ATLANTIS HEALTH PLAN

Summary of Benefits
HMO: Plan 25E

DOCTOR'S SERVICES	**What You Pay**
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
HOSPITAL SERVICES	
Inpatient Services	No co-payment
Inpatient Cardiac Rehabilitation	No 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*	No 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
REHABILITATIVE SERVICES	
Physical/Speech/Occupational	
Inpatient: per continuous confinement (Limited to 30 days per diagnosis per calendar year)	No co-payment
Outpatient: limited to 20 visits per diagnosis per calendar year	$40 co-payment
MENTAL HEALTH	
Inpatient Admission: per continuous confinement (30 days per calendar year)	No co-payment
Outpatient: 20 visits per calendar year	$40 co-payment
SUBSTANCE ABUSE	
Inpatient Detoxification: per continuous confinement (Limited to 7 days per calendar year)	No 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

*Benefit riders available to satisfy the "make available" provisions of Section 4303(e) of the New York State Insurance Laws

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.

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