MEDICAL, HOSPITAL AND DENTAL PLAN

FOR STAFF MEMBERS

AWAY FROM HEADQUARTERS

Version 01/07/2022

Cigna®

CONTENT

This document contains a general description of the medical cover provided by the United Nations to its staff members away from headquarters. Should you have any questions about an item that is not listed below or want additional information, please contact Cigna or consult your personal webpages which are accessible through www.cignahealthbenefits.com.

OUR SERVICES

24/7 Availability

You can reach us anytime, anywhere in your preferred language. If you want to know how to submit a claim or have any other questions, or in case of emergency, you can contact us by phone, e-mail, fax or postal service. Our contact details are mentioned on your (electronic) membership card and on your personal webpages and Cigna Health Benefits App.

New! We're always on the lookout for ways to reduce our impact on the environment, and meet the needs of our customers in an ever-evolving world. One of the ways we can do this is to change the way we issue our membership cards. As from 1 July 2022, we are making a progressive transition to electronic membership cards which have the same features and validity as the plastic card. We will no longer print new plastic cards by default. The quickest and easiest way to consult your electronic membership card is to use the Cigna Health Benefits app.

Our contact details

You can reach us 24 hours a day, 7 days a week, 365 days a year. In case of emergency or if you simply have a question, you can contact our multilingual staff in several ways. Our contact details are also mentioned on your personal webpages and on your (electronic) membership card.

	Antwerp office	Kuala Lumpur office	Sunrise office	Nairobi office
	www.cignahealthbenefits.com For claims: un.wwp@cigna.com For membership: clientservice1@cigna.com For guarantees of payment: admissions@cigna.com (or use the contact form on our personal webpages) Please mention your Cigna reference number in the email subject.			
	+ 32 3 217 68 42	+ 60 3 2178 05 55	+ 1 305 908 91 01	+32 3 217 68 42
	When you call us, we'll need your full name and date of birth. Please make sure you have your personal reference number ready as well.			
	Cigna P.O. Box 69 2140 Antwerpen Belgium	Cigna P.O. Box 10612 50718 Kuala Lumpur Malaysia	Cigna P.O. Box 451989 Sunrise, Florida 33345 USA	One Africa Place Westlands Waiyaki Way P.O Box 331-00606 Nairobi Kenya

Callback functionality and toll-free numbers

Did you know that the Contact section on your personal webpages and Cigna Health Benefits App has an automated call-back functionality? Just leave your number of choice and you will get an immediate call from a Cigna representative. Wherever feasible, you can also call us for free through a toll-free number. If there is no toll-free number available for your country of stay, you can use the UN dedicated phone number, which is also mentioned on your (electronic) membership card. You can find the full list of available toll-free numbers per country on your personal webpages.

Your personal webpages – Access to online information and services

All information regarding your plan is gathered on your personal webpages. Basically, everything you need to know is easily available in one place that is accessible at any time from anywhere in the world. Here you can also access our online services: you can search our worldwide health care provider network for a particular provider, download fillable forms and consult your settlement details.

Tip: We master all major languages in-house, so there is no need for you to translate any of the documents you wish to send us.

Access to quality health care at preferential rates

Wherever you are, you have access to our worldwide network of health care providers. We make sure you benefit from health care services at preferential rates. To find a provider that best suits your needs, search our provider list by location, type of facility and/or specialty on your personal webpages.

Free choice of health care provider

You have free choice of health care provider anywhere in the world. However, consulting a provider from our network can be beneficial to you, as we have negotiated advantageous rates with most of our providers. Your out-of-pocket expenses will be lower.

Let us pay your medical bills

By simply showing your (electronic) membership card upon admission to a hospital, you do not have to advance your medical expenses first and submit a claim for reimbursement afterwards. You will only have to pay the out-of-pocket expenses.

Prior approval: no surprises by notifying us in advance

For all non-emergency hospitalisations you must request prior approval by our medical consultant. By contacting us before a planned admission, you will benefit from our direct payment service and pre-negotiated prices. This means lower out-of-pocket expenses and no unpleasant surprises when you receive your medical bill.

Information on chronic diseases and possibility to contact our medical consultant

We help raise awareness about the risk of developing serious or chronic diseases like diabetes, cardiovascular disorders or cancer. If you would like personal advice, feel free to contact our medical consultant through your personal webpages.

Swift processing of your medical claims

As we have claims processing offices in three time zones, we can quickly process your queries and handle your claims.

Cigna Global Telehealth

Cigna's Global Telehealth service – available through the Cigna Wellbeing App – connects patients to licensed doctors around the world (by telephone or video) for non-emergency health issues. The service can be accessed 24 hours a day, seven days a week, and appointments with general practitioners are set within 48 hours. Within five days of the initial consultation, the general practitioner can schedule a follow-up consultation with a specialist, when and where appropriate.

The Cigna Wellbeing application can be downloaded for free from the App Store (IOS) and Google Play (Android).

The Global Telehealth doctor is assigned on the basis of the date, time and language preference in your time zone. Currently, video consultations are available in English and Spanish while telephonic consultations are available in English, Spanish, French, German, Portuguese, Mandarin Chinese, Japanese, Hindi and Arabic.

To ensure the shortest waiting period for appointments, a plan participant may be paired with a different doctor for each consultation. However, all doctors will be able to review notes from previous Global Telehealth consultations, allowing for a shared and comprehensive patient file, which provides consistency and ensures that all users receive optimal care.

How can Global Telehealth help you?

Global Telehealth doctors will listen to your specific concerns and provide clear advice and guidance on the best steps to take. You will be able to share documents, images and files to help explain your symptoms and condition. The doctors can also help you to understand the local health-care system. They'll tell you how to organize any potential upcoming doctor appointments.

What services are provided through Global Telehealth?

Global Telehealth provides access to clinical guidance from doctors by phone or video. You may:

- Access a trusted doctor, including specialists, for a medical consultation, even when based in a remote location
- Discuss pressing medical symptoms, such as a fever, a rash and aches and pains
- Receive a working diagnosis when enough medical information is available
- Discuss a medical report, test results or treatment plans
- Prepare for upcoming consultations, treatment and hospitalizations
- Get support for navigating the local health-care system
- Obtain referrals to in-network Cigna health-care providers

What if there is an emergency?

Cigna's Global Telehealth is not for medical emergencies. In those cases, patients are advised to reach out to their local emergency service.

YOUR COVERAGE

1. In general

Benefits	Description
Overall maximum	Maximum of 250,000 USD per person per calendar year
Aim	The plan covers reasonable and customary expenses of medical, hospital and dental treatment resulting from sickness, accident or maternity. The plan only reimburses treatment, supplies or other services that are widely and generally accepted as medically necessary and appropriate for the condition being treated, and when such treatment, supplies or other services are prescribed by a licensed, qualified medical professional. Cigna has the fiduciary duty and discretionary authority to determine, on behalf of the United Nations, what constitutes a benefit or a covered service under the programme. Additionally, the plan provides cover for some aspects of preventive care, see Summary of benefits.
Reasonable and customary	By 'reasonable and customary' is meant: fees and prices that are commonly charged for the treatment or purchase in question, taking into account the geographical area where the treatment is given or the item is purchased. Furthermore, the treatment or purchase must also be reasonable and customary from a medical point of view. This means, for example, that the number of treatment sessions/days of admission/dosage of medication should be medically justified. Any excesses in this regard will be limited to the reasonable and customary level.
Eligibility	The plan covers eligible staff members, former staff members en their dependants who reside in all parts of the world, except the United States of America. Staff members, former staff members and their dependants who reside in the United States of America are not eligible for Cigna coverage. The sole exception to this exclusion arises in the case of a dependent child attending school or university in the United States, who will be required by the educational institution to enrol in the health insurance it offers. In this case, the student's health insurance plan at the school or university will be primary and the Cigna coverage will be secondary. Staff members and dependants (including students not enrolled in school insurance) who do not meet the requirements stated above will be required to switch their insurance to a US-based plan.

Care in the USA	The procedure for medical treatment in the USA can be found on your personal webpages under My plan > Care in the USA. You should always refer to this page before seeking medical services in the USA.
Coordination of benefits	The plan does not reimburse the cost of services that have been, or are expected to be reimbursed under another insurance, social security or similar arrangement. For Plan members covered by two or more plans, the medical insurance plan coordinates benefits to ensure that the member receives as much coverage as possible but not in excess of the expenses incurred. Plan members are expected to inform Cigna when a claim can also be submitted to another insurer.
Currency of reimbursement	Claims will be reimbursed in USD by default. Upon request, reimbursement in other currencies is possible: - If expenses were incurred in that specific currency; - Provided that the payment can be made by bank transfer. The extended list of currencies is USD, EUR, AUD, CAD, CHF, CLP, DKK, EGP, GBP, HKD, INR, IDR, JOD, MAD, MYR, NZD, PHP, SEK, SGD, THB, TND, XAF and XOF. Only one payment currency per claim is possible. Since 1st July 2020: The list of available currencies is extended with AED, BHD, BOB, BRL, JPY, KWD, MMK, PKR, SSP and TJS.
Date of exchange rate	The rate of exchange used will be that of the UN, as applicable, on the date the expenses were incurred (date of service). Claims incurred in LBP for services rendered starting 1 June 2021 will be reimbursed in USD, converted at the exchange rate from SAYRAFA BDL (Central Bank) on the date of the service.
Validity of prescriptions	One year (even for prescriptions mentioning 'permanent use')
Claim submission deadline	All claims must reach Cigna within two years after the date on which the expenses were incurred.
Outpatient treatment/outpatient surgery/day case	Treatment given on an outpatient basis, where the date of admission is the same as the date of discharge.
Inpatient treatment/hospitalisation	Treatment given on an inpatient basis, where the date of admission differs from the date of discharge.
Insurance year	An insurance year is equal to a calendar year.
Prior approval	Prior approval from Cigna's medical consultant is required **for all non-emergency hospitalisations**. Prior approval means that reimbursement is guaranteed only in

	cases where our medical consultant grants his explicit approval for the treatment, on the basis of the medical justification, as well as a cost estimate furnished by the beneficiary at least one week prior to the planned admission. In case of a medical emergency, approval can be obtained *post factum*, on the basis of the same medical criteria. Other benefits that require prior approval Cigna's medical consultant include acupuncture, speech therapy, home health care, durable medical equipment or orthopaedic appliances, vitamins, minerals and food/nutritional supplements. If Plan members don't comply with this requirement, they run the risk of having their claim denied.
Appeals process	**First-level appeal** • Review of a benefit determination needs to be requested from Cigna through the regular communication channels (see Our contact details) within 60 days following receipt of the corresponding settlement note. Plan members are encouraged to submit any additional information that can support their appeal. Cigna will review and make a decision within 60 days following receipt of the appeal request, except if special circumstances require an extension of time. The review is based on the following parameters: - Applicable plan design or contract language; - Claims and utilization management guidelines and policies; - Relevant medical and dental records; In case the appeal is denied, Cigna will send the Plan member a written notice that includes all specific reasons for the denial. **Second-level appeal: external review** • If the claim dispute remains open after the first-level appeal and the value of the disputed claim is at least 500 USD, a review by an external arbitrator may be requested within 60 days following receipt of the denial of the first-level appeal. • The external review will be performed by an independent medical expert designated jointly by Cigna's Medical consultant and the Plan member's attending physician. The decision made by this arbitrator shall be considered final and shall be binding on both parties to the dispute. • Each party shall pay its own medical doctor. The cost of arbitration and fees payable to the medical arbitrator shall be borne half by the plan member and half by the plan except where the arbitrator settles the dispute in favour of the Plan member, in which case the fees will be payable solely by the plan.

2. Reimbursement rates: Basic (BMIP) and Major Medical Benefits Plan (MMBP)

The UN health plan provides for 2 levels of cover, namely BMIP (= Basic Medical Insurance Plan) and MMBP (= Major Medical Benefits Plan) **in two different geographic areas, namely the USA and the rest of the world**. Both the BMIP and the MMBP cover periods run from 1 January until 31 December.

2.1. Countries other than the USA

For services received in countries other than the USA, the major medical component does not apply for dental treatment, treatment for substance abuse (alcohol and/or drug), expenses for hearing aids, or expenses for optical lenses, nor does MMBP apply for costs that are reimbursed at 100% under BMIP (e.g. other hospital expenses and hospital stay), as there is no balance left on these charges. Expenses that are subject to a maximum reimbursement (e.g. dental care, optical care, etc.) are not subject to a reimbursement under the MMBP component. Also, expenses that are not reasonable and customary are not counted towards the co-payment.

The MMBP covers 80% of the difference between the accepted costs and the amount reimbursed under the BMIP. In order to be entitled to any reimbursement under the MMBP, a calendar year maximum co-payment of 200 USD per plan member or 600 USD per family has to be reached. All payments under the MMBP are applied automatically and do not need to be applied by the UN Staff Member.

Please note that the calendar year maximum co-payment is sometimes also called the out-of-pocket (OOP) maximum.
Example: The following example illustrates reimbursement in respect of BMIP and MMBP **for countries other than the USA**:

Doctor's fees	**5,600 USD**
Reimbursement under BMIP (at 80%) (1)	**4,480 USD**
Residual (20%) = Basis for MMBP	1,120 USD
Calendar year maximum co-pay	-200 USD
Basis for MMBP after application of co-pay	920 USD
Reimbursement under MMBP (at 80%) (2)	**736 USD**
Total reimbursed (1)+(2)	**5,216 USD**
Patient's own out-of-pocket expenses	**384 USD**

2.2. In the USA

2.2.1. Prior Approval

For treatment in the US, prior approval is required for all planned or non-emergency treatments.

2.2.2. What does prior approval mean and how does it work?

Prior approval means that you are requested to contact Cigna before you will receive the necessary medical care. Cigna's medical consultant will then evaluate and assess your request. Approval for care in the US will solely be given if the medical care can only be rendered in the US. If this is not the case, Cigna will provide prior approval for the treatment at the duty station or a country near to the duty station where the necessary medical care is available.

Note:
prior approval also applies for an insured who already finds himself/herself in the United States, after travelling from his duty station or country of residence. Only in case of emergency hospitalisations and treatments incurred in or outside of the United States, prior approval is not obligatory. Cigna's medical consultant will consider a "medical emergency" as hospitalisation and medical treatments, including follow-up visits, which are undertaken due to an unplanned, sudden and acute illness or injury and which, for medical reasons, cannot be delayed or postponed. In the case of a woman who goes into labour after her 32nd week of pregnancy, the delivery and care rendered to the new-born child in the US will not be considered a medical emergency as it relates to the pre-approval requirement for care in the United States.

2.2.3. If prior approval can be given or if it concerns medical care for which prior approval is not required, the following benefits will be applied :

A deductible of 5,000 USD per insured person or 15,000 USD per family per calendar year has to be met before any reimbursement is made under the programme. The programme will reimburse 80% of all medically necessary treatment under the BMIP and the participant will pay the 20% residual cost after the deductible is met.

Only in case the treatment follows a medical emergency in the USA, the MMBP will reimburse an additional 80% of the participant's 20% share. In case of medical emergency, no deductible will apply. However, the participant's total out-of-pocket cost (the 20% share) is 2,200 USD, or 6,600 USD for the family, before the MMBP kicks in.

Example 1: The following example illustrates how reimbursement is determined for an individual in respect of basic coverage (figures are in United States dollars), under the condition that the treatment doesn't follow a medical emergency in the USA.

Doctor's fees	**9,600 USD**
Deductible	- **5,000** USD
Basis for BMIP	= 4,600 USD
Total reimbursed (at 80%)	**3,680 USD**
Patient's own out-of-pocket expenses	**5,920 USD**

The deductible of 5.000 USD per person (or 15.000 USD per family) will NOT apply in the following cases:

- outpatient treatments subject to a monetary ceiling: optical care, dental care, hearing aids and routine physical exams;
- medical emergency in the USA.

Example 2: The following example illustrates how reimbursement is determined for an individual in respect of basic and major coverage (figures are in United States dollars), under the condition that it concerns a medical emergency in the USA.

Doctor's fees	**15,600 USD**
Basis for BMIP	= 15,600 USD
Reimbursement under BMIP (at 80%) (1)	**12,480 USD**
Residual (20%) = Basis for MMBP	3,120 USD
Out-of-pocket maximum	- 2,200 USD
Basis for MMBP after application of OOP	= 920 USD
Reimbursement under MMBP (at 80%) (2)	**736 USD**
Total reimbursed (1)+(2)	**13,216 USD**
Patient's own out-of-pocket expenses	**2,384 USD**

Note!
Emergency care rendered to a newborn, following a non-emergency delivery in USA, will be subject to all restrictions and limitations of planned care.

3. Summary of benefits

3.1. In the hospital

GENERAL RULE

All treatments and medicines must be prescribed by a qualified and registered medical doctor. The items below are reimbursed at 80% + Major Medical Benefits Plan (MMBP), unless indicated otherwise in the remarks.

Item	Remarks
Prior approval from Cigna's medical consultant is required for all non-emergency hospitalisations. Notification of such hospitalisations should be given at least 1 week prior to the admission date.	

Bed and board
(Western Europe, including Cyprus))
	• Standard semi-private room or ward: 100% up to 900 USD per day
	• Private room: 100% of semi-private room rate up to 900 USD per day
	  • Note: 100% of a private room is exceptionally reimbursable up to 900 USD:
	  • When the hospital does not have semi-private accommodation (only private rooms and general wards);
	  • If there is a medical necessity for a private room;
	  • In case of medical emergency and no semi-private room is available;
	  • If the patient is obliged to stay in a private room as a foreigner.
	
	Note: Western Europe includes Andorra, Austria, Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Luxembourg, Malta, the Netherlands, Norway, Portugal, Spain, Sweden, Switzerland and the United Kingdom of Great Britain and Northern Ireland.
	
	Note: Bed and board encompasses the following charges (non-exhaustive list): room charges, general nursing services provided in the hospital (cost of the nurses, taxes, other), meals, cleaning, etc.

Bed and board (Western Turkey)	Standard private, semi-private room or ward: 100% up to **450 USD** per day Note: Bed and board encompasses the following charges (non-exhaustive list): room charges, general nursing services provided in the hospital (cost of the nurses, taxes, other), meals, cleaning, etc.

Item	Remarks
Bed and board (remainder of Turkey)	Standard private, semi-private room or ward: 100% up to **450 USD** per day Note: Bed and board encompasses the following charges (non-exhaustive list): room charges, general nursing services provided in the hospital (cost of the nurses, taxes, other), meals, cleaning, etc.
Bed and board (Argentina, South Africa and United Arab Emirates)	Standard private, semi-private room or ward: 100% up to **450 USD** per day Note: Bed and board encompasses the following charges (non-exhaustive list): room charges, general nursing services provided in the hospital (cost of the nurses, taxes, other), meals, cleaning, etc.
Bed and board (Chile and Mexico)	Standard private, semi-private room or ward: 100% up to **450 USD** per day Note: Bed and board encompasses the following charges (non-exhaustive list): room charges, general nursing services provided in the hospital (cost of the nurses, taxes, other), meals, cleaning, etc.

Bed and board
(Australia)
	• Standard semi-private room or ward: 100% up to **900 USD** per day
	• Private room: 100% of semi-private room rate up to **900 USD** per day
	Note: 100% of a private room is exceptionally reimbursable up to 900 USD:
	  • When the hospital does not have semi-private accommodation (only private rooms and general wards);
	  • If there is a medical necessity for a private room;
	  • In case of medical emergency and no semi-private room is available;
	  • If the patient is obliged to stay in a private room as a foreigner.
	
	Note: Bed and board encompasses the following charges (non-exhaustive list): room charges, general nursing services provided in the hospital (cost of the nurses, taxes, other), meals, cleaning, etc.

Bed and board (Canada and Israel)	• Standard semi-private room or ward: 100% up to **750 USD** per day • Private room: 100% of semi-private room rate up to **750 USD** per day Note: 100% of a private room is exceptionally reimbursable up to 750 USD: • When the hospital does not have semi-private

Item	Remarks
	accommodation (only private rooms and general wards); • If there is a medical necessity for a private room; • In case of medical emergency and no semi-private room is available; • If the patient is obliged to stay in a private room as a foreigner. Note: Bed and board encompasses the following charges (non-exhaustive list): room charges, general nursing services provided in the hospital (cost of the nurses, taxes, other), meals, cleaning, etc.
Bed and board (New Zealand)	• Standard semi-private room or ward: 100% up to **750 USD** per day • Private room: 100% of semi-private room rate up to **750 USD** per day Note: 100% of a private room is exceptionally reimbursable up to 750 USD: • When the hospital does not have semi-private accommodation (only private rooms and general wards); • If there is a medical necessity for a private room; • In case of medical emergency and no semi-private room is available; • If the patient is obliged to stay in a private room as a foreigner. Note: Bed and board encompasses the following charges (non-exhaustive list): room charges, general nursing services provided in the hospital (cost of the nurses, taxes, other), meals, cleaning, etc.
Bed and board (USA)	• Standard semi-private room or ward: 100% up to **600 USD** per day • Private room: 100% of semi-private room rate up to **600 USD** per day Note: 100% of a private room is exceptionally reimbursable up to 600 USD: • When the hospital does not have semi-private accommodation (only private rooms and general wards); • If there is a medical necessity for a private room; • In case of medical emergency and no semi-private room is available; • If the patient is obliged to stay in a private room as a foreigner. Note: For admissions in the United States the 600 USD limit does not apply in three specific circumstances: • Medical evacuation approved by the UN Medical

Item	Remarks
	Director; • A medical emergency arising while in the USA; • Necessary treatment can only be given at a hospital in which the daily semi-private room rate exceeds 600 USD (Prior approval is required). Note: Bed and board encompasses the following charges (non-exhaustive list): room charges, general nursing services provided in the hospital (cost of the nurses, taxes, other), meals, cleaning, etc.
Bed and board (in the rest of the world)	Standard private, semi-private room or ward: 100% up to **330 USD** per day Note: Bed and board encompasses the following charges (non-exhaustive list): room charges, general nursing services provided in the hospital (cost of the nurses, taxes, other), meals, cleaning, etc.
Stay in the Intensive Care Unit (ICU)	100%
Doctor's fees (surgeon, treating physician, assistant, anaesthetist, midwife)	80% + MMBP
Other hospital expenses (e.g. use of operating theatre and equipment, lab, x-rays, medication for use during the hospital admission)	100%
All-in or package prices	In case the hospital cannot provide a detailed invoice listing separately the bed & board charges, doctors' fees and other hospital expenses, the bill will be split up in: - 40% bed & board expenses (reimbursable at 100% and no ceiling will be applied) - 40% other hospital expenses (reimbursable at 100%) - 20% doctor's fees (reimbursable at 80% + MMBP)
Accompanying person	Not covered, except when the patient is under the age of 12 or when it is required by local legislation.
Outpatient surgery	• Doctor's fees: 80% + MMBP • Other hospital expenses: 100%
Chemotherapy, radiotherapy, haemodialysis, etc.	• Doctor's fees: 80% + MMBP • Other hospital expenses: 100%

Item	Remarks
Specific admissions/surgeries	
Admission related to alcohol and drug abuse	Covered if medically necessary and preauthorized. Detailed benefits: see Bed and board, Other hospital expenses and Doctor's fees
Fertility treatment: • Artificial Insemination (AI); • Intra-Uterine Insemination (IUI); • Micro-Epididymal Sperm Aspiration (MESA); • Percutaneous Epididymal Sperm Aspiration (PESA); • TEsticular Sperm Aspiration (TESA); • TEsticular Sperm Extraction (TESE). • In Vitro Fertilisation (IVF)	Prior approval is required. If medically necessary, a total of 3 attempts per lifetime is covered and **only for women up to 45 years of age (<45 year when treatment is started)**
Cryopreservation of stem cells/umbilical cord (= preservation by cooling to low sub-zero temperatures)	Prior approval is required. Please provide us with a detailed medical report including: • A diagnosis and description of the current treatment with prognosis; • The motivation to conserve stem cells/umbilical cord.
Abortion	See Outpatient surgery
Sterilisation/Vasectomy/Tubal ligation	See Outpatient surgery
Reversal of sterilisation/Vaso-vasectomy	Not covered
Blepharoplasty (= eyelid surgery)	Prior approval is required. Please provide us with a detailed medical report including: • The results of a visual field test measuring the field of vision by an ophthalmologist; • Pre-operative photographs.
Corrective eye surgery to change the dioptre/LASIK	Covered under the available maximum for glasses/lenses
Rehabilitation/convalescence after surgery	Prior approval is required.
Home for the elderly/nursing home	Not covered
Institution for the disabled	Not covered
Cures	Not covered
Cosmetic surgery	Not covered

Item	Remarks
Reconstructive surgery	Prior approval is required.
Breast reduction	Prior approval is required. Please provide us with a detailed medical report including: • An estimation of the amount of body tissue to be removed; • The patient's weight and length; • Description of functional complaints; • Pre-operative photographs.
Male circumcision	Covered for both medical and religious reasons – has to be performed by a person with a medical degree. Female circumcision is not covered.
Rhinoplasty (= plastic surgery of the nose) /Septoplasty (= surgical procedure to correct the shape of the nasal septum, the separation between the 2 nostrils)	Prior approval is required. Please provide us with a detailed medical report including: • The result of a nasal endoscopy; a CT or other appropriate imaging documenting the degree of nasal obstruction.

3.2. Ambulance and transportation expenses

GENERAL RULE

All treatments and medicines must be prescribed by a qualified and registered medical doctor. The items below are reimbursed at 80% + Major Medical Benefits Plan (MMBP), unless indicated otherwise in the remarks.

Item	Remarks
General transportation costs	Not covered
Ambulance	Transportation between the place where you are injured by an accident or stricken by sickness and the first hospital where appropriate medical care can be given.
Repatriation	Not covered
Evacuation	Not covered

3.3. At the General Practitioner's

GENERAL RULE

All treatments and medicines must be prescribed by a qualified and registered medical doctor. The items below are reimbursed at 80% + Major Medical Benefits Plan (MMBP), unless indicated otherwise in the remarks.

Item	Remarks
Consultation	80% + MMBP
Virtual consultation (by telephone or video)	80% + MMBP
Annual subscription fees	Not covered
Minor surgical intervention in a doctor's office	80% + MMBP
Vaccination	80% + MMBP HPV (only up to 25), Hepatitis A, Hepatitis B, Yellow Fever, Tetanus (Diphteria), Pneumococcal, Polio, Influenza (all types), Combined vaccines of the foregoing. All immunisations for adults that are recommended by the local health authorities and/or the World Health Organization are reimbursable.
Routine physical exam	100% up to 1.050 USD Includes related x-rays, laboratory and any other charges, urologic examinations and prostate specific antigen (PSA) screening, gynaecological exams, mammography screening and Pap smears.
Well-child care	Covered up to the age of 19 in addition to the routine physical exams at the rate of 100% + MMBP in accordance with the following schedule: • Well-child care up to the age of 7: - 6 visits per year between 0 to 1 year old; - 2 visits per year between 1 to 2 years old; - 1 visit per year between 2 to 7 years old; • 1 visit every 24 months from the age of 7 to 19. All vaccinations administered in the context of well-child care visits are reimbursed at 100% up to midnight before turning 19.
Testing for the HIV virus	100% Unlimited number of blood tests per year

3.4. At the specialist's

GENERAL RULE

All treatments and medicines must be prescribed by a qualified and registered medical doctor. The items below are reimbursed at 80% + Major Medical Benefits Plan (MMBP), unless indicated otherwise in the remarks.

Item	Remarks
Consultation	80% + MMBP
Virtual consultation (by telephone or video)	80% + MMBP
Treatment	80% + MMBP
Second surgical opinion	100%
Outpatient mental health care	80% + MMBP
Immunotherapy	Prior approval is required. Please provide us with your allergy test results.
IUD (intrauterine device)	Covered at 80% + MMBP when prescribed by a medical doctor.
Check-ups (mammography, Pap smear etc)	If preventive: covered at 100% under the maximum of a Routine physical exam If diagnostic (in case of an illness or suspicion of an illness): covered at 80% + MMBP
Hearing test	Covered under the maximum available for hearing aids
Eye test to determine the dioptre by an ophthalmologist, optometrist or optician	Maximum one test per 12 month period
Eye examination due to a medical condition (i.e. not routine or to determine the dioptre)	80 % + MMBP

3.5. At the licensed qualified health care provider's (other than doctor)

GENERAL RULE

All treatments and medicines must be prescribed by a qualified and registered medical doctor. The items below are reimbursed at 80% + Major Medical Benefits Plan (MMBP), unless indicated otherwise in the remarks.

Item	Remarks
A doctor's prescription is required for care given by a person holding a paramedical degree (e.g. nurse, physiotherapist).	
Medical act (e.g. dressing wounds, giving injections) and supervision by a nurse	Prior approval is required. Please provide us with a detailed medical report including: • The patient's medical condition for which the attention of a home nurse is required; • The period during which the attention of a home nurse is required; • The treatment plan, including a list of tasks the home nurse is expected to perform and the approximate amount of time required for each individual task.
Nursing assistance for activities of daily living (e.g. dressing, feeding, supervision)	Not covered
Home health care	100% up to a maximum of 5,000 USD per illness, if it is provided as an alternative equal in cost to, or cheaper than, a medically required inpatient hospitalisation. Prior approval is required. Approval will be given for limited time periods only. Note: Custodial care or assistance with activities of daily living (for example, feeding, bathing, dressing, providing companionship) is not covered.

Item	Remarks

Dietician and nutritional counselling	• 80% + MMBP for one dietary-oriented consultations per calendar year.
	• Up to ten sessions per lifetime for patients with:
	  • A chronic disease (namely: cardiovascular disease, diabetes mellitus, hypertension, kidney disease, eating disorders and gastrointestinal disorders);
	  • A BMI (Body Mass Index) higher than 30.
	For these patients, dietary adjustment is medically necessary and has a therapeutic role.
	
	The nutritional counselling must be prescribed by a physician and furnished by a health care provider (e.g. a registered dietician, licensed nutritionist or other qualified licensed health professional).

Education programmes for diabetes/asthma/severe allergy patients, …	Covered
Prenatal and postnatal exercises guidance	Covered
Physiotherapy	• 80% + MMBP • Up to sixty sessions per calendar year • The therapy must be rendered by a qualified medical doctor or licensed physiotherapist.The attending physician's prescription must indicate: (a) Diagnosis; (b) Type of treatment; (c) Number of sessions; (d) Actual length of treatment. The invoice should mention: • The health care provider's medical degree; • The date(s) of treatment; • The type of treatment given.
Paramedical therapy sessions	Covered under the maximum of physiotherapy if there is sufficient scientific proof of its therapeutic effectiveness.
Podotherapy	Covered if it is medically necessary. The doctor's prescription should clearly indicate the diagnosis and the number of sessions prescribed.
Combined therapies (eg. occupational therapy, speech therapy)	• 80% + MMBP • Up to sixty sessions per calendar year

Item	Remarks
	• The therapy must be rendered by a licensed therapist.The attending prescription must indicate: (a) Diagnosis; (b) Type of treatment; (c) Number of sessions; (d) Actual length of treatment. The invoice should mention: • The health care provider's degree; • The date(s) of treatment; • The type of treatment given.
Psychological treatment given by a • Psychiatrist; • Licensed psychologist; • Licensed psychoanalyst; • Licensed psychiatric social worker; • Neurologist.	Covered at 80% + MMBP Prior approval is required as from the 31st session in a calendar year.
Custodial care	Not covered
New! Palliative/Hospice care	Home hospice care is reimbursable under the cover for home health care at 100% up to a maximum of 5,000 USD after prior approval from Cigna's medical consultant and at the following conditions: • The treatment has to be provided by specialized providers; • The treatment must be an alternative that is equal in price or cheaper than in-patient hospitalization; • Certification will be given for a limited period of time; • Persons residing in the US are not covered; • Only medical acts are eligible for reimbursement.
Relationship therapy	Not covered
Outpatient treatment for alcohol and drug abuse	Covered at the rate of 80% if medically necessary and after prior approval from Cigna's medical consultant. 40% of the allowable visits may be allocated to counsel covered family members of the participant undergoing treatment for the substance abuse problem.
Smoking cessation	Covered at 80% + MMBP The treatment must be provided by a doctor or licensed psychologist with experience on addiction and/or

Item	Remarks
	smoking cessation
Applied Behaviour Analysis (ABA)	Covered at 80% + MMBP Only one-on-one sessions with the therapist and patient are reimbursable. Prior approval from Cigna's medical board is required. Not covered are: - Group- or family sessions; - Sessions where the therapist accompanies the patient in real-world settings to observe (during school, work,…).

3.6 At the optician's

GENERAL RULE

All treatments and medicines must be prescribed by a qualified and registered medical doctor. The items below are reimbursed at 80% + Major Medical Benefits Plan (MMBP), unless indicated otherwise in the remarks.

Item	Remarks
Eye test to determine the dioptre by an ophthalmologist, optometrist or optician	Maximum one test per 12-month period
Corrective glasses and contact lenses	Participation of 12 months in the Cigna scheme is required. 80% up to 250 USD per 24 months, including frames. The 24-month period starts on the first date of purchase of the optical device. Replacement in case of dioptre change is allowed. For claiming purposes, please send the following information and documentation: • The dioptre of the optical devices; • A detailed official invoice stating the separate prices per item purchased.
Frames	Covered under the limit for corrective glasses and contact lenses.
Fluid for contact lenses	Not covered

3.7. At the dentist's

GENERAL RULE

All treatments and medicines must be prescribed by a qualified and registered medical doctor. The items below are reimbursed at 80% + Major Medical Benefits Plan (MMBP), unless indicated otherwise in the remarks.

Item	Remarks
General cover for dental care	80% up to 1,000 USD Any unspent balance can be carried over to the next year. In practice this means that in case there is an unspent balance for dental care on 31/12/2011, this can be carried over and used in 2012.
Half-yearly dental exam	Included in the General cover for dental care
Dental x-rays	Included in the General cover for dental care
Prostheses (including bridges, implants, dentures)	Included in the General cover for dental care
Orthodontic care (including the orthodontic device)	Treatment has to start before the patient's 15th birthday; The maximum treatment period is 4 years. Never reimbursable for adults over the age of 18 unless the treatment is medically necessary as a result of an accident; Included in the General cover for dental care
Reconstructive dental or orthodontic care where it is necessary as the result of an accident or illness	Prior approval is required.
Dental surgery performed in hospital for which a hospital theatre is required (e.g. surgical tooth extraction)	The doctor's fees and the cost of the dental items are included in the General cover for dental care. For other expenses (e.g. use of an operating theatre, bed and board in case of an inpatient admission): see In the hospital
Toothbrush, toothpaste, mouthwash	Not covered
Tooth whitening	Not covered

3.8. At the pharmacist's

GENERAL RULE

All treatments and medicines must be prescribed by a qualified and registered medical doctor. The items below are reimbursed at 80% + Major Medical Benefits Plan (MMBP), unless indicated otherwise in the remarks.

Item	Remarks

General cover of prescribed pharmaceutical products
• Containing active medical components; and
• Generally medically recognised and fully approved by the relevant legislation in force; and
• Required as a result of illness, accident or maternity.
	For claiming purposes, please provide us with the following documents together with your Claim form:
	• Doctor's prescription stating:
	  • The name of the patient:
	  • The diagnosis:
	  • The name of the medication:
	  • The dosage;
	• The official original invoice clearly mentioning:
	  • The date of purchase;
	  • The name(s) of the medication;
	  • The price paid for each product.

Over-the-counter (OTC) drugs	OTC drugs are only covered in case they are an essential part of a treatment and when the following conditions are met: • The medication must be generally medically accepted as medicine (containing enough active pharmaceutical components). This means that there has to be enough scientific proof of its effectiveness in the peer reviewed medical literature. • The medication needs to be prescribed by a doctor for a well specified diagnosis and this diagnosis needs to be mentioned on the prescription. The following products are never reimbursable: • cosmetics such as creams/lotions to remove wrinkles, Retin A products (unless for diagnosed severe acne), body washes/soaps, moisturizers/barrier creams, skin cleansers; • non-mediated eye drops, hypo tears, eye lubricants
Food/nutritional supplements	Not covered

Item	Remarks
Vitamins and minerals	• Not covered, unless when the vitamin/mineral in question is taken to cure an existing deficit. • Please send the results of the relevant laboratory test so that our medical consultant can ascertain whether this is the case.
Vitamin D	Only covered for patients with documented osteoporosis or osteopenia.
Multivitamins	Not covered
Calcium	Only covered for patients with documented osteoporosis or osteopenia.
Homeopathy	Covered
Phytotherapy, herbal products	Not covered
Traditional Chinese medicine (TCM) / Alternative medicine	TCM or alternative medicine are reimbursable if there is a medical condition that requires the treatment; if the treatment is provided by a licensed medical doctor in the country where the treatment is rendered; and if the treatment is recognized as a valid treatment modality by the competent health authorities in the country of treatment.
Ayurvedic treatment	See above. Ayurvedic treatment is reimbursable if: - There is a medical condition that requires the treatment; - If the treatment is provided by a licensed medical doctor in the country where the treatment is rendered; - If the treatment is given in Bangladesh, India, Nepal, Pakistan or Sri Lanka.
Appetite inhibitors aimed at weight loss / dietary products	Not covered
Drugs for obesity management (Xenical, Meridia and Reductil)	For patients with a Body Mass Index (BMI) greater than or equal to 30, in conjunction with any of the following severe co-morbidities: • Coronary heart disease; • Type II diabetes mellitus; • Clinically significant obstructive sleep apnoea; • Medically refractory hypertension; • Well-documented and serious orthopaedic problems. Prior approval is required. Please provide us with a detailed medical report confirming your BMI (Body Mass Index) and any relevant medical disorders.

Item	Remarks
	Approval can be granted for a period of maximum six months, but can be prolonged based on an updated evaluation report documenting the treatment's effectiveness (percentage of weight loss).
Products aimed at quitting smoking	Not covered
Bifosfonates/Medication to treat osteoporosis (Fosamax, Evista etc.)	Prior approval is required. Please provide us with the result of the BMM (Bone Mass Measurement) taken before the treatment started mentioning the T- and Z-scores. This type of medication will only be covered if the BMM results show that the patient is suffering from osteoporosis (i.e. if the T-score is -2.5 or below and the Z-score is -1.0 or below). Reimbursement of such products is limited to a period of five years.
HIV/AIDS medication	Covered
Daily care products (soap, shampoo etc.)	Not covered
Contraceptives	80% + MMBP for all birth control devices that require a prescription. Over the counter drugs and devices are not covered.
Glucosamine, chondroitin sulphate	Not covered
Hair and nail growth stimulating products	Not covered
Medication to (temporarily) treat impotence (e.g. Viagra, Levitra)	Only covered if the product is prescribed by a doctor • Following a prostatectomy (= surgical removal of all or part of the prostate gland); • In case of diabetic neuropathy (= nerve damage as a result of high blood sugar levels). The prescription must include the patient's diagnosis. Maximum reimbursement for 6 tablets per month. Erectile dysfunction as a result of ageing and psychogenic impotence are not valid conditions.
Malaria prophylaxis (= prevention of malaria)	Not covered
Nicotine substitutes	Not covered
Preventive vaccinations for children (well-child care)	See Well-child care
Vaccines	Not covered except for:

Item	Remarks
	Influenza, Hepatitis A, Hepatitis B, Hepatitis A+B, Yellow Fever, Tetanus (diphtheria), Pneumococcal vaccinations and inoculations for children up to 19 years of age (see Well-child-care).
Tamiflu	Not covered if used for preventive reasons. Covered if the patient has been diagnosed with the flu or when there is an immediate real threat.
HPV vaccine (e.g. Gardasil, Cervarix)	80% + MMBP for girls up to the age of 19.
Insulin, syringes for diabetics	Covered
Glucometer, insulin pump, blood testing strips	Prior approval is required.
Strips for urine testing for diabetics	Covered
Hormonal treatment to stimulate fertility	See fertility treatment

3.9. At the specialised supplier's office

GENERAL RULE

The plan covers the rental of medical appliances at 80% + Major Medical Benefits Plan (or the purchase thereof when purchase of the appliance is more economical than rental or when it is impossible to rent the appliance in question), if considered medically necessary by Cigna's medical consultant.

Item	Remarks
Orthopaedic devices in general	Prior approval is required. Please provide us with a medical prescription indicating the diagnosis and the device prescribed and a Cost estimate.
Orthopaedic shoes Inlay soles	Prior approval is required. Please provide us with a detailed medical report justifying its need and a Cost estimate.
Hearing aids	Participation of 12 months in the health plan is required. Prior approval is required. Please provide us with a detailed medical report and audiogram. Covered at 80% up to 750 USD per hearing apparatus (including the cost of the relevant hearing exam and repair) and with a maximum of one hearing aid per ear

Item	Remarks
	per 36 months period (no MMBP) The date of the hearing test or the date of purchase, whichever comes first, is considered when determining the eligibility for reimbursement of the expenses in question.
Rental of an aerosol/nebulizer	Prior approval is required. Please provide us with a detailed medical report justifying its need.
Rental of a CPAP appliance	Prior approval is required. • Please provide us with a detailed medical report including the results of a sleep study that confirm the existence of a sleep apnoea and a Cost estimate.
Rental of sphygmomanometer (= a blood pressure meter)/blood pressure gauge	Not covered, except for the following persons: • Diabetics (both type I and type II, provided that the patient is taking medicines to control the illness, namely, insulin and/or oral antidiabetics); • Pregnant women who present a clinical risk for developing toxicosis or pre-eclampsia; • Elderly people suffering from multiple co-morbidities; • Patients on home dialysis; • Patients with cerebrovascular malformations. Prior approval is required. Please provide us with a detailed medical report and a Cost estimate.
Wheelchair	Prior approval is required. Please provide us with a detailed medical report justifying its need and a Cost estimate.
Crutches	Prior approval is required. Please provide us with a detailed medical report justifying their need and a Cost estimate.
Rollator	
Standing frame	
Support stockings for varicose veins	Prior approval and confirmation of the number of pairs reimbursable is required.
Anti-allergic eiderdown cover, mattress cover, pillow cover	Not covered

3.10. In the laboratory/medical imaging facility

GENERAL RULE

All treatments and medicines must be prescribed by a qualified and registered medical doctor. The items below are reimbursed at 80% + Major Medical Benefits Plan (MMBP), unless indicated otherwise in the remarks.

Item	Remarks
X-rays	Covered
Magnetic Resonance Imaging (MRI)	Covered
Ultrasound	Covered
Electrocardiogram (ECG)	Covered
Preventive routine mammography	See Routine physical exam
Preventive routine mammography for persons with a prior history of breast cancer or whose mother or sister has had a prior history of breast cancer	Covered
Mammography for diagnostic purposes	Covered
Laboratory tests	Covered
Amniocentesis	Covered
HIV testing	100%
PSA testing	See Routine physical exam
Pap smear	See Routine physical exam

4. Exclusions

- Insured participants who are mobilised or who volunteer for military service in time of war;
- Injuries resulting from motor-vehicle racing or dangerous competitions in respect of which betting is allowed (normal sports competitions are covered);
- The consequences of insurrections or riots if, by taking part, the plan member has broken the applicable laws; and the consequences of brawls, except in cases of self-defence;
- Spa cures, rejuvenation cures or cosmetic treatment (reconstructive surgery is covered where it is necessary as a result of an accident for which coverage is provided);
- The direct or indirect results of explosions, heat release or irradiation produced by transmutation of the atomic nucleus or by radioactivity or resulting from radiation produced by the artificial acceleration of nuclear particles;
- Expenses for, or in connection with, travel or transportation, whether by ambulance or otherwise, except that charges for professional ambulance service used to transport the insured participant between the place where he or she is injured by an accident or stricken by disease and the first hospital where treatment is given will not be excluded;
- Expenses that are not deemed to be reasonable and customary. The determination of the reasonable and customary charge for each service is made by Cigna, based on the prevailing charges for the service at the place where treatment is rendered and considering the complexity of the treatment, including related services or supplies. Fees for treatments, supplies or services that are determined by Cigna to be excessive compared with prevailing fee levels will be reimbursed up to the reasonable and customary level for the geographical area in which such medical services are received;
- Medical care that is not medically necessary or medical care that is not medically recognized as a treatment for the diagnosis provided;
- Products, the effectiveness of which has not been sufficiently proved scientifically and which are not generally medically recognized in the medical world, are not covered under the health plan. One example of this exclusion is products containing glucosamine or chondroitin sulphate;
- Elective surgery not resulting from illness, accident or maternity.

5. Access to forms

On your personal webpages you can download various forms. You can access your personal webpages as follows:

- Go to www.cignahealthbenefits.com and click ‘Plan members’
- Fill in your personal reference number and password. You can find your personal reference number on your (electronic) membership card (001/xxxxx).

Claims can be submitted via the personal webpages or by using the Cigna Health Benefits App which includes photoclaiming. The Cigna Health Benefits application can be downloaded for free from the App Store (IOS) and Google Play (Android).

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