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

PayPal Inc.

Benefits at a Glance
Policy #06725A
Plan Start January 1, 2019

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	$100	$100	$300
• Per Family	$300	$300	$900
Coinsurance (The percentage of covered expenses the plan pays)	90%	90%	70%
Out-of-Pocket Maximum • Per Individual	$500	$500	$900
• Per Family **Includes 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%.	$1,500	$1,500	$2,700
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	90% after deductible	90% after deductible(except if not a true emergency, then 70% after deductible)
Urgent Care Services	90% after deductible	90% after deductible	90% after deductible(except if not a 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

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Global Medical Plan			
	International (Outside of the U.S.)	**U.S. In-Network**	**U.S. Out-of-Network**
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
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

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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	**Network Pharmacy**	**Non-Network Pharmacy**
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 Pharmacy. A written prescription is required.		
You can look at Cigna's Prescription Drug List to see if your medication is covered, if it requires Prior Authorization or Step Therapy and which tier it falls under to determine what your copay or coinsurance will be. You can view Cigna's drug list on www.Cigna.com/druglist. Select "Performance 3 Tier" from the drug list drop-down menu.		
Prior Authorizations – Some medications on your drug list require prior authorization. This means you need to get approval from Cigna to have them covered under the pharmacy benefit plan. Step Therapy is required. It encourages you to try the most cost-effective and appropriate medications available first before more expensive medications are approved. Dispense as Written (DAW) – you will pay the copay/coinsurance plus the difference in the cost between the brand name and generic medication unless your doctor requests the brand name medication.		
Prescription Drug Products at Retail Pharmacies	**The amount you pay for up to a consecutive 30-day supply at a Network Pharmacy**	**The amount you pay for up to a consecutive 30-day supply at a non-Network Pharmacy**
Tier 1 – Generic Drugs on the Prescription Drug List	10% not subject to deductible	10% after deductible
Tier 2 - Brand Drugs designated as preferred on the Prescription Drug List	10% not subject to deductible	10% after deductible
Tier 3 - Brand Drugs designated as non-preferred on the Prescription Drug List	10% not subject to deductible	10% after deductible
Prescription Drug Products at Retail Pharmacies	**The amount you pay for up to a consecutive 90-day supply at a Network Pharmacy**	**The amount you pay for up to a consecutive 90-day supply at a non-Network Pharmacy**
Specialty Prescription Drug Products are limited to up to a consecutive 90-day supply per Prescription Order or Refill.		
Tier 1 – Generic Drugs on the Prescription Drug List	10% not subject to deductible	10% after deductible
Tier 2 - Brand Drugs designated as preferred on the Prescription Drug List	10% not subject to deductible	10% after deductible
Tier 3 - Brand Drugs designated as non-preferred on the Prescription Drug List	10% not subject to deductible	10% after deductible
Prescription Drug Products at Home Delivery Pharmacies	**The amount you pay for up to a consecutive 90-day supply at a Network Pharmacy**	**The amount you pay for up to a consecutive 90-day supply at a non-Network Pharmacy**
Specialty Prescription Drug Products are limited to up to a consecutive 90-day supply per Prescription Order or Refill.		
Tier 1 – Generic Drugs on the Prescription Drug List	10% not subject to deductible	In-Network coverage only
Tier 2 - Brand Drugs designated as preferred on the Prescription Drug List	10% not subject to deductible	In-Network coverage only
Tier 3 - Brand Drugs designated as non-preferred on the Prescription Drug List	10% not subject to deductible	In-Network coverage only

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Global Vision Care			
	International (Outside the U.S.)	**U.S. In-Network**	**U.S. Out-of-Network**
Examinations One Eye Exam every 12 consecutive months Maximum Benefit: $100	100% not subject to deductible	100% not subject to deductible	100% not subject to deductible
Vision Hardware			
Frames Every 12 consecutive months Maximum Benefit: $150	100% not subject to deductible	100% not subject to deductible	100% not subject to deductible
Lenses Every 12 consecutive months Maximum Benefit: $100	100% not subject to deductible	100% not subject to deductible	100% not subject to deductible

Global Dental Care		
Combined Calendar Year Maximum (for Class I, II, III)		$2,000
Lifetime Maximum (for Class IV)		$2,000
Calendar Year Deductible		$50 Individual / $150 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% not subject to deductible
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% after deductible
Class III	**Major Restorative** For Major Restorations: • Dentures • Bridgework • Crowns	50% after deductible
Class IV	**Orthodontia** (for dependent children under age 19)	50% after deductible

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