



## Atlantis Health Plan Options - Rates for 08/01/2010-09/30/2010

	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F
Plan Type	HMO L25/40	HMO GL20	HMO 20	HMO 15E	HMO 20E	HMO 10E
Referral Required	NO	NO	NO	NO	NO	NO
Type of Network	In Network	In Network	In Network	In Network	In Network	In Network
In Network Deductible	N/A	N/A	N/A	N/A	N/A	N/A
In Network Coinsurance	N/A	N/A	N/A	N/A	N/A	N/A
Office Copay	\$25	\$20	\$20	\$15	\$20	\$10
Specialist Copay	\$40	\$20	\$20	\$15	\$20	\$10
Inpatient Hospital Copay	\$500 per admission	\$500 per admission	\$250 per admission	\$0	\$0	\$0
Outpatient/Surgical Copay	\$75	\$75	\$0	\$0	\$0	\$0
ER Copay	\$50	\$50	\$50	\$50	\$50	\$50

	PRESCRIPTION BENEFITS					
Pharmacy Benefit	Sign \$0 Generic	\$0/30/50	\$0/30/50	\$20/30/40	\$10/20/30	\$0/20/30
Pharmacy Deductible & Rx Max	*\$250 deductible & \$2,000 max	N/A	N/A	N/A	N/A	N/A

	RATES					
Employee Only	\$363.20	\$412.58	\$462.52	\$468.49	\$503.55	\$515.13
EE with Spouse/DP	\$726.40	\$825.16	\$925.04	\$936.98	\$1,007.10	\$1,030.26
EE with Child(ren)	\$730.40	\$829.70	\$930.13	\$942.13	\$1,012.64	\$1,035.93
Family	\$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.*

