

ATLANTIS HEALTH PLAN
LOW OPTION POS- SUMMARY OF BENEFITS

<u>Financials</u>	IN NETWORK
Office visit Co pay	\$20 Co-payment
Deductible Single/Family	N/A
Coinsurance	N/A
Maximum Out of Pocket (After deductible) Single/Family	N/A
<u>Doctor Services</u>	
Office Visits (PCP or Specialist)	\$20 Co-payment
Inpatient Hospital Visits	No Cost
Allergy Testing and Treatment	\$20 Co-payment
Anesthesia	No Cost
Diagnostic Services and Treatments	\$20 Co-payment
Mammography Screening and Prostate Cancer Screening	\$20 Co-payment
Mastectomy Care	\$20 Co-payment
Obstetrical/ Gynecological Services and Pap Smears	\$20 Co-payment
Infertility services	\$20 Co-payment
Bone Mineral Density Measurements, Testing, and Devices	\$20 Co-payment
Enteral Formulas	\$20 Co-payment
Contraceptive drugs and devices	\$20 Co-payment
All Second Surgical and Medical Opinions	No Cost
Periodic Adult Physical Examinations	\$20 Co-payment
Well-Child Care Visits (including immunizations)	No Cost
Experimental/Investigational services recommended by external appeal agent	\$20 Co-payment
Pre- & Post-Natal Care	\$20 Co-payment
Delivery of Child	No Cost
Inpatient Surgical Services	No Cost
Outpatient Ambulatory Surgical Services	Lesser of 20% or \$200
Ambulatory Services	
<u>Radiation Therapy and Chemotherapy</u>	<u>\$20 Co-payment</u>
Hemodialysis	\$20 Co-payment
Pre-admission Testing	\$20 Co-payment
X-ray and Laboratory Services	\$20 Co-payment
<u>Hospital Services</u>	
Inpatient Admission (per continuous confinement)	\$500 Co-payment per continuous confinement
Cardiac Rehabilitation (per continuous confinement)	\$500 Co-payment per continuous confinement
Outpatient Surgery Facility Charges	\$75 Co-payment
Blood and Blood Products	No Cost
Ambulance Service	\$50 Co-payment
Emergency Room Care (no admission to hospital)	\$50 Co-payment
<u>Hospital Alternatives</u>	
# Skilled Nursing Facility: 45 days per calendar year	\$500 Co-payment per continuous confinement
Home Health Care: 60 visits per calendar year	\$20 Co-payment
End of Life Care Program	No Cost
Hospice Care: Inpatient (210 days combined with outpatient)	No Cost
Hospice Care (5 Bereavement days)	No Cost
Hospice Care: Outpatient	No Cost
<u>Rehabilitative Services Physical/Speech/Occupational</u>	
Inpatient: 30 days per diagnosis per calendar year	\$500 Co-payment per continuous confinement
# Outpatient: 20 Visits per diagnosis per calendar year (only following inpatient stay)	\$20 Co-payment
<u>Mental Health</u>	
Inpatient Admission: 30 days per calendar year	\$500 Co-payment per continuous confinement
Outpatient: 20 visits per calendar year	\$20 Co-payment
<u>Substance Abuse</u>	
Inpatient Detoxification: (limited to 7 days per calendar year)	\$500 Co-payment per continuous confinement
Outpatient 60 visits per calendar year (20 of the visits may be used for Family Therapy)	\$20 Co-payment
<u>Medical Equipment & Supplies</u>	
Durable Medical Equipment, Supplies and Prosthetic Devices	\$20 Co-payment
Diabetic Education, Equipment and Supplies	\$20 Co-payment
<u>Chiropractic Care</u>	\$20 Co-payment
LIFETIME MAXIMUM	None

Benefit riders available to satisfy the "make available" provisions of Section 4303(e) of the New York State Insurance Laws

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 show subject to Restrictions, Exclusions and Limitations found in the Group Subscriber Certificate of Coverage.

Form AHP-POS-GRP F20