



# 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

**Northwest University**  
Benefits at a Glance  
Global Plan for all covered Members  
Policy # 10617A  
Plan Start Date August 1, 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		
<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 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
<b>Area of Cover</b>	Worldwide		
<b>U.S. Medical Network</b>	OAP		
<b>Eligibility</b>	Refer to eligibility definition in the certificate		
<b>Lifetime Maximum</b>	Unlimited		
<b>Annual Maximum</b>	\$500,000		
<b>Policy Year Deductible</b> · Per Individual	\$0	\$0	\$0
· Per Family	\$0	\$0	\$0
<b>Coinsurance</b> (The percentage of covered expenses the plan pays)	100%	100%	80%
<b>Out-of-Pocket Maximum</b> · Per Individual	\$2,500	\$2,500	\$5,000
· Per Family	\$7,500	\$7,500	\$15,000



Global Medical Plan	
<b>Deductible Calculation</b>	<p>Claims for a family member are covered at plan coinsurance:</p> <ul style="list-style-type: none"> <li>• When that family member satisfies the Individual Deductible</li> <li>-OR-</li> <li>• When the Family Deductible is satisfied regardless of whether or not the Individual Deductible is satisfied.</li> </ul>
<b>Out-of-Pocket Calculation</b>	<p>Claims for a family member are covered at 100% coinsurance:</p> <ul style="list-style-type: none"> <li>• When that family member satisfies the Individual Out-of-Pocket Maximum</li> <li>-OR-</li> <li>• When the Family Out-of-Pocket Maximum is satisfied regardless of whether or not the Individual Out-of-Pocket Maximum is satisfied.</li> </ul> <p>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.</p>
<b>Network Accumulation</b>	<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"> <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>	



	International (Outside of the U.S.)	U.S. In-Network	U.S. Out-of-Network
<b>Physician's Services</b>			
· Physician's Office Visit	100%	\$15 copay, then 100%	80%
· Surgery Performed In the Physician's Office	100%	\$15 copay, then 100%	80%
<b>Student Health Center</b> (if applicable)	Not Covered	Not Covered	Not Covered
<b>Preventive Care</b>			
· Routine Preventive Care	Not Covered	Not Covered	Not Covered
· Policy Year Maximum:			
· Immunizations	100%	100%	80%
<b>Travel Immunizations</b> (Immunizations as required for travel)	100%	100%	80%
<b>Mammograms, PSA, PAP Smear and Colorectal Cancer Screenings</b>	Not Covered	Not Covered	Not Covered
<b>Inpatient Hospital</b>			
· Inpatient Hospital - Facility Services (Limited to the Semi-Private Room Rate)	100%	\$40 copay, then 100%	100%
· Inpatient Hospital Physician Visits/Consultations	100%	100%	100%
· Inpatient Professional Services (Surgeon, Radiologist, Pathologist, Anesthesiologist)	100%	100%	100%
<b>Outpatient Services</b>			
· Outpatient Facility Services	100%	\$40 copay, then 100%	80%
· Outpatient Professional Services	100%	100%	80%
<b>Emergency Room</b>	100%	\$250 per visit copay, then 100%	\$250 per visit copay, then 100%
<b>Urgent Care Services</b>	100%	\$30 copay, then 100%	80%
<b>Ambulance</b>	100%	100%	80%



Global Medical Plan			
	International (Outside of the U.S.)	U.S. In-Network	U.S. Out-of-Network
<b>Laboratory Services</b> • Physician Office Visit • Outpatient Facility • Laboratory Services at an Independent Lab facility	100% 100% 100%	100% 100% 100%	80% 80% 80%
<b>Radiology Services</b> • Physician Office Visit • Outpatient Facility	100% 100%	100% 100%	80% 80%
<b>Advanced Radiology</b> (i.e., MRIs, MRAs, CAT Scans, PET Scans) • Physician Office Visit • Inpatient Facility • Outpatient Facility	100% 100% 100%	100% \$40 copay, then 100% 100%	80% 100% 80%
<b>Outpatient Therapy Services</b> • Physician Office Visit • Outpatient Hospital Facility Policy Year Maximum:	100% 100%	\$40 copay, then 100% \$40 copay, then 100%	80% 80%
30 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
<b>Chiropractic Care</b> Policy Year Maximum:	Not Covered	Not Covered	Not Covered
<b>Maternity Care Services</b>			
· Initial Visit to Confirm Pregnancy	Not Covered	Not Covered	Not Covered
· All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)	Not Covered	Not Covered	Not Covered
· Physician's Office Visits in addition to the global maternity fee when performed by an OB/GYN or Specialist	100%	\$15 copay, then 100%	80%
· Delivery – Facility			
· Inpatient Hospital	Not Covered	Not Covered	Not Covered
· Birthing Center	Not Covered	Not Covered	Not Covered

Global Medical Plan			
	International (Outside of the U.S.)	U.S. In-Network	U.S. Out-of-Network
<b>Infertility, Fertility and Conception Services</b> <ul style="list-style-type: none"> <li>Physician Office Visit and Counseling</li> <li>Lab and Radiology Tests</li> <li>Inpatient Facility</li> <li>Outpatient Facility</li> </ul>	Not Covered Not Covered Not Covered Not Covered	Not Covered Not Covered Not Covered Not Covered	Not Covered Not Covered Not Covered Not Covered
<b>Hearing Exam</b>	Not Covered	Not Covered	Not Covered
<b>Hearing Device / Aids</b>	Not Covered	Not Covered	Not Covered
<b>Dental Care</b> 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"> <li>Physician Office Visit</li> <li>Inpatient Facility</li> <li>Outpatient Facility</li> </ul> Policy Year Maximum	100% 100% 100%	\$40 copay, then 100% \$40 copay, then 100% \$40 copay, then 100% \$500	80% 100% 80%
<b>Mental Health</b> <ul style="list-style-type: none"> <li>Physician Office Visit</li> <li>Outpatient Facility</li> </ul> Maximum: (applies to Physician Office Visit and Outpatient Facility, and is combined with Substance Use Disorder) <ul style="list-style-type: none"> <li>Inpatient Facility</li> </ul> Maximum: (combined with Substance Use Disorder)	100% 100% 100%	\$15 copay, then 100% 100% 30 Visits \$40 copay 30 Days	80% 80%
<b>Substance Use Disorder</b> <ul style="list-style-type: none"> <li>Physician Office Visit</li> <li>Outpatient Facility</li> </ul> Maximum: (applies to Physician Office Visit and Outpatient Facility, and is combined with Mental Health) <ul style="list-style-type: none"> <li>Inpatient Facility</li> </ul> Maximum: (combined with Mental Health)	100% 100% 100%	\$15 copay, then 100% 100% 30 Visits \$40 copay, then 100% 30 Days	80% 80%





Prescription Drug Benefits		
International (Outside of the U.S.)		
Purchased outside the United States	No Charge, not subject to 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 \$5 copay	You pay 20% not subject to plan deductible
Tier 2 – Brand Drugs designated as preferred on the Prescription Drug List	No charge after you pay the \$15 copay	You pay 20% not subject to plan deductible
Tier 3 – Brand Drugs designated as non-preferred on the Prescription Drug List	No charge after you pay the \$50 copay	You pay 20% not subject to plan deductible
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 \$15 copay	In-Network coverage only
Tier 2 – Brand Drugs designated as preferred on the Prescription Drug List	No charge after you pay the \$45 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	
To see if your medication is covered, you can view Cigna’s Prescription Drug List by going to <a href="http://www.Cigna.com/druglist">www.Cigna.com/druglist</a> and select "Legacy 3-Tier"		





Global Evacuation Plan	
<b>Toll Free telephone number</b>	1.800.441.2668
<b>Emergency Medical Evacuation</b>	100% of covered expenses for approved services.
<b>Family Travel Arrangements</b>	Roundtrip Airfare at Economy Rates to the place of hospitalization for 1 Family Member for hospitalizations in excess of 7 Days
<b>Return of Dependent Children</b>	One-way Airfare at Economy Rates to return dependent children to country of residence
<b>Repatriation of Mortal Remains</b>	100% coverage

Global Telehealth	
<b>Teladoc Health International</b>	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 ( <a href="http://cignaenvoy.com">cignaenvoy.com</a> ).

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

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

### Contact us options

Toll-free telephone number .....	<b>+1.800.441.2668</b>
Toll-free TDD telephone number (for the hearing impaired) .....	<b>+1.800.558.3604</b>
Direct phone (collect calls accepted) .....	<b>+1.302.746.3059</b>
Toll-free facsimile number .....	<b>+1.800.243.6998</b>
Direct facsimile number (inside the U.S.) .....	<b>+1.302.797.3150</b>
Website .....	<b><a href="#">CignaEnvoy.com</a></b>

## Global Health Benefits



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