Insured and/or administered by:

**Cigna Health and Life Insurance Company**

# Motorola Solutions Inc

Benefits at a Glance
Global Plan for all covered Employees.
Policy # A005
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:**<br>**Direct Telephone:**<br>**Toll Free Fax Number:**<br>**Direct Fax Number:** | 1.800.441.2668<br>1.302.797.3100 (collect calls accepted)<br>1.800.243.6998<br>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<br>P.O. Box 15050<br>Wilmington DE 19850-5050 U.S.A. | Cigna Global Health Benefits<br>300 Bellevue Parkway<br>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** | PPO - Limited US Care (ER Only) | | |
| **Eligibility** | Refer to eligibility definition in the certificate | | |
| **Lifetime Maximum** | Unlimited | | |
| **Calendar Year Deductible**<br>· Per Individual | $0 | $0 | $0 |
| · Per Family | $0 | $0 | $0 |
| **Coinsurance**<br>(The percentage of covered expenses the plan pays) | 100% | 100% | 100% |
| **Out-of-Pocket Maximum**<br>· Per Individual | $0 | $0 | $0 |
| · Per Family | $0 | $0 | $0 |

| Global Medical Plan | | | |
|---|---|---|---|
| **Deductible Calculation** | Claims for a family member are covered at plan coinsurance:<br>• When that family member satisfies the Individual Deductible<br>-OR-<br>• 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:<br>• When that family member satisfies the Individual Out-of-Pocket Maximum<br>-OR-<br>• When the Family Out-of-Pocket Maximum is satisfied regardless of whether or not the Individual Out-of-Pocket Maximum is satisfied.<br>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. | | |
| | **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 | 100% | Not Covered | Not Covered |
| · Surgery Performed In the Physician's Office | 100% | Not Covered | Not Covered |
| **Preventive Care** | | | |
| · Routine Preventive Care - Adult | 100% | Not Covered | Not Covered |
| · Immunizations - Adult | 100% | Not Covered | Not Covered |
| · Routine Preventive Care - Child | 100% | Not Covered | Not Covered |
| · Immunizations - Child | 100% | Not Covered | Not Covered |
| **Travel Immunizations** (Immunizations as required for travel) | 100% | Not Covered | Not Covered |
| **Mammograms, PSA, PAP Smear and Colorectal Cancer Screenings** | 100% | Not Covered | Not Covered |
| **Inpatient Hospital** | | | |
| · Inpatient Hospital - Facility Services | 100% | 100% | 100% |
| · Inpatient Hospital Physician Visits/Consultations | 100% | 100% | 100% |
| · Inpatient Professional Services (Surgeon, Radiologist, Pathologist, Anesthesiologist) | 100% | 100% | 100% |
| **Outpatient Services** | | | |
| · Outpatient Facility Services | 100% | Not Covered | Not Covered |
| · Outpatient Professional Services | 100% | Not Covered | Not Covered |
| **Emergency Room** Treatment in the United States is excluded, except for Emergency Medical Service | 100% | 100% | 100% |
| **Urgent Care Services** | 100% | Covered for Emergency Medical Services only. | Covered for Emergency Medical Services only. |
| **Ambulance** | 100% | 100% | 100% |

| 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 | 100% | Not Covered | Not Covered |
| · Outpatient Facility | 100% | Not Covered | Not Covered |
| · Laboratory Services at an Independent Lab facility | 100% | Not Covered | Not Covered |
| **Radiology Services** | | | |
| · Physician Office Visit | 100% | Not Covered | Not Covered |
| · Outpatient Facility | 100% | Not Covered | Not Covered |
| **Advanced Radiology** (i.e., MRIs, MRAs, CAT Scans, PET Scans) Worldwide Care including the United States. | | | |
| · Physician Office Visit | 100% | Not Covered | Not Covered |
| · Inpatient Facility | 100% | 100% | 100% |
| · Outpatient Facility | 100% | Not Covered | Not Covered |
| **Short-Term Rehabilitation** | | | |
| · Physician Office Visit | 100% | Not Covered | Not Covered |
| · Outpatient Hospital Facility | 100% | 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.<br>**Note:** The Short-Term Rehabilitation Therapy maximum does not apply to the treatment of Autism<br>*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 | 100% | Not Covered | Not Covered |
| · Outpatient Hospital Facility | 100% | Not Covered | Not Covered |
| Calendar Year Maximum: Unlimited for all Therapies Combined | | | |
| **Chiropractic Care**<br>Calendar Year Maximum: Unlimited | 100% | Not Covered | Not Covered |
| **Maternity Care Services** | | | |
| · Initial Visit to Confirm Pregnancy | 100% | Not Covered | Not Covered |
| · All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee) | 100% | Not Covered | Not Covered |
| · Physician's Office Visits in addition to the global maternity fee when performed by an OB/GYN or Specialist | 100% | Not Covered | Not Covered |
| · Delivery – Facility | | | |
| · Inpatient Hospital | 100% | Not Covered | Not Covered |
| · Birthing Center | 100% | 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:<br>· GIFT, ZIFT, etc.<br>· In-vitro<br>· Artificial Insemination | | |
| · Physician Office Visit and Counseling | 100% | Not Covered | Not Covered |
| · Lab and Radiology Tests | 100% | Not Covered | Not Covered |
| · Inpatient Facility | 100% | Not Covered | Not Covered |
| · Outpatient Facility | 100% | Not Covered | Not Covered |
| **Hearing Exam**<br>· 1 Exam Every 24 Months | 100% | Not Covered | Not Covered |
| **Hearing Device / Aids**<br>· Limited to Dependent Children Under 24 Years<br>· 1 Per Ear Every 36 Months up to $1,000 | 100% | Not Covered | Not Covered |
| **Mental Health**<br>· Physician Office Visit | 100% | Not Covered | Not Covered |
| · Inpatient Facility | 100% | Not Covered | Not Covered |
| Maximum: (combined with Substance Use Disorder) | | | |
| · Outpatient Facility | 100% | Not Covered | Not Covered |
| Maximum: (combined with Substance Use Disorder) | | Unlimited | |
| **Substance Use Disorder**<br>· Physician Office Visit | 100% | Not Covered | Not Covered |
| · Inpatient Facility | 100% | Not Covered | Not Covered |
| Maximum: (combined with Mental Health) | | | |
| · Outpatient Facility | 100% | Not Covered | Not Covered |
| 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** | No Charge |

| 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 |

| 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<br>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.<br>• Video or phone consultations with licensed doctors when medically necessary<br>• Prescriptions for common health concerns when medically necessary and permitted<br>• Treating medical conditions like fever, rash, pain and more<br>• Assistance with preparations for an upcoming consultation<br>• Discussing medication plan and potential side effects<br>• Diagnosing non-emergency health issues ranging from acute conditions to complex chronic conditions |

| Global Vision Plan | |
|---|---|
| | **International (Outside of the U.S.)** |
| **Examinations**<br>One every 24 consecutive months | 100% |
| **Lenses and Frames or Contacts**<br>One every 24 consecutive months | 100% |
| **Hardware Maximum Benefit** | $100 |

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