



## Atlantis Health Plan Options - Rates for 08/1/2010-09/30/2010

Plan Type Referral Required Type of Network In Network Deductible In Network Coinsurance Office Copay Specialist Copay Inpatient Hospital Copay Outpatient/Surgical Copay ER Copay	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F
	HMO L25/40	HMO GL20	HMO 20	HMO 15E	HMO 20E	HMO 10E
	NO	NO	NO	NO	NO	NO
	In Network	In Network	In Network	In Network	In Network	In Network
	N/A	N/A	N/A	N/A	N/A	N/A
	N/A	N/A	N/A	N/A	N/A	N/A
	\$25	\$20	\$20	\$15	\$20	\$10
	\$40	\$20	\$20	\$15	\$20	\$10
Pharmacy Benefit Pharmacy Deductible & Rx Max	\$500 per admission	\$500 per admission	\$250 per admission	\$0	\$0	\$0
	\$75	\$75	\$0	\$0	\$0	\$0
	\$50	\$50	\$50	\$50	\$50	\$50
PRESCRIPTION BENEFITS						
Employee Only EE with Spouse/DP EE with Child(ren) Family	Sign \$0 Generic	\$0/30/50	\$0/30/50	\$20/30/40	\$10/20/30	\$0/20/30
	*\$250 deductible & \$2,000 max	N/A	N/A	N/A	N/A	N/A
RATES						
	\$363.20	\$412.58	\$462.52	\$468.49	\$503.55	\$515.13
	\$726.40	\$825.16	\$925.04	\$936.98	\$1,007.10	\$1,030.26
	\$730.40	\$829.70	\$930.13	\$942.13	\$1,012.64	\$1,035.93
	\$1,117.93	\$1,269.92	\$1,423.64	\$1,442.01	\$1,549.93	\$1,585.57

\* This rider only covers generic prescription drugs. If no generic is available, the member is responsible for an annual deductible of \$250 for brand name drugs and a \$25 co-payment for each covered brand name drug filled. There is an annual maximum benefit of \$2,000 per covered member for brand name prescriptions.

*Note: The rates contained in this document have been filed with the Department of Insurance but have not received final approval and therefore subject to change.*

Spreadsheet is for illustration purposes only.

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