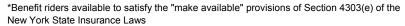
ATLANTIS HEALTH PLAN

Summary of Benefits

DOCTOR'S SERVICES

HMO: Low Option Plan 25

DOCTOR'S SERVICES	<u>wnat You Pay</u>
Office Visits (PCP)	\$25 co-payment
Office Visits (Specialist)	\$40 co-payment
Ambulatory Service visits (Hemodialysis, Chemotherapy, Radiotherapy)	\$25 co-payment
Inpatient Hospital Visits	No co-payment
Allergy Testing and Treatment	\$25 co-payment
Anesthesia	\$25 co-payment
Diagnostic Services and Treatments	\$25 co-payment
Mammography Screening and Prostate Cancer Screening	\$25 co-payment
Mastectomy Care	\$25 co-payment
Obstetrical/Gynecological Services and Pap Smears	\$25 co-payment
Radiology Services	\$25 co-payment
Infertility Services	\$25 co-payment
Bone Mineral Density Measurements, Testing and Devices	\$25 co-payment
Enteral Formulas	\$25 co-payment
Contraceptive drugs and devices	\$25 co-payment
All second surgical/medical opinions	\$25 co-payment
Periodic routine physicals	\$25 co-payment
Well-Child Visits	· · ·
	No co-payment
Experimental or investigational services recommended by external appeal agent	\$25 co-payment
Pre- & Post-Natal Care	\$25 co-payment
Chiropractic Care	\$40 co-payment
Delivery Of Child/ Ambulatory and Out Patient Surgery	Lesser of: 20% or \$200
AMBULATORY SERVICES	
Ambulatory/Out patient Facility Services	\$75 co-payment
Pre-admission Testing	\$25 co-payment
X-ray and Laboratory Services	\$25 co-payment
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HOSPITAL SERVICES	¢500 as novement
Inpatient Services (per continuous confinement)	\$500 co-payment
Inpatient Cardiac Rehabilitation	\$500 co-payment
Ambulatory Surgery Facility	\$75 co-payment
Blood and Blood Products	No co-payment
Ambulance Services	\$50 co-payment
Emergency Room Care (no admission to hospital)	\$50 co-payment
HOSPITAL ALTERNATIVES	
Skilled Nursing Facility: 30 days per calendar year* (per continuous confinement)	\$500 co-payment
Home Health Care: 40 visits per calendar year	\$25 co-payment
End of Life Care Program	No co-payment
Hospice Care: Inpatient (210 days combined with outpatient)	No co-payment
Hospice Care- Outpatient bereavement counseling-5 visits	No co-payment
Hospice Care: Outpatient	No co-payment
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REHABILITATIVE SERVICES	
Physical/Speech/Occupational	
Inpatient: per continuous confinement (Limited to 30 days per diagnosis per calendar year)	\$500 co-payment
Outpatient: limited to 20 visits per diagnosis per calendar year (only following inpatient stay)	\$40 co-payment
MENTAL HEALTH	
Inpatient Admission: per continuous confinement (30 days per calendar year)	\$500 co-payment
Outpatient: 20 visits per calendar year	\$40 co-payment
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SUBSTANCE ABUSE	
Inpatient Detoxification: per continuous confinement (Limited to 7 days per calendar year)	\$500 co-payment
Outpatient Rehabilitation: 60 visits per calendar year (20 of the visits may be used for Family Therapy)	\$40 co-payment
MEDICAL EQUIPMENT & SUPPLIES	
Durable Medical Equipment & Supplies	20% co-insurance
Diabetic Equipment and Supplies	\$25 co-payment
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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.



What You Pay