



Insured and/or administered by:  
**Cigna Health and Life Insurance Company**

**Merck, Sharp & Dohme Corp**  
 Benefits at a Glance  
 Global Plan for all covered Active Employees  
 Policy #01119A

**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			
<b>Toll Free Telephone Number:</b>	1.800.441.2668		
<b>Direct Telephone:</b>	1.302.797.3100 (collect calls accepted)		
<b>Toll Free Fax Number:</b>	1.800.243.6998		
<b>Direct Fax Number:</b>	001.302.797.3150		
<b>Secure Website:</b>	<a href="http://www.CignaEnvoy.com">www.CignaEnvoy.com</a> . Registration is required. (See member kit for registration information.) Secure email available at this site.		
<b>Mail Delivery:</b>	<table border="0"> <tr> <td>Cigna Global Health Benefits P.O. Box 15050 Wilmington, DE 19850-5050 U.S.A.</td> <td>Cigna Global Health Benefits 300 Bellevue Parkway Wilmington, DE 19809 U.S.A</td> </tr> </table>	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
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		

Global Medical Plan			
	International (Outside of the U.S.)	U.S. In-Network	U.S. Out-of-Network
<b>Eligibility</b>	Refer to eligibility definition in the certificate		
<b>Lifetime Maximum Active Employees</b>	Unlimited		
<b>Calendar Year Deductible</b>			
• Per Individual	\$0	\$0	\$0
• Per Family	\$0	\$0	\$0
<b>Coinsurance</b> (The percentage of covered expenses the plan pays)	80%	80%	80% of Maximum Reimbursable Charge; see below
<b>Out-of-Pocket Maximum</b>			
• Per Individual	\$2,500	\$2,500	\$2,500
• Per Family	\$5,000	\$5,000	\$5,000
<b>Deductible</b>	Family members meet only their individual Out-of-Pocket and then their claims will be covered at 100%; if the family Out-of-Pocket has been met prior to their individual Out-of-Pocket being met, their claims will be paid at 100%.		
<b>Accumulation:</b>	Accumulation of Plan Deductible and Out-of-Pocket Maximums: Deductible and Out-of-Pocket Maximums will cross-accumulate between In-Network, Out-of-Network and International. All other plan maximums and service specific maximums (dollar and occurrence) will also cross-accumulate.		

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## 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.

## Maximum Reimbursable Charge

Maximum Reimbursable Charge is determined based on the lesser of the provider's normal charge for a similar service or supply; or a percentage of a schedule Cigna has developed that is based upon a methodology similar to a methodology utilized by Medicare to determine the allowable fee for the same or similar services within the geographic market. In some cases, a Medicare based schedule will not be used and the Maximum Reimbursable Charge for covered services is determined based on the lesser of:

- the provider's normal charge for a similar service or supply; or
- the 80th percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by Cigna.

If sufficient charge data is unavailable in the database for that geographic area to determine the Maximum Reimbursable Charge, then data in the database for similar services may be used.

Note: The provider may bill you for the difference between the provider's normal charge and the Maximum Reimbursable Charge, in addition to applicable deductibles and Coinsurance.

## Global Medical Plan

	International (Outside of the U.S.)	U.S. In-Network	U.S. Out-of-Network
<b>Physician's Services</b>			
• Physician's Office Visit	80%	80%	80% of Maximum Reimbursable Charge
• Surgery Performed In the Physician's Office	80%	80%	80% of Maximum Reimbursable Charge
• Physician's Telehealth Visit	80%	80%	80% of Maximum Reimbursable Charge
<b>Preventive Care</b>			
Routine Preventive Care – all ages	100%	100%	100% of Maximum Reimbursable Charge
Immunizations – all ages			
<b>Travel Immunizations</b> (Immunizations as required for travel)	100%	100%	100% of Maximum Reimbursable Charge
<b>Mammograms, PSA, PAP Smear and Colorectal Cancer Screenings</b>	100%	100%	100% of Maximum Reimbursable Charge
<b>Inpatient Hospital Facility Services</b>			
• Facility	80%	80%	80% of Maximum Reimbursable Charge
• Physician	80%	80%	80% of Maximum Reimbursable Charge
<b>Outpatient Facility Services</b>	80%	80%	80% of Maximum Reimbursable Charge
<b>Emergency Room</b> (Refer to certificate for coverage and exclusions)	80%	80%	80% of Maximum Reimbursable Charge
<b>Urgent Care Services</b>	80%	80%	80% of Maximum Reimbursable Charge

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Global Medical Plan			
	International (Outside of the U.S.)	U.S. In-Network	U.S. Out-of-Network
<b>Laboratory and Radiology Services (including pre-admission testing)</b>	80%	80%	80% of Maximum Reimbursable Charge
<b>Outpatient Short-Term Rehabilitation Physician Office Visit &amp; Outpatient Hospital Facility</b> (Calendar Year Maximum: Unlimited for all therapies combined) <i>Includes:</i> Speech, Occupational, Pulmonary and Cognitive Therapy  <b>Note:</b> The Short-Term Rehabilitation Therapy maximum does not apply to the treatment of Autism and/or Mental Health conditions.	80%	80%	80% of Maximum Reimbursable Charge
<b>Outpatient Short-Term Rehabilitation Therapy Physical/Physio Therapy Physician Office Visit &amp; Outpatient Hospital Facility</b> Calendar Year Maximum: Unlimited	80%	80%	80% of Maximum Reimbursable Charge
<b>Outpatient Cardiac Rehabilitation Physician Office Visit &amp; Outpatient Hospital Facility</b> Calendar Year Maximum: Unlimited	80%	80%	80% of Maximum Reimbursable Charge
<b>Chiropractic Care</b> Physician's Office Visit Calendar Year Maximum: Unlimited	80%	80%	80% of Maximum Reimbursable Charge
<b>Maternity Care Services</b> • Initial Visit to Confirm Pregnancy	80%	80%	80% of Maximum Reimbursable Charge
• All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)	80%	80%	80% of Maximum Reimbursable Charge
• Physician's Office Visits in addition to the global maternity fee when performed by an OB/GYN or Specialist	80%	80%	80% of Maximum Reimbursable Charge
• Delivery – Facility (Inpatient Hospital, Birthing Center)	80%	80%	80% of Maximum Reimbursable Charge
<b>Infertility Services</b>	Diagnosis of Infertility is covered under general Physician Office Visits. Coverage will be provided for the following services: <ul style="list-style-type: none"> <li>· GIFT, ZIFT, etc.</li> <li>· In-vitro</li> <li>· Artificial Insemination</li> </ul>		
· Physician Office Visit and Counseling	80%	80%	80% of Maximum Reimbursable Charge
· Lab and Radiology Tests	80%	80%	80% of Maximum Reimbursable Charge
· Inpatient Facility	80%	80%	80% of Maximum Reimbursable Charge
· Outpatient Facility	80%	80%	80% of Maximum Reimbursable Charge

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Global Medical Plan			
	International (Outside of the U.S.)	U.S. In-Network	U.S. Out-of-Network
<b>Hearing Exam</b> • Exam: One every 24 month period	80%	80%	80% of Maximum Reimbursable Charge
<b>Hearing Aid Maximum</b> Up to \$3,000 per hearing aid unit necessary for each hearing impaired ear every 3 years for a dependent child under age 24	80%	80%	80% of Maximum Reimbursable Charge
<b>Mental Health and Substance Use Disorder</b> • Physician Office Visit	80%	80%	80% of Maximum Reimbursable Charge
• Inpatient Facility	80%	80%	80% of Maximum Reimbursable Charge
• Outpatient Facility	80%	80%	80% of Maximum Reimbursable Charge

Global Telehealth	
<b>Teladoc Health International</b>	Available 24/7 via the Cigna Wellbeing App, Global Telehealth gives you access to licensed doctors around the world. <ul style="list-style-type: none"> <li>• Video or phone consultations with licensed doctors when medically necessary</li> <li>• Prescriptions for common health concerns when medically necessary and permitted</li> <li>• Treating medical conditions like fever, rash, pain and more</li> <li>• Assistance with preparations for an upcoming consultation</li> <li>• Discussing medication plan and potential side effects</li> <li>• Diagnosing non-emergency health issues ranging from acute conditions to complex chronic conditions</li> </ul>

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Prescription Drug Benefits		
International (Outside of the U.S.)		
Merck Brand Prescriptions purchased inside or outside the U.S.	100%	
Merck Brand Prescriptions purchased inside or outside the U.S. with a generic equivalent (with exception of women's contraceptives) or Non- Merck Prescriptions	80%	
Purchased outside the United States	No Charge	
Certain preventive care medications covered under this plan and required as part of preventive care services (detailed information is available at <a href="http://www.healthcare.gov">www.healthcare.gov</a> ) 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	
Merck Brand Prescription Drugs	\$0 per prescription order or refill	\$0 per prescription order or refill
Merck Brand Prescription Drugs with a generic equivalent (with exception of Women's contraceptives)	20%	20%
Non-Merck Prescription Drugs*	20%	20%
*Designated as per generally-accepted industry sources and adopted by the Insurance Company		
Prescription Drug Products at HomeDelivery Pharmacies	The amount you pay for up to a consecutive 90-day supply	
Merck Brand Prescription Drugs	\$0 per prescription order or refill	U.S. In-Network coverage only
Merck Brand Prescription Drugs with a generic equivalent (with exception of Women's contraceptives)	20%	U.S. In-Network coverage only
Non-Merck Prescription Drugs*	20%	U.S. In-Network coverage only
*Designated as per generally-accepted industry sources and adopted by the Insurance Company		

Global Vision Care			
	International (Outside the U.S.)	U.S. In-Network	U.S. Out-of-Network
<b>Examinations</b> One Eye Exam every 24 consecutive months	80%	80%, MRC does not apply	

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Global Dental Care		
<b>Calendar Year Maximum</b> (Combined for Class I, II, III, V)		\$2,000
<b>Lifetime Maximum</b> (for Class IV)		\$1,500
<b>Class I</b>	<b>Preventive Care</b> For diagnostic and preventative services including: <ul style="list-style-type: none"> <li>• Oral Exam - 2 per person, per year</li> <li>• Cleanings - 2 per person, per year</li> <li>• Bitewing X-rays - 2 per person, per year</li> <li>• Fluoride Applications - 1 per person, per year (Up to age 19)</li> <li>• Sealants - 1 per tooth, per 3 years</li> <li>• Full Mouth X-rays – 1 per person, per 3 years</li> <li>• Panoramic X-rays - 1 per person, per 3 years</li> </ul>	100% *
<b>Class II</b>	<b>Basic Restorative</b> For Basic Restorations: <ul style="list-style-type: none"> <li>• Endodontics</li> <li>• Periodontics</li> <li>• Prosthodontics Maintenance</li> <li>• Oral Surgery</li> <li>• Fillings</li> <li>• Root Canal</li> <li>• Periodontal Scaling and Root Planing</li> <li>• Repair to Bridgework and Dentures</li> </ul>	100% *
<b>Class III</b>	<b>Major Restorative</b> For Major Restorations: <ul style="list-style-type: none"> <li>• Dentures</li> <li>• Bridgework</li> <li>• Crowns</li> </ul>	50% *
<b>Class IV</b>	<b>Orthodontia</b> (Children and Adults)	50% *
<b>Class V</b>	<b>Implants</b>	80% *

**\*Dental Maximum Reimbursable Charge Services in the United States for Non-Participating Providers**

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*Note: The provider may bill you for the difference between the provider's normal charge and the Maximum Reimbursable Charge, in addition to applicable deductibles and Coinsurance.*