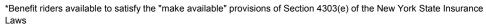
ATLANTIS HEALTH PLAN

Summary of Benefits

HMO: Low Option Plan 15

| DOCTOR'S SERVICES | What You Pay |
|--|-------------------------|
| Office Visits (PCP or Specialist) | \$15 co-payment |
| Ambulatory Service visits (Hemodialysis, Chemotherapy, Radiotherapy) | \$15 co-payment |
| Inpatient Hospital Visits | No co-payment |
| Allergy Testing and Treatment | \$15 co-payment |
| Anesthesia | No co-payment |
| Diagnostic Services and Treatments | \$15 co-payment |
| Mammography Screening and Prostate Cancer Screening | \$15 co-payment |
| Mastectomy Care | \$15 co-payment |
| Obstetrical/Gynecological Services and Pap Smears | \$15 co-payment |
| Radiology Services | \$15 co-payment |
| Infertility Services | \$15 co-payment |
| Bone Mineral Density Measurements, Testing and Devices | \$15 co-payment |
| Enteral Formulas | \$15 co-payment |
| Contraceptive drugs and devices | \$15 co-payment |
| All second surgical/medical opinions | \$15 co-payment |
| Periodic routine physicals | \$15 co-payment |
| Well-Child Visits | No co-payment |
| Experimental or investigational services recommended by external appeal agent | \$15 co-payment |
| Pre- & Post-Natal Care | \$15 co-payment |
| Chiropractic Care | \$15 co-payment |
| Delivery Of Child/ Ambulatory and Outpatient Surgery | Lesser of: 20% or \$200 |
| AMBULATORY SERVICES | |
| Ambulatory/Out patient Facility Services | \$75 co-payment |
| Radiation Therapy and Chemotherapy | \$15 co-payment |
| Pre-admission Testing | \$15 co-payment |
| X-ray and Laboratory Services | \$15 co-payment |
| HOSPITAL SERVICES | |
| Inpatient Services (per continuous confinement) | \$500 co-payment |
| Inpatient Cardiac Rehabilitation (per continuous confinement) | \$500 co-payment |
| Ambulatory Surgery Facility | \$75 co-payment |
| Blood and Blood Products | No co-payment |
| Ambulance Services | \$50 co-payment |
| Emergency Room Care (no admission to hospital) | \$50 co-payment |
| HOSPITAL ALTERNATIVES | |
| Skilled Nursing Facility: 30 days per calendar year* (per continuous confinement) | \$500 co-payment |
| Home Health Care: 40 visits per calendar year | \$15 co-payment |
| End of Life Care Program | No co-payment |
| Hospice Care: Inpatient (210 days combined with outpatient) | No co-payment |
| Hospice Care- Outpatient bereavement counseling-5 visits | No co-payment |
| Hospice Care: Outpatient | No co-payment |
| | nto do paymont |
| REHABILITATIVE SERVICES | |
| Physical/Speech/Occupational | 0500 |
| Inpatient: per continuous confinement (Limited to 30 days per diagnosis per calendar year) | \$500 co-payment |
| Outpatient: limited to 20 visits per diagnosis per calendar year (only following inpatient stay) | \$15 co-payment |
| MENTAL HEALTH | |
| Inpatient Admission: per continuous confinement (30 days per calendar year) | \$500 co-payment |
| Outpatient: 20 visits per calendar year | \$15 co-payment |
| SUBSTANCE ABUSE | |
| Inpatient Detoxification: per continuous confinement (Limited to 7 days per calendar year) | \$500 co-payment |
| Outpatient Rehabilitation: 60 visits per calendar year (20 of the visits may be used for Family Therapy) | \$15 co-payment |
| MEDICAL EQUIPMENT & SUPPLIES | . • |
| Durable Medical Equipment & Supplies | 20% co-insurance |
| Diabetic Equipment and Supplies | \$15 co-payment |
| при | ψ το σο paymont |



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 Group Subscriber Contract.



Form AHP-HMO-GL15 02.13.07