



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

**Tufts University**  
 Benefits at a Glance  
 Policy # 03051A  
 Plan Start 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.**

<b>Cigna Global Customer Service</b>		
<b>Universal International Free Number (UIFN)</b>	International Access Code + UIFN Toll-free number 800.441.2668.1	
<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

<b>Global Medical Plan</b>	
<b>Eligibility</b>	Refer to eligibility definition in the certificate
<b>Lifetime Maximum</b>	Unlimited
<b>Calendar Year Deductible</b>	
• Per Individual	\$250
• Per Family	\$500
<b>Coinsurance</b> (The percentage of covered expenses the plan pays)	100%

<b>Certification Requirements – For services rendered inside the United States</b>
Precertification for inpatient and outpatient services received in the U.S. is required. <ul style="list-style-type: none"> <li>• Providers must call our toll-free number, 1.800.441.2668 to pre-certify services.</li> <li>• The customer is responsible for ensuring that Out-of-Network providers pre-certify services.</li> <li>• Failure to obtain precertification may affect Out-of-Pocket costs.</li> <li>• This is a summary only and further details can be found in the insurance booklet.</li> </ul>

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## Global Medical Plan

<b>Physician's Services</b> • Physician's Office Visit	100% after deductible
• Surgery performed In the Physician's Office	100% after deductible
• Allergy Treatment	100% after deductible
<b>Preventive Care</b> Routine Preventive Care – all ages Immunizations – all ages	100% not subject to deductible
<b>Travel Immunizations</b> (Immunizations as required for travel)	100% not subject to deductible
<b>Mammograms, PSA, PAP Smear and Colorectal Cancer Screenings</b>	100% not subject to deductible
<b>Inpatient Hospital Facility Services</b> • Facility	100% after deductible
• Physician	100% after deductible
<b>Outpatient Facility Services</b>	100% after deductible
<b>Emergency Care</b> (Refer to certificate for coverage and exclusions)	100% after deductible
<b>Urgent Care Services</b>	100% after deductible
<b>Laboratory and Radiology Services (including pre-admission testing)</b>	100% after deductible
<b>Outpatient Short-Term Rehabilitation Therapy</b> (60-day maximum per calendar year for all therapies combined) Includes: Cardiac Rehab, Physical Therapy, Speech Therapy, Occupational Therapy, Pulmonary Rehab and Cognitive Therapy. <b>Note:</b> Short-Term Rehabilitation Therapy maximum does not apply to the treatment of Autism.	100% after deductible
<b>Chiropractic Care</b> Physician's Office Visit Calendar Year Maximum:	100% after deductible (20-day maximum per calendar year, excludes U.S. In-Network visits)
<b>Maternity Care Services</b> • Initial Visit to Confirm Pregnancy	100% after deductible
• All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)	100% after deductible
• Physician's Office Visits in addition to the global maternity fee when performed by an OB/GYN or Specialist	100% after deductible
• Delivery – Facility (Inpatient Hospital, Birthing Center)	100% after deductible
<b>Hearing Benefit</b> • Exam: One every 24 month period <b>Benefit maximum: \$150</b>	100% after deductible
<b>Hearing Aid Maximum</b> Up to \$1,000 per hearing aid unit necessary for each hearing impaired ear every 3 years for a dependent child under age 24	100% after deductible
<b>Mental Health and Substance Use Disorder</b> • Inpatient Facility	100% after deductible
• Outpatient office visit	100% after deductible

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Prescription Drug Benefits	International (Outside of the U.S.)	
Purchased outside the United States	100% 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 <a href="http://www.healthcare.gov">www.healthcare.gov</a> ) 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 <a href="http://www.Cigna.com/druglist">www.Cigna.com/druglist</a> . 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	100% after deductible
Tier 2 - Brand Drugs designated as preferred on the Prescription Drug List	No Charge	100% after deductible
Tier 3 - Brand Drugs designated as non-preferred on the Prescription Drug List	No Charge	100% 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	No Charge	100% after deductible
Tier 2 - Brand Drugs designated as preferred on the Prescription Drug List	No Charge	100% after deductible
Tier 3 - Brand Drugs designated as non-preferred on the Prescription Drug List	No Charge	100% 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	No Charge	In-Network coverage only
Tier 2 - Brand Drugs designated as preferred on the Prescription Drug List	No Charge	In-Network coverage only
Tier 3 - Brand Drugs designated as non-preferred on the Prescription Drug List	No Charge	In-Network coverage only

## Global Vision Care

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	<b>International (Outside the U.S.)</b>	<b>U.S. In-Network</b>	<b>U.S. Out-of-Network</b>
<b>Examinations</b> One Eye Exam every 24 Consecutive months	100% no deductible	100% no deductible	100% no deductible
<b>Vision Hardware</b>			
<b>Lenses &amp; Frames</b> One pair of glasses or contact lenses per 24 Consecutive months <b>Maximum Benefit: \$100</b>	100% no deductible	100% no deductible	100% no deductible

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

<b>International Employee Assistance Program (IEAP)</b>	
<b>Toll free:</b>	1.888.851.7032 or 1.877.857.2952
<b>Level 2 International EAP Assist</b>	Direct dial 24/7 immediate access to confidential services for behavioral issues. Services include telephonic triage for emergent and urgent referrals, crises intervention and referrals to community resources. Referrals for 6 face-to-face sessions with licensed behavioral professionals (currently available in 160 countries).

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<b>Group Term Life Insurance</b>	
<b>Classification</b>	<b>Amount of Insurance</b>
<b>Employee Benefit</b>	1 times Annual Compensation
<b>Guaranteed Issue Amount</b>	The lesser of 1 times Annual Compensation or \$75,000
<b>Maximum Benefit</b>	The lesser of 1 times Annual Compensation or \$75,000

<b>Group Accidental Death &amp; Dismemberment (AD&amp;D) Insurance</b>	
<b>Classification</b>	<b>Principal Amount</b>
<b>Employee Benefit</b>	The lesser of 1 times Annual Compensation or \$150,000

<b>Age Based Reductions</b>	
<b>If you are age 65 or older, your Life Insurance and AD&amp;D Benefits are payable as follows:</b>	
<b>Age 65 to 69</b>	65% of Life Insurance and AD&D Benefits
<b>Age 70 and over</b>	50% of Life Insurance and AD&D Benefits

If the Life Insurance Amount for which an employee is eligible exceeds the guaranteed issue amount, evidence of insurability for the excess insurance must be provided to the Insurance Company. Please refer to your certificate booklet to see if evidence of insurability applies.

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<b>Long Term Disability Insurance</b>	
<b>Gross Disability Benefit</b>	The lesser of 60% of your monthly Covered Earnings rounded to the nearest dollar or the Maximum Disability Benefit
<b>Elimination Period</b>	180 days
<b>Maximum Disability Benefit</b>	\$10,000 per month
<b>Minimum Disability Benefit</b>	\$50 per month
<b><u>Age at Disability</u></b>	<b><u>Maximum Benefit Period</u></b>
62 or under	Your 65 <sup>th</sup> birthday or the date the 42 <sup>nd</sup> monthly benefit is payable, if later
63	The date the 36 <sup>th</sup> monthly benefit is payable
64	The date the 30 <sup>th</sup> monthly benefit is payable
65	The date the 24 <sup>th</sup> monthly benefit is payable
66	The date the 21 <sup>st</sup> monthly benefit is payable
67	The date the 18 <sup>th</sup> monthly benefit is payable
68	The date the 15 <sup>th</sup> monthly benefit is payable
69 and over	The date the 12 <sup>th</sup> monthly benefit is payable
<b>Definition of Disability</b>	Initial 24 months: regular occupation. After 24 months: any occupation
<b>Return to Work Incentive</b>	Included
<b>Successive Periods of Disability</b>	6 months, or less
<b>Survivor Benefits</b>	Single lump sum payment equal to 3 months Disability Benefits
<b>Other Income Benefits</b>	U.S. Social Security, CPP-QPP, Local Country Social Programs and other standard offsets
<b>Limited Benefit Period</b>	24 months (conditions include, but are not limited to, Mental Health and Substance Use)
<b>Pre-existing Condition Limitation</b>	12/6/24
<b>When Coverage Continues (Waiver of Premium)</b>	Included

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