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

University of Notre Dame du Lac

Benefits at a Glance
Policy #06946A
Effective Date 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	$0	$400	$800
• Per Family	$0	$800	$1,600
Coinsurance (The percentage of covered expenses the plan pays)	100%	85%	65% of the Maximum Reimbursable Charge
Out-of-Pocket Maximum • Per Individual	$0	$1,950	$3,900
• 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%.	$0	$4,600	$7,800
Accumulation	Accumulation of Plan Deductible and Out-of-Pocket Maximums: Deductible and Out-of-Pocket Maximums will cross-accumulate between In-Network and Out-of-Network. 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	100%	$30 per office visit copay	65% after plan deductible
• Surgery Performed In the Physician's Office	100%	$30 per office visit copay	65% after plan deductible
• Allergy Treatment	100%	$30 per office visit copay	65% after plan deductible
Preventive Care Routine Preventive Care – all ages Immunizations – all ages	100%	100% (Not subject to deductible)	100% (Not subject to deductible)
Travel Immunizations (Immunizations as required for travel)	100%	100% (Not subject to deductible)	100% (Not subject to deductible)
Mammograms, PSA, PAP Smear and Colorectal Cancer Screenings	100%	100% (Not subject to deductible)	100% (Not subject to deductible)
Inpatient Hospital Facility Services • Facility	100%	85% after plan deductible	65% after plan deductible
• Physician	100%	85% after plan deductible	65% after plan deductible
Outpatient Facility Services	100%	85% after plan deductible	65% after plan deductible
Emergency Care (Refer to certificate for coverage and exclusions)	100%	85% after plan deductible	85% after plan deductible (except if not a true emergency, then 65% after plan deductible)
Urgent Care Services	100%	$30 per office visit copay	$30 per office visit copay
Laboratory and Radiology Services (including pre-admission testing) Physician's Office Visit Inpatient Facility Outpatient Facility Independent X-Ray and/ or Lab Facility	 100% 100% 100% 100%	 $30 per office visit copay 85% after plan deductible 85% after plan deductible 85% after plan deductible	 65% after plan deductible 65% after plan deductible 65% after plan deductible 65% after plan 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 Physician's Office Outpatient Hospital Facility **Note**: The Short-Term Rehabilitation Therapy maximum does not apply to the treatment of Autism and/or Mental Health conditions.	 100% 100%	 $30 per office visit copay 85% after plan deductible	 65% after plan deductible 65% after plan deductible
Chiropractic Care Physician's Office Visit Calendar Year Maximum:	100% 20 days	100% not subject to plan deductible Unlimited	65% after plan 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	100%	$30 per office visit copay	65% after plan deductible
• All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)	100%	85% after plan deductible	65% after plan deductible
• Physician's Office Visits in addition to the global maternity fee when performed by an OB/GYN or Specialist	100%	$30 per office visit copay	65% after plan deductible
• Delivery – Facility (Inpatient Hospital, Birthing Center)	100%	85% after plan deductible	65% after plan deductible
Hearing Benefit • One examination per 24 month period	100%	85% after plan deductible	65% after plan deductible
Hearing Aid Maximum Up to $1,500 per hearing aid unit necessary for each hearing impaired ear every 3 years for a dependent child under age 24	100%	85% after plan deductible	65% after plan deductible
Mental Health and Substance Use Disorder • Inpatient Facility	100%	85% after plan deductible	65% after plan deductible
• Outpatient Office Visit	100%	$30 per office visit copay	65% after plan deductible

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Prescription Drug Benefits		
	International (Outside of the U.S.)	
Purchased outside the United States	100%	
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	No Charge after $5 copay	50% after plan deductible
Tier 2 - Brand Drugs designated as preferred on the Prescription Drug List	No Charge after $30 copay	50% after plan deductible
Tier 3 - Brand Drugs designated as non-preferred on the Prescription Drug List	No Charge after $45 copay	50% after plan 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	No Charge after $15 copay	50% after plan deductible
Tier 2 - Brand Drugs designated as preferred on the Prescription Drug List	No Charge after $90 copay	50% after plan deductible
Tier 3 - Brand Drugs designated as non-preferred on the Prescription Drug List	No Charge after $135 copay	50% after plan 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	No Charge after $15 copay	In-Network coverage only
Tier 2 - Brand Drugs designated as preferred on the Prescription Drug List	No Charge after $90 copay	In-Network coverage only
Tier 3 - Brand Drugs designated as non-preferred on the Prescription Drug List	No Charge after $135 copay	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 months	100%	85% after plan deductible	65% after plan deductible
Vision Hardware			
Lenses & Frames One pair of glasses or contact lenses every 12 months	100%	100% after plan deductible	100% after plan deductible
Combined Maximum Benefit	$200		

Global Dental Care		
Calendar Year Maximum (for Class I, II, III)		$1,500
Lifetime Maximum (for Class IV)		$1,500
Calendar Year Deductible		$25 Individual / $75 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 plan 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 plan deductible
Class III	**Major Restorative** For Major Restorations: • Dentures • Bridgework • Crowns	50% after plan deductible
Class IV	**Orthodontia** (Class IV Orthodontia applies only to a Dependent Child less than 19 years of age)	50% after plan deductible, additionally there will be an Orthodontia separate deductible of $50

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Emergency Evacuation	
Toll Free telephone number:	1.800.441.2668
Emergency Evacuation	100% of covered expenses not subject to the deductible for services approved by Cigna.
Family Travel Arrangements	Economy round-trip airfare to the place of hospitalization for one family member for hospitalizations in excess of 7 days
Return of Dependent Children	One-way economy airfare to return dependent children to their country of residence
Repatriation of Mortal Remains	100% coverage