ATLANTIS HEALTH PLAN

Summary of Benefits

POS: Plan E $15 Co-pay Open Access

	IN NETWORK	OUT OF NETWORK
FINANCIALS	**What You Pay**	**What You Pay**
Office visit Co-pay	$15 co-payment	Subject to deductible and co-insurance
Deductible Single/Family	N/A	$2,000/$4,000
Co-insurance	N/A	70/30
Maximum Out of Pocket (after deductible) Single/Family	N/A	$5,000/$10,000
Lifetime Maximum	None	$1,000,000
DOCTOR'S SERVICES		
Office Visits (PCP or Specialist)	$15 co-payment	Subject to deductible and co-insurance
Inpatient Hospital Visits	No co-payment	Subject to deductible and co-insurance
Allergy Testing and Treatment	$15 co-payment	Subject to deductible and co-insurance
Anesthesia	No cost	Subject to deductible and co-insurance
Diagnostic Services	$15 co-payment	Subject to deductible and co-insurance
Mammography Screening	$15 co-payment	Subject to deductible and co-insurance
Prostate Cancer Screening	$15 co-payment	Subject to deductible and co-insurance
Breast Reconstructive Services after a Mastectomy	$15 co-payment	Subject to deductible and co-insurance
Obstetrical/Gynecological Services	$15 co-payment	Subject to deductible and co-insurance
Pap Smears and Cervical Ctyology Screenings	$15 co-payment	Subject to deductible and co-insurance
Infertility services	$15 co-payment	Subject to deductible and co-insurance
Bone Mineral Density Measurements, Testing and Devices	$15 co-payment	Subject to deductible and co-insurance
Enteral Formulas	$15 co-payment	Subject to deductible and co-insurance
Second Surgical and Medical Opinions	$15 co-payment	Subject to deductible and co-insurance
Second Medical Opinions (diagnosis of cancer, negative or positive)	$15 co-payment	Not subject to deductible and co-insurance ^
Periodic Adult Physical Examinations	$15 co-payment	In network benefits only
Well-Child Care Visits (including immunizations)	No co-payment	In network benefits only
Experimental/Investigational services recommended by external appeal agent	$15 co-payment	Subject to deductible and co-insurance
Pre- & Post-Natal Care	$15 co-payment	Subject to deductible and co-insurance
Delivery of Child	No co-payment	Subject to deductible and co-insurance
Inpatient Surgical Services #	No co-payment	Subject to deductible and co-insurance
Outpatient Ambulatory Surgical Services #	No co-payment	Subject to deductible and co-insurance
Chiropractic Care	$15 co-payment	Subject to deductible and co-insurance
Diabetic Education	$15 co-payment	Subject to deductible and co-insurance
AMBULATORY SERVICES		
Radiation Therapy and Chemotherapy	$15 co-payment	Subject to deductible and co-insurance
Hemodialysis	$15 co-payment	Subject to deductible and co-insurance
Pre-admission Testing	$15 co-payment	Subject to deductible and co-insurance
X-Ray and Laboratory Services	$15 co-payment	Subject to deductible and co-insurance
HOSPITAL SERVICES**		
Inpatient Admission (per continuous confinement)	$250 co-payment	Subject to deductible and co-insurance
Cardiac Rehabilitation (per continuous confinement)	$250 co-payment	Subject to deductible and co-insurance
Outpatient Surgery Facility Charges	No co-payment	Subject to deductible and co-insurance
Blood and Blood Products	No co-payment	Subject to deductible and co-insurance
Ambulance Service	No co-payment	Subject to deductible and co-insurance
Emergency Room Care (no admission to hospital)	$50 co-payment	Subject to deductible and co-insurance
HOSPITAL ALTERNATIVES		
Skilled Nursing Facility: 45 days per calendar year *	No co-payment	Subject to deductible and co-insurance
Home Health Care: 60 visits per calendar year	No co-payment	Subject to deductible and co-insurance
End of Life Care Program	No co-payment	Subject to co-insurance only
Hospice Care: Inpatient (210 days combined with outpatient)	No co-payment	Subject to deductible and co-insurance
Hospice Care (5 Bereavement counseling visits)	No co-payment	Subject to deductible and co-insurance
REHABILITATIVE SERVICES		
Physical/Speech/Occupational		
Inpatient: 30 days per diagnosis per calendar yea	No co-payment	Subject to deductible and co-insurance
Outpatient: 20 visits per diagnosis per calendar year*	$15 co-payment	Subject to deductible and co-insurance
MENTAL HEALTH		
Inpatient Admission: 30 days per calendar yea	No co-payment	Subject to deductible and co-insurance
Outpatient: 20 visits per calendar year	$15 co-payment	Subject to deductible and co-insurance
SUBSTANCE ABUSE		
Inpatient Detoxification: (limited to 7 days per calendar year	No co-payment	Subject to deductible and co-insurance
Outpatient 60 visits per calendar year (20 of the visits may be used for Family Therapy)	$15 co-payment	Subject to deductible and co-insurance
MEDICAL EQUIPMENT & SUPPLIES		
Durable Medical Equipment & Supplies	$0 co-payment	Subject to deductible and co-insurance
Diabetic Equipment and Supplies	$15 co-payment per item or 34-day supply	Subject to deductible and co-insurance

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

Failure to Pre-authorize all non-emergency, or elective surgery hospital admissions, will result in a penalty.

^ Must be authorized. Provider will be paid at the Atlantis usual, customary rate.

Note: Benefit limitations and maximums are per Member per calendar year.

EXCLUSIONS: This SUMMARY OF BENEFITS highlights the standard benefits of the HMO Point of Service contract. Benefits shown may be subject to Restrictions, Exclusions and Limitations found in the Group Subscriber Contract.

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