

HIP Medicare Summary of Benefits

INTRODUCTION

Introduction to the Summary of Benefits Report for HIP PART D NEW YORK (PDP) & HIP ENHANCED PART D NEW YORK (PDP)

January 1, 2010 - December 31, 2010

NEW YORK STATE

Thank you for your interest in HIP Part D New York (PDP). Our plan is offered by HIP HEALTH PLAN OF NEW YORK/HIP Medicare PDP, a Medicare Prescription Drug Plan that contracts with the Federal government. This Summary of Benefits tells you some features of our plan. It doesn't list every drug we cover, every limitation, or exclusion. To get a complete list of our benefits, please call HIP Part D New York (PDP) and ask for the "Evidence of Coverage".

YOU HAVE CHOICES IN YOUR MEDICARE PRESCRIPTION DRUG COVERAGE

As a Medicare beneficiary, you can choose from different Medicare prescription drug coverage options. One option is to get prescription drug coverage through a Medicare Prescription Drug Plan, like HIP Part D New York (PDP). Another option is to get your prescription drug coverage through a Medicare Advantage Plan that offers prescription drug coverage. You make the choice.

HOW CAN I COMPARE MY OPTIONS?

The charts in this booklet list some important drug benefits. You can use this Summary of Benefits to compare the benefits offered by HIP Part D New York (PDP) to the benefits offered by other Medicare Prescription Drug Plans or Medicare Advantage Plans with prescription drug coverage.

WHERE IS HIP PART D NEW YORK (PDP) AVAILABLE?

The service area for this plan includes: New York. You must live in one of these areas to join this plan.

WHO IS ELIGIBLE TO JOIN?

You can join this plan if you are entitled to Medicare Part A and/or enrolled in Medicare Part B and live in the service area.

If you are enrolled in an MA coordinated care (HMO or PPO) plan or an MA PFFS plan that includes Medicare prescription drugs, you may not enroll in a PDP unless you disenroll from the HMO, PPO or MA PFFS plan.

Enrollees in a private fee-for-service plan (PFFS) that does not provide Medicare prescription drug coverage, or an MA Medical Savings Account (MSA) plan may enroll in a PDP. Enrollees in an 1876 Cost plan may enroll in a PDP.

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

HIP Part D New York (PDP) does not cover drugs that are covered under Medicare Part B as prescribed and dispensed. Generally, we only cover drugs, vaccines, biological products and medical supplies that are covered under the Medicare Prescription Drug Benefit (Part D) and that are on our formulary.

WHERE CAN I GET MY PRESCRIPTIONS?

HIP Part D New York (PDP) has formed a network of pharmacies. You must use a network pharmacy to receive plan benefits. We will not pay for your prescriptions if you use an out-of-network pharmacy, except in certain cases.

HIP Part D New York (PDP) has a list of preferred pharmacies. At these pharmacies, you may get your drugs at a lower co-pay or co-insurance. A non-preferred pharmacy is still a network pharmacy, but you may have to pay more for your prescription drugs.

The pharmacies in our network can change at any time. You can ask for a Pharmacy Directory or visit us at www.hipusa.com. Our customer service number is listed at the end of this introduction.

WHAT IS A PRESCRIPTION DRUG FORMULARY?

HIP Part D New York (PDP) uses 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.

WHAT SHOULD I DO IF I HAVE OTHER INSURANCE IN ADDITION TO MEDICARE?

If you have a Medigap (Medicare Supplement) policy that includes prescription drug coverage, you must contact your Medigap Issuer to let them know that you have joined a Medicare Prescription Drug Plan. If you decide to keep your current Medigap supplement policy, your Medigap Issuer will remove the prescription drug coverage portion of your policy. This will occur as of the effective date of your coverage in the Medicare Prescription Drug Plan and they will adjust your premium. Call your Medigap Issuer for details.

If you or your spouse has, or is able to get, employer group coverage, you should talk to your employer to find out how your benefits will be affected if you join HIP Part D New York (PDP). Get this information before you decide to enroll in this plan.

HOW CAN I GET EXTRA HELP WITH MY 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 Part D New York (PDP), 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/TTD users should call **1-877-486-2048**.

WHAT ARE MY PROTECTIONS IN THIS PLAN?

All Medicare Prescription Drug 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 Prescription Drug Plan leaves the program, you will not lose Medicare prescription drug 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 Part D New York (PDP), you have the right to request an organization determination, which includes the right to file an appeal if we deny coverage for an item or service, and the right to file a grievance. You have the right to request an organization determination if you want us to provide or pay for an item or service that you believe should be covered. If we deny coverage for your requested item or service, you have the right to appeal and ask us to review our decision. You may ask us for an expedited (fast) coverage determination

or appeal if you believe that waiting for a decision could seriously put your life or health at risk, or affect your ability to regain maximum function. If your doctor makes or supports the expedited request, we must expedite our decision. Finally, you have the right to file a grievance with us if you have any type of problem with us or one of our network providers that does not involve coverage for an item or service. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state, Island Peer Review Organization (IPRO) **1-800-331-7767**.

As a member of HIP Part D New York (PDP), 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 Part D New York (PDP) for more details.

PLEASE CALL HIP MEDICARE PDP FOR MORE INFORMATION ABOUT HIP PART D NEW YORK (PDP).

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

Customer Service Hours:

Sunday, Monday, Tuesday, Wednesday, Thursday, Friday, Saturday, 8 am - 8 pm Eastern

Current members should call toll-free **1-800-447-8255**. (TTY/TDD **1-888-447-4833**)

Prospective members should call toll-free **1-866-447-6979**. (TTY/TDD **1-888-447-4833**)

Current members should call locally **1-800-447-8255**. (TTY/TDD **1-888-447-4833**)

Prospective members should call locally **1-866-447-6979**. (TTY/TDD **1-888-447-4833**)

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.

If you have special needs, this document may be available in other formats.

HIP Medicare Summary of Benefits

IN-NETWORK AND OUT-OF-NETWORK COVERAGE

Benefit	Original Medicare
Prescription Drugs	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.

NEW YORK STATE

HIP Part D Standard

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 www.hipusa.com on the web.

Different out-of-pocket costs may apply for people who

- have limited incomes,
- live in long term care facilities, or
- have access to Indian/Tribal/Urban (Indian Health Service).

\$30.60 monthly premium

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).

Total yearly drug costs are the total drug costs paid by both you and the plan.

The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.

Some drugs have quantity limits.

Your provider must get prior authorization from HIP Part D New York (PDP) for certain drugs.

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 plan's website, formulary, and printed materials, as well as on the Medicare Prescription Drug Plan Finder on www.medicare.gov.

If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost,

HIP Part D Enhanced

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 www.hipusa.com on the web.

Different out-of-pocket costs may apply for people who

- have limited incomes,
- live in long term care facilities, or
- have access to Indian/Tribal/Urban (Indian Health Service).

\$68.60 monthly premium

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).

Total yearly drug costs are the total drug costs paid by both you and the plan.

The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.

Some drugs have quantity limits.

Your provider must get prior authorization from HIP Enhanced Part D New York (PDP) for certain drugs.

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 plan's website, formulary, and printed materials, as well as on the Medicare Prescription Drug Plan Finder on www.medicare.gov.

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

HIP Medicare Summary of Benefits

IN-NETWORK AND OUT-OF-NETWORK COVERAGE

Benefit	Original Medicare
Prescription Drugs (Continued)	

NEW YORK STATE

HIP Part D Standard

not the higher cost-sharing amount.

If you request a tier exception in this plan, you will pay Tier #3 cost sharing.

In-Network

\$310 yearly deductible.

Initial Coverage

After you pay your yearly deductible, you pay the following until total yearly drug costs reach \$2,830:

Retail Pharmacy

Tier #1

\$4 copay for a one-month (30-day) supply of drugs in this tier from a preferred pharmacy

\$8 copay for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy

\$12 copay for a 60-day supply of drugs in this tier from a preferred pharmacy

\$4 copay for a one-month (30-day) supply of drugs in this tier from a non-preferred pharmacy

\$12 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred pharmacy

\$12 copay for a 60-day supply of drugs in this tier from a non-preferred pharmacy

Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.

Tier #2

25% coinsurance for a one-month (30-day) supply of drugs in this tier from a preferred pharmacy

25% coinsurance for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy

HIP Part D Enhanced

higher cost-sharing amount.

If you request a tier exception in this plan, you will pay Tier #3 cost sharing.

In-Network

\$0 deductible.

Initial Coverage

You pay the following until total yearly drug costs reach \$2,520:

Retail Pharmacy

Tier #1

\$5 copay for a one-month (30-day) supply of drugs in this tier from a preferred pharmacy

\$10 copay for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy

\$15 copay for a 60-day supply of drugs in this tier from a preferred pharmacy

\$5 copay for a one-month (30-day) supply of drugs in this tier from a non-preferred pharmacy

\$15 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred pharmacy

\$15 copay for a 60-day supply of drugs in this tier from a non-preferred pharmacy

Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.

Tier #2

\$25 copay for a one-month (30-day) supply of drugs in this tier from a preferred pharmacy

\$50 copay for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy

HIP Medicare Summary of Benefits

IN-NETWORK AND OUT-OF-NETWORK COVERAGE

Benefit	Original Medicare
Prescription Drugs (Continued)	

NEW YORK STATE

HIP Part D Standard	HIP Part D Enhanced
<p>25% coinsurance for a 60-day supply of drugs in this tier from a preferred pharmacy</p> <p>25% coinsurance for a one-month (30-day) supply of drugs in this tier from a non-preferred pharmacy</p> <p>25% coinsurance for a three-month (90-day) supply of drugs in this tier from a non-preferred pharmacy</p> <p>25% copay for a 60-day supply of drugs in this tier from a non-preferred pharmacy</p> <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Tier #3</p> <p>40% coinsurance for a one-month (30-day) supply of drugs in this tier from a preferred pharmacy</p> <p>40% coinsurance for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy</p> <p>40% coinsurance for a 60-day supply of drugs in this tier from a preferred pharmacy</p> <p>40% coinsurance for a one-month (30-day) supply of drugs in this tier from a non-preferred pharmacy</p> <p>40% coinsurance for a three-month (90-day) supply of drugs in this tier from a non-preferred pharmacy</p> <p>40% copay for a 60-day supply of drugs in this tier from a non-preferred pharmacy</p> <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Tier #4</p> <p>25% coinsurance for a one-month (30-day) supply of drugs in this tier from a preferred pharmacy</p> <p>25% coinsurance for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy</p>	<p>\$75 copay for a 60-day supply of drugs in this tier from a preferred pharmacy</p> <p>\$25 copay for a one-month (30-day) supply of drugs in this tier from a non-preferred pharmacy</p> <p>\$75 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred pharmacy</p> <p>\$75 copay for a 60-day supply of drugs in this tier from a non-preferred pharmacy</p> <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Tier #3</p> <p>40% coinsurance for a one-month (30-day) supply of drugs in this tier from a preferred pharmacy</p> <p>40% coinsurance for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy</p> <p>40% coinsurance for a 60-day supply of drugs in this tier from a preferred pharmacy</p> <p>40% coinsurance for a one-month (30-day) supply of drugs in this tier from a non-preferred pharmacy</p> <p>40% coinsurance for a three-month (90-day) supply of drugs in this tier from a non-preferred pharmacy</p> <p>40% copay for a 60-day supply of drugs in this tier from a non-preferred pharmacy</p> <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Tier #4</p> <p>25% coinsurance for a one-month (30-day) supply of drugs in this tier from a preferred pharmacy</p> <p>25% coinsurance for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy</p>

HIP Medicare Summary of Benefits

IN-NETWORK AND OUT-OF-NETWORK COVERAGE

Benefit	Original Medicare
Prescription Drugs (Continued)	

NEW YORK STATE

HIP Part D Standard	HIP Part D Enhanced
<p>25% coinsurance for a 60-day supply of drugs in this tier from a preferred pharmacy</p> <p>25% coinsurance for a one-month (30-day) supply of drugs in this tier from a non-preferred pharmacy</p> <p>25% coinsurance for a three-month (90-day) supply of drugs in this tier from a non-preferred pharmacy</p> <p>25% copay for a 60-day supply of drugs in this tier from a non-preferred pharmacy</p> <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Long Term Care Pharmacy</p> <p>Tier #1</p> <p>\$4 copay for a one-month (31-day) supply of drugs in this tier</p> <p>Tier #2</p> <p>25% coinsurance for a one-month (31-day) supply of drugs in this tier</p> <p>Tier #3</p> <p>40% coinsurance for a one-month (31-day) supply of drugs in this tier</p> <p>Tier #4</p> <p>25% coinsurance for a one-month (31-day) supply of drugs in this tier</p> <p>Mail Order</p> <p>Tier #1</p> <p>\$4 copay for a one-month (30-day) supply of drugs in this tier</p> <p>\$8 copay for a three-month (90-day) supply of drugs in this tier</p> <p>\$8 copay for a 60-day supply of drugs in this tier</p> <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p>	<p>25% coinsurance for a 60-day supply of drugs in this tier from a preferred pharmacy</p> <p>25% coinsurance for a one-month (30-day) supply of drugs in this tier from a non-preferred pharmacy</p> <p>25% coinsurance for a three-month (90-day) supply of drugs in this tier from a non-preferred pharmacy</p> <p>25% copay for a 60-day supply of drugs in this tier from a non-preferred pharmacy</p> <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Long Term Care Pharmacy</p> <p>Tier #1</p> <p>\$5 copay for a one-month (31-day) supply of drugs in this tier</p> <p>Tier #2</p> <p>\$25 copay for a one-month (31-day) supply of drugs in this tier</p> <p>Tier #3</p> <p>40% coinsurance for a one-month (31-day) supply of drugs in this tier</p> <p>Tier #4</p> <p>25% coinsurance for a one-month (31-day) supply of drugs in this tier</p> <p>Mail Order</p> <p>Tier #1</p> <p>\$5 copay for a one-month (30-day) supply of drugs in this tier</p> <p>\$10 copay for a three-month (90-day) supply of drugs in this tier</p> <p>\$10 copay for a 60-day supply of drugs in this tier</p> <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p>

HIP Medicare Summary of Benefits

IN-NETWORK AND OUT-OF-NETWORK COVERAGE

Benefit	Original Medicare
Prescription Drugs (Continued)	

NEW YORK STATE

HIP Part D Standard

Tier #2

25% coinsurance for a one-month (30-day) supply of drugs in this tier

25% coinsurance for a three-month (90-day) supply of drugs in this tier

25% coinsurance for a 60-day supply of drugs in this tier

Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.

Tier #3

40% coinsurance for a one-month (30-day) supply of drugs in this tier

40% coinsurance for a three-month (90-day) supply of drugs in this tier

40% coinsurance for a 60-day supply of drugs in this tier

Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.

Tier #4

25% coinsurance for a one-month (30-day) supply of drugs in this tier

25% coinsurance for a three-month (90-day) supply of drugs in this tier

25% coinsurance for a 60-day supply of drugs in this tier

Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.

Coverage Gap

After your total yearly drug costs reach \$2,830, you pay 100% until your yearly out-of-pocket drug costs reach \$4,550.

HIP Part D Enhanced

Tier #2

\$25 copay for a one-month (30-day) supply of drugs in this tier

\$50 copay for a three-month (90-day) supply of drugs in this tier

\$50 copay for a 60-day supply of drugs in this tier

Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.

Tier #3

40% coinsurance for a one-month (30-day) supply of drugs in this tier

40% coinsurance for a three-month (90-day) supply of drugs in this tier

40% coinsurance for a 60-day supply of drugs in this tier

Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.

Tier #4

25% coinsurance for a one-month (30-day) supply of drugs in this tier

25% coinsurance for a three-month (90-day) supply of drugs in this tier

25% coinsurance for a 60-day supply of drugs in this tier

Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.

Coverage Gap

The plan covers many generics (65%-99% of formulary generic drugs) through the coverage gap.

You pay the following:

HIP Medicare Summary of Benefits

IN-NETWORK AND OUT-OF-NETWORK COVERAGE

Benefit	Original Medicare
Prescription Drugs (Continued)	

NEW YORK STATE

HIP Part D Standard

Catastrophic Coverage

After your yearly out-of-pocket drug costs reach \$4,550, you pay the greater of:

A \$2.50 copay for generic (including brand drugs treated as generic) and a \$6.30 copay for all other drugs, or

5% coinsurance.

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 for the drug and submit documentation to receive reimbursement from HIP Part D New York (PDP).

Out-of-Network Initial Coverage

After you pay your yearly deductible, you will be reimbursed up to the full cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach \$2,830:

Tier #1

\$4 copay for a one-month (30-day) supply of drugs in this tier

Tier #2

25% coinsurance for a one-month (30-day) supply of drugs in this tier

Tier #3

40% coinsurance for a one-month (30-day) supply of drugs in this tier

Tier #4

25% coinsurance for a one-month (30-day) supply of drugs in this tier

HIP Part D Enhanced

Retail Pharmacy

Tier #1

\$5 copay for a one-month (30-day) supply of All Preferred Generics drugs covered in this tier from a preferred pharmacy

\$10 copay for a three-month (90-day) supply of All Preferred Generics drugs covered in this tier from a preferred pharmacy

\$15 copay for a 60-day supply of All Preferred Generics drugs covered in this tier from a preferred pharmacy

\$5 copay for a one-month (30-day) supply of All Preferred Generics drugs you get at a non-preferred pharmacy

\$15 copay for a three-month (90-day) supply of All Preferred Generics drugs covered in this tier from a non-preferred pharmacy

\$15 copay for a 60-day supply of All Preferred Generics drugs covered in this tier from a non-preferred pharmacy

Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.

Long Term Care Pharmacy

Tier #1

\$5 copay for a one-month (31-day) supply of All Preferred Generics drugs covered in this tier

Mail Order

Tier #1

\$5 copay for a one-month (30-day) supply of All Preferred Generics drugs covered in this tier

\$10 copay for a three-month (90-day) supply of All Preferred Generics drugs covered in this tier

\$10 copay for a 60-day supply of All Preferred Generics drugs covered in this tier

HIP Medicare Summary of Benefits

IN-NETWORK AND OUT-OF-NETWORK COVERAGE

Benefit	Original Medicare
Prescription Drugs (Continued)	

NEW YORK STATE

HIP Part D Standard

Out-of-Network Coverage Gap

After your total yearly drug costs reach \$2,830, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach \$4,550. You will not be reimbursed by HIP Part D New York (PDP) for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to HIP Part D New York (PDP) so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.

Out-of-Network Catastrophic Coverage

After your yearly out-of-pocket drug costs reach \$4,550, you will be reimbursed for drugs purchased out-of-network up to the full cost of the drug minus the following:

A \$2.50 copay for generic (including brand drugs treated as generic) and a \$6.30 copay for all other drugs, or

5% coinsurance.

HIP Part D Enhanced

Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.

Please contact the plan for a complete list of drugs covered through the gap.

For all other covered drugs, after your total yearly drug costs reach \$2,520, you pay 100% until your yearly out-of-pocket drug costs reach \$4,550.

Catastrophic Coverage

After your yearly out-of-pocket drug costs reach \$4,550, you pay the greater of:

A \$2.50 copay for generic (including brand drugs treated as generic) and a \$6.30 copay for all other drugs, or

5% coinsurance.

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 for the drug and submit documentation to receive reimbursement from HIP Enhanced Part D New York (PDP).

Out-of-Network Initial Coverage

You will be reimbursed up to the full cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach \$2,520:

Tier #1

\$5 copay for a one-month (30-day) supply of drugs in this tier

Tier #2

\$25 copay for a one-month (30-day) supply of drugs in this tier

HIP Medicare Summary of Benefits

IN-NETWORK AND OUT-OF-NETWORK COVERAGE

Benefit	Original Medicare
Prescription Drugs (Continued)	

NEW YORK STATE

HIP Part D Standard

HIP Part D Enhanced

Tier #3

40% coinsurance for a one-month (30-day) supply of drugs in this tier

Tier #4

25% coinsurance for a one-month (30-day) supply of drugs in this tier

Out-of-Network Coverage Gap

You will be reimbursed for these drugs purchased out-of-network up to the full cost of the drug minus the following:

Tier #1

\$5 copay for a one-month (30-day) supply of All Preferred Generics drugs covered in this tier

Tier #2

After your total yearly drug costs reach \$2,520, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach \$4,550. You will not be reimbursed by HIP Enhanced Part D New York (PDP) for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to HIP Enhanced Part D New York (PDP) so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.

Tier #3

After your total yearly drug costs reach \$2,520, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach \$4,550. You will not be reimbursed by HIP Enhanced Part D New York (PDP) for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to HIP Enhanced Part D New York (PDP) so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.

HIP Medicare Summary of Benefits

IN-NETWORK AND OUT-OF-NETWORK COVERAGE

Benefit	Original Medicare
Prescription Drugs (Continued)	

NEW YORK STATE

HIP Part D Standard

HIP Part D Enhanced

Tier #4

After your total yearly drug costs reach \$2,520, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach \$4,550. You will not be reimbursed by HIP Enhanced Part D New York (PDP) for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to HIP Enhanced Part D New York (PDP) so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.

Out-of-Network Catastrophic Coverage

After your yearly out-of-pocket drug costs reach \$4,550, you will be reimbursed for drugs purchased out-of-network up to the full cost of the drug minus the following:

A \$2.50 copay for generic (including brand drugs treated as generic) and a \$6.30 copay for all other drugs, or

5% coinsurance.

We understand that getting a grasp on your prescription drug coverage can be confusing. That's why we've produced this Special Features section to simplify things. It covers your prescription drug coverage benefits in more detail that were only referenced in the prior section of the Standardized Summary of Benefits charts. Now let's get started.



SAVE EVEN MORE: MEDICARE SAVINGS PROGRAM

If your monthly income is less than \$1190 (\$1595 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 maybe 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 Part D New York Standard or Enhanced you are enrolled in one of HIP's Medicare Part D prescription drug plans. Both plans offer generic and brand name drugs from the HIP Medicare Drug Formulary. The plans will differ regarding your premium and copay amounts as outlined below.

Drugs that are not on the HIP formulary are not covered.

To view the HIP Medicare Drug Formulary, visit www.hipusa.com or call HIP Customer Service.

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 Generic/Brand formulary medications

Tier 4 Specialty formulary medications

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 Preferred Generic prescription drugs will receive 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 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.

HIP Part D New York Standard

	DEDUCTIBLE \$310	INITIAL \$310–\$2,830 ^a	GAP Over \$2,830 ^b	CATASTROPHIC Over \$4,550 ^c
	You Pay	You Pay	You Pay	You Pay
Tier 1 Preferred Generic formulary medications	100%	\$4	100%	5% ^d
Tier 2 Preferred Brand formulary medications	100%	25%	100%	5% ^d
Tier 3 Non-preferred Brand/Generic formulary medications	100%	40%	100%	5% ^d
Tier 4 Specialty formu- lary medications	100%	25%	100%	5% ^d

* After you have paid \$4,550 out-of-pocket, you will pay the greater of \$2.50 or 5% for generic drugs or \$6.30 or 5% for Preferred Brand, Brand and Specialty Drugs.

a Amounts between \$0 and \$2830 are paid by both the member and the plan.

b All of these drug amounts are paid by the member, with the exception of the balance the plan pays for Tier 1 medications.

c The member enters the catastrophic phase once they have paid a total out-of-pocket amount of \$4,550.

d After you have paid \$4,550 out-of-pocket, you will pay the greater of \$2.50 or 5% for generic drugs or \$6.30 or 5% for Preferred Brand, Brand and Specialty Drugs.

The HIP Part D New York Standard benefit has a \$310 yearly deductible. After your deductible, you will enter the initial coverage phase, in which you have a copay for Tier 1 drugs and a coinsurance (a percentage of drug cost) for Tier 2, Tier 3 and Tier 4 drugs, until the total costs, including your deductible, reach \$2,830.

Once the total drug costs have exceeded \$2,830, you will then pay 100% of your prescription drug costs until your true out-of-pocket drug costs reach \$4,550. This is called the coverage gap phase. After your yearly true out-of-pocket costs reach \$4,550, HIP will cover your remaining drug costs, and you will continue to have some nominal copays or coinsurance costs beyond this expense level.

HIP Part D New York Enhanced

	DEDUCTIBLE	INITIAL	GAP	CATASTROPHIC
	\$0	\$0–\$2,520 ^a	Over \$2,520 ^b	Over \$4,550 ^c
	You Pay	You Pay	You Pay	You Pay
Tier 1 Preferred Generic formulary medications	No Deductible	\$5	\$5	5% ^d
Tier 2 Preferred Brand formulary medications	No Deductible	\$25	100%	5% ^d
Tier 3 Non-preferred Brand/Generic formulary medications	No Deductible	40%	100%	5% ^d
Tier 4 Specialty formu- lary medications	No Deductible	25%	100%	5% ^d

* After you have paid \$4,550 out-of-pocket, you will pay the greater of \$2.50 or 5% for generic drugs or \$6.30 or 5% for Preferred Brand, Brand and Specialty Drugs.

a Amounts between \$0 and \$2520 are paid by both the member and the plan.

b All of these drug amounts are paid by the member, with the exception of the balance the plan pays for Tier 1 medications.

c The member enters the catastrophic phase once they have paid a total out-of-pocket amount of \$4,550.

d After you have paid \$4,350 out-of-pocket, you will pay the greater of \$2.50 or 5% for generic drugs or \$6.30 or 5% for Preferred Brand, Brand and Specialty Drugs.



The HIP Part D Enhanced benefit has no deductible. During the initial coverage phase, you will have a copay for Tier 1 and Tier 2 drugs and a coinsurance (a percentage of drug cost) for Tier 3 and Tier 4 drugs, until the total costs reach \$2,520.

Once the total drug costs have exceeded \$2,520 you will enter the “coverage gap” phase. Your plan benefits include unlimited preferred generic prescription coverage with a copay for Tier 1 medications until you have paid a total of \$4,550. For Tier 2, Tier 3 and Tier 4 drugs, you will be responsible for the full cost of drugs covered by HIP—which have been negotiated at a discounted price—until your yearly out-of-pocket costs reach \$4,550. After this point, HIP will cover the remaining drug costs and you will continue to pay some nominal copays or coinsurance costs beyond this expense level.

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.

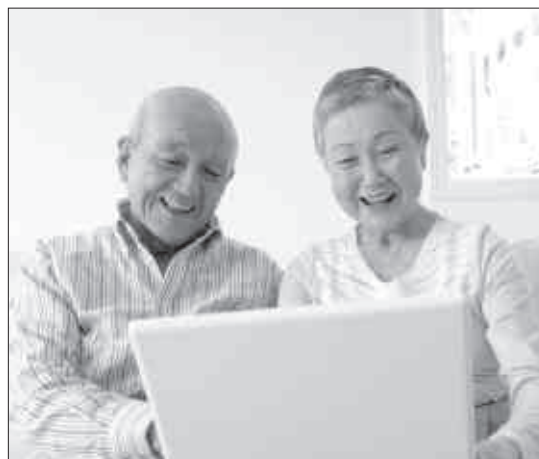
FILLING YOUR PRESCRIPTIONS

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.

PAYMENT MADE EASY: DIRECT DEBIT

If you must pay a monthly plan premium, you will be billed monthly unless you have chosen to have this money directly deducted from your Social Security check. Most members pay by check, but you can also choose to pay through our convenient Direct Debit Program. With Direct Debit, your monthly plan premium will be automatically taken out of your checking account each month. To sign up for Direct Debit, call HIP Customer Service for an enrollment form.



RESOURCES

For a list of participating pharmacies, visit www.hipusa.com or call HIP Customer Service.

HIP Members:	Non-Members:
<p>1-800-HIP-TALK (1-800-447-8255) Daily, 8 am - 8 pm</p>	<p>1-800-447-9169 Daily, 8 am - 8 pm</p>
<p>TDD: 1-888-447-4833 Monday - Friday, 8:30 am - 5 pm</p>	<p>TDD: 1-888-447-4833 Monday - Friday, 8:30 am - 5 pm</p>

