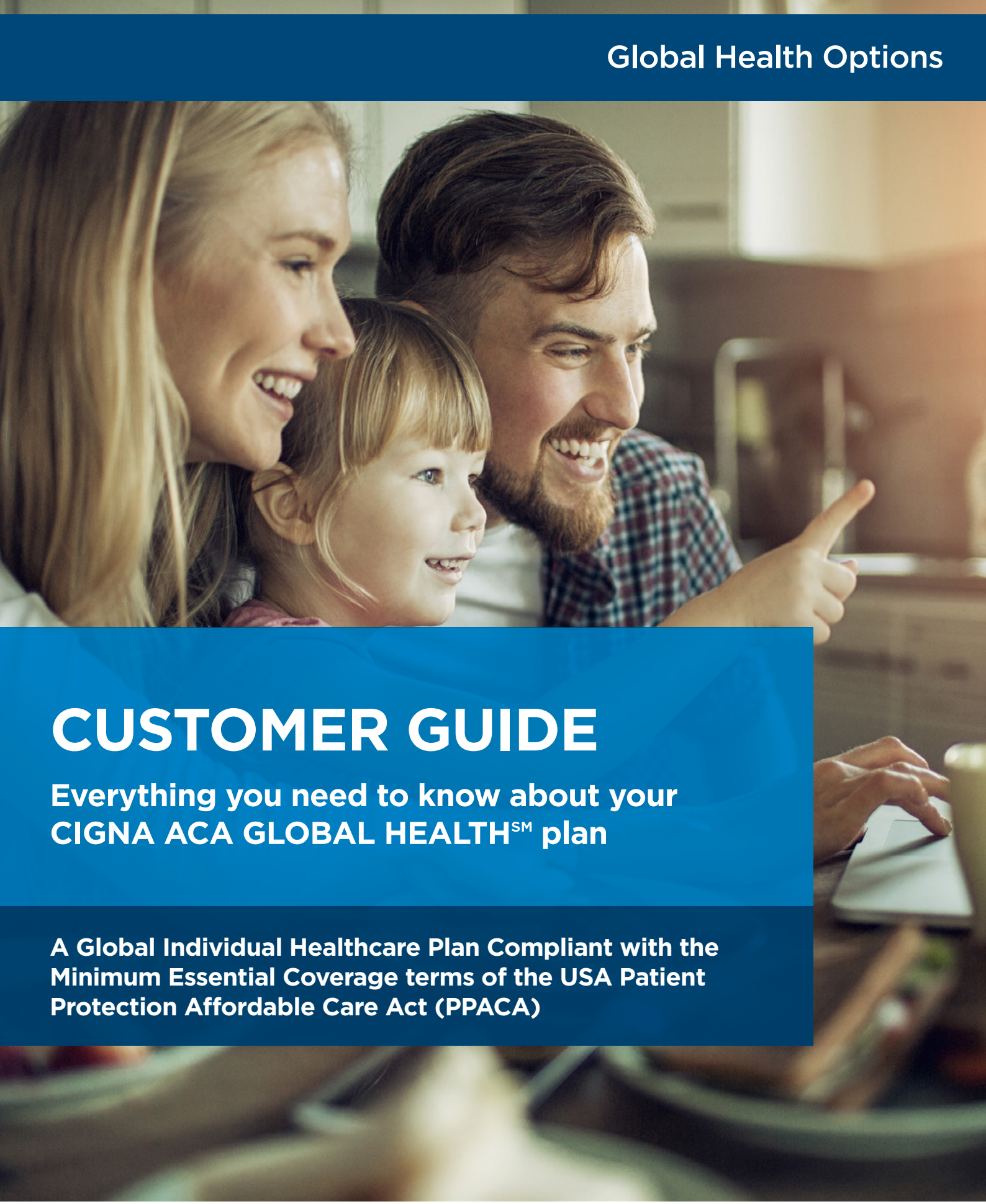
Global Health Options



CUSTOMER GUIDE

Everything you need to know about your CIGNA ACA GLOBAL HEALTH℠ plan

A Global Individual Healthcare Plan Compliant with the Minimum Essential Coverage terms of the USA Patient Protection Affordable Care Act (PPACA)

Together, all the way.℠

Cigna®

PROTECTING YOU AND YOUR FAMILY WHILE LIVING ABROAD

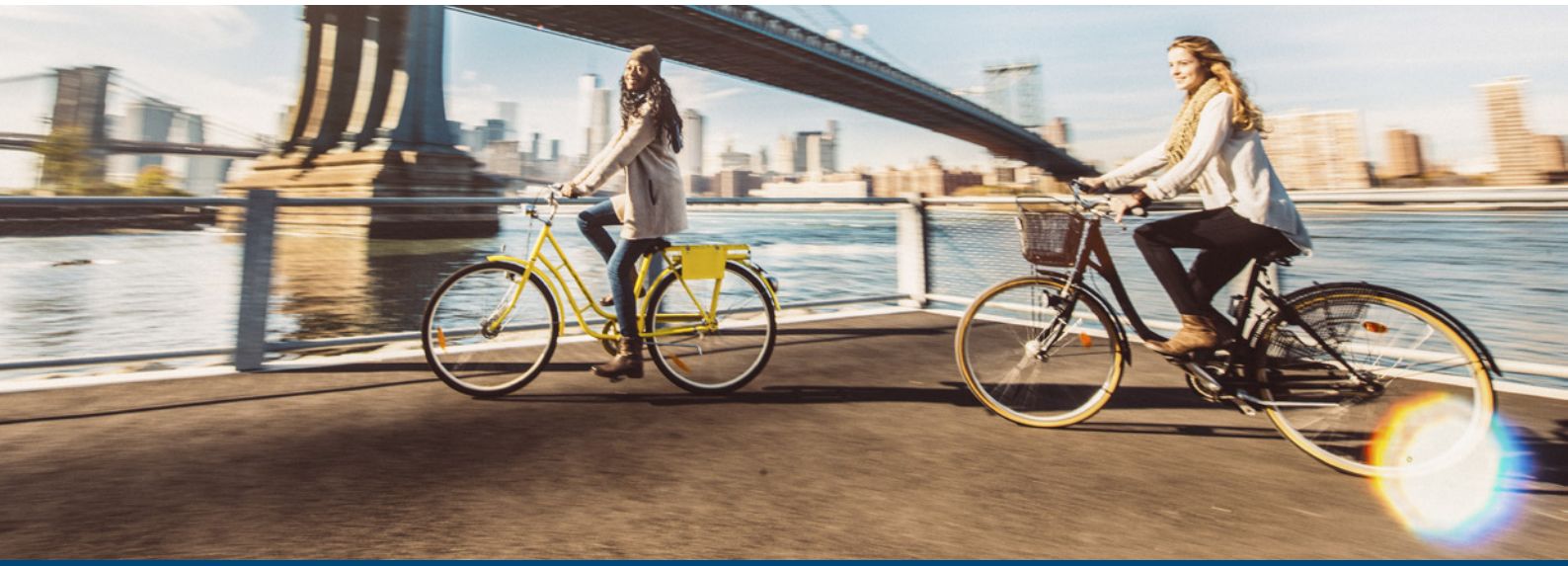
It's our mission to help improve your health, wellbeing and sense of security - and everything we do is designed to achieve this.

YOUR CIGNA ACA GLOBAL HEALTH℠ PLAN

Please read this *Customer Guide*, along with *your Certificate of Insurance* and *your Policy Rules* as they all form part of *your* contract between *you* and *us* for this *period of cover*.

You have chosen a plan to meet *your* own unique needs, so as *you* look through *your Customer Guide* and discover the full extent of the coverage *we* provide, *you* may see some terms that are in *italics*. These terms are clearly defined in *your Policy Rules* so as to avoid any confusion.

In the meantime, *we* hope *you* enjoy the peace of mind that comes from knowing *you* and *your* family have quick access to the quality medical *treatment you* need, whenever and wherever *you* need it.



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YOUR CIGNA ACA GLOBAL HEALTH℠ PLAN

Thank *you* for choosing a *Cigna* plan to protect *you* and *your* family. It's *our* mission to help improve *your* health, wellbeing and sense of security - and everything *we* do is designed to achieve this.

This *policy* is designed for *expatriates* who are either US citizens relocating or non-US citizens relocating to the *USA* and who in each case are required to have medical coverage as prescribed by the US Patient Protection and Affordable Care Act (*PPACA*). If *you* are required to have medical health *insurance* under *PPACA* and do not have a *policy* which provides *minimum essential coverage* then *you* (and *your* family members) may be liable to make an individual shared responsibility payment for each month that *you* do not have such a *policy* in force. The cost of the contribution is calculated in one of two ways: (1) *you'll* either pay a percentage of *your* total household gross income, or (2) a flat rate, whichever is greater. *Your* tax return will help determine *your* contribution amount.

This *PPACA* compliant plan, coupled with *worldwide* coverage, not only gives *you* peace of mind in the *USA* but also protects *you* when *you* are travelling around the globe for business or pleasure.

- *Our* plan meets and exceeds the *minimum essential coverage* requirements of the *PPACA* so that *you* will not be liable for an individual shared responsibility payment for each month that the *policy* is in force when living in the *USA*.
- No need to purchase multiple policies anymore – a truly global solution.
- As well as the *minimum essential coverage benefits*, *our* plan offers additional optional *benefits* to help *you* build a plan that suits *your* needs and budget.
- A range of *cost share* options to suit *your* budget.
- Preventative care *benefits* for *you* and *your* family with no *cost share*.
- Because *our* plan is designed for *expatriates*, *you* don't need to purchase the plan during the open enrolment period in the *USA*.
- *Our* Global Health Assist service gives *you* access to a dedicated team of *doctors* and nurses when *you* need them. *Our* clinical team is there to support *you*.
- If *you* no longer have a need for a *minimum essential coverage* plan, e.g. *you* move to another country, *we* can transition *you* on to another *Cigna* plan that is appropriate for *you* and *your* family (terms apply, including medical underwriting).

OUR CUSTOMER PROMISE

We pride ourselves in offering *you* exceptional customer service. This is *our* promise to *you*:

- *you* can speak to *our* highly experienced Customer Care Team 24 hours a day;
- *you* will have quick and easy access to healthcare facilities and professionals around the world through *our* extensive network;
- *we* will reimburse *your treatment* provider directly in most cases. On the rare occasion that *you* have to pay for *treatment* yourself, *we* aim to process *your* claim within 5 working days after receiving all necessary documentation;
- *you* can receive payment in over 135 currencies.

How this is delivered

Customer Service centres with multi-language assistance and support.

A medical network comprising of over 1 million partnerships, including 89,000 behavioural health care professionals, and 11,400 facilities and *clinics*.

A simple claims system that enables *you* to access *treatment* without paying in many cases, simply by calling *our* Customer Care Team first.

GETTING IN TOUCH

If *you* have any questions about *your* policy, need to get approval for *treatment*, or have any other needs, please contact *our* Customer Care Team 24 hours a day, 7 days a week, 365 days a year.

Inside the USA:

Call: **800 835 7677**

Fax: **855 358 6457**

@ Email: **cignaglobal_customer.care@cigna.com**

Worldwide:

Call: +44 (0) 1475 788 182
Fax: +44 (0) 1475 492 113

Inside Hong Kong:

Call: 2297 5210

Inside Singapore:

Call: 800 186 5047

YOUR ONLINE CUSTOMER AREA

As a *Cigna* customer *you* have access to a wealth of information wherever *you* are in the world through *your* secure online Customer Area. Here *you* will be able to effectively manage *your policy* including;

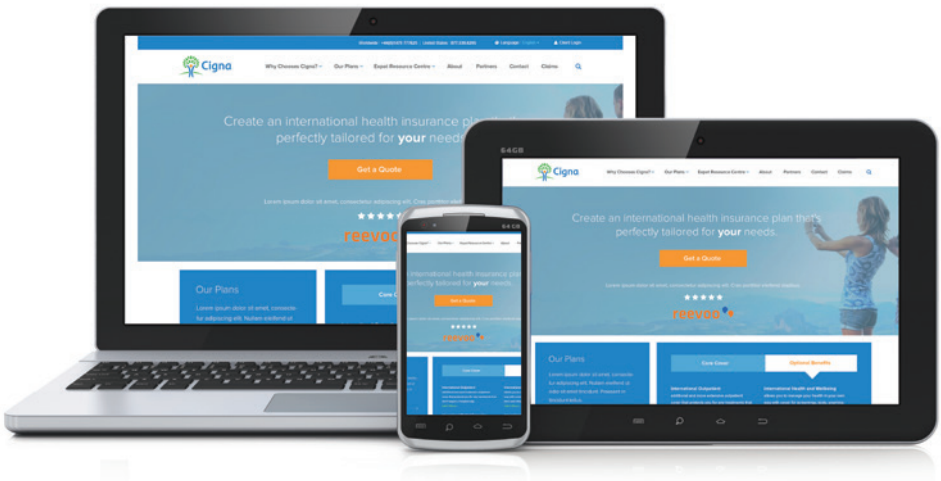
- View *your policy documents*, including *your Certificate of Insurance* and *Cigna* ID cards for all the people covered under *your plan*
- Check the *Policy Rules* that apply to *your policy*
- Check *your* coverage for *you* and *your* family
- Submit claims online
- Search for healthcare facilities and professionals near *your* location
- View *our* country guides which highlight security and cultural information for many destinations around the globe
- View *our* quarterly customer magazine
- Download the Safe Travel app

To access *your* secure online Customer Area, please log on to **www.cignaglobal.com** then;

Click on the 'Customer Area Login' button at the top right of the page

Next, click on the 'Log into the Customer Area' button to access the Customer Area Login page

In the User ID field type the email address that *you* provided *us* with and then *your* password



If *you* have any problems accessing the Customer Area, please contact *our* Customer Care Team.

YOUR GUIDE TO GETTING TREATMENT

***We* want to make sure that getting *treatment* is as stress free as possible for *you* or *your* family member.**

Prior authorisation for treatment

Please contact *our* Customer Care Team prior to any *treatment*. *We* can help *you* arrange *your treatment* plan, and point *you* in the right direction, saving *you* the time and hassle of looking for a *hospital*, *clinic* or *medical practitioner* yourself. What's more, in most cases *we* can arrange direct payment with *your treatment* provider, cutting down the hassle and letting *you* focus on *your* health.

If *we* cannot arrange direct payment with the provider, *we* will advise *you* of the nearest billing provider when *you* call for approval. There may be instances when *we* cannot arrange direct payments with a provider, and in such instances, *we* will let *you* know.

Treatment in the USA

There are some *benefits* detailed in the table of *benefits* in this *Customer Guide* which *we* will only pay for if the *treatment* takes place in a *Cigna* network of *hospitals*, *medical practitioners* or *clinics* in the *USA* (*in-network provider*). *We* understand that there may be occasions when it is not reasonably possible for *treatment* to be provided by *hospitals*, *medical practitioners* or *clinics* in the *Cigna* network. In these cases, *we* will not apply the out of network *coinsurance*. Examples include, but are not limited to; when there is no *Cigna* network of *hospitals*, *medical practitioners* or *clinics* within 30 miles/50 kilometres of the *beneficiary's* home address; or when the *treatment* the *beneficiary* needs is not available from at an *in-network provider.*

Our experts are available 24/7 to discuss *your treatment* plan and liaise directly with *your treatment* provider to arrange *guarantee of payment*, and ensure the *treatment* that *you* are about to undertake is covered under *your policy*.

We may ask for further information, such as a medical report in order for *us* to approve *treatment*. *We* will confirm approval, and where applicable, the number of *treatments* approved.

Emergency Treatment

We appreciate that there will be times when it will not be practical or possible for a *beneficiary* to contact *us* for prior authorisation (for example, emergencies, or when a family member is suddenly sick and the priority is to get *treatment* for them as soon as possible). In circumstances like these, *we* ask that *you* or the affected *beneficiary* get in touch with *us* within 48 hours after *treatment* has been sought, so that *we* can confirm whether *treatment* is covered and arrange settlement with *your* provider. This will also allow *us* to make sure that *you* or the affected *beneficiary* is making the best use of the cover.

In the event of *emergency treatment we* will ask for an explanation of why the *treatment* was needed urgently, and may ask for evidence of this. If *we* agree that it was not reasonably possible or practical to seek prior approval, *we* will cover the cost of the initial *treatment* (including any prescribed medication) which was urgent (within the terms of this *policy*).

If a *beneficiary* has been taken to a *hospital*, *medical practitioner* or *clinic* which is not part of the *Cigna* network or *in-network provider*, then *we* may make arrangements (with the *beneficiary's* consent) to move the *beneficiary* to a *Cigna* network *hospital*, *medical practitioner* or *clinic* to continue *treatment*, once it is medically appropriate to do so.

Getting Treatment

Please remember to take *your Cigna* ID card with *you* when *you* go for *treatment* and ask *your hospital*, *medical practitioner* or *clinic* about direct billing if this has not already been confirmed. *We* will give the provider a *guarantee of payment*, if required. A copy of *your Cigna* ID card is available in *your* secure online Customer Area.

Guarantee of payment

In some circumstances, *we* may give a *beneficiary* or a *hospital*, *medical practitioner* or *clinic* a *guarantee of payment*. This means that *we* agree in advance to pay some or all of the cost of a particular *treatment*. Where *we* have given a *guarantee of payment we* will pay the *beneficiary* or *hospital*, *medical practitioner* or *clinic* the agreed amount on receipt of an appropriate request and a copy of the relevant invoice, after the *treatment* has been provided.

Important note

Prior authorisation must be obtained from *us* for all *treatment*. This will help ensure *your* claim is covered under the *policy*. If *you* do not get prior authorisation from *us*, there may be delays in processing claims, or *we* may decline to pay all or part of the claim.

We will reduce the amount which *we* will pay by a further:

- 50% if *you* did not obtain prior authorisation when it was required for *treatment* inside the *USA*;
- 20% if *you* did not obtain prior authorisation for *treatment* outside the *USA*.

Getting treatment in the USA

If prior authorisation is obtained, but the *beneficiary* decides to receive *treatment* at an *out of network provider*, the out of network *coinsurance* will apply as per the option *you* selected as part of *your application*. There may be times where it is not reasonably possible for *treatment* to take place on an *in-network provider* basis. In these cases, *we* will not apply the *out of network provider coinsurance*.

A list of *Cigna* network *hospitals*, *clinics* and *medical practitioners* is available in *your* secure online Customer Area or *you* can contact *our* Customer Care Team for more information.

All *beneficiaries* are responsible for paying any *cost share* directly to the *hospital*, *medical practitioner* or *clinic* at the time of *treatment*.

Important note

There are some *benefits*, as detailed in the *list of benefits* in this *Customer Guide* that *we* will only pay for *treatment* by an *in-network provider*. If *you* choose to use an *out of network provider*, *we* will pay for the cost of *treatment*, subject to the *out of network provider coinsurance* amount (please note, *out of network coinsurance* amounts do not contribute towards *your* annual *out of pocket maximum*).

Our customer service team will confirm this when a *beneficiary* contacts them for prior authorisation.

We realise that there may be occasions when it is not reasonably possible for *treatment* to be provided by an *in-network provider*. In these cases, *we* will not apply the *out of network coinsurance* amount. Examples include, but are not limited to;

- when there is no *Cigna* network *hospital*, *medical practitioner* or *clinic* within 30 miles/50 kilometres of the *beneficiary*'s home address; or
- when the *treatment* the *beneficiary* needs is not available from a local *Cigna* network *hospital*, *medical practitioner* or *clinic*.

How we will pay claims after treatment

We pay your hospital, clinic or medical practitioner directly

Some *hospitals*, *medical practitioners* or *clinics* are willing to invoice *us* directly. If the *treatment* is covered, the *hospital*, *medical practitioner* or *clinic* should send *us* the original invoice and *we* will pay them directly.

If your hospital, clinic or medical practitioner gives you an invoice

If a *hospital*, *medical practitioner* or *clinic* invoices a *beneficiary* directly, and the *hospital*, *medical practitioner* or *clinic* has not been paid, the *beneficiary* must send the original invoice to *us* as soon as possible, and *we* will make any payment under this *policy* to that *hospital*, *medical practitioner* or *clinic* directly.

If you have paid your hospital, clinic or medical practitioner

If the *hospital*, *medical practitioner* or *clinic* invoices a *beneficiary* directly, and the invoice is paid, the *beneficiary* may send *us* the original invoice, receipt and claim form for the payment which has been made to the *hospital*, *medical practitioner* or *clinic* as soon as possible. *We* will then reimburse the *beneficiary* for any portion of the cost of the *treatment* which is covered.

In each case, *we* will only pay the parts of the costs incurred which are covered. *We* will let *you* know if *we* believe that any part of the cost incurred is not covered. *We* can reimburse *you* using bank wire transfer or cheque.

You can submit claims online via *your* secure online Customer Area, email, fax or send them in the post. Please see page 13 on how to submit claims for *your* specific region.

You can download claim forms from *your* secure online Customer Area or at **www.cignaglobal.com/help/claims**.

We will pay for the following costs related to your claim:

- Costs as described in the *list of benefits* section of this *Customer Guide* as applicable on the date(s) of the *beneficiary's treatment*, including *benefits* that are not subject to PPACA *minimum essential coverage*.
- Costs for *treatment* which have taken place; however, *we* will not cover future *treatment* costs that require payment deposits or payment in advance.
- *Treatment* which is *medically necessary* and clinically appropriate for the *beneficiary* as determined by *us* and *Appropriate Preventative Care*. The *treatment* must occur during the *period of cover* and any *cost share* on specific *benefits* and limits of cover may apply.
- Reasonable and customary costs for *treatment*, and services related to *treatments* which are shown in the *list of benefits*. *We* will pay for such *treatment* costs in line with the appropriate fees in the location of *treatment* and according to established clinical and medical practice.

Important note

We may need to ask for extra information to help *us* assess any request for *treatment* or process a claim, for example; medical reports or other information about the *beneficiary's* condition or the results of any independent medical examination that *we* may ask and pay for.

Beneficiaries should submit claim forms and invoices as soon as possible after any *treatment*. If the claim and invoice is not submitted to *us* within 12 months of the date of *treatment*, the claim will not qualify for payment or reimbursement by *us*.

OUR GLOBAL HEALTH ASSIST PROGRAM

Looking after you when you need us most

Our unique Global Health Assist program is carried out by our dedicated team of doctors and nurses, who work hand in hand with customers with serious or complex health conditions to bring them the full medical support they deserve.

Our Clinical team will contact *you* at the start of *your policy* to welcome *you* to *Cigna* and discuss any existing health conditions *you* may have.

We are dedicated to helping *you* and *your* family live happier, healthier lives with an unparalleled level of clinical expertise, which grants all *beneficiaries* access to:

MEDICAL SECOND OPINION SERVICE

We provide *our* customers with access to speak with a *doctor* or nurse. This can offer an international second opinion service or simple reassurance to *our* customers at what can often be a sensitive and potentially emotional time. Included within this service may be an independent view on their diagnosis or *treatment* plan.

NURSE COMPLEX CASE MANAGEMENT

When *treatment* is more complex, *our* nurses can take over the case providing clinical guidance and reassurance. In addition, that nurse can become the *beneficiary's* dedicated point of contact throughout the *treatment* process.

Our Global Health Assist service works with a proactive and personalised approach to manage complex health conditions.

Our qualified nurses from the Clinical team will immediately contact customers suffering from pre-existing conditions or serious illnesses and confirm a personalised and dedicated point of contact for the customer, and *you* will receive personalised support and information about;

- *Our* second medical opinion program;
- Medical network/preferred provider information;
- *Hospital* visits and navigating the "Healthcare Maze";
- Detailed coverage information and;
- Personalised support and case management.

SUBMITTING YOUR CLAIM

If *you*'ve paid for *your treatment* yourself, *you* can send *your* invoice and claim form to *us* using any of the following methods. Please clearly state *your policy* number on all documentation.

Online Customer Area: www.cignaglobal.com

Email: cignaglobal_customer.care@cigna.com

Fax: +44 (0) 1475 492 113

Post:

Inside the USA:

Fax: 855 358 6457

Treatment incurred in the USA
Cigna International
PO Box 15964
Wilmington
Delaware 19850
USA

Treatment incurred outside the USA, Hong Kong and Singapore
Cigna Global Health Options
Customer Service
1 Knowe Road
Greenock
Scotland PA15 4RJ

Treatment incurred in Hong Kong
Cigna Worldwide General Insurance Company Ltd
Cigna Global Health Options
Customer Service
14/F to 15/F, 28 Hennessy Road
Wan Chai
Hong Kong

Treatment incurred in Singapore
Cigna Europe Insurance Company S.A.-N.V. - Singapore Branch
Cigna Global Health Options
152 Beach Road
#26-05 The Gateway East
Singapore 189721

SUMMARY OF YOUR GUIDE TO GETTING TREATMENT

The diagram below summarises how the *treatment* and claiming process works

We aim to process *your* claim within 5 working days after receiving all necessary documentation

Claims Submission

You and all *beneficiaries* must comply with the claims procedures set out in this *Customer Guide*.

HELPFUL INFORMATION

Don't understand some words and terms?

If *you*'re not sure what any of the terms in this guide mean, don't worry. *You*'ll find a handy list of definitions in *your Policy Rules*.

Paying your premiums

You can choose to pay for *your* premiums on a quarterly or annual basis. *You* can make payments by debit or credit card, or alternatively if *you* pay annually, *you* can pay by bank wire transfer. Please let *us* know if *your* credit card has expired or if *you* get a new credit card so that *we* can update *your* card number and expiry date.

Renewing your policy

We will contact *you* at least one calendar month prior to the end of *your period of cover* regarding renewal of *your policy*. If *we* renew, *we* will inform *you* of any changes (if any) to *your benefits* and *policy* terms and conditions which will apply on renewal. *Your policy* documentation for the forthcoming *period of cover* will be available in *your* secure online Customer Area, including *your* schedule of *insurance* which details *your* premium. If *you* have chosen to receive printed copies of *your policy documents*, *we* will send them to the postal address *you* gave *us*. If *you* decide to renew, *you* don't need to do anything, and *your* cover will be renewed automatically for another 12 months subject to the terms of this *policy* (including *our* right to request confirmation that *you* and all *beneficiaries* are still in possession of an *eligible visa*). *We* will issue a *Certificate of Insurance* for *your* new *period of cover* on *your annual renewal date*.

We will not provide cover for any *beneficiary* aged sixty five (65) years old or older at the *annual renewal date* of the *policy*.

Changing your beneficiaries

Unless there has been a relevant *qualifying life event*, *you* can only add or remove a *beneficiary* when *your* cover is being renewed at the end of the annual *period of cover*. If there has been a relevant *qualifying life event*, such as marriage, divorce, or the birth of a child, *you* can add or remove a *beneficiary* at any time during *your* annual *period of cover*. If *you* would like to add, remove or change a *beneficiary*, just call the Customer Care Team, and they will be happy to help *you*.

Making changes to your plan

If *you* want to make any changes to *your* plan, this can be done when *your* cover is being renewed at the end of the annual *period of cover*. Please contact the Customer Care Team who will be happy to help, and discuss the various options and any additional premiums payable.

Cancelling your policy

If *you* choose to terminate *your policy* and end cover for all *beneficiaries*, *you* can do so at any time by giving *us* at least seven days' notice in writing.

Residing in the USA

Please remember all *beneficiaries* must have an *eligible visa* throughout the *period of cover*. *You* must inform *us* immediately should *you* or any *beneficiary* cease to hold an *eligible visa* or otherwise lose the right to live and/or work in the *USA*.

We may periodically check that *beneficiaries* are still in possession of an *eligible visa* and require *you* to provide relevant evidence to *us*.

We may exercise *our* right to cancel the *policy* in circumstances where evidence of an *eligible visa* has not been provided to *us*.

EVERYTHING YOU NEED TO KNOW ABOUT COST SHARE AND YOUR OUT OF POCKET MAXIMUM

Our wide range of *cost share* options allow *you* to tailor *your* plan to suit *your* needs.

The *cost share* option *you* have selected determines the annual *out of pocket maximum* for the *period of cover* for each *beneficiary* and at a *policy* level as mandated by the *US* government. In general, the more *you* pay in *cost share* the lower *your* premium will be.

PPACA limits the maximum amount of costs for covered *benefits you* will pay out of pocket annually. For example, in 2016, *your out of pocket maximum* can be no more than $6,850 for an individual and no more than $13,700 per *policy* (commonly known as family level), per *period of cover.*

You will be responsible for paying the amount of any *cost share* directly to the *hospital, medical practitioner* or *clinic*. *We* will let *you* know what that amount is. The *cost share* and *out of pocket maximum* are only related to the *Core plan* and not any of the optional modules *you* may have selected.

What is the out of pocket maximum?

The *out of pocket maximum* is the most *you* could pay during *your period of cover* for *your* share of the cost of covered *benefits* and services as detailed in this plan. This limit helps *you* plan for healthcare expenses. It is the maximum amount of *cost share* any *beneficiary* would have to pay per *period of cover* before *we* start to pay 100% for covered essential health *benefits*, subject to the terms of the *policy*.

Please remember there are some *benefits* as detailed in the *list of benefits*, which *we* will pay for *treatment* on an *in-network provider* basis only in the *USA*.

If *you* do use an *out of network provider*, the *coinsurance* amount will not count towards *your* annual *out of pocket maximum*, with the exception of some circumstances.

Your out of pocket maximum is set at an individual level and at a *policy* level (commonly known as family level) each year. The *policy* or family *out of pocket maximum* is double the individual *out of pocket maximum* selected.

What is cost share?

Your cost share is any applicable *deductible* and *coinsurance you* have selected as part of *your* plan.

What is a deductible?

This is the amount of any claim which a *beneficiary* must pay themselves. This will be shown in the *Certificate of Insurance*, if selected. There is an individual *deductible* and a family level maximum *deductible*, which is double the individual *deductible* selected.

What is a coinsurance?

This is the percentage of each claim which a *beneficiary* must pay themselves. There are different *coinsurance* amounts for *treatment* that takes place at an *USA in-network provider*, an *USA out of network provider* and any *treatment* that takes place outside of the *USA.* These will be shown in the *Certificate of Insurance*.

Are there any costs for treatment where I don't pay any cost share?

Yes, the *cost share* does not apply to the Wellbeing and Preventative Care Programme and the Child Wellness and Preventative Care Services, as detailed in the *list of benefits* in this *Customer Guide*.

What is not included in my annual out of pocket maximum?

Penalties for failure to obtain prior authorisation for *treatments* and services, *coinsurance* amounts as a result of using *out of network providers, your* premium and any healthcare this plan doesn't cover. So even though *you* pay these expenses, they don't count towards the *out of pocket maximum.* All deductible amounts count towards the *out of pocket maximum*.

The following examples show how the cost share and out of pocket maximum work.

Example 1

You chose Option 1 cost share and a deductible of $500

Claim value:	$1,500
In-network provider coinsurance:	20%
Out of network provider coinsurance:	40%
Out of pocket maximum:	$3,000

**You* received *treatment* at an *in-network provider* in the *USA*.*

After *you* have paid *your deductible* of $500, the remaining claim amount is $1,000. *Your coinsurance* payment is 20%* of $1,000 ($200). This is less than *your out of pocket maximum*, so *you* pay the $200 towards satisfying the *out of pocket maximum* for the *coinsurance* (the initial $500 *deductible* that *you* paid at the outset also counts towards the *out of pocket maximum*) and *we* cover the rest. ***You* have satisfied $700 towards *your out of pocket maximum*.**

Example 2

You chose option 2 cost share and a deductible of $2,000

Claim value:	$20,000
In-network provider coinsurance:	10%
Out of network provider coinsurance:	30%
Out of pocket maximum:	$4,000

**You* received *treatment* at an *out of network provider* in the *USA*.*

After *you* have paid *your deductible* of $2,000, the remaining claim amount is $18,000. *Your coinsurance* payment is 30%* of $18,000 ($5,400). However, in these circumstances, as *you* received treatment at an *out of network provider* in the *USA* whilst *you* remain liable for the *coinsurance* payment, only the *deductible* amount counts towards satisfying *your out of pocket maximum*. ***You* have satisfied $2,000 towards *your out of pocket* maximum.**

Example 3

You chose option 3 cost share and a deductible of $5,000

Claim value:	$7,580
In-network provider coinsurance:	0%
Out of network provider coinsurance:	20%
Out of pocket maximum:	$6,850

**You* received *treatment* at an *in-network provider* in the *USA*.*

You have paid *your deductible* of $5,000*, this is less than *your out of pocket maximum* of $6,850 and as *you* do not have any *coinsurance*, the $5,000 paid by *you* goes towards satisfying the *out of pocket maximum* and *we* cover the rest. ***You* have satisfied $5,000 towards *your out of pocket* maximum.**

Example 4

You chose option 1 cost share and a deductible of $500

Claim value:	$350	**You* received *treatment* at an *in-network provider* in the *USA*.
In-network provider coinsurance:	20%	
Out of network provider coinsurance:	40%	
Out of pocket maximum:	$3,000	

You have paid $350 towards satisfying *your deductible* amount. **This satisfies $350 of *your out of pocket maximum* amount.**

Example 5

You chose option 2 cost share and a deductible of $1,000

Claim value:	$22,000	
In-network provider coinsurance:	10%	**You* received *treatment* at an *in-network provider* in the *USA*.
Out of network provider coinsurance:	30%	
Out of pocket maximum:	$3,000	

After *you* have paid *your deductible* of $1,000, *your coinsurance* is 10%* of $21,000 ($2,100). As the total of the *deductible* and *coinsurance* amount ($3,100) is more than the *out of pocket maximum* ($3,000), *you* only pay $2,000 of the *coinsurance* (and the initial $1,000 *deductible* that *you* paid at the outset) and *we* cover the rest. ***You* will pay no further cost sharing on any future claims which are in-network in the *USA*, as you have reached *your out of pocket* maximum.**

YOUR COST SHARE OPTIONS

The *cost share* options are detailed in the table below.

Please check *your Certificate of Insurance* to remind yourself of the *cost share* option *you* have chosen.

Choose *your cost share* option This is what *you* will pay towards *treatment*	International *coinsurance* *Beneficiaries* residing in the *USA**	International *coinsurance* *Beneficiaries* residing outside of the *USA***	*USA In-network provider coinsurance*	*USA Out of network provider coinsurance*	*Deductible*	Annual *Out of pocket maximum*
Option 1	**0%**	**20%**	**20%**	**40%**	**$0**	**$2,000**
					$500	**$3,000**
					$1,000	**$4,000**
					$2,000	**$6,850**
					$5,000	**$6,850**
Option 2	**0%**	**10%**	**10%**	**30%**	**$0**	**$1,000**
					$500	**$2,000**
					$1,000	**$3,000**
					$2,000	**$4,000**
					$5,000	**$6,850**
Option 3	**0%**	**0%**	**0%**	**20%**	**$0**	**$1,000**
					$500	**$1,000**
					$1,000	**$2,000**
					$2,000	**$3,000**
					$5,000	**$6,850**

* This is the amount of *coinsurance you* will pay for *treatment* that takes place when *you* are on a visit outside of the *USA*.
** *Beneficiaries* who are *USA* citizens. This is the amount of *coinsurance you* will pay for *treatment* that takes place outside of the *USA* (typically *your* country of residence).

YOUR BENEFITS IN DETAIL

When building *your* tailored CIGNA ACA GLOBAL HEALTH℠ plan, *you* may have chosen optional *benefits* to add to *your Core plan*. In this section, *we* detail exactly what *you* can expect. To remind *yourself* of which *benefits you've* chosen, take a look at *your Certificate of Insurance*.

The *benefit* tables detail what is covered in *your* plan and also includes some additional *benefits* that are not mandated by the *PPACA*.

The International Vision and Dental and the International Medical Evacuation options will only be available if *you* have purchased these in addition to *your Core plan*. Please read the additional accompanying notes applicable to each *benefit* in the *list of benefits*.

The *benefits* and any additional options chosen are provided subject to all of the terms, conditions, limits and exclusions of this *policy* (including the General Exclusions found in the *Policy Rules* and any specific exclusions set out in the *list of benefits*). The *list of benefits* in this *Customer Guide* shows any limits which may apply to the *benefits*. There are some *benefits* in the International Vision and Dental option which have waiting periods, meaning *you* can only submit a claim for *treatments* incurred after the duration of the waiting period has been satisfied.

The *benefit* limits are displayed in USD only (where applicable) and *your* premium is payable in USD currency also.

LIST OF BENEFITS

INPATIENT AND DAYPATIENT TREATMENT AND CARE

Please note, there are some *benefits* detailed below that include *outpatient treatment*.

Paid in full after applicable *deductible* and *coinsurance* payments are fulfilled
Hospital charges for: Nursing and accommodation for *inpatient* and *daypatient treatment* and recovery room

We will pay for nursing care and accommodation whilst a *beneficiary* is receiving *inpatient* or *daypatient treatment*; or the cost of a *treatment* room while a *beneficiary* is undergoing *outpatient surgery*, if one is required. *We* will only pay these costs if:

- it is *medically necessary* for the *beneficiary* to be treated on an *inpatient* or *daypatient* basis;
- they stay in *hospital* for a medically appropriate period of time;
- the *treatment* which they receive is provided or managed by a *specialist*; and
- they stay in a standard single room with a private bathroom or equivalent.

If a *hospital's* fees vary depending on the type of room which the *beneficiary* stays in, then the maximum amount which *we* will pay is the amount which would have been charged if the *beneficiary* had stayed in a standard single room with a private bathroom or equivalent.

If the treating *medical practitioner* decides that the *beneficiary* needs to stay in *hospital* for a longer period than *we* have approved in advance, or decides that the *treatment* which the *beneficiary* needs is different to that which *we* have approved in advance, then that *medical practitioner* must provide *us* with a report, explaining: how long the *beneficiary* will need to stay in *hospital*; the diagnosis (if this has changed); and the *treatment* which the *beneficiary* has received, and needs to receive.

Hospital charges for: Operating theatre costs

- *We* will pay any costs and charges relating to the use of an operating theatre, if the *treatment* being given is covered under this *policy*.

Hospital charges for: *Intensive care*, including intensive therapy, coronary care and high dependency unit

- *We* will pay for a *beneficiary* to be treated in an *intensive care*, intensive therapy, coronary care or high dependency facility if that facility is the most appropriate place for them to be treated; the care provided by that facility is an essential part of their *treatment*; and the care provided by that facility is routinely required by patients suffering from the same type of illness or *injury*, or receiving the same type of *treatment*.

Hospital charges for: Surgeons' and anaesthetists' fees

- *We* will pay for *inpatient*, *daypatient* or *outpatient* costs for surgeons' and anaesthetists' *surgery* fees; and surgeons' and anaesthetists' fees in respect of *treatment* which is needed immediately before or after *surgery* (i.e. on the same day as the *surgery*).

Hospital charges for: *Specialists*' consultation fees

We will pay for regular visits by a *specialist* during stays in *hospital* including *intensive care* by a *specialist* for as long as is required by *medical necessity*.

- *We* will pay for consultations with a *specialist* during stays in a *hospital* where the *beneficiary*:
  - is being treated on an *inpatient* or *daypatient* basis;
  - is having *surgery*; or
  - where the consultation is a *medical necessity*.

Emergency *inpatient dental treatment* after a serious accident

- *We* will pay for emergency *dental treatment* which is required by a *beneficiary* while they are in *hospital* as an *inpatient*, if that emergency *inpatient dental treatment* is recommended by the treating *medical practitioner* because of a *dental emergency* (but is not the primary *treatment* which the *beneficiary* is in *hospital* to receive). This *benefit* is paid instead of any other dental *benefits* the *beneficiary* may be entitled to in these circumstances.

Bariatric *surgery*

We will pay for bariatric *surgery* if a *beneficiary* is morbidly obese as determined by a *medical practitioner*, and is *medically necessary*.

We will only pay for *surgery* if:

- the *beneficiary* is more than twice their ideal weight, or 100 pounds or more above the ideal weight, whichever is greater. This is determined by accepted standard weight tables for frame, age, height, and sex. *We* will also pay if the *beneficiary* has a body mass index (BMI) of 40 or more; and
- the *beneficiary* has been morbidly obese for at least 5 years; and
- non-surgical methods of weight reduction have been unsuccessfully attempted for at least 5 years under the supervision of a physician.

Important note

USA in-network provider only.
We will only pay for bariatric *surgery* if the *treatment* takes place in the *Cigna* network of *hospitals*, *medical practitioners* or *clinics*. There may be occasions when it is not reasonably possible for *treatment* to be provided by an *in-network provider*. In these cases, *we* will not apply the out of network *coinsurance*. Examples include, but are not limited to; when there is no *Cigna* network *hospital*, *medical practitioner* or *clinic* within 30 miles/50 kilometres of the *beneficiary's* home address; or when the *treatment* the *beneficiary* needs is not available from a local *Cigna* network *hospital*, *medical practitioner* or *clinic*.

Local ambulance and air ambulance services

- Where it is *medically necessary*, *we* will pay for a local ambulance to transport a *beneficiary*:
  - from the scene of an accident or *injury* to a *hospital*;
  - from one *hospital* to another; or
  - from their home to a *hospital*; or
  - from the nearest *hospital* to the *beneficiary's* home, nursing home, or skilled nursing facility in the same locale when other means of transportation would endanger their health or safety.
- *We* will only pay for a local ambulance where its use relates to *treatment* which a *beneficiary* needs to receive in a *hospital*, nursing home, or skilled nursing facility.

Air ambulance cover is subject to the following conditions and limitations:

- In some situations it will be impossible, impractical or unreasonably dangerous for an air ambulance to operate. In these situations, *we* will not arrange or pay for an air ambulance. This *policy* does not guarantee that an air ambulance will always be available when requested, even if it is medically appropriate;
- This *policy* does not provide cover for mountain rescue services;
- Cover for medical evacuation or repatriation is only available if *you* have cover under the International Medical Evacuation option. Please refer to the relevant section of the optional *benefits* for details of this option.

Inpatient cash *benefit*

No *deductible* payable

- *We* will make cash payments directly to a *beneficiary* who has received *inpatient treatment* but has not been charged for that *treatment* or for accommodation, if the *treatment* is covered under this *policy*.
- Up to 30 nights per *period of cover*.

TESTS, SCANS AND THERAPIES

Paid in full after applicable *deductible* and *coinsurance* payments are fulfilled

Pathology, radiology and *diagnostic tests*

We will pay for investigations on an *inpatient*, *daypatient* and *outpatient* basis, including:

- blood and urine tests;
- X-rays;
- ultrasound scans;
- electrocardiograms (ECG); and
- other *diagnostic tests* (excluding advanced medical imaging).

Advanced Medical Imaging (MRI, CT and PET scans)

We will pay for the following scans on an *inpatient*, *daypatient* and *outpatient* basis, including:

- magnetic resonance imaging (MRI);
- computed tomography (CT); and/or
- positron emission tomography (PET).

Physiotherapy

Where *treatment* is provided on an *inpatient* or *daypatient* basis.

- *We* will pay for *treatment* provided by a physiotherapist if these therapies are recommended by a *specialist* as part of the *beneficiary's hospital* stay for *inpatient* or *daypatient treatment* (but are not the primary *treatment* which they are in *hospital* to receive).
- *We* will pay for physiotherapy *treatment* on an *outpatient* basis that is *medically necessary* and restorative in nature to help *you* to carry out *your* normal activities of daily living. The *treatment* must be carried out by a properly qualified practitioner who holds the appropriate license to practice in the country where the *treatment* is received. This excludes any sports medicine *treatment*.
- *We* will require a medical report and *treatment* plan prior to approval.

Osteopathy and chiropractic *treatment*

- *We* will pay osteopathy and chiropractic *treatment* on an *outpatient* basis which is *evidence-based treatment*, *medically necessary* and recommended by a treating *specialist*, if a *medical practitioner* recommends the *treatment* and provides a referral. The *treatment* must be carried out by a properly qualified practitioner who holds the appropriate license to practice in the country where the *treatment* is received. *We* will require a medical report and *treatment* plan prior to approval. This excludes any sports medicine *treatment*.

Important note

USA in-network provider only.
We will only pay for chiropractic *treatment* if it takes takes place in a *Cigna* network of *hospitals*, *medical practitioners* or *clinics*. There may be occasions when it is not reasonably possible for *treatment* to be provided by an *in-network provider*. In these cases, *we* will not apply the out of network *coinsurance*. Examples include, but are not limited to; when there is no *Cigna* network *hospital*, *medical practitioner* or *clinic* within 30 miles/50 kilometres of the *beneficiary's* home address; or when the *treatment* the *beneficiary* needs is not available from a local *Cigna* network *hospital*, *medical practitioner* or *clinic*.

Acupuncture, Homeopathy, and Chinese medicine

- *We* will pay for *treatment* provided by *complementary therapists*; (acupuncturists, homeopaths and practitioners of Chinese medicine) if these therapies are recommended by a *specialist* as part of the *beneficiary's hospital* stay for *inpatient* or *daypatient treatment* (but are not the primary *treatment* which they are in *hospital* to receive).
- *We* will pay for a combined maximum total of 15 consultations on an *outpatient* basis with acupuncturists, homeopaths and practitioners of Chinese medicine for each *beneficiary* in any one *period of cover*, if those *treatments* are recommended by a *medical practitioner*.
- The *treatment* must be carried out by a properly qualified practitioner who holds the appropriate license to practice in the country where the *treatment* is received.

Important note

USA in-network provider only.
We will only pay for acupuncture, homeopathy, and Chinese medicine if the *treatment* takes place in a *Cigna* network of *hospitals*, *medical practitioners* or *clinics*. There may be occasions when it is not reasonably possible for *treatment* to be provided by a *Cigna* network *hospital*, *medical practitioner* or *clinic*. In these cases, *we* will not apply the out of network *coinsurance*. Examples include, but are not limited to; when there is no *Cigna* network *hospital*, *medical practitioner* or *clinic* within 30 miles/50 kilometres of the *beneficiary's* home address; or when the *treatment* the *beneficiary* needs is not available from a local *Cigna* network *hospital*, *medical practitioner* or *clinic*.

Restorative speech therapy

We will pay for restorative speech therapy on an *outpatient* basis if:

- it is required immediately following *treatment* which is covered under this *policy* (for example, as part of a *beneficiary's* follow-up care after they have suffered a stroke);
- it is confirmed by a *specialist* to be *medically necessary* on a *short-term* basis.

Important notes

We will only pay for speech therapy if the aim of that therapy is to restore impaired speech function.

We will not pay for speech therapy which:

- aims to improve speech skills which are not fully developed;
- is educational in nature;
- is intended to maintain speech communication;
- aims to improve speech or language disorders (such as stammering); or
- is as a result of learning difficulties, developmental problems (such as dyslexia), attention-deficit hyperactivity disorder or autism.

OTHER OUTPATIENT/AMBULATORY TREATMENT AND CARE

We will pay for the following *outpatient treatment* and care that does not require a *hospital* admission; including but not limited to;

Paid in full after applicable *deductible* and *coinsurance* payments are fulfilled

Consultations with *medical practitioners* and *specialists*

- *We* will pay for consultations or meetings with a *medical practitioner* which are necessary to diagnose an illness, or to arrange or receive *treatment*.
- *We* will pay for non-surgical *treatment* on an *outpatient* basis, which is recommended by a *specialist* as being *medically necessary*.

Surgical procedures

- *We* will pay for surgical procedures and *treatments* that are required on an *outpatient* basis, which are recommended by a *specialist* as being *medically necessary*.

Diabetes Services

We will pay for the following *outpatient treatment*:

- equipment and supplies; and
- *outpatient* self-management training and education, including medical nutrition therapy for the *treatment* of insulin-dependent diabetes, insulin using diabetes, gestational diabetes and noninsulin using diabetes, if *medically necessary*.

Emergency dental care as a result of an accident

If a *beneficiary* needs *dental treatment* as a result of injuries which they have suffered in an accident, *we* will pay for *outpatient dental treatment* for any *sound natural tooth/teeth* or teeth damaged or affected by the accident, provided the *treatment* commences immediately after the accident and is completed within 30 days of the date of the accident.

In order to approve this *treatment*, *we* will require confirmation from the *beneficiary's* treating *dentist* of:

- the date of the accident; and
- the fact that the tooth/teeth which are the subject of the proposed *treatment* are *sound natural tooth/teeth*.

We will pay for this *treatment* instead of any other *dental treatment* the *beneficiary* may be entitled to under this *policy*, when they need *treatment* following accidental damage to a tooth or teeth.

We will not pay for the repair or provision of dental implants, crowns or dentures under this part of this *policy*.

PHARMACY PRESCRIPTION DRUGS

- *We* will pay for generic prescription drugs and dressings which are prescribed by a *medical practitioner* on an *inpatient*, *daypatient* or *outpatient* basis.
- *We* will only pay for branded or preferred prescription drugs if there is no generic available.

MATERNITY, CHILDBIRTH AND NEWBORN CARE

Important notes:

- A further 10% *coinsurance* applies to routine childbirth. For example, if *you* have chosen a 20% *coinsurance* on *your* plan, *you* will pay 30% *coinsurance*, subject to the *out of pocket maximum*.
- *USA in-network provider* only.
  We will only pay for maternity and childbirth, including pre-natal and post-natal care if it takes place in a *Cigna* network of *hospitals*, *medical practitioners* or *clinics*. There may be occasions when it is not reasonably possible for *treatment* to be provided by a *Cigna* network *hospital*, *medical practitioner* or *clinic*. In these cases, *we* will not apply the out of network *coinsurance*. Examples include, but are not limited to; when there is no *Cigna* network *hospital*, *medical practitioner* or *clinic* within 30 miles/50 kilometres of the *beneficiary's* home address; or when the *treatment* the *beneficiary* needs is not available from a local *Cigna* network *hospital*, *medical practitioner* or *clinic*.

Paid in full after applicable *deductible* and *coinsurance* payments are fulfilled

Routine maternity and childbirth cover

Inpatient and *daypatient treatment*, including *hospital* charges, obstetricians' and midwives' fees for routine maternity and childbirth.

We will pay for the following parent and baby care and *treatment*, on an *inpatient* or *daypatient* basis as appropriate:

- *hospital*, obstetricians' and midwives' fees for routine childbirth; and any fees as a result of post-natal care required by the mother immediately following routine childbirth.

We will not pay for surrogacy or any related *treatment*. *We* will not pay for *maternity benefit* care or *treatment* for a *beneficiary* acting as a surrogate or anyone acting as a surrogate for a *beneficiary*.

Benefits in connection with childbirth for the mother or newborn child are not restricted in any way for lengths of stay less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by caesarean section.

Pre-natal and post-natal care

- *We* will pay for *medically necessary* pre-natal and post-natal care on an *outpatient* basis. Examples of such *treatment* and tests include: routine obstetricians' and midwives' fees; all scheduled ultrasounds and examinations; prescribed medicines, drugs and dressings; routine pre-natal blood tests, if required; amniocentesis procedure (also referred to as amniotic fluid test or AFT) or chorionic villous sampling (also referred to as CVS); non-invasive pre-natal testing (NIPT) for high risk individuals; and any fees as a result of post-natal care required by the mother immediately following routine childbirth.

Complications from Maternity

- *We* will pay for *inpatient* or *outpatient treatment* relating to complications resulting from pregnancy or childbirth.

This is limited to conditions which can only arise as a direct result of pregnancy or childbirth, including miscarriage and ectopic pregnancy.

This part of the *policy* does not provide cover for home births.

We will only pay for a Caesarean section, where it is *medically necessary*.

We will not pay for surrogacy or any related *treatment*. *We* will not pay for *maternity benefit* care or *treatment* for a *beneficiary* acting as a surrogate or anyone acting as a surrogate for a *beneficiary*.

Homebirths

- *We* will pay midwives' and *specialists*' fees relating to routine home births if it is medically appropriate.

Please note that the Complications from maternity cover explained above does not include cover for home childbirth.

Newborn care

- Provided the newborn is added to the *policy*, *we* will pay for *treatment* within the first 90 days following birth.

Congenital conditions

- *We* will pay for *treatment* on an *inpatient* or *daypatient* basis for *congenital conditions*.

CANCER CARE

Paid in full after applicable *deductible* and *coinsurance* payments are fulfilled

- *We* will pay costs for the *treatment* of *cancer* if the *treatment* is considered by *us* to be *active treatment* and *evidence-based treatment*. This includes chemotherapy, radiotherapy, oncology, reconstructive *surgery*, *diagnostic tests* and drugs, whether the *beneficiary* is staying in a *hospital* overnight or receiving *treatment* as a *daypatient* or *outpatient*.

Important note

USA in-network provider only.
We will only pay for *Cancer treatment* if it takes place in a *Cigna* network of *hospitals*, *medical practitioners* or *clinics*. There may be occasions when it is not reasonably possible for *treatment* to be provided by an *in-network provider*. In these cases *we* will not apply the out of network *coinsurance*. Examples include, but are not limited to; when there is no *Cigna* network *hospital*, *medical practitioner* or *clinic* within 30 miles/50 kilometres of the *beneficiary's* home address; or when the *treatment* the *beneficiary* needs is not available from a local *Cigna* network *hospital*, *medical practitioner* or *clinic*.

MENTAL HEALTH AND ADDICTION TREATMENT AND CARE

Paid in full after applicable *deductible* and *coinsurance* payments are fulfilled

- *We* will pay for *treatment* of mental health conditions and disorders and addiction *treatment*, whether the *beneficiary* is staying in a *hospital* overnight or receiving *treatment* as a *daypatient* or on an *outpatient* basis.
- *We* will only pay for *evidence-based treatment* and *medically necessary treatment*.
- With regards to addiction *treatment*, *we* will pay for the diagnosis of addictions (including alcoholism); and a programme of addiction *treatment* at a *specialist* centre providing *evidence-based treatment*, if that *treatment* is *medically necessary* and recommended by a *medical practitioner*.
- *We* will pay for *detoxification treatment*. Any further *detoxification treatment* will be paid for if the *beneficiary* completes a formal *outpatient* course or programme of addiction *treatment*.
- *We* will only pay for *evidence-based treatment* and *medically necessary treatment*.

Important note

USA in-network provider only.
We will only pay for Mental Health and Addiction *treatment* and care in a *Cigna* network of *hospitals*, *medical practitioners* or *clinics*. There may be occasions when it is not reasonably possible for *treatment* to be provided by an *in-network provider*. In these cases, *we* will not apply the out of network *coinsurance*. Examples include, but are not limited to; when there is no *Cigna* network *hospital*, *medical practitioner* or *clinic* within 30 miles/50 kilometres of the *beneficiary's* home address; or when the *treatment* the *beneficiary* needs is not available from a local *Cigna* network *hospital*, *medical practitioner* or *clinic*.

KIDNEY DIALYSIS

Paid in full after applicable *deductible* and *coinsurance* payments are fulfilled

- *We* will pay for *treatment* for kidney dialysis on an *inpatient*, *daypatient*, or *outpatient* basis.
- *We* will also pay for kidney dialysis *treatment* outside the *beneficiary's country of habitual residence* on a *daypatient* basis. Travel and accommodation expenses incurred in connection with such *treatment* will not be covered.

Important note

USA in-network provider only.
We will only pay for kidney dialysis *treatment* if it takes place in a *Cigna* network of *hospitals*, *medical practitioners* or *clinics*. There may be occasions when it is not reasonably possible for *treatment* to be provided by an *in-network provider*. In these cases, *we* will not apply the out of network *coinsurance*. Examples include, but are not limited to; when there is no *Cigna* network *hospital*, *medical practitioner* or *clinic* within 30 miles/50 kilometres of the *beneficiary's* home address; or when the *treatment* the *beneficiary* needs is not available from a local *Cigna* network *hospital*, *medical practitioner* or *clinic*.

TRANSPLANT SERVICES FOR ORGAN, BONE MARROW AND STEM CELL TRANSPLANTS

Paid in full after applicable *deductible* and *coinsurance* payments are fulfilled

We will pay for *inpatient treatment* directly associated with an organ transplant, for the *beneficiary* if the transplant is *medically necessary*, and the organ to be transplanted has been donated by a member of the *beneficiary's* family or comes from a verified and legitimate source.

We will pay for anti-rejection medicines following a transplant, when they are given on an *inpatient* basis.

We will pay for *inpatient treatment* directly associated with a bone marrow or peripheral stem cell transplant if:

- the transplant is *medically necessary*; and
- the material to be transplanted is the *beneficiary's* own bone marrow or stem cells, or bone marrow taken from a verified and legitimate source.

We will not pay for bone marrow or peripheral stem cell transplants under this part of this *policy* if the transplants form part of *cancer treatment*. The cover which *we* provide in respect of *cancer treatment* is explained in other parts of this *policy*.

If a person donates bone marrow or an organ to a *beneficiary*, *we* will pay for:

- the harvesting of the organ or bone marrow;
- any *medically necessary* tissue matching tests or procedures;
- the donor's *hospital* costs; and
- any costs which are incurred if the donor experiences complications, for a period of 30 days after their procedure; whether or not the donor is covered by this *policy*.

The amount which *we* will pay towards a donor's medical costs will be reduced by the amount which is payable to them in relation to those costs under any other insurance *policy* or from any other source.

If a *beneficiary* donates an organ for a *medically necessary* transplant, *we* will cover the medical costs incurred by the *beneficiary* associated with this donation up to any *policy* limits. However, *we* will only pay for the harvesting of the donated organ if the intended recipient is also a *beneficiary* under this plan.

We will consider all *medically necessary* transplants. Other transplants (such as transplants which are considered to be experimental procedures) are not covered under this *policy*. This is because of conditions or limitations to coverage which are explained elsewhere in this *policy*.

Important note

A *beneficiary* must contact *us* and get approval in advance before they incur any costs relating to organ, bone marrow or stem cell donation or transplant.

WELLBEING AND PREVENTATIVE CARE PROGRAMME

No *deductible* or *coinsurance* apply to Wellbeing and Preventative Care *benefits*

We will pay for the following screenings, tests and examinations:

- Routine adult physical examinations (including but not limited to: height, weight, bloods, urinalysis, blood pressure, lung function etc.)
- Screening tests including;
  - Papanicolaou test (pap smear)
    - *We* will pay for one papanicolaou test (pap smear) for female *beneficiaries*.
  - Prostate examination
    - *We* will pay for one prostate examination (prostate specific antigen (PSA) test) for male *beneficiaries* aged 50 or over.
  - Mammograms for breast *cancer* screening
    - Aged 35-39: one baseline mammogram for asymptomatic women.
    - Aged 40-49: one mammogram for asymptomatic women every two years.
    - Aged 50 or older: one mammogram.
  - Bowel *cancer* screening
    - *We* will pay for one bowel *cancer* screening for *beneficiaries* aged 55 or older.
  - Bone density screening
    - *We* will pay for one scan to determine the density of the *beneficiary's* bones.
- Dietetic consultations.
  We will pay for up to 4 meetings with a dietician per *period of cover*.

We will pay for the following adult vaccinations and immunisations namely:

- Tetanus (once every 10 years); Hepatitis A; Hepatitis B; Meningitis; Rabies; Cholera; Yellow fever; Japanese encephalitis; Polio booster; Influenza; Varicella; Human papillomavirus (HPV) for females and males; Zoster; Measles; Mumps; Rubella (MMR); Pneumococcal 13-valent conjugate (PCV13); Pneumococcal polysaccharide (PPSV23); Haemophilus influenza type b (Hib); as well as Tetanus; Diphtheria; Pertussis (Td/Tdap); Typhoid; and Malaria (in tablet form, either daily or weekly).

We will pay for the following screenings, tests and counselling sessions:

- Abdominal aortic aneurysm screening: men;
- Alcohol misuse screening and counselling;
- Aspirin to prevent cardiovascular disease: men;
- Cholesterol abnormalities screening: men 35 and older;
- Cholesterol abnormalities screening: men younger than 35;
- Cholesterol abnormalities screening: women 45 and older;
- Cholesterol abnormalities screening: women younger than 45;
- Depression screening: adults;
- Diabetes screening;
- Falls prevention in older adults: exercise or physical therapy;
- Falls prevention in older adults: vitamin D;
- Gestational diabetes mellitus screening;
- Healthy diet and physical activity counselling to prevent cardiovascular disease: adults with cardiovascular risk factors;
- Hepatitis B screening: non pregnant adolescents and adults;
- Hepatitis B screening: pregnant women;
- Hepatitis C virus infection screening: adults;
- HIV screening: non pregnant adolescents and adults;
- HIV screening: pregnant women;
- Lung *cancer* screening;
- Obesity screening and counselling: adults;
- Sexually transmitted infections counselling;
- Skin *cancer* behavioural counselling;
- Tobacco use counselling and interventions: non pregnant adults;
- Tobacco use interventions: children and adolescents;

WELLBEING AND PREVENTATIVE CARE PROGRAMME (CONTINUED)

No *deductible* or *coinsurance* apply to Wellbeing and Preventative Care *benefits*

We will also pay for the following services for female *beneficiaries*:

- Aspirin to prevent cardiovascular disease: women;
- Anaemia screening: pregnant women;
- Bacteriuria screening: pregnant women;
- BRCA risk assessment and genetic counselling/testing;
- Breast *cancer* preventative medications;
- BRCA risk assessment and genetic counselling/testing;
- Breast *cancer* preventative medications;
- Breastfeeding support, supplies, and counselling;
- Chlamydia screening: women;
- All FDA-approved contraceptive methods, sterilization procedures, and patient education and counselling for all women with reproductive capacity;
- Counselling for sexually transmitted infections;
- Counselling and screening for human immune-deficiency virus;
- Gonorrhea screening: women;
- Human papillomavirus testing;
- Intimate partner violence screening: women of childbearing age;
- Preeclampsia prevention: aspirin;
- Rh incompatibility screening: first pregnancy visit;
- Rh incompatibility screening: 24-28 weeks' gestation;
- Screening for gestational diabetes;
- Screening and counselling for interpersonal and domestic violence.
- Tobacco use counselling: pregnant women;
- Syphilis screening: non pregnant persons; and,
- Syphilis screening: pregnant women;

as determined by the US Preventive Task Force. https://www.healthcare.gov/coverage/preventive-care-benefits

Online health education, health assessments and web-based coaching programmes:

- Access to *our* health and wellbeing section is available in *your* secure online Customer Area.

REHABILITATION, HABILITATION AND OTHER THERAPIES

We will pay for the following *treatments* and care on an *inpatient*, *daypatient* or *outpatient* basis, where appropriate:

Paid in full after applicable *deductible* and *coinsurance* payments are fulfilled

Rehabilitation treatment

- *We* will pay for *rehabilitation treatment* in a skilled nursing facility that is recommended by a *specialist* and is *medically necessary* after a traumatic event such as a stroke or spinal *injury*. This includes up to 30 days accommodation and living costs, for each separate condition which requires *rehabilitation treatment*.
- If the *rehabilitation treatment* is required following an orthopaedic, spinal or neurological event, *we* will, subject to prior approval being obtained prior to the commencement of any *treatment*, pay for *rehabilitation treatment* for more than 30 days, if further *treatment* is *medically necessary* and is recommended by the treating *specialist*.
- *We* will only pay for *rehabilitation treatment* if it is needed after, or as a result of, *treatment* which is covered by this *policy*; and it begins within 30 days of the end of that original *treatment*.
- All *rehabilitation treatment* must be approved by *us* in advance. *We* will only approve *rehabilitation treatment* if the treating *specialist* provides *us* with a report, explaining:
  - how long the *beneficiary* will need to stay in *hospital*;
  - the diagnosis; and
  - the *treatment* which the *beneficiary* has received, or needs to receive.

Habilitative *treatment*

- *We* will pay for habilitiative *treatment* which is *medically necessary* and assists an individual in partially or fully acquiring or improving skills and functioning and that are necessary to address a health condition.

Respiratory therapy

- *We* will pay for the *treatment* of respiratory illness and/or disease by use of inhaled oxygen and/or medication if the equipment used is necessary to allow adequate oxygen to be delivered to the lungs in an effort to appropriately oxygenate the *beneficiary's* blood on an *inpatient*, *daypatient* or *outpatient* basis.

Home nursing

We will pay for a *beneficiary* to have up to 30 days of *home nursing* care per *period of cover* if:

- it is recommended by a *specialist* following *inpatient* or *daypatient treatment* which is covered by this *policy*;
- it starts immediately after the beneficiary leaves *hospital*; and
- it reduces the length of time for which the *beneficiary* needs to stay in *hospital*.

Important note

We will only pay for *home nursing* if it is provided in the *beneficiary's* home by a qualified nurse and it comprises *medically necessary* care that would normally be provided in a *hospital*. *We* will not pay for *home nursing* which only provides non-medical care or personal assistance.

Hospice and *palliative care*

- If a *beneficiary* is given a terminal diagnosis, and there is no available *treatment* which will be effective in aiding recovery, *we* will pay for *hospital* or hospice care and accommodation, nursing care, prescribed medicines, and physical and psychological care. *We* will also pay for up to 12 bereavement counselling sessions for *beneficiaries* during the 12 months following the death of a terminally ill family member.

Prosthetics, devices and appliances

Internal prosthetic devices/*surgical and medical appliances*

We will pay for internal prosthetic implants, devices or appliances which are put in place during *surgery* as part of a *beneficiary's treatment*.

External prosthetic devices/*surgical and medical appliances*

We will pay for external prosthetics, devices or appliances which are necessary as part of a beneficiary's *treatment* (subject to the limitations explained below).

We will pay for:

- a prosthetic device or appliance which is a necessary part of the *treatment* immediately following *surgery* for as long as is required by *medical necessity*;
- a prosthetic device or appliance which is *medically necessary* and is part of the recuperation process on a *short-term* basis.

We will pay for an external prosthetic device:

- By an external 'prosthetic device', *we* mean an external artificial body part, such as a prosthetic limb or prosthetic hand which is *medically necessary*.

We will pay for replacement prosthetic devices if they are necessary due to wear, or a change in the *beneficiary's* condition which makes a new appliance necessary.

Rental of durable medical equipment

We will pay for the rental of durable medical equipment if the use of that equipment is recommended by a *specialist* in order to support the *beneficiary's treatment*.

We will only pay for the rental of durable medical equipment which:

- is not disposable, and is capable of being used more than once;
- serves a medical purpose;
- is fit for use in the home; and
- is of a type only normally used by a person who is suffering from the effect of a disease, illness or *injury*.

CHILD DENTAL, VISION AND HEARING CARE AND; CHILD WELLNESS AND PREVENTATIVE CARE SERVICES

We will pay for the following *benefits* for all children aged 21 years and younger, in accordance with the Health Resources and Services Administration (HRSA) and required services for children. If a *beneficiary* reaches their 22nd birthday during the *policy* year, the *benefits* will be paid up until the end of the *policy* year.

Paid in full after applicable *deductible* and *coinsurance* payments are fulfilled

Child Dental care

A complete list of all the *dental treatments* covered under this *benefit* can be found on page 44 of this *Customer Guide*.

We will pay for the following categories of *dental treatment* for *beneficiaries* aged 21 years or younger. No waiting periods apply to these services.

- General services;
- Diagnostic and *treatment* services;
- Preventative services;
- Minor restorative services;
- Endodontic services;
- Periodontal services;
- Prosthodontic services;
- Orthodontic services;
- Oral *surgery*;
- Major restorative services.

Important notes

- A 50% refund applies per claim for all Prosthodontic *treatment*.
- A 50% refund applies per claim for all Orthodontic *treatment*.

  We will only pay for orthodontic *treatment* if:
  - the *dentist* or orthodontist who is going to provide the *treatment* provides *us*, in advance, with a detailed description of the proposed *treatment* (including X-rays and models), and an estimate of the cost of *treatment*; and *we* have approved the *treatment* in advance.

  Treatment excludes:
  - repair of damaged orthodontic appliances.
  - replacement of lost or missing appliance.
  - services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth *rehabilitation*, and restoration for misalignment of teeth.

  ***In-network provider* only.**

  We will only pay for orthodontic *treatment* if it takes place in a *Cigna* network of *hospitals*, *medical practitioners* or *clinics*. There may be occasions when it is not reasonably possible for *treatment* to be provided by an *in-network provider*. In these cases, *we* will not apply the out of network *coinsurance*. Examples include, but are not limited to; when there is no *Cigna* network *hospital*, *medical practitioner* or *clinic* within 30 miles/50 kilometres of the *beneficiary's* home address; or when the *treatment* the *beneficiary* needs is not available from a local *Cigna* network *hospital*, *medical practitioner* or *clinic*.

Child Vision and Hearing care

One eye test and hearing test for children aged 21 or younger.

We will pay for an eye exam once a year with dilation and a routine ophthalmologic exam with refraction.

We will also pay for:

- glass/plastic lenses including single, bi-focal, tri-focal, and lenticular lenses;
- contact lenses in lieu of glass/plastic lenses;
- spectacle frames;
- fashion and gradient tinting;
- oversized glass-grey #3 prescription sunglasses;
- polycarbonate prescription lenses with scratch resistance coating; and
- other items to address low vision.

Important note

USA in-network provider only.
We will only pay for spectacle frames, lenses and contacts on an *in-network provider* only basis. There may be occasions when it is not reasonably possible for *treatment* to be provided by a *Cigna* network *hospital*, *medical practitioner* or *clinic*. In these cases, *we* will not apply the out of network *coinsurance*. Examples include, but are not limited to; when there is no *Cigna* network *hospital*, *medical practitioner* or *clinic* within 30 miles/50 kilometres of the *beneficiary's* home address; or when the *treatment* the *beneficiary* needs is not available from a local *Cigna* network *hospital*, *medical practitioner* or *clinic*.

Child Immunisations

Important note
No *coinsurance* or *deductible* applies to this *benefit*.

- *We* will pay for the following immunisations for *beneficiaries* aged 21 or younger, in accordance with the Advisory Committee on Immunization Practices (ACIP), including:
  - DPT (diphtheria, pertussis and tetanus); MMR (measles, mumps and rubella); HiB (haemophilus influenza type b); Polio; Influenza; Hepatitis B; Rotavirus; Pneumococcal 13-valent conjugate (PCV13); Pneumococcal polysaccharide (PPSV23); Varicella; Hepatitis A; Meningitis and Human papilloma virus (HPV).

Well Child tests

Important note
No *coinsurance* or *deductible* applies to this *benefit*.

We will pay for well child routine tests and for a *medical practitioner* to provide preventative care in in accordance with the Health Resources and Services Administration (HRSA) and the guidelines as set out by the American Academy of Paediatrics (AAP) and Bright Futures.

We will pay for the following screenings, tests and assessments for *beneficiaries* up to age 21 years:-

- Evaluating medical history;
- Physical examinations;
- Development assessment;
- Anticipatory guidance;
- Appropriate immunisations and laboratory tests;
- One school entry health check, to assess growth, hearing and vision, for each child;
- Diabetic retinopathy screening for children who have diabetes;
- Measurements of Length/Height and Weight, Head Circumference, Weight for Length, Body Mass Index, and Blood Pressure;
- Sensory screening (risk assessment for vision and hearing);
- Behavioural Assessments of Psychosocial/Behavioural Assessment;
- Alcohol and Drug Use Assessment, and Depression Screening;
- Newborn Blood Screening;
- Critical Congenital Heart Defect Screening;
- Hematocrit or Hemoglobin;
- Lead Screening;
- Tuberculosis Testing;
- Dyslipidemia Screening;
- STI/HIV Screening;
- Cervical Dysplasia Screening;
- Oral Health;
- Obesity screening and counselling: children;
- Phenylketonuria screening: newborns;
- Dental caries prevention: infants and children up to age 5 years;
- Hemoglobinopathies screening: newborns;
- Iron supplementation in children; and
- Phenylketonuria screening: newborns.

Hospital accommodation for a parent or guardian

- If a *beneficiary* who is aged 21 years or younger needs *inpatient treatment* and has to stay in *hospital* overnight, *we* will also pay for hospital accommodation for a parent or legal guardian, if accommodation is available in the same *hospital*.
- *We* will only pay for *hospital* accommodation for a parent or legal guardian if the *treatment* which the *beneficiary* is receiving during their stay in *hospital* is covered under this *policy*.

OPTIONAL BENEFITS

The following pages detail the optional benefits you may have chosen to add to your Core plan.

Build a plan that suits your unique needs.

Please note the optional *benefits* apply to all *beneficiaries* of the *policy*.

Important note: No *deductible* or *coinsurance* apply to the optional *benefits.*

INTERNATIONAL VISION AND DENTAL CARE

Our International Vision and Dental care covers a wide range of eye care and preventative, routine and major *dental treatments* for *beneficiaries* aged 22 years old and older.

VISION CARE

Eye examination

We will pay for one routine eye examination per *period of cover*, to be carried out by either an ophthalmologist or optometrist.

We will not pay for more than one eye examination in any one *period of cover*.

The *benefit* also includes expenses for:

- Spectacle lenses;
- Contact lenses;
- Spectacle frames;
- Prescription sunglasses;

when all are prescribed by an optometrist or ophthalmologist.

Important note

Expenses are paid up to a maximum of $310 per period of cover.

DENTAL TREATMENT

Important note: *We* will reduce the amount which *we* will pay for *dental treatment* by 20% if a *beneficiary* receives *treatment* at a *clinic* or *medical practitioner* that is not part of the *Cigna* network in the *USA*.

The annual overall benefit limit per beneficiary per period of cover is $5,500.

Paid in full up to the overall *benefit* limit

Preventative *dental treatment*

After the *beneficiary* has been covered on this option for 3 months, *we* will pay for the following preventative *dental treatment* recommended by a *dentist*:

- two dental check-ups per *period of cover*;
- X-rays, including bitewing, single view, and orthopantomogram (OPG);
- scaling and polishing including topical fluoride *application* when necessary (two per *period of cover*);
- one mouth guard per *period of cover*;
- one night guard per *period of cover*; and
- fissure sealant.

Routine *dental treatment*

After the *beneficiary* has been covered on this option for 3 months, *we* will pay *treatment* costs for the following routine *dental treatment* if that *treatment* is necessary for continued *oral health* and is recommended by a *dentist*:

- root canal *treatment*;
- extractions;
- surgical procedures;
- occasional *treatment*;
- anaesthetics; and
- periodontal *treatment*.

Major restorative *dental treatment*

After the *beneficiary* has been covered on this option for 12 months, *we* will pay *treatment* costs for the following major restorative *dental treatments*:

- dentures (acrylic/synthetic, metal and metal/acrylic);
- crowns;
- inlays; and
- placement of dental implants.

If a *beneficiary* needs major restorative *dental treatment* before they have had the International Vision and Dental care optional cover for 12 months, *we* will pay 50% of the *treatment* costs.

Other dental treatment

If a *beneficiary* requires a form of *dental treatment* which is not provided for in this *Customer Guide*, they may contact *us* (before the *treatment* is received) to enquire whether *we* will provide cover for that *treatment*. *We* will consider the request, and will decide, at *our* discretion:

- whether *we* will pay for the *treatment*;
- if so, whether *we* will pay all or part of the cost; and
- which of the areas of cover it will come within (for the purposes of calculating when limits of cover are reached).
- prior approval should be obtained before any *treatment* is received.

Dental exclusions

The following exclusions apply to *dental treatment*, in addition to those set out elsewhere in this *policy.*

We will not pay for:

- Purely *cosmetic treatments*, or other *treatments* which are not necessary for continued or improved *oral health*.
- The replacement of any dental appliance which is lost or stolen, or associated *treatment*.
- The replacement of a bridge, crown or denture which (in the reasonable opinion of a *dentist* of ordinary competence and skill in the *beneficiary's country of habitual residence*) is capable of being repaired and made usable.
- The replacement of a bridge, crown or denture within five years of its original fitting unless:
    - it has been damaged beyond repair, whilst in use, as a result of a *dental injury* suffered by the *beneficiary* whilst they are covered under this *policy*; or
    - the replacement is necessary because the *beneficiary* requires the extraction of a *sound natural tooth/teeth*; or
    - the replacement is necessary because of the placement of an original opposing full denture.
- Acrylic or porcelain veneers.
- Crowns or pontics on, or replacing, the upper and lower first, second and third molars unless:
    - they are constructed of either porcelain; bonded-to-metal or metal alone (for example, a gold alloy crown); or
    - a temporary crown or pontic is necessary as part of routine or emergency *dental treatment*.
- *Treatments*, procedures and materials which are experimental or do not meet generally accepted dental standards.
- *Treatment* for dental implants directly or indirectly related to:
    - failure of the implant to integrate;
    - breakdown of osseointegration;
    - peri-implantitis;
    - replacement of crowns, bridges or dentures; or
    - any accident or *emergency treatment* including for any prosthetic device.
- Advice relating to plaque control, oral hygiene and diet.
- Services and supplies, including but not limited to mouthwash, toothbrush and toothpaste.
- Medical *treatment* carried out in *hospital* by an oral *specialist* may be covered under the *Core plan* except when *dental treatment* is the reason for *you* being in *hospital*.
- Bite registration, precision or semi-precision attachments.
- Any *treatment*, procedure, appliance or restoration (except full dentures) if its main purpose is to:
    - change vertical dimensions; or
    - diagnose or treat conditions or dysfunction of the temporomandibular joint; or
    - stabilise periodontally involved teeth; or
    - restore occlusion.

INTERNATIONAL MEDICAL EVACUATION

International Medical Evacuation provides coverage for reasonable transportation costs to the nearest centre of medical excellence in the event that the *treatment* is not available locally in an emergency. This option also includes repatriation coverage. It also includes compassionate visits for a parent, *spouse*, partner, sibling or child to visit a *beneficiary* after an accident or sudden illness and the *beneficiary* has not been evacuated or repatriated.

Paid in full

Medical Evacuation

Transfer to the nearest centre of medical excellence if the *treatment* the *beneficiary* needs is not available locally in an emergency.

If a beneficiary requires *emergency treatment*, *we* will pay for medical evacuation for them:

- to be taken to the nearest *hospital* where the necessary *treatment* is available (even if this is in another part of the country, or in another country); and
- to return to the place they were taken from, provided the return journey takes place no more than 14 days after the *treatment* is completed.

As regards to the return journey, *we* will pay:

- the price of an economy class air ticket; or
- the reasonable cost of travel by land or sea; whichever is lesser.

We will only pay for taxi fares if:

- it is medically preferable for the *beneficiary* to travel to the airport by taxi, rather than by ambulance; and
- approval is obtained in advance from the *medical assistance service*.

We will pay for evacuation (but not repatriation) if the *beneficiary* needs *diagnostic tests* or *cancer treatment* (such as chemotherapy) if, in the opinion of *our medical assistance service*, evacuation is appropriate and *medically necessary* in the circumstances.

We will not pay any other costs related to an evacuation (such as accommodation costs).

Important note

If *you* require to return to the *hospital* where *you* were evacuated for follow up *treatment*, *we* will not pay for travel costs or living allowance costs.

Medical Repatriation

If a *beneficiary* requires a medical repatriation, *we* will pay:

- for them to be returned to their *country of habitual residence* or *country of nationality*; and
- to return them to the place they were taken from, provided the return journey takes place no more than 14 days after the *treatment* is completed.

The above journey must be approved in advance by *our medical assistance service* and to avoid doubt all transportation costs are required to be reasonable and customary.

As regards to the return journey, *we* will pay:

- the price of an economy class air ticket; or
- the reasonable cost of travel by land or sea; whichever is lesser.

We will only pay for taxi fares if:

- it is medically preferable for the *beneficiary* to travel to the airport by taxi, rather than by ambulance; and
- approval is obtained in advance from the *medical assistance service*.

We will not pay any other costs related to a repatriation (such as accommodation costs).

Important notes

- If *you* require to return to the *hospital* where *you* were repatriated for follow up *treatment*, *we* will not pay or travel costs or living allowance costs.
- If a *beneficiary* contacts the *medical assistance service* to ask for prior approval for repatriation, but the *medical assistance service* does not consider repatriation to be *medically appropriate*, *we* may instead arrange for the *beneficiary* to be evacuated to the nearest *hospital* where the necessary *treatment* is available. *We* will then repatriate the *beneficiary* to his or her specified *country of nationality* or *country of habitual residence* when his or her condition is stable, and it is *medically appropriate* to do so.

Repatriation of mortal remains

- If a *beneficiary* dies outside their *country of habitual residence* during the *period of cover*, the *medical assistance service* will arrange for their mortal remains to be returned to their *country of habitual residence* or *country of nationality* as soon as reasonably practicable, subject to airlines requirements and restrictions.
- *We* will not pay any costs associated with burial or cremation or the transport costs for someone to collect or accompany the *beneficiary's* mortal remains.

Travel costs for an accompanying person

If a *beneficiary* needs a parent, sibling, child, *spouse* or partner to travel with them on their journey in conjunction with a medical evacuation or repatriation, because they:

- need help getting on or off an aeroplane or other vehicle;
- are travelling 1000 miles (or 1600km) or further;
- are severely anxious or distressed, and are not being accompanied by a nurse, paramedic or other medical escort; or
- are very seriously ill or injured;

we will pay for a relative or partner to accompany them. The journeys (for the avoidance of doubt shall mean one outbound and one return) must be approved in advance by the *medical assistance service* and the return journey must take place not more than 14 days after the *treatment* is completed.

We will pay:

- the price of an economy class air ticket; or
- the reasonable cost of travel by land or sea; whichever is the lesser.

If it is appropriate, considering the *beneficiary's* medical requirements, the family member or partner who is accompanying them may travel in a different class.

If it is *medically necessary* for a *beneficiary* to be evacuated or repatriated, and they are going to be accompanied by their *spouse* or partner, *we* will also pay the reasonable travel costs of any children aged 17 or under, if those children would otherwise be left without a parent or guardian.

Important notes

- *We* will not pay for a third party to accompany a *beneficiary* if the original purpose of the evacuation was to enable the *beneficiary* to receive *outpatient treatment*.
- *We* will not pay for any other costs relating to third party travel costs, such as accommodation or local transportation.

If you have purchased this option, we will also make available the provision below for compassionate visits to you by immediate family members.

Compassionate visits - travel costs

Up to a maximum of 5 trips per lifetime.
Up to the maximum amount of $ 1,200 per period of cover.

Compassionate visits - living allowance costs

Up to the maximum amount of $155 per day for each visit with a maximum of 10 days per visit.

- For each *beneficiary we* will pay for up to 5 compassionate visits over the lifetime of the cover. Compassionate visits must be approved in advance by *our medical assistance service*.
- *We* will pay the cost of economy class return travel for a parent, *spouse*, partner, sibling or child to visit a *beneficiary* after an accident or sudden illness, if the *beneficiary* is in a different country and is anticipated to be hospitalised for five days or more, or has been given a *short-term* terminal prognosis.
- *We* will also pay for living expenses incurred by a family member during a compassionate visit, for up to 10 days per visit while they are away from their *country of habitual residence* up to the limits shown in the *list of benefits* (subject to being provided with receipts in respect of the costs incurred).

Important note

- *We* will not pay for a compassionate visit when the *beneficiary* has been evacuated or repatriated. If an evacuation or repatriation takes place during a compassionate visit, *we* will not pay any further third party transportation costs.

The following important notes and general conditions apply to all of the cover which is provided under the International Medical Evacuation option.

Important notes

The services described in this section are provided or arranged by the *medical assistance service* under this *policy*. The following conditions apply to both emergency medical evacuations and repatriations:

- All evacuations and repatriations must be approved in advance by the *medical assistance service*, which is contactable through the Customer Care Team;
- The *treatment* for which, or following which, the evacuation or repatriation is required must be recommended by a *qualified nurse* or *medical practitioner*;
- Evacuation and repatriation services are only available under this *policy* if the *beneficiary* is being treated (or needs to be treated) on an *inpatient* or *daypatient* basis;
- The *treatment* because of which the evacuation or repatriation service is required must:
  - be *treatment* for which the *beneficiary* is covered under this *policy*; and
  - not be available in the location from which the *beneficiary* is to be evacuated or repatriated;
  - the *beneficiary* must already have cover under the International Medical Evacuation option, before they need the evacuation or repatriation service.
- *We* will only pay for evacuation or repatriation services if all arrangements are approved in advance by *our medical assistance service*. Before that approval will be given, *we* must be provided with any information or proof that *we* may reasonably request;
- *We* will not approve or pay for an evacuation or repatriation if, in *our* reasonable opinion, it is not appropriate, or if it is against medical advice. In coming to a decision as to whether an evacuation or repatriation is appropriate, *we* will refer to established clinical and medical practice;
- From time to time *we* may carry out a review of this cover and reserve the right to contact *you* to obtain further information when it is reasonable for *us* to do so.

General conditions

- Where local conditions make it impossible, impractical, or unreasonably dangerous to enter an area, for example because of political instability or war, *we* may not be able to arrange evacuation or repatriation services. This *policy* does not guarantee that evacuation or repatriation services will always be available when requested, even if they are medically appropriate.
- *We* will only pay for *hospital* accommodation for as long as the *beneficiary* is being treated. *We* will not pay for *hospital* accommodation if a *beneficiary* is no longer being treated but is waiting for a return flight.
- Any medical *treatment* which a *beneficiary* receives before or after an evacuation or repatriation will be paid from the *Core plan* provided that the *treatment* is covered under this *policy*.
- *We* cannot be held liable for any delays or lack of availability of evacuation or repatriation services which result from adverse weather conditions, technical or mechanical problems, conditions or restrictions imposed by public authorities, or any other factor which is beyond *our* reasonable control.
- *We* will only pay for evacuation, repatriation and third party transportation if the *treatment* for which, or because of which, the evacuation or repatriation is necessary is covered under this *policy*.
- All decisions as to:
  - the *medical necessity* of evacuation or repatriation;
  - the means and timing of any evacuation or repatriation;
  - the medical equipment and medical personnel to be used; and
  - the destination to which the *beneficiary* should be transported;

  will be made by *our medical team*, after consultation with the *medical practitioners* who are treating the *beneficiary*, taking into account all of the relevant medical factors and considerations.

CHILD DENTAL CARE BENEFITS

The following tables are a complete list of the child *dental treatment*s that are covered under the Child Dental care *benefit* on page 33 of this *Customer Guide*. *We* will pay for the following services for *beneficiaries* aged 21 or younger:

TREATMENT

- Deep sedation/general anesthesia - first 30 minutes
- Deep sedation/general anesthesia - each additional 15 minutes
- Intravenous conscious sedation/analgesia - first 30 minutes
- Intravenous conscious sedation/analgesia - each additional 15 minutes
- Consultation (diagnostic service provided by *dentist* or physician other than practitioner providing *treatment*)
- Therapeutic drug injection, by report
- *Treatment* of complications (post-surgical) unusual circumstances, by report

BASIC

Diagnostic and *Treatment* Services

- Oral/Facial Photographic Images
- Diagnostic Models
- Periodic oral evaluation - Limited to 1 every 6 months
- Limited oral evaluation - problem focused - Limited to 1 every 6 months
- Comprehensive oral evaluation - Limited to 1 every 6 months*
- Comprehensive periodontal evaluation - Limited to 1 every 6 months*
- Intraoral – complete set of radiographic images including bitewings - 1 every 60 (sixty) months
- Intraoral - periapical radiographic image
- Intraoral - additional periapical image
- Intraoral - occlusal radiographic image
- Bitewing - single image - Children - 1 set every 6 months
- Bitewings - two images - Children - 1 set every 6 months
- Bitewings - four images - Children - 1 set every 6 months
- Vertical bitewings – 7 to 8 images - Children - 1 set every 6 months
- Panoramic radiographic image – 1 image every 60 (sixty) months
- Cephalometric radiographic image
- Interpretation of Diagnostic Image

PREVENTATIVE SERVICES

- Topical Fluoride - Varnish - Less than age 22 - 2 every 12 months
- Sealant - per tooth - unrestored permanent molars - Less than age 19. 1 sealant per tooth every 36 months
- Preventative resin restorations in a moderate to high caries risk patient - permanent tooth - 1 sealant per tooth every 36 months.
- Space maintainer – fixed – unilateral - Limited to children under age 19
- Space maintainer – fixed – bilateral - Limited to children under age 19
- Space maintainer - removable – unilateral - Limited to children under age 19
- Space maintainer - removable – bilateral - Limited to children under age 19
- Re-cementation of space maintainer - Limited to children under age 19
- Palliative *treatment* of dental pain – minor procedure
- Prophylaxis – Child - Limited to 1 every 6 months
- Topical application of fluoride (excluding prophylaxis) - Less than age 22 - 2 every 12 months

* A maximum of two evaluations a year for comprehensive evaluations

INTERMEDIATE

Minor Restorative Services

- Amalgam - one surface, primary or permanent
- Amalgam - two surfaces, primary or permanent
- Amalgam - three surfaces, primary or permanent
- Amalgam - four or more surfaces, primary or permanent
- Resin–based composite - one surface, anterior
- Resin-based composite - two surfaces, anterior
- Resin-based composite - three surfaces, anterior
- Resin-based composite - four or more surfaces or involving incisal angle (anterior)
- Protective Restoration
- Pin retention - per tooth, in addition to restoration
- Re-cement inlay
- Re-cement crown
- Prefabricated porcelain crown - primary - Limited to 1 every 60 months
- Prefabricated stainless steel crown - primary tooth – Under age 15 - Limited to 1 per tooth in 60 months
- Prefabricated stainless steel crown - permanent tooth - Under age 15 - Limited to 1 per tooth in 60 months

ENDODONTIC SERVICES

- Therapeutic pulpotomy (excluding final restoration) - If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and *benefits* are not payable separately.
- Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and *benefits* are not payable separately.
- Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration) - Limited to primary incisor teeth for members up to age 6 and for primary molars and cuspids up to age 11 and is limited to once per tooth per lifetime.
- Pulpal therapy (resorbable filling) - posterior, primary tooth excluding final restoration). Incomplete endodontic *treatment* when *you* discontinue *treatment*. Limited to primary incisor teeth for members up to age 6 and for primary molars and cuspids up to age 11 and is limited to once per tooth per lifetime.

ORAL SURGERY

- Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth
- Surgical access of an unerupted tooth
- Alveoloplasty in conjunction with extractions - per quadrant
- Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant
- Alveoloplasty not in conjunction with extractions - per quadrant
- Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant
- Removal of exostosis
- Incision and drainage of abscess - intraoral soft tissue
- Suture of recent small wounds up to 5 cm
- Excision of pericoronal gingiva
- Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
- Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth
- Removal of impacted tooth - soft tissue
- Removal of impacted tooth – partially bony
- Removal of impacted tooth - completely bony
- Removal of impacted tooth - completely bony with unusual surgical complications
- Surgical removal of residual tooth roots (cutting procedure)
- Coronectomy - intentional partial tooth removal
- Bone replacement graft for ridge preservation-per site

MAJOR

With respect to alternate benefits; if *we* determine a service less costly than the one performed by *your* dentist, *we* will pay *benefits* based upon the less costly services.

Major Restorative Services

- Detailed and extensive oral evaluation - problem focused, by report
- Onlay - metallic - two surfaces – Limited to 1 per tooth every 60 months
- Onlay - metallic - three surfaces – Limited to 1 per tooth every 60 months
- Onlay - metallic - four or more surfaces – Limited to 1 per tooth every 60 months
- Core buildup, including any pins – Limited to 1 per tooth every 60 months
- Inlay - metallic – one surface – An alternate *benefit* will be provided
- Inlay - metallic – two surfaces – An alternate *benefit* will be provided
- Inlay - metallic – three surfaces – An alternate *benefit* will be provided
- Crown - porcelain/ceramic substrate - Limited to 1 per tooth every 60 months
- Crown - porcelain fused to high noble metal - Limited to 1 per tooth every 60 months
- Crown - porcelain fused to predominately base metal – Limited to 1 per tooth every 60 months
- Crown - porcelain fused to noble metal – Limited to 1 per tooth every 60 months
- Crown - 3/4 cast high noble metal – Limited to 1 per tooth every 60 months
- Crown - 3/4 cast predominately base metal – Limited to 1 per tooth every 60 months
- Crown - 3/4 porcelain/ceramic – Limited to 1 per tooth every 60 months
- Crown - full cast high noble metal – Limited to 1 per tooth every 60 months
- Crown - full cast predominately base metal – Limited to 1 per tooth every 60 months
- Crown - full cast noble metal– Limited to 1 per tooth every 60 months
- Crown – titanium – Limited to 1 per tooth every 60 months
- Prefabricated post and core, in addition to crown – Limited to 1 per tooth every 60 months
- Crown repair, by report
- Inlay Repair
- Onlay Repair
- Veneer Repair
- Resin infiltration/smooth surface - Limited to 1 in 36 months

ENDODONTIC SERVICES

- Apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.)
- Apexification/recalcification – interim medication replacement (apical closure/calcific repair of perforations, rootresorption, etc.)
- Apexification/recalcification - final visit (includes completed root canal therapy, apical closure/calcific repair of perforations, root resorption, etc.)
- Pulpal regeneration (completion of regenerative *treatment* in an immature permanent tooth with a necrotic pulp) does not include final restoration
- Apicoectomy/periradicular *surgery* - anterior
- Apicoectomy/periradicular *surgery* - bicuspid (first root)
- Apicoectomy/periradicular *surgery* - molar (first root)
- Apicoectomy/periradicular *surgery* (each additional root)
- Root amputation - per root
- Hemisection (including any root removal) - not including root canal therapy
- Anterior root canal (excluding final restoration)
- Bicuspid root canal (excluding final restoration)
- Molar root canal (excluding final restoration)
- Retreatment of previous root canal therapy-anterior
- Retreatment of previous root canal therapy-bicuspid
- Retreatment of previous root canal therapy-molar

PERIODONTAL SERVICES

- Gingivectomy or gingivoplasty – four or more teeth - Limited to 1 every 36 months
- Gingivectomy or gingivoplasty – one to three teeth - Limited to 1 every 36 months
- Gingival flap procedure, four or more teeth – Limited to 1 every 36 months
- Clinical crown lengthening-hard tissue
- Osseous *surgery* (including flap entry and closure), four or more contiguous teeth or bounded teeth spaces per quadrant – Limited to 1 every 36 months
- Pedicle soft tissue graft procedure
- Free soft tissue graft procedure (including donor site *surgery*) 1st tooth
- Free soft tissue graft procedure (including donor site *surgery*)-additional teeth
- Subepithelial connective tissue graft procedures (including donor site *surgery*)
- Full mouth debridement to enable comprehensive evaluation and diagnosis – Limited to 1 per lifetime
- Gingivectomy or gingivoplasty - with restorative procedures, per tooth - Limited to 1 every 36 months
- Gingival flap procedure, including root planning - one to three contiguous teeth or tooth bounded spaces per quadrant – Limited to 1 every 36 months
- Osseous *surgery* (including flap entry and closure), one to three contiguous teeth or bounded teeth spaces per quadrant – Limited to 1 every 36 months
- Bone replacement graft - first site in quadrant - Limited to 1 every 36 months
- Soft tissue allograft - Limited to 1 every 36 months
- Periodontal scaling and root planning-four or more teeth per quadrant – Limited to 1 every 24 months
- Periodontal scaling and root planning-one to three teeth, per quadrant – Limited to 1 every 24 months
- Collect - Apply Autologous Product - Limited to 1 in 36 months

PROSTHODONTIC SERVICES

Note: An implant is a covered procedure of the plan only if determined to be a dental necessity. *Cigna* claim review is conducted by a panel of licensed *dentists* who review the clinical documentation submitted by *your* treating *dentist*. If the dental consultants determine an arch can be restored with a standard prosthesis or restoration, no *benefits* will be allowed for the individual implant or implant procedures. Only the second phase of *treatment* (the prosthodontic phase-placing of the implant crown, bridge denture or partial denture) may be subject to the alternate *benefit* provision of the plan.

All major prosthodonic services are combined under one replacement limitation under the plan. *Benefits* for prosthodonic services are combined and limited to one every 60 months. For example, if *benefits* for a partial denture are paid, this includes *benefits* to replace all missing teeth in the arch. No additional *benefits* for the arch would be considered until the 60 month replacement limit was met. When dental services that are subject to a frequency limitation were performed prior to *your* effective date of coverage the date of the prior service may be counted toward the time, frequency limitations and/or replacement limitations under this dental coverage.

- Implant Maintenance Procedures - 1 every 60 months
- Repair Implant Abutment - 1 every 60 months
- Implant Removal - 1 every 60 months
- Onlay – porcelain/ceramic – Limited to 1 every 60 months
- Onlay – metallic – three surfaces - 1 every 60 months
- Onlay – metallic – four or more surfaces - 1 every 60 months
- Complete denture - maxillary – Limited to 1 every 60 months
- Complete denture - mandibular – Limited to 1 every 60 months
- Immediate denture - maxillary – Limited to 1 every 60 months
- Immediate denture - mandibular – Limited to 1 every 60 months
- Maxillary partial denture - resin base (including any conventional clasps, rests and teeth) – Limited to 1 every 60 months
- Mandibular partial denture - resin base (including any conventional clasps, rests and teeth) – Limited to 1 every 60months
- Maxillary partial denture - cast metal framework with resin denture base (including any conventional clasps, rests and teeth) – Limited to 1 every 60 months
- Mandibular partial denture - cast metal framework with resin denture base (including any conventional clasps, rests and teeth) – Limited to 1 every 60 months
- Removable unilateral partial denture-one piece cast metal (including clasps and teeth) – Limited to 1 every 60 months
- Endosteal Implant - 1 every 60 months
- Surgical Placement of Interim Implant Body - 1 every 60 months
- Eposteal Implant – 1 every 60 months
- Transosteal Implant, Including Hardware – 1 every 60 months
- Implant supported complete denture

PROSTHODONTIC SERVICES (CONTINUED)

- Implant supported partial denture
- Connecting Bar – implant or abutment supported - 1 every 60 months
- Prefabricated Abutment – 1 every 60 months
- Custom Abutment - 1 every 60 months
- Abutment supported porcelain ceramic crown - 1 every 60 months
- Abutment supported porcelain fused to high noble metal - 1 every 60 months
- Abutment supported porcelain fused to predominately base metal crown - 1 every 60 months
- Abutment supported porcelain fused to noble metal crown - 1 every 60 months
- Abutment supported cast high noble metal crown - 1 every 60 months
- Abutment supported cast predominately base metal crown - 1 every 60 months
- Abutment supported cast noble metal crown - 1 every 60 months
- Implant supported porcelain/ceramic crown - 1 every 60 months
- Implant supported porcelain fused to high metal crown - 1 every 60 months
- Implant supported metal crown - 1 every 60 months
- Abutment supported retainer for porcelain/ceramic fixed partial denture - 1 every 60 months
- Abutment supported retainer for porcelain fused to high noble metal fixed partial denture - 1 every 60 months
- Abutment supported retainer for porcelain fused to predominately base metal fixed partial denture - 1 every 60 months
- Abutment supported retainer for porcelain fused to noble metal fixed partial denture - 1 every 60 months
- Abutment supported retainer for cast high noble metal fixed partial denture 1 every 60 months
- Abutment supported retainer for predominately base metal fixed partial denture - 1 every 60 months
- Implant supported retainer for ceramic fixed partial denture - 1 every 60 months
- Implant supported retainer for porcelain fused to high noble metal fixed partial denture - 1 every 60 months
- Implant supported retainer for cast metal fixed partial denture - 1 every 60 months
- Implant/abutment supported fixed partial denture for completely edentulous arch - 1 every 60 months
- Implant/abutment supported fixed partial denture for partially edentulous arch - 1 every 60 months
- Repair Implant Prosthesis -1 every 60 months
- Abutment supported retainer for cast noble metal fixed partial denture - 1 every 60 months
- Replacement of Semi-Precision or Precision Attachment -1 every 60 months
- Debridement periimplant defect, covered if implants are covered - Limited to 1 every 60 months
- Debridement and osseous periimpant defect, covered if implants are covered - Limited to 1 every 60 months
- Bone graft periimplant defect, covered if implants are covered
- Bone graft implant replacement, covered if implants are covered
- Implant Index - 1 every 60 months
- Pontic - cast high noble metal – Limited to 1 every 60 months
- Pontic - cast predominately base metal – Limited to 1 every 60 months
- Pontic - cast noble metal– Limited to 1 every 60 months
- Pontic – titanium – Limited to 1 every 60 months
- Pontic - porcelain fused to high noble metal – Limited to 1 every 60 months
- Pontic - porcelain fused to predominately base metal – Limited to 1 every 60 months
- Pontic - porcelain fused to noble metal – Limited to 1 every 60 months
- Pontic - porcelain/ceramic – Limited to 1 every 60 months
- Inlay – porcelain/ceramic – Limited to 1 every 60 months
- Inlay – metallic – two surfaces – Limited to 1 every 60 months
- Inlay – metallic – three or more surfaces - Limited to 1 every 60 months
- Onlay – metallic – three surfaces - 1 every 60 months
- Onlay – metallic – four or more surfaces -1 every 60 months
- Retainer - cast metal for resin bonded fixed prosthesis -1 every 60 months
- Retainer - porcelain/ceramic for resin bonded fixed prosthesis -1 every 60 months
- Crown - porcelain/ceramic - 1 every 60 months
- Crown - porcelain fused to high noble metal - 1 every 60 months
- Crown - porcelain fused to predominately base metal - 1 every 60 months
- Crown - porcelain fused to noble metal - 1 every 60 months
- Crown - 3/4 cast high noble metal - 1 every 60 months
- Crown - 3/4 cast predominately base metal - 1 every 60 months
- Crown - 3/4 cast noble metal - 1 every 60 months
- Crown - 3/4 porcelain/ceramic - 1 every 60 months

PROSTHODONTIC SERVICES (CONTINUED)

- Crown - full cast high noble metal - 1 every 60 months
- Crown - full cast predominately base metal - 1 every 60 months
- Crown - full cast noble metal - 1 every 60 months
- Occlusal guard, by report - 1 in 12 months for patients 13 and older
- Tissue conditioning (maxillary)
- Tissue conditioning (mandibular)
- Adjust complete denture – maxillary
- Adjust complete denture – mandibular
- Adjust partial denture – maxillary
- Adjust partial denture - mandibular
- Repair broken complete denture base
- Replace missing or broken teeth - complete denture (each tooth)
- Repair resin denture base
- Repair cast framework
- Repair or replace broken clasp
- Replace broken teeth - per tooth
- Add tooth to existing partial denture
- Add clasp to existing partial denture
- Rebase complete maxillary denture - Limited to 1 in a 36-month period 6 months after the initial installation
- Rebase maxillary partial denture - Limited to 1 in a 36-month period 6 months after the initial installation
- Rebase mandibular partial denture - Limited to 1 in a 36-month period 6 months after the initial installation
- Reline complete maxillary denture - Limited to 1 in a 36-month period 6 months after the initial installation
- Reline complete mandibular denture - Limited to 1 in a 36-month period 6 months after the initial installation
- Reline maxillary partial denture - Limited to 1in a 36-month period 6 months after the initial installation
- Reline mandibular partial denture - Limited to 1 in a 36-month period 6 months after the initial installation
- Reline complete maxillary denture (laboratory) - Limited to 1 in a 36-month period 6 months after the initialinstallation
- Reline complete mandibular denture (laboratory) - Limited to 1 in a 36-month period 6 months after the initial installation
- Reline maxillary partial denture (laboratory) - Limited to 1 in a 36-month period 6 months after the initial installation
- Reline mandibular partial denture (laboratory) Rebase/Reline - Limited to 1 in a 36-month period 6 months after the initial installation.
- Recement fixed partial denture
- Fixed partial denture repair, by report

NOTES

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Together, all the way.[SM]

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