



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

**Autodesk, Inc.**  
Benefits at a Glance  
Global Plan for all covered Employees.  
Policy # 03742B001, B002  
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		
<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>	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
<b>Area of Cover</b>	Worldwide		
<b>U.S. Medical Network</b>	OAP		
<b>Eligibility</b>	Refer to eligibility definition in the certificate		
<b>Lifetime Maximum</b>	Unlimited		
<b>Calendar Year Deductible</b> · Per Individual	\$0	\$250	\$500
· Per Family	\$0	\$500	\$1,000
<b>Coinsurance</b> (The percentage of covered expenses the plan pays)	90%	90%	70%
<b>Out-of-Pocket Maximum (Excludes Deductible)</b> · Per Individual	\$1,600	\$1,600	\$3,200
· Per Family	\$3,200	\$3,200	\$6,400



Global Medical Plan	
<b>Deductible Calculation</b>	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.
<b>Out-of-Pocket Calculation</b>	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.
<b>Network Accumulation</b>	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
<b>Physician's Services</b>			
· Physician's Office Visit	\$10 copay, then 100%	\$10 copay, then 100% not subject to deductible	70% after deductible
· Surgery Performed In the Physician's Office	90%	90% after deductible	70% after deductible
<b>Preventive Care</b>			
· Routine Preventive Care - Adult	100%	100% not subject to deductible	100% not subject to deductible
· Immunizations - Adult	100%	100% not subject to deductible	100% not subject to deductible
· Routine Preventive Care - Child	100%	100% not subject to deductible	100% not subject to deductible
· Immunizations - Child	100%	100% not subject to deductible	100% not subject to deductible
<b>Travel Immunizations</b> (Immunizations as required for travel)	100%	100% not subject to deductible	100% not subject to deductible
<b>Mammograms, PSA, PAP Smear and Colorectal Cancer Screenings</b>	100%	100% not subject to deductible	100% not subject to deductible
<b>Inpatient Hospital</b>			
· Inpatient Hospital - Facility Services	90%	90% after deductible	70% after deductible
· Inpatient Hospital Physician Visits/Consultations	90%	90% after deductible	70% after deductible
· Inpatient Professional Services (Surgeon, Radiologist, Pathologist, Anesthesiologist)	90%	90% after deductible	70% after deductible
<b>Outpatient Services</b>			
· Outpatient Facility Services	90%	90% after deductible	70% after deductible
· Outpatient Professional Services	90%	90% after deductible	70% after deductible
<b>Emergency Room</b>	\$25 per visit copay, then 100%	\$25 per visit copay, then 100% not subject to deductible	\$25 per visit copay, then 100% not subject to deductible
<b>Urgent Care Services</b>	90%	\$10 copay, then 100% not subject to deductible	70% after deductible
<b>Ambulance</b>	90%	100% after deductible	100% after deductible



Global Medical Plan			
	International (Outside of the U.S.)	U.S. In-Network	U.S. Out-of-Network
<b>Laboratory Services</b> · Physician Office Visit · Outpatient Facility · Laboratory Services at an Independent Lab facility	100% 90% 100%	100% not subject to deductible 90% after deductible 100% not subject to deductible	70% after deductible 70% after deductible 70% after deductible
<b>Radiology Services</b> · Physician Office Visit · Outpatient Facility	100% 90%	100% not subject to deductible 90% after deductible	70% after deductible 70% after deductible
<b>Advanced Radiology</b> (i.e., MRIs, MRAs, CAT Scans, PET Scans) · Physician Office Visit · Inpatient Facility · Outpatient Facility	100% 90% \$10 copay, then 100%	100% not subject to deductible 90% after deductible \$10 copay, then 100% not subject to deductible	70% after deductible 70% after deductible 70% after deductible
<b>Short-Term Rehabilitation</b> · Physician Office Visit · Outpatient Hospital Facility Calendar Year Maximum:	100% 100%	\$10 copay, then 100% not subject to deductible 90% after deductible	70% after deductible 70% after deductible
30 Days for all Therapies Combined			
The limit is not applicable to Mental Health and Substance Use Disorder conditions. <b>Note:</b> The Short-Term Rehabilitation Therapy 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	U.S. Out-of-Network
<b>Short-Term Rehabilitation - Physical Therapy / Physiotherapy</b> <ul style="list-style-type: none"> <li>· Physician Office Visit</li> <li>· Outpatient Hospital Facility</li> </ul> Calendar Year Maximum: Unlimited for all Therapies Combined	100%  100%	100% not subject to deductible  100% not subject to deductible	70% after deductible  70% after deductible
<b>Chiropractic Care</b> Calendar Year Maximum: Unlimited	100%	100% not subject to deductible	70% after deductible
<b>Maternity Care Services</b>  <ul style="list-style-type: none"> <li>· Initial Visit to Confirm Pregnancy</li> <li>· All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)</li> <li>· Physician's Office Visits in addition to the global maternity fee when performed by an OB/GYN or Specialist</li> <li>· Delivery – Facility</li> <li>· Inpatient Hospital</li> <li>· Birthing Center</li> </ul>	\$10 copay, then 100%  90%  \$10 copay, then 100%  90%  90%	\$10 copay, then 100% not subject to deductible  90% after deductible  \$10 copay, then 100% not subject to deductible  90% after deductible  90% after deductible	70% after deductible  70% after deductible  70% after deductible  70% after deductible  70% after deductible



Global Medical Plan			
	International (Outside of the U.S.)	U.S. In-Network	U.S. Out-of-Network
<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	\$10 copay, then 100%	\$10 copay, then 100% not subject to deductible	70% after deductible
· Lab and Radiology Tests	100%	100% not subject to deductible	70% after deductible
· Inpatient Facility	90%	90% after deductible	70% after deductible
· Outpatient Facility	90%	90% after deductible	70% after deductible
<b>Hearing Exam</b> · 1 Exam Every 24 Months	90%	Not Covered	Not Covered
<b>Hearing Device / Aids</b> · Limited to Dependent Children Under 24 Years · 1 Per Ear Every 36 Months up to \$4,000	100%	100% not subject to deductible	100% not subject to deductible
<b>Mental Health</b> · Physician Office Visit	\$10 copay, then 100%	100% not subject to deductible	70% after deductible
· Inpatient Facility Maximum: (combined with Substance Use Disorder)	90%	90% after deductible	70% after deductible
· Outpatient Facility Maximum: (combined with Substance Use Disorder)	100%	100% not subject to deductible  Unlimited	70% after deductible
<b>Substance Use Disorder</b> · Physician Office Visit	\$10 copay, then 100%	100% not subject to deductible	70% after deductible
· Inpatient Facility Maximum: (combined with Mental Health)	90%	90% after deductible	70% after deductible
· Outpatient Facility Maximum: (combined with Mental Health)	100%	100% not subject to deductible  Unlimited	70% after deductible
<b>Important Note on Mental Health &amp; Substance Use Disorder Coverage:</b> 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".			



<b>Prescription Drug Benefits</b>		
<b>International (Outside of the U.S.)</b>		
<b>Purchased outside the United States</b>	You pay 20% not subject to plan deductible	
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.		
<b>Purchased Inside the United States Only</b>		
<b>Benefit Highlights</b>	<b>Network Pharmacy (U.S. In-Network)</b>	<b>Non-Network Pharmacy (U.S. Out-of-Network)</b>
<b>Prescription Drug Products at Retail Pharmacies</b>	<b>The amount you pay for up to a consecutive 30-day supply</b>	
<b>Tier 1 - Generic Drugs on the Prescription Drug List</b>	No charge after you pay the \$5 copay	You pay 20% after plan deductible
<b>Tier 2 – Brand Drugs designated as preferred on the Prescription Drug List</b>	No charge after you pay the \$20 copay	You pay 20% after plan deductible
<b>Tier 3 – Brand Drugs designated as non-preferred on the Prescription Drug List</b>	No charge after you pay the \$35 copay	You pay 20% after plan deductible
<b>Prescription Drug Products at Home Delivery Pharmacies</b>	<b>The amount you pay for up to a consecutive 90-day supply</b>	
<b>Tier 1 - Generic Drugs on the Prescription Drug List</b>	No charge after you pay the \$15 copay	In-Network coverage only
<b>Tier 2 – Brand Drugs designated as preferred on the Prescription Drug List</b>	No charge after you pay the \$60 copay	In-Network coverage only
<b>Tier 3 – Brand Drugs designated as non-preferred on the Prescription Drug List</b>	No charge after you pay the \$105 copay	In-Network coverage only



Pharmacy Plan Features for Prescriptions Drugs Purchased Inside the United States Only	
<b>Prescription Drug List</b>	Performance 3-Tier
<b>Dispense As Written</b>	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
<b>Utilization Management</b>	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
<b>Step Therapy</b>	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.
<b>Prior Authorization</b>	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.
<b>Quantity Limits</b>	Includes maximum daily dose edits, quantity over time edits, duration of therapy edits, and dose optimization edits
To see if your medication is covered, you can view Cigna's Prescription Drug List by going to <a href="http://www.Cigna.com/druglist">www.Cigna.com/druglist</a> and select "Performance 3-Tier"	

Global Evacuation Plan	
<b>Toll Free telephone number</b>	1.800.441.2668
<b>Emergency Medical Evacuation</b>	100% of covered expenses for approved services.
<b>Family Travel Arrangements</b>	Roundtrip Airfare at Economy Rates to the place of hospitalization for 1 Family Member for hospitalizations in excess of 7 Days
<b>Return of Dependent Children</b>	One-way Airfare at Economy Rates to return dependent children to country of residence
<b>Repatriation of Mortal Remains</b>	100% coverage

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>





Global Vision Plan			
	International (Outside of the U.S.)	U.S. In-Network	U.S. Out-of-Network
<b>Examinations</b> One every 12 consecutive months	100%	100% not subject to deductible	
<b>Lenses and Frames or Contacts</b> One every 24 consecutive months	100%	100% not subject to deductible	
<b>Hardware Maximum Benefit</b>		\$150	



Global Dental Plan		
<b>Calendar Year Maximum</b> Combined for: Class I Class II Class III Class V		\$2,500
<b>Lifetime Class IV Maximum</b>		\$2,500
<b>Calendar Year Deductible</b> Combined for: Class II Class III Class V		\$50 Individual / \$150 Family
<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 Person Per 3 Years</li> <li>• Diagnostic X-rays –Unlimited</li> <li>• Full Mouth / Panoramic X-rays -Not Applicable</li> </ul>	100% not subject to deductible
<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>	80% after deductible
<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>	60% after deductible
<b>Class IV</b>	<b>Orthodontia</b> Children and Adults	50% not subject to deductible
<b>Class V</b>	<b>Implants</b>	60% after deductible