ATLANTIS
HEALTH PLAN

MEMBER HANDBOOK *Page*

Important Contact Information

Member Services **866-747-8422**
For questions regarding member related issues, eligibility, claims and benefits.

Utilization Management/Health Services **800-270-9072**
For questions regarding Pre-authorization.

Prescription Drug Services **888-341-8570**
For information regarding prescription drug benefits and Participating Pharmacies.

Vision Care Services **866-747-8422**
For information regarding vision benefits and Participating Vision Providers.

Hearing and Speech Impaired **711**
Members who require assistance, please dial 711 from your telephone. TRS (Telecommunication Relay Service) and STS (Speech-to-Speech) services are available. A representative will connect you to Atlantis.

Non-English Speaking Members
Members who do not speak English or prefer to communicate in a language other than English, our Members Services staff can assist you in understanding your coverage and/or with any other questions/concerns you may have. Multi-lingual staff and translation services are available.

Vision Impaired Members
Please call Member Services to request a large print handbook or transcription of the written word on to audio-cassette. You will receive your handbook within 72 hours.

To contact Atlantis through U.S. Mail, Fax, or email:

Atlantis Health Plan, Inc.
45 Broadway, Suite 300
New York, NY 10006
Fax (212) 747-0843

For email please click on “Contact Us” on our website: www.atlantishp.com

Member Materials

Important information about your benefits can be found in the following documents:

- **Group Subscriber Contract** is the agreement made between your group and Atlantis. The Contract outlines the obligations regarding the provision of and payment for Covered Services provided to Members. The Contract also describes in detail, your available benefits, eligibility, exclusions, and limitations

- **Member Handbook** contains information about how to navigate through your plan benefits.

- **Riders** are addendums to your Contract. Your Group must purchase the Rider in order for it to be included in your benefits. Some examples of elected Riders are:

    - Prescription Drug Benefit
    - Student Coverage to Age 23 or 25
    - Vision High Option or Low Option

- **Summary of Benefits** highlights Covered Services and provides a benefit comparison of your In-Network versus Out-of-Network options.

- **Provider Directory** contains the names, addresses and telephone numbers of Participating Hospitals, Physicians and Ancillaries in the Atlantis Health Plan network.

- **Pre-authorization Summary List** outlines the medications and procedures that require Pre-authorization.

Welcome to Atlantis

Congratulations! You have joined Atlantis Health Plan, Inc. ("AHP", "the Plan"), a healthcare plan that values your membership and is committed to your good health. As a member of AHP, you are eligible to receive quality healthcare services and health education through a Network of AHP Participating Hospitals and Physicians. These comprehensive services represent your In-Network benefits.

For added flexibility, as a Point of Service (POS) Member, you may choose to see doctors or use facilities that do not participate with Atlantis. Benefits that are received Out-of-Network will probably not be as comprehensive as benefits received In-Network.

Your POS Subscriber Contract provides complete details of your healthcare coverage. The Summary of Benefits highlights Covered Services and provides a benefit comparison of your In-Network versus Out-of-Network options. Please review this document thoroughly.

This handbook will help answer questions about your membership with AHP. For easy reference keep it in an accessible place so you will have information readily available. If after reading this book, you still have questions; please call our Member Services Department at 866-747-8422.

Thank you for choosing AHP where our roots run deep and our commitment to service is strong!

The AHP Identification Card

As a member of AHP, you and each enrolled member of your family will have an individualized AHP Identification Card. It is important that you keep this card with you at all times, so that you can identify yourself as an AHP member each time you need health services. Your identification card contains the following information:

- Your AHP identification number
- Your first and last name, and
- Plan design and co-pay

The reverse side of the card provides instructions for Emergency Services.

Anytime your basic enrollment information changes and you report it to AHP, you will receive a new card automatically. Examples of basic information that should be reported to the Plan are a name or address change, addition or deletion of a family member, change of Primary Care Provider, or change or correct your social security number.

The identification card is only to be used by the person listed on the card; it may not be used by anyone else. Should you need to replace a card, please call AHP's Member Services Department at 866-747-8422.

Provider Directory

For a list of AHP physicians and hospitals please call Member Services Department at 866-747-8422 to request an Atlantis Health Plan Provider Directory. The most current information is reflected on the Atlantis Health Plan website, www.atlantishp.com . Atlantis makes every effort to provide an accurate listing of Participating Providers. Provider information changes frequently; additions, changes and deletions are updated periodically. Prior to receiving services from a provider, we strongly recommend that you confirm his or her participation with Atlantis by calling Member Services at 866-747-8422.

Provider Appointments

Please contact your provider to schedule appointments for services. Make sure that you bring your Member ID Card for the visit. Present the card upon arrival.

Your Primary Care Provider

AHP believes that staying healthy requires a healthy lifestyle and a good relationship with your Primary Care Provider (PCP). When you enrolled with AHP, you were asked to select a Participating Primary Care Provider. In general, a PCP will be a General Practitioner, Family Practitioner, Internist, or Pediatrician. Selected specialists and other healthcare practitioners who are recognized in the community as providers of primary care may also be allowed the PCP designation.

Members must select an In-Network PCP to coordinate their routine care. Each family member will have his/her own In-Network PCP. This is not to suggest that all family Members can't choose the same PCP. It is important that each member must have a PCP designated on the enrollment form.

Your PCP is responsible for the coordination of your healthcare and will perform your routine care services. Examples of routine care services:

- Periodic adult physical exams
- Well-Child Care visits
- Immunizations

These services will only be covered when received through your In-Network PCP. Each time you visit your PCP, your relationship will continue to grow and he/she will be able to advise and assist you in building a healthy foundation of care.

If you have not had an initial PCP visit, contact his or her office as soon as possible in order to set up an appointment. If you become ill or injured, your PCP will already have information about you and your health history in order to make a determination regarding coordination of care. If you do not select a PCP, Atlantis will automatically designate a PCP to you based on geographical proximity.

Some PCPs do not accept new patients that are not already established with them. If you have a question as to whether you are considered an established patient, or if the PCP will accept you into his or her practice, contact the PCP's office directly.

Be sure to call your Primary Care Provider's office in advance to schedule an appointment for care. When you arrive at the office, always show your AHP identification card and pay any applicable co-payment amount. Primary care services are covered one hundred percent (100%) after payment of the applicable co-payment.

If for some reason you want to change your Primary Care Provider, call Member Services toll free at 866-747-8422. Member Services will note your request or assist you in choosing a new PCP if necessary. The change will be effective immediately. You may change your PCP up to three (3) times per Contract year.

Specialty Care Services

As an Open Access POS member, you have the freedom to receive care from specialists without referrals. You have the option to visit an In-Network or Out-of-Network provider. Your Subscriber Contract has an Out-of-Network option for all doctors other than your PCP. This Out-of-Network option allows you to receive care from a provider who is not contracted with Atlantis. Remember, however, when using Out-of-Network providers you will be responsible for the Out-of-Network deductible and co-insurance, and any portion of the provider's charge in excess of the applicable Atlantis usual, reasonable and customary fee schedule. In addition, some Out-of-Network provider services must be

Pre-authorized by Atlantis. Please refer to your Subscriber Contract and Page 11 in this handbook for more information on the Pre-authorization process.

Specialist as Primary Care Provider

As a new Member upon enrollment, or a current member upon diagnosis with a life-threatening condition or disease or a degenerative and disabling condition or disease, either of which requires specialized care over a prolonged period of time, you may request to elect an AHP Specialist as your PCP. As the designated Specialist/PCP, he/she will be responsible for providing and coordinating all of your primary and specialty care. The Specialist will be able to order tests, arrange procedures and medical services in the same capacity as a PCP. To become a Specialist/PCP, he/she must have the necessary qualifications and expertise to treat your condition or disease. This election will be permitted only if the AHP Medical Director, after consulting with both your Specialist and your original PCP agree that your care would most appropriately be coordinated in this manner.

You, the Specialist, and/or your original PCP may call the Atlantis Utilization Management Department at 800-270-9072 to request this election.

Choosing/Changing Your Specialist

You have the option to receive specialty care from In-Network and Out-of-Network providers. As always it is best to use In-Network providers to avoid charges associated with co-insurance/deductibles applied if you use an Out-of-Network provider. Visit our website www.atlantishp.com for the most up-to-date online Provider Directory or request from Member Services a hard copy of the current Provider Directory to help you find a provider at a location nearest to you. You may also call Member Services to assist you over the phone in choosing a new provider. We will be happy to help you locate a provider that best suits your needs.

Out-of-Network Benefits Treated on an In-Network Basis

Under certain circumstances, Atlantis may treat Out-of-Network specialty care on an In-Network basis. Utilization Management considers the following situations for an appointment to Non-Participating Provider:

- If the Plan does not have a healthcare provider with appropriate training and experience in the network to meet the particular needs of a Member.
- If the Plan deems it necessary to use providers outside the Network and approves such care in writing.
- If the first opinion concerns a diagnosis of cancer (either negative or positive) or a recurrence of cancer or a recommendation for a course of treatment for cancer, the Plan will approve coverage for a second medical opinion from a Non-Participating Specialist, including but not limited to a specialist affiliated with a specialty care center for the treatment of cancer. This is at no additional cost to you beyond what you would have paid for services from a Participating appropriate specialist.
- If a member has a life threatening condition or disease or degenerative and disabling condition or disease, which requires prolonged specialized medical care, the Plan may approve an appointment to an Out-of-Network specialist to provide and coordinate the Member's primary and specialist care. The Plan may limit the number of visits or period of authorization and require the specialist to provide information to the Member's Primary Care Provider.
- If a member has a life threatening condition or disease or degenerative and disabling condition or disease, which requires prolonged specialized medical care, the Plan may approve an appointment to a designated or accredited specialty care center.

The Plan does not cover travel expenses associated with Out-of-Network appointments to specialty care centers even if significant travel is required unless travel is included in the rate of payment negotiated with the specialty care center.

Process for Handling and Resolving Out-of-Network Appointments
To request an appointment to an Out-of-Network provider, please call Health Services at 800-270-9072. Evaluation of the Member's condition will be determined by the Atlantis Health Plan Medical Director to determine if such an appointment is appropriate and medically necessary. The appointment will be provided pursuant to a treatment plan that has been approved by the Atlantis Health Plan Medical Director. If approved, this care will be provided at no additional cost to you beyond what you would otherwise pay for services received within the network.

Covered Services

As an AHP member, your benefits package is one of the most comprehensive available today. Basic primary care and preventive benefits are available through your In-Network Primary Care Provider. These benefits include periodic physical examinations, annual gynecological examinations and pap smears, Well-Child care and immunizations, routine mammograms, health education services, periodic eye and hearing examinations, routine allergy injections, treatment for routine illness or injury as well as after hours, or urgently needed care. Basic primary and preventative benefits must be received by a Participating Provider. All Covered Services must be medically necessary.

Urgent Care After-Hours

If your medical situation is *not* an emergency but still requires urgent medical attention **Call Your Primary Care Provider**. Your PCP has agreed to be available to you for urgent care, personally or through another Participating AHP Provider, twenty-four (24) hours a day, seven (7) days a week. These hours include holidays. Be sure to call during normal office hours for routine situations and only call after hours in URGENT situations. If necessary, leave a message with the answering service and the doctor will return your call.

Emergency Care

What is a Medical Emergency?
A medical emergency is defined as follows: 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 afflicted Member with such condition in serious jeopardy, or, in the case of a behavioral condition, placing the health of such Member or others in serious jeopardy;
- √ Serious impairment to the Member's bodily functions;
- √ Serious dysfunction of any bodily organ or part of such Member; or
- √ Serious disfigurement of such Member.

Emergencies that do not require prior Authorization

Some examples of Medical Emergencies are:

- Severe Chest Pains
- Shortness of Breath
- Loss of Consciousness
- Uncontrolled Breathing
- Poisoning

Some examples of situations that are usually NOT Medical Emergencies:

- Earaches
- Pink Eye
- Fatigue
- Sprains & Strains
- Poison Ivy
- Colds, Coughs, & Sore Throats

If you believe that you or a covered family member has a medical emergency:

- Go to the nearest hospital emergency room or call 911 if the condition warrants it.
- Call your Primary Care Provider within forty-eight (48) hours after the emergency visit, or as soon as is reasonably possible.

Emergency Services within the Service Area:
AHP covers Emergency Services one hundred percent (100%), after applicable member financial responsibilities. The following guidelines should be followed for services to be covered:

- Your PCP, or covering provider, is available for emergency consultation (24) hours a day, (7) days a week, to include holidays.
- Your PCP will coordinate or provide follow-up care that you may require after your emergency visit.

You can use the emergency room of the nearest hospital for emergency medical attention. The facility does not have to be a Participating Facility. If necessary, Atlantis Health Plan will make a determination as to whether or not the situation was an emergency, based on your medical records from the emergency facility. You will be responsible for all charges for care that does not meet the definition of an emergency as stated above.

Emergency Services Outside of the Service Area:
As an AHP member, you are covered for emergency care, for as long as the emergency exists, even if the emergency happens outside of the service area. If you have an emergency situation outside of the AHP service area, you should do the following:

- Seek treatment at the nearest emergency facility
- Call your Primary Care Provider and AHP as soon as possible
- Consult with your PCP for any follow-up care that needs to be provided

Emergency Care: Student Rider Participants
If your benefits include a Student Rider then full time students living outside of the Service Area may receive coverage for Emergency Services. All other routine and specialist visits must be obtained from a Participating Provider within the Service Area.

Remember:

- The back of your Atlantis Membership Identification card has the telephone number where emergency providers can call if there are questions about your coverage
- Atlantis will encourage them to bill the plan directly. If it is necessary for you to pay for the services, and you believe that it is the responsibility of Atlantis Health Plan, please refer to the section on “Submitting Claims” in this handbook.

Using Out-of-Network Benefits

Some services require a Pre-authorization from Atlantis before the visit. When using Out-of-Network benefits, members are fully responsible for obtaining all required Pre-authorizations for these services. The member must obtain approval from Atlantis in advance with regard to services that are outlined in the Pre-authorization list. If you do not contact Atlantis in advance, you will be subject to a penalty and will be responsible for 50% of the cost of the service in addition to any deductible and or co-insurance. Please refer to Page 11 in this handbook for more information on Pre-authorization.

Before electing to use Out-of-Network benefits we recommend that you carefully review the “Summary of Benefits” for limitations, coinsurance, deductibles, annual and lifetime maximums on Out-of-Network benefits. You are encouraged to call Member Services prior to receiving such services to verify coverage and cost sharing arrangements. Upon written request, you may also obtain the Atlantis reimbursement amount for a particular elective surgical procedure or treatment. The request should be sent to Member Services. Please provide details on the procedure, to include the procedure name, CPT code (if available) and or your provider’s name, address and telephone number.

Submitting Claims

Atlantis makes payment for Medical and Hospital Services to the provider of services or, at its sole discretion, directly to the Member. Atlantis’ liability to the Member for bills for Covered Services is limited to bills received by Atlantis within twelve (12) months of the date of service.

With respect to **In-Network services**, it is not anticipated that a Member will make payment other than any applicable co-payment to any person or institution providing benefits under the Contract. If the Member furnishes evidence to

Atlantis that he or she has made such other payments with respect to services, payment will be made to the Member.

Claims for **Out-of-Network services** should be submitted directly to Atlantis. Claims forms are available by calling Member Services at 866-747-8422. The completed claim should be mailed to:

Atlantis Health Plan, Inc.
Member Claims
45 Broadway, Suite 300
New York, NY 10006

Be sure the bill contains the name and address of the provider of service, a diagnosis, service code, date, and amount billed for each service. Claims missing information will be returned. Balance bills, photocopies, and faxes are not acceptable.

If you are Billed by a Provider
Any bills received by a Member directly from a provider should be brought to the attention of Atlantis Health Plan's Member Services Department 866-747-8422. Co-payments, co-insurance and deductibles may still apply. Most claims for services will be paid directly by the Plan if the services received are In-Network and the appropriate Pre-authorization is given. Because of this process, you will probably never receive a bill for appropriately authorized or In-Network medically necessary Covered Services. However, there are instances where you or another group health plan is responsible for the bill. Examples of these instances follow:

- If AHP is not the primary insurance carrier as more fully described in the Coordination of Benefits section of your Subscriber Contract.
- If you receive services which are not covered by AHP as more fully described in the exclusions and limitations section of you Subscriber Contract.
- If you receive services, or care from a doctor or hospital (when the situation is not an emergency) without obtaining Pre-authorization first.
- If you receive care in an emergency facility in your service area when it was not an emergency, or if you receive follow-up care as a result of an emergency when the follow-up care was not authorized by your PCP.

Please check your Certificate of Coverage for information on covered benefits and exclusions.

Second Opinions

There may be instances when you will disagree with a provider's recommended course of treatment or surgical recommendation. In such cases, you may receive a second opinion or second surgical opinion from another Participating Provider. You must pay the normal office visit co-payment for second opinions that you request. You, the Specialist, and/or your original PCP may call the Atlantis Utilization Management Department at 800-270-9072 to request a second opinion.

In some instances, we may require a second opinion before Pre-authorizing certain procedures. If AHP requests a second opinion, the member must go to a physician chosen by AHP for services to be covered. There is no cost to you when we request a second opinion if services are received by the physician chosen by AHP.

If the first opinion concerns a diagnosis of cancer (either negative or positive) or a recurrence of cancer or a recommendation for a course of treatment for cancer, you may request a referral from your attending physician to access a Non-Participating Provider Specialist for a second opinion, including a specialist affiliated with a specialty care center for the treatment of cancer. This is at no additional cost to you beyond what you would have paid for services from a Participating appropriate specialist.

Pre-authorization

In-Network Pre-authorization
Pre-authorization means obtaining the Plan's approval before you receive a medical service or supply. In-Network Participating Providers have been provided with a list of all services that require prior approval and will communicate directly with the Plan in order to receive such approval. In general, Pre-authorization is required for certain medications, all elective inpatient admissions, all outpatient surgical procedures, certain diagnostic and treatment procedures and some medical equipment. Upon receipt of a request for Pre-authorization by your physician, Atlantis

will review the clinical findings for Medical Necessity. If the proposed admission, procedure, service or supply is a Covered Service and we agree that it is Medically Necessary, approval will be given to the physician. This prospective utilization review assures that the treatment you receive is appropriate for you and is delivered in the most cost-effective setting.

Out-of-Network Pre-authorization
If you choose to receive Out-of-Network Services, ***you*** will be responsible for obtaining approval from Atlantis in advance of all non-emergency hospital admissions, elective inpatient admissions, all outpatient surgical procedures, certain medications, certain diagnostic and treatment procedures, facilities and some medical equipment. The list of procedures requiring Pre-authorization is enclosed with your Welcome Package. The list is updated from time to time by Atlantis. All updates to the list will be sent to you by mail.

Members must complete the Pre-authorization process with Atlantis prior to an elective admission to a Non-Participating Hospital, or when admitted to a Plan hospital by a Non-Participating Physician. Pre-authorization for inpatient services includes, all elective hospital admissions, both maternity and non-maternity, as well as facilities for hospice, mental health, rehabilitation care, and skilled nursing.

Your Subscriber Contract provides complete instructions on the Pre-authorization process.

Hospital Services
Pre-authorization is necessary for any hospital admission and/or outpatient surgery you may need, unless you are admitted on an emergency basis.

When using In-Network benefits for elective hospital services, you will be admitted to the hospital where your Primary Care Provider or specialist is affiliated. All non-emergency hospital admissions must be Pre-authorized by AHP. The Participating Provider will contact Atlantis for Pre-authorization. All appropriately Pre-authorized hospital services are covered one hundred percent (100%), after payment of the required co-payment, co-insurance and deductibles if applicable.

If you are admitted to a Non-Participating Hospital because of an emergency, you may be transferred to an AHP Participating Hospital when you are stable enough in order for your AHP doctor to treat you. There will be no additional cost to you for the transfer.

*When using Out-of-Network benefits, ***you*** must obtain approval from Atlantis in advance of any elective ambulatory surgery or proposed hospital admission. A penalty of 50% of the cost of the case per each non-authorized occurrence will be deducted from Atlantis' payment.

Transitional Care

Existing Members
If a member's healthcare provider leaves the Plan's network for reasons unrelated to quality of patient care, question of imminent harm to patients, fraud, or disciplinary action, the Plan will allow the Member to request to continue an ongoing course of treatment with the provider for a transition period of no less than 90 days, that begins when the Participating Provider's contractual obligation to provide services to Atlantis members terminates or exhaustion of benefits, whichever comes first. In the case of a pregnancy that has entered the second trimester at the time of the provider's disaffiliation; the transitional period will include the provision of postpartum care directly related to the delivery.

Please call Atlantis customer service at 1 (866) 747-8422 to request such transitional care.

New Members
The Plan will allow a new member to continue an ongoing course of treatment with an existing provider if the Member has a life threatening condition or disease or degenerative and disabling condition or disease for a transitional period of up to sixty (60) days from the Effective Date of enrollment. In the case of a Member who has entered the second trimester of pregnancy at the time of enrollment, the transitional period will include the provision of post-partum care directly related to the delivery.

Transitional care will only be authorized if the healthcare provider agrees to the following:
(1) To accept AHP's reimbursement rates as payment in full;
(2) To adhere to AHP's quality assurance requirements and to provide the necessary medical information related to

such care; and
(3) To otherwise adhere to AHP policies and procedures including, but not limited to procedures regarding referrals and obtaining Pre-authorization and a treatment plan approved by AHP.

Experimental and/or Investigational Treatment Procedures

Experimental and investigational therapies or procedures are healthcare modalities, which are undergoing evaluation in clinical trials to determine their efficacy on a disease or injury. Depending upon the period during the evaluation, the experimental and investigational therapies or procedure may or may not have been deemed safe and/or effective by the Food and Drug Administration (FDA) or National Institutes of Health (NIH).

Upon written request, AHP will evaluate the experimental and investigational therapy or procedure for authorization for use. If a more conventional treatment or procedure is available, and is similarly effective and appropriate, AHP may not authorize the experimental or investigational treatment or procedure. The determination for approval will be based upon medical necessity, safety, effectiveness and whether or not the procedure or treatment has received approval by the FDA or NIH. Lack of approval by FDA or NIH will not prevent it from being authorized if the procedure or treatment is the only medically appropriate option available.

Informed Consent Option

As a member of Atlantis Health Plan, you are entitled to obtain complete current information concerning a diagnosis, treatment and prognosis from a physician or other provider in terms and language you can understand. When it is not advisable to give such information to you, the information will be made available to an appropriate person on your behalf. In addition, you are entitled to receive information from a physician or other provider necessary to give informed consent prior to the start of any procedure or treatment. Lastly, you have the right to refuse treatment to the extent permitted by law and to be informed of the medical consequences of the action.

Advance Directives

You have the right to participate in decisions relating to your healthcare. Working with your doctor, you can decide whether to accept or reject proposed medical treatments. This right extends to situations where, because of your medical condition, you are unable to communicate with your doctor or the hospital. This is done by the creation of an Advance Directive.

An Advance Directive is a written, signed document that provides instructions for your care if you are unable to communicate your wishes directly. Depending on the state where you are receiving treatment, the most common forms of Advanced Directives are Living Wills and Durable Powers of Attorney. These documents instruct your healthcare providers how to proceed if you are not able to communicate with them.

Additionally, The New York State Healthcare Proxy Law allows an adult to designate another adult, such as a trusted friend or loved one who knows the person and his or her wishes, to make treatment decisions if the adult becomes incapacitated and is unable to do so.

You are not required to have an Advance Directive or proxy, however, if you are interested in obtaining further information or receiving the appropriate forms please call or write the AHP Member Services Department.

Pre-existing Condition Limitation

Please note in your Certificate of Coverage the information regarding Pre-existing Conditions, which may affect your coverage. A Pre-existing Condition is a condition (whether physical or mental), regardless of the cause of the condition for which medical advice; diagnosis, care or treatment was recommended or received within the 6 month period ending on the Covered Person's Enrollment Date. Definition of "Enrollment Date" is the first day of coverage of the individual under the policy or, if earlier, the first day of the waiting period that must pass with respect to an individual before such individual is eligible to be covered for benefits. The exclusion of coverage for a Pre-existing Condition is for an eleven (11) month period following the Covered Person's Enrollment Date. The Pre-existing Condition Limitation does not apply to members of Large Groups. Any Member whose prior coverage lapsed for more than a period of sixty-three (63) consecutive days will be subject to the full extent of the Pre-existing Condition Limitation. **It is the responsibility of a new member to AHP to submit proof of prior coverage when requesting**

for preauthorization of health services. The lack of HIPAA information can affect the approval of requested services.

Notice of Privacy Practices-HIPAA

THIS NOTICE INCLUDED IN YOUR WELCOME PACKAGE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

Member Financial Responsibilities

Member is responsible for pertinent premiums, co-payments, co-insurance and deductibles as applicable to the Member's specific plan and benefit coverage.

In-Network Co-payments
When using In-Network benefits, you will be responsible for co-payments for certain professional services. A co-payment is a portion of the cost of the service that you are responsible for at the time the service is received.

Co-payments for professional services apply to most "visits" to a physician or other provider. Co-payments are on a "per visit" basis so that a visit to a provider that involves more than one service, for example, a visit to an OB/GYN that involves lab tests, will only be subject to a single co-payment.

Out-of-Network Deductible
When accessing Out-of-Network benefits, you will be financially responsible for a certain accumulated amount before Atlantis begins reimbursing for services. This amount is referred to as the Contract Deductible.

Deductibles are per calendar year and apply to all enrollees in the Contract. Expenses incurred in the last three months of a calendar year may not be carried over and applied to the deductible for the ensuing year. The Summary of Benefits reflects the deductible you and any covered family member(s) must meet. Please remember that only Covered Services are applied to the annual deductible.

Out-of-Network Co-insurance
When accessing Out-of-Network benefits, you will be financially responsible for a percentage of the service after reaching your deductible. In general, the amount that you are responsible for is 20% plus the balance after Atlantis pays Usual, Customary or Reasonable (UCR) charges. In other words, for each service that is provided Out-of-Network, Atlantis will pay 80% of the amount approved for that service and you will be responsible for the balance. For example:

Provider Service Charge $300.00
Approved UCR $250.00
Atlantis Payment (80% of UCR) $200.00
Member Responsibility (After Deductible) $100.00

Please refer to your Summary of Benefits for co-insurance amounts that are applicable to specific benefits.

Out-of-Network Service Penalties
Members that receive Out-of-Network services without obtaining Pre-authorization on non-emergency inpatient admissions and elective surgical procedures will be held responsible for 50% of the cost of services. This 50% reduction in benefits is taken after calculating the available benefit, including any deductible and or co-insurance. Penalties are not applied to the annual Out-of-Pocket Maximum.

Out-of-Network Benefits Maximum
In each calendar year, you are responsible for a portion of the cost of most benefits. When using In-Network services, your share of the cost is called a co-payment.

On Out-of-Network benefits your share is called co-insurance. There is a maximum Out-of-Pocket expense for Out-of-Network services. The co-insurance amounts count towards your annual maximum. The prescription drug deductible and In-Network co-payments are **not** applied. Please refer to the Schedule of Benefits for the amount of your Out-of-Pocket Maximum.

Once the Out-of-Pocket Maximum is reached for a calendar year, we pay 100% of the Usual, Customary or Reasonable charge for Covered Services for that calendar year.

Excluded Services

Please refer to the Restrictions, Exclusions, and Limitations section of your AHP Subscriber Contract for a complete description of restrictions, exclusions and limitations to your benefits.

Utilization Review

Atlantis Health Plan's Utilization Department is open Monday through Friday from 9 a.m. to 5 p.m. and can be reached toll free at 800-270-9072. If you are unable to contact us during these times, you may leave a voice mail message and/or FAX your request to AHP at 212-747-8375 at anytime.

Utilization review is a process used by HMO's to monitor how physicians, hospitals and ancillary providers are providing services. Utilization Review is defined as the process of determining the necessity of medical services, either with regard to professional, institutional, experimental and/or investigational services. Utilization review will occur whenever judgments pertaining to medical necessity and the provision of services or treatments are rendered. AHP will not, during retrospective review, revise or modify the specific standards, criteria, or procedures used for the utilization review of procedures, treatment, and services delivered to the member during the same course of treatment.

There are three types of utilization review, which may be used at Atlantis Health Plan: Prospective, Concurrent and Retrospective. The following is a brief description of each and the time frames involved in each.

A. Prospective
Prospective utilization review is the process of determining medical necessity prior to the provision of the service. Prior approval and authorization of services, such as elective surgery, are examples of prospective utilization review.

Decisions regarding prospective utilization review will be completed in three (3) business days or less after AHP receives the necessary information with which to render a decision. You, your designee, and the provider will be notified by telephone and in writing of the determination.

B. Concurrent
Concurrent utilization review is the process of determining ongoing medical necessity while the service is being provided. Evaluation of the continued need for inpatient utilization is an example of concurrent utilization review. Decisions regarding concurrent utilization review will be completed within one (1) business day after AHP receives the necessary information with which to render a decision. You, your designee, and the provider will be notified in writing and by telephone, of the amount of extended services approved, a summary of all services approved to date, the dates and duration of services approved, and the date of the next concurrent review date.

C. Retrospective
Retrospective utilization review is the process of determining medical necessity after the service has been provided. Evaluation of Emergency Room utilization to determine if the conditions were met to conform to the definition of an emergency service is an example of retrospective utilization review.

Atlantis may reverse a Pre-authorized treatment service, or procedure retrospectively when:

1. The relevant medical information presented to the Plan or UR Agent is materially different from the information that was presented during the Pre-authorization review;
2. The relevant medical information presented to the Plan or UR Agent upon retrospective review existed at the time of the Pre-authorization but was withheld from or not made available to the Plan or UR Agent;
3. The Plan or UR Agent was not aware of the existence of the information at the time of review; and
4. If the Plan or UR Agent had been aware of this information, the treatment, service or procedure being requested would have not been authorized. The determination is to be made using the same specific standards, criteria or procedures as used during the Pre-authorization review.

Decisions regarding retrospective utilization review will be completed within thirty (30) days or less after Atlantis Health Plan receives the necessary information with which to render the decision. The member, member's designee, and provider will be notified in writing of the determination.

Failure by AHP to make a determination within the required time periods set forth in Article 49 of the Public Health Law shall be deemed to be an adverse determination subject to internal appeal.

Clinical Review Criteria
Atlantis Health Plan utilizes nationally recognized criteria as well as internal practice guidelines and standards for determination of clinical appropriateness. These criteria whether utilized internally or through delegation to an authorized external review agent, are selected, developed, approved, applied, managed and overseen by the plan's Utilization Management/Quality Improvement Committee with the support of administration, the medical directors, and the utilization management department, to ensure clinical consistency and appropriateness of all criteria utilized by AHP. Clinical review criteria and practice guidelines are reviewed annually or as necessary by the UM/QI committee. Along with industry recognized criteria, decisions and determinations are also based upon the clinical reviewer's knowledge and judgment on a case by case basis.

AHP clinical reviewers utilize InterQual criteria sets to assist in the review of inpatient, outpatient procedures, and imaging requests to confirm the appropriateness and medical necessity of the services. Complete criteria sets are maintained at AHP's administrative offices, and are available for reference to authorized entities, providers and subscribers upon request. *To ensure the appropriate release of criteria to members/providers when a review of requested health care services results in a determination to deny services or at any time during the review process, the request should be made to:*

Atlantis Health Plan, Health Services Department
45 Broadway, Suite 300
New York, NY 10006.

Appeal Procedures

Adverse determinations will only be made by a clinical peer reviewer of AHP when requested health services or a level of care are denied because they fail to meet the established written utilization review criteria of the plan for medical necessity and appropriateness of the level of care.

A clinical peer reviewer is a physician who possesses a current and valid non-restricted license to practice medicine, or a healthcare professional other than a licensed physician who, where applicable, possesses a current and valid non-restricted license, certification or registration or, where no provision for a license, certificate or registration exists, is credentialed by the national accrediting body appropriate to the profession and is in the same profession/specialty as the healthcare provider who typically manages the medical condition.

Notices of adverse determination are made in writing and include:

- √ The reasons for the determination
- √ The clinical rationale, if any,
- √ Instructions on how to initiate an appeal
- √ Notice of availability of the clinical review criteria upon which the determination was based, upon request of the member or the member's designee,
- √ Specification of any additional information which should be provided to, or obtained by the plan in order to render a decision on the appeal. As a member you have the right to designate a representative to file an appeal. Only qualified clinical personnel will review appeals.

You, your designee, or your healthcare provider may request from AHP a reconsideration or appeal of the adverse determination. Various types of appeals and time frames for responses are provided for, depending on the following circumstances under which the adverse determination was made:

- Reconsideration within one (1) business day of receipt of the request;
- Expedited appeal with access to a clinical peer reviewer within one (1) business day and a determination completed in two (2) business days of receipt of necessary information to conduct the appeal.
- Standard appeal with a determination completed within sixty (60) days of receipt of necessary information to conduct the appeal. AHP will issue written notification of the appeal determination within two (2) business days.
- Retrospective review determination is made within thirty (30) days of receipt of necessary information with which to render the decision.

Failure by AHP to make an appeal determination within the applicable time periods set forth in Article 49 of the Public Health Law shall be deemed to be a reversal of AHP's initial adverse determination.

Internal Appeal Procedures

1. Except in cases of adverse determinations made during retrospective review, when an adverse determination is made without attempting to discuss the plan of care with the healthcare provider who specifically recommended the healthcare service, procedure or treatment under review, the provider may request a reconsideration of the adverse determination.

Reconsideration will occur within one (1) business day of receipt of the request, and will be conducted between the member's healthcare provider and the clinical peer reviewer who made the initial determination (or a designated substitute if the original reviewer is not available).

If the adverse determination is upheld after reconsideration, AHP will issue a written notice of adverse determination within one (1) business day after the determination. The member or the member's designee or the member's healthcare provider may then proceed to further appeal the decision using either the expedited appeal or the standard appeal, as defined below.

2. Except in cases of adverse determinations made during retrospective review, an Expedited Appeal is allowed in situations involving:

a. Continued or extended healthcare services, procedures or treatments or additional services for a member undergoing a course of continued treatment prescribed by a healthcare provider;

b. The healthcare provider believes an immediate appeal is warranted. AHP will provide the member's healthcare provider with reasonable access within one (1) business day of receiving notice of the taking of an expedited appeal, to a clinical peer reviewer other than the clinical peer reviewer who rendered the adverse determination.

The clinical peer reviewer will render a determination within two (2) business days of receipt of necessary information to conduct the appeal.

Expedited appeals, which do not result in a resolution satisfactory to the appealing party, may be further appealed through the standard appeal process, as defined below, or a request can be made for an external appeal (refer to page 21–External Appeal Procedure)

3. Except in cases of adverse determinations made during retrospective review, a Standard Appeal process is required in all other situations than those described above.

These appeals may be filed in writing or by telephone. To file a standard appeal of an adverse determination, an appealing party has no less than forty-five (45) days after the member receives a notice of adverse determination and AHP receives all necessary information to conduct the appeal.

AHP will send written acknowledgment of receipt of the appeal to the appealing party within fifteen (15) days of the date of the appeal. AHP will assign a clinical peer reviewer other than the one who rendered the adverse determination, and the appeal determination will be rendered within sixty (60) days of receipt of information necessary to conduct the appeal.

Thereafter, AHP will issue written notification of the appeal determination within two (2) business days to the member, the member's designee and the member's healthcare provider. This notice will include reasons for the determination, with the clinical rationale provided where the adverse determination is upheld on the appeal and notice of the member's right to external appeal and the timeframes for such external appeals.

4. Retrospective review determinations involve services, which have already been delivered to the member. An appeal or reconsideration of adverse determinations of this type will comply with the procedures of the standard appeal except that the appeal determination must be made within thirty (30) days of receipt of information necessary to conduct the appeal. AHP will assign a clinical peer reviewer other than the one who rendered the adverse determination.

External Appeal Procedure
You may file an application for an external appeal by a state approved external appeal agent if you have received a denial of coverage based on medical necessity or because the service is experimental and/or investigational.

To be eligible for an external appeal, you must have received a final adverse determination (FAD) as a result of AHP's first-level utilization review (UR) appeal process or both you and AHP must jointly agree to waive the UR appeal process. An external appeal application will be attached to the FAD that you receive from the Plan.

The application will provide clear instructions for completion. You must include $50.00 with the application. Your healthcare provider may not charge you for this fee. This money will be refunded if the external appeal is decided in your favor. You may obtain a waiver of this fee if you meet AHP's criteria for a hardship exemption. To apply for this exemption, please call our Member Services Department at 866-747-8422.

The external appeal application will instruct you to send the completed form 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 independent external appeal agent approved by the State will review your request to determine if the denied service is medically necessary and should be covered by AHP. All external appeals are conducted by clinical peer reviewers certified by the State. The agent's decision is final and binding on both you and AHP.

The application for external appeal must be made within forty-five (45) days of your receipt of the notice of final adverse determination as a result of AHP's first-level appeal process, or within forty-five (45) days of when you and AHP jointly agree to waive the internal appeal process. The Plan does not require you to exhaust the second level of appeal to be eligible for external appeal.

However, regardless of whether you participate in this additional AHP internal appeal process, an application for external appeal must be filed with the New York State Department of Insurance within forty-five (45) days from your receipt of the notice of final adverse determination from AHP's first-level appeal to be eligible.

You will lose your right to an external appeal if you do not file an application for an external appeal within forty-five (45) days from your receipt of the final adverse determination from the first level internal plan appeal.

An external appeal agent must decide a standard appeal within thirty (30) days of receiving your application for external appeal from the state. Five (5) additional business days may be added if the agent needs additional information. If the agent determines that the information submitted to it is materially different from that considered by AHP, AHP will have three (3) additional business days to reconsider or affirm its decision. You and AHP will be notified within two (2) business days of the agent's decision.

You may request an expedited 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. Every reasonable effort will be made to notify you and AHP of the decision by telephone or fax immediately. This will be followed immediately by a written notice.

In the event an adverse determination is overturned on external appeal, or in the event that AHP reverses a denial, which is the subject of external appeal, AHP shall provide or arrange to provide the healthcare service(s), which is the basis of the external appeal to you.

If you are no longer insured by AHP at the time of an external appeal agent's reversal of AHP's utilization review denial, AHP will not be required to provide any healthcare services to you. You, your designee or your healthcare provider, may request an external appeal of a retrospective adverse determination if the services in question were denied based on medical necessity and/or were considered experimental and/or investigational.

Contact Information for External Appeals:

- The New York State Department of Insurance at 800-400-8882, or its website (www.ins.state.ny.us)
- The New York State Department of Health **website only** (www.health.state.ny.us) or
- Our Member Services Department at 866-747-8422.

The Grievance Process

AHP attempts to solve your problems or complaints through the Member Services Department in an efficient manner. You may file a complaint or grievance regarding services provided by Atlantis Health Plan (AHP) or a contracted practitioner and/or facility, denial of access to a referral, a requested benefit that is not covered pursuant to the contract provisions, or concerning the professional and/or business conduct of AHP, employees, contracted practitioners and/or their employees or personnel. A member may also submit a verbal or written request to review an adverse determination concerning an administrative decision not related to medical necessity, for example, the processing and payment of a claim, balance billing etc.

AHP has established the following grievance policy and procedure for use by its members.

1. For purposes of clarity, the term *grievance* or *complaint* may be used interchangeably.
2. Qualified clinical personnel will make determination of all complaints involving clinical decisions.
3. AHP will allow only qualified personnel to make determinations with regard to the provision of your benefits. Any denial will be accompanied by an explanation and a basis behind the decision and further appeal rights.
4. AHP will not retaliate or take any discriminatory action against the member because they filed a complaint or appeal.
5. The member has the right to designate a representative to file complaints and appeals on his behalf. Any member who wants to access the grievance process, but is unable to put his/her grievance into writing due to a disability and/or lack of literacy may contact the AHP Member Service department. The Member Service Representative will then document the member's grievance. In the event, a non-English speaking member files a grievance, AHP will arrange to have an interpreter available.
6. The member has a right to file a complaint verbally when the dispute is about referrals or covered benefits. To file a complaint verbally, please call AHP Member Services Department at **866-747-8422.** To send a written grievance or a complaint, please address your letter to:

Atlantis Health Plan, Grievance Dept.
45 Broadway, Suite 300
New York, NY, 10006

Members may contact the State Insurance or Health Department at any time during the complaint process. Listed below are the toll-free telephone numbers for each Agency.

New York State Department of Health
800-206-8125
90 Church Street
New York, New York 10007

New York State Department of Insurance, Consumer Services Unit
800-342-3736
25 Beaver Street
New York, NY 10004

7. Each complaint will be promptly investigated and AHP will provide a member with a response to a complaint or grievance within thirty (30) days of receipt of all necessary information in the case of requests for referrals and/or for dispute involving member Contract benefits and forty-five (45) days for all other disputes. AHP will give a response within forty-eight (48) hours after receipt of all necessary information when a delay would significantly increase the risk to the member's health. The notification will be made within three (3) business days after a decision is rendered. The notice of determination shall include (i) detailed reasons for the determination; (ii) in cases where the determination has a clinical basis, the clinical rationale for the determination without releasing protected peer review information or a written statement that insufficient information was presented or available to reach a determination; and a procedure for filing an appeal of the determination.

Members who are dissatisfied with the Plan's handling of a complaint or who receive a claim denial from AHP may file a Grievance. To make this process more accessible to non-English speaking members, AHP can arrange to have an interpreter available who speaks your language. You also have the right to file a complaint orally when your dispute is about referrals or covered benefits.

The following timeframes apply to the Grievance Appeal Procedure:

1. The Member or designee has at least 60 business days after receipt of the notice of the complaint determination to file a grievance appeal.
2. Grievance appeals should be submitted in writing, on a form provided by AHP.
3. Personnel qualified to review the complaint, including licensed, certified or registered healthcare professionals who did not make the initial determination will decide grievance appeals related to clinical matters.
4. Qualified personnel at a higher level than the personnel who made the original complaint determination will make grievance appeal determinations relating to non-clinical matters.
5. Appeals will be decided and notification provided to the Member no more than:
   - 2 business days after the receipt of all necessary information when a delay would significantly increase the risk to a Member's health.
   - Thirty (30) business days after the receipt of all necessary information in all other instances, including requests for referrals.
6. The written notice of an appeal determination will include the following:
   - Detailed reasons for the determination;
   - The clinical rationale if applicable, without releasing protected peer review information;
   - Atlantis Health Plan does not provide any other level of appeals after this level has been exhausted.

For all grievances and grievance appeals AHP shall provide written acknowledgment within 15 business days of receipt. The letter will include the name, address and telephone number of the individual designated to respond to the grievance/grievance appeal. AHP will indicate what additional information, if any must be provided for AHP to render a decision.

Member Rights & Responsibilities

As an Atlantis Health Plan Member, you have the following RIGHTS AND RESPONSIBILITIES:

1. To obtain complete, current information concerning a diagnosis, treatment and prognosis from a physician or other provider in terms that you can be reasonably expected to understand. When it is not advisable to give such information to the Member, the information will be made available to an appropriate person on the Member's behalf;
2. To receive information from a physician or other provider necessary to give informed consent prior to the start of any procedure or treatment; and to refuse treatment to the extent permitted by law and to be informed of the medical consequences of that action.
3. To participate in decisions relating to your healthcare. Working with your doctor, you can decide whether to accept or reject proposed medical treatments. That right extends to situations where, because of your medical condition, you are unable to communicate with your doctor or the hospital. This is done by the creation of an Advance Directive.

As a Member or Prospective Member, you also have the RIGHT to request AHP to provide:

1. A list of the names, business addresses and official positions of the board of directors, controlling persons, owners or partners of the health maintenance organization
2. A copy of the most recent annual AHP certified financial statement, including a balance sheet and summary of receipts and disbursements prepared by a certified public accountant;
3. A copy of the most recent individual, Direct Pay Subscriber Contracts;
4. Information relating to consumer complaints compiled pursuant to section two hundred of the insurance law;
5. AHP procedures for protecting the confidentiality of medical records and other Member information;
6. To inspect drug formularies, if used by AHP, and obtain information on whether individual drugs are included or excluded from coverage;
7. A written description of the quality assurance procedures used by AHP;
8. A description of the procedures followed by AHP in making decisions about the experimental or investigational nature of individual drugs, medical devices or treatments in clinical trials;
9. A list of individual health practitioner affiliations with Participating Hospitals, if any;
10. Specific written clinical review criteria relating to a particular condition or disease and, where appropriate, other clinical information which AHP might consider in our utilization review, along with how it will be used in the utilization review process, provided, however, that the information is only used by you in evaluating the Covered Services provided by AHP;
11. A copy of the application procedures and minimum qualification requirements for healthcare providers to be considered by AHP; and
12. Other information as required by the New York State Insurance Commissioner provided that such requirements are promulgated pursuant to the state administrative procedure act.

Member Services Department

AHP's Member Services Representatives are available to answer any questions you may have about the Plan. Please call us to request an additional identification card, change primary care physicians, report an emergency or request clarification on a particular benefit. Call AHP's Member Services Department: at **866-747-8422** or you may FAX us at **212-747-0843.** If you prefer to contact us in writing, please send all correspondence to:

Atlantis Health Plan
Member Services
45 Broadway, Suite 300
New York, New York 10006

Membership Issues

There are two types of membership with Atlantis:
1. You are an employee or member of a Group who remits premium payments to Atlantis on your behalf;
2. You apply directly to Atlantis and make direct premium payments for your health insurance coverage. This Contractual arrangement is referred to as Individual Membership Contract or Direct Payment coverage.

Your Subscriber Contract provides details on eligibility and enrollment in the Plan. Please carefully review the terms and conditions of coverage. As a reminder, the following membership regulations apply:

Member Eligibility
To be eligible to enroll as a Group Member, you must be an employee or member of an organization having a Remittance Agreement with Atlantis Health Plan, meet the eligibility requirements of the Group, and reside, live or work in the Plan's service area.

To be eligible to enroll as an Individual Membership Subscriber, you must meet the eligibility requirements under the Individual Contract, or meet the Individual Conversion Privileges guidelines, and live in the Plan's service area.

Enrollment
- Effective enrollment of the Subscriber and any dependents listed on the application form is subject to AHP acceptance of the Subscriber and his or her dependents.
- All dependent children must be unmarried and within the age limits stated in the Subscriber.
- Contract or any attached Rider.
- Dependent children with developmental disabilities, or a physical handicap over the age of nineteen (19), who cannot support themselves due to their condition, may qualify for continued membership as a dependent. However, the condition must have been documented by a Participating AHP Primary Care Provider, and must have existed before the dependent reached the age of nineteen (19).

Enrollment Changes
It is important to notify AHP whenever there is a change in your family status. AHP automatically covers newborn or newly adopted children for the first thirty-one (31) days of their lives. However, in order for the dependent's claims to be covered during this period, you are required to complete an AHP "change in dependent status" form, pay any additional premium or contribution and submit it to AHP within the thirty-one days.

Should you get married and wish to change from single to family status, or convert a family Member who is no longer eligible as a dependent to his/her own coverage, please notify us.

Group members should submit notification of changes to your employer or remitting agent. If the form is not submitted in a timely fashion, you may have to wait until the next open enrollment period to add a child or spouse to the Plan or make other changes to your family status. Please refer to your Subscriber Contract for more details.

Benefit Coverage
Timely payment of premiums is required in order to continue healthcare coverage and benefits. The Plan may terminate coverage and benefits based on non-payment of premiums as defined in the Subscriber Contract and or Group Remittance Agreement.

Coordination of Benefits for Group Members
If you are covered under any other health insurance plan, tell your doctor and AHP. Any time more than one Group health insurance policy is effective for an individual, the insurance companies must coordinate their payments to ensure all Covered Services are paid, and that the combined payments do not exceed the charges for the services rendered.

The rules that determine which insurance carrier is primary or secondary are standard in the insurance industry. However, all AHP procedures must be followed in order for AHP to assume payment, even if AHP coverage is not primary. **Should you have questions about Coordination of Benefits after carefully reading the information in your Subscriber Contract, please call the AHP Member Services Department at 866-747-8422.**

Subrogation
If you or a dependent receive medical care due to an injury or illness resulting from negligence of another party, the at-fault party can be held financially responsible for the medical care received as a result of the incident. When requesting health services as a result of the incident, please notify the UM department @ 800-270-9072.

Termination of Coverage
Your coverage and or the coverage of your dependents may terminate for the following reasons:

- If your premium is not paid per Contractual terms.
- If you move outside the service area (unless you continue to work in the area and receive all of your covered healthcare within the AHP service area).
- If you use your AHP ID card in a fraudulent manner.
- If an employer provides your group coverage and you leave the company.
- If you decide to cancel the Contract with AHP or the group remittance agreement is canceled by the remitting agent.
- If AHP decides to discontinue this class of HMO Contract.

Coverage for dependents and or your spouse will end:

- If your marriage is terminated, coverage for your spouse will end on the date of your divorce or annulment.
- If a dependent ceases to meet eligible age requirements, coverage will end on the last day of the month in which the qualifying age was met.
- If Atlantis Health Plan finds the member's behavior to be abusive or unlawful to the extent that they pose a potential threat to Atlantis providers and/or staff.

Continuation of Group Coverage
Should you or your dependents become ineligible for coverage through your current group, you may be able to continue the coverage if you qualify as required by the Federal Consolidated Omnibus Budget Reconciliation Act (COBRA) or the laws of the State of New York. Please contact your employer for further details of this and other applicable laws.

Conversion to Individual Membership
If you or a Covered Dependent are not eligible for continuation of group coverage, you may convert to an individual membership Contract with Atlantis on a Direct Payment basis.

Please Note: Prescription, vision and or any dental "Riders" which may have been available to you from your group remittance coverage ARE NOT convertible to individual membership coverage. A complete description of enrollment regulations may be found in your Subscriber Contract.

Medical Information & Records
As a Member of AHP, you authorize any healthcare provider to provide AHP, or its designee, with medical information/records for yourself as Subscriber, or for any dependents as listed on your application form.

Governing Agreement
The rights and responsibilities of Members are defined in the Subscriber Contract and should any discrepancy occur between the Subscriber Contract and any other Plan literature, the Subscriber Contract is the governing Agreement.

Independent Contractors
All AHP Participating Primary Care Providers, as well as all other healthcare providers are independent Contractors. In other words, they are not employees or agents of Atlantis Health Plan.