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|--------------------------------------|---|
| Annual Deductible | \$100 per person / \$300 maximum per family |
| Stop Loss (Per Calendar Year) | \$2,000 co-insurance per person / \$6,000 per family |
| Lifetime Maximum | \$1,500,000 per covered person per lifetime, all benefits combined (+ maximum of \$15,000 per calendar year, with no carry-over) |
| Student Coverage | Available up to age 26 |

| BENEFITS | PARTICIPATING PROVIDER | | NON-PARTICIPATING PROVIDER | |
|--|---------------------------------|---------------------------|---------------------------------|---|
| | \$100 ANNUAL DEDUCTIBLE APPLIES | Plan Pays: | \$100 ANNUAL DEDUCTIBLE APPLIES | Plan Pays: |
| | | | | Will be calculated on a lower eligible charge. The member is responsible for paying the applicable co-payments, co-insurance & deductibles plus any remaining balances over the eligible charge up to the full billed amount. |
| Physician Services | | | | |
| • Office Visits | No | 100% after \$15 co-pay | No | 100% after \$15 co-pay |
| • Hospital Visits | No | 80% | No | 80% |
| Hospital Services | | | | |
| • Room & Care (semi-private rate) | No | 80% | No | 80% |
| • Intensive Care Unit, Coronary Care Unit, Ancillary Services, Inpatient Lab & X-Ray | No | 80% | No | 80% |
| Surgical Services | | | | |
| • Surgery and Anesthesiology | No | 80% | No | 80% |
| Outpatient Lab & X-Ray | | | | |
| • Non-Hospital & Office Based | No | 100% after \$10 per visit | No | 100% after \$10 per visit |
| • Hospital Outpatient | No | 80% | No | 80% |
| Mental Health Services | | | | |
| • Inpatient or Partial Day | No | 80% | No | 80% |
| • Individual, Group or Family Therapy | No | 100% after \$15 co-pay | No | 100% after \$15 co-pay |
| • Psychological Testing | No | 100% after \$25 per visit | No | 100% after \$25 per visit |

Note: Reimbursement is based on a percentage of HMAA's eligible charges, not the billed charges. Eligible charges may be based on a procedure fee schedule, a percentage of billed charges, per day (per diem) fees, per case fees, per treatment fees, or other methods.

| BENEFITS | PARTICIPATING PROVIDER | | NON-PARTICIPATING PROVIDER | |
|---|---------------------------------|---|---------------------------------|---|
| | \$100 ANNUAL DEDUCTIBLE APPLIES | Plan Pays: | \$100 ANNUAL DEDUCTIBLE APPLIES | Plan Pays: |
| Other Services | | | | Will be calculated on a lower eligible charge. The member is responsible for paying the applicable co-payments, co-insurance & deductibles plus any remaining balances over the eligible charge up to the full billed amount. |
| • Allergy Testing/Treatment (one series per year) | Yes | 80% | Yes | 80% |
| • Allergy Shots | No | 100% after \$5 co-pay | No | 100% after \$5 co-pay |
| • Chemotherapy | Yes | 80% | Yes | 80% |
| • Dialysis | Yes | 80% | Yes | 80% |
| • Outpatient Injections | Yes | 80% | Yes | 80% |
| • Physical Therapy, Speech Therapy, Occupational Therapy (60 visits maximum) | Yes | 80% | Yes | 80% |
| • Emergency Room | No | 80% | No | 80% |
| • Ambulance - Land | No | 80% | No | 80% |
| • Ambulance - Air | Yes | 80% | Yes | 80% |
| • Skilled Nursing Facility (120-day maximum per calendar year) | No | 80% | No | 80% |
| • Hospice | No | 80% | No | 80% |
| • Home Health Care (150 visits per calendar year) | No | 80% | No | 80% |
| Preventive Care | | | | |
| • Physical Exams (Ages 6-18, one per year; 18-49, one every two years; 49+, one per year) | No | 100% after \$10 co-pay | No | 100% after \$10 co-pay |
| • Well Baby Care (through age 5) | No | 100% | No | 100% |
| • Immunizations (through age 5) | No | 100% | No | 100% |
| • Immunizations (age 6+) | No | 100% after \$5 co-pay | No | 100% after \$5 co-pay |
| • Mammograms (routine screening: age 35-39, one baseline; age 40+, one every 12 months) | No | 100% after \$10 co-pay | No | 100% after \$10 co-pay |
| • Pap Smears (one per calendar year) | No | 100% | No | 100% |
| • Prostate Specific Antigen | No | 100% after \$10 co-pay | No | 100% after \$10 co-pay |
| Employee Assistance Program (EAP) | N/A | Up to 6 visits per calendar year at no charge | N/A | Not a benefit |
| <p>Included with Medical Plan. HMAA's Employee Assistance Program (EAP) has one primary goal - to help employees live healthier, more fulfilling lives. By helping employees resolve their personal and work-related problems, we can boost productivity and morale at the workplace.</p> | | | | |

Note: Reimbursement is based on a percentage of HMAA's eligible charges, not the billed charges. Eligible charges may be based on a procedure fee schedule, a percentage of billed charges, per day (per diem) fees, per case fees, per treatment fees, or other methods.



Plan Amendment
to
Comprehensive Basic
Medical Plan Schedule of Benefits

Implemented pursuant to the Patient Protection and Affordable Care Act, amended by Health Care and Education Reconciliation Act of 2010 ("PPACA").

The following changes are made to your Plan effective
January 1, 2011:

| | |
|----------------------------------|--|
| Lifetime Maximum Benefits Limit: | Unlimited |
| Annual Maximum Benefit Limit: | \$1,500,000 |
| Preventive Care: | Plan pays 100% of the In-Network Eligible Charge |
| Emergency Services: | No Pre-Authorization is required, and Out-of-Network Benefits are paid at the In-Network (Par) Benefit level |
| Adult Children Coverage: | Available up to Age 26 (regardless of marital status, enrollment in school, financial dependency or residency) |

This plan amendment is being implemented pursuant to the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010) ("PPACA"). If any relevant provision of PPACA, or the application thereof to any person, entity, or circumstance shall, to any extent or for any reason, be held to be invalid, illegal, or unenforceable in any respect by a court or government entity of competent jurisdiction, then this plan amendment shall be deemed immediately null, void, and of no further force or effect.