EPO *two*

Small Business Medical Plan Schedule of Benefits

Annual Deductible — **$100 per person / maximum of 3 individual deductibles per family**

Stop Loss (Per Calendar Year)
- Participating Provider — **$2,500 co-insurance per person**
- Non-Participating Provider — **$5,000 co-insurance per person**

(Excludes deductibles and co-payments)

Lifetime Maximum — **$2,000,000 per person**

Dependent Coverage — **Available up to age 26**

Life Insurance — **$20,000**

Accidental Death & Dismemberment — **$20,000**

Primary subscriber coverage only (exclusions may apply)

BENEFITS	PARTICIPATING PROVIDER		NON-PARTICIPATING PROVIDER	
	$100 ANNUAL DEDUCTIBLE APPLIES	*Plan Pays:*	$100 ANNUAL DEDUCTIBLE APPLIES	*Plan Pays:*
				Benefit level will be at a lower percentage & 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	80% after $5 co-pay	No	70% after $10 co-pay
• Hospital Visits	Yes	80%	Yes	70%
Hospital Services				
• Hospital Deductible Per Confinement		None	No	$250 in addition to Annual Deductible
• Room & Care (semi-private rate)	Yes	80%	Yes	70% after $250 Hospital Deductible
• Intensive Care Unit, Coronary Care Unit, Ancillary Services, Inpatient Lab & X-Ray	Yes	80%	Yes	70%
Surgical Services				
• Surgery and Anesthesiology (includes maternity benefits)	Yes No	80% Inpatient 80% Outpatient	Yes No	70% Inpatient 70% Outpatient
Outpatient Lab & X-Ray				
• X-Ray Films, Diagnostic Services & Radiotherapy	Yes	80%	Yes	70%
Mental Health Services				
• Hospital & Doctor Services (30 days max per calendar year - inpatient)	Yes	80%	Yes	70% after $250 Hospital Deductible
• Psychiatrist & Psychologist Services (24 visits max per calendar year - outpatient)	No	80% after $5 co-pay	No	70% after $10 co-pay

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.

EPO *two*

Small Business Medical Plan Schedule of Benefits *(continued)*

BENEFITS	PARTICIPATING PROVIDER		NON-PARTICIPATING PROVIDER	
	$100 ANNUAL DEDUCTIBLE APPLIES	*Plan Pays:*	$100 ANNUAL DEDUCTIBLE APPLIES	*Plan Pays:*
				Benefit level will be at a lower percentage & 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.
Other Services				
• Allergy Testing/Treatment (one series per year)	Yes	80% after $15 co-pay	Yes	70% after $25 co-pay
• Appliances & Equipment, Blood, Chemotherapy, Dialysis & Supplies, Organ Donor Services, Outpatient Injections (including immunizations)	Yes	80%	Yes	70%
• Physical Therapy, Speech Therapy, Occupational Therapy (pre-certification required after 10 visits)	No	80% after $5 co-pay	No	70% after $10 co-pay
• Emergency Room	Yes	80% after $50 co-pay	Yes	70% after $50 co-pay
• Urgent Care Center	Yes	100% after $25 co-pay	Yes	100% after $25 co-pay
• Ambulance	Yes	$200 maximum	Yes	$200 maximum
• Skilled Nursing Facility (30-day maximum per calendar year)	Yes	80%	Yes	$60 per day maximum
• Hospice (150-day maximum per lifetime)	Yes	100%	Yes	100%
• Home Health Care (150 visits per calendar year)	No	80% after $5 co-pay	No	70% after $10 co-pay
Chiropractic, Naturopathic, Acupuncture				
• Initial Examination	No	100% after $5 co-pay	Yes	$20 maximum after $10 co-pay
• Treatment	No	100% after $5 co-pay	Yes	$20 maximum after $10 co-pay
(Maximum of 10 examinations/treatments per calendar year for all benefits in this category)				
Preventive Care				
• Physicals (including related tests) ($125 maximum per age category: Ages 6-39, every 36 months; 40-49, every 24 months; 50+, every 12 months)	No	80%	No	70%
• Well Baby Care (through age 5)	No	80% after $5 co-pay	No	70% after $10 co-pay
• Immunizations (through age 5)	No	100%	No	100%
• Mammograms (routine screening: age 35-39, one baseline; age 40+, one every 12 months)	No	80%	No	70%
• Pap Smears (one per calendar year)	No	80%	No	70%
Employee Assistance Program (EAP)	No	Up to 6 visits per calendar year at no charge	N/A	Not a benefit

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 help boost productivity and morale at the workplace.

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.

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Plan Amendment

to

EPO *Two*

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:	$2,000,000
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)
Ground Ambulance:	No maximum

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.

Small Business Prescription Drug & Vision Plan

Schedule of Benefits

PRESCRIPTION DRUG PLAN - Mandatory Generic

This Prescription Drug Plan has a $1,000 maximum per family per calendar year.

BENEFITS	RETAIL PROGRAM PARTICIPATING PHARMACY (up to 30-day supply)	(31-90 day supply)*	MAIL ORDER PROGRAM (60-90 day supply)	NON-PARTICIPATING PHARMACY
Generic (cost under $150 at pharmacy / under $300 through mail order)	$5 co-pay	$15 co-pay	$10 co-pay	No 31-90 day retail or mail order benefits. Member pays the total amount up front and is reimbursed the wholesale price minus the applicable co-payments.
Preferred Brand Name (cost under $150 at pharmacy / under $300 through mail order)	$20 co-pay	$60 co-pay	$45 co-pay	
Non-Preferred Brand Name (cost under $150 at pharmacy / under $300 through mail order)	$35 co-pay	$105 co-pay	$75 co-pay	
Prescriptions over $150 pharmacy / $300 mail order	20% of ingredient cost	20% of ingredient cost	20% of ingredient cost	
DIABETIC SUPPLIES & INSULIN:				
Preferred Brand Name (cost under $150 at pharmacy / under $300 through mail order)	$5 co-pay	$15 co-pay	$10 co-pay	
Non-Preferred Brand Name (cost under $150 at pharmacy / under $300 through mail order)	$20 co-pay	$60 co-pay	$45 co-pay	
Prescriptions over $150 pharmacy / $300 mail order	20% of ingredient cost	20% of ingredient cost	20% of ingredient cost	

**** Please refer to the participating provider directory for the 31-90 day pharmacy network.***

If there is a generic equivalent available and a brand name drug is dispensed, then the member is responsible for the respective brand name co-pay PLUS the cost difference between the generic and the brand name drug.

VISION PLUS PLAN

BENEFITS	PARTICIPATING PROVIDER *Plan Pays:*	NON-PARTICIPATING PROVIDER *Plan Pays:*
Examination & Diagnosis		
• Vision Exam	100% after $25 deductible	$40
Frames		
• Standard Frames	100% after $25 deductible (for frames up to $105) Plus, 20% off any out-of-pocket costs	$45
Lenses ($25 deductible if lenses are purchased separately)		
• Single Vision Lens	100%	$40
• Bifocal Lens	100%	$60
• Trifocal Lens	100%	$80
Contact Lenses		
• In Lieu of Frames and Lenses	$105 Plus, 15% off cost of contact lens exam	$105
Frequency of Services		
• Examination	Once every 12 months	Once every 12 months
• Lenses	Once every 24 months	Once every 24 months

Note: Polycarbonate lenses for dependent children up to age 19 are covered in full
Vision Plans are underwritten by Vision Service Plan (VSP) for HMAA

This is a summary of benefits. Refer to the Summary Plan Description for additional details.
Prescription Drug & Vision Plans are subject to underwriting - may or may not be offered.

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Small Business Dental Plan
Schedule of Benefits

DENTAL PLAN		
BENEFITS	PLAN D	
	HIDA DENTISTS *Plan Pays:*	ALL OTHER HMAA PARTICIPATING DENTISTS *Plan Pays:*
Annual Maximum	**$750**	**$750**
Basic Services	**70%**	**60%**
• Oral Exams (once per calendar year)		
• Bitewing X-rays (twice per calendar year)		
• Full Mouth X-rays (once per 3 calendar years)		
Preventive Services	**70%**	**60%**
• Cleanings (twice per calendar year)		
• Fluoride Treatments (once per calendar year through age 17)		
• All Other X-rays (as required)		
Restorative Services	**70%**	**60%**
• Restorative Treatment		
• Palliative Treatment		
• Oral Surgery		
Root Canal/Gum Disease*	**50%**	**40%**
• Endodontics		
• Periodontics		
Major Services**	**50%**	**40%**
• Crowns†		
• Bridges and Dentures† (repairs and adjustments)		

NO BENEFITS ARE AVAILABLE FOR SERVICES BY NON-PARTICIPATING PROVIDERS.

* Root canal and gum disease treatment are available to members who have been enrolled continuously with the same HMAA group for the 6 months preceding the date of service.
** Major dental services are available to members who have been enrolled continuously with the same HMAA group for the 12 months preceding the date of service.
† Replacements are covered if the existing crown, bridge or denture is at least 5 years old.

This is a summary of benefits. Refer to the Summary Plan Description for additional details.
Dental Plan is subject to underwriting - may or may not be offered.

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