

ATLANTIS HEALTH PLAN

Summary of Benefits

POS: Plan AE \$15 Co-Pay Open Access

| | IN NETWORK | OUT OF NETWORK | ATLANTIS OUTPATIENT CENTERS |
|---|---|--|--|
| | What You Pay | What You Pay | What You Pay |
| FINANCIALS | | | |
| Office visit Co-pay | \$15 co-payment | Subject to deductible and co-insurance | |
| Deductible Single/Family | N/A | \$1,000/\$2,500 | |
| Co-insurance | N/A | 70/30 | |
| Maximum Out of Pocket (after deductible) Single/Family | N/A | \$3,000/\$7,500 | |
| Lifetime Maximum | None | \$1,000,000 | |
| DOCTOR'S SERVICES | | | |
| Office Visits (PCP or Specialist) | \$15 co-payment | Subject to deductible and co-insurance | No co-payment |
| 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 | No co-payment |
| Anesthesia | No cost | Subject to deductible and co-insurance | |
| Diagnostic Services | \$15 co-payment | Subject to deductible and co-insurance | No co-payment |
| Mammography Screening | \$15 co-payment | Subject to deductible and co-insurance | |
| Prostate Cancer Screening | \$15 co-payment | Subject to deductible and co-insurance | No co-payment |
| 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 Cytology 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 | No co-payment |
| Second Medical Opinions (diagnosis of cancer, negative or positive) | No co-payment | Not subject to deductible and co-insurance ^ | |
| Periodic Adult Physical Examinations | \$15 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 |
| 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 | No co-payment |
| Outpatient Ambulatory Surgical Services # | No co-payment | Subject to deductible and co-insurance | No co-payment |
| Chiropractic Care | \$15 co-payment | Subject to deductible and co-insurance | |
| Diabetic Education | \$15 co-payment | Subject to deductible and co-insurance | No co-payment |
| 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 | No co-payment |
| X-Ray and Laboratory Services | \$15 co-payment | Subject to deductible and co-insurance | No co-payment |
| HOSPITAL SERVICES** | | | |
| Inpatient Admission (per continuous confinement) | No co-payment | Subject to deductible and co-insurance | |
| Cardiac Rehabilitation (per continuous confinement) | No 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 | | | |
| <u>Physical/Speech/Occupational</u> | | | |
| Inpatient: 30 days per diagnosis per calendar year | 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 | No co-payment |
| MENTAL HEALTH | | | |
| Inpatient Admission: 30 days per calendar year | No co-payment | In network benefits only | |
| Outpatient: 20 visits per calendar year | \$25 co-payment | In network benefits only | |
| SUBSTANCE ABUSE | | | |
| Inpatient Detoxification: (limited to 7 days per calendar year) | No co-payment | In network benefits only | |
| 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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