

International Health Plan Summary of Coverage

| BENEFITS | Tier 1 Cleveland Clinic Provider Network | Tier 2 CHN, Medical Mutual Traditional, and USAMCO Provider Networks* |
|--|--|---|
| Benefit Period | January 1st through December 31st | |
| Dependent Age Limit | end of month age 23; end of month age 26 if full-time student | |
| Lifetime Maximum Benefit | none | |
| Annual Deductible — Individual/Family | \$0 | \$200/\$600 |
| Co-insurance | 0% | 20% |
| Co-insurance Out-of-Pocket Maximum (excluding deductible) — Individual/Family | N/A | \$3,000/\$6,000 |
| PHYSICIAN/OFFICE SERVICES | PERCENTAGE PAID BY PLAN | |
| Office Visit (Illness/Injury) | 100% | 80% of Allowed Amount after deductible |
| Urgent Care Facility Services | 100% | 80% of Allowed Amount after deductible |
| Medical/Surgical | 100% | 80% of Allowed Amount after deductible |
| Immunizations (including tetanus toxoid, rabies vaccine, and meningococcal polysaccharide vaccine) | 100% | not covered |
| Allergy Testing and Treatments | 100% | 80% of Allowed Amount after deductible |
| PREVENTIVE SERVICES | | |
| Office Visit/Routine Physical Exam | 100% | not covered |
| Routine Vision or Hearing Exam | 100% | not covered |
| Well Child Care | 100% | not covered |
| Routine Mammogram | 100% | not covered |
| Routine Pap Test | 100% | not covered |
| Routine EKG, Chest X-ray, Complete blood count, comprehensive metabolic panel, urinalysis | 100% | not covered |
| OUTPATIENT SERVICES | | |
| Medical/Surgical | 100% | 80% of Allowed Amount after deductible |
| Diagnostic Services | 100% | 80% of Allowed Amount after deductible |
| Physical/Occupational/Chiropractic/Speech Therapies (maximum 26 visits per calendar year for each type of therapy) | 100% | 80% of Allowed Amount after deductible |
| Professional Services | 100% | 80% of Allowed Amount after deductible |
| Emergency use of an Emergency Room | 100% | 100% (no deductible) |
| Non-Emergency use of an Emergency Room | 100% | 80% of Allowed Amount after deductible |
| INPATIENT FACILITY | | Services Require Preauthorization |
| Semi-Private room and board | 100% (private room at Cleveland Clinic) | 80% of Allowed Amount after deductible |
| Medical/Surgical | 100% | 80% of Allowed Amount after deductible |
| Maternity | 100% | 80% of Allowed Amount after deductible |
| Skilled Nursing Facility following hospital discharge (preauthorization required) | 100% up to 180 days | 100% of Allowed Amount up to 180 days |
| ADDITIONAL SERVICES | | |
| Ambulance (Emergency) | 100% | 100% (no deductible) |
| Durable Medical Equipment | 100% | 80% of Allowed Amount after deductible |
| Home Healthcare (preauthorization required) | 100% up to 100 visits per year | 100% of Allowed Amount up to 100 visits per year |
| Hospice | 100% | 100% (no deductible) |
| Organ Transplants | 100% | 80% of Allowed Amount after deductible |
| Oral Accident | 100% | 100% (no deductible) |
| Temporomandibular Joint (preauthorization required) | 100% | 80% of Allowed Amount after deductible |
| Infertility Treatment | 100%; invitro — 100%, 3 attempted egg recoveries in a 4 year period | not covered |
| HEARING AIDS | 50% (every 3 years) | not covered |

*If a service is received outside of these networks, in addition to the deductible and co-insurance, the Plan Member is also responsible to pay any charges in excess of the "Allowed Amount," i.e., the amount that would have been charged for the service by an in-network provider.