Insured and/or administered by:

Cigna Global Insurance Company Limited

Willam Jessup University

Benefits at a Glance
Global Plan for all covered Students
Policy # 10612A
Plan Start Date August 1, 2026

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: **Direct Telephone:** **Toll Free Fax Number:** **Direct Fax Number:**	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 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	$500,000		
Policy Year Deductible · Per Individual · Per Family	$100 $300	$100 $300	$100 $300
Coinsurance (The percentage of covered expenses the plan pays)	100%	100%	80%
Out-of-Pocket Maximum (Excludes Deductible) · Per Individual · Per Family	$2,500 $7,500	$2,500 $7,500	$2,500 $7,500

Global Medical Plan	
Deductible Calculation	Claims for a family member are covered at plan coinsurance: • 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	Claims for a family member are covered at 100% coinsurance: • 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. 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.
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.

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% after deductible	$30 copay, then 100% after deductible	80% after deductible
· Surgery Performed In the Physician's Office	100% after deductible	$30 copay, then 100% after deductible	80% after deductible
Student Health Center *(if applicable)*	Not Covered	Not Covered	Not Covered
Preventive Care			
· Routine Preventive Care	100% not subject to deductible	100% not subject to deductible	80% after deductible
· Policy Year Maximum: Unlimited			
· Immunizations	100% not subject to deductible	100% not subject to deductible	80% after deductible
Travel Immunizations (Immunizations as required for travel)	100% not subject to deductible	100% not subject to deductible	80% after deductible
Mammograms, PSA, PAP Smear and Colorectal Cancer Screenings	100% not subject to deductible	100% not subject to deductible	80% after deductible
Inpatient Hospital			
· Inpatient Hospital - Facility Services (Limited to the Semi-Private Room Rate)	100% after deductible	$50 copay, then 100% after deductible	80% after deductible
· Inpatient Hospital Physician Visits/Consultations	100% after deductible	100% after deductible	80% after deductible
· Inpatient Professional Services (Surgeon, Radiologist, Pathologist, Anesthesiologist)	100% after deductible	100% after deductible	80% after deductible
Outpatient Services			
· Outpatient Facility Services	100% after deductible	100% after deductible	80% after deductible
· Outpatient Professional Services	100% after deductible	100% after deductible	80% after deductible
Emergency Room	100% after deductible	$100 per visit copay, then 100% after deductible	$100 per visit copay, then 100% after deductible
Urgent Care Services	100% after deductible	$50 copay, then 100% after deductible	80% after deductible
Ambulance	100% after deductible	100% after deductible	80% 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	100% after deductible	100% after deductible	80% after deductible
· Outpatient Facility	100% after deductible	100% after deductible	80% after deductible
· Laboratory Services at an Independent Lab facility	100% after deductible	100% after deductible	80% after deductible
Radiology Services			
· Physician Office Visit	100% after deductible	100% after deductible	80% after deductible
· Outpatient Facility	100% after deductible	100% after deductible	80% after deductible
Advanced Radiology (i.e., MRIs, MRAs, CAT Scans, PET Scans)			
· Physician Office Visit	100% after deductible	100% after deductible	80% after deductible
· Inpatient Facility	100% after deductible	$50 copay, then 100% after deductible	80% after deductible
· Outpatient Facility	100% after deductible	100% after deductible	80% after deductible
Outpatient Therapy Services			
· Physician Office Visit	100% after deductible	$30 copay, then 100% after deductible	80% after deductible
· Outpatient Hospital Facility	100% after deductible	$30 copay, then 100% after deductible	80% after deductible
Policy Year Maximum:	20 Days for all Therapies Combined		
The limit is not applicable to Mental Health and Substance Use Disorder conditions. *Includes:* 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: 20 Days	100% after deductible	100% after deductible	80% after deductible
Maternity Care Services			
· Initial Visit to Confirm Pregnancy	100% after deductible	$30 copay, then 100% after deductible	80% after deductible
· All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)	100% after deductible	100% after deductible	80% after deductible
· Physician's Office Visits in addition to the global maternity fee when performed by an OB/GYN or Specialist	100% after deductible	$30 copay, then 100% after deductible	80% after deductible
· Delivery – Facility			
· Inpatient Hospital	100% after deductible	$50 copay, then 100% after deductible	80% after deductible
· Birthing Center	100% after deductible	$50 copay, then 100% after deductible	80% 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			
· 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	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			
· Physician Office Visit	100% after deductible	$30 copay, then 100% after deductible	80% after deductible
· Inpatient Facility	100% after deductible	$50 copay, then 100% after deductible	80% after deductible
· Outpatient Facility	100% after deductible	100% after deductible	80% after deductible
Policy Year Maximum	$500		
Mental Health · Physician Office Visit	100% after deductible	$30 copay, then 100% after deductible	80% after deductible
· Outpatient Facility	100% after deductible	100% after deductible	80% after deductible
Maximum: (applies to Physician Office Visit and Outpatient Facility, and is combined with Substance Use Disorder)	30 Visits		
· Inpatient Facility	100% after deductible	$50 copay after deductible	80% after deductible
Maximum: (combined with Substance Use Disorder)	$10,000		
Substance Use Disorder · Physician Office Visit	100% after deductible	$30 copay, then 100% after deductible	80% after deductible
· Outpatient Facility	100% after deductible	100% after deductible	80% after deductible
Maximum: (applies to Physician Office Visit and Outpatient Facility, and is combined with Mental Health)	30 Visits		
· Inpatient Facility	100% after deductible	$50 copay, then 100% after deductible	80% after deductible
Maximum: (combined with Mental Health)	$10,000		

Prescription Drug Benefits

International (Outside of the U.S.)		
Purchased outside the United States	No Charge After 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 $20 copay	In-Network Coverage Only
Tier 2 – Brand Drugs designated as preferred on the Prescription Drug List	No charge after you pay the $30 copay	In-Network Coverage Only
Tier 3 – Brand Drugs designated as non-preferred on the Prescription Drug List	No charge after you pay the $40 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 $60 copay	In-Network coverage only
Tier 2 – Brand Drugs designated as preferred on the Prescription Drug List	No charge after you pay the $90 copay	In-Network coverage only
Tier 3 – Brand Drugs designated as non-preferred on the Prescription Drug List	No charge after you pay the $120 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

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

Global Evacuation Plan - Evac/Repat $250k	
Toll Free telephone number	1.800.441.2668
Emergency Medical Evacuation	100% of covered expenses not subject to the deductible for approved services.
Family Travel Arrangements	Roundtrip Airfare at Economy Rates to the place of hospitalization for 1 Family Member for hospitalizations in excess of 7 Days
Return of Dependent Children	One-way Airfare at Economy Rates to return dependent children to country of residence
Repatriation of Mortal Remains	100% coverage

Global Telehealth	
Teladoc Health International	Global telehealth gives you no cost 24/7 access to licensed doctors for non-emergency health issues. Common outreaches include fever, rash, pain, non-emergency pediatric care, and more. Referrals to specialists and prescriptions available when medically necessary and locally permitted. Telephone or video consultations can be arranged through Cigna Envoy (cignaenvoy.com).

Global Accidental Death & Dismemberment	
Member Benefit	A flat benefit amount of $10,000
Reduction of Benefits	To 65% at age 65 and 50% at age 70; Terminate at Retirement
Scope of Coverage	24 Hour Coverage

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