# Definition of Covered Medical Services

## International Plan

### Routine Preventive Care Benefits

- You and your covered dependents are eligible for routine preventive care benefits (for example, standard annual physicals, including standard laboratory tests and immunizations).

### Ambulances

- Charges for local ambulance services are for emergency medical needs only and to the nearest hospital where medical care and treatment can be provided. Local ambulance service may include Medivac helicopters but only if their use is for emergency medical care, and it is warranted.

### Hospital bed, hospital board, services, and supplies

- Charges made by a hospital for bed and board, and for other necessary services and supplies (subject to the limits shown in the Table of Covered Medical Services).

### Outpatient hospital medical care

- Charges made by a hospital, for medical care and treatment provided on an outpatient basis.

### Surgical facility charges

- Charges made by a freestanding surgical facility, for medical care and treatment.

### Mental health services

- Charges made by a licensed facility for care and treatment of mental illness on an outpatient or inpatient basis. After 45 days of inpatient stay, medical necessity required.

### Treatment of alcohol and drug abuse

- Charges made by a facility licensed to furnish treatment of alcohol and drug abuse, on its own behalf, for care and treatment provided on an outpatient or inpatient basis. After 45 days of inpatient stay, medical necessity required.

### Physician and other fees

- Charges made by a physician, a psychologist and other licensed health care professional services.

### Professional nursing services

- Charges made by a nurse for professional nursing services.

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### Anesthetics

- Charges made for anesthetics and their administration.

### Lab tests and X-rays

- Charges for diagnostic X-ray and laboratory examinations.

### Radiation and other treatments

- Charges for radium and radioactive isotope treatment, and chemotherapy.

### Blood

- Charges for blood transfusions, and blood not donated or replaced.

### Gases

- Charges for oxygen and other gases and their administration.

### Hearing Aid

- Charges for hearing aids or examinations for prescription or fitting thereof.

### Equipment

- Durable medical equipment may be purchased if it provides cost-effective alternative to rental. Your assigned claims administrator must approve all durable medical equipment purchases.

### Prosthetic devices

- Replacements for a part of the body.

### Dressings and prescriptions

- Charges for dressings, and drugs and medicines lawfully dispensed only upon the written prescription of a physician.

### Physical, occupational, or speech therapy

- Charges for therapy provided by a licensed physical, occupational or speech therapist. After 30 days of treatment, medical necessity review is required.

### Applied Behavioral Therapy (ABA)

- Charges for ABA when determined to be medically necessary for the treatment of autism for dependent children under the age of 19, with annual limit of $40,000 per child. Services are subject to periodic review for continued medical necessity.

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### Organ transplants

- Charges made for or in connection with approved organ transplant services, including immune-suppressive medication; organ procurement cost, donor's medical costs and transportation up to a limit of $10,000 per case only at the in-network level. The amount payable for donor's medical costs will be reduced by the amount payable for those costs from any other plan.

### Cataract surgery follow-up

- Charges made for the purchase of the first pair of eyeglasses or therapeutic contact lenses following cataract surgery.

### Home Health Care

- Charges made by a home health care agency for the following medical services and supplies provided under the terms of a medically warranted home health care plan for the person named in that plan:
  - Part-time or intermittent nursing care by or under the supervision of a registered graduate nurse.
  - Part-time or intermittent services of a home health aide.
  - Physical, occupational, respiratory or speech therapy.
- Medical supplies; drugs and medicines lawfully dispensed only on the written prescription of a physician; and laboratory services; but only to the extent that such charges would have been considered covered expenses had a person required confinement in the hospital as a registered bed patient or confinement in a skilled nursing facility.

Please note that these services are covered for up to 40 days per calendar year total for any combination of the cited services. Any continuation of services beyond 40 days per calendar year must be reviewed for medical necessity.

### Hospice care

Charges made due to terminal illness for the following hospice care services provided under a hospice care program:

- By a certified hospice facility for bed and board and services and supplies, subject to the administrator's established criteria.
- By a hospice facility for services provided in the home.
- By a physician for professional services.
- For pain relief treatment, including prescribed drugs and medical supplies.

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### Guarantee of Payment (GOP)

For those members of the International Plan residing outside of the United States and Puerto Rico, Cigna Global has established a process to issue a Guarantee of Payment (GOP) for any non-network provider or hospital so you may receive necessary services without the need to pay up front and file a claim.

Plan members may request a GOP in order to establish arrangements for Cigna Global to pay directly to the providers for services rendered.

The GOP establishes the procedures/services to be rendered, the amounts to be paid, and the service provider who will receive payment. Members, or representatives on their behalf, can start the GOP request process prior to their scheduled hospitalization/surgery.

Although many Cigna Global network providers may not require a GOP, it is always a good idea to request a GOP in advance of scheduled services, and especially if there is uncertainty as to whether the provider is in- or out-of-network for Cigna Global or the services required are medically necessary and eligible under the Plan.

In principle, a GOP should be granted by Cigna Global within 48 hours after the request has been made, except in cases of emergencies in which a GOP should be issued within 2 hours if requested by phone. In the case of planned procedures, it is advisable that the GOP request is made 14 days before the procedure is schedule to take place.

# Definition of Non-Covered Medical Services

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The Medical Plan does not pay benefits for:

- Ambulance travel by airplane.
- Charges for or in connection with experimental or investigational procedures or treatment methods not approved by relevant national authorities or medical specialty societies (e.g., Food and Drug Administration (FDA) or the American Medical Association (AMA) in the U.S. for drugs and medical procedures, respectively) or which are not in accordance with the assigned plan administrator's established standards (i.e., as reflected in its published Clinical Policy Bulletins or coverage policy documents).
- Charges made by a physician for or in connection with multiple surgeries that exceed the following maximum: when two or more surgical procedures are performed through the same surgical incision, the maximum amount payable will be the amount otherwise payable for the most expensive procedure, and one-half the amount otherwise payable for all other surgical procedures.
- Charges made by an assistant surgeon in excess of 20 percent of the surgeon's allowable charge (for purposes of this limitation, allowable charge means the amount payable to the surgeon prior to any reductions due to coinsurance or deductible amounts).
- Amniocentesis, ultrasound, or any other procedures requested solely for sex determination of a fetus, unless medically necessary to determine the existence of a sex-linked genetic disorder.
- Transsexual surgery and related services.
- Charges made for or in connection with tired, weak, or strained feet for which treatment consists of routine foot care, such as the removal of calluses and corns or the trimming of nails, unless medically necessary
- Charges for or in connection with cosmetic surgery, unless (a) a person receives an injury, while insured for these benefits, which results in bodily damage requiring the surgery; or (b) it qualifies as reconstructive surgery performed on a person following surgery; and both the surgery and the reconstructive surgery are essential and medically necessary; or (c) it is performed on any one of your dependents who is less than 16 years old to correct a congenital anomaly.
- Charges for a second surgical opinion rendered more than six months after a surgeon has first recommended the surgical procedure.
- Charges made for or in connection with the routine eye refractions, eye exercises, and for the surgical treatment for correction of refractive errors, including radial keratotomy, when eyeglasses or contact lenses may be worn, except as provided for under the vision care plan of the Program.
- Charges related to chemical peels of any type, dermabrasion, intense pulsed light (IPL) and laser therapy (e.g., pulsed dye).

## Home Health Care

The following expenses for medical services and supplies of a home health care agency are not included as covered expenses:

- Home health care visits in excess of 40 during a calendar year, for all categories of home health care collectively, unless

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- determined to be medically necessary and to be provided under a provider's formal written home health care plan for the person named in that plan.

» Care or treatment that is not stated in the home health care plan; or

» Any period when a person is not under the care of a physician.

» The Medical Benefits Plan does not cover **long-term care services, whether provided in the home or in a facility**, that are custodial in nature. Custodial care consists primarily of assistance with activities of daily living (ADLs), such as personal hygiene, and dressing, eating, maintaining continence, and transferring.

## Hospice Care

The following expenses for hospice care services are not included as covered expenses:

» Any period when you or your eligible dependent is not under the care of a physician.

» Services or supplies not listed in the hospice care program.

» Any curative or life-prolonging procedures

» Services or supplies that are primarily to aid you or your eligible dependent in the activities of daily living; or

» To the extent that any other benefits are payable for those expenses under the coverage of the Plan.

## International Plan

To learn more about your Health Benefits for the International Plan visit the IDB Group Medical Benefits Web App following this link.