Global Health Options

CIGNA CLOSE CARE℠ CUSTOMER GUIDE

Everything you need to know about your plan

Together, all the way.℠

Cigna®

A PLAN SPECIFICALLY DESIGNED FOR YOU WHEN YOU NEED IT MOST

YOUR CIGNA CLOSE CARE℠ PLAN

Thank *you* for choosing the *Cigna* Close Care℠ plan. 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 Close Care℠ plan, is designed to provide *you* with health cover where *you* need it most, in *your country of nationality* and in *your country of habitual residence.* For added protection, *you* will also be covered under *our* Out of Area Emergency *benefit,* for times when *you* are outwith *your area of coverage,* ensuring *you* always have the protection *you* need through *Cigna.*
For *your* added peace of mind, the *Cigna* Close Care℠ plan also includes *our* unique Global Health Assist Service. This service is provided by *our* expert Clinical team who are with *you* every step of the way throughout *your treatment* journey and time with *Cigna.*

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 cover *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.

With *Cigna,* we hope *you* enjoy the peace of mind that comes from knowing *you* have quick access to the quality medical *treatment you* need, whenever *you* need it.

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OUR CUSTOMER PROMISE

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

- *you* will have quick and easy access to healthcare facilities and professionals in *your area of coverage* through *our* network;
- *we* will reimburse *your treatment* provider directly in most cases. On the occasion that *you* have to pay for *treatment yourself*, *we* aim to process *your* claim within 5 working days after receiving all necessary documentation; and
- *you* can receive payment in over 135 currencies.

How this is delivered

Customer Service centres: Here to assist *you* 24/7 with multi-language assistance and support.

Global Health Assist Service: *Our* dedicated Clinical team will help *you* every step of the way when *you* require advice, help or guidance with regards to any medical *treatment* *you* or any *beneficiaries* may need to receive.

Access to the extensive *Cigna* medical network: A medical network comprising of over 1 million partnerships, including 180,700 behavioural health care professionals, and 13,900 facilities and *clinics*. With *Cigna, you* can access any *medical practitioner*, *clinic* or provider of *your* choice in most countries, offering *you* the access to best care and *treatment* possible.

Simple claims process: *Our* claims process enables *you* to access *treatment* without paying upfront 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 for any other reason, please contact *our* Customer Care Team 24 hours a day, 7 days a week, 365 days a year.

Call: **+44 (0) 1475 788 182**

Fax: **+44 (0) 1475 492 113**

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

Inside the USA:

Call: 800 835 7677
Fax: 855 358 6457

Inside Hong Kong:

Call: 2297 5210

Inside Singapore:

Call: 800 186 5047

Your Cigna Close Care℠ plan explained

Area of coverage

The *Cigna* Close Care℠ plan covers *you* in *your country of habitual residence* and *your country of nationality*. This means *you* only pay for coverage where *you* need it most, in the country *you* will be living and when *you* return home for temporary visits.

Out of Area Emergency cover

For additional peace of mind, when visiting a location outwith *your area of coverage*, *your* plan includes emergency medical coverage. *Beneficiaries* will be covered for *emergency treatment* on an *inpatient* or *daypatient* basis, or *outpatient* basis (if the Outpatient and Wellness Care option has been purchased under *your policy*) during temporary trips, outside *your area of coverage*. Coverage is limited to a maximum period of twenty one (21) days per trip and a maximum of forty five (45) days per *period of cover* for all trips combined. Please read the full terms and conditions relating to this *benefit* in clause 10.6 of *your Policy Rules.*

Condition limit

Your Cigna Close Care℠ plan has a *Condition* limit of $250,000/€200,000/£165,000 per *beneficiary*, per *period of cover*. This includes all claims paid across all sections of *inpatient*, *daypatient* and *outpatient treatment* in relation to the primary *condition*. For the avoidance of doubt, this excludes any *pre-existing conditions*. For full details please refer to the *list of benefits* on page 16.

YOUR GUIDE TO GETTING TREATMENT

We want to make sure that getting treatment is as stress free as possible.

Prior approval

Please contact *our* Customer Care Team prior to *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.

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 approval (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 forty eight (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*).

Important note

Prior approval should be obtained from *us* for all *treatment*. This will help ensure *your* claim is covered under the *policy*. If *you* do not get prior approval 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:

- 20% if *you* did not obtain prior approval for *treatment* outside the *USA*.
- 50% if *you* did not obtain prior approval when it was required for *treatment* inside the *USA* (if the *USA* is included in *your area of coverage*).

If a *beneficiary* has been taken to a *hospital*, *medical practitioner* or *clinic* which is not part of the *Cigna* network, 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.

Getting treatment in the USA

Treatment in the *USA* is covered under the terms of the *policy*, if it is covered within *your area of coverage.* If prior approval is obtained, but the *beneficiary* decides to receive *treatment* at a *hospital*, *medical practitioner* or *clinic* which is not part of the *Cigna* network, *we* will reduce any amount which *we* will pay by 20%. 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.

We realise that 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 any reduction to the payments *we* will make. 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 *benefit beneficiary's* home address; or
- when the *treatment* the *beneficiary* needs is not available from a local *Cigna* network hospital, *medical practitioner* or *clinic*.

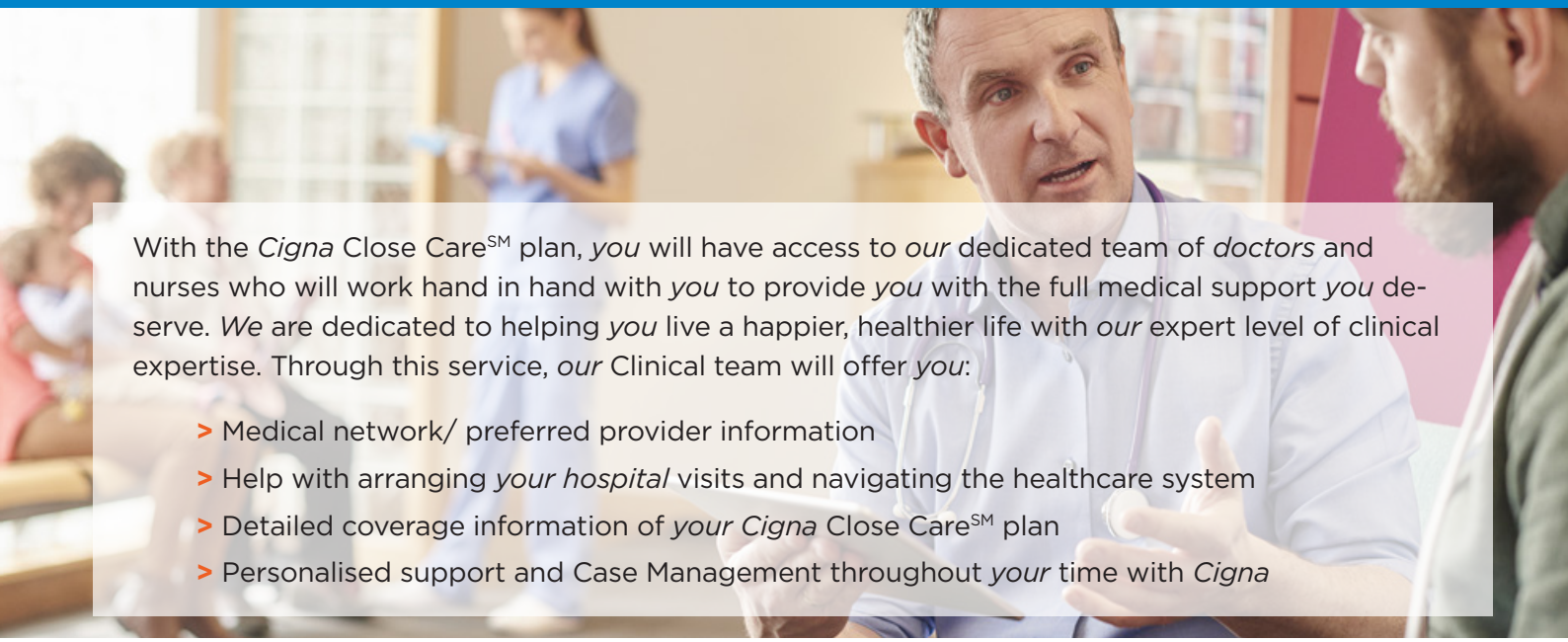
Important note

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

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.

OUR GLOBAL HEALTH ASSIST SERVICE



With the *Cigna* Close Care℠ plan, *you* will have access to *our* dedicated team of *doctors* and nurses who will work hand in hand with *you* to provide *you* with the full medical support *you* deserve. *We* are dedicated to helping *you* live a happier, healthier life with *our* expert level of clinical expertise. Through this service, *our* Clinical team will offer *you*:

- Medical network/ preferred provider information
- Help with arranging *your hospital* visits and navigating the healthcare system
- Detailed coverage information of *your Cigna* Close Care℠ plan
- Personalised support and Case Management throughout *your* time with *Cigna*

GUARANTEE OF PAYMENT

Our Clinical Team can make *your treatment* journey even easier by issuing a *guarantee of payment* prior to receiving *treatment*. This means that *we* will agree in advance to pay some or all of the cost of a particular *treatment* which *you* are due to receive. Where *we* have approved a *guarantee of payment*, *we* will pay the *beneficiary*, *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. This provides *you* with added security, enabling *you* to gain easier access to *treatment.*

COMPLEX CASE MANAGEMENT

As *you* go through *treatment*, *you* can find confidence in the fact that if *you* require *treatment* which is more complex, *our nurses* can take over management of the case and provide *you* with clinical guidance and reassurance through *our* complex case management. In addition, *you* will have a dedicated *nurse* as *your* main point of contact throughout *your* entire *treatment,* allowing *you* to concentrate on getting better as *we* liaise directly with the *hospitals, medical practitioners* and providers for *you.*

CHRONIC CONDITION SUPPORT

What's more, *our* Global Health Assist Service works with a proactive and personalised approach to manage chronic 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. Even if *you* have a *pre-existing condition* which was evident prior to taking out *your Cigna* Close Care℠ plan which is excluded from *your policy*, *we* can still offer *you* guidance, support and information to help *you* control *your condition* and maintain a healthy lifestyle.

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:

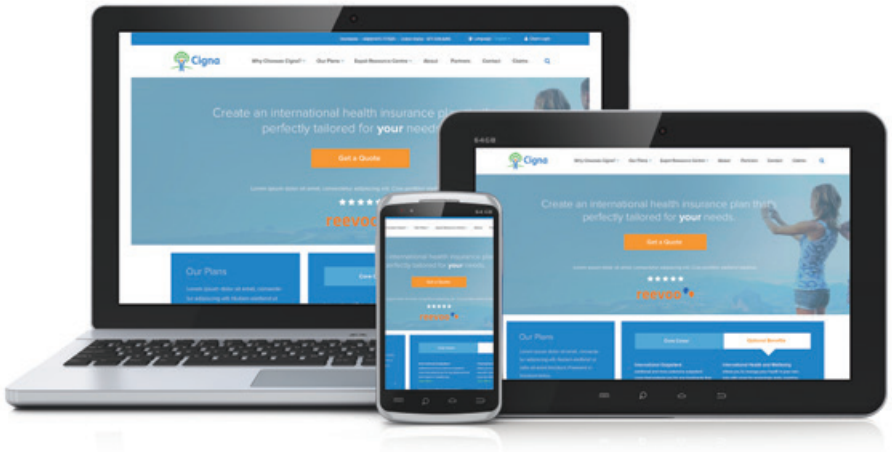
- View *your policy documents*, including *your Certificate of Insurance* and *Cigna* ID cards for all the people covered under *your* plan
- Check the *Policy Rules* that apply to *your policy*
- Check *your* coverage for *you* and *your* family
- Submit claims online
- Search for healthcare facilities and professionals near *your* location
- View *our* quarterly customer magazine

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.

HOW TO SUBMIT YOUR CLAIM

You can submit claims online via *your* secure online Customer Area, email, fax or send them in the post. 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

Inside the USA:
Fax: 855 358 6457

Treatment incurred outside the USA

Cigna Global Health Options
Customer Service
1 Knowe Road
Greenock
Scotland PA14 4RJ

Treatment incurred inside the USA

Cigna International
PO Box 15964
Wilmington
Delaware 19850
USA

Important note

We may need to ask for extra information to help *us* 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 twelve (12) months of the date of *treatment*, the claim will not qualify for payment or reimbursement by *us*.

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.*
- **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.*
- ***Treatment*** inside *your area of coverage*, unless this is covered under the Out of Area Emergency *benefit*.
- **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.

YOUR GUIDE TO GETTING TREATMENT

The diagram below summarises how the treatment and claiming process works

Before getting *treatment* call *our* Customer Care Team. Please see relevant contact details on page 5

If it's an emergency and *you* can't call *us* before *treatment*, contact *us* in the next 48 hours

In most cases *we* will pay *your hospital, clinic* or *medical practitioner* directly

If *you've* chosen a *deductible* and/or *cost share* option, *you* pay this amount directly to *your hospital, clinic* or *medical practitioner* and *we* will pay the rest

If *your hospital, clinic* or *medical practitioner* gives *you* an invoice	Submit *your* invoice and claims form to *us*	*We* will reimburse *your hospital, clinic* or *medical practitioner* (less *your* applicable *deductible* and/or *cost share* option)
If *you've* paid *your hospital, clinic* or *medical practitioner yourself*	Submit *your* invoice and claims form to *us*	*We* will reimburse *you* (less *your* applicable *deductible* and/or *cost share* option)

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

What your exclusions mean

Exclusions are costs or *treatments* that are not covered by *your* plan. Please refer to *your Policy Rules* to see the list of General Exclusions that apply to all coverage and options under the *Cigna* Close Care℠ plan. If *you* have any special exclusions applied to *your policy*, they will be detailed on *your Certificate of Insurance*.

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 monthly, 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.

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 (7) days' notice in writing.

HOW THE DEDUCTIBLE, COST SHARE AND OUT OF POCKET MAXIMUM WORK

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

You can choose to have a *deductible* and/or *cost share* on the *Core cover* and/or Outpatient and Wellness Care option.

You will be responsible for paying the amount of any *deductible* and *cost share* directly to the *hospital, medical practitioner* or *clinic*.

We will let *you* know what this amount is. If *you* select both a *deductible* and a *cost share*, the amount *you* will need to pay due to the *deductible* is calculated before the amount *you* will need to pay due to the *cost share*. The *out of pocket maximum* is the maximum amount of *cost share* any *beneficiary* would have to pay per *period of cover.*

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

EXAMPLE 1: DEDUCTIBLE

(also known as 'excess')

This is the amount of money *you* pay towards *your* medical expenses per *period of cover*.

Claim value:	**$1,200**
Deductible:	**$500**

YOU PAY..
Deductible of $500

WE PAY...
$700

WHAT THIS MEANS FOR YOU...

You only pay the *deductible* amount and *we* pay the rest.

EXAMPLE 2: COST SHARE AND OUT OF POCKET MAXIMUM AFTER DEDUCTIBLE

(when *your cost share after deductible* amount is under the *out of pocket maximum*)

Cost share is the percentage of every claim *you* will pay. Out of pocket is the maximum amount *you* would have to pay in *cost share* per *period of cover*.

Claim value:	**$5,000**
Deductible:	**$0**
20% cost share:	**$1,000**
Out of pocket maximum:	**$2,000**

YOU PAY..
The 20% cost share of **$1,000**

WE PAY...
$4,000

WHAT THIS MEANS FOR YOU...

Your cost share is 20% of $5,000 ($1,000). This is less than *your out of pocket maximum*, so *you* pay $1,000 and *we* cover the rest.

EXAMPLE 3: COST SHARE AND OUT OF POCKET MAXIMUM AFTER DEDUCTIBLE

(when *your cost share after deductible* amount is over the *out of pocket maximum*)

Cost share is the percentage of every claim *you* will pay. Out of pocket is the maximum amount *you* would have to pay in *cost share* per *period of cover*.

Claim value:	**$20,000**
Deductible:	**$0**
20% cost share:	**$4,000**
Out of pocket maximum:	**$2,000**

YOU PAY..

The out of pocket maximum of

$2,000

WE PAY...

$18,000

WHAT THIS MEANS FOR YOU...

Your cost share is 20% of $20,000 ($4,000). This is more than *your out of pocket maximum*, so *you* only pay $2,000 and *we* cover the rest.

EXAMPLE 4: DEDUCTIBLE, COST SHARE AND OUT OF POCKET MAXIMUM AFTER DEDUCTIBLE

(when *your cost share after deductible* amount is under the *out of pocket maximum*)

Cost share is the percentage of every claim *you* will pay. Out of pocket is the maximum amount you would have to pay in *cost share* per *period of cover*.

Claim value:	**$20,000**
Deductible:	**$375**
20% cost share:	**$3,925**
Out of pocket maximum:	**$5,000**

YOU PAY..

The deductible of **$375** and the cost share of

$3,925

WE PAY...

$15,700

WHAT THIS MEANS FOR YOU...

After *you've* paid *your deductible* of $375, *your cost share* is 20% of $19,625 ($3,925). This is not more than *your out of pocket maximum*, so *you* pay the $3,925 towards satisfying the *out of pocket maximum* for the *cost share* (and the initial $375 deductible that *you* paid at the outset) and *we* cover the rest.

Please note:

The *deductible*, *cost share after deductible*, and *out of pocket maximum* is determined separately for each *beneficiary* and each *period of cover*.

YOUR BENEFITS IN DETAIL

When building *your* tailored *Cigna* Close Care℠ plan, *you* may have chosen optional *benefits* to add to *your Core cover*. In this section *we* detail exactly what cover *you* can look forward to with each option. To remind *yourself* of which *benefits you've* chosen, take a look at *your Certificate of Insurance*. *Your Certificate of Insurance* will detail *your area of coverage* for this plan, which is restricted to *your country of nationality* and *country of habitual residence* as stated on *your application*.

The *benefit* tables detail what is covered in *your* plan. The *Core cover,* Outpatient and Wellness Care option and the Dental Care and Treatment option, all have annual maximums. These are the maximum amounts *we* will pay for per *beneficiary* per *period of cover*.

The *benefits* under Outpatient and Wellness Care, and Dental Care and Treatment options will only be available if *you* have purchased these in addition to *your Core cover*. Please read the additional accompanying notes applicable to each *benefit* in the *benefit* tables.

The Outpatient and Wellness Care option includes *treatments* which take place at a *hospital,* consulting room or *outpatient clinic* when an admission as an *inpatient* or *daypatient* is not required. This means that *emergency treatment* that does not require an admission as an *inpatient* or *daypatient* will only be covered if *you* have purchased the Outpatient and Wellness Care option. This option also includes wellness *benefits* such as pre-cancer screenings and adult physical examinations.

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*, specific exclusions set out in the *list of benefits* and any special exclusions set out in *your Certificate of Insurance).* The *list of benefits* in this *Customer Guide* shows any limits which apply to the *benefits*. *Benefits* that are 'paid in full' are subject to the overall annual benefit maximum, where applicable. There are some *benefits* 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, EUR and GBP. The currency in which *you* have chosen to pay *your* premium is the currency that applies to *your* plan *benefits*.

YOUR CORE COVER

Your Core cover is detailed in the table below. This is *your* essential cover for *inpatient*, *daypatient* and accommodation costs, as well as cover for *cancer*, mental health care and much more. All amounts apply per *beneficiary* and per *period of cover* (except where otherwise noted).

LIST OF BENEFITS

INPATIENT AND DAYPATIENT BENEFITS

Area of Coverage

- The *area of coverage* is limited to *your country of habitual residence* and *country of nationality*.
- *USA* coverage is included if the *country of habitual residence* is the *USA*.
- *USA* nationals can choose to purchase *USA* coverage (if the *policyholder* does not elect to purchase *USA* coverage, then *beneficiaries* do not have coverage on visits home).
- *USA area of coverage* is not permitted if either of the options above do not apply.

YOUR OVERALL LIMIT

Annual *benefit* - maximum per *beneficiary* per *period of cover*. This includes claims paid across all sections of *inpatient* and *daypatient benefits*.	**$500,000** **€400,000** **£325,000**

***Condition* limit** Up to the maximum amount per *period of cover*.	**$250,000** **€200,000** **£165,000**

This is the annual amount *we* will pay towards all costs of *treatment* following the diagnosis of a *condition*. This includes all claims paid across *inpatient*, *daypatient* and *outpatient* in relation to the primary *condition*. This applies to each *beneficiary* per *period of cover*.

Important notes

- *We* will only pay up to the maximum amount in aggregate per *period of cover* as detailed in the *list of benefits*.
- The costs do not include any evacuation or repatriation services.
- Any further costs directly related to the medical *condition*, that exceed the *benefit* limit, will not be covered by *us*.
- In determining when this limit has been reached, *our medical team* will take into account and review all of the relevant medical *treatment* and care received.
- *We* will only pay for *outpatient* costs if the Outpatient and Wellness Care option has been selected, with the exception of certain *benefits* which include *outpatient treatment* as part of *your Core cover*.

Out of area emergency cover Up to the maximum amount per *period of cover*.	**$40,000** **€29,600** **£26,600**

- Emergency *inpatient*, *daypatient* and *outpatient* medical *treatment* during temporary trips outside *your country of habitual residence* or *country of nationality*.
- This is limited to 21 days per trip and a maximum of 45 days per *policy* year.
- Emergency *outpatient treatment* is included up to $2,500/€1,850/£1,650. This is only available if *you* have selected the Outpatient and Wellness Care option. Please refer to Policy Rules clause 10.6 for terms relating to this overall *benefit* limit.

Hospital charges for:

Nursing and accommodation for *inpatient* and *daypatient treatment* and recovery room.

Paid in full for a semi-private 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 semi-private room with shared bathroom.
- 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 semi-private room with shared 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.
- prescribed medicines, drugs and dressings for *inpatient* or *daypatient treatment*.
- *treatment* room fees for *outpatient surgery*.

Paid in full

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*.

Medicines, drugs and dressings:

- *We* will pay for medicines, drugs and dressings which are prescribed for the *beneficiary* whilst he or she is receiving *inpatient* or *daypatient treatment*.
- Medicines, drugs and dressings which are prescribed for use at home will be covered under the limits of the prescribed drugs and dressing limit in the Outpatient and Wellness Care *benefits* (unless they are prescribed as part of *cancer treatment*).

Intensive care:

- intensive therapy.
- coronary care.
- high dependency unit.

Paid in full

- *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*.

Surgeons' and Anaesthetists' fees

Paid in full

- *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*).
- *We* will only pay for *outpatient treatments* received before or after *surgery* if the *beneficiary* has cover under the Outpatient and Wellness Care option (unless the treatment is given as part of *cancer treatment*).

Specialists' consultation fees

Paid in full

- *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*.

Kidney Dialysis

$5,000
€3,700
£3,325

- *Treatment* for kidney dialysis will be covered if such *treatment* is available in the *beneficiary's country of habitual residence*. *We* will pay for this on an *inpatient*, *daypatient*, or *outpatient* basis.
- *We* will not pay for kidney dialysis *treatment outside the beneficiary's area of coverage* unless it is covered under the terms of the out of area emergency cover *benefit.*

Pathology, radiology and *diagnostic tests* (excluding Advanced Medical Imaging)

Paid in full

- Where investigations are provided on an *inpatient* or *daypatient* basis.
- *We* will pay for:
  - blood and urine tests;
  - X-rays;
  - ultrasound scans;
  - electrocardiograms (ECG); and
  - other *diagnostic tests*;

  where they are *medically necessary* and are recommended by a *specialist* as part of a *beneficiary's hospital* stay for *inpatient* or *daypatient treatment*.

Advanced Medical Imaging (MRI, CT and PET scans)

Up to the maximum amount shown per *period of cover*.

$2,500
€1,850
£1,650

- *We* will pay for the following scans if they are recommended by a *specialist* as a part of a *beneficiary's inpatient*, *daypatient* or *outpatient treatment*:
  - magnetic resonance imaging (MRI);
  - computed tomography (CT); and/or
  - positron emission tomography (PET);
- *We* may require a medical report in advance of a magnetic resonance imaging (MRI) scan.

Physiotherapy and complementary therapies

Up to the maximum amount shown per *period of cover*.

$2,000
€1,480
£1,330

- Where *treatment* is provided on an *inpatient* or *daypatient* basis.
- *We* will pay for *treatment* provided by physiotherapist and *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 is not the primary *treatment* which they are in *hospital* to receive).

Rehabilitation

Up to 30 days and the maximum amount shown per *period of cover*.

$2,000
€1,480
£1,330

- *We* will pay for *rehabilitation treatments* (physical, occupational and speech therapies), which are recommended by a *specialist* and are *medically necessary* after a traumatic event such as a stroke or spinal *injury*.
- If the *rehabilitation treatment* is required in a residential *rehabilitation* centre *we* will pay for accommodation and board for up to 30 days for each separate *condition* that requires *rehabilitation treatment*.

  In determining when the 30 days limit has been reached:
  - *we* count each overnight stay during which a *beneficiary* receives *inpatient treatment* as 1 day; and
  - *we* count each day on which a *beneficiary* receives *outpatient* and *daypatient treatment* as 1 day.
- Subject to prior approval being obtained, prior to the commencement of any *treatment*, *we* will pay for *rehabilitation treatment* for more than 30 days, if further *treatment* is *medically necessary* and is recommended by the treating *specialist*.

Important notes

- *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:

  i) how long the *beneficiary* will need to stay in *hospital*;

  ii) the diagnosis; and

  iii) the *treatment* which the *beneficiary* has received, or needs to receive.

Hospice and *palliative care*

Up to the maximum amount shown per lifetime.

$2,500
€1,850
£1,650

- 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.

Internal prosthetic devices/*surgical* and *medical appliances*

Up to the maximum amount shown per *period of cover*.

Paid in full

- *We* will pay for internal prosthetic implants, devices or appliances which are put in place during *surgery* as part of a *beneficiary's treatment*.
- A *surgical appliance* or a *medical appliance* can mean:
  - an artificial limb, prosthesis or device which is required for the purpose of or in connection with *surgery*;
  - an artificial device or prosthesis which is a necessary part of the *treatment* immediately following *surgery* for as long as required by *medical necessity*; or
  - a prosthesis or appliance which is *medically necessary* and is part of the recuperation process on a *short-term* basis.

External prosthetic devices/*surgical* and *medical appliances*

Up to the maximum amount shown per *period of cover*.

$2,500
€1,850
£1,650

- *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*; or
  - a prosthetic device or appliance which is *medical necessary* and is part of the recuperation process on a *short-term* basis.
- *We* will pay for an initial external prosthetic device for *beneficiaries* aged 18 or over per *period of cover*. *We* do not pay for any replacement prosthetic devices for *beneficiaries* who are aged 18 and over.
- *We* will pay for an initial external prosthetic device and up to 2 replacements for *beneficiaries* aged 17 or younger per *period of cover*.
- By an external 'prosthetic device', *we* mean an external artificial body part, such as a prosthetic limb or prosthetic hand which is *medically necessary* as part of *treatment* immediately following the *beneficiary's surgery* or as part of the recuperation process on a *short-term* basis.

Local ambulance services

Paid in full

- Where it is *medically necessary*, *we* will pay for a local road 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*.
- *We* will only pay for a local road ambulance where its use relates to *treatment* which a *beneficiary* needs to receive in *hospital*. Where it is *medically necessary*.
- This *policy* does not provide cover for mountain rescue services.
- Cover for a medical evacuation or repatriation is not available.

Emergency *inpatient dental treatment*

$2,500
€1,850
£1,650

- *We* will cover *dental treatment* in *hospital* after a serious accident, subject to the *conditions* set out below.
- *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.

Treatment for mental health conditions and disorders

Up to the maximum amount shown per *period of cover*.

$3,000
€2,200
£2,000

- Subject to the limits explained below *we* will pay for the *treatment* of mental health *conditions* and disorders on an *inpatient*, *daypatient* or *outpatient* basis.

Important notes

- *We* will not pay for the *treatment* and diagnosis of addictions (including alcoholism) or any facilities specialised in addictions *treatments*.
- For *treatment* of mental health conditions and disorders, *we* will only pay for *evidence-based*, *medically necessary treatment* and which is recommended by a *medical practitioner*.
- *We* will pay for up to a combined maximum total of 60 days of *treatment* for mental health *conditions* and disorders in any 1 *period of cover*, including a maximum of 30 days of *inpatient treatment*.
- *We* will pay for up to a combined maximum total of 90 days of *treatment* for mental health *conditions* and disorders in any 5 year *period of cover*. For example, if a *beneficiary* uses 30 days of mental health *treatment* in 1 *period of cover* and 60 days of mental health *treatment* in the following *period of cover*, *we* will not pay for any further mental health *treatment* for the next 3 consecutive years of cover.
- In determining when these 30, and 90 day limits have been reached:
  - *we* count each overnight stay during which a *beneficiary* received *inpatient treatment* as 1 day; and
  - *we* count each day on which a *beneficiary* received *outpatient* and *daypatient treatment* as 1 day.
- *We* will not pay for prescription drugs or medication prescribed on an *outpatient* basis for any of these *conditions*, unless *you* have purchased the Outpatient and Wellness Care option.

Cancer care

Paid in full

- Following a diagnosis of *cancer*, *we* will pay for 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, *diagnostic tests* and drugs, whether the *beneficiary* is staying in a *hospital* overnight or receiving *treatment* as a *daypatient* or *outpatient*.
- *We* do not pay for genetic *cancer* screening.

Deductible (various) A *deductible* is the amount which *you* must pay before any claims are covered by *your* plan.	$0 / $375 / $750 / $1,500 / $3,000 / $7,500 / $10,000 €0 / €275 / €550 / €1,100 / €2,200 / €5,500 / €7,400 £0 / £250 / £500 / £1,000 / £2,000 / £5,000 / £6,650
Cost share after _deductible_ and _out of pocket maximum_ *Cost share* is the percentage of each claim not covered by *your* plan. The *out of pocket maximum* is the maximum amount of *cost share you* would have to pay in a *period of cover*. The *cost share* amount is calculated after the *deductible* is taken into account. Only amounts *you* pay related to *cost share* contribute to the *out of pocket maximum*.	First, choose *your cost share* percentage: 0% / 10% / 20% / 30% Next, choose *your out of pocket maximum*: $2,000 or $5,000 €1,480 or €3,700 £1,330 or £3,325

THE FOLLOWING PAGES DETAIL THE OPTIONAL BENEFITS YOU MAY HAVE CHOSEN TO ADD TO YOUR **CORE COVER**.

TAKE A LOOK AT YOUR CERTIFICATE OF INSURANCE TO REMIND YOURSELF EXACTLY WHAT COVER YOU HAVE.

OUTPATIENT AND WELLNESS CARE

Outpatient and Wellness Care covers *you* more comprehensively for *outpatient* care and medical emergencies that may arise where a *hospital* admission as a *daypatient* or *inpatient* is not required. As well as this, this *benefit* will cover *you* for consultations with *specialists* and *medical practitioners*, prescribed drugs and dressings, physiotherapy and osteopathic and chiropractic *treatments*. *You* will also be covered for pre-cancer screenings, and routine adult physical exams.

YOUR OVERALL LIMIT

Annual *benefit* - maximum per *beneficiary* per *period of cover* This includes claims paid across all sections of Outpatient and Wellness Care.	**$5,000 €3,700 £3,325**

YOUR STANDARD MEDICAL BENEFITS

Consultations with *medical practitioners* and *specialists* Up to the maximum amount shown per *period of cover*.	**$100/€75/£65 per visit. Up to 8 visits per year.**

- *We* will pay for consultations or meetings with a *medical practitioner* which are necessary to diagnose an illness, or to arrange or receive *treatment* up to the maximum number of visits shown in the *benefit* table.
- *We* will pay for non-surgical *treatment* on an *outpatient* basis, which is recommended by a *specialist* as being *medically necessary*.

Pathology, radiology and *diagnostic tests* (excluding Advanced Medical Imaging) Up to the maximum amount shown per *period of cover*.	**$1,000 €740 £665**

- *We* will pay for the following tests where they are *medically necessary* and are recommended by a *specialist* as part of a *beneficiary's outpatient treatment*:
  - blood and urine tests;
  - X-rays;
  - ultrasound scans;
  - electrocardiograms (ECG); and
  - other *diagnostic tests* (excluding advanced medical imaging).

Physiotherapy Up to the maximum amount shown per *period of cover*.	**$1,000 €740 £665**

- *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*

Up to the maximum amount shown per *period of cover*.

$100/€75/£65 per visit. Up to 8 visits per year.

- *We* will pay up to a combined maximum total of 8 visits in any 1 *period of cover* for osteopathy and chiropractic *treatment* 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. This excludes any sports medicine *treatment*.
- *We* will require a medical report and *treatment* plan prior to approval.

Acupuncture, Homeopathy and Chinese medicine

Up to a combined maximum of 15 visits per *period of cover*.

$100/€75/£65 per visit. Up to 15 visits per year.

- *We* will pay for a combined maximum total of 15 consultations with acupuncturist, homeopaths and practitioners of Chinese medicine for each *beneficiary* in any 1 *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.
- *We* will require a medical report and *treatment* plan prior to approval.

Prescribed drugs and dressings

Up to the maximum amount shown per *period of cover*.

$500
€370
£330

- *We* will pay for prescription drugs and dressings which are prescribed by a *medical practitioner* on an *outpatient* basis.

Rental of durable equipment

Up to the maximum of 45 days per *period of cover*.

$1,500
€1,100
£1,000

- *We* will pay for the rental of durable medical equipment for up to 45 days per *period of cover*, 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*.

Adult vaccinations

Up to the maximum amount shown per *period of cover*.

$250
€185
£165

- *We* will pay for certain vaccinations and immunisations that are clinically appropriate, namely:
  - Influenza (flu);
  - Tetanus (once every 10 years);
  - Hepatitis A;
  - Hepatitis B;
  - Meningitis;
  - Rabies;
  - Cholera;
  - Yellow Fever;
  - Japanese Encephalitis;
  - Polio booster;
  - Typhoid; and
  - Malaria (in tablet form, either daily or weekly).

Dental accidents

Up to the maximum amount shown per *period of cover*.

$500
€370
£330

- 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* 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*.

Well child tests

$1,000
€740
£665

- Payable for children at *appropriate age intervals* up to the age of 6.
- *We* will pay for well child routine tests at any of the *appropriate age intervals* (birth, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 2 years, 3 years, 4 years, 5 years and 6 years) and for a *medical practitioner* to provide preventative care consisting of:
  - evaluating medical history;
  - physical examinations;
  - development assessment;
  - anticipatory guidance; and
  - appropriate immunisations and laboratory tests; for children aged 6 or younger.

  We will pay for 1 visit to a *medical practitioner* at each of the *appropriate age intervals* (up to a total of 13 visits for each child) for the purposes of receiving preventative care services.
- In addition, *we* will pay for:
  - 1 school entry health check, to assess growth, hearing and vision, for each child aged 6 or younger; and
  - diabetic retinopathy screening for children over the age of 12 who have diabetes.

Child immunisations

$1,000
€740
£665

- *We* will pay for the following vaccinations and immunisations as appropriate, for children aged 17 or younger:
  - DPT (Diphtheria, Pertussis and Tetanus);
  - MMR (Measles, Mumps and Rubella);
  - HiB (Haemophilus influenza type b);
  - Polio;
  - Influenza;
  - Hepatitis B;
  - Meningitis; and
  - Human Papilloma Virus (HPV).

Annual eye and hearing test for children aged 15 and younger

Paid in full

- *We* will pay for the following routine tests for children aged 15 or younger:
  - 1 eye test; and
  - 1 hearing test.

Routine adult physical examination

Up to the maximum amount shown per *period of cover*.

$100
€75
£65

› *We* will pay for 1 routine adult physical examination (including but not limited to: height, weight, bloods, urinalysis, blood pressure, lung function etc.) for persons aged 18 or older.

Pap smear

Up to the combined maximum amount shown per *period of cover*.

› *We* will pay for 1 papanicolaou test (pap smear) for female *beneficiaries*.

Prostate *cancer* screening

Up to the combined maximum amount shown per *period of cover*.

› *We* will pay for 1 prostate examination (prostate specific antigen (PSA) test) for male *beneficiaries* aged 50 or over.

Mammograms for breast *cancer* screening

Up to the combined maximum amount shown per *period of cover*.

› *We* will pay for:

- Aged 35-39: 1 baseline mammogram for asymptomatic women.
- Aged 40-49: 1 mammogram for asymptomatic women every 2 years.
- Aged 50 or older: 1 mammogram each year.

Bowel *cancer* screening

Up to the combined maximum amount shown per *period of cover*.

› *We* will pay for 1 bowel *cancer* screening for *beneficiaries* aged 55 or older.

Bone densitometry

Up to the combined maximum amount shown per *period of cover*.

› *We* will pay for 1 scan to determine the density of the *beneficiaries* bones.

Combined aggregate limit of
$400
€300
£260

Deductible (various)

A *deductible* is the amount which *you* must pay before any claims are covered by *your* plan.

$0 / $150 / $500 / $1,000 / $1,500
€0 / €110 / €370 / €700 / €1,100
£0 / £100 / £335 / £600 / £1,000

Cost share after *deductible* and *out of pocket maximum*

Cost share is the percentage of each claim not covered by *your* plan.

The *out of pocket maximum* is the maximum amount of *cost share you* would have to pay in a *period of cover*.

The *cost share* amount is calculated after the *deductible* is taken into account. Only amounts *you* pay related to *cost share* contribute to the *out of pocket maximum*.

First, choose *your cost share* percentage:

0% / 10% / 20% / 30%

Next, choose *your out of pocket maximum*:

$3,000
€2,200
£2,000

DENTAL CARE AND TREATMENT

Maintain *your oral health* with the Dental Care and Treatment option. This option covers *you* for a wide range of preventative, routine and major *dental treatments*.

YOUR OVERALL LIMIT

Annual *benefit* - maximum per *beneficiary* per *period of cover*.	**$750 €550 £500**

YOUR STANDARD DENTAL BENEFITS

Preventative *dental treatment* After the *beneficiary* has been covered on this option for 3 months.	**Paid in full**

› *We* will pay for the following preventative *dental treatment* recommended by a *dentist* after a *beneficiary* has had Dental Care and Treatment cover for at least 3 months:

- 2 dental check-ups per *period of cover*;
- X-rays, including bitewing, single view, and or thopantomogram (OPG);
- scaling and polishing including topical fluoride *application* when necessary (2 per *period of cover*);
- 1 mouth guard per *period of cover*;
- 1 night guard per *period of cover*; and
- fissure sealant.

Routine *dental treatment* After the *beneficiary* has been covered on this option for 3 months.	**80% refund per *period of cover***

› *We* will pay *treatment* costs for the following routine *dental treatment* after the *beneficiary* has had Dental Care and Treatment cover for at least 3 months (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.	**70% refund per *period of cover***

› *We* will pay *treatment* costs for the following major restorative *dental treatments* after the *beneficiary* has had Dental Care and Treatment cover for at least 12 months:

- 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 Dental Care and Treatment option 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;
- which of the areas of cover it will come within (for the purposes of calculating when limits of cover are reached); and
- 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* and in *your Certificate of Insurance.*

› *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 (5) 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*;
  - 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 *your core cover* and/or Outpatient and Wellness Care option, if this option has been bought, 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;
  - diagnose or treat *conditions* or dysfunction of the temporomandibular joint;
  - stabilise periodontally involved teeth; or
  - restore occlusion.

NOTES

Details of the *Cigna* company who provides the cover under *your policy* can be found in *your Policy Rules* and on *your Certificate of Insurance*.

Together, all the way.℠

Cigna Close Care℠ Customer Guide 05/2018