Addendum

Benefit Requirements for TECRO Group Health Insurance Contract

OVERVIEW MATRIX

Benefit Highlights	International	U.S. Participating Provider	U.S. Non Participating Provider
Lifetime Maximum	Unlimited	Unlimited	Unlimited
The Percentage of Covered Expenses the Plan Pays	60%	85%	60% of the Maximum Reimbursable Charge
Maximum Reimbursable Charge	Not Applicable	Not Applicable	150% of Medicare Rates
Policy Year Medical Deductible			
Individual	$350	$350	$700
Family Maximum	2 times the individual Deductible	2 times the individual Deductible	2 times the individual Deductible
Out-of-Pocket Maximum			
Individual	$4,700	$2,250	$4,700
Family Maximum	2 times the individual Out-of- Pocket Maximum	2 times the individual Out-of- Pocket Maximum	2 times the individual Out-of- Pocket Maximum
Physician's Services			
Physician's Office Visit - Primary Care Physician	60%, No Deductible	100%, No Deductible, $20 Copay	60%, No Deductible, $40 Copay
Office Visit – Specialist	60%, No Deductible	100%, No Deductible, $20 Copay	60%, No Deductible, $40 Copay
Surgery Performed In the Physician's Office	60%, After Deductible	85%, After Deductible	60%, After Deductible
Second Opinion Consultations (provided on a voluntary basis)	60%, No Deductible	100%, No Deductible, $20 Copay	60%, No Deductible, $40 Copay
Allergy Treatment/Injections	60%, No Deductible	100%, No Deductible, $20 Copay	60%, No Deductible, $40 Copay

Benefit Highlights	International	U.S. Participating Provider	U.S. Non-Participating Provider
Preventive Care Routine Preventive Care – all ages	100% not subject to Plan Deductible or Copayments	100% not subject to Plan Deductible or Copayments	60%, No Deductible
Immunizations – all ages	100% not subject to Plan Deductible or Copayments	100% not subject to Plan Deductible or Copayments	60%, No Deductible
Mammograms, PSA, PAP Smear and Colorectal Cancer Screenings	100% not subject to Plan Deductible or Copayments	100% not subject to Plan Deductible or Copayments	60%, No Deductible
Lead Poisoning Screening Tests For Children under age 6	100% not subject to Plan Deductible or Copayments	100% not subject to Plan Deductible or Copayments	60%, No Deductible
Inpatient Hospital – Facility/Professional Charges			
Bed and Board Charges	60%, After Deductible	85%, After Deductible	60%, After Deductible
Physician's Visits/Consultations	60%, After Deductible	85%, After Deductible	60%, After Deductible
Professional Services (Surgeon, Radiologist, Pathologist, Anesthesiologist)	60%, After Deductible	85%, After Deductible	60%, After Deductible
Inpatient Services at Other Heath Care Facilities	60%, After Deductible	85%, After Deductible	60%, After Deductible
Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities			
Policy Year Maximum of 120 day limit.			
Ambulatory Surgical Services			
Operating Room, Recovery Room, Procedure Room, Treatment Room and Observation Room	60%, After Deductible	85%, After Deductible	60%, After Deductible

Benefit Highlights	International	U.S. Participating Provider	U.S. Non-Participating Provider
Professional Services (Surgeon, Radiologist, Pathologist, Anesthesiologist)	60%, After Deductible	85%, After Deductible	60%, After Deductible
Emergency and Urgent Care Services			If You have a true Emergency Medical Condition, the benefits will be paid at the U.S. Participating Provider Rate
Hospital Emergency Room	60%, After Deductible	85%, After Deductible	60%, After Deductible
Outpatient Professional Services (radiology, pathology and ER Physician)	60%, After Deductible	85%, After Deductible	60%, After Deductible
Urgent Care Facility	60%, After Deductible	85%, After Deductible	60%, After Deductible
X-ray and/or Lab performed at the Emergency Room or Urgent Care Facility (billed as part of the visit)	60%, After Deductible	85%, After Deductible	60%, After Deductible
X-ray and/or Lab performed at the Independent facility in conjunction with the Emergency Room visit	60%, After Deductible	85%, After Deductible	60%, After Deductible
Ambulance	60%, After Deductible	85%, After Deductible	60%, After Deductible
Laboratory and Radiology Services (includes pre-admission testing)			
Inpatient Facility	60%, After Deductible	85%, After Deductible	60%, After Deductible
Outpatient Facility	60%, After Deductible	85%, After Deductible	60%, After Deductible
Independent X-ray and/or Lab Facility	60%, After Deductible	85%, After Deductible	60%, After Deductible

Benefit Highlights	International	U.S. Participating Provider	U.S. Non-Participating Provider
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans and PET Scans)			
Inpatient Facility	60%, After Deductible	85%, After Deductible	60%, After Deductible
Outpatient Facility	60%, After Deductible	85%, After Deductible	60%, After Deductible
Independent Facility	60%, After Deductible	85%, After Deductible	60%, After Deductible
Maternity Care/Obstetrical Services			
Physician's Office visit to confirm pregnancy	60%, No Deductible	100%, No Deductible, $20 Copay	60%, No Deductible, $40 Copay
Global Maternity Fee (Prenatal, Postnatal and Physician's delivery charge)	60%, After Deductible	85%, After Deductible	60%, After Deductible
Physician's Office visits in addition to the global maternity fee	60%, No Deductible	100%, No Deductible, $20 Copay	60%, No Deductible, $40 Copay
Laboratory, Radiology Services and or Advance Radiological Imaging	60%, After Deductible	85%, After Deductible	60%, After Deductible
Delivery Charges – Facility (Hospital, Birthing Center)	60%, After Deductible	85%, After Deductible	60%, After Deductible
Services of a Doula In home or facility up to 10 visits (pre and post-natal combined	60%, After Deductible	Not Covered	Not Covered
Termination of Pregnancy			
Medically Necessary	60%, After Deductible	85%, After Deductible	60%, After Deductible
Elective	60%, After Deductible	85%, After Deductible	60%, After Deductible
Infertility Expenses – Basic			

Benefit Highlights	International	U.S. Participating Provider	U.S. Non-Participating Provider
Covered Expenses include Charges made by a Physician to diagnose and to surgically treat the underlying medical cause of infertility.			
Physician's Office Visit	60%, No Deductible	100%, No Deductible, $20 Copay	60%, No Deductible, $40 Copay
Inpatient Facility	60%, After Deductible	85%, After Deductible	60%, After Deductible
Outpatient Facility	60%, After Deductible	85%, After Deductible	60%, After Deductible
Physician's Services	60%, After Deductible	85%, After Deductible	60%, After Deductible
Infertility Expenses – Comprehensive			
Limited Benefit – See benefit description for specific coverages and exclusions. Pre-authorization is required.			
Physician's Office Visit	60%, No Deductible	100%, No Deductible, $20 Copay	60%, No Deductible, $40 Copay
Outpatient Facility	60%, After Deductible	85%, After Deductible	60%, After Deductible
Physician's Services	60%, After Deductible	85%, After Deductible	60%, After Deductible
Family Planning/Contraception Management See benefit description for specific coverages			
For Women			
Physician's Office Visit	100% not subject to Plan Deductible or Copayments	100% not subject to Plan Deductible or Copayments	60%, No Deductible
Inpatient Facility	100% not subject to Plan Deductible or Copayments	100% not subject to Plan Deductible or Copayments	60%, No Deductible
Outpatient Facility	100% not subject to Plan Deductible or Copayments	100% not subject to Plan Deductible or Copayments	60%, No Deductible
Physician's Services	100% not subject to Plan Deductible or Copayments	100% not subject to Plan Deductible or Copayments	60%, No Deductible

Benefit Highlights	International	U.S. Participating Provider	U.S. Non-Participating Provider
For Men			
Physician's Office Visit	60%, No Deductible	100%, No Deductible, $20 Copay	60%, No Deductible, $40 Copay
Inpatient Facility	60%, After Deductible	85%, After Deductible	60%, After Deductible
Outpatient Facility	60%, After Deductible	85%, After Deductible	60%, After Deductible
Physician's Services	60%, After Deductible	85%, After Deductible	60%, After Deductible
Obesity/Bariatric Surgery			
Subject to Medical Necessity and Clinical guidelines for someone who is Morbidly Obese. Pre-authorization is required			
Physician's Office Visit	60%, No Deductible	100%, No Deductible, $20 Copay	60%, No Deductible, $40 Copay
Inpatient Facility	60%, After Deductible	85%, After Deductible	60%, After Deductible
Outpatient Facility	60%, After Deductible	85%, After Deductible	60%, After Deductible
Physician's Services	60%, After Deductible	85%, After Deductible	60%, After Deductible
Organ Transplant Services			
Includes all medically appropriate, non-Experimental transplants. Pre-authorization is required			
Physician's Office Visit	60%, No Deductible	100%, No Deductible, $20 Copay	60%, No Deductible, $40 Copay
Inpatient Facility	60%, After Deductible	85%, After Deductible	60%, After Deductible
Physician's Services	60%, After Deductible	85%, After Deductible	60%, After Deductible
Lifetime Travel Maximum: $10,000 per transplant	100% of Reasonable Expenses after Plan Deductible	100% of Reasonable Expenses after Plan Deductible	Not Covered
Transgender Services			
See benefit description for covered services. Pre-authorization is required			

Benefit Highlights	International	U.S. Participating Provider	U.S. Non-Participating Provider
Physician's Office Visit	60%, No Deductible	100%, No Deductible, $20 Copay	60%, No Deductible, $40 Copay
Inpatient Facility	60%, After Deductible	85%, After Deductible	60%, After Deductible
Outpatient Facility	60%, After Deductible	85%, After Deductible	60%, After Deductible
Physician's Services	60%, After Deductible	85%, After Deductible	60%, After Deductible
Nutritional Evaluation	60%, No Deductible	100%, No Deductible, $20 Copay	60%, No Deductible, $40 Copay
Policy Year Maximum of 3 visit limit. Limit does not apply to treatment of diabetes or for services due to a mental health or substance abuse diagnosis.	60%, No Deductible 60%, After Deductible	100%, No Deductible, $20 Copay 85%, After Deductible	60%, No Deductible, $40 Copay 60%, After Deductible
Physician's Office Visit **Nutritional Formulas** **Acupuncture** Physician's office visit	60%, No Deductible 60%, After Deductible 60%, No Deductible	100%, No Deductible, $20 Copay 85%, After Deductible 100%, No Deductible, $20 Copay	60%, No Deductible, $40 Copay 60%, After Deductible 60%, No Deductible, $40 Copay
Chiropractic Care/Spinal Manipulations Physician's office visit Policy Year Maximum of 20 visit limit.	60%, No Deductible	100%, No Deductible, $20 Copay	60%, No Deductible, $40 Copay
Annual Physical/Executive Health Screening for Services not covered as Preventive Care Policy Year Maximum of $500	60%, After Deductible	85%, After Deductible	60%, After Deductible
Telehealth	60%, No Deductible	100%, No Deductible, $20 Copay	60%, No Deductible, $40 Copay
Dental Services due to an Injury and Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth) Limited Benefits – please see the benefit description for limitation on Dental Services due to an Injury			

Benefit Highlights	International	U.S. Participating Provider	U.S. Non-Participating Provider
Physician's Office Visit	60%, No Deductible	100%, No Deductible, $20 Copay	60%, No Deductible, $40 Copay
Inpatient Facility	60%, After Deductible	85%, After Deductible	60%, After Deductible
Outpatient Facility	60%, After Deductible	85%, After Deductible	60%, After Deductible
Physician's Services	60%, After Deductible	85%, After Deductible	60%, After Deductible
TMJ Treatment	60%, After Deductible	85%, After Deductible	60%, After Deductible
Diabetic Equipment	60%, After Deductible	85%, After Deductible	60%, After Deductible
Durable Medical Equipment	60%, After Deductible	85%, After Deductible	60%, After Deductible
External Prosthetic Appliances	60%, After Deductible	85%, After Deductible	60%, After Deductible
Wigs (for hair loss due to alopecia areata or cancer treatment) Policy Year Maximum of $500	60%, After Deductible	85%, After Deductible	60%, After Deductible
Mental Health			
Inpatient Facility	60%, After Deductible	85%, After Deductible	60%, After Deductible
Outpatient (Includes Individual, Group and Intensive Outpatient)			
Physician's Office Visit	60%, No Deductible	100%, No Deductible, $20 Copay	60%, No Deductible, $40 Copay
Outpatient Facility	60%, After Deductible	85%, After Deductible	60%, After Deductible
Psycho-Educational Testing	60%, After Deductible	85%, After Deductible	60%, After Deductible
Substance Abuse Health			
Inpatient Facility	60%, After Deductible	85%, After Deductible	60%, After Deductible
Outpatient (Includes Individual, Group and Intensive Outpatient)			
Physician's Office Visit	60%, No Deductible	100%, No Deductible, $20 Copay	60%, No Deductible, $40 Copay
Outpatient Facility	60%, After Deductible	85%, After Deductible	60%, After Deductible

Benefit Highlights	International	U.S. Participating Provider	U.S. Non-Participating Provider
Hearing Benefit One Examination per 12 month period	60%, No Deductible	100%, No Deductible, $20 Copay	60%, No Deductible, $40 Copay
Hearing Aid Benefit Up to $1,000 per hearing aid unit necessary for each hearing impaired ear every 36 months	60%, After Deductible	85%, After Deductible	60%, After Deductible
Home Health Care Services Policy Year Maximum of 120 visit limit.	60%, After Deductible	85%, After Deductible	60%, After Deductible
Private Duty Nursing Policy Year Maximum of 120 visit limit.	60%, After Deductible	85%, After Deductible	60%, After Deductible
Hospice Care Services	60%, After Deductible	85%, After Deductible	60%, After Deductible
Infusion Therapy			
Outpatient Facility	60%, After Deductible	85%, After Deductible	60%, After Deductible
Physician's Services	60%, After Deductible	85%, After Deductible	60%, After Deductible
Short Term Rehabilitative Therapy			
Policy Year Maximum of 30 visit limit for all therapies combined.			
Physician's Office Visit	60%, No Deductible	100%, No Deductible, $20 Copay	60%, No Deductible, $40 Copay
Outpatient Hospital Facility	60%, After Deductible	85%, After Deductible	60%, After Deductible
Note: The Short Term Rehabilitative Therapy maximum does not apply to the treatment of autism.			

Vision Care Rider

Examinations **One Eye Exam every 12 Consecutive months**	100% coverage, not subject to any Deductible
Lenses & Frames **One pair of glasses or contact lenses per 12 Consecutive months**	100% coverage, not subject to any Deductible, up to a Maximum Benefit of $250

Prescription Drugs Purchased Outside of the United States	
Retail Pharmacies or Drugs dispensed by a Physician or medical facility on an Outpatient basis – Copayments based on a one (1) month supply	
Tier 1 Prescription Drugs – Generic	40% Copayment per Prescription or refill. Deductible does not apply.
Tier 2 Prescription Drugs – Preferred Brand	40% Copayment per Prescription or refill. Deductible does not apply.
Tier 3 Prescription Drugs – non Preferred Brand	40% Copayment per Prescription or refill. Deductible does not apply.
Mail Order Prescription Drugs using the Insurer's mail order Prescription Drug vendor – Copayments based on a three (3) month supply	
Tier 1 Prescription Drugs – Generic	40% Copayment per Prescription or refill. Deductible does not apply.
Tier 2 Prescription Drugs – Preferred Brand	40% Copayment per Prescription or refill. Deductible does not apply.
Tier 3 Prescription Drugs – non Preferred Brand	40% Copayment per Prescription or refill. Deductible does not apply.

Prescription Drugs Purchased Inside of the United States		
Retail Pharmacies or Drugs dispensed by a Physician or medical facility on an Outpatient basis – Copayments based on a one (1) month supply		
	Participating Retail Pharmacy	**Non Participating Retail Pharmacy**
Tier 1 Prescription Drugs – Generic	$15 Copayment per Prescription or refill Deductible does not apply	$15 Copayment per Prescription or refill Deductible does not apply
Tier 2 Prescription Drugs – Preferred Brand	$30 Copayment per Prescription or refill Deductible does not apply	$30 Copayment per Prescription or refill Deductible does not apply
Tier 3 Prescription Drugs – non Preferred Brand	30% Copayment per Prescription or refill Deductible does not apply. The Maximum Copayment per 1 month supply is $150.	30% Copayment per Prescription or refill Deductible does not apply. The Maximum Copayment per 1 month supply is $150.
Mail Order Prescription Drugs using the Insurer's mail order Prescription Drug vendor – Copayments based on a three (3) month supply		
	Participating Provider Mail Order Pharmacy	**Non-Participating Mail Order Pharmacy**
Tier 1 Prescription Drugs – Generic	$45 Copayment per Prescription or refill Deductible does not apply	**Not Covered**
Tier 2 Prescription Drugs – Preferred Brand	$90 Copayment per Prescription or refill Deductible does not apply	**Not Covered**
Tier 3 Prescription Drugs – non Preferred Brand	30% Copayment per Prescription or refill Deductible does not apply. The Maximum Copayment per 3 month supply is $450.	**Not Covered**