GLOSSARY OF COMMONLY USED TERMS

Types of Plans:

- **HMO:** Plan whereby members are required to utilize providers that are part of the Atlantis Health Plan Network (click on the following link to search the **NY network** http://atlantishp.com/search/index.asp.
- **POS:** Plan which gives members the choice to utilize providers that are part of the Atlantis Network (in-network) or any others that are not part of the Atlantis network (out-of-network).

In-Network Provider: A physician, hospital, or other healthcare professional that is under contract with Atlantis Health Plan to provide care to members.

Out-of-Network Provider: A physician, hospital, or other healthcare professional that is not under contract with Atlantis to provide care to members.

Co-payments: The amount paid by members when receiving medical care (Range: $20-$40 each visit, depending on plan chosen).

Deductible: A flat dollar amount members pay before insurance starts to pay for covered expenses. This amount only applies to services rendered by out-of-network providers. (Range: $500-$2,500, depending on plan chosen).

Coinsurance: The set percentage members pay of the total cost of healthcare expenses. In most traditional plans it only applies to out-of-network providers.

Hospital Co-payments: All plans provide benefits for various hospital services, including inpatient care (surgery and room), outpatient surgery, and emergency room visits. The amount an employee/member pays toward the overall cost of hospital services varies by plan and whether the hospital and/or the admitting physician are “in-network”. (Range: $250-$500 or deductible and coinsurance).

Lifetime Maximum Benefit: The Lifetime Maximum Benefit is the total dollars that will be paid under the plan, per covered member. All plans have unlimited in-network benefits with an out-of-network maximum of $1,000,000.

Pharmacy Benefits: Prescription benefits are included. Plans B, C, E and F include a 3 tier co-pay with no annual deductible. Plans A and D include a 2 tier co-pay with a $250 annual Rx deductable for all brand name drugs with a $2,000 annual maximum. This annual maximum may be of concern if you have high prescription costs.

Pre-existing Conditions: Medical conditions diagnosed 6 months prior to the health insurance becoming effective may be excluded from coverage for up to 12 months after your coverage becomes effective, unless proof of creditable prior coverage (HIPAA certificate, present carrier bill or copy of your current insurance card) is provided.

FREQUENTLY ASKED QUESTIONS

1. **How do I know if my physician accepts Atlantis?**
   You may ask your physician or visit http://atlantishp.com/search/index.asp to search for participating physicians/hospitals in NY. Currently the network consist of approximately 10,000 physicians, providing healthcare services in over 25,000 location and 42 hospitals, mostly concentrated in the NYC and surrounding areas (see FAQ 3 for other areas).

2. **My physician/hospital is not on the list. Should I still sign up for coverage?**
   Yes, you should still consider signing up for a plan with out-of-network benefits. Keep in mind that all options with out-of-network benefits have deductibles and coinsurance requirements (see plan options and glossary of terms).

3. **I live or work in Westchester, NJ or CT. Can I still sign up for coverage?**
   Yes, as long as you live or work in one of the five boroughs of NYC.

4. **If I am traveling out of town and/or internationally and need to go to the emergency room, will my coverage still be valid?**
   Medically necessary visits to the emergency room are covered throughout the World. You will need to file claims forms with Atlantis to be reimbursed.

5. **After I sign up, if I move to another part of the US but still work in one of the five boroughs of NYC, will my insurance still be valid?**
   You may still keep your health coverage however, since the network of providers is only available in the NYC region, you will need to utilize your out-of-network benefits (if applicable).

6. **I am currently not working. Can I still sign up for coverage?**
   Yes you can. See our sign up requirements page.

7. **I have been offered a new job but my benefits will not start for three months. Can I sign up for coverage for just three months?**
   Yes you can. You may sign up for as little as one month and coverage may be cancelled at any time (effective first of the month) as long as you advise the plan administrator in writing.

8. **Can I sign up for one plan and then decide that I want to switch to another?**
   Yes, however plan changes can only be made once a year on the plan anniversary, which is September 30, 2009.

9. **My spouse/children/domestic partner did not want to be covered initially but now they changed their minds and want to be covered. Can I add them to my plan?**
   You may add them to your plan upon the open enrollment plan anniversary, which is September 30, 2009.

10. **Are Domestic Partners of the insured, eligible for coverage?** Yes, qualified Domestic Partners of the same sex or opposite sex can enroll as a spouse.

11. **Who qualifies as dependents? Children to what age?**
    Only your legally married spouse, domestic partner and children up to age 19 can be covered as dependents.

12. **Are pre-existing conditions covered?**
    Medical conditions diagnosed 6 months prior to the health insurance becoming effective may be excluded from coverage for up to 12 months after coverage becomes effective, unless proof of creditable prior coverage (HIPAA certificate, prior carrier bill or copy of insurance card) is provided.

13. **Can the company change the premium rates?**
    The rates and plan benefits are fixed until September 30, 2009. On October 1st, 2009, your plan renews and Atlantis will review plan design and pricing for the following year.

14. **How do I file claim forms?** If you are using an in-network provider, you do not need to file claim forms. The provider/hospital will do it for you. With out-of-network providers, you will need to file a claim form and submit detailed bills in order to be reimbursed.

15. **Do I need to get a referral from my Primary Care Physician (PCP) to see a Specialist?**
    No, you do not need to get a referral from your PCP to see a Specialist.

16. **If I use out-of-network providers and pay out-of-pocket, how long does re-imbursement typically take?**
    Most claims are processed within 45 days.

17. **What are the out-of-network benefits, co-payments, deductibles?**
    As indicated on the summary of available options, different plans have different benefits. Remember that HMO plans have no out-of-network benefits.

18. **Are annual check-ups, dental care or eye care covered?**
    Annul check-ups are covered as long as they are performed by your PCP. Dental and eye care are not covered.