GLOBAL HEALTH 1500

Schedule of Benefits

COMPREHENSIVE MEDICAL COVERAGE

EFFECTIVE DATE: JANUARY 1, 2027

Intended for GSFR Member Use Only

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

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cigna healthcare

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. Claims for a family member are covered at plan co-insurance only when the Family Deductible is satisfied. All family members contribute towards the Family Deductible. The individual Deductible is not applicable. Any individual amount only applies to Employee-Only coverage. This is considered a non-embedded Deductible.

Maximum Out-of-Pocket limit
Family members meet only their individual Out-of-Pocket maximum and then their claims will be covered without additional member cost share; if the family Out-of-Pocket limit has been met prior to their individual Out-of-Pocket limit being met, their claims will be paid with no additional member cost share. This is considered an embedded Maximum Out-of-Pocket limit. The maximum Out-of-Pocket will include Deductible payments, Co-pay payments, pharmacy Co-pays, pharmacy Co-insurance payments, Pre-Admission Certification and Continued Stay Review penalties.

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 80th 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 60% to the surgery of lesser charge. The most expensive procedure is paid as any other surgery.

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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.)

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BENEFIT HIGHLIGHTS	INTERNATIONAL	IN-NETWORK U.S.	OUT-OF-NETWORK U.S.
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Emergency Evacuation or Repatriation Benefits	100% not subject to plan Deductible	100% not subject to plan Deductible	100% not subject to plan Deductible
Co-insurance Level	80% of the Maximum Reimbursable Charge	80% of the Maximum Reimbursable Charge	60% of the Maximum Reimbursable Charge
Calendar Year Deductible			

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BENEFIT HIGHLIGHTS	INTERNATIONAL	IN-NETWORK U.S.	OUT-OF-NETWORK U.S.
Individual	$1,750 per person	$1,750 per person	$3,000 per person
Family	$3,500 per family	$3,500 per family	$6,000 per family
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. Claims for a family member are covered at plan co-insurance only when the Family Deductible is satisfied. All family members contribute towards the Family Deductible. The individual Deductible is not applicable. Any individual amount only applies to Employee-Only coverage. This is considered a non-embedded Deductible.			
Maximum Out-of-Pocket limit			
Individual	$4,250 per person	$4,250 per person	$8,500 per person
Family Maximum	$8,000 per family	$8,000 per family	$16,000 per family
Family members meet only their individual Out-of-Pocket maximum and then their claims will be covered without additional member cost share; if the family Out-of-Pocket limit has been met prior to their individual Out-of-Pocket limit being met, their claims will be paid with no additional member cost share. This is considered an embedded Maximum Out-of-Pocket limit. The maximum Out-of-Pocket will include Deductible payments, Co-pay payments, pharmacy Co-pays, pharmacy Co-insurance payments, Pre-Admission Certification and Continued Stay Review penalties.			

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BENEFIT HIGHLIGHTS	INTERNATIONAL	IN-NETWORK U.S.	OUT-OF-NETWORK U.S.
Combined Medical/Pharmacy Maximum Out-of-Pocket limit			
Combined Medical/ Pharmacy Maximum Out-of-Pocket limit includes retail and mail order drugs	Yes	Yes	Yes
Physician's Services			
Physician's Office Visit	80% after plan Deductible	80% after plan Deductible	60% after plan Deductible
Surgery Performed In the Physician's Office	80% after plan Deductible	80% after plan Deductible	60% after plan Deductible
Second Opinion Consultations (provided on a voluntary basis)	80% after plan Deductible	80% after plan Deductible	60% after plan Deductible
Allergy Treatment/Injections/ Serum	80% after plan Deductible	80% after plan Deductible	60% after plan Deductible
Specialist Office Visit	80% after plan Deductible	80% after plan Deductible	60% 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

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BENEFIT HIGHLIGHTS	INTERNATIONAL	IN-NETWORK U.S.	OUT-OF-NETWORK U.S.
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
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans and PET Scans Inpatient Facility Outpatient Facility	 80% after plan Deductible 80% after plan Deductible	 80% after plan Deductible 80% after plan Deductible	 60% after plan Deductible 60% after plan Deductible
Annual Routine Mammograms, PSA, Pap Smear and Colorectal Cancer Screenings	100% not subject to plan Deductible	100% not subject to plan Deductible	NOT COVERED

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BENEFIT HIGHLIGHTS	INTERNATIONAL	IN-NETWORK U.S.	OUT-OF-NETWORK U.S.
Autism Therapy (covered under medical) **Speech Therapy** 60 days per calendar year for Dependent child under age 6 **Physical Therapy** 60 days per calendar year for Dependent child through age 16 **Occupational Therapy** 60 days per calendar year for Dependent child through age 16	80% after plan Deductible	80% after plan Deductible	60% after plan Deductible
Bereavement Counseling Services Provided as part of Hospice Care			
Inpatient	80% after plan Deductible	80% after plan Deductible	60% after plan Deductible
Outpatient	80% after plan Deductible	80% after plan Deductible	60% after plan Deductible
Services Provided by Mental Health Professional	Covered under Mental Health benefit	Covered under Mental Health benefit	Covered under Mental Health benefit

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BENEFIT HIGHLIGHTS	INTERNATIONAL	IN-NETWORK U.S.	OUT-OF-NETWORK U.S.
Chiropractic Care Services Office Visit Calendar Year Maximum: 20 days	80% after plan Deductible	80% after plan Deductible	60% after plan Deductible
Dental Care Limited to charges made for a continuous course of dental treatment started within 6 months of an injury to sound, natural teeth			
Physician's Office Visit	80% after plan Deductible	80% after plan Deductible	60% after plan Deductible
Inpatient Facility	80% after plan Deductible	80% after plan Deductible	60% after plan Deductible
Physician's Services	80% after plan Deductible	80% after plan Deductible	60% after plan Deductible
Durable Medical Equipment	80% after plan Deductible	80% after plan Deductible	60% after plan Deductible

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BENEFIT HIGHLIGHTS	INTERNATIONAL	IN-NETWORK U.S.	OUT-OF-NETWORK U.S.
Emergency and Urgent Care Services			
Physician's Office Visit	80% after plan Deductible	80% after plan Deductible	60% after plan Deductible
Hospital Emergency Room	80% after plan Deductible	80% after plan Deductible	80% after plan Deductible
Outpatient Professional services (radiology, pathology and ER Physician)	80% after plan Deductible	80% after plan Deductible	60% after plan Deductible
Urgent Care Facility	80% after plan Deductible	80% after plan Deductible	60% after plan Deductible
X-ray and/or Lab performed at the Emergency Room/Urgent Care Facility (billed by the facility as part of the ER/UC visit)	80% after plan Deductible	80% after plan Deductible	60% after plan Deductible
Independent X-ray and/or Lab Facility in conjunction with an ER visit	80% after plan Deductible	80% after plan Deductible	60% after plan Deductible
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans, etc.)	80% after plan Deductible	80% after plan Deductible	60% after plan Deductible
Ambulance	80% after plan Deductible	80% after plan Deductible	60% after plan Deductible
External Prosthetic Appliances	80% after plan Deductible	80% after plan Deductible	60% after plan Deductible

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BENEFIT HIGHLIGHTS	INTERNATIONAL	IN-NETWORK U.S.	OUT-OF-NETWORK U.S.
Family Planning Services			
Men's Family Planning Services			
Office Visits and Counseling	80% after plan Deductible	80% after plan Deductible	60% after plan Deductible
Lab and Radiology Tests	80% after plan Deductible	80% after plan Deductible	60% after plan Deductible
Surgical Sterilization Procedures for Vasectomy (excludes reversals)			
Physician's Office Visit	80% after plan Deductible	80% after plan Deductible	60% after plan Deductible
Inpatient Facility	80% after plan Deductible	80% after plan Deductible	60% after plan Deductible
Outpatient Facility	80% after plan Deductible	80% after plan Deductible	60% after plan Deductible
Physician's Services	80% after plan Deductible	80% after plan Deductible	60% after plan Deductible
Women's Family Planning Services			
Office Visits and Counseling	100% not subject to plan Deductible	100% not subject to plan Deductible	60% after plan Deductible
Lab and Radiology Tests	100% not subject to plan Deductible	100% not subject to plan Deductible	60% after plan Deductible
Surgical Sterilization Procedures for Tubal Ligation (excludes reversals)			
Physician's Office Visit	100% not subject to plan Deductible	100% not subject to plan Deductible	60% after plan Deductible
Inpatient Facility	100% not subject to plan Deductible	100% not subject to plan Deductible	60% after plan Deductible

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BENEFIT HIGHLIGHTS	INTERNATIONAL	IN-NETWORK U.S.	OUT-OF-NETWORK U.S.
Outpatient Facility Physician's Services	100% not subject to plan Deductible 100% not subject to plan Deductible	100% not subject to plan Deductible 100% not subject to plan Deductible	60% after plan Deductible 60% after plan Deductible
Hearing Benefit Exam Frequency: One Exam per 12 month period Ages 4-6, then at ages 8, 10, 12 and 15 Hearing Aids	100% not subject to plan Deductible 80% after plan Deductible Available for dependents through age 18. Hearing aids are covered, one per ear every 3 years.	100% not subject to plan Deductible 80% after plan Deductible Available for dependents through age 18. Hearing aids are covered, one per ear every 3 years.	NOT COVERED NOT COVERED
Home Healthcare Calendar Year Maximum: 120 visits (includes outpatient private nursing when approved as medically necessary)	80% after plan Deductible	80% after plan Deductible	60% after plan Deductible
Hospice Inpatient Services Outpatient Services	80% after plan Deductible 80% after plan Deductible	80% after plan Deductible 80% after plan Deductible	60% after plan Deductible 60% after plan Deductible

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BENEFIT HIGHLIGHTS	INTERNATIONAL	IN-NETWORK U.S.	OUT-OF-NETWORK U.S.
Inpatient Hospital - Facility Services	80% after plan Deductible	80% after plan Deductible	60% 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	80% after plan Deductible	80% after plan Deductible	60% after plan Deductible
Inpatient Hospital Professional Services Surgeon Radiologist Pathologist Anesthesiologist	80% after plan Deductible	80% after plan Deductible	60% after plan Deductible

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BENEFIT HIGHLIGHTS	INTERNATIONAL	IN-NETWORK U.S.	OUT-OF-NETWORK U.S.
Inpatient Services at Other Healthcare Facilities Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities Calendar Year Maximum (combined for all facilities listed above): 120 days	80% after plan Deductible	80% after plan Deductible	60% after plan Deductible
Laboratory and Radiology Services (includes pre-admission testing)			
Physician's Office	80% after plan Deductible	100% not subject to plan Deductible	60% after plan Deductible
Outpatient Hospital Facility	80% after plan Deductible	80% after plan Deductible	60% after plan Deductible
Independent X-ray and/or Lab Facility	80% after plan Deductible	80% after plan Deductible	60% after plan Deductible
Lead Poisoning Screening Tests For Children under age 6	100% not subject to plan Deductible	100% not subject to plan Deductible	NOT COVERED

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BENEFIT HIGHLIGHTS	INTERNATIONAL	IN-NETWORK U.S.	OUT-OF-NETWORK U.S.
Maternity Care Services			
Initial Visit to Confirm Pregnancy	80% after plan Deductible	80% after plan Deductible	60% after plan Deductible
All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)	80% after plan Deductible	80% after plan Deductible	60% after plan Deductible
Physician's Office Visits in addition to the Global maternity fee when performed by an OB or Specialist	80% after plan Deductible	80% after plan Deductible	60% after plan Deductible
Delivery - Facility (Inpatient Hospital, Birthing Center) (refer to pre-admission certification procedures)	80% after plan Deductible	80% after plan Deductible	60% after plan Deductible
Mental Health and Substance Abuse			
Inpatient Facility	80% after plan Deductible	80% after plan Deductible	60% after plan Deductible
Outpatient (Includes Individual, Group and Intensive Outpatient) Physician's Office Visit	80% after plan Deductible	80% after plan Deductible	60% after plan Deductible

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BENEFIT HIGHLIGHTS	INTERNATIONAL	IN-NETWORK U.S.	OUT-OF-NETWORK U.S.
Outpatient Facility	80% after plan Deductible	80% after plan Deductible	60% after plan Deductible

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BENEFIT HIGHLIGHTS	INTERNATIONAL	IN-NETWORK U.S.	OUT-OF-NETWORK U.S.
Nutritional Evaluation Calendar Year Maximum: 3 visits per person, however the three visit limit will not apply to treatment of diabetes			
Physician's Office Visit	80% after plan Deductible	80% after plan Deductible	60% after plan Deductible
Inpatient Facility	80% after plan Deductible	80% after plan Deductible	60% after plan Deductible
Outpatient Facility	80% after plan Deductible	80% after plan Deductible	60% after plan Deductible
Physician's Services	80% after plan Deductible	80% after plan Deductible	60% 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	80% after plan Deductible	80% after plan Deductible	60% after plan Deductible
Inpatient Facility	80% after plan Deductible	80% after plan Deductible	60% after plan Deductible
Outpatient Facility	80% after plan Deductible	80% after plan Deductible	60% after plan Deductible
Physician's Services	80% after plan Deductible	80% after plan Deductible	60% after plan Deductible
Lifetime Maximum: None			

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BENEFIT HIGHLIGHTS	INTERNATIONAL	IN-NETWORK U.S.	OUT-OF-NETWORK U.S.
Organ Transplant Includes all medically appropriate, non-experimental transplants			
Office Visit	80% after plan Deductible	80% after plan Deductible	60% after plan Deductible
Inpatient Facility	80% after plan Deductible	80% after plan Deductible	60% after plan Deductible
Physician's Services	80% after plan Deductible	80% after plan Deductible	60% after plan Deductible
Outpatient Facility Services Operating Room, Recovery Room, Procedures Room, Treatment Room and Observation Room	80% after plan Deductible	80% after plan Deductible	60% after plan Deductible
Outpatient Professional Services Surgeon Radiologist Pathologist Anesthesiologist	80% after plan Deductible	80% after plan Deductible	60% after plan Deductible

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BENEFIT HIGHLIGHTS	INTERNATIONAL	IN-NETWORK U.S.	OUT-OF-NETWORK U.S.
Outpatient Short-Term Rehabilitative Therapy Calendar Year Maximum: None Includes: Cardiac Rehab Physical Therapy Speech Therapy Occupational Therapy Pulmonary Rehab Cognitive Therapy	80% after plan Deductible	80% after plan Deductible	60% after plan Deductible
Prescription Drug Benefit	80% after plan Deductible	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 services associated with foot care for diabetes and peripheral vascular disease.		
TMJ TMJ Treatment Benefit Lifetime Maximum: None	80% after plan Deductible	80% after plan Deductible	60% after plan Deductible
Travel Immunizations For Employees and Dependents	100% not subject to plan Deductible	100% not subject to plan Deductible	100% not subject to plan Deductible

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BENEFIT HIGHLIGHTS	INTERNATIONAL	IN-NETWORK U.S.	OUT-OF-NETWORK U.S.
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			
One examination per calendar year	80% after plan Deductible	80% after plan Deductible	80% after plan Deductible
Eyewear	NOT COVERED	NOT COVERED	NOT COVERED
Wigs Maximum: One per lifetime for individuals undergoing cancer treatment	80% after plan Deductible	80% after plan Deductible	80% after plan Deductible

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