

## **GLOBAL HEALTH 1250**

## **Schedule of Benefits**

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.FE: JANUARY 1, 2026



#### IMPORTANT INFORMATION

Please be aware that the coverage made available hereunder may be prohibited or unadvisable in certain countries. The Company may be able to provide some general information or assistance in this regard, but the Company is not in a position to provide legal advice to employers or employees in such countries.

The benefits provided under the Plan are provided by the Company and are paid from the general assets of the Company. Cigna Health and Life Insurance Company (CIGNA) provides claim administration services only to the Plan.

The Company reserves the right at any time and for any reason to terminate, suspend, withdraw, amend or modify the plan or any of its provisions. If any material changes are made in the future, you will be notified.

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Contact Information: www.cignaenvoy.com or International access code + 1 + 800.441.2668 or (302) 797-3100



# **Comprehensive Medical Coverage**

#### The Schedule

#### For You and Your Dependents

To receive Comprehensive Medical Coverage, you and your Dependents may be required to pay a portion of the Covered Expenses for services and supplies. That portion is the Deductible, Co-payment and Co-insurance.

#### Co-insurance

The term Co-insurance means the percentage of charges for Covered Expenses that a covered person is required to pay under the Plan.

#### Co-payments/Deductibles

Co-payments are expenses to be paid by you or your Dependent for the services received. Deductibles are also expenses to be paid by you or your Dependent. Deductible amounts are separate from and not reduced by Co-payments. Co-payments and Deductibles are in addition to any Co-insurance. Once the Deductible maximum in The Schedule has been reached, you and your family need not satisfy any further medical Deductible for the rest of that year.

#### Maximum Out-of-Pocket limit

The term Maximum Out-of-Pocket limit means the amount a Covered Person or Family must pay for International, In-Network U.S., and Out-of-Network U.S. Eligible Expenses in a calendar year before the plan pays 100%.

#### **Maximum Reimbursable Charge**

Unless otherwise noted, services are paid based on the Maximum Reimbursable Charge. For this plan, the Maximum Reimbursable Charge is calculated at the 80<sup>th</sup> percentile of all charges made by providers of such service or supply in the geographic area.

#### **Multiple Surgical Reduction**

Multiple surgeries performed during one operating session result in payment reduction of 50% to the surgery of lesser charge. The most expensive procedure is paid as any other surgery.

#### **Assistant Surgeon and Co-Surgeon Charges**

#### **Assistant Surgeon**

The maximum amount payable will be limited to charges made by an assistant surgeon that do not exceed 20 percent of the surgeon's allowable charge. (For purposes of this limitation, allowable charge means the amount payable to the surgeon prior to any reductions due to Co-insurance or Deductible amounts.)

#### Co-Surgeon

The maximum amount payable will be limited to charges made by co-surgeons that do not exceed 20 percent of the surgeon's allowable charge plus 20 percent. (For purposes of this limitation, allowable charge means the amount payable to the surgeons prior to any reductions due to Co-insurance or Deductible amounts.)



BENEFIT HIGHLIGHTS	INTERNATIONAL	IN-NETWORK U.S.	OUT-OF-NETWORK U.S.
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Emergency Evacuation or	100% not subject to plan	100% not subject to plan Deductible	100% not subject to plan
Repatriation Benefits	Deductible		Deductible
Co-insurance Level	100% of the Maximum	80% of the Maximum	50% of the Maximum
	Reimbursable Charge	Reimbursable Charge	Reimbursable Charge

### Calendar Year Deductible

Individual \$0 per person \$1,250 per person \$2,000 per person

Family Maximum \$0 per family \$2,500 per family \$4,000 per family

Family members meet only their individual Deductible and then their claims will be covered under the plan Co-insurance; if the family Deductible has been met prior to their individual Deductible being met, their claims will be paid at the plan Co-insurance level.

#### Co-payments/ Deductibles

Co-payments are expenses to be paid by you or your Dependent for the services received. Deductibles are also expenses to be paid by you or your Dependent. Deductible amounts are separate from and not reduced by Co-payments. Co-payments and Deductibles are in addition to any Co-insurance. Once the Deductible maximum in The Schedule has been reached, you and your family need not satisfy any further medical Deductible for the rest of that year.

# **Maximum Out-of-Pocket** limit

Individual \$0 per person \$4,000 per person \$10,000 per person\*

Family Maximum \$0 per family \$8,000 per family \$20,000 per family\*

Maximum Out-of-Pocket limit—Family Maximum Calculation; Family members meet only their individual Maximum Out-of-Pocket limit and then their claims will be covered at 100%; if the family Maximum Out-of-Pocket limit has been met prior to their individual Maximum Out-of-Pocket limit being met, their claims will be paid at 100%.

\*Co-insurance and Deductible Out-of-Pocket limit. This amount excludes Co-payments.



healthcare		T	T
Combined Medical/Pharmacy Maximum Out-of-Pocket limit  Combined Medical/ Pharmacy Maximum Out-of-Pocket limit includes retail and mail	Yes	Yes	Yes
order drugs			
Physician's Services			
Physician's Office Visit	100%	\$20 per visit Co-pay	50% after plan Deductible
Surgery Performed In the Physician's Office	100%	80% after plan Deductible	50% after plan Deductible
Second Opinion Consultations (provided on a voluntary basis)	100%	\$20 per visit Co-pay	50% after plan Deductible
Allergy Treatment/Injections/ Serum	100%	\$20 per visit Co-pay	50% after plan Deductible
Specialist Office Visit	100%	\$20 per visit Co-pay	50% after plan Deductible
Adult Preventive Care Routine Preventive Care for adults ages 18 and over (including immunizations)	100% not subject to plan Deductible	100% not subject to plan Deductible	NOT COVERED
Child Preventive Care Routine Preventive Care for children through age 17 (including immunizations and developmental screenings)	100% not subject to plan Deductible	100% not subject to plan Deductible	NOT COVERED



19%		
0%		
	80% after plan Deductible	50% after plan Deductible
0%	80% after plan Deductible	50% after plan Deductible
9%	100% not subject to plan Deductible	NOT COVERED
9%	80% after plan Deductible	50% after plan Deductible
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%	80% after plan Deductible	50% after plan Deductible
0%	80% after plan Deductible	50% after plan Deductible
vered under Mental alth benefit	Covered under Mental Health benefit	Covered under Mental Health benefit
	% % % ered under Mental	80% after plan Deductible 100% not subject to plan Deductible 80% after plan Deductible 80% after plan Deductible 80% after plan Deductible 80% after plan Deductible Covered under Mental



healthcare			
Chiropractic Care Services	100%	\$20 per visit Co-pay	50% after plan Deductible
Office Visit Calendar Year Maximum: 20 days			
Dental Care			O(U)
Limited to charges made for a continuous course of dental treatment started within 6 months of an injury to sound, natural teeth			USE
Physician's Office Visit	100%	\$20 per visit Co-pay	50% after plan Deductible
Inpatient Facility	100%	80% after plan Deductible	50% after plan Deductible
Outpatient Facility	100%	80% after plan Deductible	50% after plan Deductible
Physician's Services	100%	80% after plan Deductible	50% after plan Deductible
Durable Medical Equipment	100%	80% after plan Deductible	50% after plan Deductible
Emergency and Urgent Care Services	, 01		
Physician's Office Visit	100%	\$20 per visit Co-pay	50% after plan Deductible unless for Emergency Services, then in-network benefits apply
Hospital Emergency Room	100%	70% after plan Deductible	70% after plan Deductible
Outpatient Professional services (radiology, pathology and ER Physician)	100%	80% after plan Deductible	50% after plan Deductible unless for Emergency Services, then in-network benefits apply



healthcare	1	,	
Urgent Care Facility	100%	\$20 per visit Co-pay	50% after plan Deductible unless for Emergency Services, then in-network benefits apply
X-ray and/or Lab performed at the Emergency Room/Urgent Care Facility (billed by	100%	80% not subject to plan Deductible	50% not subject to plan Deductible unless for Emergency Services, then in-network benefits apply
the facility as part of the ER/UC visit)  Independent X-ray and/or Lab Facility in	100%	80% not subject to plan Deductible	50% not subject to plan Deductible unless for Emergency Services, then in-network benefits apply
conjunction with an ER visit	100%	(S)	
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans, etc.)	100%	80% not subject to plan Deductible	50% not subject to plan Deductible unless for Emergency Services, then in-network benefits apply
Ambulance	c.S.K	80% after plan Deductible	50% after plan Deductible unless for Emergency Services, then in-network benefits apply
External Prosthetic Appliances	100%	80% after plan Deductible	50% after plan Deductible
Family Planning Services Men's Family Planning Services	5.		
Office Visits and Counseling	100%	\$20 per visit copay	50% after plan deductible
Lab and Radiology Tests  Surgical Sterilization Procedures for Vasectomy (excludes reversals)	100%	80% after plan deductible	50% after plan deductible
Physician's Office Visit	100%	\$20 per visit copay	50% after plan deductible
Inpatient Facility	100%	80% after plan deductible	50% after plan deductible



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Outpatient Facility	100%	80% after plan deductible	50% after plan deductible
Physician's Services	100%	80% after plan deductible	50% after plan deductible
Women's Family			
Planning Services			4
Office Visits and	100%	100%	100%
Counseling	10070	10070	10070
Lab and Radiology	100%	100%	100%
Tests			
Surgical Sterilization			
Procedures for Tubal			
Ligation (excludes		(2)	
reversals)	1000/	1000/	1000/
Physician's Office Visit	100%	100%	100%
Inpatient Facility	100%	100%	100%
		10	
Outpatient Facility	100%	100%	100%
Physician's Services	100%	100%	100%
		•	
	-65,		
Hearing Benefit	6		
Exam Frequency: One	100%	100% not subject to plan	NOT COVERED
Exam per 12 month period	(0)	Deductible	
Ages 4-6, then at ages			
8, 10, 12 and 15	1000/		
Hearing Aids	100%	80% after plan Deductible	NOT COVERED
	Available for dependents	r-m 2 - m-1016	
	through age 18. Hearing aids		
	are covered, one per ear	through age 18. Hearing	
	every 3 years.	aids are covered, one per ear every 3 years.	
		car every 5 years.	



healthcare			
Home Health Care	100%	80% after plan Deductible	50% after plan Deductible
Calendar Year Maximum: 120 visits (includes outpatient private nursing when approved as medically necessary)			
Hospice			01
Inpatient Services	100%	80% after plan Deductible	50% after plan Deductible
Outpatient Services	100%	80% after plan Deductible	50% after plan Deductible
Inpatient Hospital - Facility Services	100%	80% after plan Deductible	50% after plan Deductible
Semi-Private Room and Board	Limited to the semi-private room rate	Limited to the semi-private room rate	Limited to the semi-private room rate
Private Room	Limited to the semi-private room rate (Private Room covered outside the United States only if no semi- private room equivalent is available)	Limited to the semi-private room rate	Limited to the semi-private room rate
Special Care Units (ICU/CCU)	Limited to the ICU/CCU daily room rate	Limited to the ICU/CCU daily room rate	Limited to the ICU/CCU daily room rate
Inpatient Hospital Physician's Visits/Consultations	100%	80% after plan Deductible	50% after plan Deductible
Inpatient Hospital Professional Services  Surgeon Radiologist Pathologist Anesthesiologist	100%	80% after plan Deductible	50% after plan Deductible



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Inpatient Services at Other Health Care Facilities	100%	80% after plan Deductible	50% after plan Deductible
Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities			
Calendar Year Maximum (combined for all facilities listed above): 120 days			180
Laboratory and Radiology Services (includes pre-admission testing)		Sex	
Physician's Office	100%	100% not subject to plan Deductible	50% after plan Deductible
Outpatient Hospital Facility	100%	80% after plan Deductible	50% after plan Deductible
Independent X-ray and/or Lab Facility	100%	80% after plan Deductible	50% after plan Deductible
Lead Poisoning Screening Tests For Children under age 6	100%	100% not subject to plan Deductible	NOT COVERED
Maternity Care Services	10,		
Initial Visit to Confirm Pregnancy	100%	\$20 Co-pay	50% after plan Deductible
All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)	100%	80% after plan Deductible	50% after plan Deductible
Physician's Office Visits in addition to the Global maternity fee when performed by an OB or Specialist	100%	\$20 per visit Co-pay	50% after plan Deductible



Delivery - Facility (Inpatient Hospital, Birthing Center)	100%	80% after plan Deductible	50% after plan Deductible
Mental Health and Substance Abuse			
Inpatient Facility	100%	80% after plan Deductible	50% after plan Deductible
Outpatient (Includes Individual, Group and Intensive Outpatient)			150
Physician's Office Visit	100%	\$20 per visit Co-pay	50% after plan Deductible
Outpatient Facility	100%	80% after plan Deductible	50% after plan Deductible
Nutritional Evaluation		VOI.	
Calendar Year		A.	
Maximum:			
3 visits per person, however the three visit			
limit will not apply to			
treatment of diabetes			
Physician's Office Visit	100%	\$20 per visit Co-pay	50% after plan Deductible
Inpatient Facility	100%	80% after plan Deductible	50% after plan Deductible
Outpatient Facility	100%	80% after plan Deductible	50% after plan Deductible
Physician's Services	100%	80% after plan Deductible	50% after plan Deductible



#### **Obesity / Bariatric Surgery**

#### Note:

Coverage is provided subject to medical necessity and clinical guidelines subject to any limitations shown in the "Exclusions, Expenses Not Covered and General Limitations" section of this certificate. Contact Cigna prior to incurring such costs.

Physician's Office Visit	100%	\$20 per visit Co-pay	50% after plan Deductible
Inpatient Facility	100%	80% after plan Deductible	50% after plan Deductible
Outpatient Facility	100%	80% after plan Deductible	50% after plan Deductible
Physician's Services	100%	80% after plan Deductible	50% after plan Deductible
Lifetime Maximum:	None	None	None
intende.	KOI GSK		



healthcare			
Organ Transplant			
Includes all medically appropriate, non-experimental transplants			
Office Visit	100%	\$20 per visit Co-pay	50% after plan Deductible
Inpatient Facility	100%	80% after plan Deductible	50% after plan Deductible
Physician's Services	100%	80% after plan Deductible	50% after plan Deductible
Outpatient Facility Services	100%	80% after plan Deductible	50% after plan Deductible
Operating Room, Recovery Room, Procedures Room, Treatment Room and Observation Room		Newlog	
Outpatient Professional Services	100%	80% after plan Deductible	50% after plan Deductible
Surgeon Radiologist Pathologist Anesthesiologist	(GSX		
Outpatient Short-Term Rehabilitative Therapy	100%	80% after plan Deductible	50% after plan Deductible
Calendar Year Maximum: None			
Includes: Cardiac Rehab Physical Therapy			
Speech Therapy Occupational			
Therapy Pulmonary Rehab Cognitive Therapy			



Prescription Drug Benefit	100%	Refer to the Prescription Drug Coverage Schedule for Participating Pharmacy	Refer to the Prescription Drug Coverage Schedule for Participating Pharmacy
Routine Foot Disorders	Not covered except for servivascular disease.	ces associated with foot care	for diabetes and peripheral
TMJ Treatment Benefit Lifetime Maximum: None	100%	80% after plan Deductible	50% after plan Deductible
Travel Immunizations For Employees and Dependents	100%	100% not subject to plan Deductible	100% not subject to plan Deductible

# **Treatment Resulting From Life Threatening Emergencies**

Medical treatment required as a result of an emergency, such as a suicide attempt, will be considered a medical expense until the medical condition is stabilized. Once the medical condition is stabilized, whether the treatment will be characterized as either a medical expense or a mental health/substance abuse expense, will be determined by the utilization review Physician in accordance with the applicable mixed services claim guidelines.

Vision Care Benefit	G		
One examination per calendar year	100%	\$20 per visit Co-pay	80% after plan Deductible
Eyewear	NOT COVERED	NOT COVERED	NOT COVERED
Wigs  Maximum: One per lifetime for individuals undergoing cancer treatment	100%	80% after plan Deductible	80% after plan Deductible



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