WORLD BANK GROUP
MEDICAL BENEFITS PLAN

SUMMARY OF BENEFITS

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CONTENT

This document contains a general description of the medical coverage provided by the World Bank Group to its locally-recruited staff members in its country offices (Active MBP (AMBP), Continuation MBP (CMBP) and Retiree MBP (RMBP)). Should you have any questions about an item that is not listed below or want additional information, please contact Cigna, the insurance administrator for the MBP, at wbg.mbp@cigna.com or consult the Cigna MBP secure website at www.cignahealthservices.com.

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SUMMARY OF BENEFITS

YOUR MBP COVERAGE

1. In general

Benefits	Description
General overview	The MBP 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. Additionally, the Plan provides coverage for defined preventive care services, see Section 2. Summary of benefits. You can also find the Preventive Care Guide on the World Bank Group's MBP website as well as on your personal webpages.
Reasonable and customary (R&C)	Only reasonable and customary expenses are covered by the Plan. This means that, generally, only fees and prices which are commonly charged in the designated MBP region of the plan member's duty country for the treatment or purchase in question can be considered for reimbursement. Only in the following cases, the reasonable and customary (R&C) level of the country of care is taken into account for treatment outside the duty country: - MET (Medical Evacuation Travel) approved by the World Bank Group's Health Services Department (HSD): R&C of the country to which MET is approved. - Accident/sudden illness while on personal or operational travel - emergency treatment: R&C of the country where expenses are incurred. - Approved Developmental Assignments (DA) or Short Term Assignment (STA) of at least 3 months, routine and non-emergency expenses for the staff member only, R&C of the country where the DA/STA is approved. - Treatment not available in duty country: R&C of the nearest country where the treatment is available. Prior approval is required in these cases. - Approved out-of-region care. See your personal web pages for detailed information regarding out-of-region care.

	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 for the Active Medical Benefits Plan (AMBP)	The following are eligible to enroll in the MBP: (1) Staff holding the following types of appointments: (a) Open-Ended Appointments, (b) Term Appointments, (c) Extended Term Consultant/Temporary Appointments (2) Legal Spouse. If a staff member has more than one legal spouse, the staff member must select one spouse and indicate his/her full name on the enrollment form. It is not possible to change enrollment among spouses. Only one spouse is eligible for MBP enrollment. (3) Registered Domestic Partners who have been approved by the HR Service Center. Contact the HR Service Center at hrservicecenter@worldbank.org for more details. (4) Children who are under age 26 and who meet the following criteria: (a) Biological children, (b) Legally adopted children, (c) Step-children of a current marriage or domestic partnership registered with the Bank Group. (5) Handicapped children who are over age 25 and who have been approved by the insurance administrator may benefit from coverage beyond age 26. You must provide the insurance administrator with proof of your child's handicap no later than 31 days after your child reaches age 25. Your child is considered handicapped if: • He or she is unmarried; and • He or she is incapable of self-sustaining employment because of a mental or physical handicap that started when the child was your dependent and before he or she reached the maximum age of 25; and • He or she depends mainly on you for principal support and maintenance The insurance administrator may require periodic health evaluations of the handicapped child after initial acceptance of the handicap. A child's coverage under this provision ends on the earliest of: (a) The date your MBP coverage ends;

	(b) The date your child is no longer handicapped; (c) The date you fail to provide medical evidence that the handicap continues; (d) The date you fail to have any required exam performed; and (e) The date your child's coverage ends for a reason other than reaching the age limit.
End of Coverage	MBP coverage ends at the earlier of the date of death or the last day of the month that you end employment with the World Bank Group. Coverage can be terminated at the Bank Group's discretion in cases of fraud committed against the MBP, refusal to refund MBP overpayments in case of enrollment error, or if a participant does not pay his/her required contribution. When your coverage ends, dependent coverage also ends except in the event of your death at which time your surviving dependents become eligible for retiree coverage.
Eligibility for Retiree Medical Benefits Plan (RMBP)	Retirees of the World Bank Group, and their surviving covered family members, provided the retirees meet the following criteria: (1) Age 50 or more at start of retirement; (2) Have at least five (5) years of "qualifying service". Qualifying service is the total of the years you were in the Staff Retirement Plan (SRP) since April 15, 1998 plus any Local Regular or Local Fixed Term service prior to April 15, 1998 when you were eligible for the Termination Grant (including any additional Termination Grant service you received as a result of the recent Past Pension Credit reform); and (3) Age and "qualifying service" when you leave Bank Group service equals 60 or more (the "rule of 60"). Eligible family members who were not enrolled in the AMBP can enroll in the RMBP. Supporting documentation must be provided at time of enrollment in the RMBP.
Eligibility for Continuation Medical Benefits Plan (CMBP)	Except for fraud/misconduct cases, any MBP participant who loses eligibility (for example, if employment ends or a staff member or retiree divorces) may continue coverage for up to three (3) years from the day coverage ends. Coverage generally ends the last day of the month during which the event occurred. Enrollees in the CMBP pay the full unsubsidized rate. The CMBP is applicable to: (1) Staff whose employment with the World Bank Group ends and their eligible family members who were enrolled in the AMBP while the staff member was still employed; (2) A child who reaches his/her 26th birthday who was enrolled in the AMBP and who, therefore, is no longer eligible for the AMBP;

	(3) A divorced spouse and his/her eligible children who were enrolled in the AMBP prior to the divorce of the staff member.
Currency of reimbursement	The same as the currency in which the plan member contributes to the MBP which is usually the currency in which salaries are paid in the country office.
Reimbursement payment mode	AMBP: payment through payroll RMBP/CMBP: individual payments
Exchange rate	The official exchange rate of the European Central Bank (ECB) valid on the date of treatment. In the event of multiple dates of treatment on one claim, the exchange rate on the first date of treatment will be used. If date of treatment is not provided for multiple dates of treatment, the date of invoice will be used as a default.
Validity of prescriptions	One (1) year provided that the physician clearly and specifically states that the medication is required for a period up to one (1) whole year. Reimbursement is limited to a three (3) month supply at a time.
Claim submission deadline	All claims must reach Cigna no later than the end of the calendar year following the year in which the expenses were incurred. Claims not received by this date will not be reimbursed by the MBP. If the claim is submitted online, then the original invoices must be retained for one year from date of submission.
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/hospitalization	Treatment given on an inpatient basis, where the date of admission differs from the date of discharge and there is an overnight stay.
Plan year	A plan year is equal to a calendar year
Prior approval	Prior approval (see Annex) from Cigna's Medical Advisory Board is required for all non-emergency hospitalizations. Prior approval means that reimbursement is guaranteed only in cases where Cigna's Medical Advisory Board grants its explicit approval for the treatment, on the basis of the medical justification, as well as a Cost estimate furnished by the beneficiary at least 10 working days prior to the planned admission. In case of a medical emergency, approval can be obtained *after the fact*, on the basis of the same medical criteria. Other benefits that require prior approval from Cigna's Medical Advisory Board are marked as such. under Section 2. Summary of benefits.
Coordination of benefits	The MBP is always secondary to other insurance plans, including social security or other similar plan or program (governmental or

	private). In case of intervention by another insurance, the MBP will consider what the other plan has paid for a service and will apply the normal MBP rules to reimbursement. However, coverage will be coordinated so it is possible for the claim to be covered 100% when processed by both plans.
AMBP	Active MBP Member
CMBP	Continuation MBP Member
RMBP	Retired MBP Member

2. Summary of benefits

2.1. In the hospital

GENERAL RULE

All treatments and medicines must be prescribed by a qualified and registered medical doctor.

Unless explicitly mentioned, all patient's portions are taken into account for the stop loss calculation.

Item	Remarks
Prior approval from Cigna's Medical Advisory Board is required for all non-emergency hospitalizations and all surgeries. Notification of such hospitalizations should be given at least 10 working days prior to the admission date.	
Bed and board: stay in a semi-private room	AMBP + CMBP: 100% RMBP: 90%
Bed and board: stay in a private room	AMBP + CMBP: 80% RMBP: 70% Same coverage as semi-private room in the following cases: ▪ Admission of children under 12 ▪ Patients with contagious diseases or confirmed medical conditions requiring isolation ▪ If semi-private room is not available at the time of admission (to be justified) ▪ If standard (semi-)private room does not exist at the hospital (subject to confirmation by Cigna)
Stay in the Intensive Care Unit (ICU)	AMBP + CMBP: 100% RMBP: 90%
Doctor's fees (surgeon, assistant, anaesthetist)	AMBP + CMBP: 90% RMBP: 80% Prior approval is required for all major surgery and recommended for minor surgery to avoid denial of coverage (e.g. cosmetic surgery or surgery if certain medical criteria are not met).
Doctor's fees (treating physician, midwife)	Inpatient: ▪ AMBP + CMBP: 100% ▪ RMBP: 90% Outpatient:

Item	Remarks
	▪ AMBP, CMBP, RMBP: 80%
Other hospital expenses (e.g., use of operating theatre and equipment, lab, x-rays, medication for use during the hospital admission)	▪ AMBP + CMBP: 100% ▪ RMBP: 90%
Accompanying person	Not covered
Outpatient surgery	80%
Chemotherapy, radiotherapy, haemodialysis, etc.	80%
Specific admissions/surgeries	
Admission related to alcohol and drug abuse	▪ AMBP + CMBP: 100% ▪ RMBP: 90%
Cataract surgery	▪ AMBP + CMBP: 90% ▪ RMBP: 80%
Delivery	Inpatient: • see bed & board expenses hospitalization & other hospital expenses • Doctor's fees: - normal delivery: 80% - surgeon's fee for C-section: 90% Outpatient: see outpatient surgery
Fertility treatment: • Artificial Insemination (AI)	80% up to 6 courses of treatment per patient's lifetime. All fertility treatment requires prior approval and is limited to a lifetime maximum reimbursement of US$25,000.
Fertility treatment: Advanced Reproductive Technology (ART) • 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) • Tubal embryo transfer (TET) and pronuclear stage tubal embryo transfer	See outpatient surgery Not covered: ▪ the purchase of donor sperm or storage of sperm; ▪ expenses of donors of any kind; ▪ care of donor egg retrievals or transfers to storage; ▪ cryo-preservation or storage; and ▪ gestational carrier programs. All fertility treatment requires prior approval and is limited to a lifetime maximum reimbursement of US$25,000.

Item	Remarks
(PROUST). • Intracytoplasmic sperm injection (ICSI) or ovum microsurgery	
Termination of pregnancy	80%
Sterilization/Vasectomy/Tubal ligation	100% Sterilization procedures, including sterilization implant and surgical sterilization (abdominal, vaginal or laparoscopic) Including male sterilization (vasectomy) Eligible charges for a sterilization procedure and all ancillary services will be covered at no cost share when it is the primary purpose of the services provided and/or if it is performed as a standalone procedure and billed separately.
Reversal of sterilization/Vaso-vasectomy	Not covered
Blepharoplasty (= eyelid surgery)	See outpatient surgery Subject to prior approval of Cigna's Medical Advisory Board. Please send medical report with justification to Cigna.
Corrective eye surgery to change the dioptre/LASIK	Not covered
Rehabilitation/convalescence after surgery	See stay in hospital Limited to 60 days per condition per plan year
Psychiatric admission	See stay in hospital
Home for the elderly/nursing home	Not covered
Institution for the disabled	Not covered
Spa Cures	Not covered
Cosmetic surgery	Not covered
Reconstructive surgery	Covered as any other surgery when approved
Breast reduction	Subject to prior approval of Cigna's Medical Advisory Board. Please send medical report with justification to Cigna.
Circumcision	See outpatient surgery
Organ transplant	See MBP Organ Transplant Policy
Rhinoplasty (= plastic surgery of the nose)	See outpatient surgery

Item	Remarks
/Septoplasty (= surgical procedure to correct the shape of the nasal septum, the separation between the 2 nostrils)	Subject to prior approval of Cigna's Medical Advisory Board. Please send medical report with justification to Cigna.

2.2. Ambulance and transportation expenses 

GENERAL RULE

All treatments and medicines must be prescribed by a qualified and registered medical doctor.

Unless explicitly mentioned, all patient's portions are taken into account for the stop loss calculation.

Item	Remarks
General transportation costs	See Ambulance
Ambulance	80% Provided professional ambulance service is to transport a patient from the place where s/he is injured or becomes ill to the nearest hospital able to provide treatment or from one medical facility to another.
Other types of transport	Not covered
Repatriation of mortal remains	Not covered
Evacuation	Not covered See provisions for medical evacuations approved by World Bank Group Health Services Department (HSD), for eligible persons only (World Bank Group Staff Rule 6.07.)

2.3. At the General Practitioner's 

GENERAL RULE

All treatments and medicines must be prescribed by a qualified and registered medical doctor.

Unless explicitly mentioned, all patient's portions are taken into account for the annual stop loss calculation.

Item	Remarks
Consultation	80%
Annual subscription fees	Not covered
Minor surgical intervention	80%
Immunization / Vaccination	See MBP Guide to Preventive Care for the list of immunizations covered at 100%. 80% for non-preventive services or services that do not meet criteria for coverage at 100%.
Routine physical exam	See MBP Guide to Preventive Care for a specification of the tests, screenings, etc; that are covered per bracket of age at 100%. 80% for non-preventive services or services that do not meet criteria for coverage at 100%.
Well-child care	See MBP Guide to Preventive Care s for the number of exams, type of screenings, and immunizations covered for children per bracket of age at 100%. 80% for non-preventive services or services that do not meet criteria for coverage at 100%.
Behavioral problems, developmental problems children	See MBP Guide to Preventive Care for a specification of the tests, screenings, etc; that are covered at 100%per age bracket . 80% for non-preventive services or services that do not meet criteria for coverage at 100%.
Testing for the HIV virus	100% - 1 preventive test per plan year See MBP Guide to Preventive Care

2.4. At the specialist's 

GENERAL RULE

All treatments and medicines must be prescribed by a qualified and registered medical doctor.

Unless explicitly mentioned, all patient's portions are taken into account for the annual stop loss calculation.

Item	Remarks
Consultation	80%
Treatment	80%
Second surgical opinion	80%
Outpatient mental health care	
Behavioral health counselling via Skype or telephone	80% On the condition that there is already a doctor patient relationship.
Immunotherapy	80%
Prenatal care	100% for: Routine prenatal office visits with OB/GYN, including initial and subsequent visits for covering history and physical examinations (maternal weight, blood pressure and fetal heart rate check) • Prenatal tests: see Preventative Care Guide Items not considered preventive include (but may not be limited to) inpatient admissions, high risk specialist visits, ultrasounds, amniocentesis, fetal stress tests, certain pregnancy diagnostic lab tests, and delivery including anesthesia. These will be covered at 80% (non-preventive services or services that do not meet criteria for coverage at 100%). Since some providers bill with a global rate that represents prenatal, delivery, and post-partum care, the Plan will cover the portion of that global rate that applies to the prenatal care at no cost share; the remaining portion covering the delivery and post-partum care will be subject to cost share according to the Plan.
IUD (intrauterine device)	See Contraceptives

Item	Remarks
Check-ups (mammography, Pap smear, etc)	See MBP Guide to Preventive Care for services covered at 100%. 80% - non-preventive services or services that do not meet criteria of MBP Guide to Preventive Services.
Hearing test	80%
Behavioral problems, developmental problems children	Screening : 100% see Preventive Care Guide Treament: 80%, maximum 10 sessions per year
Developmental delays	Diagnostic testing: 100% see Preventive Care Guide Treatment: Speech, Therapy and/or Occupational Therapy for minor children with a diagnosis of Developmental Delay covered at 80% for up to 60 visits combined per plan year. Must be performed by a licensed practitioner.
Eye examination by a medical doctor (ophthalmologist or optometrist)	90% with a maximum of one (1) test per plan year
Eye examination by an optician	Not covered
Eye examination due to a medical condition (i.e. not routine)	80%

2.5. At the licensed qualified medical service providers (other than doctor)

GENERAL RULE

All treatments and medicines must be prescribed by a qualified and registered medical doctor.

Unless explicitly mentioned, all patient's portions are taken into account for the annual stop loss calculation.

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	80%
Private home duty nursing	80% Reimbursable if prescribed by attending physician as medically necessary. Attending physician's prescription must indicate: • medical condition requiring medical care at home;

Item	Remarks
	and • treatment plan including type and length. If the duration of the treatment exceeds three (3) months, the attending physician must reassess the treatment and issue a new prescription. Services must be rendered by a qualified nurse. This benefit does not cover charges made for a person who usually lives with the patient, who is a member of his/her family or who is a member of his/her spouse's family.
Nursing assistance for activities of daily living (e.g., dressing, feeding, supervision)	Not covered
Home health care	80% Reimbursable if prescribed by the attending physician as medically necessary and **as an alternative to either hospitalization, or a stay in a skilled nursing facility.** **Prior approval is required**. To obtain prior approval, please submit a medical prescription indicating: • the medical condition requiring home health care; and • the treatment plan including type and length of the treatment. If the duration of the treatment exceeds three (3) months, the attending physician must reassess treatment and issue a new prescription. Services must be rendered by a qualified nurse or a certified home health care agency which is licensed to operate as such. The benefit does not cover charges made for a person who usually lives with the patient, who is a member of his/her family or who is a member of his/her spouse's family. Does not cover custodial care, home help, maid service or similar household help.
Dietician and nutritional counselling	80% Subject to prior approval of Cigna's Medical Advisory Board. Please send medical report with justification to Cigna.

Item	Remarks
Education programmes for diabetes/asthma/severe allergy patients	80%
Prenatal and postnatal exercises guidance	See physiotherapy
Prenatal classes or Lamaze classes	Not covered
Breast feeding / lactation	100% coverage for interventions to promote and support lactation/breastfeeding (up to 6 visits per plan year to qualified lactation consultant for either individual or group classes)
Physiotherapy/Physical Therapy	80% **Up to 60 sessions per condition per plan year**: medical prescription mentioning the diagnosis If **more than 60 sessions** are needed: prior approval is needed. To obtain prior approval, the following information must be submitted to Cigna's Medical Advisor: - A medical report showing the progress made against the treatment goals and confirming the diagnosis - Future treatment plan with goals and target dates - A detailed cost estimate per session
Occupational therapy/functional rehabilitation	See physiotherapy
Alternative medicine	Normally not covered unless specifically mentioned and approved in advance by Cigna. The following treatments are not covered • Aromatherapy • Biofeedback therapy • bionergetic therapy • collagen therapy • colonic irrigation • Craniosacral therapy • Gemstone, crystal, chakra therapy • Iridology • Magnetic field therapy • Music therapy • Naturopathic therapy • Reflexology • Rolfing treatment

Item	Remarks
	This list is not limitative or exhaustive. If the treatment you are considering is not explicitly mentioned, please contact Cigna prior to engaging the treatment to verify whether the treatment qualifies for reimbursement.
Acupuncture	80% Covered for up to thirty (30) visits per plan year. Additional sessions are reimbursable subject to medical review by the insurance administrator. If the duration of the treatment exceeds thirty (30) sessions, **prior approval** from Cigna's Medical Advisor is required. In that case, please submit a medical report mentioning: • the patient's diagnosis; • the type of treatment planned; • number of sessions planned; • total length of treatment planned; and • specific adjustments or modalities to be applied.
Ayurveda	80% Only reimbursed if that type of care is generally accepted in the country where care is rendered. This care must also be appropriate and necessary for the diagnosis.
Chiropractic treatment	80% up to 30 sessions per plan year If the duration of the treatment exceeds thirty (30) sessions, **prior approval** from Cigna's Medical Advisor is required. In that case, please submit a medical report mentioning: • the patient's diagnosis; • the type of treatment planned; • number of sessions planned; • total length of treatment planned; and • specific adjustments or modalities to be applied.
Podotherapy	80%. Treatment must be conducted by a qualified medical doctor.
Speech therapy	80% Only if the treatment is following illness, surgery, injury

Item	Remarks
	or accident. **Up to 60 sessions per condition per plan year**: medical prescription mentioning diagnosis. If **more than 60 sessions** are needed: prior approval is needed. To obtain prior approval the following information must be submitted to Cigna's Medical Advisor: - A medical report showing the progress made against the treatment goals and confirming the diagnosis. - Future treatment plan with goals and target dates. - A detailed cost estimate per session. Not covered for educational reasons. For developmental delays: see developmental delays
Psychological treatment given by a • psychiatrist; • licensed psychologist; • licensed psychoanalyst; • licensed psychiatric social worker; • neurologist	80% **Up to 10 sessions without medical prescription** If **10 sessions or more** are needed: prior approval is needed. To obtain prior approval, the following information must be submitted to Cigna's Medical Advisor: Up to 30 sessions:A prescription from a doctor or psychiatrist with: The documented diagnosis; A treatment plan; and A progress report showing achievable goals within a limited timeframe (3-6 months) - A detailed cost estimate per session. • As of 31 sessions: - A medical report from a doctor or pschiatrist showing - a documented diagnosis; - a description of the symptoms; - the current medical condition; - a treatment plan; - a progress report with clearly established

Item	Remarks
	treatment objectives (short and long-term goals) and criteria for a recovery process from psychotherapy. A detailed cost estimate per session. Counselling by non-physicians for non-medical reasons is not covered.
Custodial care	Not covered
Hospice care	Outpatient :80% Inpatient: see Hospitalization For a patient with a confirmed life expectancy of twelve (12) months or less. Covers pain management, chronic symptom management, medical, and drug supplies as prescribed by a physician. Bereavement counseling will be covered in-country only at 100% with a maximum of $75 per session for up to six (6) sessions in either 3 month period prior to the date of death or the 12 month period following the date of death. Prior approval is required
Relationship therapy	80%, maximum 10 sessions per year
Outpatient treatment for alcohol and drug abuse	80% Prior approval is advisable

2.6. At the optician's

GENERAL RULE

All treatments and medicines must be prescribed by a qualified and registered medical doctor.

Unless explicitly mentioned, all patient's portions are taken into account for the annual stop loss calculation.

Item	Remarks
Eye examination by a medical doctor (an ophthalmologist or optometrist)	90% with a maximum of one (1) test per plan year
Corrective glasses and contact lenses	100% up to US$200 every two (2) years Any co-pay exceeding the ceiling does not count toward the annual stop loss.

Item	Remarks
Frames	See corrective glasses and contact lenses
Fluid for contact lenses	Not covered

2.7. At the dentist's

GENERAL RULE

All treatments and medicines must be prescribed by a qualified and registered medical doctor.

Co-pay for dental care does not count towards the annual out-of-pocket (stop loss).

Item	Remarks
General cover for dental care	80% up to a ceiling of US$3,200 per plan year. Charges in connection with dental services primarily for the purpose of improving appearance are not covered, such as: • alteration or extraction and replacement of sound teeth; • porcelain or other veneer crowns, facing on crowns, or pontics to replace molar teeth; • any treatment of the teeth to remove or lessen discoloration; • replacement of congenitally missing teeth; and • all appliances and restorations for the purpose of splinting teeth, except A-splinting and provision splinting in connection with periodontal treatment If gold fillings are elected, the reimbursement is limited to the expense for an amalgam or porcelain material. Removal of fillings is only reimbursed if removal is required for a dental or medical reason
Half-yearly dental exam	100% with a maximum of two (2) visits per plan year
Dental cleaning	100% with a maximum of two (2) per plan year
Dental fluoride (topical application of sodium or stannous fluoride)	80% up to a maximum of two (2) applications per plan year Subject to annual ceiling for dental care
Dental x-rays	See dental care
Dental crowns	See dental care If three (3) or more crowns are required in one planned treatment, prior approval is needed. Please submit the

Item	Remarks
	following documents: • diagnosis and dental report • x-rays if needed (may be requested by Cigna) • detailed cost estimate
Prostheses (including bridges, implants, dentures)	See dental care Prior approval is required. Please submit the following documents: • diagnosis and dental report; • x-rays if needed (may be requested by Cigna); • detailed cost estimate. Temporary restorations are not reimbursed since these are inclusive in the final restoration and should not be billed separately by the provider. The MBP also covers: • replacement when ordered in cases of wear or damage. ***Note:*** Replacements will not be reimbursed if the bridge or item has been in place for less than five (5) years; and • reasonable costs for repairing, fitting, maintaining, and adjusting appliances/devices If surgery is performed as part of the procedure, surgical charges may be treated as medical benefits and, therefore, not fall under the annual ceiling for dental care. If you want to know beforehand whether part of the expenses will be considered as medical rather than dental, please contact Cigna with a detailed cost estimate and dental report.
Orthodontic care (including the orthodontic device)	See dental care Treatment must start before the age of 18 and not lasting longer than 4 years from start date. Subject to lifetime maximum benefit of US$2,400. Charges are not applied to the US$3,200 annual maximum benefit for dental care. The age limit can be waived when: • it concerns medical necessity, prior approval from Cigna is required based on the IOTN index (Index on Orthodontic Treatment Need); • the treatment is the result of an accident or injury while the patient was insured and as long as the treatment begins within 90 days from the accident.
Dental surgery performed in hospital for which a hospital theatre is required	Dentist's fees (surgeon + anaesthesist): see dental care Other hospital expenses (theatre, medication, etc.):

Item	Remarks
(e.g., surgical tooth extraction)	outpatient surgery/hospitalization.
Stomatology and orthofacial surgery	To be considered as medical expenses, see outpatient surgery/hospitalization
Toothbrush, toothpaste, mouthwash	Not covered
Tooth whitening	Not covered

2.8. At the pharmacist's

GENERAL RULE

All treatments and medicines must be prescribed by a qualified and registered medical doctor.

Unless explicitly mentioned, all patient's portions are taken into account for the annual stop loss calculation.

Item	Remarks
General cover of prescribed pharmaceutical products	80% Covered in case the products meet the following requirements: • containing enough active medical components to qualify as medication; • generally medically recognized (peer reviewed medical literature) and fully approved by the relevant legislation in force; • required and prescribed by a doctor for a well specified diagnosis or risk; the dosage and the quantity purchased need to be reasonable and customary for the specified diagnosis. Prescriptions (and medication refills) are valid for a period of one (1) year provided that the attending physician clearly and specifically indicates that drug treatment is required for the whole year. Reimbursement is limited to up to a three (3) month supply at one time. If the duration of the treatment exceeds one (1) year, the attending physician must reassess the treatment and issue a new prescription.
Over-the-counter (OTC) drugs	See prescribed pharmaceutical products The following products are not covered: • cosmetics such as creams/lotions to remove wrinkles, Retin A products (unless for diagnosed severe acne) body washes/soaps, moisturizers/

Item	Remarks
	barrier creams, skin cleansers; • non-medicated eye drops, hypo tears; eye lubricants; and • products listed as non-covered in this document This list is not limitative, so in case you have doubts, please contact Cigna.
Biphosphonates medication to treat osteoporosis (Fosamax, Evista e.d.)	See general pharmaceutical products Subject to prior approval of Cigna's Medical Advisory Board. Please send medical report with justification to Cigna.
Food/nutritional supplements	Not covered Only reimbursable upon prior approval if prescribed by the attending physician to treat a medical condition (e.g anemia or administered during a hospitalization) The following information needs to be sent to Cigna: - prescription mentioning the condition to be treated and the length of the treatment (new prescription is required every 3 months) - Laboratory results to demonstrate the need
Vitamins and minerals	Not covered Except under the following circumstances: • to treat a diagnosed deficiency as a result of an illness or treatment; and • Prenatal vitamins for documented pregnancy. See prescribed pharmaceutical products
Multivitamins	See vitamins and minerals
Calcium	See vitamins and minerals
Homeopathy	80% Only reimbursed if that type of care is generally accepted in the country where care is rendered.
Phytotherapy, herbal products	Not covered
Chinese medication	See prescribed pharmaceutical products Only reimbursed if that type of care is generally accepted in the country where care is rendered.

Item	Remarks
Appetite inhibitors aimed at weight loss / dietary products	Not covered unless: At 80% for morbid obesity where the prescription of appetite suppressants is medically necessary and appropriate. Must be pre-approved by the insurance administrator. Attending physician's prescription must specify the length of treatment. If the duration of the treatment exceeds three (3) months, the attending physician must reassess the treatment and issue a new prescription.
Drugs for obesity management (Xenical, Meridia and Reductil)	80% Subject to prior approval of Cigna's Medical Advisory Board. Please send medical report with justification to Cigna.
Products aimed at quitting smoking	80% with a maximum of a six (6) month lifetime supply per patient. This includes nicotine patches, gum, cures and medication. **As of February 1, 2011** Two (2) cycles of Generic Zyban are reimbursable at 100%. See MBP Guide to Preventive Care
HIV/AIDS medication	See general pharmaceutical products
Daily care products (soap, shampoo, etc.)	Not covered
Special shampoos	80% Following conditions have to be met: • shampoo has to be prescribed by the attending physician to treat a medical condition (e.g., seborrheic dermatitis); and • the hair lotion/shampoo is not an over-the-counter (OTC) product. Prior approval required.
Contraceptives	100% or 80% See MBP Guide to Preventive Care for services covered at 100% Office visits for administration of contraceptive devices and cost of the contraceptive device, if billed by provider. Including 2 visits per plan year for contraceptive

Item	Remarks
	counseling. Condoms are not reimbursable.
Dressings / bandages	See general pharmaceutical products
Glucosamine, chondroitin sulfate	Not covered
Hair and nail growth stimulating products	Not covered
Medication to (temporarily) treat impotence (e.g., Viagra, Levitra)	80% with a maximum of six (6) tablets per month as long as prescribed with a physician's prescription showing the patient name and diagnosis.
Malaria prophylaxis (= prevention of malaria)	100% See MBP Guide to Preventive Care for services covered at 100%.
Nicotine substitutes	See products aimed at quitting smoking
Preventive vaccinations for children (well-child care)	See Well child care
Vaccines	See Immunizations / vaccinations
HPV vaccine (e.g., Gardasil, Cervarix)	See MBP Guide to Preventive Care for services covered at 100% per bracket of age. 80% - for non-preventive services or services that do not meet criteria for coverage at 100%
Insulin, syringes for diabetics	See general pharmaceutical products
Glucometer, insulin pump, blood testing strips for insulin-dependant diabetics	See general pharmaceutical products
Glucometer, insulin pump, blood testing strips for non-insulin-dependant diabetics	Not covered
Strips for urine testing for diabetics	See general pharmaceutical products
Hormonal treatment to stimulate fertility	80% Ovulation induction with ovulatory stimulant drugs is subject to a maximum of six (6) courses of treatment in a member's lifetime and the ceiling foreseen for fertility treatment. (A course of treatment is one (1) cycle of treatment that corresponds to one (1) ovulation attempt.) The woman must have a condition that: • is a demonstrated cause of infertility; • has been recognized by a gynecologist or infertility

Item	Remarks
	specialist; and • was not caused by voluntary sterilization, or its reversal, for patient or for partner, or hysterectomy.

2.9. At the specialised supplier's office

GENERAL RULE

The plan covers the rental of medical appliances at 80% (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 Cigna's Medical Advisory Board.

Unless explicitly mentioned, all patient's portions are taken into account for the annual stop loss calculation.

Item	Remarks
Orthopaedic devices/durable medical equipment in general	80% Prior approval is required. The following equipment never qualifies for reimbursement: • replacement or repair of durable medical equipment due to loss, theft or negligence; • durable medical equipment prescribed as a convenience (e.g., blood pressure kit) or accommodation to the patient even when ordered by a physician; • bathroom safety equipment; • posture chair/recliner; • environmental control equipment (air cleaners, air conditioners, air or water filters, dehumidifiers); • exercise equipment; • whirlpool equipment; • jacuzzi; • health club or athletic club fees; • professional medical equipment: (stethoscopes, etc.); • non-hospital or water beds; • modifications to automobiles or other transportation devices; • van and stair lifts; • traction devices; and • intercoms or communication devices.
Breast feeding support (including breast pump)	100% of: **Rental** of a hospital-grade electric pump when the baby is detained in the hospital. **Purchase** of a manual or standard electric breast pump on the condition that: - It costs less to buy a breast pump than to rent one, if requested within 60 days from the date of birth.

Item	Remarks
	- Only in case no standard electric breast pump or a manual breast pump has been reimbursed within the previous three years. - ·the request is sent within 12 months from the date of birth. For a woman using a breast pump from a prior pregnancy, a new set of breast pump supplies in any year when a woman would not qualify for the purchase of a new pump. The purchase of a heavy duty electrical (hospital grade) breast pump will not be standardly covered.
Repair orthopaedic devices/durable medical equipment	See orthopaedic devices / durable medical equipment in general
Artificial eye	See orthopaedic devices / durable medical equipment in general
Orthopaedic shoes	See orthopaedic devices / durable medical equipment in general
Inlay soles	Subject to prior approval of Cigna's Medical Advisory Board. Please send medical report with justification to Cigna.
Hearing aids	80% up to US$4,000 per five (5) plan years
Rental of an aerosol/nebulizer	See orthopaedic devices / durable medical equipment in general
Rental of a CPAP appliance	See orthopaedic devices / durable medical equipment in general
Rental of sphygmomanometer (= a blood pressure meter)/blood pressure gauge	Not covered
Wheelchair	See orthopaedic devices / durable medical equipment in general
Crutches	See orthopaedic devices / durable medical equipment in general
Rollator	
Standing frame	
Support stockings for varicose veins	See orthopaedic devices / durable medical equipment in general Subject to prior approval of Cigna's Medical Advisory Board. Please send medical report with justification to Cigna.

Item	Remarks
Wig	See orthopaedic devices / durable medical equipment in general Reimbursable only for patients with hair loss due to an illness or injury or due to treatment of a disease such as chemotherapy or radiation treatment. Must be pre-approved by the insurance administrator.
Special bathing suit, bra after breast amputation	See orthopaedic devices / durable medical equipment in general
Humidifier	Not covered
Anti-allergic eiderdown cover, mattress cover, pillow cover	Not covered

2.10. In the laboratory/medical imaging facility 

GENERAL RULE

All treatments and medicines must be prescribed by a qualified and registered medical doctor.

Unless explicitly mentioned, all patient's portions are taken into account for the annual stop loss calculation.

Item	Remarks
X-rays	80%
Magnetic Resonance Imaging (MRI)	80%
Ultrasound	80%
Electrocardiogram (ECG)	80%
Preventive routine mammography	See MBP Guide to Preventive Services for criteria for coverage at 100%. 80% - for non-preventive services or services that do not meet criteria for coverage at 100%
Mammography for diagnostic purposes	80%
Laboratory tests	80%
Amniocentesis	80%
HIV testing	See MBP Guide to Preventive Care for coverage at 100%.

Item	Remarks
PSA testing	See MBP Guide to Preventive Care for criteria for coverage at 100%. 80% - for non-preventive services or services that do not meet criteria for coverage at 100%.
Pap smear	See MBP Guide to Preventive Care for criteria for coverage at 100%. 80% - for non-preventive services or services that do not meet criteria for coverage at 100%.

3. Exclusions

- Expenses that are not medically necessary.
- Custodial care: home help, family help, maid or similar household assistance, and fees of persons who are not qualified nurses.
- Charges which exceed the reasonable and customary (usual and prevailing) amounts valid in the duty country, except as defined under reasonable and customary expenses.
- For services which are not generally accepted as the standard medical practice in the country of service by the insurance administrator. In general, “alternative” medical practices or items are not covered unless specifically confirmed by the insurance adminisrator.
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- Treatment that is not given by licensed practitioners, doctors, nurses, psychiatrists, psychologists, clinical social workers, certified nurse midwives and other licensed medical professionals, holding appropriate qualifications and licenses applicable in the country where care is rendered.
- Registration fees or advance payment fees that are used to guarantee care by, reduce costs of care from or facilitate delivery of care regardless of whether or not the patient has received or will receive treatment from the provider.
- Experimental or investigational care.
- Experimental drugs.
- Old age homes.
- Personal expenses: hospital charges for telephone, television, persons other than the patient, etc.
- Food and dietary products (other than those normally provided during a hospitalization), dietary supplements, cosmetics, toilet articles.
- Meals for the non-patient
- Discount cards.
- Blood cord preservation.
- Charges for treatment furnished or medicine provided by the following person who are related to the covered person: person’s spouse, parent, child, grandparent, brother, sister, niece, nephew, aunt, uncle, parent-in law.
- Services that a member would not legally pay if there were no insurance.
- Medical services due to an ‘on-the-job’ injury or illness. ‘On the job’ means employment with any employer or self-employment where the patient has a compensable workers compensation claim against that employer.

- Radial keratotomies or laser surgery performed to treat myopia/short sightedness or long sightedness.
- Blood pressure monitoring equipment.
- Spa cures, rejuvenation cures.
- Cosmetic treatment.
- All items mentioned in the summary of benefits as “not covered”.

4. Stop loss benefit or Annual out-of-pocket

The **individual** stop loss limit is equivalent to 5% of the net annual salary for the market reference point (MRP) for an individual’s grade in force on 1 January of that calendar year. This is established on an annual basis and is set once per year. If your expenses meet the stop loss limit during the year, the MBP will reimburse medical expenses at 100% for all covered expenses for the rest of that plan year.

This limit does not apply to:

- dental expenses;
- other non covered expenses, or the amount above the R&C level for treatment received outside the duty country.

Family stop loss is equivalent to 10% of the net annual salary for the market reference point (MRP) in force on 1 January of that calendar year. When the individual stoploss amount changes, so does the family one.