

**ATLANTIS HEALTH PLAN**

**Summary of Benefits  
POS 25/40 1000 Plus, \$0/\$30/\$50**

<b>FINANCIALS</b>	<b>IN NETWORK</b>	<b>OUT OF NETWORK</b>
	<b>What You Pay</b>	<b>What You Pay</b>
Office visit Co-pay (PCP/Specialist)	\$25/\$40 co-payment	Subject to deductible and co-insurance
Deductible Single/Family	N/A	\$1,000/\$2,500
Co-insurance	N/A	70/30
Maximum Out of Pocket (after deductible) Single/Family	N/A	\$3,000/\$7,500
Lifetime Maximum	None	\$1,000,000
<b>DOCTOR'S SERVICES</b>		
Office Visits (PCP)	\$25 co-payment	Subject to deductible and co-insurance
Office Visits (Specialist)	\$40 co-payment	Subject to deductible and co-insurance
Inpatient Hospital Visits	No co-payment	Subject to deductible and co-insurance
Allergy Testing and Treatment	\$25 co-payment	Subject to deductible and co-insurance
Anesthesia	No cost	Subject to deductible and co-insurance
Diagnostic Services	\$25 co-payment	Subject to deductible and co-insurance
Mammography Screening	\$25 co-payment	Subject to deductible and co-insurance
Prostate Cancer Screening	\$25 co-payment	Subject to deductible and co-insurance
Breast Reconstructive Services after a Mastectomy	\$25 co-payment	Subject to deductible and co-insurance
Obstetrical/Gynecological Services	\$25 co-payment	Subject to deductible and co-insurance
Pap Smears and Cervical Cytology Screenings	\$25 co-payment	Subject to deductible and co-insurance
Infertility services	\$25 co-payment	Subject to deductible and co-insurance
Bone Mineral Density Measurements, Testing and Devices	\$25 co-payment	Subject to deductible and co-insurance
Enteral Formulas	\$25 co-payment	Subject to deductible and co-insurance
Second Surgical and Medical Opinions	\$25/\$40 co-payment	Subject to deductible and co-insurance
Second Medical Opinions (diagnosis of cancer, negative or positive)	No co-payment	Not subject to deductible and co-insurance ^
Periodic Adult Physical Examinations	\$25 co-payment	In network benefits only
Well-Child Care Visits (including immunizations)	No co-payment	In network benefits only
Experimental/Investigational services recommended by external appeal agent	\$25 co-payment	Subject to deductible and co-insurance
Pre- & Post-Natal Care	\$25 co-payment	Subject to deductible and co-insurance
Delivery of Child	No co-payment	Subject to deductible and co-insurance
Inpatient Surgical Services #	No co-payment	Subject to deductible and co-insurance
Outpatient Ambulatory Surgical Services #	No co-payment	Subject to deductible and co-insurance
Chiropractic Care	\$40 co-payment	Subject to deductible and co-insurance
Diabetic Education	\$25 co-payment	Subject to deductible and co-insurance
<b>AMBULATORY SERVICES</b>		
Radiation Therapy and Chemotherapy	\$25 co-payment	Subject to deductible and co-insurance
Hemodialysis	\$25 co-payment	Subject to deductible and co-insurance
Pre-admission Testing	\$25 co-payment	Subject to deductible and co-insurance
X-Ray and Laboratory Services	\$25 co-payment	Subject to deductible and co-insurance
<b>HOSPITAL SERVICES**</b>		
Inpatient Admission (per continuous confinement)	No co-payment	Subject to deductible and co-insurance
Cardiac Rehabilitation (per continuous confinement)	No co-payment	Subject to deductible and co-insurance
Outpatient Surgery Facility Charges	No co-payment	Subject to deductible and co-insurance
Blood and Blood Products	No co-payment	Subject to deductible and co-insurance
Ambulance Service	No co-payment	Subject to deductible and co-insurance
Emergency Room Care (no admission to hospital)	\$50 co-payment	Subject to deductible and co-insurance
<b>HOSPITAL ALTERNATIVES</b>		
Skilled Nursing Facility: 45 days per calendar year *	No co-payment	Subject to deductible and co-insurance
Home Health Care: 60 visits per calendar year	No co-payment	Subject to deductible and co-insurance
End of Life Care Program	No co-payment	Subject to co-insurance only
Hospice Care: Inpatient (210 days combined with outpatient)	No co-payment	Subject to deductible and co-insurance
Hospice Care (5 Bereavement counseling visits)	No co-payment	Subject to deductible and co-insurance
<b>REHABILITATIVE SERVICES</b>		
Physical/Speech/Occupational		
Inpatient: 30 days per diagnosis per calendar year	No co-payment	Subject to deductible and co-insurance
Outpatient: 20 visits per diagnosis per calendar year*	\$40 co-payment	Subject to deductible and co-insurance
<b>MENTAL HEALTH</b>		
Inpatient Admission: 30 days per calendar year	No co-payment	Subject to deductible and co-insurance
Outpatient: 20 visits per calendar year	\$40 co-payment	Subject to deductible and co-insurance
<b>SUBSTANCE ABUSE</b>		
Inpatient Detoxification: (limited to 7 days per calendar year)	No co-payment	Subject to deductible and co-insurance
Outpatient 60 visits per calendar year (20 of the visits may be used for Family Therapy)	\$40 co-payment	Subject to deductible and co-insurance
<b>MEDICAL EQUIPMENT &amp; SUPPLIES</b>		
Durable Medical Equipment & Supplies	\$0 co-payment	Subject to deductible and co-insurance
Diabetic Equipment and Supplies	\$25 co-payment per item or 34-day supply	Subject to deductible and co-insurance

\* Benefit riders available to satisfy the "make available" provisions of Section 4303(e) of the New York State Insurance Laws  
# Failure to Pre-authorize all non-emergency, or elective surgery hospital admissions, will result in a penalty.

^ Must be authorized. Provider will be paid at the Atlantis usual, customary rate.

Note: Benefit limitations and maximums are per Member per calendar year.

EXCLUSIONS: This SUMMARY OF BENEFITS highlights the standard benefits of the HMO Point of Service contract.  
Benefits shown may be subject to Restrictions, Exclusions and Limitations found in the Group Subscriber Contract.





### **Prescription Rider Rx P – 0/30/50**

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**

- Outpatient Federal 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 34-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.
- 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 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.
- Bone mineral density 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. The 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), 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.

### **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 a \$0 co-payment for each generic prescription filled at a Pharmacy.
- You are responsible for a \$30 co-payment for each brand formulary prescription filled at a Pharmacy.
- You are responsible for a \$50 co-payment for each brand non-formulary prescription filled at a Pharmacy.
- 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. Any drug which does not require a prescription, such as over-the-counter or non-legend drugs, even if a prescription is written.
2. Antibacterial soaps/detergents, shampoos, toothpaste/gels and mouthwashes/rinses.
3. Prescription drugs dispensed to a Member while he is a patient in a hospital, nursing home, or other institution.
4. Prescription drugs used in connection with drug addiction, unless medically necessary and pre-authorized by Atlantis.
5. Amphetamines, appetite suppressants, and hair growth stimulants unless medically necessary and pre-authorized by Atlantis.
6. Medications for cosmetic purposes only.
7. Prescription drugs dispensed by a provider office.
8. Experimental and Investigational Drugs which are defined as drugs which have not been approved by the FDA and or NHI 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.
9. Replacements of drugs resulting from loss, theft or breakage.
10. The maximum coverage for any authorized modified solid food products for any continuous period of 12 months shall not exceed \$2,500.
11. Some drugs require Pre-authorization. Provider/Member is responsible for obtaining the necessary authorization prior to prescribing the drug.

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