Insured and/or administered by:

Cigna Health and Life Insurance Company

Leidos

Benefits at a Glance
Global Plan for all covered Employees.
Policy # 00666A
Plan Start Date January 1, 2027

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 Healthcare, Global Health Benefits 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 Healthcare P.O. Box 15050 Wilmington DE 19850-5050 U.S.A.	Cigna Healthcare 900 Cottage Grove Road Bloomfield, Connecticut, 06002 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	U.S. Out-of-Network
Area of Cover	Worldwide		
U.S. Medical Network	OAP		
Eligibility	Refer to eligibility definition in the certificate		
Lifetime Maximum	Unlimited		
Calendar Year Deductible · Per Individual	$200	$1,000	$2,000
· Per Family	$400	$2,000	$4,000
Coinsurance (The percentage of covered expenses the plan pays)	85%	80%	60%
Out-of-Pocket Maximum (Includes Deductible) · Per Individual	$1,250	$2,000	$4,000
· Per Family	$2,500	$4,000	$8,000

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.

Certification Requirements - For services rendered inside the United States

Precertification for inpatient and outpatient services received in the U.S. may be required.

- Providers must call our toll-free number, 1.800.441.2668 to pre-certify services.
- You or your dependents are responsible for ensuring that Out-of-Network providers pre-certify services.
- Failure to obtain precertification may affect Out-of-Pocket costs.
- This is a summary only and further details can be found in the certificate booklet.

Global Medical Plan			
	International (Outside of the U.S.)	**U.S. In-Network**	**U.S. Out-of-Network**
Physician's Services · Physician's Office Visit	85% after deductible	80% after deductible	60% after deductible
· Surgery Performed In the Physician's Office	85% after deductible	80% after deductible	60% after deductible
Preventive Care			
· Routine Preventive Care - Adult	100% not subject to deductible	100% not subject to deductible	100% not subject to deductible
· Immunizations - Adult	100% not subject to deductible	100% not subject to deductible	100% not subject to deductible
· Routine Preventive Care - Child	100% not subject to deductible	100% not subject to deductible	100% not subject to deductible
· Immunizations - Child	100% not subject to deductible	100% not subject to deductible	100% not subject to deductible
Travel Immunizations (Immunizations as required for travel)	100% not subject to deductible	100% not subject to deductible	100% not subject to deductible
Mammograms, PSA, PAP Smear and Colorectal Cancer Screenings	100% not subject to deductible	100% not subject to deductible	100% not subject to deductible
Inpatient Hospital			
· Inpatient Hospital - Facility Services (Limited to the Semi-Private Room Rate)	$200 copay, then 85% after deductible	$250 copay, then 80% after deductible	$250 copay, then 60% after deductible
· Inpatient Hospital Physician Visits/Consultations	85% after deductible	80% after deductible	60% after deductible
· Inpatient Professional Services (Surgeon, Radiologist, Pathologist, Anesthesiologist)	85% after deductible	80% after deductible	60% after deductible
Outpatient Services			
· Outpatient Facility Services	85% after deductible	80% after deductible	60% after deductible
· Outpatient Professional Services	85% after deductible	80% after deductible	60% after deductible
Emergency Room	85% after deductible	80% after deductible	80% after deductible
Urgent Care Services	85% after deductible	80% after deductible	60% after deductible
Ambulance	85% after deductible	100% after deductible	100% after deductible

Global Medical Plan			
	International (Outside of the U.S.)	**U.S. In-Network**	**U.S. Out-of-Network**
Laboratory Services			
· Physician Office Visit	85% after deductible	80% after deductible	60% after deductible
· Outpatient Facility	85% after deductible	80% after deductible	60% after deductible
· Laboratory Services at an Independent Lab facility	85% after deductible	80% after deductible	60% after deductible
Radiology Services			
· Physician Office Visit	85% after deductible	80% after deductible	60% after deductible
· Outpatient Facility	85% after deductible	80% after deductible	60% after deductible
Advanced Radiology (i.e., MRIs, MRAs, CAT Scans, PET Scans)			
· Physician Office Visit	85% after deductible	80% after deductible	60% after deductible
· Inpatient Facility	$200 copay, then 85% after deductible	$250 copay, then 80% after deductible	$250 copay, then 60% after deductible
· Outpatient Facility	85% after deductible	80% after deductible	60% after deductible
Outpatient Therapy Services			
· Physician Office Visit	85% after deductible	80% after deductible	60% after deductible
· Outpatient Hospital Facility	85% after deductible	80% after deductible	60% after deductible
Calendar Year Maximum:	60 Days for all Therapies Combined		
The limit is not applicable to Mental Health and Substance Use Disorder conditions. **Note:** The Outpatient Therapy Services 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**	**U.S. Out-of-Network**
Outpatient Therapy Services - Physical Therapy / Physiotherapy			
· Physician Office Visit	85% after deductible	80% after deductible	60% after deductible
· Outpatient Hospital Facility	85% after deductible	80% after deductible	60% after deductible
Calendar Year Maximum: Unlimited for all Therapies Combined			
Chiropractic Care Calendar Year Maximum: Unlimited	85% after deductible	80% after deductible	60% after deductible
Maternity Care Services			
· Initial Visit to Confirm Pregnancy	85% after deductible	80% after deductible	60% after deductible
· All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)	85% after deductible	80% after deductible	60% after deductible
· Physician's Office Visits in addition to the global maternity fee when performed by an OB/GYN or Specialist	85% after deductible	80% after deductible	60% after deductible
· Delivery – Facility			
· Inpatient Hospital	$200 copay, then 85% after deductible	$250 copay, then 80% after deductible	$250 copay, then 60% after deductible
· Birthing Center	$200 copay, then 85% after deductible	$250 copay, then 80% after deductible	$250 copay, then 60% after deductible

Global Medical Plan			
	International (Outside of the U.S.)	**U.S. In-Network**	**U.S. Out-of-Network**
Infertility, Fertility and Conception Services			
· Physician Office Visit and Counseling	85% after deductible	80% after deductible	60% after deductible
· Lab and Radiology Tests	85% after deductible	80% after deductible	60% after deductible
· Inpatient Facility	$200 copay, then 85% after deductible	$250 copay, then 80% after deductible	$250 copay, then 60% after deductible
· Outpatient Facility	85% after deductible	80% after deductible	60% after deductible
Hearing Exam · 1 Exam Every 24 Months	85% after deductible	80% after deductible	60% after deductible
Hearing Device / Aids	85% after deductible	80% after deductible	60% after deductible
Mental Health · Physician Office Visit	85% after deductible	80% after deductible	60% after deductible
· Inpatient Facility	85% after deductible	80% after deductible	60% after deductible
Maximum: (combined with Substance Use Disorder)			
· Outpatient Facility	85% after deductible	80% after deductible	60% after deductible
Maximum: (combined with Substance Use Disorder)		Unlimited	
Substance Use Disorder · Physician Office Visit	85% after deductible	80% after deductible	60% after deductible
· Inpatient Facility	85% after deductible	80% after deductible	60% after deductible
Maximum: (combined with Mental Health)			
· Outpatient Facility	85% after deductible	80% after deductible	60% after deductible
Maximum: (combined with Mental Health)		Unlimited	
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 15% after plan deductible	
Certain preventive care medications covered under this plan and required as part of preventive care services (detailed information is available at www.healthcare.gov) are payable at 100% with no copayment or deductible, when purchased from a Network Pharmacy. A written prescription is required.		
Purchased Inside the United States Only		
Benefit Highlights	**Network Pharmacy (U.S. In-Network)**	**Non-Network Pharmacy (U.S. Out-of-Network)**
Prescription Drug Products at Retail Pharmacies	**The amount you pay for up to a consecutive 30-day supply**	
Tier 1 - Generic Drugs on the Prescription Drug List	You pay 20% not subject to plan deductible	You pay 40% after plan deductible
Tier 2 – Brand Drugs designated as preferred on the Prescription Drug List	You pay 20% not subject to plan deductible	You pay 40% after plan deductible
Tier 3 – Brand Drugs designated as non-preferred on the Prescription Drug List	You pay 20% not subject to plan deductible	You pay 40% after plan deductible
Prescription Drug Products at Home Delivery Pharmacies	**The amount you pay for up to a consecutive 90-day supply**	
Tier 1 - Generic Drugs on the Prescription Drug List	You pay 20% not subject to plan deductible	In-Network coverage only
Tier 2 – Brand Drugs designated as preferred on the Prescription Drug List	You pay 20% not subject to plan deductible	In-Network coverage only
Tier 3 – Brand Drugs designated as non-preferred on the Prescription Drug List	You pay 20% not subject to plan deductible	In-Network coverage only

Pharmacy Plan Features for Prescriptions Drugs Purchased Inside the United States Only	
Prescription Drug List	Performance 3-Tier
Dispense As Written	If you request to fill a brand name drug that has a generic equivalent available, you will be financially responsible for the difference in cost between the brand name and the generic drug, plus any required brand name drug copayment and/or coinsurance, if applicable. However, if your doctor has determined a generic drug is not an acceptable alternative for you, you will only be responsible for payment of the appropriate brand name drug copayment and/or coinsurance, if applicable
Utilization Management	Your plan features drug management programs and edits to ensure safe prescribing, and access to medications proven to be the most reliable and cost effective for your medical condition
Step Therapy	Certain drugs are subject to step therapy requirements. To identify whether a particular drug is subject to step therapy, please refer to your prescription drug list.
Prior Authorization	Coverage for certain drugs require your Physician to obtain prior authorization from Cigna. To identify whether a particular drug requires prior authorization, please refer to your prescription drug list.
Quantity Limits	Includes maximum daily dose edits, quantity over time edits, duration of therapy edits, and dose optimization edits
Patient Assurance Program	Your plan includes the Patient Assurance Program, which waives the deductible, if applicable, and reduces the amount you owe for certain medications used to treat chronic conditions included in the program. Additionally: •Any amount you pay for these medications only count toward meeting your out-of-pocket maximum, if applicable. •Any discount provided by a pharmaceutical manufacturer for these medications only count toward meeting your out-of-pocket maximum, if applicable.
To see if your medication is covered, you can view Cigna's Prescription Drug List by going to www.Cigna.com/druglist and select "Performance 3-Tier"	

Global Family Building & Hormonal Health Support	
Carrot	As a Cigna Healthcare global member, you and your covered spouse/partner can access Carrot, the leading global fertility, hormonal health, and family-building benefit provider. Carrot provides: • Personalized care plans and support for fertility, pregnancy, postpartum, parenting, menopause and low testosterone symptom relief and more • Unlimited 1:1 telehealth support from clinicians and specialists • Multilingual localized expertise, country-specific care, and provider navigation • Access to expert-authored articles, videos, guides, and group sessions Create your account and explore your Carrot benefit.

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

Global Telehealth	
Teladoc Health International	Global telehealth gives you no cost 24/7 access to licensed doctors for non-emergency health issues. Common outreaches include fever, rash, pain, non-emergency pediatric care, and more. Referrals to specialists and prescriptions available when medically necessary and locally permitted. Telephone or video consultations can be arranged through Cigna Envoy (cignaenvoy.com).

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Global Vision Plan			
	International (Outside of the U.S.)	**U.S. In-Network**	**U.S. Out-of-Network**
Examinations One every 12 consecutive months	100% not subject to deductible	100% not subject to deductible	100% not subject to deductible
Maximum	Unlimited	Unlimited	$40
Contact Lens Professional Service			
Fit & Follow-up Standard	100% not subject to deductible	100% not subject to deductible	100% not subject to deductible
Maximum	Unlimited	Unlimited	$20
Fit & Follow-up Premium	100% not subject to deductible	100% not subject to deductible	100% not subject to deductible
Maximum	Unlimited	$40	$20
Frames One every 12 consecutive months	100% not subject to deductible	100% not subject to deductible	100% not subject to deductible
Maximum	$250	$250	$200
Costco Maximum	Combined with Frames Maximum	$140	Not Covered
Lenses One pair every 12 consecutive months (In lieu of Contacts)			
Single Lenses	100% not subject to deductible	100% not subject to deductible	100% not subject to deductible
Maximum	Unlimited	Unlimited	$30
Bifocal Lenses	100% not subject to deductible	100% not subject to deductible	100% not subject to deductible
Maximum	Unlimited	Unlimited	$50
Trifocal Lenses	100% not subject to deductible	100% not subject to deductible	100% not subject to deductible
Maximum	Unlimited	Unlimited	$70
Lenticular Lenses	100% not subject to deductible	100% not subject to deductible	100% not subject to deductible
Maximum	Unlimited	Unlimited	$70
Polycarbonate Lenses	100% not subject to deductible	100% not subject to deductible	100% not subject to deductible
Maximum	Unlimited	Unlimited	$20
Photochromatic Lenses	Not Covered	100% not subject to deductible	100% not subject to deductible
Maximum		Unlimited	$20

Global Vision Plan			
	International (Outside of the U.S.)	**U.S. In-Network**	**U.S. Out-of-Network**
Standard Progressive Lenses	100% not subject to deductible	100% not subject to deductible	100% not subject to deductible
Maximum	Unlimited	Unlimited	$50
Premium Progressive Lenses			
Tier 1	100% not subject to deductible	$85 copay not subject to deductible	100% not subject to deductible
Tier 2	100% not subject to deductible	$95 copay not subject to deductible	100% not subject to deductible
Tier 3	100% not subject to deductible	$110 copay not subject to deductible	100% not subject to deductible
Tier 4	100% not subject to deductible	$175 copay not subject to deductible	100% not subject to deductible
Maximum	Unlimited	Unlimited	$50
Tints and Coating	Not Covered	100% not subject to deductible	100% not subject to deductible
Maximum		Unlimited	$8
Contact Lenses	100% not subject to deductible	100% not subject to deductible	100% not subject to deductible
Maximum	$250	$250	$200
Medically Necessary Contact Lenses	100% not subject to deductible	100% not subject to deductible	100% not subject to deductible
Maximum	Unlimited	Unlimited	$250
Additional coverage may be included with your Vision plan. Refer to Envoy for additional information.			

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