

HRA SIMPLE 5000



| | <u>Plan Year Deductible</u> \$5,000 <i>per Individual or Family</i> | <u>Out-of-Pocket Maximum</u> \$5,000 <i>per Individual or Family</i> | <u>Lifetime Maximum</u> \$2,000,000 <i>per Person</i> | |
|--|---|--|---|--------------------------|
| | | <u>Co-Pay *</u> | <u>Deductible</u> | <u>Plan Cost Sharing</u> |
| Professional Office Visits | | | | |
| Well Child Care (Up to 24 Months) | <i>These charges are billed by the physician for time spent with the patient. Coverage includes Preventive Check-Ups & Physicals, Maternity: Pre & Post natal care. Office visits do not include charges for diagnostic, surgical or medical procedures performed by the physician. Medication Management limited to 4 visits per year.</i> | \$10 | N/A | 100% |
| Primary Care | | \$20 | N/A | 100% |
| Specialist | | \$40 | N/A | 100% |
| Outpatient Diagnostic Tests, Lab & X-Ray | <i>Includes diagnostic tests performed in a physician's office or a free standing non-hospital based facility only.</i> | \$20 | N/A | 100% |
| Vision | <i>Maximum annual benefit of \$60 after Copayment. Covered Person must submit claim for reimbursement.</i> | \$40 | N/A | 100% |
| Short Term Rehabilitation Services | <i>Physical, Chiropractic, Speech and Occupational Therapy: Up to 30 visits per condition, per Plan Year.</i> | \$40 | N/A | 100% |
| Emergency Services | | | | |
| Hospital Emergency Room (Facility Charge Only) | <i>ER Copayment waived if admitted; \$500 penalty for non-emergency use of a hospital emergency room.</i> | \$150 | N/A | 100% |
| Urgent Care/Physician | | \$20 | N/A | 100% |
| Ambulance | | \$40 | N/A | 100% |
| Allergy Treatment | | | | |
| Testing and Injections | | \$20 | N/A | 100% |
| Serum | | \$100 | N/A | 100% |
| Inpatient Hospitalization | | | | |
| Medical Services and Facility | <i>Organ Transplant Benefits are subject to specific procedures and limitations as indicated in the Organ Transplant Benefits section of the SPD.</i> | N/A | APPLIES | 100% |
| Anesthesiologist and Surgeon Fees | | N/A | APPLIES | 100% |
| Outpatient Services | | | | |
| Medical Services | <i>Includes outpatient services or procedures at a freestanding surgery center or hospital (when approved), miscellaneous medical services and supplies. Including, but not limited to Surgical, Diagnostic and Therapeutic Procedures. Surgical/invasive procedures done in a physician's office also included.</i> | N/A | APPLIES | 100% |
| Facility Charges | | N/A | APPLIES | 100% |
| Home Health Care & Skilled Nursing Facility | <i>Up to 60 days or visits in a Plan Year.</i> | N/A | APPLIES | 100% |
| Hospice Care | | N/A | APPLIES | 100% |
| Mental Health & Substance Abuse | | | | |
| Inpatient Hospitalization | <i>Excludes counseling for behavioral disorders.</i> | N/A | APPLIES | 100% |
| Outpatient Office Visits | | \$40 | N/A | 100% |
| Durable Medical Equipment | <i>Maximum annual benefit of \$5,000 per person, per Plan Year.</i> | N/A | APPLIES | 100% |

* Copayments never apply to the Plan Year Deductible or Out-of-Pocket Maximum.

Pre-Certification Penalty: Certain procedures or medical care require pre-certification in order to qualify for full benefits. Failure to pre-certify will result in a \$250 penalty per service, procedure or confinement. Please refer to the Pre-Certification section in your SPD for details.

Please Note: This schedule applies as indicated in the Summary Plan Description. This schedule must be read in conjunction with the entire Summary Plan Description and has no full meaning by itself.