CGI Technologies and Solutions Inc.

Benefits at a Glance
Policy #02763A
Effective January 1, 2018

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		
Universal International Free Number (UIFN) **Toll Free Telephone Number:** **Direct Telephone:** **Toll Free Fax Number:** **Direct Fax Number:**	International Access Code + UIFN Toll-free number 800.441.2668.1 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

Global Medical Plan	International (Outside of the U.S.)	U.S. In-Network	U.S. Out-of-Network
Eligibility	Refer to eligibility definition in the certificate		
Lifetime Maximum	Unlimited		
Calendar Year Deductible • Per Individual	$250	$250	$500
• Per Family	$500	$500	$1,500
Coinsurance (The percentage of covered expenses the plan pays)	90%	90%	70%
Out-of-Pocket Maximum • Per Individual	$1,500	$1,500	$3,000
• Per Family **Excludes Deductible** 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%.	$3,000	$3,000	$9,000
Accumulation	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.		

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.

Global Medical Plan			
	International (Outside of the U.S.)	**U.S. In-Network**	**U.S. Out-of-Network**
Physician's Services • Physician's Office Visit	90% after deductible	90% after deductible	70% after deductible
• Surgery Performed In the Physician's Office	90% after deductible	90% after deductible	70% after deductible
• Allergy Treatment	90% after deductible	90% after deductible	70% after deductible
Preventive Care Routine Preventive Care – all ages Immunizations – all ages	100% (Not subject to deductible)	100% (Not subject to deductible)	100% (Not subject to deductible)
Travel Immunizations (Immunizations as required for travel)	100% (Not subject to deductible)	100% (Not subject to deductible)	100% (Not subject to deductible)
Mammograms, PSA, PAP Smear and Colorectal Cancer Screenings	100% (Not subject to deductible)	100% (Not subject to deductible)	100% (Not subject to deductible)
Inpatient Hospital Facility Services • Facility	90% after deductible	90% after deductible	70% after deductible
• Physician	90% after deductible	90% after deductible	70% after deductible
Outpatient Facility Services	90% after deductible	90% after deductible	70% after deductible
Emergency Care (Refer to certificate for coverage and exclusions)	90% after deductible	$200 copay, then 90% after deductible	$200 copay, then 90% after deductible (except if not true emergency, then 70% after deductible)
Urgent Care Services	90% after deductible	90% after deductible	90% after deductible (except if not true emergency then 70% after deductible)
Laboratory and Radiology Services (including pre-admission testing)	90% after deductible	90% after deductible	70% after deductible
Outpatient Short-Term Rehabilitation Therapy (Calendar Year Maximum: 60-days for all therapies combined) *Includes:* Cardiac and Pulmonary Rehab, Physical, 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.	90% after deductible	90% after deductible	70% after deductible
Chiropractic Care Physician's Office Visit Calendar Year Maximum:	90% after deductible 20 days	90% after deductible unlimited	70% after deductible 20 days
Maternity Care Services • Initial Visit to Confirm Pregnancy	90% after deductible	90% after deductible	70% after deductible
• All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)	90% after deductible	90% after deductible	70% after deductible
• Physician's Office Visits in addition to the global maternity fee when performed by an OB/GYN or Specialist	90% after deductible	90% after deductible	70% after deductible
• Delivery – Facility (Inpatient Hospital, Birthing Center)	90% after deductible	90% after deductible	70% after deductible

Publication Date 10.18.17 SCL-F

Global Medical Plan			
	International (Outside of the U.S.)	**U.S. In-Network**	**U.S. Out-of-Network**
Hearing Benefit • Exam: One every 24 month period	90% after deductible	90% after deductible	70% after deductible
Hearing Aid Maximum Up to $1,000 per hearing aid unit necessary for each hearing impaired ear every 3 years for a dependent child under age 24	90% after deductible	90% after deductible	70% after deductible
Mental Health and Substance Use Disorder • Inpatient Facility	90% after deductible	90% after deductible	70% after deductible
• Outpatient Office Visit	90% after deductible	90% after deductible	70% after deductible

Prescription Drug Benefits		
	International (Outside of the U.S.)	
Purchased outside the United States	90% after deductible	
Purchased Inside the United States Only		
Benefit Highlights	**Participating Pharmacy (U.S. In-Network)**	**Non-Participating Pharmacy (U.S. Out-of-Network)**
Retail Drugs	**The amount you pay for each 30 day supply**	**The amount you pay for each 30 day supply**
Generic	$10 copay	30% after deductible
Preferred Brand Name	$20 copay	30% after deductible
Home Delivery Prescription Drugs	**The amount you pay for each 90 day supply**	**The amount you pay for each 90 day supply**
Generic	$30 copay	U.S. In-Network coverage only
Preferred Brand Name	$60 copay	U.S. In-Network coverage only

Publication Date 10.18.17 SCL-F

Global Vision Care			
	International (Outside the U.S.)	**U.S. In-Network**	**U.S. Out-of-Network**
Examinations One Eye Exam every 24 consecutive months	90%	90%	70%
Vision Hardware			
Lenses & Frames One pair of glasses or contact lenses per 24 consecutive months	Not Covered	Not Covered	Not Covered

Global Dental Care		
Calendar Year Maximum (for Class I, II, III)		$1,500
Lifetime Maximum (for Class IV)		$1,500
Calendar Year Deductible		$0 Individual / $0 Family
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 tooth, per 3 years • Full Mouth X-rays – 1 per person, per 3 years • 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 19)	50%