



Cigna StudyWell®

Summary of Benefits for:

Policy Number:

Global Health Benefits

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Insured and/or administered by:
Cigna Global Insurance Company Limited

Weber State University
Benefits at a Glance
Global Plan for all covered Members
Policy # 10581A
Plan Start Date August 15, 2025

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 Healthcare, Global Health Benefits Customer Service		
Toll Free Telephone Number:	1.800.441.2668	
Direct Telephone:	1.302.797.3100 (collect calls accepted)	
Toll Free Fax Number:	1.800.243.6998	
Direct Fax Number:	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 Healthcare P.O. Box 15050 Wilmington DE 19850-5050 U.S.A.	Cigna Healthcare 300 Bellevue Parkway 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	\$500,000		
Annual Maximum	\$250,000		
Policy Year Deductible · Per Individual	\$200	\$200	\$200
· Per Family	\$400	\$400	\$400
Coinsurance (The percentage of covered expenses the plan pays)	90%	90%	70%
Out-of-Pocket Maximum (Excludes Deductible) · Per Individual	\$2,500	\$2,500	\$2,500
· Per Family	\$5,000	\$5,000	\$5,000



Global Medical Plan	
Deductible Calculation	<p>Claims for a family member are covered at plan coinsurance:</p> <ul style="list-style-type: none"> • When that family member satisfies the Individual Deductible -OR- • When the Family Deductible is satisfied regardless of whether or not the Individual Deductible is satisfied.
Out-of-Pocket Calculation	<p>Claims for a family member are covered at 100% coinsurance:</p> <ul style="list-style-type: none"> • When that family member satisfies the Individual Out-of-Pocket Maximum -OR- • When the Family Out-of-Pocket Maximum is satisfied regardless of whether or not the Individual Out-of-Pocket Maximum is satisfied. <p>Out-of-Pocket will: Exclude deductible payments; Exclude copay payments; Exclude pharmacy copays; Exclude pharmacy coinsurance payments; Exclude Pre-Admission Certification/Continued Stay Review penalties.</p>
Network Accumulation	<p>Plan Deductible, Out-of-Pocket, maximums and service specific maximums (dollar and occurrence) will cross-accumulate across international and domestic networks.</p>
Certification Requirements - For services rendered inside the United States	
<p>Precertification for inpatient and outpatient services received in the U.S. may be required.</p> <ul style="list-style-type: none"> • 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. 	



	International (Outside of the U.S.)	U.S. In-Network	U.S. Out-of-Network
Physician's Services · Physician's Office Visit · Surgery Performed In the Physician's Office	90% after deductible 90% after deductible	\$35 copay, then 100% after deductible \$35 copay, then 100% after deductible	70% after deductible 70% after deductible
Student Health Center (if applicable)	Not Covered	Not Covered	Not Covered
Preventive Care · Routine Preventive Care · Policy Year Maximum: Unlimited · Immunizations	100% not subject to deductible 100% not subject to deductible	100% not subject to deductible 100% not subject to deductible	70% after deductible 70% after deductible
Travel Immunizations (Immunizations as required for travel)	100% not subject to deductible	100% not subject to deductible	70% after deductible
Mammograms, PSA, PAP Smear and Colorectal Cancer Screenings	100% not subject to deductible	100% not subject to deductible	70% after deductible
Inpatient Hospital · Inpatient Hospital - Facility Services (Limited to the Semi-Private Room Rate) · Inpatient Hospital Physician Visits/Consultations · Inpatient Professional Services (Surgeon, Radiologist, Pathologist, Anesthesiologist)	90% after deductible 90% after deductible 90% after deductible	\$100 copay, then 90% after deductible 90% after deductible 90% after deductible	70% after deductible 70% after deductible 70% after deductible
Outpatient Services · Outpatient Facility Services · Outpatient Professional Services	90% after deductible 90% after deductible	90% after deductible 90% after deductible	70% after deductible 70% after deductible
Emergency Room	90% after deductible	\$100 per visit copay, then 100% after deductible	\$100 per visit copay, then 100% after deductible
Urgent Care Services	90% after deductible	\$45 copay, then 100% after deductible	70% after deductible
Ambulance	90% after deductible	90% after deductible	70% after deductible



Global Medical Plan			
	International (Outside of the U.S.)	U.S. In-Network	U.S. Out-of-Network
Laboratory Services • Physician Office Visit • Outpatient Facility • Laboratory Services at an Independent Lab facility	90% after deductible 90% after deductible 90% after deductible	90% after deductible 90% after deductible 90% after deductible	70% after deductible 70% after deductible 70% after deductible
Radiology Services • Physician Office Visit • Outpatient Facility	90% after deductible 90% after deductible	90% after deductible 90% after deductible	70% after deductible 70% after deductible
Advanced Radiology (i.e., MRIs, MRAs, CAT Scans, PET Scans) • Physician Office Visit • Inpatient Facility • Outpatient Facility	90% after deductible 90% after deductible 90% after deductible	90% after deductible \$100 copay, then 90% after deductible 90% after deductible	70% after deductible 70% after deductible 70% after deductible
Outpatient Therapy Services • Physician Office Visit • Outpatient Hospital Facility Policy Year Maximum:	90% after deductible 90% after deductible	\$35 copay, then 100% after deductible \$35 copay, then 100% after deductible	70% after deductible 70% after deductible
20 Days for all Therapies Combined			
The limit is not applicable to Mental Health and Substance Use Disorder conditions. <i>Includes:</i> Cardiac and Pulmonary Rehab, Speech, Occupational, Cognitive, and Physical Therapy / Physiotherapy.			



Global Medical Plan			
	International (Outside of the U.S.)	U.S. In-Network	U.S. Out-of-Network
Chiropractic Care Policy Year Maximum: 10 Days	90% after deductible	90% after deductible	70% after deductible
Maternity Care Services <ul style="list-style-type: none"> Initial Visit to Confirm Pregnancy All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee) Physician's Office Visits in addition to the global maternity fee when performed by an OB/GYN or Specialist Delivery – Facility <ul style="list-style-type: none"> Inpatient Hospital Birthing Center 	90% after deductible 90% after deductible 90% after deductible 90% after deductible 90% after deductible	\$35 copay, then 100% after deductible 90% after deductible \$35 copay, then 100% after deductible \$100 copay, then 90% after deductible \$100 copay, then 90% after deductible	70% after deductible 70% after deductible 70% after deductible 70% after deductible 70% after deductible



Global Medical Plan			
	International (Outside of the U.S.)	U.S. In-Network	U.S. Out-of-Network
Infertility, Fertility and Conception Services <ul style="list-style-type: none"> Physician Office Visit and Counseling Lab and Radiology Tests Inpatient Facility Outpatient Facility 	Not Covered Not Covered Not Covered Not Covered	Not Covered Not Covered Not Covered Not Covered	Not Covered Not Covered Not Covered Not Covered
Hearing Exam	Not Covered	Not Covered	Not Covered
Hearing Device / Aids	Not Covered	Not Covered	Not Covered
Dental Care Limited to changes made for a continuous course of dental treatment started within six months of an injury to teeth <ul style="list-style-type: none"> Physician Office Visit Inpatient Facility Outpatient Facility Policy Year Maximum	90% after deductible 90% after deductible 90% after deductible	\$35 copay, then 100% after deductible \$100 copay, then 90% after deductible 90% after deductible \$500	70% after deductible 70% after deductible 70% after deductible
Mental Health <ul style="list-style-type: none"> Physician Office Visit Outpatient Facility Maximum: (applies to Physician Office Visit and Outpatient Facility, and is combined with Substance Use Disorder) <ul style="list-style-type: none"> Inpatient Facility Maximum: (combined with Substance Use Disorder)	90% after deductible 90% after deductible 90% after deductible	\$35 copay, then 100% after deductible 90% after deductible \$100 copay, then 90% after deductible \$10,000	70% after deductible 70% after deductible 70% after deductible
Substance Use Disorder <ul style="list-style-type: none"> Physician Office Visit Outpatient Facility Maximum: (applies to Physician Office Visit and Outpatient Facility, and is combined with Mental Health) <ul style="list-style-type: none"> Inpatient Facility Maximum: (combined with Mental Health)	90% after deductible 90% after deductible 90% after deductible	\$35 copay, then 100% after deductible 90% after deductible \$100 copay, then 90% after deductible \$10,000	70% after deductible 70% after deductible 70% after deductible



Prescription Drug Benefits		
International (Outside of the U.S.)		
Purchased outside the United States	You pay 10% 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	No charge after you pay the \$10 copay	In-Network Coverage Only
Tier 2 – Brand Drugs designated as preferred on the Prescription Drug List	No charge after you pay the \$35 copay	In-Network Coverage Only
Tier 3 – Brand Drugs designated as non-preferred on the Prescription Drug List	No charge after you pay the \$50 copay	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	No charge after you pay the \$30 copay	In-Network coverage only
Tier 2 – Brand Drugs designated as preferred on the Prescription Drug List	No charge after you pay the \$105 copay	In-Network coverage only
Tier 3 – Brand Drugs designated as non-preferred on the Prescription Drug List	No charge after you pay the \$150 copay	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
Patient Assurance Program	Your plan includes the Patient Assurance Program, which waives the deductible, if applicable, and reduces the amount you owe for certain medications used to treat chronic conditions included in the program. Additionally: <ul style="list-style-type: none"> •Any amount you pay for these medications only count toward meeting your out-of-pocket maximum, if applicable. •Any discount provided by a pharmaceutical manufacturer for these medications only count toward meeting your out-of-pocket maximum, if applicable.
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"	

Global Telehealth	
Teladoc Health International	Available 24/7 via the Cigna Wellbeing App and Envoy Home Page (cignaenvoy.com) , Global Telehealth gives you access to licensed doctors around the world. <ul style="list-style-type: none"> • Video or phone consultations with licensed doctors when medically necessary • Prescriptions for common health concerns when medically necessary and permitted • Treating medical conditions like fever, rash, pain and more • Assistance with preparations for an upcoming consultation • Discussing medication plan and potential side effects • Diagnosing non-emergency health issues ranging from acute conditions to complex chronic conditions



Global Vision Plan			
	International (Outside of the U.S.)	U.S. In-Network	U.S. Out-of-Network
Examinations One every 12 consecutive months	100% not subject to deductible	100% not subject to deductible	
Lenses and Frames or Contacts One every 12 consecutive months	100% not subject to deductible	100% not subject to deductible	
Exam Maximum Benefit	Unlimited		
Hardware Maximum Benefit	\$150		

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We're here for you, anytime you need us, 24/7/365 customer service

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You can also contact Cigna Healthcare through the secure mailbox in [Cigna Envoy](#)[®].*

Contact us options

Toll-free telephone number	+1.800.441.2668
Toll-free TDD telephone number (for the hearing impaired)	+1.800.558.3604
Direct phone (collect calls accepted)	+1.302.746.3059
Toll-free facsimile number	+1.800.243.6998
Direct facsimile number (inside the U.S.)	+1.302.797.3150
Website	CignaEnvoy.com

Global Health Benefits



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