employment as well as damage to medical braces, artificial limbs and other prosthetic devices. If you are a federal or postal employee, ask your supervisor to authorize medical treatment by use of form CA-16 before you obtain treatment. If your medical treatment id accepted by the Dept. of Labor Office of Workers' Compensation (OWCP), the provider will be compensated by OWCP. If your treatment is determined not job-related, we will process your benefit according to the terms of this plan, including use of in-network providers. Take form CA-16 and form OWCP-1500/HCFA-1500 to your provider, or send it to your provider as soon as possible after treatment, to avoid complications about whether your treatment is covered by this plan or by OWCP.

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.

- **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 or employing 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

Our right to pursue and receive subrogation and reimbursement recoveries is a condition of, and a limitation on, the nature of benefits or benefit payments and on the provision of benefits under our coverage.

If you have received benefits or benefit payments as a result of an injury or illness and you or your representatives, heirs, administrators, successors, or assignees receive payment from any party that may be liable, a third party's insurance policies, your own insurance policies, or a workers' compensation program or policy, you must reimburse us out of that payment. Our right of reimbursement extends to any payment received by settlement, judgment, or otherwise.

We are entitled to reimbursement to the extent of the benefits we have paid or provided in connection with your injury or illness. However, we will cover the cost of treatment that exceeds the amount of the payment you received.

Reimbursement to us out of the payment shall take first priority (before any of the rights of any other parties are honored) and is not impacted by how the judgment, settlement, or other recovery is characterized, designated, or apportioned. Our right of reimbursement is not subject to reduction based on attorney fees or costs under the "common fund" doctrine and is fully enforceable regardless of whether you are "made whole" or fully compensated for the full amount of damages claimed.

We may, at our option, choose to exercise our right of subrogation and pursue a recovery from any liable party as successor to your rights.

If you do pursue a claim or case related to your injury or illness, you must promptly notify us and cooperate with our reimbursement or subrogation efforts.

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 www.BENEFEDS.com or by phone 877-888-3337 (TTY 877-889-5680), 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.

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.

When you have Medicare

For more detailed information on "What is Medicare?" and "Should I Enroll in Medicare?" please contact Medicare at 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048) or at www.medicare.gov.

- **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 800-HIP-TALK (800-447-8255) or see our website at www.emblemhealth.com.

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

Please review the following examples which illustrates your cost share if you are enrolled in Medicare Part B. Medicare will be primary for all Medicare eligible services. Members must use providers who accept Medicare's assignment.

Benefit Description - Deductible

High Option You Pay **without** Medicare: $0

Standard Option You Pay **without** Medicare: $3,000 per person/ $6,000 per family

High Option You Pay **with** Medicare Part B: $0

Standard Option You Pay **with** Medicare Part B: $3,000 per person/ $6,000 per family

Benefit Description - Catastrophic Protection Out of Pocket Maximum

High Option You Pay **without** Medicare: $6,850 for Self Only/ $13,700 Family

Standard Option You Pay **without** Medicare: $8,550 for Self Only/ $17,100 Family

High Option You Pay **with** Medicare Part B: $6,850 for Self Only/ $13,700 Family

Standard Option You Pay **with** Medicare Part B: $8,550 for Self Only/ $17,100 Family

Benefit Description - Part B Premium Reimbursement Offered

High Option You Pay **without** Medicare: N/A

Standard Option You Pay **without** Medicare: N/A

High Option You Pay **with** Medicare Part B: N/A

Standard Option You Pay **with** Medicare Part B: N/A

Benefit Description - Primary Care Provider

High Option You Pay **without** Medicare:$30 Copay - Adult; $0 Copay - Children to age 26

Standard Option You Pay **without** Medicare: $30 copay, not subject to deductible

High Option You Pay **with** Medicare Part B: $30 Copay - Adult; $0 Copay - Children to age 26

Standard Option You Pay **with** Medicare Part B: $30 copay, not subject to deductible

Benefit Description - Specialist

High Option You Pay **without** Medicare: $50 copay/$0 child copay

Standard Option You Pay **without** Medicare: $75 copay, after deductible

High Option You Pay **with** Medicare Part B: $50 copay/$0 child copay

Standard Option You Pay **with** Medicare Part B: $75 copay, after deductible

Benefit Description - Inpatient Hospital

High Option You Pay **without** Medicare: $100 copay per admission

Standard Option You Pay **without** Medicare: $250 copay per admission, after deductible

High Option You Pay **with** Medicare Part B: $100 copay per admission

Standard Option You Pay **with** Medicare Part B: $250 copay per admission, after deductible

Benefit Description - Outpatient - Hospital

High Option You Pay **without** Medicare: $150 copay per visit

Standard Option You Pay **without** Medicare: $150 copay per visit, after deductible

High Option You Pay **with** Medicare Part B: $150 copay per visit

Standard Option You Pay **with** Medicare Part B: $150 copay per visit, after deductible

Benefit Description - Incentives Offered

High Option You Pay **without** Medicare: N/A

Standard Option You Pay **without** Medicare: N/A

High Option You Pay **with** Medicare Part B: N/A

Standard Option You Pay **with** Medicare Part B: N/A

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 Prime (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 healthcare choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 800-MEDICARE (800-633-4227), (TTY 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 High Option FEHB plan only. In this case, we do waive some cost-sharing for your FEHB coverage.

  This Plan and another plan's Medicare Advantage plan: For High Option only, 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).

  However, 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 or employing 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		✓*
9) Are a Federal employee receiving 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.

Section 10. Definitions of Terms We Use in This Brochure

Assignment

An authorization by you (the enrollee or covered family member) that is approved by us (the Carrier), for us to issue payment of benefits directly to the provider.

- We reserve the right to pay you directly for all covered services. Benefits payable under the contract are not assignable by you to any person without express written approval from us, and in the absence of such approval, any assignment shall be void.
- Your specific written consent for a designated authorized representative to act on your behalf to request reconsideration of a claim decision (or, for an urgent care claim, for a representative to act on your behalf without designation) does not constitute an Assignment.
- OPM's contract with us, based on federal statute and regulation, gives you a right to seek judicial review of OPM's final action on the denial of a health benefits claim but it does not provide you with authority to assign your right to file such a lawsuit to any other person or entity. Any agreement you enter into with another person or entity (such as a provider, or other individual or entity) authorizing that person or entity to bring a lawsuit against OPM, whether or not acting on your behalf, does not constitute an Assignment, is not a valid authorization under this contract, and is void.

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

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 (FDA); or is a drug trial that is exempt from the requirement of an investigational new drug application.

- 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. These costs are generally covered by the clinical trials. This plan does not cover these costs.

Copayment

See Section 4, page 23.

Cost-sharing

See Section 4, page 23.

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

See Section 4, page 23.

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.

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.
Reimbursement	A carrier's pursuit of a recovery if a covered individual has suffered an illness or injury and has received, in connection with that illness or injury, a payment from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, and the terms of the carrier's health benefits plan require the covered individual, as a result of such payment, to reimburse the carrier out of the payment to the extent of the benefits initially paid or provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation
Subrogation	A carrier's pursuit of a recovery from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, as successor to the rights of a covered individual who suffered an illness or injury and has obtained benefits from that carrier's health benefits plan.
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 determine whether or not 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 800-HIP-TALK (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.
Healthcare professional	A physician or other healthcare professional licensed, accredited, or certified to perform specified health services consistent with state law.
Plan Allowance	Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Plans determine their allowances in different ways. You should also see Important Notice About Surprise Billing - Know Your Rights in Section 4 that describes your protection against surprise billing under the No Surprises Act.
Surprise bill	An unexpected bill you receive for: • emergency care - when you have little or no say in the facility or provider from whom you receive care, or for • non-emergency services furnished by nonparticipating providers with respect to patient visits to participating health care facilities, or for • air ambulance services furnished by nonparticipating providers of air ambulance services.

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 - 2024

- **Do not rely on this chart alone.** This is a summary. All benefits are subject to the definitions, limitations, and exclusions in this brochure. Before making a final decision, please read this FEHB brochure. You can also obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at www.emblemhealth.com/federal.
- 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.
- A separate $50 calendar year deductible applies for Durable Medical Equipment (DME) and for orthopedic and prosthetic devices. **The brand name only prescription drug calendar year deductible is $100 per individual.**

High Option Benefits	You pay	Page
Medical services provided by physicians: Diagnostic and treatment services provided in the office	Office visit copay: $30 primary care; $50 specialist; $0 dependent children to age 26	28
Services provided by a hospital: Inpatient	$100 per admission copay	60
Services provided by a hospital: Outpatient	$150 per visit	61
Emergency benefits: In-area	$250 per visit	65
Emergency benefits: Out-of-area	$250 per visit	65
Mental health and substance use disorder treatment:	Regular cost-sharing	66-68
Prescription drugs: Retail pharmacy (up to a 30-day supply)	$25 for generic formulary drugs $50 for brand name formulary drugs $100 for non-formulary drugs $200 for specialty drugs	70
Prescription drugs: Mail order (up to a 90-day supply) *No mail order on non-formulary or specialty drugs*	$37.50 for generic formulary drugs or $75 for brand name formulary drugs	70
Dental care:	Nothing for Pediatric Dental Adult Dental: $5 for one exam; $10 for one prophylaxis (cleaning)	73-74
Vision care:	$50 per visit	43
Special features:	Flexible benefits option, 24-Hour Nurse Advice Line, Services for deaf and hearing impaired, Travel benefit/services overseas, Healthy Futures Program.	75
Protection against catastrophic costs (out-of-pocket maximum)**:**	$6,850 for Self Only $13,700 for Self Plus One and Self and Family	23-24

Summary of Benefits for the Standard Option HIP/HMO - 2024

- **Do not rely on this chart alone.** This is a summary. All benefits are subject to the definitions, limitations, and exclusions in this brochure. Before making a final decision, please read this FEHB brochure. You can also obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at www.emblemhealth.com/federal.
- 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.
- The calendar year deductible is $3,000 per individual, $6,000 per family. A separate $100 calendar year deductible applies to Durable Medical Equipment (DME). **A separate brand name only prescription drug calendar year deductible is $300 per individual.**

Standard Option Benefits	You pay	Page
Medical services provided by physicians: Diagnostic and treatment services provided in the office	Office visit copay: $30 primary care; $75 specialist, after deductible	28
Services provided by a hospital: Inpatient	$250 copay per admission, after deductible	60
Services provided by a hospital: Outpatient	$150 per visit, after deductible	61
Emergency benefits: In-area	$250 per visit, after deductible	65
Emergency benefits: Out-of-area	$250 per visit, after deductible	65
Mental health and substance use disorder treatment:	Regular cost-sharing	66-68
Prescription drugs: Retail pharmacy (up to a 30-day supply)	$25 for generic formulary drugs $50 for brand name formulary drugs $100 for non-formulary drugs $200 for specialty drugs	70
Prescription drugs: Mail order (up to a 90-day supply) *No mail order on non-formulary or specialty drugs*	$38 for generic formulary drugs, or $75 for brand name formulary drugs	70
Dental care:	Nothing for Pediatric Dental (Covered for children age 19 and under) No benefit for Adult Dental	73-74
Vision care:	$50 per office visit, after deductible	43
Special features:	Flexible benefits option, 24-Hour Nurse Advance Line, Services for deaf and hearing impaired, Travel benefit/services overseas, Healthy Futures Program.	75
Protection against catastrophic costs (out-of-pocket maximum):	$8,550 for Self Only $17,100 Self Plus One or Self and Family	23-24

2024 Rate Information for Health Insurance Plan (HIP/HMO)

To compare your FEHB health plan options please go to www.opm.gov/fehbcompare.

To review premium rates for all FEHB health plan options please go to **www.opm.gov/FEHBpremiums** or **www.opm.gov/Tribalpremium**.

Premiums for Tribal employees are shown under the Monthly Premium Rate column. The amount shown under employee pay is the maximum you will pay. Your Tribal employer may choose to contribute a higher portion of your premium. Please contact your Tribal Benefits Officer for exact rates.

Type of Enrollment	Enrollment Code	Premium Rate			
		Biweekly		Monthly	
		Gov't Share	Your Share	Gov't Share	Your Share
New York					
Standard Option Self Only	YL4	$271.43	$233.95	$588.10	$506.89
Standard Option Self Plus One	YL6	$586.50	$336.32	$1,270.75	$728.69
Standard Option Self and Family	YL5	$646.18	$822.94	$1,400.06	$1,783.03
New York					
High Option Self Only	511	$271.43	$264.43	$588.10	$572.93
High Option Self Plus One	513	$586.50	$392.00	$1,270.75	$849.33
High Option Self and Family	512	$646.18	$911.59	$1,400.06	$1,975.11