GLOBAL HEALTH 2000 Plus

Schedule of Benefits

COMPREHENSIVE MEDICAL COVERAGE

EFFECTIVE DATE: JANUARY 1, 2023

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 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 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 Repatriation Benefits	100%	100% not subject to plan Deductible	100% not subject to plan Deductible
Co-insurance Level	100% of the Maximum Reimbursable Charge	80% of the Maximum Reimbursable Charge	50% of the Maximum Reimbursable Charge
Calendar Year Deductible			
Individual	$0 per person	$2,000 per person	$4,000 per person
Family Maximum	$0 per family	$4,000 per family	$8,000 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	$6,350 per person	$6,350 per person	$24,000 per person*
Family Maximum	$10,000 per family	$10,000 per family	$28,000 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.			

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	100%	$25 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%	$25 per visit Co-pay	50% after plan Deductible
Allergy Treatment/Injections/ Serum	100%	$25 per visit Co-pay	50% after plan Deductible
Specialist Office Visit	100%	$45 per visit Co-pay	50% after plan Deductible
Adult Preventive Care Routine Preventive Care for adults ages 18 and over (including immunizations)	100%	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%	100% not subject to plan Deductible	NOT COVERED

BENEFIT HIGHLIGHTS	INTERNATIONAL	IN-NETWORK U.S.	OUT-OF-NETWORK U.S.
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans and PET Scans			
Inpatient Facility	100%	80% after plan Deductible	50% after plan Deductible
Outpatient Facility	100%	80% after plan Deductible	50% after plan Deductible
Annual Routine Mammograms, PSA, Pap Smear and Colorectal Cancer Screenings	100%	100% not subject to plan Deductible	NOT COVERED
Autism Therapy (covered under medical) **Speech Therapy** 50 days per calendar year for Dependent child under age 6 **Physical Therapy** 50 days per calendar year for Dependent child through age 16 **Occupational Therapy** 50 days per calendar year for Dependent child through age 16	100%	80% after plan Deductible	50% after plan Deductible
Bereavement Counseling			
Services Provided as part of Hospice Care			
Inpatient	100%	80% after plan Deductible	50% after plan Deductible
Outpatient	100%	80% after plan Deductible	50% after plan Deductible
Services Provided by Mental Health Professional	Covered under Mental Health benefit	Covered under Mental Health benefit	Covered under Mental Health benefit

BENEFIT HIGHLIGHTS	INTERNATIONAL	IN-NETWORK U.S.	OUT-OF-NETWORK U.S.
Chiropractic Care Services Office Visit Calendar Year Maximum: 20 days	100%	$45 per visit Co-pay	50% 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	100%	$45 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

BENEFIT HIGHLIGHTS	INTERNATIONAL	IN-NETWORK U.S.	OUT-OF-NETWORK U.S.
Emergency and Urgent Care Services			
Physician's Office Visit	100%	$25 per visit Co-pay	50% after plan Deductible unless for Emergency Services, then in-network benefits apply
Hospital Emergency Room	100%	$100 per visit Co-pay, then 80%, not subject to plan Deductible	$100 per visit Co-pay, then 80%, not subject to 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
Urgent Care Facility	100%	$45 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 the facility as part of the ER/UC visit)	100%	80% not subject to plan Deductible	50% not subject to plan Deductible unless for Emergency Services, then in-network benefits apply
Independent X-ray and/or Lab Facility in conjunction with an ER visit	100%	80% not subject to plan Deductible	50% not subject to plan Deductible unless for Emergency Services, then in-network benefits apply
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		80% after plan Deductible	50% after plan Deductible unless for Emergency Services, then in-network benefits apply

BENEFIT HIGHLIGHTS	INTERNATIONAL	IN-NETWORK U.S.	OUT-OF-NETWORK U.S.
External Prosthetic Appliances	100%	80% after plan Deductible	50% after plan Deductible
Family Planning Services			
Men's Family Planning Services			
Office Visits and Counseling	100%	$25 per visit copay	50% after plan deductible
Lab and Radiology Tests	100%	80% after plan deductible	50% after plan deductible
Surgical Sterilization Procedures for Vasectomy (excludes reversals)			
Physician's Office Visit	100%	$25 per visit copay	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
Women's Family Planning Services			
Office Visits and Counseling	100%	100% not subject to plan deductible	100% not subject to plan deductible
Lab and Radiology Tests	100%	100% not subject to plan deductible	100% not subject to plan deductible
Surgical Sterilization Procedures for Tubal Ligation (excludes reversals)			
Physician's Office Visit	100%	100% not subject to plan deductible	100% not subject to plan deductible
Inpatient Facility	100%	100% not subject to plan deductible	100% not subject to plan deductible
Outpatient Facility	100%	100% not subject to plan deductible	100% not subject to plan deductible
Physician's Services	100%	100% not subject to plan deductible	100% not subject to plan deductible

BENEFIT HIGHLIGHTS	INTERNATIONAL	IN-NETWORK U.S.	OUT-OF-NETWORK U.S.
Hearing Benefit Exam Frequency: One Exam per 12 month period Ages 4-6, then at ages 8, 10, 12 and 15 Hearing Aids	100% 80% 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 Health Care Calendar Year Maximum: 120 visits (includes outpatient private nursing when approved as medically necessary)	100%	80% after plan Deductible	50% after plan Deductible
Hospice Inpatient Services Outpatient Services	100% 100%	80% after plan Deductible 80% after plan Deductible	50% after plan Deductible 50% after plan Deductible
Inpatient Hospital - Facility Services Semi-Private Room and Board Private Room Special Care Units (ICU/CCU)	100% Limited to the semi-private room rate 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 ICU/CCU daily room rate	80% after plan Deductible Limited to the semi-private room rate Limited to the semi-private room rate Limited to the ICU/CCU daily room rate	50% after plan Deductible Limited to the semi-private room rate Limited to the semi-private room rate Limited to the ICU/CCU daily room rate

BENEFIT HIGHLIGHTS	INTERNATIONAL	IN-NETWORK U.S.	OUT-OF-NETWORK U.S.
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
Inpatient Services at Other Health Care Facilities Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities Calendar Year Maximum (combined for all facilities listed above): 120 days	100%	80% after plan Deductible	50% after plan Deductible
Laboratory and Radiology Services (includes pre-admission testing)			
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

BENEFIT HIGHLIGHTS	INTERNATIONAL	IN-NETWORK U.S.	OUT-OF-NETWORK U.S.
Maternity Care Services			
Initial Visit to Confirm Pregnancy	100%	$25 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%	$25 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)			
Physician's Office Visit	100%	$25 per visit Co-pay	50% after plan Deductible
Outpatient Facility	100%	80% after plan Deductible	50% after plan Deductible

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	100%	$25 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%	$45 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			

BENEFIT HIGHLIGHTS	INTERNATIONAL	IN-NETWORK U.S.	OUT-OF-NETWORK U.S.
Organ Transplant Includes all medically appropriate, non-experimental transplants Office Visit Inpatient Facility Physician's Services	 100% 100% 100%	 $25 per visit Co-pay 80% after plan Deductible 80% after plan Deductible	 50% after plan Deductible 50% after plan Deductible 50% after plan Deductible
Outpatient Facility Services Operating Room, Recovery Room, Procedures Room, Treatment Room and Observation Room	100%	80% after plan Deductible	50% after plan Deductible
Outpatient Professional Services Surgeon Radiologist Pathologist Anesthesiologist	100%	80% after plan Deductible	50% after plan Deductible
Outpatient Short-Term Rehabilitative Therapy Calendar Year Maximum: None Includes: Cardiac Rehab Physical Therapy Speech Therapy Occupational Therapy Pulmonary Rehab Cognitive Therapy	100%	80% after plan Deductible	50% after plan Deductible

BENEFIT HIGHLIGHTS	INTERNATIONAL	IN-NETWORK U.S.	OUT-OF-NETWORK U.S.
Prescription Drug Benefit	80%	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	100%	80% after plan Deductible	50% 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
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 Eyewear	100% NOT COVERED	$25 per visit Co-pay NOT COVERED	50% after plan Deductible NOT COVERED
Wigs Maximum: One per lifetime for individuals undergoing cancer treatment	100%	80% after plan Deductible	80% after plan Deductible