ATLANTIS HEALTH PLAN

Summary of Benefits

POS: Plan C $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	$500/$1,250	
Co-insurance	N/A	80/20	
Maximum Out of Pocket (after deductible) Single/Family	N/A	$2,000/$5,000	
Lifetime Maximum	None	$1,000,000	
DOCTOR'S SERVICES			
Office Visits (PCP or Specialist)	$10 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	$10 co-payment	Subject to deductible and co-insurance	**No co-payment**
Anesthesia	No cost	Subject to deductible and co-insurance	
Diagnostic Services	$10 co-payment	Subject to deductible and co-insurance	**No co-payment**
Mammography Screening	$10 co-payment	Subject to deductible and co-insurance	
Prostate Cancer Screening	$10 co-payment	Subject to deductible and co-insurance	**No co-payment**
Breast Reconstructive Services after a Mastectomy	$10 co-payment	Subject to deductible and co-insurance	
Obstetrical/Gynecological Services	$10 co-payment	Subject to deductible and co-insurance	
Pap Smears and Cervical Ctyology Screenings	$10 co-payment	Subject to deductible and co-insurance	
Infertility services	$10 co-payment	Subject to deductible and co-insurance	
Bone Mineral Density Measurements, Testing and Devices	$10 co-payment	Subject to deductible and co-insurance	
Enteral Formulas	$10 co-payment	Subject to deductible and co-insurance	
Second Surgical and Medical Opinions	$10 co-payment	Subject to deductible and co-insurance	**No co-payment**
Second Medical Opinions (diagnosis of cancer, negative or positive)	$10 co-payment	Not subject to deductible and 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**
Experimental/Investigational services recommended by external appeal agent	$10 co-payment	Subject to deductible and co-insurance	
Pre- & Post-Natal Care	$10 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	$10 co-payment	Subject to deductible and co-insurance	
Diabetic Education	$10 co-payment	Subject to deductible and co-insurance	**No co-payment**
AMBULATORY SERVICES			
Radiation Therapy and Chemotherapy	$10 co-payment	Subject to deductible and co-insurance	
Hemodialysis	$10 co-payment	Subject to deductible and co-insurance	
Pre-admission Testing	$10 co-payment	Subject to deductible and co-insurance	**No co-payment**
X-Ray and Laboratory Services	$10 co-payment	Subject to deductible and co-insurance	**No co-payment**
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 year	No co-payment	Subject to deductible and co-insurance	
Outpatient: 20 visits per diagnosis per calendar year*	$10 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)	$10 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	$10 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.

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.