Coast Community College District

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

The following benefit design has been created to meet the needs of your international students. Cigna's direct pay network, 24/7 customer service via 10 global customer service centers and industry leading global network allows your students to focus on their mission, while Cigna focuses on theirs - to help the people they serve improve their health, well-being and sense of security.

Policy Year:	8/12/2024 -8/12/2025	

Global Medical - Students

	International (Outside of the U.S.)	U.S. In-Network	U.S. Out-of-Network
Area of Cover	Worldwide		
U.S. Medical Network	Open Access Plus (OAP), a Cigna Network		
Eligibility	Student		
Lifetime Maximum	$2,000,000		
Policy Year Deductible · Per Individual · Per Family	$0 $0	$0 $0	$0 $0
Coinsurance (The percentage of covered expenses the plan pays)	100%	100%	80%
Out-of-Pocket Maximum (Includes Deductible) · Per Individual · Per Family	$0 $0	$2,500 $5,000	$2,500 $5,000
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: 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.		

Global Medical - Students

	International (Outside of the U.S.)	U.S. In-Network	U.S. Out-of-Network
Physician's Services • Physician's Office Visit • Specialty Care Physician's Office Visit • Surgery Performed In the Physician's Office	100% not subject to deductible 100% not subject to deductible 100% not subject to deductible	$20 copay, then 100% not subject to deductible $20 copay, then 100% not subject to deductible $20 copay, then 100% not subject to deductible	80% not subject to deductible 80% not subject to deductible 80% not subject to deductible
Student Health Center *(if applicable)*	Not Covered	100% not subject to deductible	100% not subject to deductible
Preventive Care • Routine Preventive Care • Policy Year Maximum: $2,000 or $2,500 (no difference in cost) • Immunizations	100% not subject to deductible 100% not subject to deductible	100% not subject to deductible 100% not subject to deductible	80% not subject to deductible 80% not subject to deductible
Travel Immunization (Immunizations as required for travel)	Not Covered	Not Covered	Not Covered
Mammograms, PSA, PAP Smear and Colorectal Cancer Screenings	100% not subject to deductible	100% not subject to deductible	80% not subject to deductible
Inpatient Hospital • Inpatient Hospital - Facility Services (Limited to the Semi-Private Room Rate) • Inpatient Professional Services (Surgeon, Radiologist, Pathologist, Anesthesiologist)	100% not subject to deductible 100% not subject to deductible	$100 copay, then 100% not subject to deductible 100% not subject to deductible	80% not subject to deductible 80% not subject to deductible
Outpatient Services • Outpatient Facility Services • Outpatient Professional Services	100% not subject to deductible 100% not subject to deductible	100% not subject to deductible 100% not subject to deductible	80% not subject to deductible 80% not subject to deductible
Emergency Room	100% not subject to deductible	$100 copay, then 100% not subject to deductible, Waived if admitted	$100 copay, then 100% not subject to deductible, Waived if admitted
Urgent Care Services All Professional Services, X ray/Lab performed	100% not subject to deductible	$20 copay, then 100% not subject to deductible	80% not subject to deductible
Ambulance	100% not subject to deductible	100% not subject to deductible	80% not subject to deductible

Global Medical - Students	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	100% not subject to deductible 100% not subject to deductible 100% not subject to deductible	100% not subject to deductible 100% not subject to deductible 100% not subject to deductible	80% not subject to deductible 80% not subject to deductible 80% not subject to deductible
Radiology Services • Physician Office Visit • Outpatient Facility	100% not subject to deductible 100% not subject to deductible	100% not subject to deductible 100% not subject to deductible	80% not subject to deductible 80% not subject to deductible
Advanced Radiology (i.e., MRIs, MRAs, CAT Scans, PET Scans) • Physician Office Visit • Inpatient Facility • Outpatient Facility	100% not subject to deductible 100% not subject to deductible 100% not subject to deductible	100% not subject to deductible $100 copay, then 100% not subject to deductible 100% not subject to deductible	80% not subject to deductible 80% not subject to deductible 80% not subject to deductible
Skilled Nursing Facility · Policy Year Maximum	Not covered	Not covered	Not covered
Home Health Care · Policy Year Maximum	100% not subject to deductible 120 days	100% not subject to deductible 120 days	80% not subject to deductible 120 days
Hospice (Inpatient)	Not covered	Not covered	Not covered
Hospice (Outpatient/Home)	Not covered	Not covered	Not covered
Diabetic Medical Supplies and Services (including equipment and training)	Covered according to the type of benefit and the place where the service is rendered.		

Global Medical - Students

	International (Outside of the U.S.)	U.S. In-Network	U.S. Out-of-Network
Outpatient Therapy Services • Physician Office Visit • Outpatient Hospital Facility Policy Year Maximum:	100% not subject to deductible 100% not subject to deductible	$20 copay, then 100% not subject to deductible $20 copay, then 100% not subject to deductible	80% not subject to deductible 80% not subject to deductible
	60 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.			
Chiropractic Care Policy Year Maximum: $500	100% not subject to deductible	100% not subject to deductible	80% not subject to deductible
Acupuncture · Policy Year Maximum	100% not subject to deductible Unlimited	100% not subject to deductible Unlimited	80% not subject to deductible Unlimited
Maternity Care Services **Policy Year Maximum: $50,000**			
• Initial Visit to Confirm Pregnancy	100% not subject to deductible	$20 copay, then 100% not subject to deductible	80% not subject to deductible
• All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)	100% not subject to deductible	100% not subject to deductible	80% not subject to deductible
• Physician's Office Visits in addition to the global maternity fee when performed by an OB/GYN or Specialist	100% not subject to deductible	$20 copay, then 100% not subject to deductible	80% not subject to deductible
• Delivery - Facility (Inpatient Hospital, Birthing Center)	100% not subject to deductible	$100 copay, then 100% not subject to deductible	80% not subject to deductible
Infertility Services • Physician Office Visit and Counseling • Lab and Radiology Tests • Inpatient Facility • Outpatient Facility	Diagnosis of Infertility is covered under general Physician Office Visits. Coverage will be provided for the following services: Not Covered Not Covered Not Covered Not Covered		

Global Medical - Students	International (Outside of the U.S.)	U.S. In-Network	U.S. Out-of-Network
Hearing Exam · 1 Exam Every 24 Months	Not Covered	Not Covered	Not Covered
Hearing Device / Aids	Not Covered	Not Covered	Not Covered
Dental Care - injury only Limited to changes made for a continuous course of dental treatment started within six months of an injury to teeth			
• Physician Office Visit	100% not subject to deductible	$20 copay, then 100% not subject to deductible	80% not subject to deductible
• Inpatient Facility	100% not subject to deductible	$100 copay, then 100% not subject to deductible	80% not subject to deductible
• Outpatient Facility	100% not subject to deductible	100% not subject to deductible	80% not subject to deductible
Policy Year Maximum		$1,000	
TMJ Maximums		Not Covered	
TMJ Office Visit	Not Covered	Not Covered	Not Covered
TMJ Surgery	Not Covered	Not Covered	Not Covered
Mental Health			
• Physician Office Visit	100% not subject to deductible	$20 copay, then 100% not subject to deductible	80% not subject to deductible
• Inpatient Facility	100% not subject to deductible	$100 copay, then 100% not subject to deductible	80% not subject to deductible
Maximum: (combined with Substance Use Disorder)		$50,000	
• Outpatient Facility	100% not subject to deductible	100% not subject to deductible	80% not subject to deductible
Maximum: (combined with Substance Use Disorder)		30 visits	
Substance Use Disorder			
• Physician Office Visit	100% not subject to deductible	$20 copay, then 100% not subject to deductible	80% not subject to deductible
• Inpatient Facility	100% not subject to deductible	$100 copay, then 100% not subject to deductible	80% not subject to deductible
Maximum: (combined with Mental Health)		$50,000	
• Outpatient Facility	100% not subject to deductible	100% not subject to deductible	80% not subject to deductible
Maximum: (combined with Mental Health)		30 visits	

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	
Generic	No charge after Member pays the $20 copay	Member pays 20% not subject to plan deductible
Preferred Brand Name	No charge after Member pays the $50 copay	Member pays 20% not subject to plan deductible
No Preferred Brand Name	No charge after Member pays the $75 copay	Member pays 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	
Generic	No charge after Member pays the $60 copay	In-Network coverage only
Preferred Brand Name	No charge after Member pays the $150 copay	In-Network coverage only
No Preferred Brand Name	No charge after Member pays the $225 copay	In-Network coverage only
Specialty Drug at Retail and Home Delivery Pharmacies	The amount you pay for up to a consecutive 30-day supply	
Generic	No charge after Member pays the $20 copay	Member pays 20% not subject to plan deductible
Preferred Brand Name	No charge after Member pays the $50 copay	Member pays 20% not subject to plan deductible
No Preferred Brand Name	No charge after Member pays the $75 copay	Member pays 20% not subject to plan deductible

Pharmacy Plan Features for Prescriptions Drugs Purchased Inside the United States Only	
Prescription Drug List	Legacy 3-Tier
Dispense As Written	If the Member requests to fill a brand name drug that has a generic equivalent available, the Member 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 the Member's doctor has determined a generic drug is not an acceptable alternative, the Member 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. This includes Step Therapy, Prior Authorization, and Quantity Limits.
Step Therapy	Certain drugs are subject to step therapy requirements. To identify whether a particular drug is subject to step therapy, the Member should refer to their prescription drug list.
Prior Authorization	Coverage for certain drugs require the Member's Physician to obtain prior authorization from Cigna. To identify whether a particular drug requires prior authorization, the Member should refer to their prescription drug list.
Quantity Limits	Includes maximum daily dose edits, quantity over time edits, duration of therapy edits, and dose optimization edits
Medications can be provided up to a 12-month supply in accordance with the instructions specified by a U.S. physician.	

Global Evacuation - $100,000 Limit	
Emergency Medical Evacuation	100% of covered expenses not subject to the deductible for approved services. Includes coverage for Students
Family Travel Arrangements	Roundtrip Airfare at Economy Rates to the place of hospitalization for 1 Family Member for hospitalizations in excess of 3 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 Vision - Students			
Students	International (Outside of the U.S.)	U.S. In-Network	U.S. Out-of-Network
Eligibility	Student		
Examinations One every 12 consecutive months	100% not subject to deductible	$20 copay, then 100% not subject to deductible	
Exam Maximum Benefit	Unlimited		

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

EXCLUSIONS AND LIMITATIONS

Medical and Dental Exclusions, Expenses Not Covered, and General Limitations

Additional coverage limitations determined by plan or provider type are shown in the Schedule. Payment for the following is specifically excluded from this plan:

1. Care for health conditions that are required by state or local law to be treated in a public facility.
2. Care required by state or federal law to be supplied by a public school system or school district.
3. Care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
4. For or in connection with an Injury or Sickness which is due to war, declared or undeclared, riot, civil commotion or police action which occurs in the Student's country of citizenship.
5. Charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan.
6. Assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other custodial services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
7. For or in connection with experimental, investigational or unproven services. Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the utilization review Physician to not be demonstrated through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or sickness for which its use is proposed;
8. Not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;
9. The subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" section of this plan; or the subject of an ongoing phase I, II or III clinical trial, except as provided in the "Clinical Trials" section of this plan.
10. Cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance.
11. The following services are excluded from coverage regardless of clinical indications: Macromastia or Gynecomastia Surgeries; Abdominoplasty; Panniculectomy; Rhinoplasty; Blepharoplasty; Redundant skin surgery; Removal of skin tags; Acupressure; Craniosacral/cranial therapy; Dance therapy, Movement therapy; Applied kinesiology; Rolfing; Prolotherapy; and Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
12. Medical and surgical services, initial and repeat, intended for the treatment or control of obesity, except for treatment of clinically severe (morbid) obesity as shown in Covered Expenses, including: medical and surgical services to alter appearance or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.
13. Unless otherwise covered in this plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and courtordered, forensic or custodial evaluations.
14. Court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.
15. Reversal of male or female voluntary sterilization procedures.
16. Any services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmy, and premature ejaculation.
17. Medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.
18. Non-medical counseling or ancillary services including but not limited to vocational rehabilitation, employment counseling, return-to-work services, work hardening programs, back school, and driving safety and services.
19. Non-medical ancillary services for learning disabilities, developmental delays, or intellectual disabilities
20. Biofeedback, neurofeedback, hypnosis, or sleep therapy.
21. Services or therapies that are primarily intended as training or education.
22. Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
23. Private hospital rooms and/or private duty nursing except as provided under the Home Health Services provision.
24. Personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
25. Artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets and wigs other than for scalp hair prostheses worn due to alopecia areata.
26. Hearing aids, including but not limited to semiimplantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs), except as covered under this plan as shown in the Covered Expenses section. A hearing aid is any device that amplifies sound.
27. Aids or devices that assist with nonverbal communications, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
28. Eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
29. All noninjectable prescription drugs, injectable prescription drugs that do not require Physician supervision and are typically considered self-administered drugs, nonprescription drugs, and investigational and experimental drugs, except as provided in this plan.
30. Routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
31. Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
32. Genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
33. Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
34. Blood administration for the purpose of general improvement in physical condition.
35. Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
36. Cosmetics, dietary supplements and health and beauty aids.
37. All nutritional supplements and formulae except for infant formula needed for the treatment of inborn errors of metabolism.
38. Medical treatment for a person age 65 or older, who is covered under this plan as a retiree, or their Dependent, when payment is denied by the Medicare plan because treatment was received from a nonparticipating provider.
39. Medical treatment when payment is denied by a Primary Plan because treatment was received from a nonparticipating provider.
40. to the extent of the exclusions imposed by any certification requirement shown in this plan;
41. Dental implants for any condition.
42. Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Home Health Services" or "Breast Reconstruction and Breast Prostheses" sections of this plan.

Optional Buy-Up per Student: Global Dental Student		
Eligibility		Student
Policy Year Maximum Combined for: Class I Class II Class III		$1,500
Lifetime Class IV Maximum		$1,500
Policy Year Deductible Combined for: Class II Class III		$50 Individual / $150 Family
Class I	**Preventive Care** For diagnostic and preventative services including: • Oral Exam -2 Per Person Per Year • Cleanings -2 Per Person Per Year • Bitewing X-rays -2 Per Person Per Year • Fluoride Applications -1 Per Person Per Year (Up to age 19) • Sealants -1 Treatment per Posterior Tooth per 3 Years • Diagnostic X-rays -Unlimited • Full Mouth / Panoramic X-rays -1 Per Person Per 3 Years	100% not subject to deductible
Class II	**Basic Restorative** For Basic Restorations: • Endodontics • Periodontics • Prosthodontics Maintenance • Oral Surgery • Fillings • Root Canal • Periodontal Scaling and Root Planing • Repair to Bridgework and Dentures	80% after deductible
Class III	**Major Restorative** For Major Restorations: • Dentures • Bridgework • Crowns	50% after deductible
Class IV	**Orthodontia** Children under 19 Years	50% not subject to deductible
Class V	**Implants**	Not Covered