Insured and/or administered by:

Cigna Health and Life Insurance Company

WSP USA Inc.

Benefits at a Glance
TCNs & KLNs
US Care Limited to Emergency Only
Policy # 05219
Plan Start Date January 1, 2024

This plan provides minimum essential coverage.

NOTE: This information is a general description of benefits and is not a contract. Refer to your certificate booklet for complete details of coverage and exclusions. If there is any difference between this summary and the certificate, the information in the certificate will apply. Please note that your plan does not cover expenses for services which are not medically necessary.

Cigna Global Customer Service

Toll Free Telephone Number: **Direct Telephone:** **Toll Free Fax Number:** **Direct Fax Number:**	1.800.441.2668 1.302.797.3100 (collect calls accepted) 1.800.243.6998 001.302.797.3150	
Secure Website:	www.CignaEnvoy.com. Registration is Required (See member kit for registration information.) Secure email available at this site.	
Mail Delivery:	Cigna Global Health Benefits P.O. Box 15050 Wilmington DE 19850-5050 U.S.A.	Cigna Global Health Benefits 300 Bellevue Parkway Wilmington DE 19809 U.S.A.

General Plan Provisions - All Amounts in U.S. Dollars

Global Medical Plan

	International (Outside of the U.S.)	U.S. In-Network Emergency Medical Services Only	U.S. Out-of-Network Emergency Medical Services Only
Area of Cover	Worldwide excluding treatment in the United States, except for Emergency Medical Services		
U.S. Medical Network	OAP - Limited US Care (ER Only)		
Eligibility	Refer to eligibility definition in the certificate		
Lifetime Maximum	Unlimited		
Calendar Year Deductible · Per Individual · Per Family	$1,000 $3,000	$1,000 $3,000	$1,000 $3,000
Coinsurance (The percentage of covered expenses the plan pays)	80%	80%	80%
Out-of-Pocket Maximum (Includes Deductible) · Per Individual · Per Family	$4,000 $8,000	$4,000 $8,000	$4,000 $8,00

Global Medical Plan	
Deductible Calculation	Claims for a family member are covered at plan coinsurance: • When that family member satisfies the Individual Deductible -OR- • When the Family Deductible is satisfied regardless of whether or not the Individual Deductible is satisfied.
Out-of-Pocket Calculation	Claims for a family member are covered at 100% coinsurance: • When that family member satisfies the Individual Out-of-Pocket Maximum -OR- • When the Family Out-of-Pocket Maximum is satisfied regardless of whether or not the Individual Out-of-Pocket Maximum is satisfied. Out-of-Pocket will: Include deductible payments; Include copay payments; Include pharmacy copays; Include pharmacy coinsurance payments; Exclude Pre-Admission Certification/Continued Stay Review penalties.
Network Accumulation	Plan Deductible, Out-of-Pocket, maximums and service specific maximums (dollar and occurrence) will cross-accumulate across international and domestic networks.

	International (Outside of the U.S.)	U.S. In-Network Emergency Medical Services Only	U.S. Out-of-Network Emergency Medical Services Only
Physician's Services · Physician's Office Visit	80% after deductible	Not Covered	Not Covered
· Surgery Performed In the Physician's Office	80% after deductible	Not Covered	Not Covered
Preventive Care			
· Routine Preventive Care - Adult	100% not subject to deductible	Not Covered	Not Covered
· Immunizations - Adult	100% not subject to deductible	Not Covered	Not Covered
· Routine Preventive Care - Child	100% not subject to deductible	Not Covered	Not Covered
· Immunizations - Child	100% not subject to deductible	Not Covered	Not Covered
Travel Immunizations (Immunizations as required for travel)	100% not subject to deductible	Not Covered	Not Covered
Mammograms, PSA, PAP Smear and Colorectal Cancer Screenings	100% not subject to deductible	Not Covered	Not Covered
Inpatient Hospital			
· Inpatient Hospital - Facility Services	80% after deductible	$250 copay, then 80% not subject to deductible	$250 copay, then 80% not subject to deductible
· Inpatient Hospital Physician Visits/Consultations	80% after deductible	80% after deductible	80% after deductible
· Inpatient Professional Services (Surgeon, Radiologist, Pathologist, Anesthesiologist)	80% after deductible	80% after deductible	80% after deductible
Outpatient Services			
· Outpatient Facility Services	80% after deductible	Not Covered	Not Covered
· Outpatient Professional Services	80% after deductible	Not Covered	Not Covered
Emergency Room Treatment in the United States is excluded, except for Emergency Medical Service	80% after deductible	$100 per visit copay, then 100% not subject to deductible	$100 per visit copay, then 100% not subject to deductible
Urgent Care Services Treatment in the United States is excluded, except for Emergency Medical Service	80% after deductible	$25 copay, then 100% not subject to deductible	$25 copay, then 100% not subject to deductible
Ambulance	80% after deductible	100% after deductible	100% after deductible

Global Medical Plan			
	International (Outside of the U.S.)	**U.S. In-Network Emergency Medical Services Only**	**U.S. Out-of-Network Emergency Medical Services Only**
Laboratory Services			
· Physician Office Visit	80% after deductible	Not Covered	Not Covered
· Outpatient Facility	80% after deductible	Not Covered	Not Covered
· Laboratory Services at an Independent Lab facility	80% after deductible	Not Covered	Not Covered
Radiology Services			
· Physician Office Visit	80% after deductible	Not Covered	Not Covered
· Outpatient Facility	80% after deductible	Not Covered	Not Covered
Advanced Radiology (i.e., MRIs, MRAs, CAT Scans, PET Scans) Worldwide Care including the United States.			
· Physician Office Visit	80% after deductible	Not Covered	Not Covered
· Inpatient Facility	80% after deductible	$250 copay, then 80% not subject to deductible	$250 copay, then 80% not subject to deductible
· Outpatient Facility	80% after deductible	Not Covered	Not Covered
Short-Term Rehabilitation			
· Physician Office Visit	80% after deductible	Not Covered	Not Covered
· Outpatient Hospital Facility	80% after deductible	Not Covered	Not Covered
Calendar Year Maximum:	60 Days for all Therapies Combined		
The limit is not applicable to Mental Health and Substance Use Disorder conditions. **Note:** The Short-Term Rehabilitation Therapy maximum does not apply to the treatment of Autism *Includes:* Cardiac and Pulmonary Rehab, Speech, Occupational and Cognitive Therapy			

Global Medical Plan			
	International (Outside of the U.S.)	**U.S. In-Network Emergency Medical Services Only**	**U.S. Out-of-Network Emergency Medical Services Only**
Short-Term Rehabilitation - Physical Therapy / Physiotherapy			
· Physician Office Visit	80% after deductible	Not Covered	Not Covered
· Outpatient Hospital Facility	80% after deductible	Not Covered	Not Covered
Calendar Year Maximum: Unlimited for all Therapies Combined			
Chiropractic Care Calendar Year Maximum: Unlimited	80% after deductible	Not Covered	Not Covered
Maternity Care Services			
· Initial Visit to Confirm Pregnancy	80% after deductible	Not Covered	Not Covered
· All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)	80% after deductible	Not Covered	Not Covered
· Physician's Office Visits in addition to the global maternity fee when performed by an OB/GYN or Specialist	80% after deductible	Not Covered	Not Covered
· Delivery – Facility			
· Inpatient Hospital	80% after deductible	Not Covered	Not Covered
· Birthing Center	80% after deductible	Not Covered	Not Covered

Global Medical Plan			
	International (Outside of the U.S.)	**U.S. In-Network Emergency Medical Services Only**	**U.S. Out-of-Network Emergency Medical Services Only**
Infertility Services	Diagnosis of Infertility is covered under general Physician Office Visits. Coverage will be provided for the following services: · GIFT, ZIFT, etc. · In-vitro · Artificial Insemination		
· Physician Office Visit and Counseling	80% after deductible	Not Covered	Not Covered
· Lab and Radiology Tests	80% after deductible	Not Covered	Not Covered
· Inpatient Facility	80% after deductible	Not Covered	Not Covered
· Outpatient Facility	80% after deductible	Not Covered	Not Covered
Hearing Exam · One examination per 24 month period	80% after deductible	Not Covered	Not Covered
Hearing Device / Aids · Limited to Dependent Children Under 24 Years · 1 Per Ear Every 36 Months up to $1,000	80% after deductible	Not Covered	Not Covered
Mental Health			
· Physician Office Visit	80% after deductible	Not Covered	Not Covered
· Inpatient Facility	80% after deductible	Not Covered	Not Covered
· Outpatient Facility	80% after deductible	Not Covered	Not Covered
Substance Use Disorder			
· Physician Office Visit	80% after deductible	Not Covered	Not Covered
· Inpatient Facility	80% after deductible	Not Covered	Not Covered
· Outpatient Facility	80% after deductible	Not Covered	Not Covered
Important Note on Mental Health & Substance Use Disorder Coverage: Covered medical services listed above, which are received to diagnose or treat a Mental Health or Substance Use Disorder condition will be payable according to the sections titled "Mental Health" and "Substance Use Disorder".			

Prescription Drug Benefits	
	International (Outside of the U.S.)
Purchased outside the United States	You pay 20% after plan deductible

Global Evacuation Plan	
Toll Free telephone number	1.800.441.2668
Emergency Medical Evacuation	100% of covered expenses not subject to the deductible for approved services.
Family Travel Arrangements	Roundtrip Airfare at Economy Rates to the place of hospitalization for 1 Family Member for hospitalizations in excess of 7 Days
Return of Dependent Children	One-way Airfare at Economy Rates to return dependent children to country of residence
Repatriation of Mortal Remains	100% coverage

International Employee Assistance Program (IEAP)	
Toll Free:	1.888.851.7032 or 1.877.857.2952
Reverse Charge Number:	+44 208 987 6230
Level 2 International EAP Assist	Direct dial 24/7 immediate access to confidential services for behavioral issues. Services include telephonic triage for emergent and urgent referrals, crises intervention and referrals to community resources. Referrals for 6 face-to-face sessions with licensed behavioral professionals (currently available in 160 countries).

Global Telehealth	
Teladoc Health International	Available 24/7 via the Cigna Wellbeing App, Global Telehealth gives you access to licensed doctors around the world. • Video or phone consultations with licensed doctors when medically necessary • Prescriptions for common health concerns when medically necessary and permitted • Treating medical conditions like fever, rash, pain and more • Assistance with preparations for an upcoming consultation • Discussing medication plan and potential side effects • Diagnosing non-emergency health issues ranging from acute conditions to complex chronic conditions

Global Vision Plan	
	International (Outside of the U.S.)
Examinations One every 12 consecutive months	100% not subject to deductible
Lenses and Frames or Contacts One every 12 consecutive months	100% not subject to deductible
Hardware Maximum Benefit	$150

Global Dental Plan		International (Outside of the U.S.)
Calendar Year Maximum Combined for: Class I Class II Class III		$1,000
Calendar Year Deductible Combined for: Class II Class III		$50 Individual / $150 Family
Class I	**Preventive Care** For diagnostic and preventative services including: • Oral Exam -2 Per Person Per Year • Cleanings -2 Per Person Per Year • Bitewing X-rays -2 Per Person Per Year • Fluoride Applications -1 Per Person Per Year (Up to age 19) • Sealants -1 Per Person Per 3 Years • Diagnostic X-rays –Unlimited • Full Mouth / Panoramic X-rays -1 Per Person Per 3 Years	100% not subject to deductible
Class II	**Basic Restorative** For Basic Restorations: • Endodontics • Periodontics • Prosthodontics Maintenance • Oral Surgery • Fillings • Root Canal • Periodontal Scaling and Root Planing • Repair to Bridgework and Dentures	80% after deductible
Class III	**Major Restorative** For Major Restorations: • Dentures • Bridgework • Crowns	50% after deductible