Please Note: There are 2 pages to this document.

Atlantis Health Plan Options - Third Quarter 2009

	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F
Plan Type	HMO	HMO	HMO	POS	POS	POS
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	$25	$20	$25	$20	$25
Specialist Copay	$40	$40	$20	$40	$20	$40
Inpatient Hospital Copay	$500 per admission	N/A	$250 per admission	$500 per admission	$250 per admission	N/A
Outpatient/Surgical Copay	$75	$75	$0	$75	$0	$75
ER Copay	$50	$50	$50	$50	$50	$50
Type of Network	Out of Network	Out of Network	Out of Network	Out of Network	Out of Network	Out of Network
Deductible	N/A	N/A	N/A	$2,000/$4000	$2,000/$4000	$1,000/$2,500
Coinsurance Max	N/A	N/A	N/A	70% to $16,666	70% to $16,666	70% to $10,000

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

	RATES					
Employee Only	$302.69	$372.90	$382.02	$342.03	$420.18	$419.19
EE with Spouse/DP	$595.38	$735.80	$754.03	$674.06	$830.33	$828.39
EE with Child(ren)	$598.60	$739.79	$758.12	$677.71	$834.86	$832.89
Family	$910.90	$1,127.00	$1,155.06	$1,031.98	$1,272.52	$1,269.50

* 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.

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Spreadsheet is for illustration purposes only.

Payments are due monthly in advance to TriState Special Marketing Corp*

I have placed an "X" in the red box above the plan I have chosen.

My new premium is $_______________(including $5.00 administrative billing fee) and a check in this amount is enclosed.

Please accept this completed form as acknowledgement of my 2009 plan election:

____

Signature Date

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