

ATLANTIS HEALTH PLAN

HIGH OPTION HMO- SUMMARY OF BENEFITS

Financials

| | |
|---|-----------------|
| Office visit Co pay | \$10 |
| Deductible Single/Family | N/A |
| Coinsurance | N/A |
| Maximum Out of Pocket per calendar year | 200% of Premium |

Doctor Services

| | |
|---|----------------|
| Office Visits (PCP or Specialist) | \$10 per visit |
| Inpatient Hospital Visits | No Cost |
| Allergy Testing and Treatment | \$10 per visit |
| Anesthesia | No Cost |
| Diagnostic Services and Treatments | \$10 per visit |
| Mammography Screening | \$10 per visit |
| Obstetrical/ Gynecological Services | \$10 per visit |
| Pap Smears | \$10 per visit |
| Second Surgical and Medical Opinions | \$10 per visit |
| Periodic Adult Physical Examinations | \$10 per visit |
| Well-Child Care Visits (including immunizations) | No Cost |
| Pre- & Post-Natal Care | \$10 per visit |
| Delivery of Child | No Cost |
| Surgical Services | No Cost |

Ambulatory Services

| | |
|------------------------------------|----------------|
| Radiation Therapy and Chemotherapy | \$10 per visit |
| Hemodialysis | \$10 per visit |
| Pre-admission Testing | \$10 per visit |
| X-ray and Laboratory Services | \$10 per visit |

Hospital Services

| | |
|--|----------------|
| Inpatient Admission | No Cost |
| Outpatient Surgery Facility Charges | No Cost |
| Blood and Blood Products | No Cost |
| Ambulance Service | No Cost |
| Emergency Room Care (no admission to hospital) | \$50 per visit |

Hospital Alternatives

| | |
|---|---------|
| Skilled Nursing Facility: 45 days per calendar year # | No Cost |
| Home Health Care: 60 visits per calendar year | No Cost |
| Hospice Care: Inpatient (210 days combined with outpatient) | No Cost |
| Hospice Care: Outpatient | No Cost |

Rehabilitative Services Physical/Speech/Occupational

| | |
|---|---------|
| Inpatient: 30days per diagnosis per calendar year | No Cost |
| Outpatient: 20 Visits per diagnosis per calendar year # | No Cost |

Mental Health

| | |
|--|----------------|
| Inpatient Admission: 30 days per calendar year | No Cost |
| Outpatient: 20 visits per calendar year | \$20 per visit |

Substance Abuse

| | |
|---|----------------|
| Inpatient Detoxification: (limited to 7 days per calendar year) | No Cost |
| Outpatient 60 visits per calendar year (20 of the visits may be used for Family Therapy) | \$10 per visit |

Medical Equipment & Supplies

Durable Medical Equipment, Supplies and Prosthetic Devices

No Cost

Diabetic Equipment and Supplies

\$10 per item or 34-day
supply

LIFETIME MAXIMUM

None

Note: Benefit limitations and maximums are per Member per calendar year.

Exclusions: This **SUMMARY OF BENEFITS** highlights the standard benefits of the HMO contract. Benefits shown may be subject to Restrictions, Exclusions and Limitations found in the Subscriber Certificate of Coverage.

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