ATLANTIS HEALTH PLAN

Summary of Benefits

POS: Individual $10 Co-pay Open Access

	IN NETWORK	OUT OF NETWORK	ATLANTIS OUTPATIENT CENTERS
FINANCIALS	**What You Pay**	**What You Pay**	**What You Pay**
Office visit Co-pay	$10 co-payment	Subject to deductible and co-insurance	
Deductible Single/Family	N/A	$1,000/$2,000	
Maximum Out of Pocket (after deductible) Single/Family	N/A	$3,000/$5,000	
Lifetime Maximum	None	$500,000	
DOCTOR'S SERVICES			
Office Visits (PCP)	$10 co-payment	In network benefits only	**No co-payment**
Office Visits (Specialist)	$10 co-payment	20% co-insurance	
Inpatient Hospital Visits	$10 co-payment	20% co-insurance	
Anesthesia	$10 co-payment	20% co-insurance	
Diagnostic Services	$10 co-payment	20% co-insurance	**No co-payment**
Mammography Screening	$10 co-payment	20% co-insurance	
Obstetrical/Gynecological Services	$10 co-payment	20% co-insurance	
Pap Smears and Cervical Cytology Screenings	$10 co-payment	20% co-insurance	
Bone Mineral Density Measurements, Testing and Devices	$10 co-payment	20% co-insurance	
Second Surgical and Medical Opinions *	$10 co-payment	Not subject to co-insurance	**No co-payment**
Second Medical Opinions (diagnosis of cancer, negative or positive)	$10 co-payment	20% co-insurance	
Periodic Adult Physical Examinations	$10 co-payment	In network benefits only	**No co-payment**
Well-Child Care Visits (including immunizations)	No co-payment	In network benefits only	**No co-payment**
Pre- & Post-Natal Care	No co-payment	20% co-insurance	
Delivery of Child †	No co-payment	20% co-insurance	
Surgical Services **	$10 co-payment	20% co-insurance	**No co-payment**
Diabetic Education	$10 co-payment	20% co-insurance	**No co-payment**
AMBULATORY SERVICES			
Radiation Therapy and Chemotherapy	$10 co-payment	20% co-insurance	
Hemodialysis	$10 co-payment	20% co-insurance	
Pre-admission Testing	$10 co-payment	20% co-insurance	**No co-payment**
X-Ray and Laboratory Services	$10 co-payment	20% co-insurance	**No co-payment**
HOSPITAL SERVICES			
Inpatient Admission (per continuous confinement) **	No co-payment	20% co-insurance	
Outpatient Surgery Facility Charges	$10 co-payment	20% co-insurance	
Blood and Blood Products	No co-payment	20% co-insurance	
Ambulance Service	No co-payment	20% co-insurance	
Emergency Room Care (no admission to hospital)	$35 co-payment	20% co-insurance	
HOSPITAL ALTERNATIVES			
Skilled Nursing Facility	No co-payment	20% co-insurance	
Home Health Care: 200 visits per calendar year *	$10 co-payment	20% co-insurance	
End of Life Care (per continuous confinement at Article 28 licensed facility)	$500 co-payment	$500 co-payment	
Hospice Care: Inpatient (210 days combined with outpatient)	No co-payment	20% co-insurance	
Hospice Care: Outpatient (210 days combined with inpatient & 5 bereavement counseling visits)	$10 co-payment	20% co-insurance	
Private Duty Nursing: $5,000 max per calendar year & $10,000 lifetime max	$10 co-payment	20% co-insurance	
REHABILITATIVE SERVICES			
Inpatient Physical Therapy (per continuous confinement)	No co-payment	20% co-insurance	
Outpatient Physical Therapy (Limited to 90 visits per condition per calendar year)	$10 co-payment	20% co-insurance	**No co-payment**
MENTAL HEALTH			
Inpatient: 30 days per calendar year combined with Inpatient Detox ‘	No co-payment	Not subject to co-insurance	
Outpatient: 30 visits for regular treatment and 3 visits for crisis intervention per calendar year	10% co-insurance	10% co-insurance	
SUBSTANCE ABUSE			
Inpatient Detoxification: 30 days per calendar year combined with Inpatient Mental Health *	No co-payment	Not subject to co-insurance	
MEDICAL EQUIPMENT & SUPPLIES			
Durable Medical Equipment & Supplies	No co-payment	20% co-insurance	
Diabetic Equipment and Supplies	$10 co-payment per item or 34-day supply	20% co-insurance	
PRESCRIPTION DRUGS ^			
Deductible Single/Family	$100/$300		
Retail - 34 day supply			
Generic	$5.00	Not Covered	
Brand Name	$10.00	Not Covered	
Mail Order - 90 day supply ‡			
Generic *	$10.00	Not Covered	
Brand Name *	$20.00	Not Covered	

* These benefits are not subject to deductible

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

‡ The mail order option allows you to obtain a 90-day supply of maintenance drugs in the following categories: anti-diabetics, anti-hyperlipidemics, anti-hypertensives, beta-blockers, calcium blockers, diuretics and thyroid medications.

Skilled Nursing Facility admissions are covered when preceded by a minimum 3 day hospital stay and further hospitalization would otherwise be necessary

^ Prescription drugs on the formulary exclusion list are not covered unless authorized by Atlantis.

† Routine newborn nursery care is covered without co-payment as it is connected to the mother's covered hospital confinement

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 Subscriber Contract.

Atlantis Outpatient Centers are owned and operated by physicians. Atlantis Health Plan has licensed the naming rights and logo of Atlantis Health Plan to the physician entity that owns and operates Atlantis Outpatient Centers.

OUT-OF-PLAN SERVICES are subject to deductible. After the deductible is paid, the coinsurance payable is based upon the Usual, Customary or Reasonable (UCR) fee for a comparable fee schedule. After deductible and coinsurance requirements are met, Atlantis will pay 100% of the UCR fee of the comparable fee schedule for Covered Services. You are always responsible for fees exceeding the UCR fee or comparable fee schedule.