

UAE / ATLANTIS HEALTH PLAN

Summary of Benefits

HMO: Plan 20

DOCTOR'S SERVICES

	<u>What You Pay</u>
Office Visits (PCP or Specialist)	\$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	\$20 co-payment
Obstetrical/Gynecological Services	\$20 co-payment
Pap Smears	\$20 co-payment
Second Surgical Opinions	\$20 co-payment
Periodic Adult Physical Examinations	\$20 co-payment
Well-Child Care Visits (including immunizations)	No co-payment
Pre- and Post-Natal Care	\$20 co-payment
Chiropractic Care	\$20 co-payment
Delivery of Child	No co-payment
Surgical Services	No co-payment

AMBULATORY SERVICES

Radiation Therapy and Chemotherapy	\$20 co-payment
Hemodialysis	\$20 co-payment
Pre-admission Testing	\$20 co-payment
X-Ray and Laboratory Services	\$20 co-payment

HOSPITAL SERVICES

Inpatient Admission (per continuous confinement)	\$250 co-payment
Outpatient Surgery Facility Charges	No co-payment
Blood and Blood Products	No co-payment
Ambulance Service	No co-payment
Emergency Room Care (no admission to hospital)	\$50 co-payment

HOSPITAL ALTERNATIVES

Skilled Nursing Facility - 45 days per calendar year	No co-payment
Home Health Care - 60 visits per calendar year	No co-payment
Hospice Care – Inpatient (210 days combined with Outpatient)	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)	\$250 co-payment
Outpatient: limited to 20 visits per diagnosis per calendar year	No co-payment

MENTAL HEALTH

Inpatient Admission: Per continuous confinement (30 days per calendar year)	\$250 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)	\$250 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	No co-payment
Diabetic Equipment and Supplies	\$20 per item or 34-day supply

* Only one \$250 co-payment is payable for either service.

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 Rx C – 20/30/40

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

Benefits

The “Benefits” section of the Subscriber Contract is amended as follows:

Outpatient Prescription Drugs or Medicines

- 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 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. The maximum coverage for any authorized modified solid food products for any calendar year or for any continuous period of 12 months shall not exceed \$2,500
- 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.
- Pre-natal Vitamins for pregnant women ONLY, when prescribed by a licensed provider.
- Allergy Serums.

Mail Order/ Maintenance

- You are encouraged to utilize our Mail Order/Maintenance drug 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 with a written prescription by a 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 \$20 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 \$40 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. Any durable medical equipment appliance or device.
3. Some drugs and medications used to treat infertility may be covered, based upon the requirements of New York State Law.
4. Antibacterial soaps/detergents, shampoos, toothpaste/gels and mouthwashes/rinses.
5. Prescription drugs dispensed to a Member while he is a patient in a hospital, nursing home, or other institution.
6. Prescription drugs used in connection with drug addiction, unless medically necessary and pre-authorized by Atlantis.
7. Amphetamines, appetite suppressants, and hair growth stimulants unless medically necessary and pre-authorized by Atlantis.
8. Medications for cosmetic purposes only.
9. Prescription drugs dispensed by a physician/provider office.
10. 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.
11. Replacements of drugs resulting from loss, theft or breakage.
12. 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.