



# CIGNA GLOBAL HEALTH PLAN

## PLAN SUMMARY 2017

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To help you make informed decisions about your insurance election, the University has prepared this 2017 CIGNA Global Health Plan Summary. This summary is intended to help you learn more about the benefit plans available to you. **It does not replace the legal plan documents or contracts for each of the benefit plans and should not, in any way, be considered a legal contract or guarantee of coverage.**

This plan is eligible to faculty, staff and their dependents traveling on University business for one semester or longer. You are responsible for notifying the Office of Human Resources at least 90 days prior to departure and 31 days after your return to the United States to update your insurance coverages.

## IMPORTANT CONTACT INFORMATION

### For CIGNA Global Health Plan (Medical, Prescription, Dental, Vision, and Evacuation coverages)

Cigna is committed to providing superior service to our clients and customers. It doesn't matter where you are working or what time zone you are in. Our clients and customers can reach us 24 hours a day, 7 days a week by calling our global Service Center or online through Cigna Envoy.

<b>Phone</b>	<b>Toll-Free (U.S. &amp; Canada)</b>	<b>1-800-441.2668</b>
	<b>Toll-free TDD (hearing impaired)</b>	<b>1-800-558-3604</b>
	<b>Direct (Collect Calls Accepted)</b>	<b>001-302-797-3100</b>
<b>Fax</b>	<b>Toll-Free Fax</b>	<b>1-800-243-6998</b>
	<b>Direct Fax</b>	<b>001-302-797-3150</b>
<b>Website</b>	<b>Cigna Global Provider Network (U.S. Domestic &amp; International)</b>	<a href="http://www.CignaEnvoy.com">www.CignaEnvoy.com</a>
	<b>ID Card; Claims submission and status; forms, tools and more</b>	<a href="http://www.CignaEnvoy.com">www.CignaEnvoy.com</a>
<b>Mail</b>	<b>Mail Delivery</b>	<b>Cigna Global Health Benefits P.O. Box 15050 Wilmington, DE 19850-5050</b>
	<b>Courier Delivery</b>	<b>Cigna Global Health Benefits 300 Bellevue Parkway Wilmington, DE 19809, U.S.A.</b>

*Plans are administered by CIGNA Global Health Benefits [www.CignaEnvoy.com](http://www.CignaEnvoy.com)*

### **CIGNA GLOBAL HEALTH PLAN SUMMARY - 2017**

To help you make informed decisions about your insurance election, the University has prepared this 2017 CIGNA Global Health Plan Summary. This summary is intended to help you learn more about the benefit plans available to you. **It does not replace the legal plan documents or contracts for each of the benefit plans and should not, in any way, be considered a legal contract or guarantee of coverage.**

This plan is eligible to faculty, staff and their dependents traveling on University business for one semester or longer. You are responsible for notifying the Office of Human Resources at least 31 days prior to departure and 31 days after your return to the United States to update your insurance coverages.

## Dependent Verification for Health Plans

The University of Notre Dame requires faculty and staff who are eligible for the health plan to provide documentation that supports current spousal or child relationship when enrolling a dependent in the plan.

**Copies of your documents should be submitted with your Benefits Enrollment Form.**

### Who is an eligible dependent?

- Your legal spouse as defined by the state of Indiana
- Your children up to age 26 who are your natural children, stepchildren, adopted children, disabled children who are unmarried and became disabled prior to age 26, and children for whom you are a court appointed guardian
- Any child for whom you are required to provide coverage under a Qualified Medical Child Support Order (QMCSO)

### Who is not eligible?

- Your common law spouse
- Your parents
- Your ex-spouse (even if you are legally responsible for providing coverage)
- Your grandchildren, nieces and nephews for whom you are not a court appointed guardian

The table below lists the documents that will be accepted for each type of dependent. Please note in certain situations, two types of documentation may be required.

**Please submit copies of the original documents to the Office of Human Resources located in 200 Grace Hall.**

**IMPORTANT: Please include your NDID number on all copies of documentation submitted.**

Acceptable Dependent Eligibility Documents	
Dependent	Documentation Required
<b>Legal Spouse</b> (The covered employee's husband or wife under Indiana Law)	Documentation must support the current spousal relationship. <ul style="list-style-type: none"> <li>- Government issued marriage certificate and Federal Tax Return within the last 2 years* <b>OR</b></li> <li>- Government issued marriage certificate and proof of joint ownership issued within the last 6 months <b>OR</b></li> <li>- Government issued marriage certificate only (if married in the last 12 months)</li> </ul>
<b>Biological Child</b> (Under age 26 and not eligible to enroll in his or her employer provided plan)	Government issued birth certificate
<b>Disabled Biological Child</b> (Over age 26; unmarried; medically certified as disabled; financially supported by employee and spouse)	Government issued birth certificate and Federal Tax Return within last two years claiming child*
<b>Adopted Child</b> (Under age 26 and not eligible to enroll in his or her employer provided plan)	Adoption placement and petition for adoption <b>OR</b> adoption certificate

<b>Disabled Adopted Child</b> (Over age 26; unmarried; medically certified as disabled; financially supported by employee and spouse)	Adoption certificate and Federal Tax Return within last 2 years claiming child*
<b>Stepchild</b> (Under age 26 and not eligible to enroll in his or her employer provided plan)	<ul style="list-style-type: none"> <li>- Government issued birth certificate, government issued marriage certificate and Federal Tax Return within last 2 years * <b>OR</b></li> <li>- Government issued birth certificate and government issued marriage certificate (if married within the last 12 months) <b>OR</b></li> <li>- Government issued birth certificate, government issued marriage certificate and a proof of joint ownership issued within last 6 months</li> </ul>
<b>Disabled Stepchild</b> (Over age 26; unmarried; medically certified as disabled; financially supported by employee and spouse)	<ul style="list-style-type: none"> <li>- Government issued birth certificate, government issued marriage certificate and Federal Tax Return within last 2 years listing spouse and claiming child * <b>OR</b></li> <li>- Government issued birth certificate and government issued marriage certificate (if married within the last 12 months) <b>OR</b></li> <li>- Government issued birth certificate, government issued marriage certificate and a proof of joint ownership issued within last 6 months</li> </ul>
<b>Legal Guardian</b>	Government issued birth certificate and court ordered document of legal custody
<b>Disabled Legal Guardian</b> (Over age 26; unmarried; must be medically certified as disabled; financially supported by employee and spouse)	Government issued birth certificate, court ordered document of legal custody and Federal Tax Return within last 2 years claiming child
<b>Qualified Medical Support Order</b> (Age 18 and under; QMSO must be ordered for the employee)	Qualified Medical Child Support Order

\*Please submit page 1 only of the Federal Tax Return. Black out all monetary amounts and Social Security Numbers.

**You will have 60 days from your benefit eligibility date or qualifying event date to provide this documentation. If documentation is not received within this timeframe, applicable dependents will not be enrolled. The next opportunity to enroll will then be during open enrollment or if you experience a qualifying event.**

PLAN COVERAGE	OUTSIDE OF U.S.	IN-NETWORK U.S.	OUT-OF-NETWORK U.S.									
<b>GENERAL PLAN PROVISIONS</b>												
<b>Eligibility</b>	All active, full-time Expatriate faculty and staff of the University regularly working a minimum of 30 Hours Per Week. Eligible populations: U.S. Expats											
<b>Lifetime Maximum</b>	Unlimited											
<b>Monthly Premiums</b> <i>(full-time Faculty and Staff)</i>	<table style="width: 100%; border: none;"> <tr> <td style="width: 50%;"></td> <td style="width: 25%;">Individual</td> <td style="width: 25%;">\$109.00</td> </tr> <tr> <td></td> <td>Individual + 1</td> <td>\$260.00</td> </tr> <tr> <td></td> <td>Family</td> <td>\$365.00</td> </tr> </table>				Individual	\$109.00		Individual + 1	\$260.00		Family	\$365.00
	Individual	\$109.00										
	Individual + 1	\$260.00										
	Family	\$365.00										
<b>Deductibles</b> <i>(Calendar Year)</i>	<b>Individual:</b> \$0 <b>Family:</b> \$0	<b>Individual:</b> \$400 <b>Family:</b> \$800	<b>Individual:</b> \$800 <b>Family:</b> \$1,600									
<b>Co-Insurance</b> <i>(What the plan pays)</i>	100% of covered expenses	85% of covered expenses	65% of covered expenses									
<b>Out-of-pocket limits</b> <i>(Calendar Year)</i>	<b>Individual:</b> \$0 <b>Family:</b> \$0	<b>Individual:</b> \$1950 (include deductible) <b>Family:</b> \$4600 (include deductible)	<b>Individual:</b> \$3900 (include deductible) <b>Family:</b> \$7800 (include deductible)									
<i>Note: Out of Pocket (OOP) Limits cross apply (Aggregate Family); OOP will include deductible payments; include copay payments; include pharmacy copays; include pharmacy coinsurance payments; exclude Pre-Admission Certification/Continued Stay Review penalties.</i>												
<b>Physician's Office Visit</b> <i>(General/Specialist)</i>	<b>Coinsurance:</b> 100% <b>Copay:</b> \$0 <b>Deductible:</b> Will Not Apply	<b>Coinsurance:</b> 100%** <b>Copay:</b> \$30 <b>Deductible:</b> Will Apply  **except for Wellness visits	<b>Coinsurance:</b> 65% <b>Copay:</b> \$0 <b>Deductible:</b> Will Apply									
<b>Outpatient Laboratory &amp; X-Ray Services</b> <i>(including pre-admission testing)</i>	<b>Coinsurance:</b> 100% <b>Copay:</b> \$0 <b>Deductible:</b> Will Not Apply	<b>Coinsurance:</b> 85% <b>Copay:</b> \$0 <b>Deductible:</b> Will Apply	<b>Coinsurance:</b> 65% <b>Copay:</b> \$0 <b>Deductible:</b> Will Apply									
<b>Inpatient Hospital Services</b> <b>Room &amp; Board**</b>	<b>Coinsurance:</b> 100% <b>Copay:</b> \$0 <b>Deductible:</b> Will Not Apply	<b>Coinsurance:</b> 85% <b>Copay:</b> \$0 <b>Deductible:</b> Will Apply	<b>Coinsurance:</b> 65% <b>Copay:</b> \$0 <b>Deductible:</b> Will Apply									
<i>**The most common semi-private room rate covered at Plan Coinsurance (private outside the U.S. if there is no intermediate level between ward and private).</i>												

PLAN COVERAGE	OUTSIDE OF U.S.	IN-NETWORK U.S.	OUT-OF-NETWORK U.S.
<b>Inpatient Hospital Services</b>	<b>Coinsurance:</b> 100% <b>Deductible:</b> Will Not Apply	<b>Coinsurance:</b> 85% <b>Deductible:</b> Will Apply	<b>Coinsurance:</b> 65% <b>Deductible:</b> Will Apply
<b>Outpatient Hospital / Surgical Services</b>	<b>Coinsurance:</b> 100% <b>Copay:</b> \$0 <b>Deductible:</b> Will Not Apply	<b>Coinsurance:</b> 85% <b>Copay:</b> \$0 <b>Deductible:</b> Will Apply	<b>Coinsurance:</b> 65% <b>Copay:</b> \$0 <b>Deductible:</b> Will Apply
<b>Hospital Emergency Room</b>	<b>Coinsurance:</b> 100% <b>Copay:</b> \$0 <b>Deductible:</b> Will Not Apply	<b>Coinsurance:</b> 85% <b>Copay:</b> \$0 <b>Deductible:</b> Will Apply	<b>Coinsurance:</b> 65%** <b>Copay:</b> \$0 <b>Deductible:</b> Will Apply
<i>**Unless deemed true emergency, then benefit is covered at In-Network values.</i>			
<b>PRESCRIPTION DRUGS</b>			
<b>Generic Brand</b>	<b>Coinsurance:</b> 100% <b>Retail Copay:</b> \$0 <b>Mail Order Rx:</b> n/a	<b>Coinsurance:</b> 100% <b>Retail Copay:</b> \$5 Per 30 Day Supply <b>Mail Order Rx:</b> n/a	<b>Coinsurance:</b> 50% <b>Retail Copay:</b> \$0 <b>Mail Order Rx:</b> n/a
<b>Brand Name</b>	<b>Coinsurance:</b> 100% <b>Retail Copay:</b> \$0 <b>Mail Order Rx:</b> n/a	<b>Coinsurance:</b> 100% <b>Retail Copay:</b> \$30 Per 30 Day Supply <b>Mail Order Rx:</b> n/a	<b>Coinsurance:</b> 50% <b>Retail Copay:</b> \$0 <b>Mail Order Rx:</b> n/a
<b>Non-Preferred Brand</b>	<b>Coinsurance:</b> 100% <b>Retail Copay:</b> \$0 <b>Mail Order Rx:</b> n/a	<b>Coinsurance:</b> 100% <b>Retail Copay:</b> \$45 Per 30 Day Supply <b>Mail Order Rx:</b> n/a	<b>Coinsurance:</b> 50% <b>Retail Copay:</b> \$0 <b>Mail Order Rx:</b> n/a
<b>Deductible (All Tiers)</b>	Will Not Apply	Will Not Apply	Will Apply
<b>Limit (All Tiers)</b>	Unlimited	Unlimited	Unlimited
<b>Over the Counter Drugs</b>	Only covered outside of the U.S. if accompanied by a prescription.		
<i>Pharmacy copays do contribute towards the out-of-pocket. Medications can be provided in up to a 12-month supply in accordance with the instructions specified by a U.S. physician. Limits cross apply.</i>			
<b>WELLNESS SERVICES</b>			
<b>Birth through Age 17 Years</b>			
<b>Well Child Care</b>	<b>Coinsurance:</b> 100% <b>Copay:</b> \$0 <b>Deductible:</b> Will Not Apply <b>Maximum:</b> No Max Applies	<b>Coinsurance:</b> 100% <b>Copay:</b> \$0 <b>Deductible:</b> Will Not Apply <b>Maximum:</b> No Max Applies	<b>Coinsurance:</b> 100% <b>Copay:</b> \$0 <b>Deductible:</b> Will Not Apply <b>Maximum:</b> No Max Applies

PLAN COVERAGE	OUTSIDE OF U.S.	IN-NETWORK U.S.	OUT-OF-NETWORK U.S.
Routine Immunizations and Mandated Immunizations	<b>Coinsurance:</b> 100% <b>Copay:</b> \$0 <b>Deductible:</b> Will Not Apply <b>Preventive Care Maximum:***</b> No Max Applies	<b>Coinsurance:</b> 100% <b>Copay:</b> \$0 <b>Deductible:</b> Will Not Apply <b>Preventive Care Maximum:***</b> No Max Applies	<b>Coinsurance:</b> 100% <b>Copay:</b> \$0 <b>Deductible:</b> Will Not Apply <b>Preventive Care Maximum:***</b> No Max Applies
Lead Poisoning	<b>Age Covered:</b> At/Around 12 mos./ High Risk <b>Coinsurance:</b> 100% <b>Copay:</b> \$0 <b>Deductible:</b> Will Not Apply <b>Preventive Care Maximum:***</b> No Max Applies	<b>Age Covered:</b> At/Around 12 mos./ High Risk <b>Coinsurance:</b> 100% <b>Copay:</b> \$0 <b>Deductible:</b> Will Not Apply <b>Preventive Care Maximum:***</b> No Max Applies	<b>Age Covered:</b> At/Around 12 mos./ High Risk <b>Coinsurance:</b> 100% <b>Copay:</b> \$0 <b>Deductible:</b> Will Not Apply <b>Preventive Care Maximum:***</b> No Max Applies
<b>Age 18 Years and Older</b>			
Adult Preventive Care	<b>Coinsurance:</b> 100% <b>Copay:</b> \$0 <b>Deductible:</b> Will Not Apply <b>Maximum:</b> No Max Applies	<b>Coinsurance:</b> 100% <b>Copay:</b> \$0 <b>Deductible:</b> Will Not Apply <b>Maximum:</b> No Max Applies	<b>Coinsurance:</b> 100% <b>Copay:</b> \$0 <b>Deductible:</b> Will Not Apply <b>Maximum:</b> No Max Applies
Routine Immunizations	<b>Coinsurance:</b> 100% <b>Copay:</b> \$0 <b>Deductible:</b> Will Not Apply	<b>Coinsurance:</b> 100% <b>Copay:</b> \$0 <b>Deductible:</b> Will Not Apply	<b>Coinsurance:</b> 100% <b>Copay:</b> \$0 <b>Deductible:</b> Will Not Apply
Travel Immunizations*	<b>Coinsurance:</b> 100% <b>Copay:</b> \$0 <b>Deductible:</b> Will Not Apply <b>Preventive Care Maximum:***</b> No Max Applies	<b>Coinsurance:</b> 100% <b>Copay:</b> \$0 <b>Deductible:</b> Will Not Apply <b>Preventive Care Maximum:***</b> No Max Applies	<b>Coinsurance:</b> 100% <b>Copay:</b> \$0 <b>Deductible:</b> Will Not Apply <b>Preventive Care Maximum:***</b> No Max Applies
<b>Cancer Screening</b>			
Pap Smear	<b>Coinsurance:</b> 100% <b>Copay:</b> \$0 <b>Deductible:</b> Will Not Apply	<b>Coinsurance:</b> 100% <b>Copay:</b> \$0 <b>Deductible:</b> Will Apply	<b>Coinsurance:</b> 100% <b>Copay:</b> \$0 <b>Deductible:</b> Will Apply
	<b>Maximum:***</b> No Age Limit; Once Per Year; Does Not Contribute to Preventive		
Mammogram	<b>Coinsurance:</b> 100% <b>Copay:</b> \$0 <b>Deductible:</b> Will Not Apply	<b>Coinsurance:</b> 100% <b>Copay:</b> \$0 <b>Deductible:</b> Will Not Apply	<b>Coinsurance:</b> 100% <b>Copay:</b> \$0 <b>Deductible:</b> Will Not Apply
	<b>Schedule:</b> Ages 35-39: One baseline exam. Ages 40-49: One exam every one or two years for asymptomatic women, but no sooner than two years after a woman's baseline. Age 50 & Over: One exam annually. Any Age: Whenever prescribed by a physician.		
<i>*Applies to Employee and Dependent immunizations required for travel.</i> <i>***Note: Maximums cross accumulate between Outside of U.S., In-Network U.S. and Out-of-Network U.S.</i>			

PLAN COVERAGE	OUTSIDE OF U.S.	IN-NETWORK U.S.	OUT-OF-NETWORK U.S.
Colorectal Screening	<b>Coinsurance:</b> 100% <b>Copay:</b> \$0 <b>Deductible:</b> Will Not Apply	<b>Coinsurance:</b> 100% <b>Copay:</b> \$0 <b>Deductible:</b> Will Not Apply	<b>Coinsurance:</b> 100% <b>Copay:</b> \$0 <b>Deductible:</b> Will Not Apply
	<b>Maximum:***</b> 50+ Years and High Risk: One per year; Does Not Contribute to Preventive		
PSA	<b>Coinsurance:</b> 100% <b>Copay:</b> \$0 <b>Deductible:</b> Will Not Apply	<b>Coinsurance:</b> 100% <b>Copay:</b> \$0 <b>Deductible:</b> Will Not Apply	<b>Coinsurance:</b> 100% <b>Copay:</b> \$0 <b>Deductible:</b> Will Not Apply
	<b>Maximum:***</b> No Age Limit; No Frequency Limit; Does Not Contribute to Preventive		
<b>Hearing</b>			
Hearing Exam	<b>Coinsurance:</b> 100% <b>Copay:</b> \$0 <b>Deductible:</b> Will Not Apply	<b>Coinsurance:</b> 85% <b>Copay:</b> \$0 <b>Deductible:</b> Will Apply	<b>Coinsurance:</b> 65% <b>Copay:</b> \$0 <b>Deductible:</b> Will Apply
	<b>Exam Frequency:</b> 1 Exam every 24 months <b>Exam Maximum:***</b> Unlimited		
Hearing Aid	<b>Coinsurance:</b> 100% <b>Deductible:</b> Will Not Apply	<b>Coinsurance:</b> 85% <b>Deductible:</b> Will Apply	<b>Coinsurance:</b> 65% <b>Deductible:</b> Will Apply
	<b>Hearing Aid Maximum:</b> Other (Specify) <b>Age Limit:</b> Limited to Dependents Under 24 Years		
<b>OBESITY/BARIATRIC SURGERY - Lifetime Surgical Maximum \$10,000</b>			
Physician's Office	<b>Coinsurance:</b> 100% <b>Copay:</b> \$0 <b>Deductible:</b> Will Not Apply	<b>Coinsurance:</b> 100% <b>Copay:</b> \$30 <b>Deductible:</b> Will Apply	<b>Coinsurance:</b> 65% <b>Copay:</b> \$0 <b>Deductible:</b> Will Apply
	Inpatient Facility	<b>Coinsurance:</b> 100% <b>Copay:</b> \$0 <b>Deductible:</b> Will Not Apply	<b>Coinsurance:</b> 85% <b>Copay:</b> \$0 <b>Deductible:</b> Will Apply
Physician Services		<b>Coinsurance:</b> 100% <b>Deductible:</b> Will Not Apply	<b>Coinsurance:</b> 85% <b>Deductible:</b> Will Apply
	Outpatient Facility	<b>Coinsurance:</b> 100% <b>Copay:</b> \$0 <b>Deductible:</b> Will Not Apply	<b>Coinsurance:</b> 85% <b>Copay:</b> \$0 <b>Deductible:</b> Will Apply
***Note: Maximums cross accumulate between Outside of U.S., In-Network U.S. and Out-of-Network U.S.			



PLAN COVERAGE	OUTSIDE OF U.S.	IN-NETWORK U.S.	OUT-OF-NETWORK U.S.
<b>MATERNITY AND FAMILY PLANNING SERVICES</b>			
<b>Family Planning</b>			
Physician's Office	<b>Coinsurance:</b> 100% <b>Copay:</b> \$0 <b>Deductible:</b> Will Not Apply	<b>Coinsurance:</b> 100% <b>Copay:</b> \$30 <b>Deductible:</b> Will Apply	<b>Coinsurance:</b> 65% <b>Copay:</b> \$0 <b>Deductible:</b> Will Apply
Vasectomy/Tubal Ligation	Benefit Not Covered	Benefit Not Covered	Benefit Not Covered
<b>Maternity</b>			
Physician's Office	<b>Coinsurance:</b> 100% <b>Copay:</b> \$0 <b>Deductible:</b> Will Not Apply	<b>Coinsurance:</b> 100% <b>Copay:</b> \$30 <b>Deductible:</b> Will Apply	<b>Coinsurance:</b> 65% <b>Copay:</b> \$0 <b>Deductible:</b> Will Apply
Inpatient	<b>Coinsurance:</b> 100% <b>Copay:</b> \$0 <b>Deductible:</b> Will Not Apply	<b>Coinsurance:</b> 85% <b>Copay:</b> \$0 <b>Deductible:</b> Will Apply	<b>Coinsurance:</b> 65% <b>Copay:</b> \$0 <b>Deductible:</b> Will Apply
Outpatient	<b>Coinsurance:</b> 100% <b>Copay:</b> \$0 <b>Deductible:</b> Will Not Apply	<b>Coinsurance:</b> 85% <b>Copay:</b> \$0 <b>Deductible:</b> Will Apply	<b>Coinsurance:</b> 65% <b>Copay:</b> \$0 <b>Deductible:</b> Will Apply
<b>Newborn Care/ Hospital Nursery</b>	<b>Coinsurance:</b> 100% <b>Copay:</b> \$0 <b>Deductible:</b> Will Not Apply	<b>Coinsurance:</b> 100% <b>Copay:</b> \$0 <b>Deductible:</b> Will Apply	<b>Coinsurance:</b> 65% <b>Copay:</b> \$0 <b>Deductible:</b> Will Apply
<b>Birthing Centers/ Midwife Services</b>	<b>Coinsurance:</b> 100% <b>Copay:</b> \$0 <b>Deductible:</b> Will Not Apply	<b>Coinsurance:</b> 85% <b>Copay:</b> \$0 <b>Deductible:</b> Will Apply	<b>Coinsurance:</b> 65% <b>Copay:</b> \$0 <b>Deductible:</b> Will Apply
<b>Infertility Treatments</b>	Diagnosis of Infertility is covered under general Physician Office Visits.		
Gift, Zift, Invitro Artificial Insemination	Benefit Not Covered Benefit Not Covered	Benefit Not Covered Benefit Not Covered	Benefit Not Covered Benefit Not Covered
<b>FDA Approved Contraceptive Drugs and Devices</b>	Benefit Not Covered	Benefit Not Covered	Benefit Not Covered

PLAN COVERAGE	OUTSIDE OF U.S.	IN-NETWORK U.S.	OUT-OF-NETWORK U.S.
<b>OTHER COVERED MEDICAL SERVICES</b>			
<b>Mental Illness &amp; Alcohol/Substance Abuse</b>			
Physician's Office	<b>Coinsurance:</b> 100% <b>Copay:</b> \$0 <b>Deductible:</b> Will Not Apply	<b>Coinsurance:</b> 100% <b>Copay:</b> \$30 <b>Deductible:</b> Will Not Apply	<b>Coinsurance:</b> 65% <b>Copay:</b> \$0 <b>Deductible:</b> Will Not Apply
Inpatient	<b>Coinsurance:</b> 100% <b>Copay:</b> \$0 <b>Deductible:</b> Will Not Apply	<b>Coinsurance:</b> 85% <b>Copay:</b> \$0 <b>Deductible:</b> Will Apply	<b>Coinsurance:</b> 65% <b>Copay:</b> \$0 <b>Deductible:</b> Will Apply
Outpatient	<b>Coinsurance:</b> 100% <b>Copay:</b> \$0 <b>Deductible:</b> Will Not Apply	<b>Coinsurance:</b> 100% <b>Copay:</b> \$0 <b>Deductible:</b> Will Apply	<b>Coinsurance:</b> 65% <b>Copay:</b> \$0 <b>Deductible:</b> Will Apply
<b>Skilled Nursing Facility</b>	<b>Coinsurance:</b> 100% <b>Copay:</b> \$0 <b>Deductible:</b> Will Not Apply <b>Maximum: ***</b> 120 Days	<b>Coinsurance:</b> 85% <b>Copay:</b> \$0 <b>Deductible:</b> Will Apply <b>Maximum: ***</b> 120 Days	<b>Coinsurance:</b> 65% <b>Copay:</b> \$0 <b>Deductible:</b> Will Apply <b>Maximum: ***</b> 120 Days
<b>Home Health Care</b>	<b>Coinsurance:</b> 100% <b>Copay:</b> \$0 <b>Deductible:</b> Will Not Apply <b>Maximum: ***</b> 120 Days	<b>Coinsurance:</b> 85% <b>Copay:</b> \$0 <b>Deductible:</b> Will Apply <b>Maximum: ***</b> 120 Days	<b>Coinsurance:</b> 65% <b>Copay:</b> \$0 <b>Deductible:</b> Will Apply <b>Maximum: ***</b> 120 Days
<b>Hospice</b>			
Inpatient	<b>Coinsurance:</b> 100% <b>Copay:</b> \$0 <b>Deductible:</b> Will Not Apply	<b>Coinsurance:</b> 85% <b>Copay:</b> \$0 <b>Deductible:</b> Will Apply	<b>Coinsurance:</b> 65% <b>Copay:</b> \$0 <b>Deductible:</b> Will Apply
Outpatient/Home	<b>Coinsurance:</b> 100% <b>Copay:</b> \$0 <b>Deductible:</b> Will Not Apply	<b>Coinsurance:</b> 85% <b>Copay:</b> \$0 <b>Deductible:</b> Will Apply	<b>Coinsurance:</b> 65% <b>Copay:</b> \$0 <b>Deductible:</b> Will Apply
<b>Short Term Rehabilitative Therapy</b>			
Therapy Combined Max***	60 Days	60 Days	60 Days
Physical Therapy	<b>Coinsurance:</b> 100% <b>Copay:</b> \$0 <b>Deductible:</b> Will Not Apply	<b>Coinsurance:</b> 100% <b>Copay:</b> \$30 <b>Deductible:</b> Will Apply	<b>Coinsurance:</b> 65% <b>Copay:</b> \$0 <b>Deductible:</b> Will Apply
***Note: Maximums cross accumulate between Outside of U.S., In-Network U.S. and Out-of-Network U.S.			

PLAN COVERAGE	OUTSIDE OF U.S.	IN-NETWORK U.S.	OUT-OF-NETWORK U.S.
Physio Therapy	<b>Coinsurance:</b> 100% <b>Copay:</b> \$0 <b>Deductible:</b> Will Not Apply	<b>Coinsurance:</b> 100% <b>Copay:</b> \$30 <b>Deductible:</b> Will Apply	<b>Coinsurance:</b> 65% <b>Copay:</b> \$0 <b>Deductible:</b> Will Apply
Speech Therapy	<b>Coinsurance:</b> 100% <b>Copay:</b> \$0 <b>Deductible:</b> Will Not Apply	<b>Coinsurance:</b> 100% <b>Copay:</b> \$30 <b>Deductible:</b> Will Apply	<b>Coinsurance:</b> 65% <b>Copay:</b> \$0 <b>Deductible:</b> Will Apply
Occupational Therapy	<b>Coinsurance:</b> 100% <b>Copay:</b> \$0 <b>Deductible:</b> Will Not Apply	<b>Coinsurance:</b> 100% <b>Copay:</b> \$30 <b>Deductible:</b> Will Apply	<b>Coinsurance:</b> 65% <b>Copay:</b> \$0 <b>Deductible:</b> Will Apply
Cardiac Rehab	<b>Coinsurance:</b> 100% <b>Copay:</b> \$0 <b>Deductible:</b> Will Not Apply	<b>Coinsurance:</b> 100% <b>Copay:</b> \$30 <b>Deductible:</b> Will Apply	<b>Coinsurance:</b> 65% <b>Copay:</b> \$0 <b>Deductible:</b> Will Apply
<b>Infusion Therapy</b>	<b>Coinsurance:</b> 100% <b>Copay:</b> \$0 <b>Deductible:</b> Will Not Apply <b>Maximum:***</b> Unlimited	<b>Coinsurance:</b> 85% <b>Copay:</b> \$0 <b>Deductible:</b> Will Apply <b>Maximum:***</b> Unlimited	<b>Coinsurance:</b> 65% <b>Copay:</b> \$0 <b>Deductible:</b> Will Apply <b>Maximum:***</b> Unlimited
<b>Dialysis Treatment</b>			
Inpatient	<b>Coinsurance:</b> 100% <b>Copay:</b> \$0 <b>Deductible:</b> Will Not Apply	<b>Coinsurance:</b> 85% <b>Copay:</b> \$0 <b>Deductible:</b> Will Apply	<b>Coinsurance:</b> 65% <b>Copay:</b> \$0 <b>Deductible:</b> Will Apply
Outpatient	<b>Coinsurance:</b> 100% <b>Copay:</b> \$0 <b>Deductible:</b> Will Not Apply	<b>Coinsurance:</b> 85% <b>Copay:</b> \$0 <b>Deductible:</b> Will Apply	<b>Coinsurance:</b> 65% <b>Copay:</b> \$0 <b>Deductible:</b> Will Apply
<b>Chiropractic Treatment</b>			
Office Visit	<b>Coinsurance:</b> 100% <b>Copay:</b> \$0 <b>Deductible:</b> Will Not Apply <b>Maximum:***</b> 20 Days	<b>Coinsurance:</b> 100% <b>Copay:</b> \$0 <b>Deductible:</b> Will Not Apply <b>Maximum:***</b> Unlimited	<b>Coinsurance:</b> 65% <b>Copay:</b> \$0 <b>Deductible:</b> Will Not Apply <b>Maximum:***</b> 20 Days
Inpatient	<b>Coinsurance:</b> 100% <b>Deductible:</b> Will Not Apply	<b>Coinsurance:</b> 85% <b>Deductible:</b> Will Apply	<b>Coinsurance:</b> 65% <b>Deductible:</b> Will Apply

\*\*\*Note: Maximums cross accumulate between Outside of U.S., In-Network U.S. and Out-of-Network U.S.

PLAN COVERAGE	OUTSIDE OF U.S.	IN-NETWORK U.S.	OUT-OF-NETWORK U.S.
Allergy Testing/Treatment	<b>Coinsurance:</b> 100% <b>Copay:</b> \$0 <b>Deductible:</b> Will Not Apply	<b>Coinsurance:</b> 100% <b>Copay:</b> \$30 <b>Deductible:</b> Will Apply	<b>Coinsurance:</b> 65% <b>Copay:</b> \$0 <b>Deductible:</b> Will Apply
Diabetic Supplies and Equipment	<b>Coinsurance:</b> 100% <b>Copay:</b> \$0 <b>Deductible:</b> Will Not Apply	<b>Coinsurance:</b> 85% <b>Copay:</b> \$0 <b>Deductible:</b> Will Apply	<b>Coinsurance:</b> 65% <b>Copay:</b> \$0 <b>Deductible:</b> Will Apply
	Coverage is for the following equipment and supplies, if recommended in writing or prescribed by a Physician: insulin pumps; blood glucose meters and strips; urine testing strips; syringes; lancets; alcohol swabs; and pharmacological agents for controlling blood sugar.		
TMJ			
Lifetime Maximum - \$1,000; Appliance Maximum – TMJ Appliances covered as a combined Maximum			
Office Visit	<b>Coinsurance:</b> 100% <b>Copay:</b> \$0 <b>Deductible:</b> Will Not Apply	<b>Coinsurance:</b> 100% <b>Copay:</b> \$30 <b>Deductible:</b> Will Apply	<b>Coinsurance:</b> 65% <b>Copay:</b> \$0 <b>Deductible:</b> Will Apply
Outpatient	<b>Coinsurance:</b> 100% <b>Deductible:</b> Will Not Apply	<b>Coinsurance:</b> 85% <b>Deductible:</b> Will Apply	<b>Coinsurance:</b> 65% <b>Deductible:</b> Will Apply
Dental Care (Accident)	<b>Coinsurance:</b> 100% <b>Copay:</b> \$0 <b>Deductible:</b> Will Not Apply	<b>Coinsurance:</b> 100% <b>Copay:</b> \$30 <b>Deductible:</b> Will Apply	<b>Coinsurance:</b> 65% <b>Copay:</b> \$0 <b>Deductible:</b> Will Apply
	Limited to charges made for a continuous course of dental treatment started within six months of an injury to sound natural teeth.		
<b>VISION</b>			
Eligibility	All active, full-time Expatriate faculty and staff of the University regularly working a minimum of 30 Hours Per Week. Eligible Populations: U.S. Expats		
Eye Exams	<b>Coinsurance:</b> 100% <b>Copay:</b> \$0 <b>Deductible:</b> Will Not Apply	<b>Coinsurance:</b> 85% <b>Copay:</b> \$0 <b>Deductible:</b> Will Apply	<b>Coinsurance:</b> 65% <b>Copay:</b> \$0 <b>Deductible:</b> Will Not Apply
	<b>Exam Frequency:</b> 1 Exam every 12 months		
Vision Hardware	<b>Coinsurance:</b> 100% <b>Deductible:</b> Will Not Apply	<b>Coinsurance:</b> 100% <b>Deductible:</b> Will Apply	<b>Coinsurance:</b> 100% <b>Deductible:</b> Will Not Apply
	<b>Hardware Frequency:</b> 1 Hardware every 12 months		
Maximums	<b>Maximum Application:</b> All Inclusive Maximum (Hardware and Exam) <b>Hardware Maximum:</b> n/a <b>Exam Maximum:</b> \$200		

PLAN COVERAGE	OUTSIDE OF U.S.	IN-NETWORK U.S.	OUT-OF-NETWORK U.S.
<b>DENTAL</b>			
<b>Eligibility</b>	All active, full-time Expatriate faculty and staff of the University regularly working a minimum of 30 Hours Per Week. Eligible Populations: U.S. Expats		
<b>Combined Maximum</b>	A \$1,500 per person Calendar Year Maximum will be applied as a combined maximum as specified below.		
<b>Calendar Year Deductible</b>	The Calendar Year Deductible will be waived for Class I and will accumulate as a Calendar Year. <b>Individual CY Deductible:</b> \$25 <b>Family CY Deductible:</b> \$75		
<b>Class I – Preventive Care</b>	100% not subject to deductible for Diagnostic and Preventive services included those described below.  <b>Oral Exam:</b> 2 Per Person Per Year <b>Cleanings:</b> 2 Per Person Per Year <b>Bitewing X-Rays:</b> 2 Per Person Per Year <b>Flouride Applications:</b> 1 Per Person Per Year (Up to Age 19) <b>Sealants:</b> 1 Per Person Per 3 Years <b>Full Mouth X-Rays:</b> Unlimited <b>Panoramic X-Rays:</b> 1 Per Person Per 3 Years  This class does not have a Class Specific Maximum.		
<b>Class II – Basic Restorative</b>	80% subject to deductible for Basic Restorations, Endodontics, Periodontics, Prosthodontic Maintenance and Oral Surgery including Fillings, Root Canal, Periodontal Scaling and Root Planing and repair to Bridgework and Dentures.  This class does not have a Class Specific Maximum.		
<b>Class III – Major Restorative</b>	50% subject to deductible for Major Restorations, Dentures and Bridgework including Crowns.  This class does not have a Class Specific Maximum.		
<b>Class IV - Orthodontia</b>	50% subject to standard deductible; additionally, there will be an Ortho specific deductible of \$50. An Ortho specific Lifetime Maximum of \$1,500 will apply. Children Under 19 Years are eligible for this benefit.		
<b>Class V – Implants</b>	Benefit Not Covered		

PLAN COVERAGE	OUTSIDE OF U.S.	IN-NETWORK U.S.	OUT-OF-NETWORK U.S.
<b>PROVISIONS</b>			
<b>Pre-Admission Certification (PAC); Continued Stay Review (CSR); Surgical Pre-Certification</b>	<p><b><u>In-Network U.S.</u></b> Will apply with penalties for noncompliance at the following levels: \$300 Penalty; 50% Benefit Reduction penalty applied to hospital Inpatient charges for failure to pre-certify admissions. Benefits are reduced 50% for any admission not certified or additional days not deemed medically necessary.</p> <p><b><u>Out-of-Network U.S.</u></b> Will apply with penalties for noncompliance at the following levels: \$300 Penalty; 50% Benefit Reduction penalty applied to hospital Inpatient charges for failure to pre-certify admissions. Benefits are reduced 50% for any admission not certified or additional days not deemed medically necessary.</p>		
<b>Case Management</b>	A service provided through CareAllies, a Cigna company, which assists individuals with treatment needs that extend beyond the acute care setting. The goal is to ensure that patients receive appropriate care in the most effective setting possible whether at home, as an outpatient, or an inpatient in hospital or specialized facility. This service works with the treatment options which will best meet the patient's needs and keep costs manageable. Case managers will help coordinate the treatment program and arrange for necessary resources.		
<b>Cigna Pharmacy Management</b>	A service provided through Cigna Pharmacy Management, a Cigna company, which offers a managed pharmacy benefit plan for prescription drugs purchased in the United States at participating retail pharmacies. Mail order drugs will also be available via Cigna Home Delivery Pharmacy, but can be shipped overseas to APO addresses only. Some limitations may apply.		
<b>Late Entrant Provision</b>	Based on selections, Late Entrant/Pre-Existing Condition does not apply.		
<b>Pre-Existing Condition Limitation</b>	Based on selections, Late Entrant/Pre-Existing Condition does not apply.		
<b>EVACUATION BENEFIT (For service incurred outside the U.S. and Home Country)</b>			
<b>Emergency Evacuation</b>	100% of covered expenses subject to the deductible for services approved by International SOS. Includes coverage for: U.S. Expats		
<b>Family Travel Arrangements</b>	Roundtrip Airfare paid at economy rates to place of hospitalization for 1 family member for hospitalization in excess of 7 days.		
<b>Return of Dependent Children</b>	Oneway Airfare paid at economy rates to return dependent children to country of residence.		
<b>Repatriation of Mortal Remains</b>	100% of covered expenses subject to the deductible.		
<b>Return of Traveling Companion</b>	In the event of hospitalization or evacuation, and a traveling companion's air ticket is no longer usable, Oneway Airfare paid at economy rates to return traveling companions to country of residence.		
<b>ADDITIONAL PLAN INFORMATION</b>			
<b>Direct Access to Obstetrician and Gynecologists</b>	You do not need prior authorization from the plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, visit <a href="http://www.CignaEnvoy.com">www.CignaEnvoy.com</a> or contact customer service at the phone number listed on the back of your ID card.		
<b>Selection of a Primary Care Provider</b>	This plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider.		