

ATLANTIS HEALTH PLAN

Summary of Benefits HMO 20A, \$0/\$25

DOCTOR'S SERVICES

	<u>What You Pay</u>
Office Visits (PCP or Specialist)	\$20 co-payment
Ambulatory Service visits (Hemodialysis, Chemotherapy, Radiotherapy)	\$20 co-payment
Inpatient Hospital Visits	No co-payment
Allergy Testing and Treatment	\$20 co-payment
Anesthesia	No co-payment
Diagnostic Services and Treatments	\$20 co-payment
Mammography Screening and Prostate Cancer Screening	\$20 co-payment
Mastectomy Care	\$20 co-payment
Obstetrical/Gynecological Services and Pap Smears	\$20 co-payment
Radiology Services	\$20 co-payment
Infertility Services	\$20 co-payment
Bone Mineral Density Measurements, Testing and Devices	\$20 co-payment
Enteral Formulas	\$20 co-payment
Contraceptive drugs and devices	\$20 co-payment
All second surgical/medical opinions	\$20 co-payment
Periodic routine physicals	\$20 co-payment
Well-Child Visits	No co-payment
Experimental or investigational services recommended by external appeal agent	\$20 co-payment
Pre- & Post-Natal Care	\$20 co-payment
Chiropractic Care	\$20 co-payment
Delivery Of Child/ Ambulatory and Outpatient Surgery	Lesser of: 20% or \$200

AMBULATORY SERVICES

Ambulatory/Outpatient Facility Services	\$75 co-payment
Pre-admission Testing	\$20 co-payment
X-ray and Laboratory Services	\$20 co-payment

HOSPITAL SERVICES

Inpatient Services	\$500 co-payment
Inpatient Cardiac Rehabilitation (per continuous confinement)	\$500 co-payment
Ambulatory Surgery Facility	\$75 co-payment
Blood and Blood Products	No co-payment
Ambulance Services	\$50 co-payment
Emergency Room Care (no admission to hospital)	\$50 co-payment

HOSPITAL ALTERNATIVES

Skilled Nursing Facility: 30 days per calendar year* (per continuous confinement)	\$500 co-payment
Home Health Care: 40 visits per calendar year	\$20 co-payment
End of Life Care Program	No co-payment
Hospice Care: Inpatient (210 days combined with outpatient)	No co-payment
Hospice Care- Outpatient bereavement counseling-5 visits	No co-payment
Hospice Care: Outpatient	No co-payment

REHABILITATIVE SERVICES

<u>Physical/Speech/Occupational</u>	
Inpatient: per continuous confinement (Limited to 30 days per diagnosis per calendar year)	\$500 co-payment
Outpatient: limited to 20 visits per diagnosis per calendar year (only following inpatient stay)	\$20 co-payment

MENTAL HEALTH

Inpatient Admission: per continuous confinement (30 days per calendar year)	\$500 co-payment
Outpatient: 20 visits per calendar year	\$20 co-payment

SUBSTANCE ABUSE

Inpatient Detoxification: per continuous confinement (Limited to 7 days per calendar year)	\$500 co-payment
Outpatient Rehabilitation: 60 visits per calendar year (20 of the visits may be used for Family Therapy)	\$20 co-payment

MEDICAL EQUIPMENT & SUPPLIES

Durable Medical Equipment & Supplies	20% co-insurance
Diabetic Equipment and Supplies	\$20 co-payment

*Benefit riders available to satisfy the "make available" provisions of Section 4303(e) of the New York State Insurance Laws

Note: Benefit limitations and maximums are per Member per calendar year.
EXCLUSIONS: This SUMMARY OF BENEFITS highlights the standard benefits of the HMO contract. Benefits shown may be subject to Restrictions, Exclusions and Limitations found in the Group Subscriber Contract.





Prescription Rider Signature “Mandatory Generic”

The following rider is an addendum to the “Group Subscriber Certificate of Coverage” which provides for the provision of all basic health services.

Benefits

The “Benefits” section of the Group Subscriber Certificate of Coverage is amended as follows:

Outpatient Prescription Drugs or Medicines:

- This rider covers only generic prescription drugs unless there is no generic drug available within an entire class of drugs or this rider specifically states that brand name drugs as well as generic drugs of a particular type are covered. If no generic drug is available within an entire class of drugs, all brand name drugs within that class of drugs are covered.
- If a member has suffered, or is likely to suffer, adverse side effects from all of the generic drugs within a class of drugs, the Plan will approve coverage of a brand name drug within that class at the request of the member. The Plan’s decision will be subject to utilization review.
- Outpatient Food and Drug Administration (FDA) approved prescription drugs or medicines are covered when medically necessary and prescribed by a licensed Provider. Each prescription is limited to a maximum 30-day supply, with up to four refills when authorized by a licensed Provider.
- If you purchase a covered drug at a non-participating pharmacy, you must pay the retail price for the drug, and then submit a claim for reimbursement from the Plan. Reimbursement for drugs purchased at non-participating pharmacies will be limited to the Reasonable Charge for the drug minus the co-payment.

Prescription drug coverage also includes:

- Medically necessary enteral formulas for home use when prescribed by a licensed provider. The formula must have been proven effective as a disease-specific treatment regime for those individuals who are or will become malnourished or suffer from disorders, which if left untreated, cause chronic disability, mental retardation or death. This rider covers brand name and generic enteral formulas.
- Modified solid food products that are low protein, when medically necessary for certain inherited diseases of amino acids and organic metabolism.
- Hypodermic needles and syringes used to administer medications that are covered by Atlantis, when prescribed by a licensed practitioner and purchased through a Plan Pharmacy.
- Certain non-FDA approved prescribed drugs, whether brand name or generic, recognized for the treatment of specific types of cancer by one of the following:
 - A. the American Medical Association Drug Evaluations;
 - B. the American Hospital Formulary Service Drug Information; or
 - C. the United States Pharmacopoeia Drug Information; or recommended by review article or editorial comment in a major peer reviewed professional journal.
- Allergy Serums, whether brand name or generic.
- Bone mineral density brand name and generic prescription drugs and devices including those covered under the federal Medicare program and those in accordance with the criteria of the National Institutes of Health and if consistent with such criteria, dual-energy x-ray absorptiometry. Covered Services shall be provided to a Member who qualifies under the criteria of the federal Medicare program and the criteria of the National Institutes of Health. This includes a Member who meets the following criteria:

- i. The Member has previously been diagnosed with osteoporosis or has a family history of osteoporosis; or
 - ii. The Member has symptoms or conditions indicative of the presence, or the significant risk, of osteoporosis; or
 - iii. Member is on a prescribed drug regimen posing a significant risk of osteoporosis, or
 - iv. The Member's age, gender, other physiological characteristics and/or lifestyle factors pose a significant risk of osteoporosis.
- For Members between the ages of twenty-one (21) and forty-four (44), brand name and generic prescription drugs approved by the federal FDA for use in the diagnosis and treatment of infertility. There is no coverage for Prescription drugs used in connection with any infertility service which is specifically excluded from coverage.
 - You have the right to file an appeal with an independent, outside review panel whenever the Plan denies coverage for prescription drugs because the drug is not considered medically necessary or is considered an experimental or investigational treatment. Further details as to how you may request an appeal are provided in the Certificate of Coverage.

Mail Order/ Maintenance

- You are encouraged to utilize our Mail Order/ Maintenance program if you are required to use a maintenance drug on the Plan's approved list.
- Maintenance drugs are covered for a 90-day supply upon a written prescription by a Licensed Provider.
- The mail order option allows you to obtain a 90-day supply of maintenance drugs in the following categories: anti-diabetics, anti-hypertensives, anti-hyperlipidemics, beta-blockers, calcium blockers, diuretics and thyroid medications.

Co-payments

- You are responsible for an annual deductible of \$0 per covered member for a generic drug.
- You are responsible for an annual deductible of \$250 for covered brand name drugs.
- \$0 co-payment for each generic prescription filled at a Pharmacy.
- You are responsible for a \$25 co-payment for each covered brand name drug filled at a Pharmacy.
- There is an annual maximum benefit of \$2,000 per covered member for covered brand name drugs.
- Co-payment for 90 day mail order is one and half times (1.5x) the regular co-pay.

Limitations and Exclusions

Except to the extent that such benefits are either medically necessary or are required to be provided by applicable Law, prescription drug benefits *do not* include:

1. All non-generic classified prescription drugs.
2. Any drug which does not require a prescription, such as over-the-counter or non-legend drugs, even if a prescription is written.
3. Antibacterial soaps/detergents, shampoos, toothpaste/gels and mouthwashes/rinses.
4. Prescription drugs dispensed to a Member while he is a patient in a hospital, nursing home, or other institution.
5. Prescription drugs used in connection with drug addiction, unless medically necessary and pre-authorized by Atlantis.
6. Amphetamines, appetite suppressants, and hair growth stimulants unless medically necessary and pre-authorized by Atlantis.
7. Medications for cosmetic purposes only.
8. Prescription drugs dispensed by a provider office.
9. Experimental and Investigational Drugs which are defined as drugs which have not been approved by the FDA and or NIH or have not been shown to be safe and effective through clinical trials or are not generally accepted as safe and effective by a majority of clinical providers with significant experience in the usage of the drugs, unless recommended by an external appeal agent.
10. Replacements of drugs resulting from loss, theft or breakage.

Other limitations on coverage are as follows:

1. The maximum coverage for any authorized modified solid food products for any continuous period of 12 months shall not exceed \$2,500.
2. Some drugs require Pre-authorization. Provider/Member is responsible for obtaining the necessary authorization prior to prescribing the drug.
3. Prescription drug coverage does not include prescription contraceptive drugs or devices unless covered by a separate Contraceptive Coverage Rider.

All of the terms, conditions and limitations of your Atlantis Health Plan Subscriber Contract to which this rider is attached also apply to this Rider, except where specifically changed by this Rider.