



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, 2026

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 | | |
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| Toll Free Telephone Number: | 1.800.441.2668 | |
| Direct Telephone: | 1.302.797.3100 (collect calls accepted) | |
| Toll Free Fax Number: | 1.800.243.6998 | |
| Direct Fax Number: | 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 300 Bellevue Parkway Wilmington DE 19809 U.S.A. |

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| General Plan Provisions - All Amounts in U.S. Dollars |
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| Global Medical Plan | | | |
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| | 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 · Per Individual | \$0 | \$0 | \$0 |
| · Per Family | \$0 | \$0 | \$0 |
| Coinsurance (The percentage of covered expenses the plan pays) | 100% | 100% | 100% |
| Out-of-Pocket Maximum · 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: <ul style="list-style-type: none">• When that family member satisfies the Individual Deductible -OR- <ul style="list-style-type: none">• 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: <ul style="list-style-type: none">• When that family member satisfies the Individual Out-of-Pocket Maximum -OR- <ul style="list-style-type: none">• 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. |



| | 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 · Surgery Performed In the Physician's Office | 100% 100% | Not Covered Not Covered | Not Covered Not Covered |
| Preventive Care · Routine Preventive Care - Adult · Immunizations - Adult · Routine Preventive Care - Child · Immunizations - Child | 100% 100% 100% 100% | Not Covered Not Covered Not Covered Not Covered | Not Covered Not Covered 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 (Limited to the Semi-Private Room Rate) · Inpatient Hospital Physician Visits/Consultations · Inpatient Professional Services (Surgeon, Radiologist, Pathologist, Anesthesiologist) | 100% 100% 100% | 100% 100% 100% | 100% 100% 100% |
| Outpatient Services · Outpatient Facility Services · Outpatient Professional Services | 100% 100% | Not Covered Not Covered | 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 | | | |
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| | 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 · Outpatient Facility · Laboratory Services at an Independent Lab facility | 100% | Not Covered | Not Covered |
| Radiology Services · Physician Office Visit · 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 · Inpatient Facility · Outpatient Facility | 100% | Not Covered | Not Covered |
| Outpatient Therapy Services · Physician Office Visit · Outpatient Hospital Facility Calendar Year Maximum: | 100% | Not Covered | Not Covered |
| 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 <i>Includes:</i> 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 |
| Outpatient Therapy Services - Physical Therapy / Physiotherapy · Physician Office Visit · Outpatient Hospital Facility Calendar Year Maximum: Unlimited for all Therapies Combined | 100% | Not Covered | Not Covered |
| Chiropractic Care Calendar Year Maximum: Unlimited | 100% | Not Covered | Not Covered |
| Maternity Care Services · Initial Visit to Confirm Pregnancy · All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee) · Physician's Office Visits in addition to the global maternity fee when performed by an OB/GYN or Specialist · Delivery – Facility · Inpatient Hospital · Birthing Center | 100% | Not Covered | Not Covered |
| | 100% | Not Covered | Not Covered |
| | 100% | Not Covered | Not Covered |
| | 100% | Not Covered | Not Covered |
| | 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, Fertility and Conception Services · Physician Office Visit and Counseling · Lab and Radiology Tests · Inpatient Facility · Outpatient Facility | 100% | Not Covered | Not Covered |
| Hearing Exam · 1 Exam Every 24 Months | 100% | Not Covered | Not Covered |
| Hearing Device / Aids | 100% | Not Covered | Not Covered |
| Mental Health · Physician Office Visit · Inpatient Facility Maximum: (combined with Substance Use Disorder) · Outpatient Facility Maximum: (combined with Substance Use Disorder) | 100% | Not Covered | Not Covered |
| Substance Use Disorder · Physician Office Visit · Inpatient Facility Maximum: (combined with Mental Health) · Outpatient Facility Maximum: (combined with Mental Health) | 100% | 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 | |
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| International (Outside of the U.S.) | |
| Purchased outside the United States | No Charge, not subject to plan deductible |



| Global Evacuation Plan | |
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| 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) | |
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| International EAP Assist & Work/Life | <p>Our program offers no cost 24/7 confidential support for you and your family's emotional and mental well-being. Services include telephonic triage for emergent and urgent referrals, crises intervention, and referrals for community resources such as childcare, eldercare, legal, and financial. Your counseling benefit includes up to 6 sessions per issue with a licensed behavioral professional. Sessions are available in-person, via video or telephone based on need, location, and your preference.</p> <p>Complete program details and country-specific contact information can be found on Cigna Envoy (cignaenvoy.com).</p> |

| Global Telehealth | |
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| Teladoc Health International | <p>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).</p> |

| Global Family Building & Hormonal Health Support | |
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| Carrot | <p>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:</p> <ul style="list-style-type: none"> • 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 <p>Create your account and explore your Carrot benefit.</p> |



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



| Global Dental Plan | | |
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| Calendar Year Maximum Combined for: Class I Class II Class III | | \$2,000 |
| Lifetime Class IV Maximum | | \$2,000 |
| Calendar Year Deductible Combined for: Class II Class III | | \$50 Individual / \$150 Family |
| Class I | Preventive Care For diagnostic and preventative services including: <ul style="list-style-type: none"> • 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 Treatment per Posterior Tooth 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: <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • Dentures • Bridgework • Crowns | 50% after deductible |
| Class IV | Orthodontia Children under 19 Years | 50% after separate \$50 deductible |

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