



HIP[®]
HEALTH PLAN OF NEW YORK

TRACEY, HUGH
1-800-HIP-TALK

HIP VIP

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STANDARDIZED SUMMARY OF BENEFITS

HIP VIP[®] DUAL ELIGIBLE AND
HIP VIP[®] MEDICAID ADVANTAGE
NEW YORK CITY

HIP VIP DUAL ELIGIBLE AND HIP VIP MEDICAID ADVANTAGE PLANS

Introduction to the Summary of Benefits for HIP Health Plan of New York

January 1, 2009 – December 31, 2009

SECTION I - INTRODUCTION TO SUMMARY OF BENEFITS

Thank you for your interest in HIP VIP Dual Eligible and HIP VIP Medicaid Advantage. Our plans are offered by HIP Health Plan of New York, a Medicare Advantage Health Maintenance Organization (HMO) Special Needs Plan. These plans are designed for people who meet specific enrollment criteria.

This includes anyone who receives medical assistance from the state and Medicare.

The **HIP VIP Dual Eligible** plan is available for anyone who receives medical assistance from the State or is in a Medicare Savings Program.

The **HIP VIP Medicaid Advantage** plan is available for anyone who receives full medical assistance from the State.

All cost sharing in this summary of benefits is based on your level of Medicaid eligibility.

Please call HIP to find out if you are eligible to join. Our number is listed at the end of this introduction.

This Summary of Benefits tells you some features of our plans. It doesn't list every service we cover or list every limitation or exclusion. To get a complete list of our benefits, please call HIP and ask for the "Evidence of Coverage."

YOU HAVE CHOICES IN YOUR HEALTH CARE

As a Medicare beneficiary, you can choose from different Medicare options. One option is the Original (fee-for-service) Medicare Plan. Another option is a Medicare health plan, like HIP VIP Dual Eligible and HIP VIP Medicaid Advantage. You may have other options too. You make the choice. No matter what you decide, you are still in the Medicare Program.

If you are eligible for both Medicare and Medicaid (dual eligible) you may join or leave a plan at any time. Please call HIP at the telephone number listed at the end of this introduction or **1-800-MEDICARE (1-800-633-4227)** for more information. TTY users should call **1-877-486-2048**. You can call this number 24 hours a day, 7 days a week.

HOW CAN I COMPARE MY OPTIONS?

You can compare HIP VIP Dual Eligible and HIP VIP Medicaid Advantage and the Original Medicare Plan using this Summary of Benefits. The charts in this booklet list some important health benefits. For each benefit, you can see what our plan covers and what the Original Medicare Plan covers.

Our members receive all of the benefits that the Original Medicare Plan offers. We also offer more benefits, which may change from year to year.

WHERE IS HIP VIP DUAL ELIGIBLE AND HIP VIP MEDICAID ADVANTAGE AVAILABLE?

The service area for this plan includes: Bronx, Brooklyn, Manhattan, Queens and Staten Island. You must live in one of these places to join the plan.

WHO IS ELIGIBLE TO JOIN HIP VIP DUAL ELIGIBLE AND HIP VIP MEDICAID ADVANTAGE?

You can join HIP VIP Dual Eligible and HIP VIP Medicaid Advantage if you are enrolled in Medicare Part A and entitled to Medicare Part B and live in the service area.

You must also either receive assistance from the New York state or be in a Medicare Saving Program to join the **HIP VIP Dual Eligible plan**.

You must also be enrolled in the New York state Medicaid program to join the **HIP VIP Medicaid Advantage**.

Please call the plan to see if you are eligible to join.

CAN I CHOOSE MY DOCTORS?

HIP VIP Dual Eligible and HIP VIP Medicaid Advantage have a network of doctors, specialists, and hospitals. You can only use doctors who are part of our network. The health providers in our network can change at any time. You can ask for a current Provider Directory for an up-to-date list or visit us at www.hipusa.com[®]. Our customer service number is listed at the end of this introduction.

WHAT HAPPENS IF I GO TO A DOCTOR WHO'S NOT IN YOUR NETWORK?

If you choose to go to a doctor outside of our network, you must pay for these services yourself. Neither HIP Health Plan of New York nor the Original Medicare Plan will pay for these services.

DOES MY PLAN COVER MEDICARE PART B OR PART D DRUGS?

HIP VIP Dual Eligible and HIP VIP Medicaid Advantage do cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs.

WHERE CAN I GET MY PRESCRIPTIONS IF I JOIN THIS PLAN?

HIP VIP Dual Eligible and HIP VIP Medicaid Advantage have formed a network of pharmacies. You must use a network pharmacy to receive plan benefits. We may not pay for your prescriptions if you use an out-of-network pharmacy, except in certain cases. The pharmacies in our network can change at any time. You can ask for a current Pharmacy Network List or visit us at www.hipusa.com. Our customer service number is listed at the end of this introduction.

HIP Health Plan of New York has a list of preferred pharmacies. At these pharmacies, you may get your drugs at a lower co-pay or co-insurance. You may go to a non-preferred pharmacy, but you may have to pay more for your prescription drugs.

WHAT IS A PRESCRIPTION DRUG FORMULARY?

HIP VIP Dual Eligible and HIP VIP Medicaid Advantage both use a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, or make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits our members' ability to fill their prescriptions, we will notify the affected enrollees before the change is made. We will send a formulary to you and you can see our complete formulary on our Web site at www.hipusa.com.

If you are currently taking a drug that is not on our formulary or subject to additional requirements or limits, you may be able to get a temporary supply of the drug. You can contact us to request an exception or switch to an alternative drug listed on our formulary with your physician's help. Call us to see if you can get a temporary supply of the drug or for more details about our drug transition policy.

HOW CAN I GET EXTRA HELP WITH PRESCRIPTION DRUG PLAN COSTS?

If you qualify for extra help with your Medicare prescription drug plan costs, your premium and costs at the pharmacy will be lower. When you join HIP VIP Dual Eligible or HIP VIP Medicaid Advantage, Medicare will tell us how much extra help you are getting. Then we will let you know the amount you will pay. If you are not getting this extra help you can see if you qualify by calling **1-800-MEDICARE (1-800-633-4227)**. TTY users should call **1-877-486-2048**. You can call this number 24 hours a day, 7 days a week.

WHAT ARE MY PROTECTIONS IN THIS PLAN?

All Medicare Advantage Plans agree to stay in the program for a full year at a time. Each year, the plans decide whether to continue for another year. Even if a Medicare Advantage Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue, it must send you a letter at least 90 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

As a member of HIP VIP Dual Eligible or HIP VIP Medicaid Advantage, you have the right to request a coverage determination, which includes the right to request an exception, the right to file an appeal if we deny coverage for a prescription drug, and the right to file a grievance. You have the right to request a coverage determination if you want us to cover a Part D drug that you believe should be covered. An exception is a type of coverage determination. You may ask us for an exception if you believe you need a drug that is not on our list of covered drugs or believe you should get a non-preferred drug at a lower out-of-pocket cost. You can also ask for an exception to cost utilization rules, such as a limit on the quantity of a drug. If you think you need an exception, you should contact us before you try to fill your prescription at a pharmacy. Your doctor must provide a statement to support your exception request. If we deny coverage for your prescription drug(s), you have the right to appeal and ask us to review our decision. Finally, you have the right to file a grievance if you have any type of problem with us or one of our network pharmacies that does not involve coverage for a prescription drug.

WHAT IS A MEDICATION THERAPY MANAGEMENT (MTM) PROGRAM?

A Medication Therapy Management (MTM) Program is a free service we may offer. You may be invited to participate in a program designed for your specific health and pharmacy needs. You may decide not to participate but it is recommended that you take full advantage of this covered service if you are selected. Contact HIP for more details.

Please call HIP Health Plan of New York for more information about this plan.

WHAT TYPES OF DRUGS MAY BE COVERED UNDER MEDICARE PART B?

Outpatient prescription drugs that may be covered under Medicare Part B. This may include, but are not

limited to, the following types of drugs. Contact HIP Health Plan of New York for more details.

- **Some Antigens:** If they are prepared by a doctor and administered by a properly instructed person (who could be the patient) under doctor supervision.
- **Osteoporosis Drugs:** Injectable drugs for osteoporosis for certain women with Medicare.
- **Erythropoietin (Epoetin alpha or Epogen®):** By injection if you have end-stage renal disease (permanent kidney failure requiring either dialysis or transplantation) and need this drug to treat anemia.
- **Hemophilia Clotting Factors:** Self-administered clotting factors if you have hemophilia.
- **Injectable Drugs:** Most injectable drugs administered incident to a physician's service.
- **Immunosuppressive Drugs:** Immunosuppressive drug therapy for transplant patients if the transplant was paid for by Medicare, or paid by a private insurance that paid as a primary payer to your Medicare Part A coverage, in a Medicare-certified facility.
- **Some Oral Cancer Drugs:** If the same drug is available in injectable form.
- **Oral Anti-Nausea Drugs:** If you are part of an anti-cancer chemotherapeutic regimen. Inhalation and infusion drugs provided through DME.

Visit us at www.hipusa.com or, call us:

Current members should call (800)-447-8255 for questions related to the Medicare Advantage program. (TTY/TDD (888)-447-4833)

Prospective members should call (800)-447-9169 for questions related to the Medicare Advantage program. (TTY/TDD (888)-447-4833)

Current members should call (800)-447-8255 for questions related to the Medicare Part D Prescription Drug program. (TTY/TDD (888)-447-4833)

Prospective members should call (866) HIP-NYRX ((866) 447-6979) for questions related to the Medicare Part D Prescription Drug program. (TTY/TDD (888)-447-4833)

For more information about Medicare, please call Medicare at 1-800 MEDICARE (1-800-633-4227).

TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week. Or, visit www.medicare.gov on the web.

**HIP VIP DUAL ELIGIBLE &
HIP VIP MEDICAID ADVANTAGE PLAN**

Bronx, Brooklyn, Manhattan,
Queens & Staten Island

Benefit	Original Medicare	HIP Dual Eligible	HIP VIP Medicaid Advantage
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Important Information

<p>1 - Premium and Other Important Information</p>	<p>The Medicare cost sharing amount may vary based on your level of Medicaid eligibility.</p> <p>In 2008 the monthly Part B Premium was \$0 or \$96.40 and will change for 2009 and the yearly Part B deductible amount was \$0 or \$135 and will change for 2009.</p> <p>If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more.</p>	<p>General General.</p> <p>\$0 monthly plan premium in addition to your monthly Medicare Part B premium.*</p>	<p>General \$0 monthly plan premium.*</p> <p>*All cost sharing in this summary of benefits is based on your level of Medicaid eligibility.</p> <p>\$0 yearly deductible.*</p> <p>In-Network \$0 yearly deductible.*</p> <p>Out-of-Network \$0 yearly deductible.*</p> <p>In and Out-of-Network \$0 yearly deductible.*</p>
<p>2 - Doctor and Hospital Choice (For more information, see Emergency - #15 and Urgently Needed Care - #16.)</p>	<p>You may go to any doctor, specialist or hospital that accepts Medicare.</p>	<p>In-Network You must go to network doctors, specialists, and hospitals.</p> <p>Referral required for network hospitals and specialists (for certain benefits).</p>	<p>In-Network You must go to network doctors, specialists, and hospitals.</p> <p>Referral required for network specialists (for certain benefits).</p>
<p>3 - Inpatient Hospital Care (includes Substance Abuse and Rehabilitation Services)</p>	<p>In 2008 the amounts for each benefit period [3] were \$0 or: Days 1 - 60: \$1024 deductible* Days 61 - 90: \$256 per day* Days 91 - 150: \$512 per lifetime reserve day. [4] These amounts will change for 2009.</p>	<p>In-Network \$0 copay.</p> <p>No limit to the number of days covered by the plan each benefit period.</p>	<p>In-Network \$0 yearly deductible.*</p> <p>\$0 copay.*</p> <p>No limit to the number of days covered by the plan each benefit period.</p>

[3] A benefit period begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

[4] Lifetime reserve days can only be used once.

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Important Information

3 - Inpatient Hospital Care (continued)	Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days.	Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.	Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.
4 - Inpatient Mental Health Care	Same deductible and copay as inpatient hospital care (see "Inpatient Hospital Care" above). 190 day lifetime limit in a Psychiatric Hospital.	In-Network \$0 copay. You get up to 190 days in a Psychiatric Hospital in a lifetime. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.	In-Network \$0 yearly deductible.* \$0 copay.* You get unlimited days in a Psychiatric Hospital in a lifetime. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.
5 - Skilled Nursing Facility (in a Medicare-certified skilled nursing facility)	In 2008 the amounts for each benefit period [3] after at least a 3-day covered hospital stay were: Days 1 - 20: \$0 per day* Days 21 - 100: \$0 or \$128 per day* These amounts will change for 2009. 100 days for each benefit period. A "benefit period" starts the day you go into a hospital or SNF. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit	In-Network \$0 copay for SNF services. Plan covers up to 100 days each benefit period. No prior hospital stay is required.	General Authorizaton rules may apply. In-Network \$0 yearly deductible.* \$0 copay for SNF services.* Plan covers up to 100 days each benefit period. No prior hospital stay is required.

[3] A benefit period begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

[4] Lifetime reserve days can only be used once.

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Important Information

5 - Skilled Nursing Facility (continued)	period begins. There is no limit to the number of benefit periods you can have.		
6 - Home Health Care (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)	\$0 copay.	General Authorization rules may apply. In-Network \$0 copay for Medicare-covered home health visits.	General Authorization rules may apply. In-Network \$0 copay for Medicare and Medicaid-covered home health visits. \$0 copay for Medicaid covered home care services
7 - Hospice	You pay part of the cost for outpatient drugs and you may pay part of the cost for inpatient respite care. You must get care from a Medicare-certified hospice.	General You must get care from a Medicare-certified hospice.	General You must get care from a Medicare-certified hospice.

Outpatient Care

8 - Doctor Office Visits	0% or 20% coinsurance [1] [2]	General See "Physical Exams," for more information. In-Network \$0 copay for each primary care doctor visit for Medicare-covered benefits. \$0 copay for each specialist doctor visit for Medicare-covered benefits.	General See "Physical Exams," for more information. In-Network \$0 copay for each primary care doctor visit for Medicare-covered benefits.* \$0 copay for the cost of each in-area, network urgent care Medicare-covered visit.* \$0 copay for each specialist doctor visit for Medicare-covered benefits.*
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(1) Each year, you pay a total of one \$135 deductible. This amount will change in 2009.

(2) If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.

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Outpatient Care

9 - Chiropractic Services	Routine care not covered. 0% or 20% coinsurance for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers. [1] [2]	In-Network \$0 copay for Medicare-covered visits. Medicare-covered chiropractic visits are for manual manipulation of the spine to correct a displacement or misalignment of a joint or body part.	In-Network \$0 copay for Medicare-covered visits.* Medicare-covered chiropractic visits are for manual manipulation of the spine to correct a displacement or misalignment of a joint or body part.
10 - Podiatry Services	Routine care not covered. 0% or 20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs. [1] [2]	In-Network \$0 copay for Medicare-covered visits. \$0 copay for up to 4 routine visit(s) every year. Medicare-covered podiatry benefits are for medically-necessary foot care.	In-Network \$0 copay for Medicare-covered podiatry benefits.* \$0 copay for up to 4 routine visit(s) every year. Medicare-covered podiatry benefits are for medically-necessary foot care.
11 - Outpatient Mental Health Care	0% or 50% coinsurance for most outpatient mental health services. [1] [2]	In-Network \$0 copay for Medicare-covered Mental Health visits.	In-Network \$0 copay for Medicare-covered Mental Health visits.* \$0 copay for each Medicare-covered visit with a psychiatrist.*
12 - Outpatient Substance Abuse Care	0% or 20% coinsurance	In-Network \$0 copay for Medicare-covered visits.	In-Network \$0 copay for Medicare-covered visits.*

(1) Each year, you pay a total of one \$135 deductible. This amount will change in 2009.

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Outpatient Care

<p>13 - Outpatient Services/Surgery</p>	<p>0% or 20% coinsurance for the doctor. [1] [2]</p> <p>0% or 20% of outpatient facility charges. [1] [2]</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for each Medicare-covered ambulatory surgical center visit.</p> <p>\$0 copay for each Medicare-covered outpatient hospital facility visit.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for each Medicare-covered ambulatory surgical center visit.*</p> <p>\$0 copay for each Medicare-covered outpatient hospital facility visit.*</p>
<p>14 - Ambulance Services (medically necessary ambulance services)</p>	<p>0% or 20% coinsurance. [1] [2]</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered ambulance benefits.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered ambulance benefits.*</p>
<p>15 - Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.)</p>	<p>0% or 20% coinsurance for the doctor. [1] [2]</p> <p>0% or 20% of facility charge. [1] [2]</p> <p>You don't have to pay the emergency room copay if you are admitted to the hospital for the same condition within 3 days of the emergency room visit.</p> <p>NOT covered outside the U.S. except under limited circumstances.</p>	<p>In-Network \$0 copay for Medicare-covered emergency room visits.</p> <p>Out-of-Network Worldwide coverage.</p>	<p>In-Network \$0 copay for Medicare-covered emergency room visits.*</p> <p>Out-of-Network Worldwide coverage.</p> <p>In and Out-of-Network If you are admitted to the hospital within 24-hour(s) for the same condition, you pay \$0 for the emergency room visit.</p>

(1) Each year, you pay a total of one \$135 deductible. This amount will change in 2009.

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Outpatient Care

<p>16 - Urgently Needed Care (This is NOT emergency care, and in most cases, is out of the service area.)</p>	<p>0% or 20% coinsurance. [1] [2] NOT covered outside the U.S. except under limited circumstances.</p>	<p>General \$0 copay for Medicare-covered urgent-care visits.</p>	<p>General \$0 copay for Medicare-covered urgent-care visits.*</p>
<p>17 - Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy)</p>	<p>0% or 20% coinsurance. [1] [2]</p>	<p>General Authorization rules may apply. In-Network \$0 copay for Medicare-covered Occupational Therapy visits. \$0 copay for Medicare-covered Physical and/or Speech/Language Therapy visits.</p>	<p>General Authorization rules may apply. In-Network \$0 copay for Medicare-covered Occupational Therapy visits.* \$0 copay for Medicare-covered Physical and/or Speech/Language Therapy visits.*</p>

Outpatient Medical Services and Supplies

<p>18 - Durable Medical Equipment (includes wheelchairs, oxygen, etc.)</p>	<p>0% or 20% coinsurance. [1] [2]</p>	<p>General Authorization rules may apply. In-Network \$0 copay for Medicare-covered items.</p>	<p>General Authorization rules may apply. In-Network \$0 copay for Medicare and Medicaid-covered items.*</p>
<p>19 - Prosthetic Devices (includes braces, artificial limbs and eyes, etc.)</p>	<p>0% or 20% coinsurance. [1] [2]</p>	<p>General Authorization rules may apply. In-Network \$0 copay for Medicare-covered items.</p>	<p>General Authorization rules may apply. In-Network \$0 copay for Medicare and Medicaid-covered items.*</p>

(1) Each year, you pay a total of one \$135 deductible. This amount will change in 2009.

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Outpatient Medical Services and Supplies

<p>20 - Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies</p> <p>(includes coverage for glucose monitors, test strips, lancets, screening tests, and self-management training)</p>	<p>0% or 20% coinsurance. [1] [2]</p> <p>Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Diabetes self-monitoring training.</p> <p>\$0 copay for Nutrition Therapy for Diabetes.</p> <p>\$0 copay for Diabetes supplies.</p>	<p>In-Network \$0 copay for Diabetes self-monitoring training.*</p> <p>\$0 copay for Nutrition Therapy for Diabetes.*</p> <p>\$0 copay for Diabetes supplies.*</p>
<p>21 - Diagnostic Tests, X-Rays, and Lab Services</p>	<p>0% or 20% coinsurance for diagnostic tests and x-rays. [1] [2]</p> <p>\$0 copay for Medicare-covered lab services.</p> <p>Lab Services: Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory that participates in Medicare. Diagnostic lab services are done to help your doctor diagnose or rule out a</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered:</p> <ul style="list-style-type: none"> - lab services - diagnostic procedures and tests - X-rays. - diagnostic radiology services (not including X-rays) - therapeutic radiology services 	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered:</p> <ul style="list-style-type: none"> - lab services* - diagnostic procedures and tests* - X-rays.* - diagnostic radiology services (not including X-rays)* - therapeutic radiology services*

(1) Each year, you pay a total of one \$135 deductible. This amount will change in 2009.

(2) If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.

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Important Information

21 - Diagnostic Tests, X-Rays, and Lab Services (continued)	suspected illness or condition. Medicare does not cover most routine screening tests, like checking your cholesterol.		
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Preventive Services

22 - Bone Mass Measurement (for people with Medicare who are at risk)	0% or 20% coinsurance. [1] [2] Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions.	In-Network \$0 copay for Medicare-covered bone mass measurement.	In-Network \$0 copay for Medicare-covered bone mass measurement.*
23 - Colorectal Screening Exams (for people with Medicare age 50 and older)	0% or 20% coinsurance. [1] [2] Covered when you are high risk or when you are age 50 and older.	In-Network \$0 copay for Medicare-covered colorectal screenings.	In-Network \$0 copay for Medicare-covered colorectal screenings.*
24 - Immunizations (Flu vaccine, Hepatitis B vaccine - for people with Medicare who are at risk, Pneumonia vaccine)	\$0 copay for Flu and Pneumonia vaccines. 0% or 20% coinsurance for Hepatitis B vaccine. [1] [2] You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information.	In-Network \$0 copay for Flu and Pneumonia vaccines. \$0 copay for Hepatitis B vaccine. No referral needed for Flu and pneumonia vaccines.	In-Network \$0 copay for Flu and Pneumonia vaccines. \$0 copay for Hepatitis B vaccine.* No referral needed for Flu and pneumonia vaccines.

(1) Each year, you pay a total of one \$135 deductible. This amount will change in 2009.

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Important Information

Preventive Services

<p>25 - Mammograms (Annual Screening) (for women with Medicare age 40 and older)</p>	<p>0% or 20% coinsurance. [1] [2] No referral needed. Covered once a year for all women with Medicare age 40 and older. One baseline mammogram covered for women with Medicare between age 35 and 39.</p>	<p>In-Network \$0 copay for Medicare-covered screening mammograms.</p>	<p>In-Network \$0 copay for Medicare-covered screening mammograms.*</p>
<p>26 - Pap Smears and Pelvic Exams (for women with Medicare)</p>	<p>\$0 copay for Pap smears. [1] [2] Covered once every 2 years. Covered once a year for women with Medicare at high risk. 0% or 20% coinsurance for Pelvic Exams. [2]</p>	<p>In-Network \$0 copay for Medicare-covered pap smears and pelvic exams.</p>	<p>In-Network \$0 copay for Medicare-covered pap smears and pelvic exams.*</p>
<p>27 - Prostate Cancer Screening Exams (for men with Medicare age 50 and older)</p>	<p>0% or 20% coinsurance for the digital rectal exam. \$0 for the PSA test; 0% or 20% coinsurance for other related services. [1] [2] Covered once a year for all men with Medicare over age 50.</p>	<p>In-Network \$0 copay for Medicare-covered prostate cancer screening.</p>	<p>In-Network \$0 copay for Medicare-covered prostate cancer screening.*</p>

(1) Each year, you pay a total of one \$135 deductible. This amount will change in 2009.

(2) If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.

* All cost sharing in this summary of benefits is based on your level of medicaid eligibility.

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Preventive Services

<p>28 - End-Stage Renal Disease</p>	<p>0% or 20% coinsurance for renal dialysis.</p> <p>0% or 20% coinsurance for Nutrition Therapy for End-Stage Renal Disease.</p> <p>Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.</p>	<p>In-Network \$0 copay for renal dialysis.*</p> <p>\$0 copay for Nutrition Therapy for End-Stage Renal Disease.*</p>	<p>In-Network \$0 copay for renal dialysis.*</p> <p>\$0 copay for Nutrition Therapy for End-Stage Renal Disease.*</p>
<p>29 - Prescription Drugs</p>	<p>Most drugs are not covered under Original Medicare. You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan, or you can get all your Medicare coverage, including prescription drug coverage, by joining a Medicare Advantage Plan or a Medicare Cost Plan that offers prescription drug coverage.</p>	<p>Drugs covered under Medicare Part B General \$0 yearly deductible for Part B-covered drugs.*</p> <p>\$0 copay for Part B-covered drugs (not including Part B-covered chemotherapy drugs).*</p> <p>\$0 copay for Part B-covered chemotherapy drugs.*</p>	<p>Drugs covered under Medicare Part B General \$0 yearly deductible for Part B-covered drugs.*</p> <p>\$0 copay for Part B-covered drugs (not including Part B-covered chemotherapy drugs).*</p> <p>\$0 copay for Part B-covered chemotherapy drugs.*</p>

* All cost sharing in this summary of benefits is based on your level of medicaid eligibility.

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Important Information

Preventive Services

<p>29 - Prescription Drugs (continued)</p>		<p>Drugs covered under Medicare Part D General This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at hipusa.com on the web.</p> <p>Different out-of-pocket costs may apply for people who</p> <ul style="list-style-type: none"> -have limited incomes, -live in long term care facilities, or -have access to Indian/Tribal/Urban (Indian Health Service). <p>The plan offers national in-network prescription coverage (i.e., this would include 50 states and DC). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel).</p> <p>Total yearly drug costs are the total drug costs paid by you, the plan, and Medicare.</p> <p>The plan may require you to first try one drug to treat your</p>	<p>Drugs covered under Medicare Part D General This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at hipusa.com on the web.</p> <p>Different out-of-pocket costs may apply for people who</p> <ul style="list-style-type: none"> -have limited incomes, -live in long term care facilities, or -have access to Indian/Tribal/Urban (Indian Health Service). <p>The plan offers national in-network prescription coverage (i.e., this would include 50 states and DC). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel).</p> <p>Total yearly drug costs are the total drug costs paid by you, the plan, and Medicare.</p> <p>The plan may require you to first try one drug to treat your</p>
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Preventive Services

<p>29 - Prescription Drugs (continued)</p>		<p>condition before it will cover another drug for that condition.</p> <p>Some drugs have quantity limits.</p> <p>Your provider must get prior authorization from HIP VIP Dual Eligible for certain drugs.</p> <p>You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements for these drugs that cannot be met by most pharmacies in your network. These drugs are listed on the plans website, formulary, and printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov.</p> <p>If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.</p> <p>In-Network You pay a \$0 yearly deductible.</p>	<p>condition before it will cover another drug for that condition.</p> <p>Some drugs have quantity limits.</p> <p>Your provider must get prior authorization from HIP VIP Medicaid Advantage for certain drugs.</p> <p>You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements for these drugs that cannot be met by most pharmacies in your network. These drugs are listed on the plans website, formulary, and printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov.</p> <p>If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.</p> <p>In-Network You pay a \$0 yearly deductible.</p>
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Preventive Services

<p>29 - Prescription Drugs (continued)</p>		<p>Initial Coverage Depending on your income and institutional status, you pay the following:</p> <p>For generic drugs (including brand drugs treated as generic), either:</p> <ul style="list-style-type: none"> - A \$0 copay or - A \$1.10 copay or - A \$2.40 copay <p>For all other drugs, either:</p> <ul style="list-style-type: none"> - A \$0 copay or - A \$3.20 copay or - A \$6.00 copay. <p>Catastrophic Coverage After your yearly out-of-pocket drug costs reach \$4,350, you pay a \$0 copay.</p> <p>Out-of-Network Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge</p>	<p>Initial Coverage Depending on your income and institutional status, you pay the following:</p> <p>For generic drugs (including brand drugs treated as generic), either:</p> <ul style="list-style-type: none"> - A \$0 copay or - A \$1.10 copay or - A \$2.40 copay <p>For all other drugs, either:</p> <ul style="list-style-type: none"> - A \$0 copay or - A \$3.20 copay or - A \$6.00 copay. <p>Catastrophic Coverage After your yearly out-of-pocket drug costs reach \$4,350, you pay a \$0 copay.</p> <p>Out-of-Network Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge</p>
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Preventive Services

<p>29 - Prescription Drugs (continued)</p>		<p>for the drug and submit documentation to receive reimbursement from HIP VIP Dual Eligible.</p> <p>Out-of-Network Initial Coverage Depending on your income and institutional status, you will be reimbursed by HIP VIP Dual Eligible up to the full cost of the drug minus the following:</p> <p>For generic drugs purchased out-of-network (including brand drugs treated as generic), either:</p> <ul style="list-style-type: none"> - A \$0 copay or - A \$1.10 copay or - A \$2.40 copay <p>For all other drugs purchased out-of-network, either:</p> <ul style="list-style-type: none"> - A \$0 copay or - A \$3.20 copay or - A \$6.00 copay. <p>Out-of-Network Catastrophic Coverage After your yearly out-of-pocket drug costs reach \$4,350, you will be reimbursed in full for drugs purchased out-of-network.</p>	<p>for the drug and submit documentation to receive reimbursement from HIP VIP Medicaid Advantage.</p> <p>Out-of-Network Initial Coverage Depending on your income and institutional status, you will be reimbursed by HIP VIP Medicaid Advantage up to the full cost of the drug minus the following:</p> <p>For generic drugs purchased out-of-network (including brand drugs treated as generic), either:</p> <ul style="list-style-type: none"> - A \$0 copay or - A \$1.10 copay or - A \$2.40 copay <p>For all other drugs purchased out-of-network, either:</p> <ul style="list-style-type: none"> - A \$0 copay or - A \$3.20 copay or - A \$6.00 copay. <p>Out-of-Network Catastrophic Coverage After your yearly out-of-pocket drug costs reach \$4,350, you will be reimbursed in full for drugs purchased out-of-network.</p> <p>\$250 benefit per year for select over the counter medications.</p>
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Preventive Services

<p>30 - Dental Services</p>	<p>Preventive dental services (such as cleaning) not covered.</p>	<p>In-Network - \$5 copay for up to 2 oral exam(s) every year - \$10 copay for up to 2 cleaning(s) every year - \$19 to \$23 for up to 2 fluoride treatment(s) every year</p>	<p>In-Network \$0 copay for Medicare and Medicaid-covered dental benefits.*</p>
<p>31 - Hearing Services</p>	<p>Routine hearing exams and hearing aids not covered. 0% or 20% coinsurance for diagnostic hearing exams. [1] [2]</p>	<p>General Authorization rules may apply. In-Network In general, routine hearing exams and hearing aids not covered. \$0 copay for Medicare-covered diagnostic hearing exams.</p>	<p>General Authorization rules may apply. In-Network \$0 copay for Medicare-covered diagnostic hearing exams.* \$0 copay for: - routine hearing tests - fitting-evaluations for a hearing aid \$0 copay for hearing aids. \$0 copay for Medicaid hearing services.</p>
<p>32 - Vision Services</p>	<p>0% or 20% coinsurance for diagnosis and treatment of diseases and conditions of the eye. [1] [2] Routine eye exams and glasses not covered. Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery. [1] [2]</p>	<p>In-Network \$0 copay for diagnosis and treatment for diseases and conditions of the eye. \$0 copay for: - one pair of eyeglasses or contact lenses after cataract surgery - up to 1 pair(s) of glasses every year</p>	<p>In-Network \$0 copay for Medicare-covered and Medicaid-covered benefits. \$0 copay for diagnosis and treatment for diseases and conditions of the eye.* - and up to 1 routine eye exam(s) every two years</p>

(1) Each year, you pay a total of one \$135 deductible. This amount will change in 2009.

(2) If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.

* All cost sharing in this summary of benefits is based on your level of Medicaid eligibility.

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Preventive Services

32 - Vision Services (continued)	Annual glaucoma screenings covered for people at risk. [1] [2]	- up to 1 pair(s) of lenses every year - up to 1 frame(s) every year \$150 limit for eye wear every year.	\$0 copay for: - up to 1 pair of glasses every two years - up to 1 pair of contacts every two years
33 - Physical Exams	0% or 20% coinsurance for one exam within the first 6 months of your new Medicare Part B coverage. When you get Medicare Part B, you can get a one time physical exam within the first 6 months of your new Part B coverage. The coverage does not include lab tests.	In-Network \$0 copay for routine exams. Limited to 1 exam(s) every year.	In-Network \$0 copay for routine exams. Limited to 1 exam(s) every year. \$0 copay for Medicare-covered benefits.*
34 - Health/Wellness Education	Smoking Cessation: Covered if ordered by your doctor. Includes two counseling attempts within a 12-month period if you are diagnosed with a smoking-related illness or are taking medicine that may be affected by tobacco. Each counseling attempt includes up to four face-to-face visits. You pay coinsurance, and Part B deductible applies.	In-Network This plan covers the following health/wellness education benefits: - Written health education materials, including Newsletters - Nutritional Training - Nursing Hotline - Other Wellness Benefits	In-Network This plan covers the following health/wellness education benefits: - Written health education materials, including Newsletters - Nutritional Training - Nursing Hotline - Other Wellness Benefits

(1) Each year, you pay a total of one \$135 deductible. This amount will change in 2009.

(2) If a doctor or supplier chooses not to accept assignment, their costs are often higher, which means you may pay more.

* All cost sharing in this summary of benefits is based on your level of medicaid eligibility.

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35 - Transportation (Routine)	Not covered.	In-Network This plan does not cover routine transportation.	In-Network This plan covers routine transportation.
36 - Acupuncture	Not covered.	In-Network This plan does not cover Acupuncture.	In-Network This plan does not cover Acupuncture.
37 - Private Duty Nursing	Not covered.	Not covered.	\$0 copay for medically necessary private duty nursing.

HIP VIP DUAL ELIGIBLE AND HIP VIP MEDICAID ADVANTAGE

We understand that getting a grasp on your coverage can be confusing. That's why we've produced this Special Features section to simplify things. It covers many of the benefits that are specific to our HIP VIP Dual Eligible and HIP VIP Medicaid Advantage plans that were only referenced in the prior section of the Standardized Summary of Benefits charts. Now let's get started.



Specialized Benefits for Your Needs

- \$0 plan premiums for Original Medicare benefits and more.
- \$0 copay for primary care physician (PCP) and specialist office visits.

Save Even More: Medicare Savings Program

If your monthly income is less than \$1,190 (\$1,595 combined if married), you could be eligible for additional benefits from New York State through the State Medical Assistance Program. This may even include receiving more money in your Social Security checks. To learn more and see if you may be eligible, call **1-888-205-6038** Monday to Friday, 9 am - 5 pm (TDD: **1-888-HIP-4833**).

[Note: Referenced income values are for 2008 and may change.]

Prescription Drug Benefits - Coverage When You Need It

As a member of HIP VIP Dual Eligible and HIP VIP Medicaid Advantage, you are automatically enrolled in Medicare Part D. Because of your eligibility for Medicaid and Medicare, you should receive extra help in paying for your prescription drug coverage. This means that you will receive help in paying for your monthly Medicare Part D premium, yearly deductible, and prescription drug copayments, as applicable.

The HIP Formulary is organized into four Tiers of coverage:

Tier 1	Preferred Generic formulary medications
Tier 2	Preferred Brand formulary medications
Tier 3	Non-preferred Brand/Generic formulary medications
Tier 4	Specialty formulary medications

Based on a determination by the Social Security Administration (SSA), you may be eligible for additional Part D Savings through the Low Income Subsidy (LIS). In this plan, depending on your eligibility level for extra help, you may pay up to a \$60 yearly deductible and some small copayments or coinsurances when you fill your prescriptions at a participating pharmacy. After your yearly out-of-pocket drug costs reach \$4,350 (both paid by you or others on your behalf, including any extra help you received from Medicare), you will pay either nothing, or small copayments when you fill your prescriptions.

Your LIS category will entitle you to one of following:

Prescription Drug Costs by LIS Category:

LIS Category	Out-of-pocket costs through the coverage gap Generic/Brand	Catastrophic Level Drug Copay Generic/Brand
Category 0	Not eligible for low income subsidy; amounts listed in benefit summary.	The greater of \$2.40/\$6.00 or 5%
Category 1	\$2.40/\$6.00	\$0
Category 2	\$1.10/\$3.20	\$0
Category 3	\$0 (institutional)	\$0
Category 4	\$60 deductible/15%	\$2.40/\$6.00

Read the “Prescription Drugs” section in your Summary of Benefits for an outline of what your plan covers. Your Evidence of Coverage will contain full details on any limitations and exclusions related to your prescription drug coverage plan.

The HIP Drug Formulary

The HIP Drug Formulary is a list of both brand name and generic drugs covered by HIP. Drugs that are not on the HIP formulary are not covered. Members who use Tier 1 prescription drugs offer the best value and lowest cost available under the plan.

HIP Health Plan of New York is dedicated to providing you with treatment that is safe and effective, at the most reasonable and affordable cost. Treatment with generic medications is one way that you can save money at the pharmacy and continue to maintain your health.

The United States Food and Drug Administration (FDA) requires that generic medications stocked in a pharmacy contain the same active ingredient as the brand version. For example, the generic version (such as simvastatin) must meet the same quality standards as the equivalent brand medication (such as Zocor). The HIP Drug Formulary only includes generic drugs that have met the highest FDA standards.

To view the HIP Medicare Formulary, visit the HIP Medicare plans and Part D information section of our Web site, www.hipusa.com or call HIP Customer Service.

Filling Your Prescriptions

You can choose from three easy ways to fill your prescriptions:

- **Online at www.hipusa.com.** Order online through our partner, a leading Internet pharmacy service staffed by licensed pharmacists, and save up to 33% on applicable copays for Preferred formulary drugs.
- **At HIP Participating Pharmacies.** With a network of over 36,000 nationwide chains, local and independent pharmacies, there is sure to be a HIP participating pharmacy near you. For a list of participating pharmacies, visit www.hipusa.com or call HIP Customer Service.
- **By Mail.** Just like filling your prescriptions online, you can save up to 33% on applicable copays for Preferred formulary drugs. For a HIP Mail Order Pharmacy Program application, please call HIP Customer Service and listen to prompts for the “Forms and Literature” menu.

Urgent Care

For those instances when you require immediate medical attention because of minor injuries and illnesses, and your primary care physician is unavailable, HIP has you covered. You can visit one of HIP's participating urgent care centers without an appointment. To find a HIP urgent care center near you in Queens, Brooklyn, Staten Island, Nassau or Suffolk Counties, please call **1-877-HIP-2911 (1-877-447-2911)**, anytime, day or night or visit the My Health section on our Web site at www.hipusa.com.

Emergency Care

No matter how careful you are, emergencies sometimes happen. If you need emergency care, you should go to the emergency room

Chiropractic Benefit

If you need to use chiropractic services, you do not need a referral for an initial consultation with a HIP participating chiropractor. HIP's chiropractic benefits are provided by Prism Network, Inc. For a list of HIP participating chiropractic providers, call HIP Customer Service or call Prism directly at **1-877-PRISM-93 (1-877-774-7693)**.

Your Personal Health Advocate

HIP understands that navigating your way through health care administrative issues can be complicated. That's why we offer you this benefit to assist all HIP Medicare Plan members at no additional cost – your Personal Health Advocate. Health Advocates are available 24 hours a day, 7 days a week at **1-866-407-9212** to help you better understand your benefits and access services. Your Personal Health Advocate can help you with a variety of issues, such as:

- Understanding your benefits
- Identifying healthcare providers and hospitals
- Scheduling appointments
- Resolving complex benefits and claims issues
- Locating community services

ADDITIONAL BENEFITS TO HIP VIP DUAL ELIGIBLE MEMBERS

Over-The-Counter Medications

In the HIP VIP Dual Eligible Plans you receive a \$500 benefit for over-the-counter medications exclusively for cough and cold, proton pump inhibitors, analgesics and antacid medications.

Inpatient Private Duty Nursing and Transitional Home Care

In the HIP VIP Dual Eligible Plan, you are entitled to additional services for inpatient private duty nursing and for transitional Home Care Services, as long as these services are medically necessary and ordered by a participating HIP provider. After the first 72 hours of hospitalization, you may receive up to 504 hours of Inpatient Private Duty Nursing care per benefit period when the care is ordered by your attending physician. Once you are discharged from the Hospital, you may receive Home Health Aid and personal care services (ADL'S) performed by a home health aide for up to 30 days following discharge from an approved hospital.

Dental Benefits

HIP will help you keep your healthy smile through our arrangement with Careington International, a leading national dental provider network. Both general and specialist dental services may be self-referred, referred by a participating dentist, or arranged through Careington International. You must use participating dentists for all care under this benefit. All fees must be paid to the participating dentist.



In-Network

Copay	Treatment
\$5	2 oral exam(s) per year
\$10	2 cleaning(s) per year
\$19-\$23	2 fluoride treatment(s) per year

To request a Careington dental provider directory, please call Careington International at **1-800-290-0523** or **1-877-LIV4HIP (1-877-548-4447)**, Monday to Friday, 8 am - 6:30 pm; or call HIP Customer Service and listen to the prompts for the “Forms and Literature” menu.

ADDITIONAL BENEFITS TO HIP VIP MEDICAID ADVANTAGE MEMBERS

Through an arrangement with the New York State Department of Health, HIP VIP Medicaid Advantage covers additional Medicaid health care benefits and services to meet your needs:

Over-The-Counter Medications

In the HIP VIP Medicaid Advantage Plan you receive a \$250 benefit for over-the-counter medications exclusively for cough and cold, proton pump inhibitors, analgesics and antacid medications.

Durable Medical Equipment & Prosthetic Devices and Medical Supplies

There is no homebound prerequisite, coinsurance or copayment for custom Medicare-covered Durable Medical Equipment, including devices and equipment other than medical/surgical supplies, enteral formula, and Prosthetic Devices. Your benefit also includes Medicaid covered DME items (e.g., tub stool, grab bar) not covered by Medicare. To receive this benefit you must see a HIP participating provider for covered items.

Hearing Benefit

HIP VIP Medicaid Advantage benefits include medically necessary Medicaid hearing services and products not covered by Medicare. There are no copays or limitations. To receive this benefit you must use HIP participating providers.

Vision Benefit

In addition to the vision coverage you are entitled to after cataract surgery under Medicare, your Medicaid Advantage benefit includes Medicaid vision services and products not covered by Medicare. There are no copays or limitations. To receive this benefit you must see a HIP participating provider.

The HIP Optical Program provides a selection of fully covered frames and is available through HIP participating providers. You will find safety, oversize, single-vision, bifocal and trifocal glasses. You will also find glass and plastic lenses. Your HIP coverage includes tinted lenses, contact lenses and prescription sunglasses when medically necessary. Progressive lenses are not covered.

You can choose upgraded frames or lenses, or both, and deduct \$150 from the total cost. (For example, HIP covers standard bifocal eyeglasses. However, if you select upgraded frames valued at \$200, you will pay \$200 minus \$150, or \$50.)



Inpatient Mental Health

With the HIP VIP Medicaid Advantage plan, you are covered for inpatient days in excess of the Medicare 190-day lifetime maximum.

Home Health

You are provided with coverage for non-Medicare covered home health services, including home health aid services and nursing supervision to medically unstable individuals.

Dental Benefit

Dental coverage includes Medicaid covered dental services, to alleviate a serious health condition, such as necessary preventive, prophylactic and other routine dental care, services and supplies and dental prosthetics. Ambulatory or inpatient surgical dental services are subject to prior authorization.

Private Duty Nursing

In HIP VIP Medicaid Advantage, you are entitled to private duty nursing services when medically necessary and ordered by a participating HIP provider.

Routine Transportation

HIP covers public transportation needed to obtain necessary medical care and services. HIP also covers ambulette, invalid coach, taxicab, livery, transportation and a transportation attendant, when medically necessary.

RESOURCES

www.hipusa.com

Our Web site, www.hipusa.com, is available in English, Spanish, Chinese and Korean, 24 hours a day, 365 days a year. You will find all of the following tools on our Web site:

- The most up-to-date listings of participating physicians and pharmacies.
- A snapshot of benefits available through HIP VIP Medicaid Advantage and other Medicare plans offered through HIP.
- Information on the prescription drug coverage and our Internet Order prescription drug program.
- Easy-to-use medical forms.
- An online encyclopedia of health terms, illustrated health guides, interactive dietary tools and more.



Customer Service

HIP Members:

1-800-HIP-TALK (1-800-447-8255)

Daily, 8 am - 8 pm

Non-Members:

1-800-447-9169

Daily, 8 am - 8 pm

TDD: 1-888-447-4833

Monday - Friday, 8:30 am - 5 pm

TDD: 1-888-447-4833

Monday - Friday, 8:30 am - 5 pm

The Plans described herein are offered by HIP Health Plan of New York., a Medicare Advantage organization with an annually renewed Medicare contract. The availability of coverage beyond the current contract year (2009) is not guaranteed. Benefits, limitations, service areas and premiums are subject to change on January 1 of each year. Anyone with Medicare Parts A & B who resides in the Bronx, Kings, New York, Nassau, Queens, Richmond, Suffolk or Westchester Counties may apply for HIP VIP Medicare Plans with/without drug coverage. Beneficiaries must continue to pay their Medicare Part B premium (and Part A, if applicable), if not otherwise paid for under Medicaid or by another third party. Prior authorization may be needed for certain in network services. Please refer to your Evidence of Coverage for complete details on participating provider networks and obtaining prior authorizations. The Medicare Prescription Drug Benefit is only available to members of the Medicare Advantage-Prescription Drug (MA-PD) Plan. If a beneficiary is already enrolled in a MA-PD plan, the enrollee must receive their Medicare Prescription Drug benefit through that plan.

The person discussing plan options with you is either employed by or contracted with HIP Health Plan of New York. The person may be compensated based on your enrollment in a plan.