

# ATLANTIS HEALTH PLAN

## Summary of Benefits

### HMO: Plan 20

---

#### **DOCTOR'S SERVICES**

	<b><u>What You Pay</u></b>
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 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.