Insured and/or administered by:

**Cigna Global Insurance Company Limited**

# Skyline College

Benefits at a Glance
Global Plan for all covered Employees.
Policy # 09741C
Plan Start Date August 1, 2023

**This plan provides minimum essential coverage.**

NOTE: This information is a general description of benefits and is not a contract. Refer to your certificate booklet for complete details of coverage and exclusions. If there is any difference between this summary and the certificate, the information in the certificate will apply. Please note that your plan does not cover expenses for services which are not medically necessary.

| Cigna Global Customer Service | | |
|---|---|---|
| **Toll Free Telephone Number:**<br>**Direct Telephone:**<br>**Toll Free Fax Number:**<br>**Direct Fax Number:** | 1.800.441.2668<br>1.302.797.3100 (collect calls accepted)<br>1.800.243.6998<br>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<br>P.O. Box 15050<br>Wilmington DE 19850-5050 U.S.A. | Cigna Global Health Benefits<br>300 Bellevue Parkway<br>Wilmington DE 19809 U.S.A. |

## General Plan Provisions - All Amounts in U.S. Dollars

| Global Medical Plan | International (Outside of the U.S.) | U.S. In-Network | U.S. Out-of-Network |
|---|---|---|---|
| **Area of Cover** | Worldwide | | |
| **U.S. Medical Network** | OAP | | |
| **Eligibility** | Refer to eligibility definition in the certificate | | |
| **Lifetime Maximum** | $1,000,000 | | |
| **Annual Maximum** | $250,000 | | |
| **Policy Year Deductible**<br>· Per Individual<br>· Per Family | $200<br>$400 | $200<br>$400 | $200<br>$400 |
| **Coinsurance**<br>(The percentage of covered expenses the plan pays) | 80% | 80% | 60% |
| **Out-of-Pocket Maximum (Includes Deductible)**<br>· Per Individual<br>· Per Family | $5,000<br>$10,000 | $5,000<br>$10,000 | $5,000<br>$10,000 |

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| Global Medical Plan | |
|---|---|
| **Deductible Calculation** | Claims for a family member are covered at plan coinsurance:<br>• When that family member satisfies the Individual Deductible<br>-OR-<br>• When the Family Deductible is satisfied regardless of whether or not the Individual Deductible is satisfied. |
| **Out-of-Pocket Calculation** | Claims for a family member are covered at 100% coinsurance:<br>• When that family member satisfies the Individual Out-of-Pocket Maximum<br>-OR-<br>• When the Family Out-of-Pocket Maximum is satisfied regardless of whether or not the Individual Out-of-Pocket Maximum is satisfied.<br>Out-of-Pocket will: Include deductible payments; Include copay payments; Include pharmacy copays; Include pharmacy coinsurance payments; Exclude Pre-Admission Certification/Continued Stay Review penalties. |
| **Network Accumulation** | Plan Deductible, Out-of-Pocket, maximums and service specific maximums (dollar and occurrence) will cross-accumulate across international and domestic networks. |

## 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.

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| | International (Outside of the U.S.) | U.S. In-Network | U.S. Out-of-Network |
|---|---|---|---|
| **Physician's Services**<br>· Physician's Office Visit | 80% after deductible | $20 copay, then 100% not subject to deductible | 60% after deductible |
| · Surgery Performed In the Physician's Office | 80% after deductible | $20 copay, then 100% not subject to deductible | 60% after deductible |
| **Student Health Center**<br>*(if applicable)* | Not Covered | 100% not subject to deductible | 100% not subject to deductible |
| **Preventive Care**<br>· Routine Preventive Care | 100% not subject to deductible | 100% not subject to deductible | 60% after deductible |
| · Policy Year Maximum for Immunizations: $250<br>· Immunizations | 100% not subject to deductible | 100% not subject to deductible | 60% after deductible |
| **Travel Immunizations**<br>(Immunizations as required for travel) | 100% not subject to deductible | 100% not subject to deductible | 60% after deductible |
| **Mammograms, PSA, PAP Smear and Colorectal Cancer Screenings** | 100% not subject to deductible | 100% not subject to deductible | 60% after deductible |
| **Inpatient Hospital**<br>· Inpatient Hospital - Facility Services | 80% after deductible | $100 copay, then 80% after deductible | 60% after deductible |
| · Inpatient Hospital Physician Visits/Consultations | 80% after deductible | 80% after deductible | 60% after deductible |
| · Inpatient Professional Services (Surgeon, Radiologist, Pathologist, Anesthesiologist) | 80% after deductible | 80% after deductible | 60% after deductible |
| **Outpatient Services**<br>· Outpatient Facility Services | 80% after deductible | 80% after deductible | 60% after deductible |
| · Outpatient Professional Services | 80% after deductible | 80% after deductible | 60% after deductible |
| **Emergency Room** | 80% after deductible | $250 per visit copay, then 80% after deductible | $250 per visit copay, then 80% after deductible |
| **Urgent Care Services** | 80% after deductible | $20 copay, then 100% not subject to deductible | 60% after deductible |
| **Ambulance** | 80% after deductible | 100% after deductible | 100% after deductible |

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| Global Medical Plan | International (Outside of the U.S.) | U.S. In-Network | U.S. Out-of-Network |
|---|---|---|---|
| **Laboratory Services** | | | |
| · Physician Office Visit | 80% after deductible | 100% not subject to deductible | 60% after deductible |
| · Outpatient Facility | 80% after deductible | 80% after deductible | 60% after deductible |
| · Laboratory Services at an Independent Lab facility | 80% after deductible | 80% after deductible | 60% after deductible |
| **Radiology Services** | | | |
| · Physician Office Visit | 80% after deductible | 100% not subject to deductible | 60% after deductible |
| · Outpatient Facility | 80% after deductible | 80% after deductible | 60% after deductible |
| **Advanced Radiology** (i.e., MRIs, MRAs, CAT Scans, PET Scans) | | | |
| · Physician Office Visit | 80% after deductible | $20 copay, then 100% not subject to deductible | 60% after deductible |
| · Inpatient Facility | 80% after deductible | $100 copay, then 80% after deductible | 60% after deductible |
| · Outpatient Facility | 80% after deductible | 80% after deductible | 60% after deductible |
| **Short-Term Rehabilitation** | | | |
| · Physician Office Visit | 80% after deductible | $20 copay, then 100% not subject to deductible | 60% after deductible |
| · Outpatient Hospital Facility | 80% after deductible | $20 copay, then 100% not subject to deductible | 60% after deductible |
| Policy Year Maximum: | Unlimited for all Therapies Combined | | |

The limit is not applicable to Mental Health and Substance Use Disorder conditions.
**Note:** The Short-Term Rehabilitation Therapy maximum does not apply to the treatment of Autism
*Includes:* Cardiac and Pulmonary Rehab, Speech, Occupational, Cognitive, and Physical Therapy / Physiotherapy.

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| Global Medical Plan | | | |
|---|---|---|---|
| | International (Outside of the U.S.) | U.S. In-Network | U.S. Out-of-Network |
| **Chiropractic Care**<br>Policy Year Maximum: 20 Visits | 80% after deductible | 100% not subject to deductible | 60% after deductible |
| **Maternity Care Services** | | | |
| · Initial Visit to Confirm Pregnancy | 80% after deductible | $20 copay, then 100% not subject to deductible | 60% after deductible |
| · All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee) | 80% after deductible | 80% after deductible | 60% after deductible |
| · Physician's Office Visits in addition to the global maternity fee when performed by an OB/GYN or Specialist | 80% after deductible | $20 copay, then 100% not subject to deductible | 60% after deductible |
| · Delivery – Facility | | | |
| · Inpatient Hospital | 80% after deductible | $100 copay, then 80% after deductible | 60% after deductible |
| · Birthing Center | 80% after deductible | $100 copay, then 80% after deductible | 60% after deductible |

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| Global Medical Plan | | | |
|---|---|---|---|
| | International (Outside of the U.S.) | U.S. In-Network | U.S. Out-of-Network |
| **Infertility Services** | Diagnosis of Infertility is covered under general Physician Office Visits. Coverage will be provided for the following services: | | |
| · Physician Office Visit and Counseling | Not Covered | Not Covered | Not Covered |
| · Lab and Radiology Tests | Not Covered | Not Covered | Not Covered |
| · Inpatient Facility | Not Covered | Not Covered | Not Covered |
| · Outpatient Facility | Not Covered | Not Covered | Not Covered |
| **Hearing Exam**<br>· 1 Exam Every 24 Months | 80% after deductible | 80% after deductible | 60% after deductible |
| **Hearing Device / Aids** | Not Covered | Not Covered | Not Covered |
| **Dental Care**<br>Limited to changes made for a continuous course of dental treatment started within six months of an injury to teeth | | | |
| · Physician Office Visit | 80% after deductible | $20 copay, then 100% not subject to deductible | 60% after deductible |
| · Inpatient Facility | 80% after deductible | $100 copay, then 80% after deductible | 60% after deductible |
| · Outpatient Facility | 80% after deductible | 80% after deductible | 60% after deductible |
| · Policy Year Maximum: $3,000 | | | |
| **Mental Health**<br>· Physician Office Visit | 80% after deductible | $20 copay, then 100% not subject to deductible | 60% after deductible |
| · Inpatient Facility | 80% after deductible | $100 copay, then 80% after deductible | 60% after deductible |
| Maximum: (combined with Substance Use Disorder) | Unlimited | | |
| · Outpatient Facility | 80% after deductible | 80% after deductible | 60% after deductible |
| Maximum: (combined with Substance Use Disorder) | Unlimited | | |
| **Substance Use Disorder**<br>· Physician Office Visit | 80% after deductible | $20 copay, then 100% not subject to deductible | 60% after deductible |
| · Inpatient Facility | 80% after deductible | $100 copay, then 80% after deductible | 60% after deductible |
| Maximum: (combined with Mental Health) | Unlimited | | |
| · Outpatient Facility | 80% after deductible | 80% after deductible | 60% after deductible |
| Maximum: (combined with Mental Health) | Unlimited | | |

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## Prescription Drug Benefits

| International (Outside of the U.S.) | |
|---|---|
| **Purchased outside the United States** | You pay 20% after plan deductible |

| Purchased Inside the United States Only | | |
|---|---|---|
| **Benefit Highlights** | **Network Pharmacy (U.S. In-Network)** | **Non-Network Pharmacy (U.S. Out-of-Network)** |
| **Prescription Drug Products at Retail Pharmacies** | **The amount you pay for up to a consecutive 30-day supply** | |
| **Tier 1 - Generic Drugs on the Prescription Drug List** | You pay 20% not subject to plan deductible | In-Network Coverage Only |
| **Tier 2 – Brand Drugs designated as preferred on the Prescription Drug List** | You pay 20% not subject to plan deductible | In-Network Coverage Only |
| **Tier 3 – Brand Drugs designated as non-preferred on the Prescription Drug List** | You pay 50% not subject to plan deductible | In-Network Coverage Only |
| **Prescription Drug Products at Home Delivery Pharmacies** | **The amount you pay for up to a consecutive 90-day supply** | |
| **Tier 1 - Generic Drugs on the Prescription Drug List** | You pay 20% not subject to plan deductible | In-Network coverage only |
| **Tier 2 – Brand Drugs designated as preferred on the Prescription Drug List** | You pay 20% not subject to plan deductible | In-Network coverage only |
| **Tier 3 – Brand Drugs designated as non-preferred on the Prescription Drug List** | You pay 50% not subject to plan deductible | In-Network coverage only |

| Pharmacy Plan Features for Prescriptions Drugs Purchased Inside the United States Only | |
|---|---|
| **Prescription Drug List** | Advantage 3-Tier |
| **Dispense As Written** | If you request to fill a brand name drug that has a generic equivalent available, you will be financially responsible for the difference in cost between the brand name and the generic drug, plus any required brand name drug copayment and/or coinsurance, if applicable. However, if your doctor has determined a generic drug is not an acceptable alternative for you, you will only be responsible for payment of the appropriate brand name drug copayment and/or coinsurance, if applicable |
| **Utilization Management** | Your plan features drug management programs and edits to ensure safe prescribing, and access to medications proven to be the most reliable and cost effective for your medical condition |
| **Step Therapy** | Certain drugs are subject to step therapy requirements. To identify whether a particular drug is subject to step therapy, please refer to your prescription drug list. |
| **Prior Authorization** | Coverage for certain drugs require your Physician to obtain prior authorization from Cigna. To identify whether a particular drug requires prior authorization, please refer to your prescription drug list. |
| **Quantity Limits** | Includes maximum daily dose edits, quantity over time edits, duration of therapy edits, and dose optimization edits |

To see if your medication is covered, you can view Cigna's Prescription Drug List by going to www.Cigna.com/druglist and select "Advantage 3-Tier"

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| Global Telehealth | |
|---|---|
| **Teladoc Health International** | Available 24/7 via the Cigna Wellbeing App, Global Telehealth gives you access to licensed doctors around the world.<br>• Video or phone consultations with licensed doctors when medically necessary<br>• Prescriptions for common health concerns when medically necessary and permitted<br>• Treating medical conditions like fever, rash, pain and more<br>• Assistance with preparations for an upcoming consultation<br>• Discussing medication plan and potential side effects<br>• Diagnosing non-emergency health issues ranging from acute conditions to complex chronic conditions |

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# CIGNA STUDYWELL

## How to reach us

### Assistance is available 24 hours a day, 7 days a week

- Website ........ CignaEnvoy.com
- Toll-free telephone number ........ +1.800.441.2668
- Direct (collect calls accepted) ........ +1.302.746.3059
- Toll-free facsimile number ........ +1.800.243.6998
- Direct facsimile number ........ +1.302.797.3150
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  PO Box 15111
  Wilmington, DE 19850-5111 U.S.A.

Cigna Global Health Benefits®

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