



Insured and/or administered by:

**Cigna Health and Life Insurance Company**

**Teradyne, Incorporated**

Benefits at a Glance

Policy #00727A

Plan Start January 1, 2020

**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		
<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

Global Medical Plan			
	International (Outside of the U.S.)	U.S. In-Network	U.S. Out-of-Network
<b>Eligibility</b>	Refer to eligibility definition in the certificate		
<b>Lifetime Maximum</b>	Unlimited		
<b>Calendar Year Deductible</b>			
• Per Individual	\$300	\$300	\$300
• Per Family	\$600	\$600	\$600
<b>Coinsurance</b> (The percentage of covered expenses the plan pays)	80%	80%	60% of the Maximum Reimbursable Charge
<b>Out-of-Pocket Maximum</b>			
• Per Individual	\$1,500	\$1,500	\$1,500
• Per Family	\$3,000	\$3,000	\$3,000
<b>Includes Deductible</b> 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%.			
<b>Accumulation</b>	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.	
<ul style="list-style-type: none"> <li>• Providers must call our toll-free number, 1.800.441.2668 to pre-certify services.</li> <li>• You or your dependents are 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 certificate booklet.</li> </ul>	

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<b>Global Medical Plan</b>			
	<b>International (Outside of the U.S.)</b>	<b>U.S. In-Network</b>	<b>U.S. Out-of-Network</b>
<b>Physician's Services</b> • Physician's Office Visit	80% after plan deductible	80% after plan deductible	60% after plan deductible
• Surgery Performed In the Physician's Office	80% after plan deductible	80% after plan deductible	60% after plan deductible
• Allergy Treatment	80% after plan deductible	80% after plan deductible	60% after plan deductible
<b>Preventive Care</b> Routine Preventive Care – all ages Immunizations – all ages	100% Not subject to deductible	100% Not subject to deductible	100% Not subject to deductible
<b>Travel Immunizations</b> (Immunizations as required for travel)	100% Not subject to deductible	100% Not subject to deductible	100% Not subject to deductible
<b>Mammograms, PSA, PAP Smear and Colorectal Cancer Screenings</b>	100% Not subject to deductible	100% Not subject to deductible	100% Not subject to deductible
<b>Inpatient Hospital Facility Services</b> • Facility	80% after plan deductible	80% after plan deductible	60% after plan deductible
• Physician	80% after plan deductible	80% after plan deductible	60% after plan deductible
<b>Outpatient Facility Services</b>	80% after plan deductible	80% after plan deductible	60% after plan deductible
<b>Emergency Care</b> (Refer to certificate for coverage and exclusions)	80% after plan deductible	80% after plan deductible	60% after plan deductible
<b>Urgent Care Services</b>	80% after plan deductible	80% after plan deductible	60% after plan deductible
<b>Laboratory and Radiology Services (including pre-admission testing)</b>	80% after plan deductible	80% after plan deductible	60% after plan deductible
<b>Outpatient Short-Term Rehabilitation Therapy</b> (Calendar Year Maximum: 60-days for all therapies combined) <i>Includes:</i> Cardiac and Pulmonary Rehab, Speech, Occupational and Cognitive Therapy <b>Note:</b> The Short-Term Rehabilitation Therapy maximum does not apply to the treatment of Autism and/or Mental Health conditions.	80% after plan deductible	80% after plan deductible	60% after plan deductible
<b>Outpatient Short-Term Rehabilitation Therapy Physical Therapy</b>	80% after plan deductible	80% after plan deductible	60% after plan deductible
<b>Chiropractic Care</b> Physician's Office Visit	80% after plan deductible	80% after plan deductible	60% after plan deductible
<b>Maternity Care Services</b> • Initial Visit to Confirm Pregnancy	80% after plan deductible	80% after plan deductible	60% after plan deductible

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• All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)	80% after plan deductible	80% after plan deductible	60% after plan deductible
• Physician's Office Visits in addition to the global maternity fee when performed by an OB/GYN or Specialist	80% after plan deductible	80% after plan deductible	60% after plan deductible
• Delivery – Facility (Inpatient Hospital, Birthing Center)	80% after plan deductible	80% after plan deductible	60% after plan deductible

<b>Global Medical Plan</b>			
	<b>International (Outside of the U.S.)</b>	<b>U.S. In-Network</b>	<b>U.S. Out-of-Network</b>
<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	80% after plan deductible	80% after plan deductible	60% after plan deductible
<b>Mental Health and Substance Use Disorder</b> • Inpatient Facility	80% after plan deductible	80% after plan deductible	60% after plan deductible
• Outpatient Office Visit	80% after plan deductible	80% after plan deductible	60% after plan deductible

## PRESCRIPTION DRUG BENEFITS

	International (Outside of the U.S.)	
<b>Purchased outside the United States</b>	80% after \$10 copayment	
<b>Purchased Inside the United States Only</b>		
Benefit Highlights	Network Pharmacy	Non-Network Pharmacy
Certain Preventive Care Medications covered under this plan are payable at 100% with no Copayment or Deductible, when purchased from a Pharmacy. A written prescription is required. (detailed information is available at <a href="http://www.healthcare.gov">www.healthcare.gov</a> )		
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.		
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
<b>Tier 1</b> – Generic Drugs on the Prescription Drug List	20% coinsurance after \$10 Copay	20% coinsurance after \$10 Copay
<b>Tier 2</b> - Brand Drugs designated as preferred on the Prescription Drug List	20% coinsurance after \$10 Copay	20% coinsurance after \$10 Copay
<b>Tier 3</b> - Brand Drugs designated as non-preferred on the Prescription Drug List	20% coinsurance after \$10 Copay	20% coinsurance after \$10 Copay
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
<b>Tier 1</b> – Generic Drugs on the Prescription Drug List	20% coinsurance after \$30 Copay	20% coinsurance after \$30 Copay
<b>Tier 2</b> - Brand Drugs designated as preferred on the Prescription Drug List	20% coinsurance after \$30 Copay	20% coinsurance after \$30 Copay
<b>Tier 3</b> - Brand Drugs designated as non-preferred on the Prescription Drug List	20% coinsurance after \$30 Copay	20% coinsurance after \$30 Copay
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
<b>Tier 1</b> – Generic Drugs on the Prescription Drug List	20% coinsurance after \$30 Copay	In-Network coverage only
<b>Tier 2</b> - Brand Drugs designated as preferred on the Prescription Drug List	20% coinsurance after \$30 Copay	In-Network coverage only
<b>Tier 3</b> - Brand Drugs designated as non-preferred on the Prescription Drug List	20% coinsurance after \$30 Copay	In-Network coverage only

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