Insured and/or administered by:

Cigna Health and Life Insurance Company

Caterpillar Inc.

Benefits at a Glance - Inpats
Global Plan for all covered Employees
Policy # 06897A
Plan Start Date January 1, 2021

This plan provides minimum essential coverage.

Please Note: This is a high level summary of your benefits. Please see your certificate booklet for detailed benefits and exclusions.

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	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		
Annual Maximum	Unlimited		
Calendar Year Deductible · Per Individual · Per Family	$0 $0	$0 $0	$0 $0
Coinsurance (The percentage of covered expenses the plan pays)	100%	100%	50%
Out-of-Pocket Maximum · Per Individual · Per Family	Unlimited Unlimited	Unlimited Unlimited	$4,600 $9,200

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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: Exclude 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.

	International (Outside of the U.S.)	U.S. In-Network	U.S. Out-of-Network
Physician's Services · Physician's Office Visit	100%	100%	50%
· Surgery Performed In the Physician's Office	100%	100%	50%
Preventive Care · Routine Preventive Care - all ages · Immunizations - all ages	100%	100%	50%
Travel Immunizations (Immunizations as required for travel)	100%	100%	50%
Mammograms, PSA, PAP Smear and Colorectal Cancer Screenings	100%	100%	50%
Inpatient Hospital Facility Services	100%	100%	50%
Inpatient Hospital Physician Visits/Consultations	100%	100%	50%
Outpatient Facility Services	100%	100%	50%
Emergency Room	100%	100%	100%
Urgent Care Services	100%	100%	100%
Ambulance	100%	100%	100%

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Global Medical Plan			
	International (Outside of the U.S.)	**U.S. In-Network**	**U.S. Out-of-Network**
Laboratory and Radiology Services (including pre-admission testing)	100%	100%	50%
Advanced Radiology (i.e., MRIs, MRAs, CAT Scans, PET Scans)	100%	100%	50%
Short-Term Rehabilitation Calendar Year Maximum: 60 Days for all Therapies Combined *Includes:* Cardiac and Pulmonary Rehab, Speech, Occupational and Cognitive Therapy **Note:** The Short-Term Rehabilitation Therapy maximum does not apply to the treatment of Autism and/or Mental Health conditions	100%	100%	50%
Short-Term Rehabilitation Physical Therapy / Physiotherapy	100%	100%	50%
Chiropractic Care	100%	100%	50%
Maternity Care Services	100%	100%	50%
· Initial Visit to Confirm Pregnancy	100%	100%	50%
· All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)	100%	100%	50%
· Physician's Office Visits in addition to the global maternity fee when performed by an OB/GYN or Specialist	100%	100%	50%
· Delivery – Facility (Inpatient Hospital, Birthing Center)	100%	100%	50%

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Global Medical Plan			
	International (Outside of the U.S.)	**U.S. In-Network**	**U.S. Out-of-Network**
Hearing Benefit · 1 exam every 24 months	100%	100%	50%
Hearing Device / Aids · Limited to Dependent Children Under 24 Years · 1 Per Ear Every 36 Months up to $1,000	100%	100%	50%
Mental Health · Inpatient Facility · Outpatient Office Visit	100% 100%	100% 100%	50% 50%
Substance Use Disorder · Inpatient Facility · Outpatient Office Visit	100% 100%	100% 100%	50% 50%

Prescription Drug Benefits		
International (Outside of the U.S.)		
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 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	No Charge	50%
Tier 2 – Brand Drugs designated as preferred on the Prescription Drug List	No charge	50%
Tier 3 – Brand Drugs designated as non-preferred on the Prescription Drug List	No charge	50%
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	No Charge	In-Network coverage only
Tier 2 – Brand Drugs designated as preferred on the Prescription Drug List	No charge	In-Network coverage only
Tier 3 – Brand Drugs designated as non-preferred on the Prescription Drug List	No charge	In-Network coverage only

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Pharmacy Plan Features for Prescriptions Drugs Purchased Inside the United States Only	
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
Prescription Drug List	Performance 3-Tier
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.
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 Evacuation Plan	
Toll Free telephone number	1.800.441.2668
Emergency Medical Evacuation	100% of covered expenses 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 Vision Plan			
	International (Outside of the U.S.)	**U.S. In-Network**	**U.S. Out-of-Network**
Examinations One every 24 consecutive months. Dependent children age 18 and under One every 12 consecutive months.	100%	100%	50%
Lenses and Frames or Contacts One every 24 consecutive months	100%	100%	100%
Hardware Maximum Benefit	$200		

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Global Dental Plan		
Calendar Year Maximum Combined for: Class I Class II Class III		$3,000
Lifetime Class IV Maximum		$1,500
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%
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%
Class III	**Major Restorative** For Major Restorations: • Dentures • Bridgework • Crowns	50%
Class IV	**Orthodontia** (for dependent children under age 22)	50%
Class V	**Implants**	Not Covered

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