

Benefit Plan Summary

	HOORAY HEALTH SELECT BASIC	HOORAY HEALTH SELECT PLUS	HOORAY HEALTH SELECT PREMIUM
HOORAY HEALTH PLAN (OUTPATIENT)			
WELLNESS BENEFITS			
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
RETAIL CLINIC & URGENT CARE BENEFITS*			
1. Physician Visit Hooray Health Network (No Balance Bills)* includes office visit, plus in-house lab, x-rays, etc.	Member Pays \$25 No Balance Bills*	Member Pays \$25 No Balance Bills*	Member Pays \$25 No Balance Bills*
2. Physician Visit with First Health Provider (Discounted rates)**	Plan Pays up to \$175	Plan Pays up to \$175	Plan Pays up to \$175
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
Total Sick Visits	3 per year	4 per year	5 per year
PHYSICIAN VISITS			
Outpatient Doctor Visit (First Health Provider Network or 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			
Diagnostic X-Ray & Laboratory benefit	\$25 per day x 2 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	N/A	\$150 per day x 1 day	\$150 per day x 1 day
INPATIENT BENEFITS			
Hospital Admission Benefit	N/A	N/A	\$2,000 per day x 1 day
Hospital Confinement Benefit	N/A	N/A	\$1,000 per day x 5 days
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	\$375 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
Benefit % Payable	100% U&C	100% U&C	100% U&C
NON-INSURANCE SERVICES⁽¹⁾			
Hooray Health Medical Concierge	Included	Included	Included
Telemedicine Doctor (Lyric Powered by MyTelemedicine)	\$0 consult; unlimited visits	\$0 consult; unlimited visits	\$0 consult; unlimited visits
Discount Prescription Program (ScriptSave WellRx)	Included	Included	Included
Discount Radiology (Green Imaging)	Included	Included	Included
Behavioral Health (Lyric Powered by MyTelemedicine)	\$0 consult; unlimited visits	\$0 consult; unlimited visits	\$0 consult; unlimited visits
Careington Discount Dental and Vision	Included	Included	Included
MONTHLY RATES			
	BASIC	PLUS	PREMIUM
MEMBER ONLY	\$81.66	\$98.81	\$160.49
MEMBER + SPOUSE	\$136.82	\$173.12	\$316.69
MEMBER + CHILD(REN)	\$129.34	\$156.95	\$245.63
FAMILY	\$194.50	\$241.26	\$411.83

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 centers.

**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.