Benefit Plan Summary



### WELLINESS BENEFITS Annual Wellness Visit Benefit amount per day ### \$125 per day x1 day ### \$150 p		HOORAY HEALTH SELECT BASIC	HOORAY HEALTH SELECT PLUS	HOORAY HEALTH SELECT PREMIUM
Annual Wellness Visit Benefit amount per day **RETAL CLINIC & WCENT CARE BENEFITS** **RETAL CLINIC & WCENT CARE BENEFITS** **RETAL CLINIC & WCENT CARE BENEFITS** **Nember Pays \$25** **Ne Balance Bills** **Ne Balance Bill	HOORAY HEALTH PLAN (OUTPATIENT)			
RETAIL CLINIC & URGENT CARE BENEFITS 1. Physician Visit books, Heldith Network (ixo Balance Bills* Includes of Fice visit, plus in-house lab, x-rays, etc. 2. Physician Visit with First Health Provider (Discounted Plan Pays up to \$175. 3. Physician Visit with Cut-of-Network Provider (Network Provider Plan Pays up to \$175. 4. Por year Fotal Sick Visits Plan Pays up to \$175. Plan Pay	WELLNESS BENEFITS			
RETAIL CLING & URGENT CARE BENEFITS 1. Physician Visit Aboracy Health Network (ixo Balance Bills' includes office visit, plus in-house lab, x-ray, etc. 2. Physician Visit with First Health Provider (Discounted Plan Pays up to \$175. 3. Physician Visit with First Health Provider (Discounted Plan Pays up to \$175. 4. Per year 5. Physician Visit with Out-of-Network Provider (ixo discounts') Total Sick Visits Plan Pays up to \$175. 7. Total Sick Visits Plan Pays up to \$175.	Annual Wellness Visit Benefit amount per day	\$125 per day x 1 day	\$150 per day x 1 day	\$150 per day x 1 day
(No Balance Bills*) includes office visit, plus in-house lab, x-rays, etc. No Balance Bills*) No Balance Bills* No Balan	RETAIL CLINIC & URGENT CARE BENEFITS*			
Pall Pags Up to 37/3 Pall Pags Up to 37/5 Pall Pags Up to 57/5				
Note Part Page up to 8 //S Part Page up to 8 //S Page up to 9 //S Page up t	2. Physician Visit with <u>First Health Provider</u> (Discounted rates)**	Plan Pays up to \$175	Plan Pays up to \$175	Plan Pays up to \$175
Cutpatient Doctor Visit (First Health Provider Network or Out-of-Network Provider) Maximum annual provider visits 1 per year 2 per year 3 per year Maximum annual provider visits 1 per year 2 per year 3 per year Maximum annual provider visits 1 per year 2 per year 3 per year Diagnostic X-Ray & Laboratory benefit S25 per day x 2 days S25 per day x 3 days S25 per day x 1 day S25 per day x	3. Physician Visit with Out-of-Network Provider (No discounts)***	Plan Pays up to \$175	Plan Pays up to \$175	Plan Pays up to \$175
Outpatient Doctor Visit (First Health Provider Network or Out-of-Network Provider) Maximum annual provider visits 1 per year 2 per year 3 per year 3 per year 3 per year 1 per year 3 per year 3 per year 1 per year 2 per day x 3 days \$25 per day x 1 day \$350 per day x 1 day \$400 per day x 1 day	Total Sick Visits	3 per year	4 per year	5 per year
Out-of-Network Provider) \$75 per day \$75 per day \$75 per day Maximum annual provider visits 1 per year 2 per year 3 per year IMAGING AND LABORATORY TEST Comment of the per day x 2 days \$25 per day x 3 days \$25 per day x 3 days \$25 per day x 3 days Specialty Radiology - MRI, CT & PET N/A \$350 per day x 1 day \$350 per day x 1 day Other Specialty Radiology - MRI, CT & PET N/A \$150 per day x 1 day \$350 per day x 1 day IMPATIENT REPREFITS Hospital Admission Benefit N/A N/A N/A \$1,000 per day x 1 day Hospital Confinement Benefit N/A N/A N/A \$1,000 per day x 1 day I/O Benefit N/A N/A N/A \$1,000 per day x 1 day I/O Benefit N/A N/A N/A \$1,000 per day x 1 day I/O Benefit N/A N/A N/A \$1,000 per day x 1 day I/O Benefit N/A N/A N/A \$1,000 per day x 1 day I/O Benefit N/A N/A N/A \$1,000 per day x 1 day <	PHYSICIAN VISITS			
MAGING AND LABORATORY TEST Diagnostic X-Ray & Laboratory benefit \$25 per day x 2 days \$25 per day x 3 days \$25 per day x 1 day \$350 per day x 1 day	·	\$75 per day	\$75 per day	\$75 per day
Diagnostic X-Ray & Laboratory benefit \$25 per day x 2 days \$25 per day x 3 days \$25 per day x 3 days \$25 per day x 1 day \$250 per day x 2 days \$250 per day x	Maximum annual provider visits	1 per year	2 per year	3 per year
Specialty Radiology - MRI, CT & PET N/A \$350 per day x 1 day \$350 per day x 1 day Other Specialty Radiology N/A \$150 per day x 1 day \$150 per day x 1 day INPATIENT BENEFITS SUBSECTION OF THE WAY I DAY	IMAGING AND LABORATORY TEST			
Other Specialty Radiology N/A \$150 per day x 1 day \$150 per day x 1 day INPATIENT BENEFITS INPATIENT BENEFITS INPATIENT BENEFITS Hospital Admission Benefit N/A N/A \$1,000 per day x 1 day Hospital Confinement Benefit N/A N/A \$1,000 per day x 1 day Surgery Benefit (Maternity Included) N/A N/A N/A \$1,000 per day x 1 day ICU Benefit N/A N/A N/A \$1,000 per day x 1 day ICU Benefit N/A N/A N/A \$1,000 per day x 1 day ICU Benefit N/A N/A N/A \$1,000 per day x 1 day ICU Benefit N/A N/A N/A \$1,000 per day x 1 day ICU Benefit N/A N/A N/A \$1,000 per day x 1 day ICU Benefit N/A N/A N/A N/A \$375 per day x 1 day Acctive Medication Program (amount up to \$5,000 per year up to \$5,000 per year up to \$10,000	Diagnostic X-Ray & Laboratory benefit	\$25 per day x 2 days	\$25 per day x 3 days	\$25 per day x 3 days
Hospital Admission Benefit Hospital Confinement Benefit N/A Hospital Confinement Benefit N/A N/A N/A N/A N/A N/A S1,000 per day x 5 days Surgery Benefit (Maternity Included) N/A N/A N/A N/A N/A S1,000 per day x 5 days N/A N/A N/A S1,000 per day x 5 days N/A	Specialty Radiology - MRI, CT & PET	N/A	\$350 per day x 1 day	\$350 per day x 1 day
Hospital Admission Benefit N/A N/A \$2,000 per day x1 day Hospital Confinement Benefit N/A N/A \$1,000 per day x 5 days Surgery Benefit (Maternity Included) N/A N/A N/A \$1,000 per day x 5 days Surgery Benefit (Maternity Included) N/A N/A N/A \$1,000 per day x 5 days ICU Benefit N/A N/A N/A \$1,000 per day x 5 days N/A N/A \$1,000 per day x 5 days N/A N/A N/A \$375 per day x 1 day N/A \$375 per day x 1 day N/A N/A \$375 per day x 1 day N/A N/A \$375 per day x 1 day N/A \$4100 \$5000 per year NON-INSURINCE \$400 \$1000 \$1000 per year NON-INSURINCE \$400 per year NON-INSURINCE \$400 per year NON-INSURINCE \$4000 per ye	Other Specialty Radiology	N/A	\$150 per day x 1 day	\$150 per day x 1 day
Hospital Confinement Benefit	INPATIENT BENEFITS			
Surgery Benefit (Maternity Included) N/A N/A \$1,500 per day x 1 day ICU Benefit N/A N/A \$1,000 per day x 5 days Anesthesia Benefit N/A N/A \$1,000 per day x 5 days Ancethesia Benefit N/A N/A \$375 per day x 1 day ACCIDENT BENEFIT Wind Benefit Amount Up to \$5,000 per year Up to \$5,000 per year Up to \$10,000 per year Deductible \$0 Deductible \$0 Deductible \$0 Deductible Benefit % Payable 100% U&C 100% U&C 100% U&C NON-INSURANCE SERVICES ¹⁰ Virtual Primary Care & Urgent Care (Recuro Telemedicine) \$0 Consults/1 per day \$0 Consu	Hospital Admission Benefit	N/A	N/A	\$2,000 per day x 1 day
ICU Benefit N/A N/A S1,000 per day x 5 days Anesthesia Benefit N/A N/A N/A S375 per day x 1 day ACCIDENT BENEFIT Maximum Benefit Amount Up to \$5,000 per year Up to \$5,000 per year Up to \$10,000 per year Deductible \$0 Deductible \$0 Deductible \$0 Deductible \$0 Deductible Benefit % Payable 100% U&C 1	Hospital Confinement Benefit	N/A	N/A	\$1,000 per day x 5 days
Anesthesia Benefit N/A N/A N/A N/A S375 per day x1 day ACCIDENT BENEFIT Maximum Benefit Amount Up to \$5,000 per year Up to \$10,000 per year Up	Surgery Benefit (Maternity Included)	N/A	N/A	\$1,500 per day x 1 day
Maximum Benefit Amount up to \$5,000 per year up to \$5,000 per year up to \$10,000 per year u	ICU Benefit	N/A	N/A	\$1,000 per day x 5 days
Maximum Benefit Amount Up to \$5,000 per year Up to \$10,000 per year Benefit % Payable 100% U&C 100% U&	Anesthesia Benefit	N/A	N/A	\$375 per day x 1 day
Deductible \$0 De	ACCIDENT BENEFIT			
Benefit % Payable 100% U&C 100	Maximum Benefit Amount	up to \$5,000 per year	up to \$5,000 per year	up to \$10,000 per year
NON-INSURANCE SERVICES® Virtual Primary Care & Urgent Care (Recuro Telemedicine) Acute Medication Program (Rx Valet) Discount Prescription Program (Simplescripts) Included	Deductible	\$0 Deductible	\$0 Deductible	\$0 Deductible
Virtual Primary Care & Urgent Care (Recuro Telemedicine)\$0 Consults/1 per day\$0 Consults/1 per day\$0 Consults/1 per dayAcute Medication Program (Rx Valet)IncludedIncludedIncludedDiscount Prescription Program (Simplescripts)IncludedIncludedIncludedDiscount Radiology (Green Imaging)IncludedIncludedIncludedBehavioral Health (Recuro)\$0 consult; \$ visits per year\$0 consult; \$ visits per year\$0 consult; \$ visits per year\$0 consult; \$ visits per yearCareington Discount Dental and VisionIncludedIncludedIncludedMONTHLY RATESBASICPLUSPREMIUMEMPLOYEE ONLY\$84.00\$101.00\$163.00EMPLOYEE + SPOUSE\$137.00\$174.00\$317.00EMPLOYEE + CHILD(REN)\$130.00\$157.00\$246.00	Benefit % Payable	100% U&C	100% U&C	100% U&C
Acute Medication Program (Rx Valet) Discount Prescription Program (Simplescripts) Included In	NON-INSURANCE SERVICES ⁽¹⁾			
Discount Prescription Program (Simplescripts) Included		\$0 Consults/1 per day	\$0 Consults/1 per day	\$0 Consults/1 per day
Discount Radiology (Green Imaging) Behavioral Health (Recuro) Careington Discount Dental and Vision MONTHLY RATES BASIC BASIC PLUS PREMIUM EMPLOYEE ONLY \$8400 \$101.00 \$101.00 \$103.00 \$137.00 \$137.00 \$137.00 \$157.00 \$246.00	Acute Medication Program (Rx Valet)	Included	Included	Included
Behavioral Health (Recuro) \$0 consult; 3 visits per year Careington Discount Dental and Vision Included	Discount Prescription Program (Simplescripts)	Included	Included	Included
Solitis per year Solitis per	Discount Radiology (Green Imaging)	Included	Included	Included
Careington Discount Dental and Vision Included Included Included MONTHLY RATES BASIC PLUS PREMIUM EMPLOYEE ONLY \$84.00 \$101.00 \$163.00 EMPLOYEE + SPOUSE \$137.00 \$174.00 \$317.00 EMPLOYEE + CHILD(REN) \$130.00 \$157.00 \$246.00	Behavioral Health (Recuro)	· · · · · · · · · · · · · · · · · · ·		
EMPLOYEE ONLY \$84.00 \$101.00 \$163.00 EMPLOYEE + SPOUSE \$137.00 \$174.00 \$317.00 EMPLOYEE + CHILD(REN) \$130.00 \$157.00 \$246.00	Careington Discount Dental and Vision	· · ·		
EMPLOYEE + SPOUSE \$137.00 \$174.00 \$317.00 EMPLOYEE + CHILD(REN) \$130.00 \$157.00 \$246.00	MONTHLY RATES	BASIC	PLUS	PREMIUM
EMPLOYEE + CHILD(REN) \$130.00 \$157.00 \$246.00	EMPLOYEE ONLY	\$84.00	\$101.00	\$163.00
EMPLOYEE + CHILD(REN) \$130.00 \$157.00 \$246.00	EMPLOYEE + SPOUSE	\$137.00	\$174.00	\$317.00
	EMPLOYEE + CHILD(REN)	\$130.00	\$157.00	\$246.00
	FAMILY			

Hooray Health Plans provide limited essential accident and sickness coverage and are not a substitute for major medical insurance.

(1) THE SERVICES DESCRIBED ARE NOT INSURANCE AND ARE NOT PROVIDED BY AN INSURANCE COMPANY,

HOORAY HEALTH OFFERS A VARIETY OF FIXED INDEMNITY, ACCIDENT AND HOSPITAL INDEMNITY POLICIES AS LIMITED BENEFIT PLANS AND THE USE OF THE TERMS "HEALTH COVERAGE", "HEALTHCARE COVERAGE" "HEALTH INSURANCE" OR "HEALTH BENEFITS", OR ANY OTHER DESCRIPTIVE LANGUAGE, ARE NOT INTENDED TO AND DO NOT IMPLY OR CONVEY OTHERWISE.

Limited benefit plans are insurance products with reduced benefits and are not intended to be an alternative to or integrated with comprehensive coverage. Please see plan documents for further details.

The Hooray Health plans listed above are summarized, full terms and conditions of coverage, including effective dates of coverage, benefits, limitations and exclusions, are set forth in the policy. All Day Limits are per plan year.

*Members \$25 payment only applies to sickness visits performed at a Hooray Health's in-network provider. No balance billing applies to covered services received at Hooray Health's in-network retail clinic and urgent care

**First Health Network contracted providers can be found at hoorayhealth.com/FHN. Discounted rates will be applied after services are rendered at physician's office through the Third Party Administrator. Member will be responsible for any payment balance above the plan payment of \$175. Please see plan policy for details.

^{***}Out-of-Network provider visits are paid \$175 per the plan policy. Member will be responsible for any payment balance above the plan payment of \$175. Please see plan policy for details.