



HEALTH MAINTENANCE ORGANIZATION (HMO)

IMPORTANT REFERENCE INFORMATION

New Yorkers know how to live.
We know how to keep them covered.



HIP Members!

We're Serving You Better By Phone And Online!

Enhanced Voice-Enabled System

As part of our commitment to outstanding member service, HIP Health Plan of New York recently upgraded our toll-free Customer Service line, **1-800-HIP-TALK (1-800-447-8255)**. The enhancements described below will result in faster, more accurate service than ever before!

HIP's Interactive Voice Response System (IVR) allows you to use "natural language" (the newly enhanced voice-enabled system) or the touch-tone keypad on your telephone for member service options, including:

- Change your primary care physician (if your plan requires one) NEW!
- Update your telephone number NEW!*
- Update your address NEW!*
- Check claim status NEW!
- Order ID cards.
- Request forms (such as claim forms, directories, or pharmacy materials).
- Verify member status.
- Check copayments.

Dedicated Customer Service Advocates

You always have the option of speaking with a Customer Service Advocate directly, anytime during your phone call. Customer Service Advocates are available to respond to your questions between 8 am and 6 pm, Monday through Friday.

Your call will be routed to a Customer Service Advocate specifically trained as a "subject matter expert" in areas such as pharmacy, benefits and enrollment, or claims. To get to your subject matter as quickly as possible, simply enter your member ID # and select a reason for your call. A Customer Service Advocate will gladly provide you with assistance.

The IVR system will give you answers to many questions 24 hours a day.

* Some employers require that their employees make these changes through the company's Human Resources department, so check with your company's Benefits Administrator.

New Design For hipusa.com[®]

Visit hipusa.com today to view our redesigned, member-friendly Web site. You can enjoy many of the features included in the IVR system and more at any time day or night. As a HIP member, log on to hipusa.com to:

- Find a participating physician, practitioner, or pharmacy location.
- Change your primary care physician.
- Request ID cards.
- Check member status and benefits.
- Inquire about claims.
- Read HIP news and announcements.
- Learn about available wellness programs, services, and health-related discounts.
- Find about about HIP's most up-to-date drug formularies.

Need To Select A PCP Or Change Other Personal Information? Try Using hipusa.com For Fast Service

Your HIP Health plan requires that you select a primary care physician (PCP) and HIP's Web site, hipusa.com, allows you to choose one in just a few minutes.

Simply go to hipusa.com and follow the directions for registering and logging on to our Web site. Once you're logged on, click on PCP Change. You'll be presented with a screen that allows you to select the PCP of your choice. You can choose a physician by name or do a search by selecting Family Practice, Internal Medicine or Pediatrics from the menu provided and then typing in your ZIP code. The name(s) of a conveniently located physician will then appear. If you want to change your PCP selection, you can also do so right then and there.

The HIP Web site also lets you update any personal information. If you change your address, need to correct a date of birth, have a birth in the family, just click on Contact Us to inform HIP Customer Service. (Note that some employers require employees to make these changes through the company's personnel department.)

We encourage you to take full advantage of all features our Web site offers. You can access hipusa.com 24 hours a day, 7 days a week. And, our Web site may eliminate the need to call HIP Customer Service. For more information about what HIP's Web site offers, please read the Important Contact Information section of your welcome kit.

Of course if you need more personal assistance, you can call a HIP Customer Service Advocate at **1-800-HIP-TALK (1-800-447-8255)** Monday through Friday, between 8 am and 6 pm. If you have a hearing or speech impairment and use a TDD, please call **1-888-447-4TDD (1-888-447-4833)** Monday through Friday, between 8:30 am and 5 pm.

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CONTACT INFORMATION >>>

Web site information and telephone numbers
you'll need when you want assistance.

HIP[®]
HEALTH PLAN OF NEW YORK

CONTACT INFORMATION

This contact information can save you time and effort when you need help. Keep it close at hand.

hipusa.com is HIP's Web site.

You can get information from HIP at your convenience, at any time at all. Depending on your coverage, you may be able to...

- Review the latest information on the HIP participating provider network.
- Change your primary care physician (PCP).
- Get health tips from HIP and links to other health information sites.
- Request a replacement for a misplaced ID card.
- Update your address. (Note that some employers require employees to make address changes through the company's personnel department.)
- Look up a benefits description.
- Inquire about a claim, or review and download claim forms.
- Search for a participating pharmacy via HIP's online pharmacy service.
- Fill a prescription via HIP's online pharmacy service.
- Learn about HIP's dental program. Get tips on dental health and review a list of participating dentists.
- Find out about HIP's alternative medicine programs – acupuncture, massage therapy, nutritionists, etc.
- Read information about HIP, including our annual financial statement.
- Send us an e-mail with your questions and comments.

You can feel secure when you visit our Web site. We have taken important precautions to prevent unauthorized access to member information.

- To begin with, we use up-to-the-minute security technology and encrypt all data.
- We also require that you obtain a PIN (Personal Identification Number) before accessing your member records. Once you've registered on the site, you'll get a temporary PIN. A permanent one will be sent to you in the mail. Make sure you have your HIP Member ID Number handy when you register for your PIN.

If you don't have Internet access, you may still be able to access our Web site. Many public libraries and community centers offer free Internet access. Check to see if this service is available in your neighborhood.

CONTACT INFORMATION

Your HIP Participating Personal Physician: _____

Write down the name and phone number of your PCP on the line above right now. That will help you and others find the number quickly when you need it.

1-800-HIP-TALK (1-800-447-8255) is HIP's Toll-free Customer Service Line.

Call this number if you have any questions concerning benefits or services. Whenever you call **1-800-HIP-TALK**, choose the Interactive Voice Response (IVR) system when you want to:

- Confirm member eligibility.
- Verify copayment requirements.
- Request a replacement ID card.
- Order HIP forms and literature.

The system will guide you through the easy steps to the information you need. Be sure to have your HIP ID card handy, so you can refer to your HIP ID number when prompted to enter it. Customer Service Advocates are on hand to respond to your call between 8 am and 6 pm, Monday through Friday.

1-888-HIP-4TDD (1-888-447-4833) is HIP's Toll-free TDD Line for the hearing- or speech-impaired. This number is available between 8:30 am and 5 pm, Monday through Friday for customer service inquiries.

Remember, try the Web site and IVR first, when you can! HIP's Web site and IVR system are available to you 24 hours a day, 7 days a week – and there's no delay.

Note: HIP works with several organizations affiliated with providers to handle certain administrative operations, such as care management or claims processing. In these cases, contact information may differ. **Please read the back of your HIP ID card carefully for special mailing or telephone contacts.** These are the contacts you should use.

CONTACT INFORMATION

1) Customer Service Department *(for inquiries about claims, payments, benefits, eligibility, ID cards, language translations, changing your PCP, name, address, telephone number or dependent information, ordering HIP forms and literature and membership cancellation)*

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

2) Insurance Fraud & Abuse *(for confidential reporting of suspected insurance fraud)*

1-877-TELL-HIP (1-877-835-5447)

3) Language Translations *(Member Handbook)*

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

4) Mental Health Care and Alcohol/Drug Treatment Prior Approval

1-888-447-2526

5) Anticipated and Continuing Care Services Program *(to obtain prior approval for certain services)*

1-866-447-9717, option #4

6) Translations or Telephone Device for the Hearing- and Speech-Impaired

1-888-447-4833

MEMBER HANDBOOK >>>

How HIP HMO will work for you.



This is your Member Handbook. It explains your HIP coverage and how you can help make it work for you. It is not your Contract or Certificate of Coverage. Your Contract or Certificate of Coverage defines your benefits as well as the terms, conditions, limitations and exclusions applied to your coverage. Please refer to your Contract or Certificate of Coverage when you have questions about your benefits.

Este es su Manual del Miembro. Explica su cobertura HIP y cómo podrá aprovecharla al máximo. No es su Constancia de Cobertura. Su Constancia de Cobertura define sus beneficios, así como los términos, condiciones y exclusiones aplicables a su cobertura. Refiérase a su Constancia de Cobertura cuando tiene preguntas acerca de sus beneficios. Si necesita una copia de este Manual del Miembro en español, llame al 1-800-447-8255.

這是您的《會員手冊》。本手冊講解您享有的 HIP 承保，以及您能夠怎樣使之為您服務。這不是您的《承保證明》。《承保證明》規定您的保險權益，以及適用於您的承保的條文、條件、限制條款和排除條款。當您對自己的保險權益有疑問時，請參閱您的《承保證明》。如果您需要一份本《會員手冊》的中文版本，請致電 1-800-447-8255 索取。

이 책자는 회원 핸드북입니다. 귀하의 HIP 보험 커버리지를 설명하고 어떻게 이용하는지 자세히 적혀있습니다. 이 책자는 보험증서(Evidence of Coverage)가 아닙니다. 귀하의 보험증서에는 커버리지에 적용되는 보험 혜택과 조건, 제한사항 및 제외사항들이 명시되어 있습니다. 보험혜택에 문의가 있으시면 보험증서를 보십시오. 한국어로 된 회원 핸드북이 필요하신 분은 1-800-447-8255 로 연락하십시오.

INTRODUCTION

Welcome to HIP Health Plan of New York, the health plan with over 58 years of experience serving members in the metropolitan New York area. As a HIP member, you enjoy many special advantages and several important choices.

If you are a member of a HIP HMO or HIP Prime[®] Plan, you choose your own personal physician from the Plan's network of participating physicians. That physician is called your primary care physician, or PCP. You can choose a PCP who practices independently in a private office or a PCP at a conveniently located physician group practice. Either way, your PCP provides or arranges all your care. Each covered dependent can choose his or her own PCP.

You can learn more about what HIP has to offer by logging on to our Web site at hipusa.com. If you don't have access to the Internet at home, many local public libraries can provide you with free Internet access. Or, you can call HIP Customer Service. HIP Customer Service Advocates are ready to help you with answers to questions about your coverage and how to access the HIP system. Just call **1-800-HIP-TALK (1-800-447-8255)** Monday through Friday between 8 am and 6 pm. If you use a telephone device for the hearing- or speech-impaired, please call **1-888-447-4TDD (1-888-447-4833)** Monday through Friday between 8:30 am and 5 pm.

Please remember to read your Contract or Certificate of Coverage. The Contract or Certificate of Coverage and your Member Handbook together give you information you need to completely understand the HIP health care delivery system, HIP policies affecting your coverage and your HIP plan's benefits, terms, conditions, limitations and exclusions.

HIP Prime[®] is a registered trademark of HIP Health Plan of New York.

INTRODUCTION

Some Important Definitions

As you read this handbook, you may find it helpful to know the definitions of the terms below.

Copayment—The fee charged to you at the time of service for certain covered services and benefits. The applicable copayment, if any, is indicated in your Schedule of Benefits.

Physician group practice—See listing beginning on page 3. Please call your physician group practice to find out what types of medical services are available at the practice.

HMO benefits—Coverage for care that is given by your HIP participating PCP or through referral by that doctor. When you receive HMO benefits, you have no out-of-pocket expenses except any copayments that may apply.

Referred services—Care arranged for you by your PCP prior to the services being rendered and/or approved in advance by the HIP Care Management Program. Referred services result in HMO benefits. PCPs usually make referrals to specialists they know and trust – usually other physicians within the same physician group practice the PCP belongs to. HIP participating PCPs in private practice are likely to refer you to specialists with whom they already have a working relationship.

Self-referred services—Care you seek directly from a participating provider or any other provider without a referral from your PCP. HIP HMO Plan members do not usually receive benefits when they are self-referred. (There are certain exceptions which are spelled out in your Contract or Certificate of Coverage.)

On the following pages you'll find a listing of physician group practices that provide both primary and specialist care. You may choose a PCP affiliated with any of the physician group practices.

PHYSICIAN GROUP PRACTICES

BRONX

Montefiore Medical Group

Astor Avenue Pediatrics

1500 Astor Ave
Bronx, NY 10469
(718) 881-0100

Bronx-East Center

2300 Westchester Ave
Bronx, NY 10462
(718) 829-1900

Burke Avenue Center

941 Burke Avenue
Bronx, NY 10469
(718) 654-5900

Castle Hill Family Practice

2175 Westchester Ave
Bronx, NY 10462
(718) 829-6770

Co-op City Office

2100 Bartow Ave
Bronx, NY 10475
(718) 320-5300

Co-op City Center

115 Dreiser Loop
Bronx, NY 10475
(718) 320-6300

Comprehensive Health Care Center - 161st Street

305 E 161st St
Bronx, NY 10451
(718) 579-2500

Comprehensive Family Care Center - Eastchester Road

1621 Eastchester Rd
Bronx, NY 10461
(718) 405-8040

Family Health Center

360 East 193rd St
Bronx, NY 10458
(718) 933-2400

Fordham Family Health Practice

One Fordham Plaza
Bronx, NY 10458
(718) 405-4010

Grand Concourse Center

2532 Grand Concourse
Bronx, NY 10458
(718) 960-1500

Marble Hill Family Practice

5525 Broadway
Bronx, NY 10463
(718) 884-0279

Medical Arts Pavilion

3400 Bainbridge Ave
Bronx, NY 10467
(718) 920-8888

Parkchester Office

1380 Metropolitan Ave
Bronx, NY 10462
(718) 597-3111

Riverdale Office

3510 Johnson Ave
Bronx, NY 10463
(718) 601-8205

South Bronx Children & Family Health Center

871 Prospect Ave
Bronx, NY 10459
(718) 991-0605

Southern Center

326 East 149th Street
Bronx, NY 10451
(718) 585-6100

University Avenue Family Practice

105 West 188th St
Bronx, NY 10468
(718) 563-0757

West Farms Family Practice

1055 East Tremont Ave
Bronx, NY 10460
(718) 842-8040

Williamsbridge Office

3448 Boston Rd
Bronx, NY 10469
(718) 547-6111

BROOKLYN

Central Brooklyn Medical Group

Bay Ridge Center

6300 8th Avenue
Brooklyn, NY 11220
(718) 439-2115

Bedford-Williamburg Center

233 Nostrand Ave
Brooklyn, NY 11205
(718) 826-5900

Brooklyn Heights Center

200 Montague Street
Brooklyn, NY 11201
(718) 422-8000

Coney Island Center

1230 Neptune Ave
Brooklyn, NY 11224
(718) 615-3200

Downtown Center

345 Schermerhorn St
Brooklyn, NY 11217
(718) 858-6300

Empire Center

546 Eastern Parkway
Brooklyn, NY 11225
(718) 604-4800

Flatbush Center

1000 Church Ave
Brooklyn, NY 11218
(718) 826-4000

Kings Highway Center

3245 Nostrand Ave
Brooklyn, NY 11229
(718) 615-3777

Lindenwood Center

2832 Linden Blvd
Brooklyn, NY 11208
(718) 240-2000

PHYSICIAN GROUP PRACTICES

MANHATTAN

Lenox Hill Medical Group

Manhattan East Center

215 East 95th Street
New York, NY 10128
(212) 996-8000

West 55th Street Center

67 West 55th St
New York, NY 10019
(212) 582-7117

NASSAU

Queens-Long Island Medical Group

Central Nassau (Hempstead)

226 Clinton St
Hempstead, NY 11550
(516) 483-2020

Hicksville Center

350 South Broadway
Hicksville, NY 11801
(516) 938-0100

New Hyde Park Center

2035 Lakeville Rd
New Hyde Park,
NY 11040
(516) 343-0600

Valley Stream Center

70 East Sunrise Hwy
5th Fl.
Valley Stream, NY 11581
(516) 825-3600

Woodbury Center

225 Froelich Farm Blvd
Woodbury, NY 11797
(516) 364-5400

QUEENS

Queens-Long Island Medical Group

Astoria Center

31-75 23rd St
Astoria, NY 11106
(718) 956-2200

Elmhurst Center

86-15 Queens Blvd
Elmhurst, NY 11373
(718) 899-6600

Elmhurst Pediatric and Multi-Specialty Center

88-06 55th Ave
Elmhurst, NY 11373
(718) 271-9730

Far Rockaway Center

29-15 Far Rockaway
Blvd
Far Rockaway, NY
11691
(718) 337-7000

Flushing Center

140-15 Sanford Ave
Flushing, NY 11355
(718) 670-6400

Flushing South Center

59-25 Kissena Blvd
Flushing, NY 11355
(718) 670-6100

Forest Hills Center

96-10 Metropolitan Ave
Forest Hills, NY 11375
(718) 459-0400

Jamaica Estates Center

180-05 Hillside Ave
Jamaica, NY 11432
(718) 526-6300

Queens Village Center

112-18 Springfield Blvd
Queens Village, NY
11429
(718) 479-6600

Richmond Hill Center

125-06 101st Ave
Richmond Hill,
NY 11419
(718) 849-2900

Rochdale Center

169-59 137th Ave
Jamaica, NY 11434
(718) 525-5600

Women's Health Center

97-45 Queens
Boulevard, 2nd Fl.
Rego Park, NY 11375
(718) 459-6500

STATEN ISLAND

Staten Island Medical Group

Annadale Center

4771 Hylan Blvd
Staten Island, NY
10312
(718) 948-8200

Clove Lake Center

1050 Clove Road
Staten Island, NY
10301
(718) 816-6440

SUFFOLK

Queens-Long Island Medical Group

Babylon Center

300 Bayshore Road
North Babylon,
NY 11703
(631) 586-2700

Ronkonkoma Center

640 Hawkins Ave
Lake Ronkonkoma,
NY 11779
(631) 737-0100

PHYSICIAN GROUP PRACTICES

WESTCHESTER

**Montefiore
Medical Group**

Cross County Center

1010 Central Park Ave
Yonkers, NY 10704
(914) 964-4000

Eastchester Office

685 White Plains Rd
Eastchester, NY 10708
(914) 395-1530

SECTION HIGHLIGHTS >>> GETTING STARTED

Your HIP Identification Card

- Your HIP ID card is your passport to accessing medical services – keep it handy. The back of your HIP ID card includes important information, including the specific mailing addresses and telephone numbers you need to use as a member.
- Your HIP ID card is easy to replace if lost. Request a new one by logging on to hipusa.com, using HIP's Interactive Voice Response (IVR) system or speaking with a Customer Service Advocate.
- To use HIP's IVR system or to speak with a Customer Service Advocate, call **1-800-HIP-TALK (1-800-447-8255)**. If you use a telephone device for the hearing- or speech-impaired, please call **1-888-447-4TDD (1-888-447-4833)**.

Your Primary Care Physician (PCP)

- If you haven't done so already, select a primary care physician (PCP). Each covered dependent can select a different PCP. Adults may choose a PCP with expertise in either Internal Medicine or Family Medicine. Children's PCPs are usually pediatricians.
- If you have already selected a PCP, the name and telephone number of the physician should appear on your HIP ID card.
- With HIP you can choose between PCPs who work independently in private practice or physicians who work in conveniently located physician group practices. The choice is yours.
- Your PCP will usually provide or coordinate all your health care.
- When you visit your PCP, you are responsible only for any copayment indicated on your HIP ID card.
- You can change your PCP at any time by accessing our Web site at hipusa.com, using our Interactive Voice Response (IVR) system or by speaking with one of our Customer Service Advocates at **1-800-HIP-TALK (1-800-447-8255)** Monday through Friday, between 8 am and 6 pm.

GETTING STARTED

Your HIP Identification Card

Your HIP ID card contains important information that you will need to obtain medical care, wherever you happen to be. Keep it safe and take it with you when you travel, in case of an emergency.

Keep your HIP ID card handy, too, when calling a HIP participating provider for an appointment or HIP Customer Service at **1-800-HIP-TALK (1-800-447-8255)** for information and advice. That way you will be ready to provide the information you'll be asked to give.

If you have family coverage, each of your covered dependents will receive his or her own HIP ID card. Be sure each one knows how important the HIP ID card is for receiving HIP benefits.

If you or one of your covered dependents did not receive a HIP ID card or if a card has been lost or stolen, please request a new one. If you have Internet access, you can log on to hipusa.com to request a card. Or, use the Interactive Voice Response (IVR) system by calling **1-800-HIP-TALK (1-800-447-8255)** to make an automated card request. If you prefer, you may also speak with a Customer Service Advocate by calling **1-800-HIP-TALK (1-800-447-8255)**.

Please read the back of your HIP ID card carefully for special mailing or telephone contacts. HIP works with several organizations affiliated with health care providers to perform certain administrative operations, such as claims processing or case management. In these cases, your contact information may differ. These are the contacts you should use.

Your Primary Care Physician (PCP)

When you enroll in HIP, you and each covered dependent choose a participating physician as your primary care physician (PCP). Adults may choose a PCP with expertise in either Internal Medicine or Family Medicine. Children's PCPs are usually pediatricians.

Whomever you choose, your PCP is now your personal physician who will provide or arrange the care you need. Your PCP's name and telephone number appear on your HIP ID card for easy reference.

Scheduling Your First Visit

Call your PCP's office to schedule an introductory visit. This visit will help you establish a relationship with your PCP. When you go for your appointment, your PCP will ask about your health history and start a confidential medical record. It is important for you to ask your former physician to send your previous medical records to your PCP's office. If at all possible, the records should be there before your first visit.

Scheduling Other Appointments

To continue receiving primary care, just call your PCP's office for appointments when you need them. When you call, be ready to explain why you want to see the doctor. Being clear about the reason will help the office schedule your appointment appropriately.

Changing Your PCP

If you wish to change your PCP or if your PCP ceases participation with HIP, you can choose another PCP by following these simple instructions:

- First, look through the HIP participating provider directory and choose a PCP who is accepting new patients. If a doctor is not currently accepting new patients, the listing will be footnoted to that effect. You can also find HIP's participating provider list on our Web site, hipusa.com.

Additional information about physicians is available from the State of New York.

Call **1-800-663-6614** or visit their Web site at www.health.state.ny.us/nysdoh/opmc/main.htm.

- Next, you can select your PCP and also update your selection using hipusa.com. You can also call **1-800-HIP-TALK (1-800-447-8255)** and select a PCP by using our interactive voice response (IVR) system. If you prefer, a Customer Service Advocate can assist you when you call.

SECTION HIGHLIGHTS >>>

SEEING A SPECIALIST

With A Referral From Your PCP

- Your PCP usually arranges specialist referrals. If you choose to go to a specialist without a referral from your PCP, you will usually not receive coverage from HIP for the medical service.
- PCPs refer patients to specialists they know and trust. In most cases, that means referrals to other physicians within the same physician group practice to which the PCP belongs. HIP participating PCPs in private practice are likely to refer you to specialists with whom they already have a working relationship.
- If you would like a second opinion, your PCP will arrange one for you.

Without A Referral From Your PCP

- You can self-refer within HIP's network for the following services:
 - Mental health services.
 - Chiropractic care.
 - To a participating optometrist for refractive eye examinations.
 - To a participating ophthalmologist for diabetic eye examinations.

Women can self-refer to a radiology department for mammography screenings and a gynecologist for primary and preventive care.

- If you have a condition or disease that needs the ongoing care of a specialist, your PCP may be able to give you a standing referral, so you won't need a new referral every time you visit the specialist. Your PCP may also be able to arrange to have that specialist act as your PCP while you are receiving specialized care. In certain cases, your PCP may also be able to arrange for treatment from a specialty care center with expertise in your condition.
- If your HIP participating physician decides to no longer participate with HIP, we will notify you and assist you in finding a new HIP participating physician. You can log on to hipusa.com and use our Web site to select a new PCP. Or, if you prefer, just call **1-800-HIP-TALK (1-800-447-8255)** and a Customer Service Advocate will initiate the transition process.

SEEING A SPECIALIST

With A Referral From Your PCP

While your PCP will provide you with much of the care you need, there may be times when he or she will refer you to a specialist. You will receive such a referral whenever your PCP believes your medical problem requires the attention of a physician who is specially trained in that area.

You can expect that your PCP will refer you to specialists he or she knows and trusts. Usually these are other physicians within the same physician group practice to which the PCP belongs. For example:

- A PCP practicing in a physician group practice will generally refer you to specialists within that medical group office or other medical group office run by the same group of doctors.
- A PCP who participates with HIP through an Independent Practice Association (IPA)* or Integrated Health System (IHS)* will usually refer you to specialists within the same IPA or IHS.
- A PCP participating independently with HIP will also tend to refer you to specialists with whom he or she works regularly.

Here are the steps involved in receiving **referred care from a HIP participating specialist**:

- 1) Call your PCP for an appointment.
- 2) After examining you, and your PCP feels it is necessary, he or she will provide you with a written **referral** or create an electronic **referral** for you to see a specialist.
- 3) Call the specialist to schedule an appointment.

Note: In some unique situations, your PCP might want to refer you to a non-participating specialist. The PCP must call HIP, prior to any visit or service provided by the non-participating specialist, to seek HIP's approval. **If HIP approves the referral, you will receive HMO coverage when you obtain services from the non-participating specialist.**

* Independent Practice Associations (IPAs) and Integrated Health Systems (IHSs) are groups of physicians and other health care providers working together to manage the health care needs of their patients. These health care professionals arrange for specialty care, ancillary health care services, and inpatient facility care through this partnership of affiliated providers. Some of the IPAs and IHSs in the HIP provider network are: Lenox Hill Community Medical Group and Montefiore Medical Center. Members selecting a PCP from one of these groups can expect to be referred to other providers from within that IPA/IHS.

SEEING A SPECIALIST

When your PCP refers you to a participating physician or HIP approves your referral to a non-participating physician, you will receive HMO benefits. This means you will have no out-of-pocket expenses, except for any copayment that might be required by your coverage.

To change your specialist, simply contact your PCP. Your PCP can refer you to another participating specialist (or, if necessary, to a non-participating specialist approved by HIP).

Without A Referral

If you have a medical problem and choose to go directly to a specialist without first obtaining a referral from your PCP, you will not receive HMO benefits for those services. **In most instances, you must pay the specialist directly, whether that specialist is a HIP participating physician or not.**

In some cases, however, you don't need a referral from your PCP and can self-refer within HIP's network for certain services. You may schedule an appointment with a participating mental health provider, a radiology department for a mammogram screening or a gynecologist for preventive and primary services without first visiting and obtaining a referral from your PCP. You may also self-refer to a chiropractor, a participating optometrist for refractive eye examinations and to an ophthalmologist for diabetic eye examinations. Be sure to check your Contract or Certificate of Coverage for complete information about when self-referrals are allowed.

Note: If you do not receive prior approval from HIP for out-of-network services, you will incur financial liability for the services received.

Annual Mammography Screening

Female members can self-refer for their annual mammography screening benefit by contacting the radiology department at their PCP's physician group practice directly for an appointment. If your PCP is in private practice, call **1-800-HIP-TALK (1-800-447-8255)** between 8 am and 6 pm, Monday through Friday to obtain a list of participating radiology providers in your area.

Special Situations

Standing Specialty Referrals And Specialists As Coordinators Of Care

If you have a condition or disease that needs the ongoing care of a specialist, a standing referral to see that specialist can be arranged. A standing referral means that you may make an appointment with your specialist and visit him or her directly. Please refer to your Contract or Certificate of Coverage for additional information. Your Contract or Certificate of Coverage provides a detailed explanation of the standing specialty referral process.

SEEING A SPECIALIST

Access To Specialty Care Centers

If you have a life-threatening or degenerative and disabling disease or condition that requires special medical treatment for a prolonged period of time, you may need to go to a center that specializes in the care of that particular condition. Specialty care centers are those centers designated by an agency of the state or federal government, or by a voluntary national health organization, as having expertise in the treatment of life-threatening or degenerative and disabling diseases or conditions. Treatment at a specialty care facility can be arranged by your PCP. Please refer to your Contract or Certificate of Coverage for additional information. Your Contract or Certificate of Coverage provides a detailed explanation of how to access specialty care centers.

Notice And Transitional Care When A Physician Is No Longer In The HIP Network Of Participating Providers

HIP will provide you with written notice within 15 days of learning that your PCP will no longer be a HIP participating physician. You will then need to select a new PCP. You may, however, request continuation of an ongoing course of treatment for a period of up to 90 days. The 90 day period begins when your PCP's contractual obligation to provide services to you ends.

To receive transitional care, you must notify the Customer Service Department at **1-800-HIP-TALK (1-800-447-8255)** prior to continuing care with the physician. Such care shall be approved by HIP only if the physician:

- Continues to accept HIP's rates of reimbursement for your care.
- Adheres to HIP's quality assurance requirements and provides HIP with all necessary information related to your care.
- Adheres to all other HIP administrative policies and procedures, including those regarding referrals and prior approval requirements.

Please refer to your Contract or Certificate of Coverage for additional information. Your Contract or Certificate of Coverage provides a detailed explanation of the transition process.

Transitional Care For New Members Receiving Ongoing Treatment

If you are a newly enrolled HIP member whose physician is not in the HIP network, HIP will permit you to continue an ongoing course of treatment with your current physician under certain circumstances and for a limited period of time. HIP will allow a transitional period of up to 60 days from your effective date of enrollment as an aid toward transitioning care to a new HIP participating physician. This transitional care will be covered only if you have a life-threatening or degenerative and disabling disease or condition. If you are in your second or third trimester of pregnancy, the transitional period will include postpartum care directly related to your child's delivery.

SEEING A SPECIALIST

If you choose to continue to receive care from your current physician during this transitional period, you must notify the Anticipated and Continuing Care Services Program at **1-866-447-9717, option 4** prior to continuing care with the physician. Such care shall be approved by HIP only if the physician:

- Accepts HIP's reimbursement rates as payment in full for the services provided to you, other than your usual copayment.
- Adheres to HIP's quality assurance requirements and provides HIP with all necessary information related to your care.
- Adheres to all other HIP administrative policies and procedures, including those regarding referrals and prior authorization requirements.

Please refer to your Contract or Certificate of Coverage for additional information. Your Contract or Certificate of Coverage provides a detailed explanation of the transition process for new members.

The above procedures shall not require HIP to provide coverage for care that is otherwise excluded due to a pre-existing condition limitation, is not medically necessary or conforms to any other exclusion or limitation contained in your Contract or Certificate of Coverage.

Second Opinions

As a HIP member you are entitled to two kinds of second opinions:

- A second opinion related to the diagnosis and treatment of cancer from an appropriate specialist that may or may not be a HIP participating physician.
- A second medical opinion from a HIP participating physician at any time, for any reason.

To obtain a second opinion, simply speak with your PCP. A referral from your PCP is required in both cases. Keep in mind that a **second opinion consists only of a consultation**. Any required treatment must be provided or arranged through a HIP participating physician.

Please refer to your Contract or Certificate of Coverage for details concerning your second opinion benefits.

SECTION HIGHLIGHTS >>>

INFORMATION ABOUT YOUR COVERAGE

Your Contract Or Certificate Of Coverage

- Refer to your HMO Contract or Certificate of Coverage for the most complete information about covered services, terms, conditions, exclusions and limitations.

Introduction To Your Welcome Kit

- Refer to the colorful “Introduction to your HIP HMO Welcome Kit” included with your Welcome Kit for a quick overview of your HIP HMO Plan. The kit anticipates and answers a number of frequently asked questions about HIP and your HIP HMO Plan.

HIP Claim Filing Procedures

- The HIP HMO Plan usually does not require any claim filing. You may need to file a claim, however, if you receive emergency care when you are outside HIP’s service area.
- To obtain a claim form, ask your PCP or call HIP Customer Service at **1-800-HIP-TALK (1-800-447-8255)**. Attach a paid itemized bill to the completed claim form for the services you received.
- Submit the claim form to the mailing address indicated on the back of your HIP ID card. This is very important since HIP works with several organizations affiliated with health care providers to handle certain operations, such as claims processing.

Coordination Of Benefits

(Primary and Secondary Insurance)

- If you are married and covered by both HIP’s HMO Plan and your spouse’s health plan, your coverage is primary. That is, HIP will pay the provider first (subject to the limitations and exclusions stated in your Contract or Certificate of Coverage). Your spouse’s coverage will pay – as the secondary insurer – what HIP does not pay (subject to the limitations and exclusions stated in your spouse’s Contract or Certificate of Coverage). In many instances, this can reduce your out-of-pocket health care expenses.

INFORMATION ABOUT YOUR COVERAGE

Understanding Your HMO Coverage

Your Welcome Kit includes a Schedule of Benefits within your Contract or Certificate of Coverage. The Schedule of Benefits is a good way to get an overview of your benefits. The Contract or Certificate of Coverage provides the most complete information about covered services, terms, conditions, exclusions and limitations.

Note also that your benefit descriptions appear on HIP's Web site at hipusa.com.

In your Welcome Kit, including this Member Handbook, you'll find the special features of your coverage as well as any responsibilities you may have. You may wish to review the definitions of some important terms in the introduction section of this handbook before reading further about your coverage.

In general, it's important to remember that, in most cases, you cannot receive HMO benefits unless the care is given or referred by your PCP. Referral is the key:

- **With a referral**—You can see either participating or non-participating physicians. Usually, however, you will receive referrals to participating physicians unless the service you require is not available within the network. Also note that all referrals to non-participating physicians must be approved in advance through HIP. Contacting HIP is the responsibility of your PCP.
- **Without a referral**—*Services will not be covered* (with a few exceptions) as part of your HMO benefits and you will be responsible for the cost.

If You Need To File Claims For Your Benefits

With HMO benefits, you rarely need to file claims. But sometimes you may need to pay a provider's bill then submit a claim for reimbursement. This might occur, for example, if you receive emergency care when you are outside of HIP's service area.

To submit a claim, consult your PCP or call HIP Customer Service at **1-800-HIP-TALK (1-800-447-8255)** for a HIP claim form. Submit a paid itemized bill for the services you received along with the completed claim form to the address on the back of your HIP ID card.

Please read the back of your HIP ID card carefully for special mailing or telephone contacts for your claims processing. HIP works with several organizations affiliated with providers to handle certain operations such as claims processing. In these cases, your contact information may differ. These are the contacts you should use to mail your claim form and bill.

You'll be reimbursed as long as the service for which you are submitting a claim meets the terms of your HIP HMO Plan Contract or Certificate of Coverage.

INFORMATION ABOUT YOUR COVERAGE

Coordination Of Benefits

Some HIP members are also covered under another health plan – for example, the plan in which a spouse may be insured. If that is true in your case, please be sure that you first file your claims with your primary insurer – the insurer with whom you have a Contract or Certificate of Coverage. If the reimbursement you receive is less than the full charge for the service you are claiming, you can then submit a claim to a secondary insurer – the insurer that covers you as a dependent or spouse of the person who has the Contract or Certificate of Coverage with that plan. Please check your Contract or Certificate of Coverage for details on how Coordination of Benefits (COB) works.

Premiums

In addition to any copayments, coinsurance or deductibles your plan requires, you may also pay all or part of the premium for your coverage. If you are responsible for paying a premium for your coverage, rest assured that HIP will make every effort to keep costs as affordable as possible.

- You may pay premiums directly to HIP if you are enrolled as a direct payment subscriber.
- You may pay premiums, or make a contribution to your premium, if you are enrolled through a group. Groups are organizations such as an employer, labor union, association or welfare fund, which act as the remitting agent and send HIP the premium for your coverage.

Our premiums are determined by our Board of Directors. Premiums are consistent with State insurance laws and regulations and are approved by the Superintendent of Insurance of the State of New York.

Special note to direct payment subscribers:

We will notify you in writing of any change in premiums at least 30 days before the new premiums go into effect. All premiums are due and payable in advance. Except for the first premium, we allow a 30-day grace period in which to pay. If the premium is paid within this grace period, you will be covered for the period of the payment. If the premium is not paid within the grace period, your coverage will terminate as of the date the payment was due. You will be responsible for the cost of all services received during the grace period. If we accept a late payment, your coverage will be reinstated to the premium due date.

SECTION HIGHLIGHTS >>>

SPECIAL KINDS OF COVERAGE

Prescription Drug Coverage

- Many of the drugs included in the HIP Drug Formulary are generic. The Food and Drug Administration (FDA) requires that generic drugs meet the same quality standards as their equivalent brand name drugs.
- If you have prescription drug coverage through HIP, please refer to the drug rider in your Contract or Certificate of Coverage for specific copayment responsibilities.
- If you have prescription drug coverage through HIP, you must fill your prescription (issued by a HIP participating doctor) at one of our more than 38,000 HIP participating pharmacies nationwide.
- You may receive a 90-day supply of HIP approved maintenance medications in the mail through Express Scripts. Fill the first prescription right away at your local HIP participating pharmacy. Submit a second prescription to Express Scripts allowing 10 to 14 business days for delivery from Express Scripts.
- You can also fill prescriptions through the Express Scripts Internet Service through hipusa.com. Depending on your coverage, your copayment may be reduced if you use the Express Scripts Internet/Mail Order Service.
- You can also order prescription refills through Express Scripts by calling **1-800-224-5502** 24 hours a day, 7 days a week.

Mental Health And Alcohol / Drug Treatment

- You do not need a referral from your PCP for mental health and alcohol/drug treatment. Call **1-888-447-2526** for help in selecting a provider. Or, turn to the listing of HIP Mental Health Centers in this section and contact a center convenient to you.

Disease Management Programs

- HIP has special programs for members with asthma, diabetes, congestive heart failure and arthritis. Each program is designed to provide support, education and other resources to help members improve their quality of life.

Dental Coverage For Group Members

- HIP offers a broad range of dental coverage through an arrangement with Careington International. To find a participating dentist near you, call Careington International at **1-800-290-0523** or **1-877-LIV4HIP (1-877-548-4447)** Monday through Friday, between 8 am and 8 pm.

SPECIAL KINDS OF COVERAGE

Prescription Drug Coverage

Details on any prescription drug coverage you may have, including copayment and annual maximum provisions, appear in your prescription drug rider. Your copayment information can also be found on your HIP ID card.

The HIP Drug Formulary

HIP prescription drug coverage is usually for prescription drugs that are listed in HIP's Drug Formulary and are filled at a HIP participating pharmacy.*

The HIP Drug Formulary is a continually updated list of medications that HIP participating physicians and other experts have approved for disease treatment and preservation of our members' health. The primary purpose of the formulary is to promote the use of safe, effective and affordable drugs and treatments while maintaining and promoting quality patient care.

Please note: depending on your benefit, some formulary drugs may be excluded from your coverage. Please refer to your prescription drug rider and/or Contract or Certificate of Coverage to find out which drugs are excluded from your coverage.

When your doctor wants to prescribe a drug that is not in the HIP Drug Formulary, he or she must contact Pharmacy Services Clinical Department to obtain prior approval. There is a phone line dedicated for this purpose: **1-646-447-3146**. Unless you have three-tiered prescription drug coverage (see next page), coverage for non-formulary prescriptions will not be provided without prior approval.

HIP participating physicians receive regular communications about changes to the HIP Drug Formulary. If you have access to the Internet, you can log on to our Web site at hipusa.com and click on "Pharmacy Services" to check the formulary status of a drug. If you don't have access to the Internet at home, many local public libraries can provide you with free Internet access.

Or, you can call HIP Customer Service at **1-800-HIP-TALK (1-800-447-8255)** to request a copy of the HIP Drug Formulary.

Brand Name vs. Generic Drugs

Generic drugs help promote cost effective health care. The Food and Drug Administration (FDA) requires that generic drugs meet the same quality standards as their equivalent brand name drugs. In some cases, brand medications will have more than one generic equivalent available. HIP's corporate and contracted pharmacies will dispense a covered generic equivalent when available and allowed by law.

* Prescription drug riders that cover non-formulary drugs are available to groups with HIP Prime coverage. Check the Contract or Certificate of Coverage of this Welcome Kit for additional information about your coverage.

SPECIAL KINDS OF COVERAGE

Tiered Benefit Structure

HIP prescription drug coverage is either one-tiered, two-tiered or three-tiered.

- **One-Tiered Coverage**—If you have a one-tiered benefit, this means that you have one copay for generic prescription drugs included in the formulary.
- **Two-Tiered Coverage**—If you have two-tiered coverage, you will have one copay for generic drugs included in the formulary and another higher copay for brand name drugs included in the formulary. If your physician has medical justification for prescribing a non-formulary medication, your physician must obtain a Physician's Prior Approval (PPA) from HIP's Pharmacy Services Clinical Department. If your physician does not obtain a PPA, you will not be covered for the non-formulary medication.
- **Three-Tiered Coverage**—If you have three-tiered coverage, you will have one copay for generic drugs included in the formulary, a higher copay for brand name drugs included in the formulary and another higher copay for drugs that are not included in the formulary. Your coverage for non-formulary medications means that your physician no longer has to contact HIP Pharmacy Services Clinical Department for a PPA. You will be covered for non-formulary drugs, but you will have a higher copay than for formulary brand or generic drugs.

The Tiered Benefit Structure Chart on the following page provides a further illustration of how the tiered benefit structure works.

Filling Your Prescriptions At Participating Pharmacies

You can fill your prescriptions (issued by a HIP participating physician) by visiting one of our more than 38,000 HIP participating pharmacies nationwide. Some physician group practices also have on-site pharmacies for your convenience.

When traveling, you may bring a prescription drug bottle from your local pharmacy to any participating pharmacy nationwide. The bottle contains all the information needed by pharmacists to arrange the transfer of a prescription filled from the original pharmacy. (All State, Federal and plan limitations will apply – e.g., on the number of refills allowed and any early refill limitations.) If a refill is available, a single telephone call by the pharmacist can complete the transfer. The processing time would then be the same as with any other prescription.

Always remember to present your HIP ID card when filling your prescriptions. Depending on your coverage, you may have to make a copayment when you obtain a 30-day supply (or less) of a prescription or refill. There may also be an annual maximum benefit on your prescription drug coverage. Please refer to your prescription drug rider for specific details.

SPECIAL KINDS OF COVERAGE

Tiered Benefit Structure Chart

Please refer to your Contract or Certificate of Coverage to find out if prescription drug coverage is included in your plan. If you have prescription drug coverage, your copayment information can also be found on your HIP ID card.

The chart below illustrates the differences among one-tiered, two-tiered and three-tiered benefits.

Tiered Benefit Coverage	Types of Drugs Covered	Non-Formulary Drugs	Cost to You
One-Tiered Coverage (One copayment)	Formulary generic drugs only.	Not Covered	One copay for generic drugs only (Example: \$5 copay – formulary generic drugs only).
Two-Tiered Coverage (Two copayments)	Formulary generic drugs and formulary brand name drugs	Not covered unless your physician obtains a Physician's Prior Approval (PPA) by calling HIP Pharmacy Services Clinical Department at 1-646-447-3146.	One copay for generic drugs and a higher copay for brand name drugs (Example: \$5 formulary generic copay; \$10 formulary brand copay).
Three-Tiered Coverage (Three copayments)	Formulary generic drugs, formulary brand name drugs and non-formulary drugs.	Covered. No Physician Prior Approval required for non-formulary drugs.	One copay for generic drugs, a higher copay for brand name drugs and another, higher copay for non-formulary drugs.

SPECIAL KINDS OF COVERAGE

Filling Your Prescription Through The Internet And Mail Order Program

HIP works with Express Scripts, one of the leading Internet and Mail Order pharmacies. You may obtain up to a 90-day supply of a HIP approved maintenance medication through Express Scripts. Since prescription drug delivery takes 10 to 14 business days through Express Scripts Internet/Mail Order Pharmacy, we recommend that you have your doctor complete two prescriptions. For new prescriptions, fill the prescription right away at your local HIP participating pharmacy. Submit the second prescription to Express Scripts in enough time to allow for processing before your initial prescription runs out.

Depending on your benefit, your copayments (if any) may be reduced by using the Express Scripts Internet/Mail Order Pharmacy. Plus, your medication is shipped right to your home. Reductions in copayments, however, only apply to formulary brand and formulary generic medications. If you have the three-tier benefit and you obtain a non-formulary medication your copayment will not be reduced.

You can also order prescriptions through Express Scripts without using the Internet. To request a Mail Order Pharmacy application, please call HIP Customer Service at **1-800-HIP-TALK (1-800-447-8255)**, Monday through Friday between 8 am and 6 pm. If you are hearing- or speech-impaired you may call **1-888-HIP-4TDD (1-888-447-4833)**. To order prescription refills directly from Express Scripts, call **1-800-224-5502** 24 hours a day, 7 days a week.

To order prescription drugs through the Internet or to review the most up-to-date formulary listings, first register as a member at HIP's Web site hipusa.com. After you have successfully registered, just click on the Pharmacy Services icon and follow the step-by-step instructions.

HIP's Specialty Pharmacy Program

Members that use a specialty drug must have their prescriptions prescribed by a participating physician and get their prescriptions filled at HIP's Specialty Pharmacy, ICORE Pharmacy Services. You cannot have a specialty drug filled at a retail or mail order pharmacy.

Specialty drugs are almost always injectable drugs used for conditions such as Multiple Sclerosis, growth deficiencies, fertility issues and Hepatitis C. For your convenience, some non-injectable drugs, such as Clomiphene citrate and Ribavarin, are also available through ICORE.

ICORE staff understands the complex needs of patients that use a specialty drug and are available 24 hours a day, 7 days a week. Additional benefits of using ICORE include:

- **Home Delivery**—ICORE will fill your prescription and deliver your drugs directly to your home.
- **Direct Pharmacist and/or Nurse Access**—You will have access to experienced pharmacists and/or nurses that ensure you get continual, prompt, personalized care while on treatments.

SPECIAL KINDS OF COVERAGE

- **Educational Materials**—You will receive support and home instruction information.
- **Ancillary Supplies**—You will receive syringes, needles and other needed supplies at no cost.
- **Comprehensive Coordination of Care**—You will get refill reminders and ICORE consult with your doctor regarding your medication(s).

Specialty drugs are subject to any copayment and coinsurance described in your Contract or Certificate of Coverage. In addition, depending on your coverage, specialty drugs that are not in HIP's Drug Formulary may require that your physician obtain a Physician's Prior Approval (PPA). Please refer to page 22 for a description of the HIP Drug Formulary and the PPA process.

All prescriptions must be submitted to ICORE by fax at 1-866-364-2673 or phoned in by your physician. Any subsequent refills of an existing prescription, filled at a local pharmacy, must be transferred to ICORE. For more information, you or your participating physician can call ICORE Pharmacy Services at **1-866-554-2673**.

Your participating physician will know which prescriptions must be filled by ICORE. If, however, you or your participating physician have any questions, please call ICORE Pharmacy Services at **1-866-554-2673**. If you have any questions regarding your benefits, please call HIP Customer Service at **1-800-HIP-TALK (1-800-447-8255)**.

Helpful Definitions

These definitions may help you understand your drug coverage.

HIP's Drug Formulary—The drug formulary is a list of medications – including both brand name and generic – that are covered under HIP's prescription drug benefit.

Formulary Medication—A formulary medication is one that is listed on HIP's Drug Formulary. Depending on the prescription benefit, members are covered for formulary items minus any applicable coinsurance, copayment and/or deductible.

Non-Formulary Medication—A non-formulary medication is one that is not listed on HIP's Drug Formulary. A member can receive coverage for a non-formulary medication, through a Prior Approval or a non-formulary copayment. The specific coverage type is dependent upon the member's prescription drug benefit.

Non-Formulary/Three-Tier Option—If you have the non-formulary/third tier benefit and you obtain a non-formulary medication, either brand name or generic, you will be responsible for a higher copayment. Physician Prior Approvals (PPAs) are not issued for this benefit.

SPECIAL KINDS OF COVERAGE

Brand Name Medication—A Brand Name Medication is the first version of a particular drug marketed by a specific drug company.

Generic Medication—When the patent on a specific brand name drug expires, a generic version can be marketed, with FDA approval, usually at a much lower price. The FDA regulates generic drugs with the same strict standards used for brand name drugs. Generic drugs have different ratings. “A” rated generics are deemed as safe and efficacious as their brand counterparts. HIP’s Drug Formulary only contains “A” rated generic drugs.

Maintenance Medication—HIP has a list of drugs that are considered maintenance medications. These medications are used in the treatment of chronic “lifelong” conditions. Members on HIP approved maintenance medications can receive up to a 90-day supply of medication. Many drugs, although they may be used to treat chronic conditions, are not covered as maintenance medications due to issues of patient safety and the need for constant supervision.

If your prescription drug coverage has an annual maximum limit for medications, and you have reached that maximum, you will be eligible to purchase medications at a discounted rate, pursuant to HIP’s agreement with its Participating Pharmacy Network.

Mental Health Care And Alcohol/Drug Treatment

Check the Schedule of Benefits included in your Contract or Certificate of Coverage for the number of visits and days of inpatient and outpatient care that your coverage may include. Be sure to check the schedule too, for any copayments you may have.

You do not need a referral from your PCP to obtain covered mental health services or alcohol or substance abuse, detoxification and rehabilitation services. You also do not need to obtain prior approval for routine outpatient mental health or alcohol/substance abuse services when received from a participating provider. Routine services include, but are not limited to, initial assessment, individual, group and family treatment and medication management.

For other services, including inpatient treatment and any service provided by a non-participating provider, prior approval is required. To obtain prior approval or to find out if a service requires prior approval, just call **1-888-447-2526**. When you call, you will be transferred to a trained professional who will assess your treatment and provide you with prior approval if needed. All calls will be treated as confidential.

SPECIAL KINDS OF COVERAGE

For mental health services only, you have another option: you can call a HIP mental health center directly. There, too, a trained professional will assess your treatment options and make arrangements for you to see a provider practicing at the center.

HIP Mental Health Centers

Brooklyn Mental Health Service

1-718-834-1500

195 Montague Street, 2nd floor
Brooklyn, NY 11201

Nassau-Suffolk Mental Health Service

1-516-921-8811

185 Froehlich Farm Boulevard
Woodbury, NY 11797

Queens Mental Health Service

1-718-459-0500

97-45 Queens Boulevard, 8th floor
Rego Park, NY 11374

You can also access information about mental health care by visiting hipusa.com.

Disease Management Programs

Asthma Program (ages 2 and above)

Through this program, all HIP members with asthma can get a peak flow meter, an asthma guidebook, 24/7 access to a licensed respiratory therapist and an asthma management plan to be completed with their PCP. High-risk asthma patients will also get a home visit by a licensed respiratory therapist based on your needs.

Diabetes Support Program

If your doctor has told you that you have diabetes, you know how important it is to manage your condition. At regular intervals, HIP will send you a letter encouraging you to get important tests and examinations that will help control your diabetes. These tests and examinations let you and your doctor know if your diabetes is under control.

SPECIAL KINDS OF COVERAGE

This letter will tell you:

- Which tests/examinations you need.
 - HbA1c
 - LDL level
 - Microalbumin in urine
 - Dilated retinal eye exam
 - Foot examination
- When you had your last test.
- What the result was (if available).
- When you should have your next test.

HIP also sends your doctor information on these tests. If you receive this letter, make sure to schedule an appointment to take the required tests.

HIP also offers diabetes education classes. These free two-hour classes are offered at select locations throughout HIP's service area. Certified Diabetes Educators, Nutritionists and/or Behavior Health Specialists share valuable information on various topics.

Arthritis Programs

For members with arthritis, HIP offers the following programs:

- **Arthritis Foundation Exercise Program**—an eight week program, conducted in weekly one-hour sessions, that teaches participants how to do gentle exercises. The program is proven to reduce pain, increase joint flexibility and range of motion, improve overall stamina and maintain muscular strength.
- **Arthritis Foundation Self-Help Program**—a six week educational program, in weekly two-hour sessions, designed to teach people with arthritis to take an active role in managing their condition.
- **Tai Chi From The Arthritis Foundation**—an eight week exercise program, led by a certified instructor in weekly one-hour sessions. This program teaches gentle agile steps and movements to reduce pain and stiffness, improve balance, enhance mobility, improve breathing and promote relaxation.

For details on arthritis programs. call:

New York Arthritis Exchange at **1-212-984-8730** (In Long Island at **1-631-427-8272**)

SPECIAL KINDS OF COVERAGE

Congestive Heart Failure (CHF) Program

Through this program, members with Congestive Heart Failure take a more active role in managing their illness. Since weight management is critical for CHF control, members who are enrolled in the program receive an electronic scale along with an interactive question and answer device. Weights and symptoms are transmitted telephonically twice a day to registered nurses who keep track of each patient's data seven days a week. If significant changes are detected, the patient's doctor is alerted right away so that prompt corrective action may be taken.

In addition, nurses call members from time to time to provide education on such topics as diet, medication, symptom recognition, exercise and lifestyle changes.

For more information, go to hipusa.com.

Dental Coverage For Group Members

HIP offers group members access to dental coverage through an arrangement with Careington International, a leading national dental network. (See important notes a, b and c on the following page.)

This coverage provides access to the following general dental services from participating dentists:

- One examination (comprehensive or periodic) every six months at \$5 per visit. (See important note b on the following page.)
- One prophylaxis (cleaning) every six months at \$10 per visit. (See important note c on the following page.)
- One topical application of fluoride (for children age 16 and under) every six months at \$5 per visit.
- Fluoride applications age 17 and over (one every six months) – copay determined by location of service.

Additional available services including, but not limited to, X-rays, fillings, crowns or dentures will be provided at a discounted rate subject to fee schedules that HIP has negotiated. For example, suppose a dentist's usual fee for a particular service is \$125, but HIP has negotiated a discounted fee of \$100 with the participating dentist. As a HIP member, you would be charged the discounted fee and, therefore, need to pay the participating dentist \$100.*

* This is only an example to illustrate how the plan works. It does not necessarily reflect a negotiated fee for any service.

SPECIAL KINDS OF COVERAGE

These schedules may change from time to time. There are several fee schedules based on the location of the provider's office. Therefore, members will pay different fees based on the location (region) of the dentist's office.

Specialist dental services, such as endodontic, oral and maxillofacial surgery, as well as orthodontic, pediatric, periodontic and prosthodontic procedures are also available from participating dentists. Charges for specialist services are discounted 20 percent off the dentist's usual and customary rates. **No fee schedule applies to specialist dental services.**

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 to take advantage of the discounted rates. You may select any participating HIP/Careington dentist and may change your choice of dentist at any time. For help locating a participating dentist near you, for answers to benefits questions or for a fee schedule or directory, call Careington International directly at **1-800-290-0523** or **1-877-LIV4HIP (1-877-548-4447)**, Monday through Friday between 8 am and 8 pm.

Important Notes:

- a. **This benefit does not apply to your coverage if you are a HIP/HMO Direct subscriber or HIP/Choice Plus Direct subscriber.** It applies only to those members enrolled through a group or an organization such as an employer, labor union, association or welfare fund that acts as a remitting agent and sends HIP the premium for your coverage.
- b. Participating dentists may recommend that members receive additional services and procedures consistent with generally accepted dental practices. For example, a recent full-mouth series of X-rays may be required at the time of examination. Frequency of X-rays depends on the practitioner's judgment of each individual case based on a multitude of factors.
- c. An examination and X-rays are required prior to cleaning.

HIP Prime® Dental*

Your group may have additional dental benefits if it has purchased HIP Prime® Dental. If you are covered by HIP Prime® Dental, you will receive a separate Welcome Kit for that plan.

*HIP Prime® Dental is a trademark of the HIP Insurance Plan of New York.

SECTION HIGHLIGHTS >>>

CARE MANAGEMENT

Care Management Program

- The Care Management Program (CMP) helps members to understand their treatment options and coverage.
- CMP consists of the following programs:
 - Anticipated and Continuing Care Services Program, which assists in making decisions about care or diagnostic services that members and their physicians anticipate the members will need to receive.
 - Concurrent Review Program, which supports appropriate hospital care and length of stay.
 - Case Management Program, which helps in case of complex or serious medical conditions.
 - Post-Service Review, which assures coverage for only medically necessary and appropriate treatment.
 - The Technology Evaluation Program, which continually updates information on non-covered experimental and investigational procedures. Services, supplies, procedures and items considered to be experimental or investigational are not covered by HIP HMO benefits.
- Generally, your PCP or other HIP participating physician will contact the Care Management Department when a decision has been made for you to undergo certain medical services. If you need to contact the CMP directly, just call **1-866-447-9717** or the number indicated on the back of your HIP ID card.

Adverse Determinations

- In some instances, it may be determined through the CMP that a particular service was not medically necessary. If that happens, you will be notified. An appeals process is available to you and your physician to request a reconsideration.

CARE MANAGEMENT

Introduction

Health care today is complicated. Sometimes it is difficult to understand all the treatment options available in every case. Sometimes it is difficult to be certain exactly what is covered and what is not – even though HIP provides detailed information to assure full disclosure and to facilitate understanding.

For these reasons, HIP has developed a series of special information, support and review programs, which are described in this section of your handbook. We have described them in detail, because we want you to understand exactly how we work to help you receive the most appropriate care in the most appropriate settings and understand exactly what benefits are available to you.

We believe these programs support sound medical choices and optimal health outcomes. In the final analysis, however, it is up to you and your physician to make the final decisions about which health care choices are best for you. HIP, however, reserves the right to determine if the medical services provided are necessary and/or covered under your Contract or Certificate of Coverage.

Care Management Program (CMP)

HIP's Care Management Program (CMP) gives you important resources to help with the medical care decisions you and your physician must make. The CMP consists of these key utilization review components:

- Anticipated and Continuing Care Services Program
- Concurrent Care Program
- Case Management Program
- Post-Service Review Program
- Technology Evaluation Program

As a managed care organization, HIP is dedicated to providing quality care and service to each of its members. The following policy statement is distributed to all HIP participating physicians and members:

“Utilization Management (UM) decisions made by HIP Health Plan of New York are based solely on the appropriate level of care and proper medical setting. HIP does not reward practitioners or other individuals conducting utilization review for issuing denials of coverage for service or care. In addition, financial incentives provided to UM decision makers do not encourage decisions that result in underutilization.”

Furthermore, all HIP employees who make utilization-related decisions (and those who supervise them) are required to sign a document acknowledging that they have received the statement. This includes Medical Directors, Care Management Directors and Managers, licensed UM staff and other people and organizations who make UM decisions on behalf of HIP.

Anticipated And Continuing Care Services Program

The CMP Anticipated and Continuing Care Services Program (ACCSP) assists in making decisions about care or diagnostic services that members and their physicians anticipate they will need to receive in the near future. Therefore, HIP requires members (or their physicians on their behalf) to contact ACCSP to assure coverage of certain services.

Prior approval must be obtained from ACCSP for the services indicated below:

- Inpatient non-emergency procedures that provide acute, rehabilitation and skilled nursing care.
- All outpatient surgery for procedures and treatment in a facility or doctor's office.
- Inpatient treatment of mental illness and chemical abuse and dependence, detoxification treatment of chemical abuse and dependence, and rehabilitation treatment of chemical abuse and dependence.
- Services provided by non-participating providers or in non-participating facilities, except in the case of an emergency.
- Non-emergent transportation.
- Home health care.
- Hospice care.
- Pre-transplant evaluation and transplant services.
- Outpatient cardiac and pulmonary rehabilitation.
- Outpatient diagnostic radiology services.

When you anticipate receiving these services, your HIP participating physician will know to contact ACCSP for you.

Determinations, including written denial notification to you or your designee and your HIP participating physician, are conducted within 15 days of the request for a utilization management determination. Once all required information is received, HIP has two business days to render a determination. The maximum time HIP will take to make a decision is 15 days from the date HIP receives your request. Notification of all determinations made by HIP will be made by telephone and in writing. To be sure those services have been approved, you may contact your physician's office staff before you are scheduled to receive the services.

Contacting ACCSP

Should you need to contact the ACCSP Department, just call **1-866-447-9717, option #4**. Representatives are available Monday through Friday from 9 am to 5 pm. If you call after those hours and your call concerns an urgent or emergency admission, you will be prompted to leave a message and a representative from ACCSP will call you or your doctor back if necessary. If the ACCSP Department receives sufficient information, the case will be routed to the appropriate Concurrent Reviewer.

CARE MANAGEMENT

If your call concerns an elective admission, you will be advised to call back the next business day when representatives are available. Please refer to your HIP member ID card for the number to call.

The ACCSP may determine that coverage cannot be provided for a service for a number of reasons. In these instances a determination may result in no approval being given and, instead, lead to the issuance of a denial, or adverse determination. (See *Care Management: Adverse Determinations*.) Prior to an adverse determination being issued, a physician from HIP will attempt to resolve any outstanding issues with your physician.

Experimental/Investigational Treatment

HIP will not provide coverage for any procedure or service, which in HIP's sole judgment, is experimental or investigational, unless required by an external appeals agent. The procedure for filing an external appeal is described in the section of this handbook entitled *If You Disagree with a Decision*.

Our Commitment To You For Timely Anticipated And Continuing Care Services Program Determinations And Notifications

Determinations for urgent care—You or your designee and your physician will be notified (by telephone) of an urgent care determination of coverage that requires prior approval as soon as possible considering your medical condition, but no later than 72 hours after the Care Management Program (CMP) receives your request. Written notification will follow in three calendar days after the decision is made.

Determinations for non-urgent care—You or your designee and your physician will be advised (by telephone and in writing) of a non-urgent care determination that requires prior approval within two business days of receiving all necessary information. The maximum time HIP will take to make a determination is 15 days from the date CMP receives your request.

Important—If the Care Management Program (CMP) does not make a determination within 3 business days of receiving all necessary information, your request will be deemed adversely determined and subject to internal appeal. This designation provides you with the ability to pursue a prompt appeal through the appeals process as described in *If You Disagree With a Decision*.

Concurrent Care Program

The Concurrent Care Program (CCP) facilitates the coordination and continuity of services rendered to a member when in a hospital or other facility. You are automatically entered into the program at the time you are admitted to the hospital.

CARE MANAGEMENT

Concurrent Care Program support begins within 24 hours of your admission to the facility. It's important for the program to start early in the facility, since typically as much as 80% of all hospital services are provided within the first 48 hours. When your admission is arranged through the Anticipated and Continuing Care Services Program, the team knows in advance that you are being admitted to a facility. When your admission is an emergency, the hospital will usually contact the CCP within 24 hours for you.

Our Commitment To You For Concurrent Care Program Determinations And Notifications

Concurrent care determinations involving coverage for continued or extended health care services, or additional services when you are undergoing a course of continued treatment prescribed by a physician, will be made and notice of such determination will be provided to you or your designee or physician.

Notification will be made (by telephone and/or fax and in writing) within the shorter of one day or sufficiently in advance so that you can appeal a denial before it goes into effect. All adverse determinations have appropriate appeals rights.

Any request to extend the course of treatment beyond the period of time or number of treatments that involve urgent care shall be decided as soon as possible taking into account your medical circumstances. HIP will notify you or your designee and your physician of the decision within twenty-four (24) hours of the receipt of this request, provided that any such request is received at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments.

Initial approvals for acute inpatient care, acute rehabilitation and skilled nursing admissions, may be extended concurrently by having your physician contact the CCP for medically necessary additional care.

Adverse Determinations

On occasion, the concurrent care program may find that the care rendered in the facility or outpatient setting does not meet nationally recognized medical necessity criteria. In addition, an adverse determination may be issued for lack of benefit or delay in service and care delivery.

When this situation occurs, and after discussion with your physician by one of the CCP physicians, an adverse determination of coverage may be made. (See *Care Management: Adverse Determinations* for more information.)

CARE MANAGEMENT

Case Management Program

The Case Management Program assists members who have complex or serious diseases or conditions. HIP constantly screens the member population looking for possible candidates: patients with conditions that are known to benefit from Case Management Program coordination.

Members may be in the program from weeks, to months, to years, and Case Management Program contact may be daily, weekly or monthly – it all depends on the individual condition and the circumstances. All contacts and services have one main purpose: the most optimal health care outcome for you.

Post-Service Review Program

The Post-Service Review Program reviews medical and hospital records after services have been provided to determine if such services were medically necessary and appropriate. For example, a post-service review may be triggered by a history of an unusually high number of tests ordered by the physician for the service provided.

Reviews may result in a post-service denial if, for example, the services you received:

- Were not approved prior to your receiving them.
- Were not a medical emergency as defined in *Emergency and Out-of-Area Care*.
- Were not medically necessary (see definition of medical necessity under *Care Management: Adverse Determinations*) or are otherwise excluded from coverage as provided in your Contract or Certificate of Coverage.

Please remember: HIP is obligated to administer coverage to ensure that all contract provisions are honored. That means providing all benefits to which members are entitled. It also means not providing benefits that are excluded from coverage. For example, HIP HMO members are generally not entitled to benefits for experimental or investigational procedures. Please refer to your Contract or Certificate of Coverage for more details.

Our Commitment To You For Timely Post-Service Review Determinations And Notifications

Determination and notification involving post-service benefit reviews shall be made no later than 30 days after receipt of the request.

Important: If the Care Management Program (CMP) does not make a post-service review determination within 30 days of receiving all necessary information, your request will be deemed adversely determined. This designation provides you with the ability to pursue a prompt appeal through the appeals process as described in *If You Disagree With A Decision*.

Our Commitment To Stand By Our Decisions

HIP may reverse a prior approved treatment, service or procedure on retrospective review only when:

- The relevant medical information presented to HIP or the utilization review agent is, upon retrospective review, materially different from the information that was presented during the prior approval review.
- The relevant medical treatment information presented to HIP or the utilization review agent, upon retrospective review, existed at the time of prior approval review but was withheld from or not made available to HIP or the utilization agent.
- HIP or utilization review agent was not aware of the existence of the information at the time of prior approval review.
- The treatment, service, or procedure being requested would not have been authorized if HIP or the utilization review agent had been aware of the information. This determination is to be made using the same specific standards, criteria or procedures as used during the prior approval review.

Technology Evaluation Program

Benefits are not available under HIP HMO for services, supplies, procedures and items considered to be investigational or experimental. A drug, device, procedure or treatment may be determined to be experimental if any of the following applies:

- There are insufficient outcomes data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the disease or injury involved.
- The FDA has not granted the required approval for general use.
- A recognized national medical or dental society or regulatory agency has determined, in writing, that it is for experimental, investigational or research purposes.
- The written protocols or informed consent used by the treating facility or the protocols or informed consent of any other facility studying substantially the same drug, device, procedure or treatment state it is for experimental, investigational or research purposes.

Also, your coverage does not include any technology or any hospitalization in connection with such technology if, in HIP's judgment, such technology is obsolete or ineffective for the diagnosis or treatment of the particular condition. Governmental approval of a technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a diagnosis or treatment of a particular condition.

CARE MANAGEMENT

HIP provides you with the opportunity to further pursue your request for coverage of a specific treatment if we have initially denied your benefits. Please refer to *If You Disagree With A Decision* for more information.

HIP's Technologies and Bioethics Subcommittee meets a minimum of ten times a year to decide when certain technologies previously considered experimental have come to satisfy the general medical standards in effect in our service area at the time of their evaluation.

Also, in making a coverage determination in an individual patient case, HIP's professional staff will consult with physicians involved in the care of a member.

Delegated Management Arrangements

HIP providers often prefer that prior approval, case management, care management and utilization review decisions be made by provider-affiliated organizations and/or reviewers who are independent of HIP. To that end, HIP has entered into several delegated arrangements with organizations and reviewers who are independent of HIP. Depending upon the PCP you select, or have been assigned to, decisions regarding your care may be delegated by HIP to one of these fully licensed, qualified organizations or reviewers.

Please note that the standards applied by these organizations and reviewers are the same standards applied by HIP. Also note that you have the right to appeal any decisions made by a delegated agent directly to that delegated entity. Please refer to *If You Disagree With A Decision* for additional information.

Please refer to your HIP ID card for the numbers to call for your PCP and to discuss your medical care. For HIP membership information, continue to telephone HIP Customer Service and check HIP's Web site at hipusa.com.

Adverse Determinations

In some instances, it may be determined through the Care Management Program that a particular service is, or in the case of a post-service review, was not medically necessary. All determinations are conducted by qualified personnel, including clinical peer reviewers.

For additional information concerning adverse determinations, please refer to *If You Disagree With A Decision*.

What Does Medically Necessary Mean?

Medically necessary health care services or supplies are those that are required to prevent, diagnose, correct or cure conditions in the member that cause acute suffering, endanger life, result in illness or infirmity, interfere substantially with the member's capacity for normal activity or threaten some significant disability. Services or supplies that are not provided in the most appropriate setting or level of care are not medically necessary.

All determinations are conducted by qualified personnel as follows:

- Licensed health care professionals who are trained in the principles and procedures of intake screening and data collection. Administrative personnel are used only to perform intake screening, data collection and nonclinical review functions. They are supervised by licensed health care professionals.
- A health care professional who is appropriately trained in the principles, procedures and standards of utilization management.
- A clinical peer reviewer when the review involves an adverse determination.

A clinical peer reviewer is a physician who possesses a current and valid nonrestricted license to practice medicine. A clinical peer reviewer may also be a health care professional other than a licensed physician who, where applicable, possesses a current and valid nonrestricted license, certification or registration.

Where no provision for a license, certificate or registration exists, a clinical peer reviewer for a health care professional other than a physician, must be credentialed by the national accrediting body appropriate to the profession. The clinical peer reviewer must also be in the same profession/specialty as the health care provider who typically manages the medical condition.

In some instances, an adverse determination is made without providing an opportunity for a discussion with the health care provider who specifically recommended the health care service, procedure or treatment under review. In such a case, the health care provider will have the opportunity to request a provider reconsideration.

CARE MANAGEMENT

Points to remember about a provider reconsideration include:

- Except in cases of post-service review, such reconsideration will occur within one business day of notice of adverse determination.
- The reconsideration will be conducted by your health care provider and the original clinical peer reviewer who made the initial determination or a designated clinical peer reviewer, if the original clinical peer reviewer is not available.

If the adverse determination is upheld after reconsideration, you will be notified as described above. Please see *If You Disagree With A Decision* for information about appeals of adverse determinations.

SECTION HIGHLIGHTS >>>

STAYING HEALTHY

Preventive Care

- Follow HIP's Preventive Health Guidelines. A chart at the end of this section spells out when you need to be screened for certain common conditions.
- Be sure that your child(ren) receives all necessary screenings, tests and immunizations. A chart at the end of this section provides an immunization and well-child visit schedule.
- If you are a woman and believe that you are pregnant, schedule an appointment with your PCP. Your PCP can order the blood test necessary to confirm your pregnancy. You can then self-refer to a participating OB/GYN or midwife for continued prenatal care (a PCP referral is NOT needed).
- If you are a smoker, consider joining the Quit for Life™ Program. This self-help program provides members who want to stop smoking with a comprehensive education kit, support and financial reimbursement for the nicotine patch, Bupropion (generic Zyban®) or Chantix™. To register, call **1-866-QUIT-4-LIFE (1-866-784-8454)**.
- To encourage you to exercise regularly, HIP offers discounts through American WholeHealth fitness facilities. For more information, please call **1-888-447-2563**.

STAYING HEALTHY

HIP coverage offers many preventive health services to help you reduce your risk for certain diseases and conditions. For instance, routine immunizations and screening tests are available to HIP members. Immunizations and tests – such as hepatitis vaccine or a diabetes test – are a simple and effective way to prevent disease. HIP services can also help you manage ongoing health conditions.

If you have a personal or family history for a particular disease or condition, or if you have specific questions about your health, you should sit down with your PCP and review your particular needs.

Adult Care

One of the best ways members can take control of their health is to follow HIP's Preventive Health Guidelines. A chart at the end of this section spells out when you need to be screened for certain common conditions. HIP advises members to get each of the services in the chart within the age ranges shown. These guidelines, recommended for all healthy adults, are adapted from the U.S. Preventive Services Task Force, American Diabetes Association, American Cancer Society and Centers for Disease Control.

Childhood And Adolescent Care

Parents will want to assure that their children receive all necessary screenings, tests and immunizations.

- Immunizations protect children from various diseases. Immunizations are key to preventive health care. If a child is sick before an appointment, it's not a good idea to cancel it. Instead, the parent should call the doctor, discuss how the child is feeling and see if the doctor advises that a shot can be safely given at this time. Note that children can receive most of their required shots within five visits before their second birthday.
- Routine physical exams (also called well-child visits) are vital to keeping children healthy. Each visit includes many tests and exams. The doctor checks important measurements, such as height and weight. After the age of three (3) blood pressure may also be checked. And if the child is under age two (2), his or her head circumference should be measured periodically.

Parents should expect their child's doctor to talk with them about the child's medical history and daily activities. This discussion will include the youngster's development (physical, psychological and social); eating and exercise habits; and medications and allergies. The doctor will also provide tips on protecting the child from injury. Safety devices such as seat belts and stair gates can be just as crucial to a child's well being as medical care. Also, adolescents and teens need counseling on issues of sexuality and abuse of substances such as tobacco and alcohol. A chart at the end of this section summarizes the important guidelines for children and adolescents.

Prenatal Care

Prenatal care is the care an expectant mother receives during pregnancy. Good health care during pregnancy increases the chances of having a healthy baby. Therefore, women who believe they are pregnant should schedule an appointment with their PCP. The PCP will order a blood test to confirm pregnancy and check the woman's overall health. If the PCP confirms pregnancy, the expectant mother should select a participating OB/GYN or midwife for continued prenatal care (PCP referral is NOT needed).

Tips For Expectant Mothers

By receiving medical care early and taking certain precautions, you can make a difference in the health and life of your baby . . .

- Schedule an appointment with your OB/GYN before the 12th week of pregnancy.
- During that visit with the OB/GYN, be ready to provide the doctor with information on your family history and current lifestyle.
- Speak with the doctor about any prescribed or over-the-counter medications, as many can cause harm to a developing baby.
- Avoid smoking, drugs and alcohol, as they also harm the developing baby.
- Eat a balanced diet to be sure that you are nutritionally fit to support both yourself and your baby.

Also, after delivery of the baby . . .

- You should make an appointment to see your OB/GYN between 21 and 56 days after childbirth.
- Schedule an appointment for the baby to be seen by his or her pediatrician between two (2) and four (4) weeks of age.

It is common for new mothers to feel overwhelmed by the emotional stresses and inadequate rest that accompany caring for a newborn. If feelings of sadness or hopelessness persist, it's important to speak to your doctor or mental health practitioner. Postpartum depression is an illness that can be treated by your health care team.

Join HIP's free Mom-To-Be program and receive a health risk assessment, a book on pregnancy, other educational information and access to a 24 hour a day nurse answer line. Just call **1-866-943-2229**.

STAYING HEALTHY

Quit For Life™

Quit for Life™ is a self-help program that provides members who want to stop smoking with a comprehensive educational kit, and support calls from a smoking cessation specialist for one year to help them quit.

By joining the Quit For Life program, members are eligible to obtain full coverage for the nicotine patch, Bupropion (generic Zyban®) or Chantix™. Members may receive coverage for Bupropion or Chantix for a total of 24 weeks of treatment as long as members continue their participation in the program.

To register for the Quit For Life program, call **1-800-QUIT-4-LIFE (1-866-784-8454)**.

Fitness Facilities Discount Program

To encourage members to exercise regularly, HIP has partnered with American WholeHealth to offer discounts at participating fitness facilities throughout HIP's service area. To receive a discount, all members need to do is select a participating facility and present their HIP ID card at the time of enrollment. For more information, please call American WholeHealth at **1-888-447-2563**.

Preventive Health Care Guidelines

Birth To 2 Years

Well-baby exam: At birth, 2 weeks and 1, 2, 4, 6, 9, 12, 15, 18 and 24 months. In addition to receiving advice about your baby's health, development and behavior, counseling should be provided on injury prevention, violence prevention, sleep positions, feeding and nutrition, daily care and activity, and dental referrals. During the exam, your child may receive the following immunizations and screenings, depending on clinical presentation and physician assessment:

Immunizations

See Childhood Immunization Schedule on page 50.

Screenings

- **Cholesterol:** If high risk, as your child's primary care physician (PCP) advises.
- **Hemoglobin and hematocrit (Hgb/Hct):** Once between ages 9 and 12 months.
- **Lead screening:** Between ages 6 months and 6 years to assess risk for lead toxicity.*
- **Lead test:** All children at ages 12 and 24 months.*
- **Mantoux (tuberculosis or TB):** Annually or periodically. If high risk, starting at age 12 months.
- **Vision and hearing:** Screening for all newborns and periodically.
- **Weight, length and head circumference:** At every visit.

* Mandated by the New York State Department of Health.

Ages 2 To 20

Well-child exam: Once a year for children ages 2 to 20. You should receive advice about your child's dental health, exercise and physical activity, diet and nutrition, sun exposure, injury and violence prevention and, when appropriate, alcohol consumption and sexual behavior; smoking cessation; and suicide prevention. In addition, during this exam your child may receive the following immunizations and screenings, depending on clinical presentation and physician assessment:

Immunizations

See **Childhood Immunization Schedule on page 50.**

Screenings

- Blood pressure measurement: Starting at 3 years of age; annually at well-child exams.
- BMI counseling: Review Body Mass Index (BMI) results with PCP.
- Cholesterol: If high risk, as your child's PCP advises.
- Height and weight: At every well-child exam.
- Hemoglobin and Hematocrit (Hgb/Hct): Once between ages 11 and 20 years, follow-up for patients at risk, annually for all menstruating females.
- Lead screening: Between ages 6 months and 6 years to assess risk for lead toxicity.*
- Lead test: All children at ages 12 and 24 months.*
- Mantoux (tuberculosis or TB): If at high risk, annually or periodically.
- Sexually Transmitted Disease (STD): All sexually active patients should be screened for STDs, including chlamydia.
- Urinalysis: At ages 5 and 16 years.
- Vision and hearing: At every well-child exam.

Ages 21 And Older

Well-person exam: As often as your PCP advises, receive periodic counseling on dental health and vision, exercise and physical activity, diet and nutrition, smoking cessation, alcohol and tobacco consumption, injury prevention, and sexual behavior. Women who are or plan to become pregnant should take a daily multivitamin with folic acid. Hormone prophylaxis and aspirin chemoprevention should be discussed with your doctor. During your exam, you may receive the following immunizations and screenings, depending on clinical presentation and physician assessment:

Immunizations

- **Hepatitis A vaccine:** For adults at risk.
- **Hepatitis B vaccine:** For adults at risk and health care workers.
- **Influenza (flu):** Annually for ages 20 to 49 if at high risk; annually for ages 50 and older.

* Mandated by the New York State Department of Health.

STAYING HEALTHY

- **MMR:** Adults born after 1956 who lack evidence of immunity.
- **Pneumonia vaccine:** One dose at age 65 or older. If under 65 and at high risk, as per PCP.
- **Rubella:** Routine screening for vaccine history or serology for all women of childbearing age at first health visit.
- **Tetanus-diphtheria (Td):** One dose every 10 years.
- **Vaccines for travelers:** Consult with PCP, local Department of Health or www.cdc.gov/travel.
- **Varicella (chickenpox):** Vaccine for adults without evidence of immunity.

Screenings

- **Aspirin therapy:** As your PCP advises.
- **Blood pressure:** Periodic screening at least once every two years or more frequently if blood pressure is $\geq 120/80$ mmHg, as per PCP.
- **Bone densitometry:** As your PCP advises; for women ages 65 and older, routine screening at least every two years.

If you are at increased risk for certain cancers, you should consult with your physician as to screening schedules and starting at an earlier age.

- **Breast exam, clinical:** Annually.
- **Breast exam, self:** Monthly.
- **Breast mammogram:** Annually for ages 40 and older.
- **Cholesterol:** A fasting lipid profile starting at 20 years, obtained once every 5 years; more frequently if at high risk, as per PCP.
- **Colon and rectal cancer:** Beginning at age 50, both men and women should follow one of these testing schedules:
 - Yearly fecal occult blood test (FOBT).
 - Flexible sigmoidoscopy every five years.
 - Yearly FOBT plus sigmoidoscopy every five years preferred.
 - Double-contrast barium enema every five years.
 - Colonoscopy every 10 years.
- **Depression:** Periodic assessment for adults.
- **Diabetes, type 2:** Screening every three years for ages 45 and older; more frequently if at high risk.
- **Hearing impairment:** Periodic assessment at the discretion of your physician.
- **Height and weight:** At each medical visit.
- **Obesity:** Use of body mass index (BMI) to identify adults at risk for disease and death due to overweight and obesity (as defined by $\text{BMI} \geq 30 \text{ kg/m}^2$).
- **Pelvic exam:** Annual pelvic exam and cervical cancer screenings (PAP test); if high risk, as per physician.

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- **Prostate cancer:** Annual digital rectal exam and prostate specific antigen (PSA) testing beginning at age 50; beginning at age 45 for those at high risk; beginning at age 40 for those at higher risk.
- **Sexually transmitted diseases (STD):** All sexually active men and women ages 25 and younger as well as older adults at risk, as part of a regular health care visit.
- **Skin cancer:** A skin evaluation should be part of a routine cancer related checkup. Perform a self-skin evaluation once a month.
- **Vision:** Annually, as needed or directed. Check with eye doctor for recommended frequency of a complete eye exam for the following risk factors: history of eye injury, diabetes, family history of eye problems and African Americans older than age 40.

Recommended Immunization Schedule for Persons Aged 0–6 Years—UNITED STATES • 2007

Vaccine ▼	Age ►	Birth	1 month	2 months	4 months	6 months	12 months	15 months	18 months	19–23 months	2–3 years	4–6 years
Hepatitis B ¹		HepB	HepB		see footnote 1		HepB				HepB Series	
Rotavirus ²				Rota	Rota	Rota						
Diphtheria, Tetanus, Pertussis ³				DTaP	DTaP	DTaP		DTaP				DTaP
Haemophilus influenzae type b ⁴				Hib	Hib	Hib ⁴	Hib			Hib		
Pneumococcal ⁵				PCV	PCV	PCV	PCV				PCV PPV	
Inactivated Poliovirus				IPV	IPV		IPV					IPV
Influenza ⁶							Influenza (Yearly)					
Measles, Mumps, Rubella ⁷							MMR					MMR
Varicella ⁸							Varicella					Varicella
Hepatitis A ⁹							HepA (2 doses)				HepA Series	
Meningococcal ¹⁰												MPSV4

Range of recommended ages
 Catch-up immunization
 Certain high-risk groups

This schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines, as of December 1, 2006, for children aged 0–6 years. Additional information is available at <http://www.cdc.gov/nip/recs/child-schedule.htm>. Any dose not administered at the recommended age should be administered at any subsequent visit, when indicated and feasible. Additional vaccines may be licensed and recommended during the year. Licensed combination vaccines may be used whenever any components of the combination are indicated and

other components of the vaccine are not contraindicated and if approved by the Food and Drug Administration for that dose of the series. Providers should consult the respective Advisory Committee on Immunization Practices statement for detailed recommendations. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS). Guidance about how to obtain and complete a VAERS form is available at <http://www.vaers.hhs.gov> or by telephone, 800-822-7967.

1. Hepatitis B vaccine (HepB). (Minimum age: birth)

At birth:

- Administer monovalent HepB to all newborns before hospital discharge.
- If mother is hepatitis surface antigen (HBsAg)-positive, administer HepB and 0.5 mL of hepatitis B immune globulin (HBIG) within 12 hours of birth.
- If mother's HBsAg status is unknown, administer HepB within 12 hours of birth. Determine the HBsAg status as soon as possible and if HBsAg-positive, administer HBIG (no later than age 1 week).
- If mother is HBsAg-negative, the birth dose can only be delayed with physician's order and mother's negative HBsAg laboratory report documented in the infant's medical record.

After the birth dose:

- The HepB series should be completed with either monovalent HepB or a combination vaccine containing HepB. The second dose should be administered at age 1–2 months. The final dose should be administered at age ≥24 weeks. Infants born to HBsAg-positive mothers should be tested for HBsAg and antibody to HBsAg after completion of ≥3 doses of a licensed HepB series, at age 9–18 months (generally at the next well-child visit).

4-month dose:

- It is permissible to administer 4 doses of HepB when combination vaccines are administered after the birth dose. If monovalent HepB is used for doses after the birth dose, a dose at age 4 months is not needed.

2. Rotavirus vaccine (Rota). (Minimum age: 6 weeks)

- Administer the first dose at age 6–12 weeks. Do not start the series later than age 12 weeks.
- Administer the final dose in the series by age 32 weeks. Do not administer a dose later than age 32 weeks.
- Data on safety and efficacy outside of these age ranges are insufficient.

3. Diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP). (Minimum age: 6 weeks)

- The fourth dose of DTaP may be administered as early as age 12 months, provided 6 months have elapsed since the third dose.
- Administer the final dose in the series at age 4–6 years.

4. Haemophilus influenzae type b conjugate vaccine (Hib).

(Minimum age: 6 weeks)

- If PRP-OMP (PedvaxHIB® or ComVax® [Merck]) is administered at ages 2 and 4 months, a dose at age 6 months is not required.
- TriHibit® (DTaP/Hib) combination products should not be used for primary immunization but can be used as boosters following any Hib vaccine in children aged ≥12 months.

5. Pneumococcal vaccine. (Minimum age: 6 weeks for pneumococcal conjugate vaccine [PCV]; 2 years for pneumococcal polysaccharide vaccine [PPV])

- Administer PCV at ages 24–59 months in certain high-risk groups. Administer PPV to children aged ≥2 years in certain high-risk groups. See *MMWR* 2000;49(No. RR-9):1–35.

6. Influenza vaccine. (Minimum age: 6 months for trivalent inactivated influenza vaccine [TIV]; 5 years for live, attenuated influenza vaccine [LAIV])

- All children aged 6–59 months and close contacts of all children aged 0–59 months are recommended to receive influenza vaccine.
- Influenza vaccine is recommended annually for children aged ≥59 months with certain risk factors, health-care workers, and other persons (including household members) in close contact with persons in groups at high risk. See *MMWR* 2006;55(No. RR-10):1–41.
- For healthy persons aged 5–49 years, LAIV may be used as an alternative to TIV.
- Children receiving TIV should receive 0.25 mL if aged 6–35 months or 0.5 mL if aged ≥3 years.
- Children aged <9 years who are receiving influenza vaccine for the first time should receive 2 doses (separated by ≥4 weeks for TIV and ≥6 weeks for LAIV).

7. Measles, mumps, and rubella vaccine (MMR). (Minimum age: 12 months)

- Administer the second dose of MMR at age 4–6 years. MMR may be administered before age 4–6 years, provided ≥4 weeks have elapsed since the first dose and both doses are administered at age ≥12 months.

8. Varicella vaccine. (Minimum age: 12 months)

- Administer the second dose of varicella vaccine at age 4–6 years. Varicella vaccine may be administered before age 4–6 years, provided that ≥3 months have elapsed since the first dose and both doses are administered at age ≥12 months. If second dose was administered ≥28 days following the first dose, the second dose does not need to be repeated.

9. Hepatitis A vaccine (HepA). (Minimum age: 12 months)

- HepA is recommended for all children aged 1 year (i.e., aged 12–23 months). The 2 doses in the series should be administered at least 6 months apart.
- Children not fully vaccinated by age 2 years can be vaccinated at subsequent visits.
- HepA is recommended for certain other groups of children, including in areas where vaccination programs target older children. See *MMWR* 2006;55(No. RR-7):1–23.

10. Meningococcal polysaccharide vaccine (MPSV4). (Minimum age: 2 years)

- Administer MPSV4 to children aged 2–10 years with terminal complement deficiencies or anatomic or functional asplenia and certain other high-risk groups. See *MMWR* 2005;54(No. RR-7):1–21.

The Recommended Immunization Schedules for Persons Aged 0–18 Years are approved by the Advisory Committee on Immunization Practices (<http://www.cdc.gov/nip/acip>), the American Academy of Pediatrics (<http://www.aap.org>), and the American Academy of Family Physicians (<http://www.aafp.org>).

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Recommended Immunization Schedule for Persons Aged 7–18 Years—UNITED STATES • 2007

Vaccine ▼	Age ▶	7–10 years	11–12 YEARS	13–14 years	15 years	16–18 years
Tetanus, Diphtheria, Pertussis ¹	see footnote 1		Tdap		Tdap	
Human Papillomavirus ²	see footnote 2		HPV (3 doses)		HPV Series	
Meningococcal ³	MPSV4		MCV4		MCV4	MCV4
Pneumococcal ⁴			PPV			
Influenza ⁵			Influenza (Yearly)			
Hepatitis A ⁶			HepA Series			
Hepatitis B ⁷			HepB Series			
Inactivated Poliovirus ⁸			IPV Series			
Measles, Mumps, Rubella ⁹			MMR Series			
Varicella ¹⁰			Varicella Series			

 Range of recommended ages

 Catch-up immunization

 Certain high-risk groups

This schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines, as of December 1, 2006, for children aged 7–18 years. Additional information is available at <http://www.cdc.gov/nip/recs/child-schedule.htm>. Any dose not administered at the recommended age should be administered at any subsequent visit, when indicated and feasible. Additional vaccines may be licensed and recommended during the year. Licensed combination vaccines may be used whenever any components of the combination are indicated and other components

of the vaccine are not contraindicated and if approved by the Food and Drug Administration for that dose of the series. Providers should consult the respective Advisory Committee on Immunization Practices statement for detailed recommendations. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS). Guidance about how to obtain and complete a VAERS form is available at <http://www.vaers.hhs.gov> or by telephone, 800-822-7967.

1. Tetanus and diphtheria toxoids and acellular pertussis vaccine (Tdap).

(Minimum age: 10 years for BOOSTRIX[®] and 11 years for ADACEL[™])

- Administer at age 11–12 years for those who have completed the recommended childhood DTP/DTaP vaccination series and have not received a tetanus and diphtheria toxoids vaccine (Td) booster dose.
- Adolescents aged 13–18 years who missed the 11–12 year Td/Tdap booster dose should also receive a single dose of Tdap if they have completed the recommended childhood DTP/DTaP vaccination series.

2. Human papillomavirus vaccine (HPV). (Minimum age: 9 years)

- Administer the first dose of the HPV vaccine series to females at age 11–12 years.
- Administer the second dose 2 months after the first dose and the third dose 6 months after the first dose.
- Administer the HPV vaccine series to females at age 13–18 years if not previously vaccinated.

3. Meningococcal vaccine. (Minimum age: 11 years for meningococcal conjugate vaccine [MCV4]; 2 years for meningococcal polysaccharide vaccine [MPSV4])

- Administer MCV4 at age 11–12 years and to previously unvaccinated adolescents at high school entry (at approximately age 15 years).
- Administer MCV4 to previously unvaccinated college freshmen living in dormitories; MPSV4 is an acceptable alternative.
- Vaccination against invasive meningococcal disease is recommended for children and adolescents aged ≥ 2 years with terminal complement deficiencies or anatomic or functional asplenia and certain other high-risk groups. See *MMWR* 2005;54(No. RR-7):1–21. Use MPSV4 for children aged 2–10 years and MCV4 or MPSV4 for older children.

4. Pneumococcal polysaccharide vaccine (PPV). (Minimum age: 2 years)

- Administer for certain high-risk groups. See *MMWR* 1997;46(No. RR-8):1–24, and *MMWR* 2000;49(No. RR-9):1–35.

5. Influenza vaccine. (Minimum age: 6 months for trivalent inactivated influenza vaccine [TIV]; 5 years for live, attenuated influenza vaccine [LAIV])

- Influenza vaccine is recommended annually for persons with certain risk factors, health-care workers, and other persons (including household members) in close contact with persons in groups at high risk. See *MMWR* 2006;55(No. RR-10):1–41.
- For healthy persons aged 5–49 years, LAIV may be used as an alternative to TIV.
- Children aged <9 years who are receiving influenza vaccine for the first time should receive 2 doses (separated by ≥ 4 weeks for TIV and ≥ 6 weeks for LAIV).

6. Hepatitis A vaccine (HepA). (Minimum age: 12 months)

- The 2 doses in the series should be administered at least 6 months apart.
- HepA is recommended for certain other groups of children, including in areas where vaccination programs target older children. See *MMWR* 2006;55(No. RR-7):1–23.

7. Hepatitis B vaccine (HepB). (Minimum age: birth)

- Administer the 3-dose series to those who were not previously vaccinated.
- A 2-dose series of Recombivax HB[®] is licensed for children aged 11–15 years.

8. Inactivated poliovirus vaccine (IPV). (Minimum age: 6 weeks)

- For children who received an all-IPV or all-oral poliovirus (OPV) series, a fourth dose is not necessary if the third dose was administered at age ≥ 4 years.
- If both OPV and IPV were administered as part of a series, a total of 4 doses should be administered, regardless of the child's current age.

9. Measles, mumps, and rubella vaccine (MMR). (Minimum age: 12 months)

- If not previously vaccinated, administer 2 doses of MMR during any visit, with ≥ 4 weeks between the doses.

10. Varicella vaccine. (Minimum age: 12 months)

- Administer 2 doses of varicella vaccine to persons without evidence of immunity.
- Administer 2 doses of varicella vaccine to persons aged <13 years at least 3 months apart. Do not repeat the second dose, if administered ≥ 28 days after the first dose.
- Administer 2 doses of varicella vaccine to persons aged ≥ 13 years at least 4 weeks apart.

The Recommended Immunization Schedules for Persons Aged 0–18 Years are approved by the Advisory Committee on Immunization Practices (<http://www.cdc.gov/nip/acip>), the American Academy of Pediatrics (<http://www.aap.org>), and the American Academy of Family Physicians (<http://www.aafp.org>).

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Catch-up Immunization Schedule

UNITED STATES • 2007

for Persons Aged 4 Months–18 Years Who Start Late or Who Are More Than 1 Month Behind

The table below provides catch-up schedules and minimum intervals between doses for children whose vaccinations have been delayed. A vaccine series does not need to be restarted, regardless of the time that has elapsed between doses. Use the section appropriate for the child's age.

CATCH-UP SCHEDULE FOR PERSONS AGED 4 MONTHS–6 YEARS					
Vaccine	Minimum Age for Dose 1	Minimum Interval Between Doses			
		Dose 1 to Dose 2	Dose 2 to Dose 3	Dose 3 to Dose 4	Dose 4 to Dose 5
Hepatitis B ¹	Birth	4 weeks	8 weeks (and 16 weeks after first dose)		
Rotavirus ²	6 wks	4 weeks	4 weeks		
Diphtheria, Tetanus, Pertussis ³	6 wks	4 weeks	4 weeks	6 months	6 months ³
<i>Haemophilus influenzae</i> type b ⁴	6 wks	4 weeks if first dose administered at age <12 months 8 weeks (as final dose) if first dose administered at age 12–14 months No further doses needed if first dose administered at age ≥15 months	4 weeks ⁴ if current age <12 months 8 weeks (as final dose) ⁴ if current age ≥12 months and second dose administered at age <15 months No further doses needed if previous dose administered at age ≥15 months	8 weeks (as final dose) This dose only necessary for children aged 12 months–5 years who received 3 doses before age 12 months	
Pneumococcal ⁵	6 wks	4 weeks if first dose administered at age <12 months and current age <24 months 8 weeks (as final dose) if first dose administered at age ≥12 months or current age 24–59 months No further doses needed for healthy children if first dose administered at age ≥24 months	4 weeks if current age <12 months 8 weeks (as final dose) if current age ≥12 months No further doses needed for healthy children if previous dose administered at age ≥24 months	8 weeks (as final dose) This dose only necessary for children aged 12 months–5 years who received 3 doses before age 12 months	
Inactivated Poliovirus ⁶	6 wks	4 weeks	4 weeks	4 weeks ⁶	
Measles, Mumps, Rubella ⁷	12 mos	4 weeks			
Varicella ⁸	12 mos	3 months			
Hepatitis A ⁹	12 mos	6 months			
CATCH-UP SCHEDULE FOR PERSONS AGED 7–18 YEARS					
Tetanus, Diphtheria/ Tetanus, Diphtheria, Pertussis ¹⁰	7 yrs ¹⁰	4 weeks	8 weeks if first dose administered at age <12 months 6 months if first dose administered at age ≥12 months	6 months if first dose administered at age <12 months	
Human Papillomavirus ¹¹	9 yrs	4 weeks	12 weeks		
Hepatitis A ⁹	12 mos	6 months			
Hepatitis B ¹	Birth	4 weeks	8 weeks (and 16 weeks after first dose)		
Inactivated Poliovirus ⁶	6 wks	4 weeks	4 weeks	4 weeks ⁶	
Measles, Mumps, Rubella ⁷	12 mos	4 weeks			
Varicella ⁸	12 mos	4 weeks if first dose administered at age ≥13 years 3 months if first dose administered at age <13 years			

- Hepatitis B vaccine (HepB).** (Minimum age: birth)
 - Administer the 3-dose series to those who were not previously vaccinated.
 - A 2-dose series of Recombivax HB[®] is licensed for children aged 11–15 years.
- Rotavirus vaccine (Rota).** (Minimum age: 6 weeks)
 - Do not start the series later than age 12 weeks.
 - Administer the final dose in the series by age 32 weeks. Do not administer a dose later than age 32 weeks.
 - Data on safety and efficacy outside of these age ranges are insufficient.
- Diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP).** (Minimum age: 6 weeks)
 - The fifth dose is not necessary if the fourth dose was administered at age ≥4 years.
 - DTaP is not indicated for persons aged ≥7 years.
- Haemophilus influenzae* type b conjugate vaccine (Hib).** (Minimum age: 6 weeks)
 - Vaccine is not generally recommended for children aged ≥5 years.
 - If current age <12 months and the first 2 doses were PRP-OMP (PedvaxHIB[®] or ComVax[®] [Merck]), the third (and final) dose should be administered at age 12–15 months and at least 8 weeks after the second dose.
 - If first dose was administered at age 7–11 months, administer 2 doses separated by 4 weeks plus a booster at age 12–15 months.
- Pneumococcal conjugate vaccine (PCV).** (Minimum age: 6 weeks)
 - Vaccine is not generally recommended for children aged ≥5 years.
- Inactivated poliovirus vaccine (IPV).** (Minimum age: 6 weeks)
 - For children who received an all-IPV or all-oral poliovirus (OPV) series, a fourth dose is not necessary if third dose was administered at age ≥4 years.
 - If both OPV and IPV were administered as part of a series, a total of 4 doses should be administered, regardless of the child's current age.
- Measles, mumps, and rubella vaccine (MMR).** (Minimum age: 12 months)
 - The second dose of MMR is recommended routinely at age 4–6 years but may be administered earlier if desired.
 - If not previously vaccinated, administer 2 doses of MMR during any visit with ≥4 weeks between the doses.
- Varicella vaccine.** (Minimum age: 12 months)
 - The second dose of varicella vaccine is recommended routinely at age 4–6 years but may be administered earlier if desired.
 - Do not repeat the second dose in persons aged <13 years if administered ≥28 days after the first dose.
- Hepatitis A vaccine (HepA).** (Minimum age: 12 months)
 - HepA is recommended for certain groups of children, including in areas where vaccination programs target older children. See *MMWR* 2006;55(No. RR-7):1–23.
- Tetanus and diphtheria toxoids vaccine (Td) and tetanus and diphtheria toxoids and acellular pertussis vaccine (Tdap).** (Minimum ages: 7 years for Td, 10 years for BOOSTRIX[®], and 11 years for ADACEL[™])
 - Tdap should be substituted for a single dose of Td in the primary catch-up series or as a booster if age appropriate; use Td for other doses.
 - A 5-year interval from the last Td dose is encouraged when Tdap is used as a booster dose. A booster (fourth) dose is needed if any of the previous doses were administered at age <12 months. Refer to ACIP recommendations for further information. See *MMWR* 2006;55(No. RR-3).
- Human papillomavirus vaccine (HPV).** (Minimum age: 9 years)
 - Administer the HPV vaccine series to females at age 13–18 years if not previously vaccinated.

Information about reporting reactions after immunization is available online at <http://www.vaers.hhs.gov> or by telephone via the 24-hour national toll-free information line 800-822-7967. Suspected cases of vaccine-preventable diseases should be reported to the state or local health department. Additional information, including precautions and contraindications for immunization, is available from the National Center for Immunization and Respiratory Diseases at <http://www.cdc.gov/nip/default.htm> or telephone, 800-CDC-INFO (800-232-4636).

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Recommended Adult Immunization Schedule United States, October 2006–September 2007

Recommended adult immunization schedule, by vaccine and age group


Age group (yrs) ▶ Vaccine ▼	19–49 years	50–64 years	≥65 years
Tetanus, diphtheria, pertussis (Td/Tdap) ^{1*}	1-dose Td booster every 10 yrs Substitute 1 dose of Tdap for Td		
Human papillomavirus (HPV) ^{2*}	3 doses (females)		
Measles, mumps, rubella (MMR) ^{3*}	1 or 2 doses	1 dose	
Varicella ^{4*}	2 doses (0, 4–8 wks)	2 doses (0, 4–8 wks)	
Influenza ^{5*}	1 dose annually	1 dose annually	
Pneumococcal (polysaccharide) ^{6,7}	1–2 doses		1 dose
Hepatitis A ^{8*}	2 doses (0, 6–12 mos, or 0, 6–18 mos)		
Hepatitis B ^{9*}	3 doses (0, 1–2, 4–6 mos)		
Meningococcal ¹⁰	1 or more doses		


Recommended adult immunization schedule, by vaccine and medical and other indications

Indication ▶ Vaccine ▼	Pregnancy	Congenital immunodeficiency; leukemia; ¹¹ lymphoma; generalized malignancy; cerebrospinal fluid leaks; therapy with alkylating agents, antimetabolites, radiation, or high-dose, long-term corticosteroids	Diabetes, heart disease, chronic pulmonary disease, chronic alcoholism	Asplenia ¹¹ (including elective splenectomy and terminal complement component deficiencies)	Chronic liver disease, recipients of clotting factor concentrates	Kidney failure, end-stage renal disease, recipients of hemodialysis	Human immunodeficiency virus (HIV) infection ¹¹	Health-care workers
Tetanus, diphtheria, pertussis (Td/Tdap) ^{1*}	1-dose Td booster every 10 yrs Substitute 1 dose of Tdap for Td							
Human papillomavirus (HPV) ^{2*}	3 doses for women through age 26 years (0, 2, 6 mos)							
Measles, mumps, rubella (MMR) ^{3*}				1 or 2 doses				
Varicella ^{4*}				2 doses (0, 4–8 wks)				2 doses
Influenza ^{5*}	1 dose annually			1 dose annually	1 dose annually			
Pneumococcal (polysaccharide) ^{6,7}	1–2 doses			1–2 doses				1–2 doses
Hepatitis A ^{8*}	2 doses (0, 6–12 mos, or 0, 6–18 mos)			2 doses (0, 6–12 mos, or 0, 6–18 mos)				
Hepatitis B ^{9*}	3 doses (0, 1–2, 4–6 mos)			3 doses (0, 1–2, 4–6 mos)				
Meningococcal ¹⁰	1 dose			1 dose	1 dose			

* Covered by the Vaccine Injury Compensation Program

These recommendations must be read along with the footnotes, which can be found on the next 2 pages of this schedule.

 For all persons in this category who meet the age requirements and who lack evidence of immunity (e.g., lack documentation of vaccination or have no evidence of prior infection)

 Recommended if some other risk factor is present (e.g., on the basis of medical, occupational, lifestyle, or other indications)

 Contraindicated

Footnotes

1. Tetanus, diphtheria, and acellular pertussis (Td/Tdap) vaccination.

Adults with uncertain histories of a complete primary vaccination series with diphtheria and tetanus toxoid-containing vaccines should begin or complete a primary vaccination series. A primary series for adults is 3 doses; administer the first 2 doses at least 4 weeks apart and the third dose 6–12 months after the second. Administer a booster dose to adults who have completed a primary series and if the last vaccination was received ≥ 10 years previously. Tdap or tetanus and diphtheria (Td) vaccine may be used; Tdap should replace a single dose of Td for adults aged <65 years who have not previously received a dose of Tdap (either in the primary series, as a booster, or for wound management). Only one of two Tdap products (Adacel[®] [sanofi pasteur, Swiftwater, Pennsylvania]) is licensed for use in adults. If the person is pregnant and received the last Td vaccination ≥ 10 years previously, administer Td during the second or third trimester; if the person received the last Td vaccination in <10 years, administer Tdap during the immediate postpartum period. A one-time administration of 1-dose of Tdap with an interval as short as 2 years from a previous Td vaccination is recommended for postpartum women, close contacts of infants aged <12 months, and all health-care workers with direct patient contact. In certain situations, Td can be deferred during pregnancy and Tdap substituted in the immediate postpartum period, or Tdap can be given instead of Td to a pregnant woman after an informed discussion with the woman (see <http://www.cdc.gov/nip/publications/acip-list.htm>). Consult the ACIP statement for recommendations for administering Td as prophylaxis in wound management (<http://www.cdc.gov/mmwr/preview/mmwrhtml/00041645.htm>).

2. Human Papillomavirus (HPV) vaccination. HPV vaccination is recommended for all women aged ≤ 26 years who have not completed the vaccine series. Ideally, vaccine should be administered before potential exposure to HPV through sexual activity; however, women who are sexually active should still be vaccinated. Sexually active women who have not been infected with any of the HPV vaccine types receive the full benefit of the vaccination. Vaccination is less beneficial for women who have already been infected with one or more of the four HPV vaccine types. A complete series consists of 3 doses. The second dose should be administered 2 months after the first dose; the third dose should be administered 6 months after the first dose. Vaccination is not recommended during pregnancy. If a woman is found to be pregnant after initiating the vaccination series, the remainder of the 3-dose regimen should be delayed until after completion of the pregnancy.

3. Measles, Mumps, Rubella (MMR) vaccination. *Measles component:* adults born before 1957 can be considered immune to measles. Adults born during or after 1957 should receive ≥ 1 dose of MMR unless they have a medical contraindication, documentation of ≥ 1 dose, history of measles based on health-care provider diagnosis, or laboratory evidence of immunity. A second dose of MMR is recommended for adults who 1) have been recently exposed to measles or in an outbreak setting; 2) were previously vaccinated with killed measles vaccine; 3) have been vaccinated with an unknown type of measles vaccine during 1963–1967; 4) are students in postsecondary educational institutions; 5) work in a health-care facility, or 6) plan to travel internationally. Withhold MMR or other measles-containing vaccines from HIV-infected persons with severe immunosuppression. *Mumps component:* adults born before 1957 can generally be considered immune to mumps. Adults born during or after 1957 should receive 1 dose of MMR unless they have a medical contraindication, history of mumps based on health-care provider diagnosis, or laboratory evidence of immunity. A second dose of MMR is recommended for adults who 1) are in an age group that is affected during a mumps outbreak; 2) are students in postsecondary educational institutions; 3) work in a health-care facility; or 4) plan to travel internationally. For unvaccinated health-care

workers born before 1957 who do not have other evidence of mumps immunity, consider giving 1 dose on a routine basis and strongly consider giving a second dose during an outbreak. *Rubella component:* administer 1 dose of MMR vaccine to women whose rubella vaccination history is unreliable or who lack laboratory evidence of immunity. For women of childbearing age, regardless of birth year, routinely determine rubella immunity and counsel women regarding congenital rubella syndrome. Do not vaccinate women who are pregnant or who might become pregnant within 4 weeks of receiving vaccine. Women who do not have evidence of immunity should receive MMR vaccine upon completion or termination of pregnancy and before discharge from the health-care facility.

4. Varicella vaccination. All adults without evidence of immunity to varicella should receive 2 doses of varicella vaccine. Special consideration should be given to those who 1) have close contact with persons at high risk for severe disease (e.g., health-care workers and family contacts of immunocompromised persons) or 2) are at high risk for exposure or transmission (e.g., teachers of young children; child care employees; residents and staff members of institutional settings, including correctional institutions; college students; military personnel; adolescents and adults living in households with children; non-pregnant women of childbearing age; and international travelers). Evidence of immunity to varicella in adults includes any of the following: 1) documentation of 2 doses of varicella vaccine at least 4 weeks apart; 2) U.S.-born before 1980 (although for health-care workers and pregnant women, birth before 1980 should not be considered evidence of immunity); 3) history of varicella based on diagnosis or verification of varicella by a health-care provider (for a patient reporting a history of or presenting with an atypical case, a mild case, or both, health-care providers should seek either an epidemiologic link with a typical varicella case or evidence of laboratory confirmation, if it was performed at the time of acute disease); 4) history of herpes zoster based on health-care provider diagnosis; or 5) laboratory evidence of immunity or laboratory confirmation of disease. Do not vaccinate women who are pregnant or might become pregnant within 4 weeks of receiving the vaccine. Assess pregnant women for evidence of varicella immunity. Women who do not have evidence of immunity should receive dose 1 of varicella vaccine upon completion or termination of pregnancy and before discharge from the health-care facility. Dose 2 should be administered 4–8 weeks after dose 1.

5. Influenza vaccination: *Medical indications:* chronic disorders of the cardiovascular or pulmonary systems, including asthma; chronic metabolic diseases, including diabetes mellitus, renal dysfunction, hemoglobinopathies, or immunosuppression (including immunosuppression caused by medications or HIV); any condition that compromises respiratory function or the handling of respiratory secretions or that can increase the risk of aspiration (e.g., cognitive dysfunction, spinal cord injury, or seizure disorder or other neuromuscular disorder); and pregnancy during the influenza season. No data exist on the risk for severe or complicated influenza disease among persons with asplenia; however, influenza is a risk factor for secondary bacterial infections that can cause severe disease among persons with asplenia. *Occupational indications:* health-care workers and employees of long-term-care and assisted living facilities. *Other indications:* residents of nursing homes and other long-term-care and assisted living facilities; persons likely to transmit influenza to persons at high risk (i.e., in-home household contacts and caregivers of children aged 0–59 months, or persons of all ages with high-risk conditions); and anyone who would like to be vaccinated. Healthy, nonpregnant persons aged 5–49 years without high-risk medical conditions who are not contacts of severely immunocompromised persons in special care units can receive either intranasally administered influenza vaccine (FluMist[®]) or inactivated vaccine. Other persons should receive the inactivated vaccine.

Footnotes

6. Pneumococcal polysaccharide vaccination. *Medical indications:* chronic disorders of the pulmonary system (excluding asthma); cardiovascular diseases; diabetes mellitus; chronic liver diseases, including liver disease as a result of alcohol abuse (e.g., cirrhosis); chronic renal failure or nephrotic syndrome; functional or anatomic asplenia (e.g., sickle cell disease or splenectomy [if elective splenectomy is planned, vaccinate at least 2 weeks before surgery]); immunosuppressive conditions (e.g., congenital immunodeficiency, HIV infection [vaccinate as close to diagnosis as possible when CD4 cell counts are highest], leukemia, lymphoma, multiple myeloma, Hodgkin disease, generalized malignancy, organ or bone marrow transplantation); chemotherapy with alkylating agents, antimetabolites, or high-dose, long-term corticosteroids; and cochlear implants. *Other indications:* Alaska Natives and certain American Indian populations and residents of nursing homes or other long-term-care facilities.

7. Revaccination with pneumococcal polysaccharide vaccine. One-time revaccination after 5 years for persons with chronic renal failure or nephrotic syndrome; functional or anatomic asplenia (e.g., sickle cell disease or splenectomy); immunosuppressive conditions (e.g., congenital immunodeficiency, HIV infection, leukemia, lymphoma, multiple myeloma, Hodgkin disease, generalized malignancy, or organ or bone marrow transplantation); or chemotherapy with alkylating agents, antimetabolites, or high-dose, long-term corticosteroids. For persons aged ≥ 65 years, one-time revaccination if they were vaccinated ≥ 5 years previously and were aged < 65 years at the time of primary vaccination.

8. Hepatitis A vaccination. *Medical indications:* persons with chronic liver disease and persons who receive clotting factor concentrates. *Behavioral indications:* men who have sex with men and persons who use illegal drugs. *Occupational indications:* persons working with hepatitis A virus (HAV)-infected primates or with HAV in a research laboratory setting. *Other indications:* persons traveling to or working in countries that have high or intermediate endemicity of hepatitis A (a list of countries is available at <http://www.cdc.gov/travel/diseases.htm>) and any person who would like to obtain immunity. Current vaccines should be administered in a 2-dose schedule at either 0 and 6–12 months, or 0 and 6–18 months. If the combined hepatitis A and hepatitis B vaccine is used, administer 3 doses at 0, 1, and 6 months.

9. Hepatitis B vaccination. *Medical indications:* Persons with end-stage renal disease, including patients receiving hemodialysis; persons seeking evaluation or treatment for a sexually transmitted disease (STD); persons with HIV infection; persons with chronic liver disease; and persons who receive clotting factor concentrates. *Occupational indications:* health-care workers and public-safety workers who are exposed to blood or other potentially infectious body

fluids. *Behavioral indications:* sexually active persons who are not in a long-term, mutually monogamous relationship (i.e., persons with > 1 sex partner during the previous 6 months); current or recent injection-drug users; and men who have sex with men. *Other indications:* household contacts and sex partners of persons with chronic hepatitis B virus (HBV) infection; clients and staff members of institutions for persons with developmental disabilities; all clients of STD clinics; international travelers to countries with high or intermediate prevalence of chronic HBV infection (a list of countries is available at <http://www.cdc.gov/travel/diseases.htm>); and any adult seeking protection from HBV infection. Settings where hepatitis B vaccination is recommended for all adults: STD treatment facilities; HIV testing and treatment facilities; facilities providing drug-abuse treatment and prevention services; health-care settings providing services for injection-drug users or men who have sex with men; correctional facilities; end-stage renal disease programs and facilities for chronic hemodialysis patients; and institutions and nonresidential daycare facilities for persons with developmental disabilities. *Special formulation indications:* for adult patients receiving hemodialysis and other immunocompromised adults, 1 dose of 40 $\mu\text{g/mL}$ (Recombivax HB[®]) or 2 doses of 20 $\mu\text{g/mL}$ (Engerix-B[®]).

10. Meningococcal vaccination. *Medical indications:* adults with anatomic or functional asplenia, or terminal complement component deficiencies. *Other indications:* first-year college students living in dormitories; microbiologists who are routinely exposed to isolates of *Neisseria meningitidis*; military recruits; and persons who travel to or live in countries in which meningococcal disease is hyperendemic or epidemic (e.g., the "meningitis belt" of Sub-Saharan Africa during the dry season [December–June]), particularly if contact with local populations will be prolonged. Vaccination is required by the government of Saudi Arabia for all travelers to Mecca during the annual Hajj. Meningococcal conjugate vaccine is preferred for adults with any of the preceding indications who are aged ≤ 55 years, although meningococcal polysaccharide vaccine (MPSV4) is an acceptable alternative. Revaccination after 5 years might be indicated for adults previously vaccinated with MPSV4 who remain at high risk for infection (e.g., persons residing in areas in which disease is epidemic).

11. Selected conditions for which *Haemophilus influenzae* type b (Hib) vaccination may be used. Hib conjugate vaccines are licensed for children aged 6 weeks–71 months. No efficacy data are available on which to base a recommendation concerning use of Hib vaccine for older children and adults with the chronic conditions associated with an increased risk for Hib disease. However, studies suggest good immunogenicity in patients who have sickle cell disease, leukemia, or HIV infection or have had splenectomies; administering vaccine to these patients is not contraindicated.

This schedule indicates the recommended age groups and medical indications for routine administration of currently licensed vaccines for persons aged ≥ 19 years, as of October 1, 2006. Licensed combination vaccines may be used whenever any components of the combination are indicated and when the vaccine's other components are not contraindicated. For detailed recommendations on all vaccines, including those used primarily for travelers or that are issued during the year, consult the manufacturers' package inserts and the complete statements from the Advisory Committee on Immunization Practices (<http://www.cdc.gov/nip/publications/acip-list.htm>).

Report all clinically significant postvaccination reactions to the Vaccine Adverse Event Reporting System (VAERS). Reporting forms and instructions on filing a VAERS report are available at <http://www.vaers.hhs.gov> or by telephone, 800-822-7967.

Information on how to file a Vaccine Injury Compensation Program claim is available at <http://www.hrsa.gov/vaccinecompensation> or by telephone, 800-338-2382. To file a claim for vaccine injury, contact the U.S. Court of Federal Claims, 717 Madison Place, N.W., Washington, D.C. 20005; telephone, 202-357-6400.

Additional information about the vaccines in this schedule and contraindications for vaccination is also available at <http://www.cdc.gov/nip> or from the CDC-INFO Contact Center at 800-CDC-INFO (800-232-4636) in English and Spanish, 24 hours a day, 7 days a week.

Approved by the Advisory Committee on Immunization Practices,
the American College of Obstetricians and Gynecologists, the American Academy of Family Physicians,
and the American College of Physicians

SECTION HIGHLIGHTS >>>

DIAGNOSTIC SERVICES

Diagnostic Services At Your Physician Group Practice

- Most routine diagnostic services such as lab tests and X-rays will be provided at your physician group practice. If your PCP determines that you need a specialized service not available at the physician group practice, he or she will usually make the arrangements and provide you with a written referral form.

Diagnostic Services In A Participating Provider's Office

- PCPs in independent practice may provide some diagnostic testing in their own offices. For other services, your PCP will usually refer you to a physician group practice or participating provider. In this case, your PCP will provide you with a written referral form.

Preparing For Diagnostic Services

- Before obtaining diagnostic services, make sure you ask your PCP the following questions:
 - Where and when will the services be provided?
 - Are there any special instructions?
 - How and when can I get my results?
 - Do you know how to reach me?

DIAGNOSTIC SERVICES

At Your Physician Group Practice

If you have chosen to receive your primary care at a physician group practice, most routine diagnostic services such as lab tests and X-rays will be provided right there, at your physician practice group. If your PCP determines that you need a specialized service not available at the physician group practice, he or she will make the necessary arrangements. Usually, this will mean going to another physician group practice or participating physician. In rare instances where the service is not available from within the HIP participating network, your PCP can seek prior approval from HIP for you to see a non-participating physician without losing HMO benefits.

Through A HIP Participating Physician In Independent Practice

If you have chosen to receive your primary care from a HIP participating physician in independent practice, your PCP may provide some diagnostic testing in his or her own office. For other services, your PCP will usually refer you to a medical group office or another participating physician. In rare instances where the service is not available from within the HIP participating network, your PCP will seek prior approval from HIP for a referral to a non-participating physician.

Before You Obtain Diagnostic Services

Before obtaining diagnostic services, make sure you ask your PCP the following questions:

- *Where and when will the services be provided?* Find out the exact time and location of your blood test or X-ray services to avoid any last-minute stress. If you have to go farther than “just down the hall,” ask for directions, too.
- *Are there special instructions?* You may have to do something (such as drink a special liquid) or not do something (such as eat) in preparation for your X-ray, mammogram or lab services. If you follow the special instructions, you will avoid having the services postponed or repeated.
- *How and when can I get my results?* If you are anxious about the results, ask how and when you can get them. Your physician or the service provider should be able to tell you about how long it will take for the results to come back and how you can find out what they are.
- *Do you know how to reach me?* We do our best to keep our records up-to-date. But if you have changed your name, address or phone number recently without telling us, make sure you update your PCP. Also, please advise HIP of the change by using hipusa.com or calling us at **1-800-HIP-TALK (1-800-447-8255)**.

Please refer to the Schedule of Benefits included in your Contract or Certificate of Coverage for any copayment, deductible or coinsurance required for diagnostic services.

SECTION HIGHLIGHTS >>>

EMERGENCY AND OUT-OF-AREA CARE

What Constitutes An Emergency

- A medical emergency is a sudden and unexpected onset of conditions or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious. Others are emergencies because they are potentially life-threatening. (See full definition on following page.)

Getting Help In An Emergency

- In a true emergency, call 911 or go to an emergency room whether at home or traveling in the U.S. or territories. There is no need for prior approval.
- All HIP network PCPs have 24-hour telephone coverage. So, you will be able to reach your PCP or another doctor at any time. If you are not sure whether you have an emergency, call your PCP at the telephone number on your HIP ID card.
- When you get care, you or someone on your behalf must notify your PCP within 48 hours, or as soon as possible after you get emergency care. We also suggest that you or someone acting on your behalf contact us at **1-866-447-9717**, if you are admitted to a hospital in an emergency.

Getting Non-Emergency, But Urgently Needed Care

- In case of non-emergency, but urgent injury or illness, contact your PCP. Examples of non-emergency, but urgently needed care, could be one of the following: a child with an earache who wakes up in the middle of the night and won't stop crying, a sprained ankle, or a bad splinter you can't remove.

Important Emergency And Urgent Care Tips

- There are a lot of things you can do just in case the need for emergency or urgent care arises. Most importantly, keep as much information about your health plan (e.g., HIP ID card), your doctor and your health handy, so you won't have to search for this information during a crisis. Also, stay calm so that you will be able to answer any questions from your PCP or HIP, if necessary.

EMERGENCY AND OUT-OF-CARE CARE

What Constitutes An Emergency

A medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition, placing the health of the person or others in serious jeopardy;
- Serious impairment of such person's bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

There are many other acute conditions that we may determine are medical emergencies.

Coverage For Emergency Care

If you need care for an emergency condition, you do not need to get HIP's prior approval.

No claim for such emergency care will be denied because HIP's prior approval was not obtained. Also, emergency services will be covered if an authorized person, acting on behalf of HIP, has approved the service. However, all claims for coverage of emergency services are subject to HIP's retrospective review to determine if the services were medically necessary. Please see *Care Management: Case Management Program* for additional information.

Getting Help In An Emergency

In an emergency as defined above, go to the nearest emergency room or call 911 to get immediate help. You do not need to call your PCP first.

All HIP network PCPs have arranged for 24-hour coverage of their telephones. So, you will be able to reach your PCP or another doctor at any time. If you are not sure whether you have an emergency, call your PCP at the telephone number on your HIP ID card. Your PCP or the doctor covering for your PCP will tell you:

- Actions you can take at home.
- To come to his/her office.
- To go to the nearest emergency room.

EMERGENCY AND OUT-OF-CARE CARE

When you get care, you or someone on your behalf must notify your PCP within 48 hours, or as soon as possible after you get emergency care. We also suggest that you or someone on your behalf contact us at **1-866-447-9717, option 4** if you are admitted to a hospital in an emergency. This is to ensure that HIP and your PCP are aware of your admission.

If you are admitted to a hospital within HIP's service area that is not in HIP's network, we may move you to a HIP network hospital as soon as it is safe to do so. If you are admitted to a hospital outside HIP's service area that is not in HIP's network, we may also move you as soon as it is safe to do so. In both instances, network physicians in HIP's service area must provide the necessary follow-up care.

Remember

- Use the Emergency Room only if you have a **true emergency**.
- The Emergency Room should **NOT** be used for problems like the flu, sore throats or ear infections.
- If you have any questions, call your PCP at the phone number on your HIP ID Card.

Getting Non-Emergency, But Urgently Needed Care

In case of non-emergency but urgent injury or illness, contact your PCP. An injury or illness that might require urgent care could be:

- A child with an earache who wakes up in the middle of the night and won't stop crying.
- A sprained ankle, or a bad splinter you can't remove.

Your PCP, or the physician covering for your PCP, will arrange for the care you need, which might include:

- A same-day appointment.
- A visit to a HIP after-hours treatment facility.
- A referral to a specialist.

EMERGENCY AND OUT-OF-CARE CARE

Care While Traveling In Other Areas Of The Country

Emergency Care

Emergency care is covered anywhere and does not require making any special arrangements. (See *Emergency And Out-of-Area Care: What Constitutes An Emergency.*)

Important Emergency And Urgent Care Tips

- Put your PCP's telephone number near your telephone.
- If your call is not answered by either an operator or a recording, your call did not go through. Hang up and dial the number again.
- If you are told to expect a call back, keep your telephone line free for the call. If you are calling from a pay telephone, let the person answering your call know. If you need to, you can speak to someone right away.
- Have your HIP Member ID number ready.
- Be ready to answer questions like:
 - What's wrong? What are your symptoms?
 - Do you have a fever? What's your temperature? (If you can, take your temperature before you call.)
 - Are you taking any medication? (Know the names of your medications, including any over-the-counter drugs, such as aspirin, Tylenol, cough or cold medicines.)
- Have the name and telephone number of your pharmacy in case you need a prescription.
- If your PCP refers you somewhere for treatment, take your HIP ID card with you. Also take your HIP ID card in case you need to fill a prescription.
- Call your PCP back if you get worse or if you have questions.

SECTION HIGHLIGHTS >>>

IF YOU DISAGREE WITH A DECISION

Appeals And Complaints

- You can appeal any determination.
- Standard internal appeals must be filed within 180 days of your receipt of our adverse determination notice. Expedited internal appeals are available in the event of an urgent medical condition.
- External Appeals are available to you if you have received a denial of coverage based on Medical Necessity or because the service is experimental and/or investigational. An external appeal must be filed within 45 days of your receipt of the final adverse determination from the standard or expedited internal plan appeal process. Or, within 45 days of when you and the health plan jointly agree to waive the internal appeals process.
- You will lose your right to an external appeal if you do not file an application for an external appeal within 45 days of your receipt of the final adverse determination from the internal Clinical appeal process. Or, within 45 days of when you and the health plan jointly agree to waive the internal appeals process.

IF YOU DISAGREE WITH A DECISION

Introduction

Appeals

This section describes the appeals processes available to you if you disagree with a Benefit Determination or Clinical Determination. It begins with some important definitions you will want to refer to as you read on.

If you have questions about how or whether you should appeal our determination, start by calling **1-800-HIP-TALK (1-800-447-8255)**, Monday through Friday, 8 am to 6 pm.

Definitions

Appeal—A request for us to reverse a Benefit Determination or a Clinical Determination. If you wish to request an Appeal, follow the steps listed under Standard Internal Appeals. Note also that an expedited appeal process is available. Please see *Expedited Internal Appeals* for additional information.

Benefit Determination—A decision we make about benefits, eligibility and claim payments as well as issues of dissatisfaction with services received under your coverage, including denials or referrals. A Benefit Determination does not include decisions as to whether a service is Medically Necessary or experimental and/or investigational.

Clinical Determination—A determination on whether a service is Medically Necessary or experimental or investigational in nature.

Complaint—Any issue of dissatisfaction with our operations other than a Benefit Determination. The appeal process for Benefit Determinations applies to Complaints.

External Appeal—You may also request that an independent New York State licensed External Review Agent review your internal clinical appeal decision. Please see *External Appeals* for additional information.

Important Note: You will lose your right to an external appeal of a Clinical Determination if you do not file an application for an external appeal within 45 days of your receipt of the final adverse determination from the internal appeal process. Or, within 45 days of when you and the plan jointly agree to waive the internal clinical appeals process. Time frames when you can expect to receive written determinations are indicated in this section.

IF YOU DISAGREE WITH A DECISION

This chart summarizes the appeals process available to you as a member.

First Level Appeal

Type of Appeal	Deadline to File an Appeal	When You Receive the Decision
First Level Standard Internal Appeal	Within 180 days of your receipt of an adverse Benefit or Clinical Determination. Submit by telephone, writing or in person.	Within two business days of the determination—not to exceed 30 calendar days of receipt of request.
First Level Expedited Internal Appeal (Information from your physician is necessary to resolve a clinical appeal.)	Within 180 days of your receipt of an adverse Benefit or Clinical Determination. Submit by telephone, writing or in person.	Within 48 hours of receipt of all necessary information, but no later than 72 hours of receipt of appeal request.

You can contact us by telephone at **1-800-HIP-TALK (1-800-447-8255)**, by mail at HIP Health Plan of New York, Appeals Department, JAF Station, P.O. Box 2844, New York, NY 10116-2844 or in person at our 55 Water Street, New York, NY lobby.

IF YOU DISAGREE WITH A DECISION

Second Level Appeal

Type of Appeal	Deadline to File an Appeal	When You Will Receive the Decision
Second Level Standard Internal Appeal (For Benefit Determinations only.)	You have at least 60 business days from receipt of your written, adverse Benefit or Clinical Determination of your First Level Standard Internal Appeal.	Within 30 days of receipt of your request.
Second Level Expedited Internal Appeal (For Benefit Determinations only.)	You have at least 60 business days from receipt of your First Level Expedited Internal Appeal determination.	The earlier of 48 hours of receipt of required information or 72 hours of receipt of your Second Level Expedited Internal Appeal.

You can contact us by telephone at **1-800-HIP-TALK (1-800-447-8255)**, by mail at HIP Health Plan of New York, Appeals Department, JAF Station, P.O. Box 2844, New York, NY 10116-2844 or in person at our 55 Water Street, New York, NY lobby.

IF YOU DISAGREE WITH A DECISION

External Appeal (For Clinical, Experimental Or Investigational Adverse Determination Only)

Type of Appeal External Appeal	Deadline to File an Appeal	When You Will Receive the Decision	When You Will Receive Notification of the External Appeal Decision
External Appeal (Filed with the New York State Insurance Department.)	Within 45 days of the Final adverse Clinical Determination. Or, within 45 days of when you and the plan jointly agree to waive the internal appeals process.		
Standard External Appeal	For both Standard and Expedited External Appeals, complete the application included with the Final Adverse Determination (FAD) letter. Or, contact the State of New York Insurance Department at 1-800-400-8882.	Within 30 days. If additional information is needed, the external appeal agent has an additional 5 business days to make a decision.	You and the plan will be notified, in writing, within 2 days.
Expedited External Appeal	You can also contact Customer Service at 1-800-HIP-TALK (1-800-447-8255).	Within 3 days.	You and the plan will be notified immediately by telephone or fax. Written notification will follow.

You can contact us by telephone at **1-800-HIP-TALK (1-800-447-8255)**, by mail at HIP Health Plan of New York, Appeals Department, JAF Station, P.O. Box 2844, New York, NY 10116-2844 or in person at our 55 Water Street, New York, NY lobby.

IF YOU DISAGREE WITH A DECISION

Standard Internal Appeals

You, your designee, or health care provider may request an appeal whenever you wish us to reverse a Benefit or Clinical Determination.

Refer to the *Care Management: Adverse Determinations* section of this handbook for additional information. Your first internal appeal (or a second internal appeal of a Benefit Determination) may be filed up to and including the 180th day after receipt of a determination or denial of coverage.

Step 1: First Level Standard Internal Appeals:

Contact the Customer Service Department Or The Appeal Department

You may contact us about an **appeal** in one of three ways, depending upon which is most convenient for you.

By phone: 1-800-HIP-TALK (1-800-447-8255). Customer Service Advocates are available to help you Monday through Friday, 8 am to 6 pm. (At other times, please leave information on the answering machine. Make sure you convey enough detail for a general understanding of your medical care issue. A Customer Service Advocate will return your call before the end of the next working day.)

In writing:

HIP Health Plan of New York
Appeals Department
JAF Station
P.O. Box 2844
New York, NY 10116-2844

In person:

HIP Health Plan of New York
55 Water Street, Lobby
New York, NY 10041-8190

Step 2: Acknowledgement Of Your Appeal

Upon our receipt of your appeal, we will mail you a written acknowledgement within 15 days of such filing, along with the name, address and telephone number of the representative responsible for handling your case. Along with that acknowledgement, we may also provide you with a notice specifying what additional information, if any, we need from you or your provider to make a decision on your appeal.

In the case of clinical appeals, if your provider requests an appeal, we will mail our request for additional information to him or her as well. Once we receive your response, and if we believe we still need additional information, we will notify you by mail within five working days of our receipt of your response.

IF YOU DISAGREE WITH A DECISION

Step 3: Review Of Your Appeal

Qualified medical personnel who were not involved in the original adverse Clinical Determination, will review your appeal. Similarly, qualified personnel who were not involved in the original Benefit Determination will review your first and second appeal of that Benefit Determination.

Step 4: Decision On Your Appeal

For a pre-service appeal, we will render a decision and notify you, your designee, and where appropriate, your health care provider, in writing, within 15 days of our receipt of your Benefit Determination Appeal or 30 days of our receipt of your Clinical Determination Appeal.

For post-service appeals, we will make our decision and notify you, your designee, and where appropriate, your health care provider, in writing, no later than 60 days from our receipt of your Clinical Determination Appeal. For all Benefit Determination Appeals, we will make our decision and notify you or your designee, 30 days from our receipt of your Benefit Determination Appeal.

If we do not render our decision on a Clinical Determination Appeal within 60 days after receipt of the necessary information to conduct the appeal – or in the case of an expedited clinical appeal, within two business days from receipt of the necessary information, our original Clinical Determination will be considered reversed and will result in approval of the requested services or benefits.

If the outcome of a Clinical Determination remains adverse to you, this decision is called a **Final Adverse Determination (FAD)** for purposes of an External Appeal discussed on page 74. Our written FAD decision will include all of the following items for Clinical Determinations but in the case of Benefit Determinations, only the relevant items listed below will be included in your written decision.

- The basis for the Benefit Determination and the basis, reason or reasons and clinical rationale and that this is a final adverse determination. Or, a written statement that insufficient information was presented or available to reach a determination.
- Where applicable, reference to the specific plan provisions on which the benefit determination is based and the enrollee's coverage type.
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits.
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the determination, the final determination will include either the specific rules, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the determination. The determination will advise you that a copy of the rule, guideline, protocol, or other similar criterion will be provided to you free of charge upon request.

IF YOU DISAGREE WITH A DECISION

- If the Clinical Determination is based on whether a service is Medically Necessary or experimental or investigational, the final adverse determination will include either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided to you free of charge upon request.
- The following statement: You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State Insurance regulatory agency.
- The name, address and telephone number of our contact person and, if HIP uses an external review agent, the external review agent.
- A description of the health care service that was denied, including, as applicable and available, the dates of service, the name of the facility and/or physician proposed to provide the treatment, and the developer/manufacturer of the health care service.

Along with the final adverse determination, we will provide you with the following:

- A statement that you may have a right to bring an action under Section 502(a) of the Employee Retirement Income Security Act of 1974.
- A statement that you are eligible for an external appeal and a standard description of the external appeal process, including the application form and instructions.
- A notice of the fee charged to you as a member to file an external appeal, including criteria for determining eligibility for waiver of the fee due to financial hardship and the process for requesting such a waiver.

Step 5: Second Level Standard Internal Appeal Of A Benefit Determination

(Not Available For Clinical Determinations, See *External Appeals Process On Page 74*)

With receipt of the written decision on your First Level Standard Internal Appeal of a Benefit Determination, you will receive information on how to request a Second Level Standard Internal Appeal. You must follow those instructions and file your request for a Second Level Standard Internal Appeal. You will have at least 60 business days from receipt of a written, adverse determination of your First Level Standard Internal Appeal to file a Second Level Standard Appeal.

Upon receipt of your appeal, we will mail to you a written acknowledgement within five working days of such filing, along with the name, address and telephone number of the representative responsible for handling your case. Along with that acknowledgement, we may also provide a notice specifying what additional information, if any, we need to make a decision on your appeal.

A decision on your Second Level Standard Internal Appeal of a Benefit Determination will be made within 30 days of receipt of your request. You will also receive notification of our decision within this time frame.

IF YOU DISAGREE WITH A DECISION

Expedited Internal Appeals

Due to the nature or urgency of your medical condition, your standard appeal may be processed in a shorter period of time than indicated in the first-level appeals section. You must provide us with information to support your request for an Expedited Internal Appeal. An Expedited Internal Appeal is available for the appeal of an adverse Clinical or Benefit Determination involving:

- Continued or extended health care services.
- Procedures, treatments or additional services while you are undergoing a course of continued treatment prescribed by your health care provider.
- An adverse determination made by us in which your health care provider believes an immediate appeal is warranted (except any post service determination).
- All requests concerning admission, continued stay or other health care services for a member who has received emergency services, but has not been discharged from the facility.
- All other prior-to-service cases will be judged case-by-case as to whether failure to grant an expedited appeal/review could mean harm to the member if a possible 30-day (Standard Appeal) wait were imposed.

Step 1: Call The Expedited Appeal Line

If you, your designee or provider feel that your condition warrants an expedited appeal, any of you may call our Expedited Appeal Line at **1-888-447-6855**. If someone other than you or your provider calls to request the expedited appeal on your behalf, we will request confirmation that your representative or designee is authorized to file an appeal on your behalf. We will accept the Appointment of Representative form (sent to you with the notice of benefit determination) signed by you or a Health Care Proxy, or a Power of Attorney form specifying the individual as an authorized party.

Step 2: Acknowledgement Of Your Expedited Internal Appeal

Upon receipt of your Appeal, you or your representative will be verbally advised of the name, address, and telephone number of our representative responsible for handling your case.

Step 3: Review Of Your Expedited Internal Appeal

Qualified medical personnel who were not involved in the original adverse Clinical Determination will review your Appeal. Similarly, qualified personnel who were not involved in the original Benefit Determination will review your first and second appeal of that Benefit Determination.

IF YOU DISAGREE WITH A DECISION

Step 4: Decision On Your First Level Expedited Internal Appeal

A First Level Expedited Internal Appeal of a Benefit or Clinical determination will be decided within 48 hours of receipt of all necessary information or 72 hours of receipt of the appeal request. We will notify you, your designee and, where appropriate, your health care provider of our determination within this same time frame.

For a First Level Expedited Internal Appeal of a Clinical Determination, information from your physician may be necessary to resolve the appeal.

If the outcome of the Clinical Determination remains adverse, this decision is called a Final Adverse Determination (FAD) for purposes of External Appeal as discussed on the following page. Our written FAD decision will include all of the following items for Clinical Determination but in the case of Benefit Determinations, only the relevant items listed below will be included in your written decision:

- The basis for the Benefit Determination and the basis, reason or reasons and clinical rationale for the final adverse determination.
- Where applicable, reference to the specific plan provisions on which the benefit determination is based.
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits.
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the determination, you will receive either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided to you free of charge upon request.
- If the Clinical Determination is based on a Medical Necessity or experimental treatment or similar exclusion or limit, you will receive either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided to you free of charge upon request.
- The following statement: Your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your State Insurance regulatory agency.
- A description of how you may further appeal to us your expedited adverse benefit determination, including the form to start a Second Level Expedited Benefit appeal.
- The name, address and telephone number of our contact person.
- A description of the health care service that was denied, including, as applicable and available, the name of the facility and/or physician proposed to provide the treatment, or the developer/manufacturer of the health care service.

IF YOU DISAGREE WITH A DECISION

- A clear statement that you are eligible for an external appeal, and the time frames for requesting such an appeal.

Along with the final adverse determination, we will provide you with the following:

- A statement that you may have a right to bring an action under Section 502(a) of the Employee Retirement Income Security Act of 1974.
- A standard description of the external appeal process, including the application form and instructions.
- A notice of the fee charged to you as a member to file an external appeal, including criteria for determining eligibility for waiver of the fee due to financial hardship and the process for requesting such a waiver.

If we fully overturn our original adverse determination, we will inform you of the procedure to have the services in question provided to you.

Step 5: Second Level Expedited Internal Appeal Of A Benefit Determination

(Not Available For Clinical Determinations, See *External Appeals*)

With receipt of the written decision on your First Level Expedited Internal Appeal of a Benefit Determination, you will receive information on how to request a Second Level Expedited Internal Appeal. You have at least 60 business days from receipt of your First Level Expedited Internal Appeal determination to file your request for a second Level Expedited Internal Appeal Determination.

Upon receipt of your appeal, we will mail to you a written acknowledgement within five working days of such filing, along with the name, address and telephone number of the representative responsible for handling your case. Along with that acknowledgement, we may also provide a notice specifying what additional information, if any, we need to make a decision on your appeal.

A decision on your Second Level Expedited Internal Appeal will be made within 60 business days of receipt of your First Level Standard Internal Appeal determination. We will notify you of our determination within the earlier of 2 business days or 72 hours of receipt of your Second Level Internal Expedited Appeal.

You may ask various regulatory agencies at any time to review your concerns. Two such agencies are the New York State Department of Health Bureau of Certification and Surveillance **(1-800-206-8125)** and the State of New York Insurance Department Consumer Services Bureau **(1-800-400-8882)**.

Note: There is no Second Level Expedited or Standard Internal Appeal of a Clinical Determination. For Clinical Determinations, after the initial appeal, you may seek an External Appeal as set forth in the following section.

IF YOU DISAGREE WITH A DECISION

External Appeals

You may file an application for an external appeal by an independent, state-approved external appeal agent if you have received a **Final Adverse Determination (FAD)** based on Medical Necessity or because the service is experimental and/or investigational. An external appeal agent certified by the state will review your request, independent from our decision, to determine if the denied service is Medically Necessary and should be provided and/or paid for by us. Expert clinical peer reviewers conduct all reviews and the results are final and binding.

To be eligible for an external appeal, you must have received a Final Adverse Determination (FAD) letter (or, within 45 days of when you and the plan jointly agree in writing to waive the internal appeals process). An External Appeal application will be included with this letter. If you need to obtain an External Appeal application, however, you may obtain one by contacting:

- The New York State Department of Insurance: Web site www.ins.state.ny.us; telephone number, **1-800-400-8882**.
- Customer Service at **1-800-HIP-TALK (1-800-447-8255)**.

The application will provide clear instructions for completion. To file an external appeal, you must include \$50.00 with the application. This money will be refunded if the External Appeal is decided in your favor. If you cannot afford to pay, inform us of the basis for your claim of inability to pay, and upon our review and acceptance of your reasons the charge will be waived. There will be no other charge to you.

The application for External Appeal must be made within 45 days of your receipt of the notice of final adverse determination as a result of the plan's internal standard or expedited appeal process, or within 45 days of when you and the plan jointly agree to waive the internal standard appeal process.

You will lose your right to an External Appeal if you do not file an application for an external appeal within 45 days of your receipt of the final adverse determination from the internal plan appeal. Or, within 45 days of when you and the plan jointly agree to waive the Internal Appeals process.

The application will instruct you to send it to the New York State Department of Insurance. You (and your doctors) must release all pertinent medical information concerning your medical condition and request for services. An external appeal agent must decide a standard Internal Appeal within 30 days of receiving your application for external appeal from the state. Five additional working days may be added if the agent needs additional information. If the agent determines that the information submitted is materially different from that considered by the plan, the plan will have three additional working days to reconsider or affirm its decision. You and the plan will be notified, in writing, within two days of the agent's decision.

IF YOU DISAGREE WITH A DECISION

You may also request an expedited external appeal if your doctor can attest that a delay in providing the recommended treatment would pose an imminent or serious threat to your health. The external appeal agent will make a decision within three days for expedited appeals. You and the plan will be notified of the decision immediately by telephone or fax. Written notification will follow.

Other Agencies

Members may request assistance from any regulatory agency at any time for review of their concerns. Two such agencies you may wish to contact are the New York State Department of Health and the New York State Insurance Department:

1. New York State Department of Health

Office of Managed Care

90 Church Street – 13th floor

New York, NY 10007

1-800-206-8125

www.health.state.ny.us

1a. New York State Department of Health

Bureau of Certification and Surveillance

Corning Tower, Empire State Plaza

Albany, NY 12237

1-800-206-8125

2. State of New York Insurance Department

Consumer Services Bureau

25 Beaver Street

New York, NY 10004

1-800-400-8882

www.ins.state.ny.us

SECTION HIGHLIGHTS >>>

YOUR HIP

MEMBERSHIP STATUS

Continuation Of Benefits

- If your HIP membership ends, you can continue your current group coverage for 18 months under COBRA. Your spouse or dependent children may be eligible for up to 36 months of COBRA benefits. Check with your employer to obtain information about COBRA, eligibility requirements and the cost to you should you elect to continue your coverage.

Continuation Of Coverage For Disabled Persons

- If you are disabled when your employment terminates or you become disabled within 60 days of COBRA coverage, continuation will be extended from 18 months to 29 months. Premiums from the 19th to the 29th month will be 150% of the group rate.
- To benefit from this extension, you must notify the employer of the Social Security Administration's determination of disability within 60 days of such determination and before the 18-month period of continuation coverage.
- You must also notify the employer within 31 days of the date any final determination by the Social Security Administration that you are no longer disabled.

Converting To A Direct Payment Contract

- If your group contract or your benefits under COBRA expire, you can convert to a HIP direct payment plan. Contact HIP Customer Service at **1-800-HIP-TALK (1-800-447-8255)**.

Canceling Your Membership

- You can cancel your membership through your Benefits Administrator or by writing to HIP.
- Cancellation of your membership by HIP occurs only in unusual, specific situations. Such situations include failure of your group to pay your premiums, not following the recommended treatments or exhibiting behavior that disrupts the operation of your health care provider(s), despite their reasonable efforts to help you follow treatments or alter behavior.

YOUR HIP MEMBERSHIP STATUS

Continuation Of Benefits

If you had HIP coverage through your employer, you may be eligible to continue that coverage after you leave your job. You may remain on the group's coverage for up to 18 months by paying the premiums yourself. This option is available if you are unemployed, self-employed or working in a job that doesn't offer medical coverage. This option is also available if you take a new job offering medical coverage that excludes pre-existing conditions.

In addition, your spouse or dependent children may be eligible for up to 36 months of continued benefits. **For information about eligibility, check with your employer. Your employer may be obligated under a federal law known as COBRA to provide this information and cover you if you elect to pay the appropriate premium.**

Continuation Of Coverage For Disabled Persons

If you are disabled (as defined by the Social Security Administration) when your employment terminates or you become disabled within 60 days of COBRA coverage, continuation will be extended from 18 months to 29 months. Premiums from the 19th to the 29th month will be 150% of the group rate.

To benefit from this extension, you must notify the employer of the Social Security Administration's determination of disability within 60 days of such determination and before the end of the 18-month period of continuation coverage. You must also notify the employer within 31 days of the date of any final determination by the Social Security Administration that you are no longer disabled.

Converting To A Direct Payment Contract

At the end of the 18, 29 or 36 months of continuation coverage, you must be allowed to enroll in an individual conversion health plan if such a plan is otherwise generally available under the Plan.

As a HIP member, you and your dependents are eligible for conversion to a direct payment HIP plan when your group contract or your benefits under COBRA expire. (The direct payment HIP plan available to you, however, may not be the same as your previous group contract or provide the same benefits you received under COBRA.) This option may have particular value for dependent children who marry, who reach the coverage age limit or who are no longer full-time students.

For direct payment coverage and premium information, contact HIP Customer Service at **1-800-HIP-TALK (1-800-447-8255)**.

YOUR HIP MEMBERSHIP STATUS

Canceling Your Membership

We hope you will never decide to cancel your membership. But if you do wish to cancel for any reason at all, contact the health benefits administrator at your company or union welfare fund.

- If you are a direct payment member, call us at **1-800-HIP-TALK (1-800-447-8255)**; or
- Write to us at:

**HIP Health Plan of New York
Enrollment Department
55 Water Street
New York, NY 10041-8190**

Rest assured that HIP cannot cancel your membership for reasons of health, regardless of your medical situation. Only in the following situations can HIP cancel your membership:

- If you or your group fails to pay your premiums.
- If you move outside the HIP geographic service area.
- If you fail to follow recommended treatments or if your behavior is such that it disrupts the operation of your health care provider(s), despite their reasonable efforts to help you follow treatments or alter behavior.
- If you engage in fraud in applying for your Contract, in seeking any benefits under your Contract or if you misuse your HIP Identification Card.
- If there is any other reason approved by the Superintendent of Insurance, including filing false or improper claims.

SECTION HIGHLIGHTS >>>

HIP AT YOUR SERVICE

Keeping Us Informed

- Keep HIP informed of any change affecting your coverage (e.g., name, address, telephone number, etc.). Contact HIP Customer Service by mail, via hipusa.com or our toll free telephone number **1-800-HIP-TALK (1-800-447-8255)**.

Accessing Information About HIP And Your Coverage

- Log on to our Web site at hipusa.com 24 hours a day/7 days a week for links to important areas providing information about HIP. If you register as a member, you'll receive a secured password that will allow you to conduct a number of transactions online, including changing your PCP. HIP's Web site is available in English, Spanish, Chinese and Korean.
- Call **1-800-HIP-TALK** and use our Interactive Voice Response system 24 hours a day/7 days a week.
- Call **1-800-HIP-TALK** to speak with Customer Service Advocates Monday through Friday, between 8 am and 6 pm.

If You Need Help In A Language Other Than English

- You can connect with a representative working the Language Line by calling **1-800-HIP-TALK**.

If You Have A Hearing Or Speech Impairment

- If you have a hearing or speech impairment and use a TDD, please call **1-888-HIP-4TDD (1-888-447-4833)**.

Information You Can Request

- New York State law entitles you to receive a wide range of information upon request. To request available information, call HIP Customer Service Department or write to us at: 55 Water Street, New York, NY 10041-8190.

Protecting Your Confidentiality

- HIP regularly instructs participating providers and their medical departments on keeping medical records confidential. If a group asks HIP for reports about our service performance or the use of medical care by member, we will only summarize group member utilization. No individual is identified.

HIP AT YOUR SERVICE

Keeping Us Informed

Please let us know if you have any change affecting your coverage, including a name, address or phone number change, a change in marital status or the birth or death of a covered family member. You can notify us of the change by using hipusa.com or contacting HIP Customer Service.

Note: If you are a State or Federal employee or Transit/TWU employee, you must contact your Benefits Administrator to make any change to your personal data.

Also, please be sure to give us your opinions and ideas. Write to the Managing Director of Customer Affairs at the Customer Service address provided in the next section, e-mail us by visiting hipusa.com or call us at **1-800-HIP-TALK (1-800-447-8255)**. HIP actively seeks member input through such vehicles as our active, broadly representative Member Council and periodic regional member forums. But individual input like yours is especially important in helping us continue to meet our commitment to service excellence. Individual input also allows for our members to participate in the development of HIP policies.

Contacting HIP Customer Service

You can access a great deal of Customer Service information and make a number of transactions and inquiries by visiting our Web site at hipusa.com. Our Web site allows you to access benefit descriptions, make claim inquiries, send e-mails to HIP Customer Service, fill prescriptions online and view our drug formulary. In addition, logging on to hipusa.com gives you the opportunity to view HIP's annual report and read about some important health education information.

You can also find answers to your questions by calling **1-800-HIP-TALK (1-800-447-8255)**. You can speak with a Customer Service Advocate Monday through Friday, 8 am to 6 pm. At all times, you can verify information and make requests through the Interactive Voice Response (IVR) system. You should be ready to enter your HIP ID number when asked, then just follow the easy instructions.

A helpful hint: Phone volume is heaviest on Mondays and between 11 am and 3 pm on other days. So, if you need to speak with a Customer Service Advocate, you may minimize delay by calling at other times.

You may also write us at :

**HIP Health Plan of New York
Customer Service Department
55 Water Street
New York, NY 10041-8190**

HIP AT YOUR SERVICE

Or visit our Walk-In Unit in the 55 Water Street lobby, New York, NY, Monday through Friday, 8:30 am to 5 pm.

If You Need Help In A Language Other Than English

HIP has a long-standing commitment to full services for our ethnically diverse membership. Accordingly, you can receive assistance through:

- The Language Line available through Customer Service at **1-800-HIP-TALK (1-800-447-8255)**. The Language Line provides over-the-telephone interpretation services in more than 100 languages, including Spanish, Russian, Chinese, French, Japanese and Korean.
- Bilingual and multilingual staff and providers working in private offices and medical group offices. When the needed language is not available at the office or medical group office, you can use the Language Line. This line can be connected to an examination room with a two-way speaker system.

In addition, HIP's Web site is available in English, Spanish, Chinese and Korean. Members can also request translations of this Member Handbook. The following languages are available:

- Spanish
- Chinese
- Korean

Call **1-800-447-8255** to request these translations.

If You Have A Hearing Or Speech Impairment

HIP maintains a special telephone message relay system that helps us communicate with hearing- or speech-impaired members. A HIP operator using a special telephone device for those who are hearing impaired (TDD) is available with benefits information Monday through Friday, between 8:30 am and 5 pm. After hours and on weekends, TDD communications are reserved for medical emergencies.

You can also arrange with HIP to have a sign language interpreter present when you visit your PCP or for any regularly scheduled medical visit.

To communicate via TDD or arrange for a sign language interpreter, call **1-888-447-4833** Monday through Friday, 8:30 am to 5 pm.

Confidentiality Of Medical Records And Identifiable Information

Medical records are documents with information about your medical treatment. HIP understands that it is important to protect the privacy of these records.

HIP AT YOUR SERVICE

To ensure confidentiality, HIP has instituted strict policies. For example, we regularly instruct participating facilities, health care professionals and their medical records departments on keeping medical records confidential. In addition, all HIP employees sign a confidentiality statement and adhere to Standards of Conduct that prohibit the unauthorized release of medical records.

In some cases, group customers ask HIP for reports about our service performance or the use of medical care by members of their group. When we provide this information, we are careful to assure that it is aggregated. That is, the information provided is a summary of all group member medical care utilization – no individual is identified.

Identifiable information is data in the medical record that could allow the patient to be recognized. Examples include name, address, date of birth and Social Security number.

When HIP members enroll, they give us their consent to use this kind of information only for certain specific reasons. These reasons, which appear on the enrollment form, include general treatment, payment/billing, coordination of care, quality assessment, utilization review, fraud detection or accreditation. *Identifiable information cannot be used for any other purpose or shared with any other organization without your clear and specific consent. The only exception is in the unusual case that such release is legally required.*

We have developed a **Special Consent Form** that we send to a member if we are seeking to release identifiable information in some way other than what was agreed to at the time of enrollment. The form specifies numerous information including: the purpose for which it will be used; the right to inspect or copy information; the option to revoke consent; a statement regarding disclosure of information made to an entity other than a health plan; and the time period the member authorizes for release. It requires the signature of the member or a qualified person on the member's behalf.

Here is a summary of your confidentiality rights.

As a HIP member, you have the right to:

- Review and copy your health information.
- Review which departments or agencies have access to your identifiable health information.
- Protection against unauthorized disclosure of identifiable health information.
- Refuse consent to release identifiable information.
- Protection against release of any identifiable health information for the collection, use or sharing of data.
- Expect that all the information used for research or performance measurement will be limited – that is, all data will be de-identified or aggregated before release.
- File a complaint or appeal if you feel that your health information was used without proper consent.

Other Information You Can Request

In accordance with New York State law, all enrollees or prospective enrollees of HIP are entitled to receive the following information upon request:

- A list of the names, business addresses and official positions of the membership of the board of directors, officers, controlling persons, owners or partners of the organization.
- A copy of the most recent annual certified financial statement of the organization, including a balance sheet and summary or receipts and disbursements prepared by a certified public accountant.
- A copy of the most recent individual, direct pay subscriber contract.
- Information relating to consumer complaints compiled pursuant to Section 210 of the insurance law.
- HIP's Drug Formulary, as well as information about whether individual drugs are included or excluded from coverage.
- A written description of the organizational arrangements and ongoing procedures of the organization's quality assurance program.
- A description of the procedures followed by the organization in making decisions about the experimental or investigational nature of individual drugs, medical devices or treatments in clinical trials.
- Individual health practitioner affiliations with participating hospitals, if any.
- Upon written request, specific written clinical review criteria relating to a particular condition or disease and, when appropriate, other clinical information that the organization might consider in its utilization review. The organization may include with the information a description of how it will be used in the utilization review.
- The written application procedures and minimum qualification requirements for health care professionals to be considered by the organization.
- Other information as required by the Commissioner of Health, provided that such requirements are put forth pursuant to the State Administrative Procedure Act.

To request any of these items, call us at: **1-800-HIP-TALK (1-800-447-8255)**.

Or, you may write us at:

**HIP Health Plan of New York
Customer Service Department
55 Water Street
New York, NY, 10041-8190**

SECTION HIGHLIGHTS >>>

MEMBER RIGHTS AND RESPONSIBILITIES

Your Rights As A Member

- Some of your rights are:
 - The right to understand your rights. If for any reason you do not understand these rights or how to interpret them, HIP and its participating physicians will provide you with assistance.
 - The right to change physicians, in accordance with the provision of your policy.
 - The right to receive from your physicians information necessary to allow you to give informed consent prior to the start of any procedure or treatment.

Your Responsibilities As A Member

- Some of your responsibilities are:
 - The responsibility to provide HIP and its participating physicians and other providers with accurate and relevant information about your medical history and health so that appropriate treatment and care can be rendered.
 - The responsibility to keep pre-scheduled appointments or to cancel appointments, giving as much notice as possible.
 - The responsibility to update your record with accurate personal data including changes in name, address, phone number, e-mail address, additional health insurance carriers and number of dependents within 30 days of the event causing the change(s).

MEMBER RIGHTS AND RESPONSIBILITIES

Rights And Responsibilities

Understanding your rights and responsibilities as a HIP member can help you and us make the most of your HIP membership. Below, we have listed what you can expect of us as well as what we expect from you.

Your Rights

You have the right to understand your rights and receive information about HIP, its services, its practitioners and providers. If for any reason, you do not understand these rights or how to interpret them, HIP and its participating physicians will provide you with assistance. Let's examine what the rest of your rights include:

- You have the right to treatment without discrimination including discrimination based on race, color, religion, gender, national origin, disability, sexual orientation or source of payment.
- The right to a non-smoking environment.
- The right to receive considerate and respectful care in a clean and safe environment.
- The right to receive, upon request, a list of the physicians and other health care providers in the HIP participating provider network.
- The right to change your physician.
- The right to be assured that HIP participating health care providers have the qualifications stated in HIP professional standards established by the HIP credentialing committee, which are available upon request.
- The right to know the names, positions and functions of any participating provider's staff and to refuse their treatment, examination or observation.
- The right to obtain from your physician, during practice hours, comprehensive information about your diagnosis, treatment and prognosis, regardless of cost or benefit coverage, in language you can understand. When it is not medically advisable to give such information to you, or when the member is a minor or is incompetent, the information will be made available to a person who has been designated to act on that person's behalf.
- The right to receive from your physician the information necessary to allow you to give informed consent prior to the start of any procedure or treatment and to refuse to participate in, or be a patient for, medical research. In deciding whether to participate, you have the right to a full explanation.
- You also have the right to refuse treatment, to the extent permitted by law, and to be informed of the medical consequences of refusing it.
- The right to have all lab reports, X-rays, specialists' reports and other medical records completed and placed in your chart so they may be available to your physician at the time of consultation.
- The right to be informed about all medication given to you, as well as the reasons for prescribing the medication and its expected effects.

MEMBER RIGHTS AND RESPONSIBILITIES

- The right to receive all information you need to give informed consent for an order not to resuscitate. You also have the right to designate an individual to give this consent if you are too ill to do so.
- The right to request a second opinion from a HIP participating physician.
- The right to privacy concerning your medical care. This means, among other things, that no person who is not directly involved in your care may be present without your permission during any portion of your discussion, consultation, examination or treatment.
- The right to expect that all communications, records and other information about your care or personal condition will be kept confidential, except if disclosure of that information is required by law or permitted by you.
- The right to request that copies of your complete medical records be forwarded to a physician or hospital of your choice at your expense. However, information may be withheld from you if, in the physician's judgment, release of the information could harm you or another person. Additionally, a parent or guardian may be denied access to medical records or information relating to a minor's pregnancy, abortion, birth control or sexually transmitted diseases if the minor's consent is not obtained.
- The right to have a person of your choice accompany you in any meeting or discussion with medical or administrative personnel.
- The right to consult by appointment, during business hours, with responsible administrative officials at HIP and your participating physician's office to make specific recommendations for the improvement of the delivery of health services.
- The right to file an appeal or external review related to a determination about care and services rendered. For additional information on filing an appeal, see *If You Disagree with a Decision* in your Member Handbook and/or call HIP's Customer Service Department at **1-800-HIP-TALK (1-800-447-8255) (TDD: 1-888-447-4833)**.
- **IMPORTANT:** State and federal laws give adults in New York State the right to accept or refuse medical treatment, including life-sustaining treatment, in the event of catastrophic illness or injury. As your health insurer, HIP has the duty to make you aware of your rights in these matters. Your membership kit contains materials on advance directives with written instructions, such as a living will or health care proxy containing your wishes relating to health care if you become incapacitated. Please read this material carefully. To request replacement copies of this material, please call **1-800-HIP-TALK (1-800-447-8255) TDD: 1-888-447-4833**.
- You have the right to make recommendations regarding HIP's member rights and responsibilities policies.

MEMBER RIGHTS AND RESPONSIBILITIES

Your Responsibilities

Now we come to the section about your responsibilities. It is important to us that you also become familiar with this section because doing so will make it easier to provide you with access to the best health care possible.

- The responsibility to provide HIP and its participating physicians and other providers with accurate and relevant information about your medical history and health so that appropriate treatment and care can be rendered.
- The responsibility to keep scheduled appointments or cancel them, giving as much notice as possible in accordance with the provider's guidelines for cancellation notification.
- The responsibility to update your HIP record with accurate personal data, including changes in name, address, phone number, additional health insurance carriers and an increase or decrease in dependents within 30 days of the change.
- The responsibility to treat with consideration and courtesy all HIP personnel and the personnel of any hospital or health facility to which you are referred.
- The responsibility to be actively involved in your own health care by seeking and obtaining information, by discussing treatment options with your physician and by making informed decisions about your health care.
- The responsibility to understand HIP's benefits, policies and procedures as outlined in your Contract or Certificate of Coverage and handbook, including policies related to prior authorization for all services that require such authorization.
- The responsibility to pay copayments, if applicable, at the time services are rendered.
- The responsibility to abide by the policies and procedures of your participating physician's office.

SECTION HIGHLIGHTS >>>

HOW HIP COMPENSATES PARTICIPATING PROVIDERS

How We Compensate Participating Providers

HIP provides access to care and coverage for services. We contract with providers or groups of providers to provide care to members. These “participating providers” are not HIP agents or employees.

HIP’s provider compensation is not intended to limit or reduce the quality or scope of medical care you receive. Participating providers are compensated in a variety of ways. For example:

- Medical groups are compensated by capitation or pre-payment arrangement.
- IPA (Independent Practice Association) physicians are compensated either through capitation or fee-for-service through the IPA, or through direct fee-for-service.
- Physicians contracting directly with HIP are compensated on a discounted fee-for-service basis.
- Facilities, such as hospitals, are compensated on a per diem (per day) or DRG (Diagnosis Related Groupings) basis.

HOW HIP COMPENSATES PARTICIPATING PROVIDERS

You have a right to information about how HIP compensates participating health care providers. The most important point to understand is that HIP does not compensate health care providers in general or make specific payments intended to limit or reduce the quality or scope of medical care you receive.

The physicians and health care providers that treat you are not HIP agents or employees. They alone are responsible for the medical care they provide. HIP does not provide medical care. Nor is HIP responsible for any acts or omissions of any physician or other health care provider. Rather, our obligation to you is to provide access to and pay for covered services in accordance with the terms of your Certificate of Coverage. You and your doctor are responsible for decisions about your medical care.

If you have questions about payment arrangements, we encourage you to discuss them with your primary care physician as well as with other participating providers, such as hospitals and other inpatient facilities. To assist you in these discussions, we have provided some important definitions below. These are terms commonly used by health care providers and health plans such as HIP when discussing compensation. Following the definitions, we have provided some general descriptions of the various methods HIP uses to compensate participating health care providers.

Definitions Of Common Compensation Terms

Fee-For-Service means payment to a provider for each covered service delivered. Payments are based upon an agreed fee schedule. The provider or the member must submit a claim to HIP for the payment to be processed.

Capitation or **Pre-Payment** means payment to a provider (such as a hospital or a large group of physicians practicing together as a professional corporation) of a fixed amount of money each month per member. This amount covers provisions of specific services to those members who have selected that provider. The provider paid through the Capitation method receives payment without submitting claims. Some providers are Capitated just for the services they provide. Others are Capitated to provide a broader array of services, which may include hospitalization, diagnostic services or prescription drugs.

Per Diem Payment means a payment based on a flat amount per day for hospital services or other inpatient facility care such as nursing home services. Unlike Fee-For-Service arrangements, hospitals or other facilities on a Per Diem system will receive the same flat rate per day regardless of the services provided each day.

HOW HIP COMPENSATES PARTICIPATING PROVIDERS

Diagnostic Related Group or **DRG**, or **Case Rate** means a hospital payment based primarily on the diagnosis and medical condition of the patient. Hospitals or other inpatient facilities paid on a DRG or Case Rate will receive that payment regardless of the actual services delivered or how long the patient remains hospitalized. The DRG reimbursement payment system is a standard methodology used by Medicare to pay hospitals for services provided to Medicare beneficiaries. This methodology may be used by HIP to reimburse hospitals when they treat members in other lines of business.

Risk means the responsibility the provider assumes to deliver covered health care services under a Capitation arrangement. When a provider accepts Capitation for a member for a particular month, that provider has been paid in full for the covered service the member requires. That payment is made based on services the provider has agreed to deliver or arrange regardless of whether the member actually uses any services. In any given month, Capitation payment is received by the provider whether or not the member receives any services in that month or if the costs of services provided to the member exceed the Capitation payment for that month.

Independent Practice Association or **IPA** means an organization of health care providers authorized by New York State to contract with health plans such as HIP and to negotiate fee schedules or other compensation arrangements on behalf of its member physicians, hospitals and other providers.

Medical Group means, for purposes of this section of the handbook, the professional corporations organized by the physicians that operate the HIP affiliated physician group practices in Queens, Brooklyn, Staten Island and Long Island. These professional corporations negotiate compensation arrangements and contract with HIP to provide services to members. The Medical Groups employ physicians, health care professionals and other staff.

Common Reimbursement Arrangements Currently Used By HIP

Medical Group Compensation

To compensate primary care physicians practicing at a medical center, HIP contracts with Medical Groups which employs these physicians. HIP pays the Medical Groups a capitation fee for medical services these physicians provide at the medical center.

Under this method, the Medical Group as a whole is at risk for the services it provides. It is also at risk for the cost of certain specialty care services that are not provided at the medical center. The group is typically not at risk for certain other services for which they provide referrals to patients. Examples of such other services, for which the Medical Groups are not at financial risk, include pharmacy, inpatient hospital care and mental health services.

HOW HIP COMPENSATES PARTICIPATING PROVIDERS

In addition, each of the Medical Groups as a whole has the opportunity to receive additional compensation in the form of quality incentive bonuses. Such bonuses may be available for achieving certain performance goals in the areas of quality improvement, quality of care, customer satisfaction and certain operational areas. For example, member satisfaction with access to care as well as decrease in hospital length of stay are some of the quality of care goals HIP measures and uses to determine if any additional compensation is paid to each of the Medical Groups. This reinforces physicians' professional commitment to achieving member satisfaction and better health outcomes through the appropriate and timely delivery of services, at the right setting, by the right provider. Quality incentive bonuses are paid when the Medical Group achieves overall performance goals for all HIP members that use the Medical Group. The bonuses are not connected to the care provided to any single member.

IPA Compensation

HIP may pay physicians participating through an IPA in one of two ways:

- HIP may pay the IPA on behalf of the physician by Capitation or Fee-For-Service, or
- HIP may pay the physician directly on a Fee-For-Service basis.

If HIP pays the IPA by Capitation, the IPA is likely to be at risk for medical services it directly provides as well as for a broader array of services. This broader array of services may include specialty care, laboratory and inpatient hospital care. The IPA may, in turn, pay the primary care physicians and specialists either by Fee-For-Service or by Capitation. In so doing, the IPA will put the physicians at risk only for the services they directly provide.

Some IPA provider agreements with HIP may include bonus compensation. Such compensation is available as an incentive for achieving high performance measures in certain specific areas such as quality improvement, quality of care, customer satisfaction and operational cooperation. HIP regularly measures the performance of its entire network against such standards. Bonus compensation is paid when the IPA achieves overall performance goals for all HIP members that use IPA physicians. The bonuses are not connected to the care provided to any single member.

In addition, HIP and the IPA may agree to certain cost goals for particular services. After an agreed upon time period HIP and the IPA calculate the actual costs for providing these services on a Fee-For-Service basis to the members that have selected IPA primary care physicians. The IPA and HIP then share the Risk related to providing those services. Therefore, if the services actually cost less than the target, the IPA receives additional compensation. If the actual cost exceeds the target, the IPA pays a portion or all of the excess cost.

HOW HIP COMPENSATES PARTICIPATING PROVIDERS

Compensation For HIP Participating Physicians Directly Contracting With HIP

Providers contracting directly with HIP are paid on a discounted Fee-For-Service basis, with no risk transferred to them.

Facility Compensation

HIP pays participating hospitals or other inpatient care facilities on a Per Diem or DRG basis. With certain high-volume hospitals, the Per Diem fee may be subject to adjustments if certain volume utilization levels are achieved over time.

SPECIAL MEMBER PROGRAMS >>>

Information about programs available to you as a HIP Member.



Please note that these programs are available to all HIP Prime®, HIP Prime POS and Federal Employees Health Benefits Program members.

Some programs are not available to all members. For example, the alternative medicine and laser vision programs are not available to members of HIP HMO Direct and HIP Choice Plus Direct members.

SENIORLINK >>>

HIP[®]
HEALTH PLAN OF NEW YORK

SENIORLINK

Your Connection To Quality Eldercare Services

Are you overwhelmed, frustrated, and in need of assistance with the care of an elderly loved one? Now HIP's Care for the Caregiver program offers you access to the resources you need through our unique partnership with Seniorlink, a national eldercare advisory service. Seniorlink's national network provides expert assistance in developing senior care planning, regardless of where the care recipient lives, and helps reduce the stress of navigating the confusing eldercare system. Seniorlink will assist you with eldercare planning for your spouse/partner, parent, in-laws and grandparents - even if the family member is not a HIP member!

Special Discounts For HIP Members

As a HIP member, you can take advantage of Seniorlink Online and Seniorlink Care Advisory Services for the low, discounted price of just \$15 for three months or \$40 for a full year. As an added bonus, you will be eligible to receive a personal emergency response system free for three months, with a one-time activation and shipping fee. Seniorlink Care Management Services are available at an additional cost depending on the services provided.

24/7 Access To Eldercare Resources By Telephone Or Web

By joining Seniorlink, members can access a wealth of valuable caregiving resources including:

- **Seniorlink Online**—24 hours a day, 7 days a week, this Web site is dedicated specifically to eldercare issues.

Do-it-yourselfers can search for information on their own at www.Seniorlinkonline.com or request the assistance of a Seniorlink Care Advisor via e-mail or telephone.

- **Seniorlink Care Advisory Services**—Every caregiver's situation is different. That's why Seniorlink offers personalized one-on-one telephone consultations with a Seniorlink Care Advisor who will offer advice and resources specific to the individual's situation. Seniorlink Care Advisors are available 24 hours a day, 7 days a week to assist caregivers with:
 - Eldercare planning
 - Coordination of available resources
 - Access to public programs and services
 - Nationwide referrals for home health care needs, assisted living facilities and nursing homes
 - Referrals for legal and financial services
 - Information about adult day care options, hospice care, meals, and transportation services
 - And much more!

SENIORLINK

Seniorlink's Care Advisors are eldercare experts with advanced degrees in nursing, social work, rehabilitation, gerontology and counseling. Their qualifications range from RN to PhD, and most have eight or more years of experience managing the care of seniors.

- **Seniorlink Care Management Services**—On-site care management services, delivered by a nationwide network of professional geriatric care managers, are also offered for those who need more comprehensive coordination of care. This may include in-home assessments and consultations, assisted living and/or nursing home evaluations, family consultations and ongoing care management. These types of services are available to members at an additional, but often discounted cost.

Getting Started Is Easy!

Simply visit our Web site at hipusa.com and click on the Seniorlink button under HIP News or call **1-866-797-2334**.

The products and services described above are neither offered nor guaranteed under HIP's contract with the Medicare program. In addition, they are not subject to the Medicare appeals process. Any disputes regarding these products and services may be subject to the HIP Health Insurance Plan of New York grievance process.

**LASER VISION >>>
CORRECTION**

HIP[®]
HEALTH PLAN OF NEW YORK

LASER VISION CORRECTION

HIP Health Plan of New York is now offering eligible members access to the laser vision correction procedures (such as LASIK) at reduced rates through our association with Davis Vision (www.davisvision.com). Davis Vision has one of the largest laser vision correction networks in the New York Metropolitan area. Although laser vision correction procedures are not eligible benefits, and therefore not reimbursable by HIP, members interested in these procedures may receive discounted rates by virtue of their HIP membership.

Laser vision correction is an FDA-approved procedure that has been used by ophthalmologists in the treatment of nearsightedness, farsightedness and astigmatism. Laser vision correction has been performed around the world since the late 1980s. It is estimated that over 5 million people have undergone laser vision correction procedures.

We encourage you to keep your physician informed of any course of treatment you receive. Visit the Davis Vision Web site at www.davisvision.com or call **1-800-743-1170** to obtain your confirmation number for laser discounts. You will need this confirmation number when accessing services and you will be responsible for paying the provider directly for these services. In addition, most providers offer a variety of financing options designed to make laser vision correction affordable. Please ask about these options when you make your appointment.

You can learn more about laser vision correction, review the discount schedule, locate a provider near you, and verify if you are an eligible member for these discounts by visiting Davis Vision online at www.davisvision.com or by calling **1-800-743-1170**. You can also call the HIP Customer Service Department at **1-800-HIP-TALK** from 8 am to 6 pm.

Important Note:

This program provides HIP members with discounts on the laser vision correction procedures. Laser vision correction is not a covered benefit and HIP makes no representation or guarantees regarding the efficacy or appropriateness of the services made available. Use of these services is strictly the member's decision and HIP is not responsible for any acts or omissions by the provider.

**ALTERNATIVE >>>
MEDICINE
PROGRAM**

HIP[®]
HEALTH PLAN OF NEW YORK

ALTERNATIVE MEDICINE DISCOUNT PROGRAM

The integration of Complementary Alternative Medicine (CAM) into conventional western medicine is quickly revolutionizing the landscape of the American health care system. Patients and providers are increasingly using alternative methods of care to complement traditional western medicine. In response to our members request for alternative medicine services, HIP has partnered with the American WholeHealth Network, Inc. to develop this Alternative Medicine Discount Program.*

Who Are CAM Practitioners?

CAM services are provided by yoga instructors, massage therapists, acupuncturists and nutritionists. Also, recognizing our members interest in health and wellness, discount memberships at over 100 fitness centers locally are available.

How Does The Program Work?

The program is simple. You schedule an appointment with a practitioner who participates with our program, receive treatment or service, pay for that service at the time of your appointment and the practitioner discounts their standard fee. There are no claim forms to complete, no prior approval process, no medical necessity criteria and no physician referrals are required to receive up to 30% discounts.

How To Locate A Participating Practitioner.

To locate a participating practitioner in your area call the HIP Alternative Medicine Discount Program Customer Service line at: **1-888-447-2563** or simply go to the Alternative Medicine section of the HIP Web site hipusa.com and click on the link **WholeHealthMD.com**. You will then enter a web link specifically designed for HIP members that can assist you in locating a practitioner.

Want To Learn More About Alternative Care?

The WholeHealthMD.com link provides more information on complementary alternative medicine.

About American WholeHealth Networks Inc.

American WholeHealth Networks Inc. (AWHN) is one of the nations leading providers of integrative medicine. Their national network of over 28,000 practitioners provides CAM to millions of members all across the country. AWHN takes great pride in the quality of its provider network and conducts a very careful and thorough screening process to ensure that participating practitioners meet their standards of practice.

* The information provided concerning the Alternative Medicine program is subject to change. Please check the hipusa.com Web site periodically for the most up-to-date information about the program. Or, if you prefer, call **1-800-HIP-TALK (1-800-447-8255)** if you need up-to-date information.

FITNESS PROGRAM >>>



FITNESS PROGRAM

Fitness Facility Discounts*

No matter what stage of fitness you're in, there's never been a better time to begin an exercise program. Regular exercise, when performed properly, can improve your flexibility and help prevent pulled or torn muscles and chronic lower back pain. It can also help you feel good about yourself and help relieve some of the stresses of day-to-day living. And now, thanks to HIP's reduced cost membership plan at more than 100 fitness centers throughout the HIP Service area, you can find a health club near you.

How To Join

To join a participating health club, simply consult the list following this introduction. Contact the facility most convenient for you and inform them that you are a HIP member and eligible for the American WholeHealth discount. Should you decide to join, present your HIP card at the health club and you will be given the appropriate discount.

If you have a question or would like more information on these discounts, call the American WholeHealth Customer Service line at **1-888-447-2563**.

Before joining a health club, here are several steps you can take to make sure the club is right for you.

- Visit the facility during the hours you would normally attend. Check to be sure enough equipment is available to handle the number of people using the facility at this time. There shouldn't be too many people waiting to use the equipment.
- Check the staff's credentials. Certification does not guarantee a terrific instructor, but it does emphasize the club's standards and commitment to its members. Some certifications to look for include the American College of Sports Medicine and the International Dance and Fitness Association of the Aerobics and Fitness Association of America.
- Check to be sure that there is enough staff to oversee all areas of the health club.
- To make it easier to visit your health club often, select one that is conveniently located to either your home or workplace and be sure that it will be open during the hours that you want to attend.

* The information provided concerning the Fitness program is subject to change. Please check the hipusa.com Web site periodically for the most up-to-date information about the program. Or, if you prefer, call **1-800-HIP-TALK (1-800-447-8255)** if you need up-to-date information.

FITNESS PROGRAM

Along with eating healthfully, getting enough exercise is one of the most important things you can do for your body. Consider its benefits: aerobic exercise, like brisk walking or jogging, can improve your heart's ability to pump blood to help your lungs and circulatory system work at top efficiency and reduce your risk of heart disease. It can also give you more endurance so that walking more than a few blocks or even running several miles won't tire you. And, it can help strengthen your bones to help you avoid bone weakening osteoporosis later in life. Exercise through strength training can also make you stronger so you can lift heavy objects without straining.

To Get In Shape And Stay That Way

- **Find an activity you enjoy**—This is the key to sticking with an exercise program.
- **Warm up**—Warming up before exercise helps you avoid injury by gradually increasing your heart rate and blood flow to improve the function of your muscles. To warm up adequately, jog or slowly walk in place for five to ten minutes.
- **Set goals you know you can achieve**—Start slowly and keep in mind that even the smallest amounts of exercise can help. As your endurance builds, gradually lengthen your workouts and step up the pace. It's generally recommended that you follow a fitness program that combine strength training with aerobic exercise for at least 20 minutes performed most days of the week. But know your limits. The “no pain, no gain” thinking that was once popular can be dangerous.
- **Wear proper footwear**—There are several different kinds of athletic shoes. Cross trainers, running and walking shoes are the most common types. If you're especially active, you may want shoes to match your sport. To find the best shoe, it's a good idea to shop at an athletic shoe store. Sales staff there often have specialized knowledge about which brands are good for particular activities and can make informed recommendations. When shopping, wear the same socks you'll be wearing when you exercise. Also, try on several pairs of shoes and walk around the store long enough to be sure they're comfortable and provide support.
- **Cool down when you're done**—Cooling down eases your body to a lower level of activity to reduce muscle stiffness and prevent the abrupt drop in blood pressure that occurs when you suddenly stop exerting yourself. To cool down, slowly stretch for five to ten minutes.

FITNESS FACILITY DISCOUNTS

ALBANY

Concepts in Fitness Equipment Inc

1545 Central Ave
Albany, NY 12205
(518) 452-2727

Curves of Albany - North

911 Central Ave
Albany, NY 12206
(518) 453-1449

Curves of Albany - South

8 Picotte Dr, # 10
Albany, NY 12208
(518) 453-2200

Curves of Bethlehem

329 Glenmont Rd
Glenmont, NY 12077
(518) 427-0725

Curves of Coeymans

Faith Plaza Rte 9W, # 20
Ravena, NY 12143
(518) 756-1800

Curves of Colonie - East

700 New Loudon Rd
Latham, NY 12110
(518) 786-1822

Curves of Colonie - West

145 Vly Rd
Schenectady, NY 12309
(518) 869-8550

Curves of Guilderland Township

2511 Western Ave
Altamont, NY 12009
(518) 464-0180

Curves of New Scotland/Voorheesville

1969 New Scotland Rd
Slingerlands, NY 12159
(518) 475-1835

Excel 180 Personal Fitness

6 Metro Park Rd
Colonie, NY 12205
(518) 482-4311

Forever Young Health Club

20 Lower Hudson Ave
Green Island, NY 12183
(518) 273-2200

Plaza Fitness at Stuyvesant Plaza

1475 Western Ave
Albany, NY 12203
(518) 482-2266

Super Fitness Inc.

145 Wolf Rd
Albany, NY 12205
(518) 438-4030

The Cardiac Wellness Center

7 Southwoods Blvd
Albany, NY 12211
(518) 292-6080

The Court Club

444 Sand Creek Rd
Albany, NY 12205
(518) 459-4444

ALLEGANY

Curves of Wellsville Township

21 E State St
Wellsville, NY 14895
(585) 593-1885

BRONX

Astral Fitness and Wellness

5500 Broadway
Bronx, NY 10463
(718) 561-2200

Bronx YMCA

2 Castle Hill Ave
Bronx, NY 10473
(718) 792-9736

Curves of Bronx - Allerton

2451 Eastchester Rd
Bronx, NY 10469
(718) 798-1800

Curves of Bronx - City Island

268 City Island Ave
Bronx, NY 10464
(718) 885-2727

Curves of Bronx - CO-OP City

691 CO-OP City Blvd
Unit C
Bronx, NY 10475
(718) 320-7303

Curves of Bronx - East Tremont/West Farms

1186 E 180th St
Bronx, NY 10460
(718) 931-4321

Curves of Bronx - Fordham

387 E Fordham Rd
Bronx, NY 10458
(718) 367-2929

Curves of Bronx - Morris Park

1120 Morris Park Ave
Bronx, NY 10461
(718) 792-2888

Curves of Bronx - Riverdale

3719 Riverdale Ave
Bronx, NY 10463
(718) 549-0555

Curves of Bronx - The Hub

337 E 149th St
Bronx, NY 10451
(718) 401-1395

Curves of Bronx - Throgs Neck

3149 Bruckner Blvd
Bronx, NY 10461
(718) 792-8855

Curves of Bronx - Wakefield/Williambridge

736 E 233rd St, # 736B
Bronx, NY 10466
(718) 231-8400

FITNESS FACILITY DISCOUNTS

Dolphin Fitness Clubs

2030 Eastchester Rd
Bronx, NY 10461
(718) 822-5700

Lucille Roberts Fitness for Women

82 Hugh Grant Circle
Bronx, NY 10472
(718) 892-2020

Lucille Roberts Fitness for Women

2449 Morris Ave
Bronx, NY 10468
(718) 329-3441

Lucille Roberts Fitness for Women

2935 3rd Ave
Bronx, NY 10455
(718) 585-5959

BROOKLYN

Bedford YMCA

1121 Bedford Ave
Brooklyn, NY 11216
(718) 789-1497

Body Elite

348 Court St
Brooklyn, NY 11231
(718) 935-0088

Brooklyn Athletic Club

4400 Glenwood Rd
Brooklyn, NY 11203
(718) 377-4646

Curves of Brooklyn - Bay Ridge North

7409 3rd Ave
Brooklyn, NY 11209
(718) 238-4523

Curves of Brooklyn - Bay Ridge South

9801 4th Ave
Brooklyn, NY 11209
(718) 680-7975

Curves of Brooklyn - Bedford Stuyvesant

1542 Fulton St, Fl 2
Brooklyn, NY 11216
(718) 771-0097

Curves of Brooklyn - Bensonhurst

7203 20th Ave
Brooklyn, NY 11204
(718) 232-6306

Curves of Brooklyn - Borough Park

4416 Fort Hamilton Pkwy
Brooklyn, NY 11219
(718) 853-6173

Curves of Brooklyn - Brighton Beach

3163 Coney Island Ave
Brooklyn, NY 11235
(718) 332-7270

Curves of Brooklyn - Brooklyn Heights

455 Court St
Brooklyn, NY 11231
(718) 852-8777

Curves of Brooklyn - Bushwick

1501 Broadway
Brooklyn, NY 11221
(718) 443-6666

Curves of Brooklyn - Canarsie

2118 Rockaway Pkwy
Brooklyn, NY 11236
(718) 241-5215

Curves of Brooklyn - Dyker Heights

7304 13th Ave
Brooklyn, NY 11228
(718) 833-4222

Curves of Brooklyn - East Williamsburg

580 Grand St
Brooklyn, NY 11211
(718) 218-8981

Curves of Brooklyn - Flatbush East

4024 Farragut Rd
Brooklyn, NY 11210
(718) 859-5333

Curves of Brooklyn - Flatbush East Central

2645 Nostrand Ave
Brooklyn, NY 11210
(718) 692-2950

Curves of Brooklyn - Flatbush West

1090 Coney Island Ave
Brooklyn, NY 11230
(718) 421-5195

Curves of Brooklyn - Fort Greene

408 Myrtle Ave
Brooklyn, NY 11205
(718) 488-8444

Curves of Brooklyn - Georgetown/ Mill Basin/Ber

6311 Avenue N
Brooklyn, NY 11234
(718) 763-0001

Curves of Brooklyn - Gravesend

196 Avenue U
Brooklyn, NY 11223
(718) 714-5821

Curves of Brooklyn - Greenpoint

128 Norman Ave
Brooklyn, NY 11222
(718) 383-0838

Curves of Brooklyn - Mapleton/Kensington

1127 McDonald Ave
Brooklyn, NY 11230
(718) 377-3290

Curves of Brooklyn - Marine Park

2976 Quentin Rd
Brooklyn, NY 11229
(718) 627-0118

Curves of Brooklyn - Park Slope

375 9th St
Brooklyn, NY 11215
(718) 788-0003

Curves of Brooklyn - Prospect Heights

317 Flatbush Ave
Brooklyn, NY 11217
(718) 230-9777

FITNESS FACILITY DISCOUNTS

Curves of Brooklyn - Remsen

383 Remsen Ave
Brooklyn, NY 11212
(718) 495-9500

Curves of Brooklyn - Sheepshead Bay

2724 Avenue U
Brooklyn, NY 11229
(718) 743-1632

Curves of Brooklyn - Sunset Park

6215 5th Ave
Brooklyn, NY 11220
(718) 492-7121

Curves of Brooklyn - Wingate

793 Flatbush Ave, Fl 2
Brooklyn, NY 11226
(718) 282-5822

Empire Fitness Clubs

2825 Nostrand Ave
Brooklyn, NY 11229
(718) 677-1400

Empire Fitness Clubs

8635 18th Ave
Brooklyn, NY 11214
(718) 621-9500

Empire Fitness Clubs

7118 3rd Ave
Brooklyn, NY 11209
(718) 921-5300

Escape Into Shape

8206 3rd Ave
Brooklyn, NY 11209
(718) 238-1113

Flatbush YMCA

1401 Flatbush Ave
Brooklyn, NY 11210
(718) 469-8100

Gold's Gym

85 Livingston St
Brooklyn, NY 11201
(718) 596-4653

Greenpoint YMCA

99 Meserole Ave
Brooklyn, NY 11222
(718) 389-3700

Harbor Fitness Center

191 15th St
Brooklyn, NY 11219
(718) 965-6200

Harbor Fitness Center

92-15 4th Ave
Brooklyn, NY 11209
(718) 238-9400

Lucille Roberts Fitness for Women

430 89th St
Brooklyn, NY 11209
(718) 680-8200

Lucille Roberts Fitness for Women

927 Flatbush Ave
Brooklyn, NY 11226
(718) 469-7272

Lucille Roberts Fitness for Women

925 Kings Hwy
Brooklyn, NY 11223
(718) 339-0990

Lucille Roberts Fitness for Women

540 Fulton St
Brooklyn, NY 11201
(718) 624-4300

Mill Basin Health & Racquet Club

2350 E 69th St
Brooklyn, NY 11234
(718) 444-5600

North Brooklyn YMCA

570 Jamaica Ave
Brooklyn, NY 11208
(718) 277-1600

Prospect Park YMCA

357 9th St
Brooklyn, NY 11215
(718) 768-7100

BROOME

Aria on the Avenue

56 Washington Ave
Endicott, NY 13760
(607) 484-2742

Curves of Binghamton

495 Court St
Binghamton, NY 13904
(607) 771-7171

Curves of Chenango Township

1149 Upper Front St
Binghamton, NY 13905
(607) 773-1400

Curves of Johnson City

435 Main St
Johnson City, NY 13790
(607) 797-0179

Curves of Union Township - excluding Johnson City

518 Hooper Rd
Endwell, NY 13760
(607) 484-9454

Curves of Vestal

237 Vestal Pkwy E
Vestal, NY 13850
(607) 748-0479

Curves of Windsor

106 Main St
Windsor, NY 13865
(607) 655-1644

CATTARAUGUS

Curves of Olean/ Allegany Township

2636 W State St
Ste 304
Olean, NY 14760
(716) 372-8084

Curves of Salamanca/ Little Valley/ Great Valley

189 Center St
Salamanca, NY 14779
(716) 945-2878

CAYUGA

Curves of Auburn/ Skaneateles/ Aurelius

31 Loop Rd, Ste 1
Auburn, NY 13021
(315) 252-4943

FITNESS FACILITY DISCOUNTS

CHAUTAUQUA

Curves of Dunkirk Township/Fredonia Township

1170 Central Ave
Dunkirk, NY 14048
(716) 366-9708

Curves of Jamestown/Lakewood

709 W 3rd St
Jamestown, NY 14701
(716) 661-3838

Curves of Westfield Township/Mayville/Ripley Township

99 E Chautauqua St
Mayville, NY 14757
(716) 753-2695

CHEMUNG

Curves of Big Flats

3358 State Rte 352
Box 306
Big Flats, NY 14814
(607) 562-3737

Curves of Elmira/Elmira Heights

1141 Broadway St, Ste 1
Elmira, NY 14904
(607) 737-7070

Curves of Horseheads

2305 Grand Central Ave
Ste B
Horseheads, NY 14845
(607) 795-1717

CHENANGO

Curves of Greene

3 Foundry St, Ste 3
Greene, NY 13778
(607) 656-8803

Curves of Norwich (City & Township)

6142 State Hwy
Rte 12 N
Norwich, NY 13815
(607) 336-1100

CLINTON

Curves of Plattsburgh (City & Township)

43 Smithfield Blvd
Plattsburgh, NY 12901
(518) 561-9478

COLUMBIA

Curves of Chatham

59A Church St
Chatham, NY 12037
(518) 392-9353

Curves of Hudson Township

187 Healy Blvd
Hudson, NY 12534
(518) 822-0303

Curves of Kinderhook

1048 Kinderhook St
Valatie, NY 12184
(518) 758-2511

Espirit Wellness Center

544 Union St
Hudson, NY 12534
(518) 828-7400

What A Girl Wants

51 Church St # 53
Chatham, NY 12037
(518) 392-7202

CORTLAND

Cortland County Family YMCA

22 Tompkins St
Cortland, NY 13045
(607) 756-2893

Curves of Cortland

3915 West Rd
Cortland, NY 13045
(607) 758-1110

DELAWARE

Body Shop Gym

32 Main St
Stamford, NY 12167
(607) 652-6772

Curves of Delhi

97 Main St, Ste 8
Delhi, NY 13753
(607) 746-9166

Curves of Deposit/Hancock/Tompkins

180 E Front St
Hancock, NY 13783
(607) 637-3900

Curves of Sidney

8 Bridge St
Sidney, NY 13838
(607) 563-8848

DUTCHESS

Curves of Amenia/North East/Pine Plains

35 Mechanic St
Amenia, NY 12501
(845) 373-9949

Curves of Beekman/Union Vale Townships

10 Dorn Rd, Ste 1
Lagrangeville, NY 12540
(845) 724-2202

Curves of Dover

12 Furlong Rd
Wingdale, NY 12594
(845) 832-2878

Curves of East Fishkill

792 Rte 82
Trinka Plaza, Fl 2
Hopewell Junction, NY 12533
(845) 223-4648

Curves of Fishkill (Township & City)

1083 Rte 9, Ste 23
Fishkill, NY 12524
(845) 296-0967

Curves of Hyde Park

4246 Albany Post Rd
Ste 12
Hyde Park, NY 12538
(845) 229-8845

FITNESS FACILITY DISCOUNTS

Curves of La Grange

1643 Rte 82, Ste 6
Lagrangeville, NY 12540
(845) 223-6842

Curves of Pleasant Valley

17 North Ave, Ste 1568
Pleasant Valley, NY
12569
(845) 635-8686

Curves of Poughkeepsie

51 Burnett Blvd, Ste 1
44 Plaza
Poughkeepsie, NY
12603
(845) 473-4009

Curves of Red Hook

7472 S Broadway, Ste 6
Red Hook, NY 12571
(845) 758-5845

Curves of Rhinebeck

6565 Spring Brook Ave
Ste 7
Rhinebeck, NY 12572
(845) 876-2027

Everyday Wellness for Women

7578 N Broadway
Red Hook, NY 12571
(845) 758-0790

ERIE

Club 50 Fitness of Amherst

708 Maple Rd
Williamsville, NY 14221
(716) 689-6135

Contemporary Lady Fitness and Aquatic Center

2106 George Urban Blvd
Depew, NY 14043
(716) 684-3102

Curves of Alden

13089 Broadway St
Alden, NY 14004
(716) 937-0414

Curves of Amherst - North

1628 Hopkins Rd
Williamsville, NY 14221
(716) 636-8875

Curves of Amherst - South/Williamsville

5759 Main St
Williamsville, NY 14221
(716) 810-0880

Curves of Aurora/ East Aurora/Elma

391 Olean St
East Aurora, NY 14052
(716) 652-1199

Curves of Buffalo - East Central

33 S Rossler Ave
Buffalo, NY 14206
(716) 826-4646

Curves of Buffalo - Northwest

2326 Delaware Ave
Buffalo, NY 14216
(716) 884-1981

Curves of Buffalo - South

469 Abbott Rd
Buffalo, NY 14220
(716) 821-0243

Curves of Buffalo - West Central

295 Main St, Rm 123
Buffalo, NY 14203
(716) 332-3585

Curves of Cheektowaga - Northeast

6348 Transit Rd
Depew, NY 14043
(716) 683-7300

Curves of Cheektowaga- Northwest

3776 Harlem Rd
Buffalo, NY 14215
(716) 834-0036

Curves of Cheektowaga - South

7 Kelly Dr
Cheektowaga, NY
14227
(716) 677-4341

Curves of Clarence

9265 Main St
Clarence, NY 14031
(716) 759-1000

Curves of Eden/ North Collins Townships

2725 Hemlock Rd
Eden, NY 14057
(716) 992-2909

Curves of Evans Township

6929 Erie Rd
Derby, NY 14047
(716) 947-5121

Curves of Grand Island Township

2098 Grand Island Blvd
Grand Island, NY 14072
(716) 773-5955

Curves of Hamburg (Township & Village)

206 Lake St
Hamburg, NY 14075
(716) 312-8002

Curves of Kenmore

1615 Kenmore Ave
Kenmore, NY 14217
(716) 875-4000

Curves of Lackawanna/Blasdell

3720 S Park Ave
Blasdell, NY 14219
(716) 824-4899

Curves of Lancaster Township

4375 Walden Ave
Lancaster, NY 14086
(716) 685-0290

Curves of Newstead Township

13035 Main Rd
Akron, NY 14001
(716) 542-5615

Curves of Orchard Park

3904 N Buffalo St
Orchard Park, NY 14127
(716) 667-7070

Curves of Springville (SM)

62 E Main St
Springville, NY 14141
(716) 592-5673

FITNESS FACILITY DISCOUNTS

Curves of Tonawanda Township

1008 Niagara Falls Blvd
Tonawanda, NY 14150
(716) 803-1000

Curves of West Seneca

3525 Seneca St, Unit 10
West Seneca, NY 14224
(716) 677-4777

Fitness Factory Inc

2852 Delaware Ave
Kenmore, NY 14217
(716) 877-1053

Fitness Institute and Pilates Studio

5427 Transit Rd
Williamsville, NY 14221
(716) 639-0200

ESSEX

Curves of Ticonderoga

105 Montcalm St
Ticonderoga, NY 12883
(518) 585-3626

FRANKLIN

Curves of Malone

3372 State, Rte 11
Malone, NY 12953
(518) 483-8377

Curves of North Elba/Harrietstown

73 Church St
Saranac Lake, NY
12983
(518) 891-7698

FULTON

Curves of Gloversville

63 Elmwood Ave
Gloversville, NY 12078
(518) 773-0533

Curves of Johnstown

90 Briggs St
Johnstown, NY 12095
(518) 762-5800

GENESEE

Curves of Batavia

563 E Main St
(Eastown Plaza)
Batavia, NY 14020
(585) 343-3535

Curves of Le Roy Township

35 Main St
Le Roy, NY 14482
(585) 768-9555

GREENE

Curves of Catskill (City & Township)

262 W Bridge St
Catskill, NY 12414
(518) 943-4341

Curves of Greenville/Cairo/Coxsackie

28 Hope Plaza, Rte 9 W
West Coxsackie, NY
12192
(518) 731-6542

HERKIMER

Curves of Herkimer

215 S Main St
Herkimer, NY 13350
(315) 866-3100

Curves of Little Falls/Little Falls Township

599 E Main St
Little Falls, NY 13365
(315) 823-4200

JEFFERSON

Curves of Watertown/Pamelia - South

1511 Washington St
Watertown, NY 13601
(315) 222-7122

Curves of Watertown/Pamelia/Calcium

22096 US Rte 11
Watertown, NY 13601
(315) 788-5247

Curves of Wilna/Champion

40 Franklin St, Ste 2
Carthage, NY 13619
(315) 493-2343

LEWIS

Curves of Lowville/New Bremen

7383 Utica Blvd
Lowville, NY 13367
(315) 376-4777

LIVINGSTON

Curves of Avon

5568 E Avon Plz
Avon, NY 14414
(585) 226-9110

Curves of Geneseo Township

4286 Lakeville Rd
Geneseo, NY 14454
(585) 243-3770

Curves of Livonia

30 Commercial St
Livonia, NY 14487
(585) 346-0920

MADISON

Curves of Cazenovia

93 Nelson St
Cazenovia, NY 13035
(315) 655-2068

Curves of Chittenango Township

700 W Genesee St
Chittenango, NY 13037
(315) 687-6500

Curves of Hamilton/Eaton/Madison Townships

2422 NY State Rte 12B
Hamilton, NY 13346
(315) 824-8200

Curves of Oneida

7 Glenwood Ave
Oneida, NY 13421
(315) 363-1280

FITNESS FACILITY DISCOUNTS

MANHATTAN

19 St Gym

22 W 19th St
New York, NY 10011
(212) 414-5800

92nd Street YMCA

1395 Lexington Ave
New York, NY 10128
(212) 415-5729

Absolute Fitness

343 Lexington Ave, Fl 5
New York, NY 10016
(212) 681-9724

Atlantis Sports Club Manhattan

811 7th Ave
New York, NY 10019
(212) 841-6714

Carnegie Park Swim & Health Club

200 E 94th St
New York, NY 10128
(212) 423-0300

Curves of Manhattan - East Village

182 Avenue C
New York, NY 10009
(212) 353-3600

Curves of Manhattan - Financial District

118 Water St
New York, NY 10005
(212) 269-3600

Curves of Manhattan - Gramercy Park

139 E 23rd St
New York, NY 10010
(212) 564-8436

Curves of Manhattan - Hamilton Heights

274 W 145th St, Fl 3
New York, NY 10039
(212) 281-2277

Curves of Manhattan - Midtown

314 W 53rd St, Fl 2
New York, NY 10019
(212) 245-8600

Curves of Manhattan - Morningside Park

2103 Frederick
Douglass Blvd
New York, NY 10026
(212) 222-3766

Curves of Manhattan - Times Square

36 W 34th St, Fl 3
New York, NY 10001
(212) 564-8436

Curves of Manhattan - Upper East Side

1460 2nd Ave
2nd Floor, Ste 2
New York, NY 10021
(212) 717-7800

Curves of Manhattan - Upper West Side

76 W 85th St
New York, NY 10024
(212) 875-0800

Curves of Manhattan - Washington Heights

854 W 181st St
New York, NY 10033
(212) 928-3288

Curves of Manhattan - Yorkville

1711 1st Ave
New York, NY 10128
(212) 410-7822

Excelsior Athletic Club

301 E 57th St
New York, NY 10022
(212) 688-5280

Harlem YMCA

180 W 135th St
New York, NY 10030
(212) 281-4100

John Street Fitness Club

80 John St
New York, NY 10038
(212) 248-3030

J's Big Gym

625 W 181st St
New York, NY 10033
(212) 568-2444

Lucille Roberts Fitness for Women

300 W 40th St
New York, NY 10018
(212) 268-4199

Lucille Roberts Fitness for Women

143 Fulton St
New York, NY 10038
(212) 267-3730

Lucille Roberts Fitness for Women

1387 Saint Nicholas Ave
New York, NY 10033
(212) 927-8376

Lucille Roberts Fitness for Women

80 5th Ave
New York, NY 10011
(212) 255-3999

Park Avenue Executive Fitness

90 Park Ave
New York, NY 10016
(212) 370-9692

Vanderbilt YMCA

224 E 47th St
New York, NY 10017
(212) 756-9600

West Side YMCA

5 W 63rd St
New York, NY 10023
(212) 875-4101

MONROE

Curves of Brighton Township

1855 Monroe Ave, Ste 6
Rochester, NY 14618
(585) 442-0910

Curves of Brockport/ Clarkson Township

3670 Lake Rd N, Ste 4
Brockport, NY 14420
(585) 637-5630

Curves of Chili

3240 Chili Ave
Rochester, NY 14624
(585) 889-7320

Curves of Gates

2340 Lyell Ave
Rochester, NY 14606
(585) 647-2630

FITNESS FACILITY DISCOUNTS

Curves of Greece - North

4400 Dewey Ave
Rochester, NY 14616
(585) 581-9110

Curves of Greece - South

2590 Ridge Rd W
Rochester, NY 14626
(585) 368-0380

Curves of Henrietta Township

2761 E Henrietta Rd
Henrietta, NY 14467
(585) 334-2020

Curves of Hilton

109 Lake Ave
Ste 105-106
Hilton, NY 14468
(585) 392-4600

Curves of Irondequoit Township

545 Titus Ave
Irondequoit, NY 14617
(585) 266-6120

Curves of Mendon

5 Assembly Dr
Mendon, NY 14506
(585) 624-5420

Curves of Ogden/Spencerport

34 Slayton Ave, # 34
Spencerport, NY 14559
(585) 352-7420

Curves of Penfield

1694 Penfield Rd
Rochester, NY 14625
(585) 385-3510

Curves of Perinton Township

104B Village Lndg
Fairport, NY 14450
(585) 377-5440

Curves of Rochester - Northeast

277 Winton Rd N
Rochester, NY 14610
(585) 288-7510

Curves of Rochester - Southeast

1655 Mount Hope Ave
Rochester, NY 14620
(585) 242-1990

Curves of Webster

910 Holt Rd
Webster, NY 14580
(585) 872-9270

PHA Health Wellness and Fitness Centers

3450 Winton Pl
Rochester, NY 14623
(585) 232-8888

Total Sports Experience

880 Elmgrove Rd
Rochester, NY 14624
(585) 458-4263

21st Century Fitness Center

4852 State Hwy 30
Amsterdam, NY 12010
(518) 843-5530

Curves of Amsterdam/Amsterdam Township

4908 State Hwy 30
Amsterdam, NY 12010
(518) 842-6965

Curves of Minden/Palatine/Canajoharie

7 Main St
Fort Plain, NY 13339
(518) 993-3525

Curves of Perth/Broadalbin

4335 State Hwy 30
Amsterdam, NY 12010
(518) 842-2244

NASSAU

Curves of Bellmore/Wantagh

2928 Merrick Rd
Bellmore, NY 11710
(516) 826-2972

Curves of East Meadows

2815 N Jerusalem Rd
East Meadow, NY 11554
(516) 679-0888

Curves of East Rockaway/Hewlett

31 Main St
East Rockaway, NY 11518
(516) 596-1100

Curves of Elmont

1546 Hempstead Tpke
Elmont, NY 11003
(516) 326-2842

Curves of Farmingdale

211 Main St
Farmingdale, NY 11735
(516) 293-2511

Curves of Floral Park/Bellerose

194 Jericho Tpke
Floral Park, NY 11001
(516) 326-6627

Curves of Franklin Square

167 Franklin Ave
Franklin Square, NY 11010
(516) 488-1488

Curves of Freeport/Baldwin

826 Merrick Rd
Baldwin, NY 11510
(516) 623-8395

Curves of Garden City

311 Nassau Blvd
Garden City, NY 11530
(516) 292-6146

Curves of Glen Cove

21 Bridge St, Fl 2
Glen Cove, NY 11542
(516) 676-8858

Curves of Hempstead

285 Fulton Ave
Hempstead, NY 11550
(516) 292-1266

Curves of Hicksville

319 Jerusalem Ave
Hicksville, NY 11801
(516) 433-8367

Curves of Levittown

3519 Hempstead Tpke
Levittown, NY 11756
(516) 796-6042

FITNESS FACILITY DISCOUNTS

Curves of Long Beach/Island Park

161 E Park Ave
Long Beach, NY 11561
(516) 670-8502

Curves of Lynbrook

194A Hempstead Ave
Lynbrook, NY 11563
(516) 887-4714

Curves of Manhasset/Port Washington

14 Park Ave
Manhasset, NY 11030
(516) 869-0338

Curves of Massapequa

183 Jerusalem Ave
Massapequa, NY 11758
(516) 795-4215

Curves of Merrick

2102 Merrick Ave
Merrick, NY 11566
(516) 546-2341

Curves of Mineola/Williston Park

74 Hillside Ave
Williston Park, NY 11596
(516) 746-5591

Curves of Oceanside

2822 Brower Ave
Oceanside, NY 11572
(516) 255-4348

Curves of Oyster Bay

132 South St
Oyster Bay, NY 11771
(516) 922-7800

Curves of Plainview

540 Woodbury Rd
Plainview, NY 11803
(516) 935-4901

Curves of Queens - Great Neck/Little Neck

98 Cuttermill Rd
Great Neck, NY 11021
(516) 829-0568

Curves of Rockville Centre

217 N Long Beach Rd
Rockville Centre, NY 11570
(516) 536-1301

Curves of Sea Cliff/Old Brookville

40 Railroad Ave
Glen Head, NY 11545
(516) 676-6650

Curves of Syosset

35 Ira Rd
Syosset, NY 11791
(516) 496-3030

Curves of Valley Stream

276 W Merrick Rd
Valley Stream, NY 11580
(516) 599-8101

Curves of West Hempstead

352 Hempstead Ave
West Hempstead, NY 11552
(516) 292-3468

Curves of Westbury/Carle Place

555 Westbury Ave
Westbury, NY 11590
(516) 333-0600

Curves of Woodmere/Cedarhurst

83 Spruce St
Cedarhurst, NY 11516
(516) 295-2878

Gold's Gym

2060 Bellmore Ave
Bellmore, NY 11710
(516) 221-1800

Gold's Gym

190 Broadway
Garden City Park, NY 11040
(516) 742-4477

Lucille Roberts Fitness for Women

231 Glen Cove Rd
Carle Place, NY 11514
(516) 746-4333

Lucille Roberts Fitness for Women

1000 Sunrise Hwy
Massapequa, NY 11758
(516) 541-8840

Lucille Roberts Fitness for Women

359 S Oyster Bay Rd
Plainview, NY 11803
(516) 681-2464

Lucille Roberts Fitness for Women

298 Sunrise Hwy
Rockville Centre, NY 11570
(516) 766-8443

Peak Performance Fitness

44 Broadway
Lynbrook, NY 11563
(516) 599-8734

Peak Performance Fitness

1730 Lakeville Rd
New Hyde Park, NY 11040
(516) 326-4580

Sky Athletic Club

310 Merrick Rd
Rockville Centre, NY 11570
(516) 678-9400

Woman's Domain

382 Old Country Rd
Hicksville, NY 11801
(516) 681-5879

Woodbury Racquet & Fitness Club

1 Jericho Tpke
Woodbury, NY 11797
(516) 367-3100

World Gym

120 Hempstead Ave
West Hempstead, NY 11552
(516) 505-0777

NIAGARA

Curves of Lewiston

222 Portage Rd
Lewiston, NY 14092
(716) 754-9720

Curves of Lockport

298 S Transit Rd
Lockport, NY 14094
(716) 433-3398

FITNESS FACILITY DISCOUNTS

Curves of Newfane/ Wilson Townships

3037 Lockport Olcott
Rd
Newfane, NY 14108
(716) 778-9398

Curves of Niagara Falls

7703 Niagara Falls Blvd
Ste 3
Niagara Falls, NY 14304
(716) 236-0775

Curves of North Tonawanda/ Tonawanda

533 Niagara Pkwy
North Tonawanda, NY
14120
(716) 695-6333

Curves of Pendleton/ Cambria Townships

2968 Saunders
Settlement Rd
Sanborn, NY 14132
(716) 625-8193

Curves of Wheatfield

3571 Niagara Falls Blvd
North Tonawanda, NY
14120
(716) 693-3547

ONEIDA

Curves of Boonville

167 Main St
Boonville, NY 13309
(315) 942-5744

Curves of Camden

35 Main St
Camden, NY 13316
(315) 245-2209

Curves of Kirkland

86 Meadow St
Clinton, NY 13323
(315) 859-0069

Curves of New Hartford - North

4679 Commercial Dr
New Hartford, NY 13413
(315) 736-3903

Curves of New Hartford - South

3987B Oneida St
New Hartford, NY 13413
(315) 737-7524

Curves of Rome

142 Black River Blvd
Rome, NY 13440
(315) 339-5595

Curves of Utica

50 Auert Ave
Utica, NY 13502
(315) 368-0062

Curves of Whites- boro/Yorkville

131 Oriskany Blvd
Ste 6
Whitesboro, NY 13492
(315) 736-4744

ONONDAGA

Champion Fitness Center

7687 Frontage Rd
Cicero, NY 13039
(315) 452-5522

Curves of Camillus Township

4123 W Genesee St
Syracuse, NY 13219
(315) 468-2282

Curves of Cicero

5620 Business Ave
Cicero, NY 13039
(315) 458-2318

Curves of Clay Township

8075 Oswego Rd
Liverpool, NY 13090
(315) 622-0200

Curves of De Witt Township

4467 E Genesee St
Syracuse, NY 13214
(315) 446-9255

Curves of Elbridge

243 E Main St
Elbridge, NY 13060
(315) 689-6530

Curves of Geddes/ Solvay Townships

527 Charles Ave
Syracuse, NY 13209
(315) 468-9707

Curves of Lysander Township

27 Oswego St
Baldwinsville, NY 13027
(315) 635-9894

Curves of Manlius Township

410 E Genesee St
Fayetteville, NY 13066
(315) 637-1030

Curves of Marcellus (City and Township)

19 North St
Marcellus, NY 13108
(315) 673-0886

Curves of Onondaga

6003 S Salina St
Syracuse, NY 13205
(315) 498-5103

Curves of Salina Township

500 Old Liverpool Rd
Liverpool, NY 13088
(315) 451-9949

Curves of Syracuse - Central

1001 E Genesee St
Syracuse, NY 13210
(315) 474-1420

Curves of Syracuse - North

366 Grant Blvd
Shop City
Syracuse, NY 13206
(315) 437-7981

Curves of Tully/ LaFayette

1 State St
Tully, NY 13159
(315) 696-6301

Curves of Van Buren

7252 State Fair Blvd
Store # 11
Syracuse, NY 13209
(315) 857-0300

Gold's Gym

7455 Morgan Rd
Liverpool, NY 13090
(315) 451-5050

FITNESS FACILITY DISCOUNTS

Gold's Gym Dewitt

5791 Widewaters Pkwy
Syracuse, NY 13214
(315) 446-0376

ONTARIO

Curves of Canandaigua (City & Township)

699 S Main St
Canandaigua, NY 14424
(585) 396-9640

Curves of Geneva

590 Pre Emption Rd
Geneva, NY 14456
(315) 781-2041

Curves of Manchester/Phelps (City and Township)

2735 Rte 96
Clifton Springs, NY
14432
(315) 462-2790

Curves of Victor Township

6385 State Rte 96
Victor, NY 14564
(585) 924-8130

ORANGE

Bare Fitness

130 Dolson Ave
Middletown, NY 10940
(845) 341-0480

Contours Express

152 Windsor Hwy
New Windsor, NY 12553
(845) 561-8669

Curves of Blooming Grove Township

2130 State Rte 94
Salisbury Mills, NY
12577
(845) 497-8332

Curves of Chester

78 Brookside Ave
Ste 147 (Chester Mall)
Chester Twp, NY 10918
(845) 469-9991

Curves of Cornwall

1 Idlewild Ave
Cornwall On Hudson,
NY 12520
(845) 534-4474

Curves of Goshen Township

112 Clowes Ave
Goshen, NY 10924
(845) 291-3919

Curves of Highlands

285 Main St
Highland Falls, NY
10928
(845) 446-1444

Curves of Monroe Township

494 State Rte 17M
Ste 6
Monroe, NY 10950
(845) 774-7991

Curves of Mont- gomery Township

40 Railroad Ave
Montgomery, NY 12549
(845) 457-7701

Curves of New Windsor Township

317 Rte 32
New Windsor, NY 12553
(845) 562-1900

Curves of Newburgh

52 Rte 17K, Ste 207
Newburgh, NY 12550
(845) 567-9156

Curves of Port Jervis

179 Jersey Ave
Port Jervis, NY 12771
(845) 856-7380

Curves of Shawan- gunk/Crawford

70 Boniface Dr
Pine Bush, NY 12566
(845) 744-6607

Curves of Wallkill/ Middletown

128 Dolson Ave
Middletown, NY 10940
(845) 342-2636

Curves of Warwick Township

25 Elm St, Ste 8
Warwick, NY 10990
(845) 986-1700

Curves of Woodbury Township

615 Rte 32
Highland Mills, NY
10930
(845) 928-3898

Proactive Health and Fitness

9 Fairlawn Dr
Washingtonville, NY
10992
(845) 496-6362

World Gym of Hudson Valley

54 Grand St
Newburgh, NY 12550
(845) 563-9900

ORLEANS

Curves of Albion/Medina

527 Main St
Medina, NY 14103
(585) 798-2977

OSWEGO

Curves of Fulton

102 Cayuga St
Fulton, NY 13069
(315) 592-7115

Curves of Hastings Township

3228 East Ave
Central Square, NY
13036
(315) 668-8689

Curves of Oswego (City & Township)

1 4th Ave, Ste E
Oswego, NY 13126
(315) 343-9244

Curves of Richland

3779 State Rte 13
Pulaski, NY 13142
(315) 298-1240

Curves of Schroepell

219 Rte 57, Unit # 3
Phoenix, NY 13135
(315) 695-3100

FITNESS FACILITY DISCOUNTS

Oswego YMCA

249 W First St
Oswego, NY 13126
(315) 343-1981

OTSEGO

Curves of Oneonta (City & Township)

12 Clinton Plaza
Oneonta, NY 13820
(607) 433-0080

Curves of Otsego/ Hartwick/Middlefield

4773 Maple Ridge Plaza
State Hwy 28
Cooperstown, NY 13326
(607) 547-0036

Healthlinks@Fox Care

1 Fox Care Dr
Oneonta, NY 13820
(607) 431-5454

PUTNAM

Curves of Brewster/ Southeast Township

865 Rte 22
Brewster, NY 10509
(845) 278-8615

Curves of Carmel Township

187 Mahopac Village Ctr
Mahopac, NY 10541
(845) 621-2522

Curves of Kent Township

1118 Rte 52, Ste 1
Carmel, NY 10512
(845) 225-8753

Curves of Patterson/ Pawling Townships

1270 Rte 311
Patterson, NY 12563
(845) 878-9290

Curves of Putnam Township

21 Peekskill Hollow Rd
Ste 203A
Putnam Valley, NY
10579
(845) 526-5535

Gold's Gym

160 Rte 52
Carmel, NY 10512
(845) 228-2818

QUEENS

American Physique Fitness Club

24513 Jamaica
Bellerose, NY 11426
(718) 343-1122

Body By Berle Personal Training Center

6117 190th St, Ste 206
Fresh Meadows, NY
11365
(718) 264-8787

Catalpa YMCA

6902 64th St
Ridgewood, NY 11385
(718) 821-6271

Cross Island YMCA

23810 Hillside Ave
Bellerose, NY 11426
(718) 479-0505

Curves of Queens - Jamaica Estates/ Fresh Meadow

17660 Union Tpke
Fresh Meadows, NY
11366
(718) 591-2878

Curves of Queens - Astoria

3610 Ditmars Blvd
Astoria, NY 11105
(718) 267-8100

Curves of Queens - Bayside

3839 Bell Blvd, Fl 1
Bayside, NY 11361
(718) 281-4321

Curves of Queens - Briarwood

8473 Parsons Blvd
Jamaica, NY 11432
(718) 206-0401

Curves of Queens - East Elmhurst

8111 Northern Blvd
Jackson Heights, NY
11372
(718) 458-1800

Curves of Queens - Elmhurst

4119 77th St
Elmhurst, NY 11373
(718) 779-1911

Curves of Queens - Far Rockaway

1827 Cornaga Ave
Far Rockaway, NY
11691
(718) 868-8200

Curves of Queens - Forest Hills

11647 Queens Blvd
Forest Hills, NY 11375
(718) 268-1696

Curves of Queens - Glen Oaks

25927 Union Tpke
Glen Oaks, NY 11004
(718) 347-3734

Curves of Queens - Hollis/St. Albans

10928 Merrick Blvd
Jamaica, NY 11433
(718) 526-6641

Curves of Queens - Howard Beach/ Linden

8217 153rd Ave
Howard Beach, NY
11414
(718) 323-5120

Curves of Queens - Kew Garden Hills

7019 Parsons Blvd
Flushing, NY 11365
(718) 591-4030

Curves of Queens - Laurelton/Rosedale

22711 Merrick Blvd
Laurelton, NY 11413
(718) 990-8741

Curves of Queens - Long Island City

3100 47th Ave
Long Island City, NY
11101
(718) 707-0920

FITNESS FACILITY DISCOUNTS

Curves of Queens - Middle Village

6471 Dry Harbor Rd
Middle Village, NY
11379
(718) 894-5390

Curves of Queens - North Beach

7525 31st Ave
East Elmhurst, NY
11370
(718) 565-0800

Curves of Queens - Ozone Park

10205 101st Ave
Ozone Park, NY 11416
(718) 805-0775

Curves of Queens - Queens Village

22413 Union Tpke
Oakland Gardens, NY
11364
(718) 454-3877

Curves of Queens - Ravenswood

4308 Broadway
Astoria, NY 11103
(718) 204-8220

Curves of Queens - Rego Park

9656 Queens Blvd
Rego Park, NY 11374
(718) 897-4638

Curves of Queens - Rockaway Park

239 Beach 116th St
Rockaway Park, NY
11694
(718) 474-1500

Curves of Queens - South Elmhurst

5519 69th St, Fl 2
Maspeth, NY 11378
(718) 424-5670

Curves of Queens - South Ozone Park

12215 111th Ave
South Ozone Park, NY
11420
(718) 848-2300

Curves of Queens - Sunnyside

46-01 Queens Blvd
(46th Street Entrance)
Sunnyside, NY 11104
(718) 707-0076

Curves of Queens - Whitestone/Beechhurst

1249 150th St
Whitestone, NY 11357
(718) 357-0511

Curves of Queens - Whitestone/Murray

2550 Francis Lewis Blvd
Fl 2
Flushing, NY 11358
(718) 886-5700

Curves of Queens - Woodhaven

8414 Jamaica Ave
Woodhaven, NY 11421
(718) 521-9001

Fitness R Us

192-23 Station Rd
Flushing, NY 11358
(718) 224-1371

Flushing YMCA

13846 Northern Blvd
Flushing, NY 11354
(718) 961-6880

Gold's Gym

15705 Crossbay Blvd
Howard Beach, NY
11414
(718) 845-4653

Jamaica YMCA

8925 Parsons Blvd
Jamaica, NY 11432
(718) 739-6600

Kew Gardens Health and Fitness Center

11940 Metropolitan Ave
Kew Gardens, NY 11415
(718) 847-9690

Ladies Workout Express

6073 Fresh Pond Rd
Maspeth, NY 11378
(718) 418-0126

Long Island City YMCA

3223 Queens Blvd
Long Island City, NY
11101
(718) 392-7932

Lucille Roberts Fitness for Women

3262 Steinway St
Astoria, NY 11103
(718) 626-6464

Lucille Roberts Fitness for Women

4119 Bell Blvd
Bayside, NY 11361
(718) 279-2299

Lucille Roberts Fitness for Women

13523 38th Ave
Flushing, NY 11354
(718) 321-0100

Lucille Roberts Fitness for Women

7024 Austin St
Forest Hills, NY 11375
(718) 261-2350

Lucille Roberts Fitness for Women

16318 Jamaica Ave
Jamaica, NY 11432
(718) 657-9885

Lucille Roberts Fitness for Women

5432 Myrtle Ave
Ridgewood, NY 11385
(718) 628-6262

Next Step Health & Fitness Center

20803 Union Tpke
Oakland Gardens, NY
11364
(718) 217-2875

RENSELAER

Curves of Brunswick

1128 Hoosick Rd
Troy, NY 12180
(518) 279-3131

Curves of East Greenbush/Schodack

597 Columbia Tpke
East Greenbush, NY
12061
(518) 479-5930

FITNESS FACILITY DISCOUNTS

Curves of North Greenbush/Sand Lake

43 Mall Way
West Sand Lake, NY
12196
(518) 674-1226

Curves of Schaghticoke Township

8 Main St
Schaghticoke, NY 12154
(518) 753-4012

Curves of Troy

505 Campbell Ave
Troy, NY 12180
(518) 273-1414

ROCKLAND

Curves of Monsey/Spring Valley

401 W Rte 59, Ste 17
Monsey, NY 10952
(845) 371-2435

Curves of Nanuet

265 W Rte 59
Nanuet, NY 10954
(845) 627-2088

Curves of Orangeburg

580 Rte 303
Westshore Plaza
Blauvelt, NY 10913
(845) 359-6565

Curves of Pomona

1581 Rte 202
Pomona, NY 10970
(845) 362-6300

Curves of Stony Point

160 N Liberty Dr, Ste N
Stony Point, NY 10980
(845) 947-7100

Curves of Suffern

296 Rte 59
Tallman, NY 10982
(845) 369-0075

Curves of Tuxedo Township/Sloatsburg

96 Orange Tpke
Sloatsburg, NY 10974
(845) 753-6500

Curves of West Haverstraw/Haverstraw

216 Rte 9W
Haverstraw, NY 10927
(845) 429-2444

Lucille Roberts Fitness for Women

240 W Rte 59
Nanuet, NY 10954
(845) 624-0500

World Gym and Aerobic Center

139 Rte 9W N
Haverstraw, NY 10927
(845) 429-0084

SAINT LAWRENCE

Curves of Gouverneur

8 Trinity Ave
Gouverneur, NY 13642
(315) 287-2999

Curves of Massena

6300 State Rte 37
Massena, NY 13662
(315) 769-9527

Curves of Ogdensburg

701 Canton St
Ogdensburg, NY 13669
(315) 393-7876

Curves of Potsdam/Canton/Norwood/Rensselaer Falls

145 Market St, Ste 3
Potsdam, NY 13676
(315) 268-8899

SARATOGA

Curves of Ballston

810 Saratoga Rd, Ste 3
Burnt Hills, NY 12027
(518) 384-1680

Curves of Clifton Park

629 Plank Rd
Clifton Park, NY 12065
(518) 371-0600

Curves of Fort Edward

48 State Rte 197
Fort Edward, NY 12828
(518) 747-7444

Curves of Glens Falls/South Glens Falls

110 Main St
South Glens Falls, NY
12803
(518) 745-1494

Curves of Greenfield

2532 Rte 9N
Greenfield Center, NY
12833
(518) 893-0220

Curves of Halfmoon

1471 Rte 9
Clifton Park, NY 12065
(518) 373-8601

Curves of Malta

5 Hemphill Pl Ste 222
Ballston Spa, NY 12020
(518) 899-1500

Curves of Mechanicville

96 N Main St
Mechanicville, NY 12118
(518) 664-1300

Curves of Milton Township

404 Rowland St
Ballston Spa, NY 12020
(518) 885-1001

Curves of Saratoga Springs

82 Congress St Ste 4
Saratoga Springs, NY
12866
(518) 581-8877

Curves of Waterford/Waterford Township

35 Saratoga Ave Ste D
Waterford, NY 12188
(518) 238-2141

Curves of Wilton

4281 Rte 50
Saratoga Springs, NY
12866
(518) 587-4114

Fit for Life Wellness Center, Inc.

The Healthplex
1673 Rte 9
Clifton Park, NY 12065
(518) 348-0198

FITNESS FACILITY DISCOUNTS

Malta Health and Fitness

43 Round Lake Rd
Ballston Lake, NY
12019
(518) 899-9146

SCHENECTADY

Best Fitness

2330 Watt St
Schenectady, NY 12304
(518) 374-1234

Curves of Glenville Township

123 Saratoga Rd
Glenville, NY 12302
(518) 384-3935

Curves of Niskayuna Township

4017 State St
Schenectady, NY 12304
(518) 377-9337

Curves of Rotterdam Township

521 Duanesburg Rd
Schenectady, NY 12306
(518) 356-4266

Curves of Schenectady Township

1619 Union St
Schenectady, NY 12309
(518) 388-8433

Elite Health and Fitness

480 Balltown Rd
Schenectady, NY 12304
(518) 377-7771

Glenville Health and Fitness

443 Saratoga Rd
Schenectady, NY 12302
(518) 384-0229

Schenectady Jewish Community Center

2565 Balltown Rd
Schenectady, NY 12309
(518) 377-8803

SCHOHARIE

Curves of Cobleskill

795 E Main St Ste 3
Cobleskill, NY 12043
(518) 234-1112

SCHUYLER

Curves of Watkins Glen/Montour Falls

300 N Franklin St
Watkins Glen, NY
14891
(607) 535-5485

SENECA

Curves of Seneca Falls Township/Waterloo

2109 Rte 5 And 20
Seneca Falls, NY 13148
(315) 568-0516

STATEN ISLAND

Curves of Staten Island - East Central

2361 Hylan Blvd
Staten Island, NY 10306
(718) 980-6060

Curves of Staten Island - Northeast

765 Forest Ave
Staten Island, NY 10310
(718) 442-4040

Curves of Staten Island - Northwest

585 N Gannon Ave
Staten Island, NY 10314
(718) 698-8088

Curves of Staten Island - Southwest

45A Page Ave
Staten Island, NY 10309
(718) 948-3333

Curves of Staten Island - West Central

1650 Richmond Ave
Staten Island, NY 10314
(718) 494-4723

Dolphin Fitness

2071 Clove Rd
Staten Island, NY 10304
(718) 815-7900

Dolphin Fitness

3295 Amboy Rd
Staten Island, NY 10306
(718) 987-0400

Dolphin Fitness

7001 Amboy Rd
Staten Island, NY 10307
(718) 605-1010

Evolution Fitness

77 Richmond Valley Rd
Staten Island, NY 10309
(718) 370-8484

Nautilus Woman Fitness Center

2795 Richmond Ave
Staten Island, NY 10314
(718) 494-2294

STEBEN

Curves of Bath Township

9 E William St, Ste 101
Bath, NY 14810
(607) 776-7111

Curves of Corning/Painted Post

116 Bridge St
Corning, NY 14830
(607) 936-1480

Curves of Hornesville/Hornell

7499 Seneca Rd N
Hornell, NY 14843
(607) 324-6160

SUFFOLK

Amritraj Fitness Racquet

225 Howells Rd
Bay Shore, NY 11706
(631) 968-8668

FITNESS FACILITY DISCOUNTS

Curves of Amityville/ Copiague

12 Broadway
Amityville, NY 11701
(631) 598-2444

Curves of Babylon

344 Little East Neck Rd
Babylon, NY 11704
(631) 893-5000

Curves of Bayshore

8 4th Ave
Bay Shore, NY 11706
(631) 968-1828

Curves of Brentwood - East

243 2nd Ave
Brentwood, NY 11717
(631) 951-3110

Curves of Bridgehampton/ Southampton

760 Montauk Hwy
Ste 1C
Water Mill, NY 11976
(631) 726-6367

Curves of Brookhaven

2468 Montauk Hwy
Brookhaven, NY 11719
(631) 286-4700

Curves of Centereach

365 Independence
Plaza
Selden, NY 11784
(631) 698-7800

Curves of Deer Park Township

450 Commack Rd, Ste C
Deer Park, NY 11729
(631) 242-5222

Curves of Dix Hills

1786 E Jericho Tpke
Ste A
Huntington, NY 11743
(631) 858-1072

Curves of East Hampton

514 Three Mile Harbor
Rd, Store # 2
East Hampton, NY
11937
(631) 324-7312

Curves of Huntington - Melville

1 Schwab Rd, Ste 15
Melville, NY 11747
(631) 421-2770

Curves of Huntington - Northport

1019 Fort Salonga Rd
Northport, NY 11768
(631) 269-7178

Curves of Huntington - Northwest

140 E Main St, Ste 11
Huntington, NY 11743
(631) 271-1221

Curves of Huntington Station

759 Pulaski Rd
Greenlawn, NY 11740
(631) 261-3274

Curves of Islip - Holbrook

480 Patchogue
Holbrook Rd, Unit 15
Holbrook, NY 11741
(631) 472-8300

Curves of Islip Terrace

876 Connetquot Ave
Islip Terrace, NY 11752
(631) 277-7575

Curves of Islip/ East Islip

232 E Main St
East Islip, NY 11730
(631) 224-7913

Curves of Lindenhurst

627 W Merrick Rd
Lindenhurst, NY 11757
(631) 226-1443

Curves of Mastic/ Moriches

1355 Montauk Hwy
Mastic, NY 11950
(631) 281-2770

Curves of Medford - South

2799 Rte 112
Medford, NY 11763
(631) 207-9010

Curves of Middle Island

1249 Middle Country Rd
Middle Island, NY 11953
(631) 205-5386

Curves of North Babylon

1350 Deer Park Ave
Ste 12
North Babylon, NY
11703
(631) 274-4547

Curves of North Lindenhurst

732 N Wellwood Ave
Lindenhurst, NY 11757
(631) 226-0026

Curves of Patchogue/ East Patchogue

31 W Main St
Patchogue, NY 11772
(631) 289-4422

Curves of Port Jefferson/Terryville

Port Jefferson Station,
NY 11776
(631) 474-9844

Curves of Riverhead

1149 Rte 58
Riverhead, NY 11901
(631) 905-0500

Curves of Ronkonkoma

299 Hawkins Ave, Ste 16
Ronkonkoma, NY 11779
(631) 619-4082

Curves of Sayville

207 Montauk Hwy
Sayville, NY 11782
(631) 218-2916

Curves of Selden

280 Middle Country Rd
Ste D
Selden, NY 11784
(631) 736-2425

Curves of Shoreham/ Wading River

6263 Rte 25A
Wading River, NY 11792
(631) 929-8600

FITNESS FACILITY DISCOUNTS

Curves of Smithtown - East

140A E Main St
Smithtown, NY 11787
(631) 863-2878

Curves of Smithtown - West

84 Main St
Kings Park, NY 11754
(631) 269-3905

Curves of Sound Beach

725 Rte 25A
Miller Place, NY 11764
(631) 744-4800

Curves of South Manor

258 Moriches Middle
Island Rd
Manorville, NY 11949
(631) 281-4700

Curves of Southold - East

53345 Main Rd
Unit 2 Bldg 7
Southold, NY 11971
(631) 765-3966

Curves of Southold - West

10095 Rte 25
Mattituck, NY 11952
(631) 298-8900

Curves of Stony Brook

243 Main St
East Setauket, NY
11733
(631) 751-1925

Curves of West Islip

456 Union Blvd
West Islip, NY 11795
(631) 422-5660

Curves of Westhampton

103 W Montauk Hwy
Ste 7
Hampton Bays, NY
11946
(631) 728-8880

Curves of Wheatley Heights

42 Colonial Springs Rd
Wheatley Heights, NY
11798
(631) 253-4700

Go Figure

1051 Montauk Hwy
Copiague, NY 11726
(631) 842-8311

Gold's Gym

41 Mercedes Way
Edgewood, NY 11717
(631) 586-4653

Gold's Gym

100 Landing Ave
Smithtown, NY 11787
(631) 863-1616

Great South Bay YMCA

200 W Main St
Bay Shore, NY 11706
(631) 665-4255

Ladies Workout Express

600 Montauk Hwy
Bayport, NY 11705
(631) 419-0098

Ladies Workout Express

926 Wheeler Rd
Hauppauge, NY 11788
(631) 265-3900

Lucille Roberts Fitness for Women

4601 Sunrise Hwy
Bohemia, NY 11716
(631) 567-6665

Lucille Roberts Fitness for Women

6149 Jericho Tpke
Commack, NY 11725
(631) 462-1222

Lucille Roberts Fitness for Women

349 William Floyd Pkwy
Shirley, NY 11967
(631) 399-9464

Lucille Roberts Fitness for Women

2304 Nesconset Hwy
Stony Brook, NY 11790
(631) 689-8911

Peconic Health and Fitness

1140 Rte 24 Flaunders
Riverhead, NY 11901
(631) 727-2642

Powerhouse Gym

275 Rte 25A, Unit 13
Miller Place, NY 11764
(631) 928-4200

Repetitions

512 W Montauk Hwy
Lindenhurst, NY 11757
(631) 957-7377

South Bay TOPS Program

1160 Montauk Hwy
Copiague, NY 11726
(631) 842-4606

The Weight Room Plus Wanda's Workout

225 Montauk Hwy
Moriches, NY 11955
(631) 878-0005

World Gym

384 Mark Tree Rd
East Setauket, NY
11733
(631) 751-6100

SULLIVAN

Curves of Liberty (City & Township)

5 Triangle Rd, Ste D
Liberty, NY 12754
(845) 292-3700

Curves of Mamakating

187 Kingston Ave
Wurtsboro, NY 12790
(845) 888-2343

Curves of Monticello / Thompson Townships

343 Broadway
Monticello, NY 12701
(845) 794-4700

TIOGA

Curves of Owego Township

19 East Ave
Owego, NY 13827
(607) 687-0999

FITNESS FACILITY DISCOUNTS

TOMPKINS

Curves of Dryden
10 W Main St
Dryden, NY 13053
(607) 844-3499

**Curves of Ithaca
(City & Township)**
609 W Clinton St
Ste 104
Ithaca, NY 14850
(607) 256-2977

Curves of Lansing
1939 E Shore Dr
Lansing, NY 14882
(607) 533-7526

ULSTER

**Curves of Esopus
Township**
316 Broadway
Port Ewen, NY 12466
(845) 331-0433

**Curves of
Kingston/ Ulster**
790 Ulster Ave
Kingston, NY 12401
(845) 338-5200

**Curves of Lloyd
Township**
50 Vineyard Ave
Highland, NY 12528
(845) 691-7720

**Curves of
Marlborough**
1191 Rte 9W, Ste 1
Marlboro, NY 12542
(845) 236-2647

Curves of New Paltz
40 Sunset Ridge Rd
Ste 130
New Paltz, NY 12561
(845) 255-3333

**Curves of Saugerties
Township**
6 Grand Union Plaza
Saugerties, NY 12477
(845) 246-6385

Curves of Wawarsing
170 Canal St
Ellenville, NY 12428
(845) 647-0035

**Curves of Woodstock/
Hurley**
300 Wynkoop Rd
Hurley, NY 12443
(845) 331-7667

Fitness Unlimited
320 Wall St
Kingston, NY 12401
(845) 338-1818

WARREN

**Curves of Queensbury
Township**
797 Rte 9
Queensbury, NY 12804
(518) 743-9199

**Curves of Warrens-
burg (City & Township)**
3785 Main St
Warrensburg, NY 12885
(518) 623-2224

WASHINGTON

**Curves of Granville/
Hartford/Hebron**
11 Main St, # 15
Granville, NY 12832
(518) 642-3410

**Curves of Greenwich/
Salem Townships**
2530 State Rte 40
Greenwich, NY 12834
(518) 692-8899

**Curves of Hoosick/
White Creek/
Cambridge/Pittstown**
45 W Main St
Cambridge, NY 12816
(518) 677-3770

**Curves of
Hudson Falls**
44 Main St
Hudson Falls, NY 12839
(518) 746-9400

WAYNE

**Curves of Lyons/
Arcadia**
126 Harrison St
Newark, NY 14513
(315) 359-9203

Curves of Macedon
1503 Canandaigua Rd
Ste 900
Macedon, NY 14502
(315) 986-1890

**Curves of Ontario
Township**
2001 Rte 104
Ontario, NY 14519
(315) 524-8766

**Curves of Palmyra
Township**
224 E Main St
Palmyra, NY 14522
(315) 597-6280

**Curves of Williamson/
Sodus**
47 Maple Ave, Ste 100
Sodus, NY 14551
(315) 483-1222

**Curves of Wolcott/
Butler**
11845 W Main St, Ste 2
Wolcott, NY 14590
(315) 594-9771

WESTCHESTER

**Curves of
Bedford Township**
701 Bedford Rd, Ste A
Bedford Hills, NY 10507
(914) 244-6272

**Curves of
Briarcliff Manor**
1872 Pleasantville Rd
Briarcliff Manor, NY
10510
(914) 762-2918

**Curves of Croton -on-
Hudson/Ossining**
171 S Riverside Ave
Croton On Hudson, NY
10520
(914) 271-2918

FITNESS FACILITY DISCOUNTS

**Curves of Dobbs Ferry/
Hastings-on-Hudson/
Irvington**

875 Saw Mill River Rd
Ardsley, NY 10502
(914) 674-4200

Curves of Eastchester

16 Columbus Ave
Tuckahoe, NY 10707
(914) 771-7680

**Curves of Harrison
Township**

66 Halstead Ave
Harrison, NY 10528
(914) 381-9500

**Curves of
Mamaroneck
Township/Larchmont**

2098 Boston Post Rd
2100
Larchmont, NY 10538
(914) 833-3939

**Curves of
Mount Vernon**

531 Gramatan Ave
Mount Vernon, NY
10552
(914) 663-2992

**Curves of
New Rochelle**

1333 North Ave
New Rochelle, NY
10804
(914) 633-7100

Curves of Peekskill

20 Welcher Ave
Peekskill, NY 10566
(914) 788-8638

**Curves of
Pelham Township**

111 Sixth St
Pelham, NY 10803
(914) 637-9111

**Curves of Pleas-
antville/Thornwood/
Chautauqua**

660 Columbus Ave
Thornwood, NY 10594
(914) 769-5555

**Curves of Pound
Ridge/Lewisboro/
North Salem**

69 Westchester Ave
Pound Ridge, NY 10576
(914) 764-9400

**Curves of
Rye Township**

3 Rye Rd
Rye, NY 10580
(914) 690-0100

**Curves of
Somers Township**

100 Gatehouse
Somers, NY 10589
(914) 276-3930

**Curves of Tarrytown/
Sleepy Hollow**

358 N Broadway
Sleepy Hollow, NY
10591
(914) 333-0822

**Curves of White
Plains - North**

96 Virginia Rd
White Plains, NY 10603
(914) 997-7177

**Curves of White
Plains - South**

207 E Post Rd
White Plains, NY 10601
(914) 328-3555

**Curves of Yonkers -
Central**

540 Palmer Rd
Yonkers, NY 10701
(914) 964-7011

**Curves of Yonkers -
Northeast**

2231 Central Park Ave
Yonkers, NY 10710
(914) 961-0876

**Curves of Yonkers -
South**

750 McLean Ave
Yonkers, NY 10704
(914) 237-4233

**Curves of Yorktown -
East**

73 Triangle Shopping
Ctr
Yorktown Heights, NY
10598
(914) 455-2654

**Curves of Yorktown -
West**

3565 Crompond Rd
Rte 202
Cortland Manor, NY
10567
(914) 737-1177

Dolphin Fitness Clubs

1 Tuckahoe Ave
Eastchester, NY 10709
(914) 395-1313

Dolphin Fitness Clubs

431 Boston Post Rd
Port Chester, NY 10573
(914) 934-9200

Dolphin Fitness Clubs

80 Beekman Ave
Sleepy Hollow, NY
10591
(914) 332-7545

Health Enhancement

955 Yonkers Ave
Yonkers, NY 10704
(914) 237-5592

**Jewish Community
Center (JCC) on
the Hudson**

371 S Broadway
Tarrytown, NY 10591
(914) 366-7898

**Lucille Roberts
Fitness for Women**

1745 Central Ave
Yonkers, NY 10710
(914) 793-2020

Simply Fit for Women

1000 E Boston Post Rd
Mamaroneck, NY 10543
(914) 967-0000

**Susan Marlowe
Fitness**

80 Maple St
Scarsdale, NY 10583
(914) 472-3335

Vadim Fitness Studio

455 Central Park Ave
Scarsdale, NY 10583
(914) 725-9553

FITNESS FACILITY DISCOUNTS

Workout Express

69 S Moger Ave
Mount Kisco, NY 10549
(914) 242-5225

WYOMING

Curves of Arcade/Holland/ Yorkshire/Sardinia

571 Main St
Arcade, NY 14009
(585) 492-0061

Curves of Attica Township (SM)

211 Main St
Attica, NY 14011
(585) 591-4312

Curves of Warsaw

14 W Buffalo St
Warsaw, NY 14569
(585) 786-9222

YATES

Curves of Penn Yan

109 Kimball Ave
Penn Yan, NY 14527
(315) 531-9200

OPTICAL PROGRAM >>>

An explanation of the HIP Optical Program.



OPTICAL PROGRAM

The HIP Optical Program provides a standard benefit for all members: reduced-cost prescription eyewear from a selection of frames at a participating provider once every 24 months. Our optical program is offered through the General Vision Services (GVS) network.

How The HIP Optical Program Works

Step 1: Get Your Eyes Examined And Obtain A Prescription.

To arrange for an eye exam, just call a conveniently located participating vendor. During your visit, the participating optometrist will examine your eyes and give you a prescription. The participating optometrist will then provide you with eyeglass frames and lenses as needed.

Step 2: Visit A Participating Provider.

If you choose to visit another participating optometrist to have your eyeglass frames and lenses made, simply bring your prescription and your HIP ID card to another participating optometrist.

Step 3: Choose Your Frames.

The HIP selection of fully covered frames is available at every participating optometrist. You will find safety, oversize, single-vision, bifocal and trifocal glasses. Lenses in glass or plastic and cosmetic tinting are included. All of our participating optometrists guarantee that the frames in the HIP selection conform to current standards established by the American National Standards Institute (ANSI).

If you prefer, you can choose frames that are not included in the HIP selection. If so, then you simply pay what you would normally pay for a frame from the HIP selection plus the difference in cost between the highest priced HIP selection frame and the frame of your choice (See the chart on the following page for copayment details.) Lenses in glass or plastic and cosmetic tinting are also included.

HIP Optical Riders

Please check to see if there is a rider describing optical benefits included with your Contract or Certificate of Coverage. If there is, it means one of two things:

1. The rider may simply be confirming that you have the basic HIP Optical Program benefits as described on this page. The rider description will be consistent with the information in the column headed HIP Basic Optical Program in the table on the following page.

OR

2. The rider may describe additional optical benefits. In this case, the rider description will be consistent with the information in the column headed HIP Basic Optical Program with Additional Benefits in the table on the following page.

OPTICAL PROGRAM

You can order a free copy of the GVS participating provider directory by calling **1-800-HIP-TALK (1-800-447-8255)** and using HIP's Interactive Voice Response (IVR) system. Or, you can log on to hipusa.com for the most up-to-date directory listing.

How Your Optical Benefits Work

	HIP Basic Optical Program	HIP Basic Optical Program With Additional Benefits
Frequency	Every 24 months.	Check the rider to see if the frequency is every 24 months or every 12 months.
HIP Frames	You pay only \$45 for any pair of eyeglasses chosen from the HIP selection.	No cost for any pair of eyeglasses chosen from the HIP selection.
Other Frames	<p>You pay the regular charge of a HIP selection frame (\$45) plus the difference in cost between the frame of your choice and the retail value of the highest priced HIP selection frame (currently \$80).</p> <p>For example, if you choose a frame that costs \$100, your final charge will be \$65. That's \$45 plus \$20, the difference between \$100 and \$80.</p>	<p>You pay only the difference in cost between the frame of your choice and the retail value of the highest priced HIP selection frame (currently \$80).</p> <p>For example, if you choose a frame that costs \$100, your final charge will be \$20 – just the difference between \$100 and \$80.</p>
Contact Lenses	Not covered.	Covered every 12 or 24 months with varying copayments. Check the rider for details.

DENTAL PROGRAM >>>

An explanation of the HIP Dental program.



DENTAL PROGRAM

Welcome to HIP's Preventive Dental program,* which provides you and your family access to dental services through the Careington International network.

How Your HIP Preventive Dental Program Works

With HIP's Preventive Dental program, you may visit any Careington network provider and you do not need a referral to see a network specialist. You must use providers who participate in the Careington network to receive benefits under the program.

When you visit a network dentist, you will be required to pay a discounted fee at the time of service. Diagnostic and preventive services and additional services such as X-rays, fillings, crowns or dentures are covered at discounted rates negotiated by HIP. Specialist services are covered at 20% off the network specialist's usual and customary rate.

For More Information

If you have any questions about HIP's Preventive Dental program, please refer to the *Special Kinds of Coverage* section of your Member Handbook. Or call Careington International at **1-800-290-0523** or **1-877-LIV4HIP (1-877-548-4447)**, Monday through Friday, 8 am to 8 pm. If you have a hearing or speech impairment and use a TDD, please call HIP at **1-888-447-4TDD (1-888-447-4833)**, Monday through Friday, 8:30 am to 5 pm.

You can order a free copy of the Careington network dental directory by calling **1-800-HIP-TALK (1-800-447-8255)** and using HIP's Interactive Voice Response (IVR) system. Or you can log on to hipusa.com for the most up-to-date directory.

* The HIP Preventive Dental program applies only to: 1) those members enrolled through a group or an organization such as an employer, labor union, association or welfare fund that acts as a remitting agent and sends HIP the premium for the members' coverage; 2) those subscribers enrolled through a HIP HMO direct payment contract effective prior to January 1, 1996.

PHARMACY PROGRAM >>>

An explanation of the HIP Pharmacy program.



PHARMACY PROGRAM

Check to see if your plan includes prescription drug coverage through HIP. Your Contract or Certificate of Coverage and any attached riders will carry full information about your prescription drug coverage if it is included in your plan.

Note that, depending on your coverage, your doctor may need to contact HIP's Department of Pharmacy Services to obtain prior approval if he or she wants to prescribe a drug not on the HIP Drug Formulary. There is a dedicated phone line for this purpose: **1-646-447-3146**.

There Are Two Convenient Ways To Fill Prescriptions

Visiting a HIP participating pharmacy—There are over 38,000 participating pharmacies nationwide, including many right here in the New York metropolitan area. Thirteen of them are corporate pharmacies located in physician group practices. When you visit a participating pharmacy, just show your HIP Identification card when you fill your prescription.

To locate a HIP participating pharmacy, just log on to hipusa.com and follow these easy steps:

- Click on Pharmacy Services.
- Click on Pharmacy Locator.
- Enter information (e.g., pharmacy, state, zip code).
- Submit request.

Ordering through the HIP Mail Order/Internet Pharmacy programs—This option may reduce your copayments, depending on your coverage. Here's how this works:

- If you need to start your medication right away, ask your physician to write two prescriptions.
- Fill one prescription immediately at a local pharmacy.
- Complete the order form included in your Welcome Kit and send it with the second prescription plus applicable copayment to HIP's Mail Order program.
- Your prescription will be delivered to your home within 14 business days.
- To order prescription drugs using HIP's Internet Pharmacy program, first register as a member at HIP's Web site, hipusa.com. After you have successfully registered, just click on the Pharmacy Services icon and follow the step-by-step instructions.

If you need additional help, please call **1-800-HIP-TALK (1-800-447-8255)** Monday through Friday, 8 am to 6 pm. If you use a telephone device for the hearing or speech impaired, please call **1-888-447-4TDD (1-888-447-4833)** Monday through Friday, 8:30 am to 5 pm, for assistance in:

- Understanding your pharmacy benefit.
- Obtaining mail order enrollment packets.
- Locating a participating pharmacy.
- Ordering a printed participating pharmacy directory.
- Asking about the Mail Order/Internet Pharmacy programs.

NOTICE OF PRIVACY >>> PRACTICES

Important information about your privacy rights.



**THIS NOTICE DESCRIBES HOW
MEDICAL INFORMATION ABOUT YOU
MAY BE USED AND DISCLOSED AND HOW
YOU CAN GET ACCESS TO THIS INFORMATION.**

PLEASE READ IT CAREFULLY.

NOTICE OF PRIVACY PRACTICES

Summary

This document contains an important message about the information we collect from you.

The document describes:

- The kind of information we collect.
- The ways that we protect this information.
- How we use and share this information.
- Your rights, as a subscriber, regarding this information.

The document tells you that:

- HIP is required by federal and state law to protect the privacy of all personal and non-public information we collect from our subscribers.
- We collect this information – name, address, date of birth, Social Security number and the like – from enrollment applications, medical records, claim forms and other documents.
- We also collect income and asset information from Medicaid, Child Health Plus, Family Health Plus and Healthy New York subscribers, as well as from Medicare subscribers applying for a Medicare savings program or for a credit to help pay for prescription drugs through the HIP Medicare Approved Prescription Drug Program.
- We don't share any of the information we collect with anyone, except as permitted by law.
- We are permitted by law to share the information in the course of administering subscriber benefits.
- We are also permitted by law to share the information under the special circumstances described in this section.
- We have internal safeguards to protect the information we collect.
- Any organization we might share the information with in the administration of benefits is obligated to have internal safeguards as well.
- If we need to share the information in a way other than the law permits, we will do so only after obtaining the subscriber's written authorization.
- Questions about how we protect subscriber information may be directed in writing to:
HIPAA Privacy Officer, HIP Health Plan of New York, 55 Water Street, New York, NY 10041.

For details, please read the entire document. At HIP, which includes Health Insurance Plan of Greater New York, HIP Insurance Company of New York and Vytra Health Plans, we appreciate the trust our members place in us and recognize the importance of protecting the confidentiality of nonpublic personal financial and health information that we collect from them. We are required by law to maintain the privacy of this information and to keep accurate reports and records related to providing health care benefits. We are also required by law to send you this Notice of Privacy Practices describing our legal duties and privacy practices related to the uses and disclosures of protected health information. For the purposes of this Notice of Privacy Practices, individually identifiable nonpublic financial and health information will be referred to as "protected health information."

NOTICE OF PRIVACY PRACTICES

The Information HIP Collects

We collect protected health information about our members from the following sources:

1. Information we receive from eligibility and enrollment applications and other forms, including such items as name, address, date of birth, Social Security number, assets, income and tax returns. (We only collect asset, income and tax return information from individuals enrolled in the Medicaid, Healthy New York, Child Health Plus and Family Health Plus benefit plans we offer. We do not collect this information from individuals enrolled in the commercial or Medicare benefit plans we offer, except when a Medicare member is applying for a Medicare Savings Program or for a credit to help pay for prescription drugs through the HIP Medicare Approved Prescription Drug Program.)
2. Information about your transactions with us, our affiliated health care providers or others, including, but not limited to, claims for benefits, medical records and coordination of benefits information.

At present, we do not disclose any protected health information about our members or former members to anyone except as permitted by law. If we were to do so in the future, we would notify you of such a change in policy and advise you of your right to instruct us not to make such disclosure.

Special Treatment Of Your Protected Health Information

HIP will not disclose any of your protected health information without your written authorization, unless such disclosure is permitted by law. Protected health information is individually identifiable information that we maintain relating to the provision of your health care, such as:

- Your medical records.
- Claims payment information.
- Health care visit and treatment patterns.

We have developed an authorization form that we will send to you to obtain your authorization to disclose your protected health information when authorization is required before information is shared. The form describes the purpose for which the information is to be used, the time period during which the authorization form will be in effect, and your right to revoke authorization at any time. The authorization form requires your signature or the signature of your duly authorized representative before we will disclose any of your protected health information.

In addition, we use a special authorization form for the release of HIV and AIDS information to comply with New York State's requirements for the release of this information.

NOTICE OF PRIVACY PRACTICES

Permitted Uses And Disclosures Of Health Information

The law permits HIP to disclose protected health information about you without your written consent or authorization when such disclosure is necessary to assist us with providing your health care benefits. We may disclose protected health information about you to our affiliates as well as to non-affiliated third parties for assistance in the administration of claims and other services necessary for the provision of your health care benefits. When we hire other organizations to provide support services, we require them to conform to our privacy standards and to allow us to audit them for compliance. In all instances, HIP will disclose the minimum necessary protected health information that the circumstances require. Here are some examples of when we may disclose information:

Treatment And Disease Management

HIP will disclose your protected health information to health care providers in the coordination of your health care or related services.

HIP may use or disclose your health information to provide you with preventive care reminders and to advise you of possible treatment options or disease management programs you may be interested in.

For example, we may send you information about programs for smoking cessation, weight loss or remote heart monitoring for congestive heart disease.

Payment

HIP may release protected health information about you, including copies or excerpts from your medical records, for the purposes of determinations of coverage, the adjudication or subrogation of health benefits claims, billing, claims management, medical data processing or reimbursement. HIP may also communicate to subscribers decisions related to payment and benefits that may contain protected health information about covered dependents.

Health Care Operations

HIP may use or disclose protected health information about you in the process of routine operations of the organization related to health care, such as quality assurance, utilization review, internal audit, accreditation, certification, credentialing or routine insurance activities. In addition, we may disclose protected health information about you to arrange for care coordination or community services (e.g., the delivery of meals to your home).

NOTICE OF PRIVACY PRACTICES

Business Associates

HIP may use and disclose certain protected health information about you to business associates who perform an activity on our behalf that requires the use or disclosure of protected health information. Some examples of business associates include consultants, accountants, lawyers, pharmacy claims adjudication providers and delegated entities. HIP will enter into agreements with business associates with specific provisions to ensure that the appropriate safeguards are maintained to prevent any improper use or disclosure of protected health information, and that members' rights to access, amend and obtain an accounting of disclosures of their protected health information are maintained.

Regulatory And Law Enforcement Authorities

HIP may also disclose certain protected health information to a variety of regulatory or law enforcement authorities. For example, HIP may share information with insurance and health oversight agencies, such as the New York State Department of Health and Department of Insurance, in the course of audits, inspections, licensure or disciplinary proceedings. We may also share information for law enforcement purposes as required to respond to a subpoena or court order, or to locate a suspect, a material witness or a missing person. We may share information for certain types of public health or disaster relief efforts, such as with the Food and Drug Administration's investigating a prescription drug or with the Centers for Disease Control and Prevention's tracking a communicable disease. In addition, we may share information with the appropriate governmental authorities in reporting instances of child abuse, neglect or domestic violence. Finally, we may share information related to a deceased person to a medical examiner or funeral director, as necessary, to carry out their duties, or with the appropriate institutions, as necessary, for organ, eye or tissue transplant.

Other uses and disclosures of protected health information that are not included in these general categories will be made only with your written authorization, which you may revoke in writing at any time, unless HIP has already taken action based on the authorization or the authorization was a condition of obtaining the health insurance. Once you give us authorization to release your health information, we cannot guarantee that the person to whom the information is released will not disclose the information.

NOTICE OF PRIVACY PRACTICES

Disclosures Of Your Plan Sponsors

HIP may disclose summary health information that is not individually identifiable to a plan sponsor, if the summary health information is sought for the purposes of obtaining premium bids or modifying, amending or terminating the group health plan coverage. We may also disclose enrollment and disenrollment information with the plan sponsor.

HIP may also disclose protected health information to a plan sponsor for the purposes of performing administrative functions, but only when the employer agrees to certify that processes are in place to safeguard the confidentiality of this information. The health plan document itself must also reflect these certifications.

These certifications will record the plan sponsor's agreement to:

- Not use or disclose the information other than as permitted by the plan or law.
- Ensure that any agent or subcontractor will maintain these same protections and restrictions on the use of the information as required by the employer.
- Not use the information for employment-related actions and decisions related to employee benefits.
- Report any uses or disclosures of the information that are inconsistent with these certifications.
- Make available the protected health information to those individuals who are entitled to such information.
- Permit individuals to amend the protected health information as permitted by law.
- Provide an accounting of disclosures of information as required by law.
- Make available its internal practices and records related to the protected information to the U.S. Department of Health and Human Services to determine compliance.
- If feasible, return to HIP, or destroy, all protected health information when it is no longer needed.
- Ensure that there is adequate separation between HIP and the employer (restricting access to certain designated employees and providing a mechanism for resolving issues of noncompliance).

Confidentiality And Security Of Protected Health Information

We restrict access to your protected health information to those HIP employees who need to know that information in order to provide services to you. We maintain physical, electronic and procedural safeguards that are designed to ensure the privacy of our members' protected health information. Employees who violate our data security policies are subject to disciplinary action, up to and including termination.

NOTICE OF PRIVACY PRACTICES

Your Rights With Respect To Protected Health Information

Members and their authorized representatives are granted specific rights related to protected health information. Your rights with respect to your health information include the right to:

- Request restrictions on certain uses and disclosures of your health information. (HIP will try to honor your requests, but we are not required to agree to a requested restriction.)
- Receive confidential communications of protected health information by reasonable alternatives or at alternative locations. (Again, we will try to honor such reasonable requests. However, we must accommodate reasonable requests to receive health information by a reasonably alternative means if you state in your request that the disclosure of the information could endanger you.)
- Upon written request, inspect and copy your health information in your “designated record set,” which includes medical, billing, enrollment, claims adjudication and case management records. (Please note that the denial of access to certain information may be required or permitted by the applicable laws and regulations, such as psychotherapy notes, information compiled in connection with a civil, criminal or administrative proceeding, or information subject to federal laws governing biological products and clinical laboratories.)
- Obtain access to your protected health information within 60 days of the request, unless additional time is required and permitted. Denials of access to protected health information will be made in writing, and you may request a review of any denial of access to protected health information.
- Amend protected health information. We may require that you submit your request in writing and provide a reason for your request. We will respond to your request within 60 days after we receive it and may extend the time by an additional 30 days, if required. If we make the amendment, we will notify you that it was made and provide the amendment to any person whom we know has received the information, as well as other people identified by you. If we deny the request to amend, we will notify you in writing of the reason for the denial and advise you of your right to file a written statement of disagreement. Your statement, at your request, may be included with your information for future disclosures.
- Upon written request, receive an accounting of disclosures of protected health information. Please note that we are not required to provide an accounting of the following:
 - Any protected health information collected prior to April 14, 2003.
 - Any information shared for treatment, payment and health care operations purposes.
 - Information disclosed pursuant to your authorization.
 - Information disclosed for national security or intelligence purposes.
 - Information disclosed to correctional institutions.
 - Information disclosed to law enforcement officials or health oversight agencies in response to a request for a temporary suspension of an accounting.

NOTICE OF PRIVACY PRACTICES

- Information disclosed as part of a limited data set for research, public health or health care operations purposes.
- Incidental or unavoidable disclosures that occur as a result of a permitted disclosure.

We will attempt to respond to your request for an accounting within 60 days, unless an additional 30 days are required. We will provide you with one free accounting every 12 months.

A fee may be charged for any additional accountings within a 12-month period, and you will be advised in advance of the fee and permitted an opportunity to withdraw or amend your request.

- Revoke authorization to use or disclose protected health information, except to the extent that action has already been taken based upon the authorization.
- Obtain a paper copy of this notice, even if you have agreed to receive notices electronically. You may also view a copy of this notice on our Web site at hipusa.com.

Complaints And Inquiries

Members may complain to HIP and the Secretary of the U.S. Department of Health and Human Services if they believe that their privacy practices have been violated. There will be no retaliation for filing a complaint.

Members wishing to file a complaint with HIP should submit their complaint in writing to: HIPAA Privacy Officer, HIP Health Plan of New York, 55 Water Street, New York, NY 10041.

Members who wish further information on HIP's Notice of Privacy Practices should call **1-800-HIP-TALK (1-800-447-8255)**. TDD: **1-888-HIP-4TDD (1-888-447-4833)**.

Changes In HIP's Notice Of Privacy Practices

HIP is required to abide by the terms of this Notice of Privacy Practices as currently in effect. HIP reserves the right to change the terms of the notice and to make the new notice effective for all the protected health information that it maintains. Prior to implementing any revised notice, HIP will mail members copies of it. In addition, for the convenience of its members, but not as a substitute to the direct delivery described above, HIP will post the revised notice on its Web site, hipusa.com.

PLANNING IN ADVANCE FOR >>> YOUR MEDICAL TREATMENT HEALTH CARE AGENT DESIGNATION

Learn how to plan for medical treatment in case
of catastrophic illness or injury.

HIP[®]
HEALTH PLAN OF NEW YORK

PLANNING IN ADVANCE FOR YOUR MEDICAL TREATMENT

Appointing Your Health Care Agent In New York State

The New York Health Care Proxy Law allows you to appoint someone you trust - for example, a family member or close friend - to make health care decisions for you if you lose the ability to make decisions yourself. By appointing a health care agent, you can make sure that health care providers follow your wishes. Your agent can also decide how your wishes apply as your medical condition changes. *Hospitals, doctors and other health care providers must follow your agent's decisions as if they were your own.* You may give the person you select as your health care agent as little or as much authority as you wish. You may allow your agent to make all health care decisions or only certain ones. You may also give your agent instructions that he or she has to follow. This form can also be used to document your wishes or instructions with regard to organ and/or tissue donation.

PLANNING IN ADVANCE FOR YOUR MEDICAL TREATMENT

About The Health Care Proxy Form

This is an important legal document. Before signing, you should understand the following facts:

1. This form gives the person you choose as your agent the authority to make all health care decisions for you, including the decision to remove or provide life-sustaining treatment, unless you say otherwise in this form. "Health care" means any treatment, service or procedure to diagnose or treat your physical or mental condition.
2. Unless your agent reasonably knows your wishes about artificial nutrition and hydration (nourishment and water provided by a feeding tube or intravenous line), he or she will not be allowed to refuse or consent to those measures for you.
3. Your agent will start making decisions for you when your doctor determines that you are not able to make health care decisions for yourself.
4. You may write on this form examples of the types of treatments that you would not desire and/or those treatments that you want to make sure you receive. The instructions may be used to limit the decision-making power of the agent. Your agent must follow your instructions when making decisions for you.
5. You do not need a lawyer to fill out this form.
6. You may choose any adult (18 years of age or older), including a family member or close friend, to be your agent. If you select a doctor as your agent, he or she will have to choose between acting as your agent or as your attending doctor, because a doctor cannot do both at the same time. Also, if you are a patient or resident of a hospital, nursing home or mental hygiene facility, there are special restrictions about naming someone who works for that facility as your agent. Ask staff at the facility to explain those restrictions.
7. Before appointing someone as your health care agent, discuss it with him or her to make sure that he or she is willing to act as your agent. Tell the person you choose that he or she will be your health care agent. Discuss your health care wishes and this form with your agent. Be sure to give him or her a signed copy. Your agent cannot be sued for health care decisions made in good faith.
8. If you have named your spouse as your health care agent and you later become divorced or legally separated, your former spouse can no longer be your agent by law, unless you state otherwise. If you would like your former spouse to remain your agent, you may note this on your current form and date it or complete a new form naming your former spouse.
9. Even though you have signed this form, you have the right to make health care decisions for yourself as long as you are able to do so, and treatment cannot be given to you or stopped if you object, nor will your agent have any power to object.
10. You may cancel the authority given to your agent by telling him or her or your health care provider orally or in writing.
11. Appointing a health care agent is voluntary. No one can require you to appoint one.
12. You may express your wishes or instructions regarding organ and/or tissue donation on this form.

PLANNING IN ADVANCE FOR YOUR MEDICAL TREATMENT

Frequently Asked Questions

Why should I choose a health care agent?

If you become unable, even temporarily, to make health care decisions, someone else must decide for you. Health care providers often look to family members for guidance. Family members may express what they think your wishes are related to a particular treatment. However, in New York State, only a health care agent you appoint has the legal authority to make treatment decisions if you are unable to decide for yourself. Appointing an agent lets you control your medical treatment by:

- Allowing your agent to make health care decisions on your behalf as you would want them decided.
- Choosing one person to make health care decisions because you think that person would make the best decisions.
- Choosing one person to avoid conflict or confusion among family members and/or significant others.

You may also appoint an alternate agent to take over if your first choice cannot make decisions for you.

Who can be a health care agent?

Anyone 18 years of age or older can be a health care agent. The person you are appointing as your agent or your alternate agent cannot sign as a witness on your Health Care Proxy form.

How do I appoint a health care agent?

All competent adults, 18 years of age or older, can appoint a health care agent by signing a form called a Health Care Proxy. You don't need a lawyer or a notary, just two adult witnesses. Your agent cannot sign as a witness. You can use the form printed here, but you don't have to use this form.

When would my health care agent begin to make health care decisions for me?

Your health care agent would begin to make health care decisions after your doctor decides that you are not able to make your own health care decisions. As long as you are able to make health care decisions for yourself, you will have the right to do so.

What decisions can my health care agent make?

Unless you limit your health care agent's authority, your agent will be able to make any health care decision that you could have made if you were able to decide for yourself. Your agent can agree that you should receive treatment, choose among different treatments and decide that treatments should not be provided, in accordance with your wishes and interests. However, your agent can only make decisions about artificial nutrition and hydration (nourishment and water provided by feeding tube or intravenous line) if he or she knows your wishes from what you have said or what you have written. The Health Care Proxy form does not give your agent the power to make non-health care decisions for you, such as financial decisions.

PLANNING IN ADVANCE FOR YOUR MEDICAL TREATMENT

Why do I need to appoint a health care agent if I'm young and healthy?

Appointing a health care agent is a good idea even though you are not elderly or terminally ill. A health care agent can act on your behalf if you become even temporarily unable to make your own health care decisions (such as might occur if you are under general anesthesia or have become comatose because of an accident). When you again become able to make your own health care decisions, your health care agent will no longer be authorized to act.

How will my health care agent make decisions?

Your agent must follow your wishes, as well as your moral and religious beliefs. You may write instructions on your Health Care Proxy form or simply discuss them with your agent.

How will my health care agent know my wishes?

Having an open and frank discussion about your wishes with your health care agent will put him or her in a better position to serve your interests. If your agent does not know your wishes or beliefs, your agent is legally required to act in your best interest. Because this is a major responsibility for the person you appoint as your health care agent, you should have a discussion with the person about what types of treatments you would or would not want under different types of circumstances, such as:

- Whether you would want life support initiated/continued or removed if you are in a permanent coma.
- Whether you would want treatments initiated/continued or removed if you have a terminal illness.
- Whether you would want artificial nutrition and hydration initiated/withheld, continued or withdrawn and under what types of circumstances.

Can my health care agent overrule my wishes or prior treatment instructions?

No. Your agent is obligated to make decisions based on your wishes. If you clearly expressed particular wishes, or gave particular treatment instructions, your agent has a duty to follow those wishes or instructions unless he or she has a good faith basis for believing that your wishes changed or do not apply to the circumstances.

Who will pay attention to my agent?

All hospitals, nursing homes, doctors and other health care providers are legally required to provide your health care agent with the same information that would be provided to you and to honor the decisions by your agent as if they were made by you. If a hospital or nursing home objects to some treatment options (such as removing certain treatment) they must tell you or your agent, **BEFORE OR UPON** admission, if reasonably possible.

PLANNING IN ADVANCE FOR YOUR MEDICAL TREATMENT

What if my health care agent is not available when decisions must be made?

You may appoint an alternate agent to decide for you if your health care agent is unavailable, unable or unwilling to act when decisions must be made. Otherwise, health care providers will make health care decisions for you that follow instructions you gave while you were still able to do so. Any instructions that you write on your Health Care Proxy form will guide health care providers under these circumstances.

What if I change my mind?

It is easy to cancel your Health Care Proxy, to change the person you have chosen as your health care agent or to change any instructions or limitations you have included on the form. Simply fill out a new form. In addition, you may indicate that your Health Care Proxy expires on a specified date or if certain events occur. Otherwise, the Health Care Proxy will be valid indefinitely. If you choose your spouse as your health care agent or as your alternate, and you get divorced or legally separated, the appointment is automatically cancelled. However, if you would like your former spouse to remain your agent, you may note this on your current form and date it or complete a new form naming your former spouse.

Can my health care agent be legally liable for decisions made on my behalf?

No. Your health care agent will not be liable for health care decisions made in good faith on your behalf. Also, he or she cannot be held liable for costs of your care just because he or she is your agent.

Is a Health Care Proxy the same as a living will?

No. A living will is a document that provides specific instructions about health care decisions. You may put such instructions on your Health Care Proxy form. The Health Care Proxy allows you to choose someone you trust to make health care decisions on your behalf. Unlike a living will, a Health Care Proxy does not require that you know in advance all the decisions that may arise. Instead, your health care agent can interpret your wishes as medical circumstances change and can make decisions you could not have known would have to be made.

Where should I keep my Health Care Proxy form after it is signed?

Give a copy to your agent, your doctor, your attorney and any other family members or close friends you want. Keep a copy in your wallet or purse or with other important papers, but not in a location where no one can access it, like a safe deposit box. Bring a copy if you are admitted to the hospital, even for minor surgery, or if you undergo outpatient surgery. *Please do not send your Health Care Proxy to HIP.*

PLANING IN ADVANCE FOR YOUR MEDICAL TREATMENT

May I use the Health Care Proxy form to express my wishes about organ and/or tissue donation?

Yes. Use the optional organ and tissue donation section on the Health Care Proxy form and be sure to have the section witnessed by two people. You may specify that your organs and/or tissues be used for transplantation, research or educational purposes. Any limitation(s) associated with your wishes should be noted in this section of the proxy.

Failure to include your wishes and instructions on your Health Care Proxy form will not be taken to mean that you do not want to be an organ and/or tissue donor.

Can my health care agent make decisions for me about organ and/or tissue donation?

No. The power of a health care agent to make health care decisions on your behalf ends upon your death. Noting your wishes on your Health Care Proxy form allows you to clearly state your wishes about organ and tissue donation.

Who can consent to a donation if I choose not to state my wishes at this time?

It is important to note your wishes about organ and/or tissue donation so that family members who will be approached about donation are aware of your wishes. However, New York law provides a list of individuals who are authorized to consent to organ and/or tissue donation on your behalf. They are listed in order of priority: your spouse, a son or daughter 18 years of age or older, either of your parents, a brother or sister 18 years of age or older, a guardian appointed by a court prior to the donor's death or any other legally authorized person.

PLANING IN ADVANCE FOR YOUR MEDICAL TREATMENT

Health Care Proxy Form Instructions

Item (1)

Write the name, home address and telephone number of the person you are selecting as your agent.

Item (2)

If you want to appoint an alternate agent, write the name, home address and telephone number of the person you are selecting as your alternate agent.

Item (3)

Your Health Care Proxy will remain valid indefinitely unless you set an expiration date or condition for its expiration. This section is optional and should be filled in only if you want your Health Care Proxy to expire.

Item (4)

If you have special instructions for your agent, write them here. Also, if you wish to limit your agent's authority in any way, you may say so here or discuss them with your health care agent. If you do not state any limitations, your agent will be allowed to make all health care decisions that you could have made, including the decision to consent to or refuse life-sustaining treatment.

If you want to give your agent broad authority, you may do so right on the form. *Simply write: I have discussed my wishes with my health care agent and alternate and they know my wishes, including those about artificial nutrition and hydration.*

If you wish to make more specific instructions, you could say: *If I become terminally ill, I do/do not want to receive the following types of treatments: ... If I am in a coma or have little conscious understanding, with no hope of recovery, then I do/do not want the following types of treatments: ... If I have brain damage or a brain disease that makes me unable to recognize people or speak and there is no hope that my condition will improve, I do/do not want the following types of treatments: ... I have discussed with my agent my wishes about _____ and I want my agent to make all decisions about these measures.*

PLANING IN ADVANCE FOR YOUR MEDICAL TREATMENT

Examples of medical treatments about which you may wish to give your agent special instructions are listed below. This is not a complete list:

- Artificial respiration.
- Artificial nutrition and hydration (nourishment and water provided by feeding tube).
- Cardiopulmonary resuscitation (CPR).
- Antipsychotic medication.
- Electric shock therapy.
- Antibiotics.
- Surgical procedures.
- Dialysis.
- Transplantation.
- Blood transfusions.
- Abortion.
- Sterilization.

Item (5)

You must date and sign this Health Care Proxy form. If you are unable to sign yourself, you may direct someone else to sign in your presence. Be sure to include your address.

Item (6)

You may state wishes or instructions about organ and/or tissue donation on this form. A health care agent cannot make a decision about organ and/or tissue donation because the agent's authority ends upon your death. The law does provide for certain individuals, in order of priority, to consent to an organ and/or tissue donation on your behalf: your spouse, a son or daughter 18 years of age or older, either of your parents, a brother or sister 18 years of age or older, a guardian appointed by a court prior to the donor's death or any other legally authorized person.

Item (7)

Two witnesses 18 years of age or older must sign this Health Care Proxy form. The person who is appointed your agent or alternate agent cannot sign as a witness.

Health Care Proxy

(print out page to complete)

(1) I, _____

hereby appoint _____
[name, home address and telephone number]

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise. This proxy will take effect when and if I become unable to make my own health care decisions.

(2) Optional: Alternate Agent. If the person I appoint is unable, unwilling or unavailable to act as my health care agent, I appoint

[name, home address and telephone number]

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise.

(3) Unless I revoke it or state an expiration date or circumstances under which it will expire, this proxy shall remain in effect indefinitely. *(Optional: If you want this proxy to expire, state the date or conditions here.)* This proxy shall expire *(specify date or conditions)*:

(4) Optional: I direct my health care agent to make health care decisions according to my wishes and limitations, as he or she knows or as stated below. *(If you want to limit your agent's authority to make health care decisions for you or to give specific instructions, you may state your wishes or limitations here.)* I direct my health care agent to make health care decisions in accordance with the following limitations and/or instructions *(attach additional pages as necessary)*:

(print out page to complete)

(5) Your Identification (Please Print):

Your Name: _____

Your Signature: _____

Date: _____

Your Address: _____

(6) Optional: Organ And/Or Tissue Donation.

I hereby make an anatomical gift, to be effective upon my death, of: *(check any that apply)*

Any needed organs and/or tissues

The following organs and/or tissues

Limitations

If you do not state your wishes or instructions about organ and/or tissue donation on this form, it will not be taken to mean that you do not wish to make a donation or prevent a person, who is otherwise authorized by law, to consent to a donation on your behalf.

Your Signature: _____

Date: _____

(7) Statement By Witnesses *(Witnesses must be 18 years of age or older and cannot be the health care agent or alternate.)*

I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting of his or her own free will. He or she signed (or asked another to sign for him or her) this document in my presence.

PRIVATE	
Date _____	Date _____
Name of Witness 1 (print) _____	Name of Witness 2 (print) _____
Signature _____	Signature _____
Address _____	Address _____

