cigna healthcare

Cigna Global Health Options

Customer Guide

Everything you need to know about your plan

Want To Get 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.

Use your Customer Area
Live chat with us
Message us
Arrange a call back

Alternatively, you can email us at:
cignaglobal_customer.care@cigna.com

Call Us
International: **+44 (0) 1475 788 182**
USA: **800 835 7677** (toll free)
Hong Kong: **2297 5210** (toll free)
Singapore: **800 186 5047** (toll free)

Contents

Understanding Your Health Insurance

You have chosen a plan to meet your unique needs, so as you look through your Customer Guide and discover the full extent of the cover we provide, please remember to take a look at your Certificate of Insurance to remind yourself exactly what optional benefits you may have chosen to add to your core cover – International Medical Insurance.

At the end of this document, we have explained the meaning of some key terms in the Definitions section.

Please read this Customer Guide, along with your Policy Rules and your Certificate of Insurance as they all form part of your contract between you and us for this period of cover. Please note, this policy has a minimum period of cover of three months. More information can be found in your Policy Rules document which can be found in your online Customer Area.

When we use the term 'you', we refer to yourself, the policyholder, as well as any other beneficiaries named on your Certificate of Insurance as being covered under this policy, including newborn children.

When we use the terms 'we,' 'us' and 'our', we refer to Cigna Healthcare, the insurer of this policy. Please refer to your Policy Rules document for details of the Cigna Healthcare legal entity providing your policy.

Welcome To Cigna Healthcare

Thank you for choosing a Cigna Global Health Options plan to protect you and your family. Our mission is to improve the health and vitality of our customers, and we specialise in supporting you and your family on your global journey.

We put people first

That means you can always expect the highest level of service and care:

- **Our multi-language Customer Care team is available 24 hours a day**
- **We always aim to process your guarantee of payment within one hour**
- **We'll aim to process any claims you submit within five working days after we receive the necessary documentation**

We are your whole health partner

We are here to support you through your wellness journey by:

- **Connecting you to our Clinical Team's medical expertise via our Clinical Case Management Programme**
- **Helping you access services like Global Telehealth through our Cigna Wellbeing® App**
- **Focussing on your preventative checks and mental health wellbeing as part of our optional Health and Wellbeing offering**

We have global expertise

We offer access to a global network of trusted hospitals, clinics, and doctors, including:

- **300,000 healthcare providers**
- **67,000 contracted pharmacies**
- **Over 150 in-house doctors and nurses**

Our Clinical Support

Did you know?

You can access Clinical Support by contacting our Customer Service Team using the contact details on page 2.

We are dedicated to helping you and your family live happier, healthier lives thanks to our clinical expertise. Please see below how our dedicated team of doctors and nurses can support you.

Feel supported on your medical journey

Case Management

- An assigned nurse will be your single point of contact
- You will receive ongoing personalised advice and support
- We will create tailored treatment plans to deal with any complex conditions.

Chronic Condition Management

A specialised nurse will support you if you are suffering from a chronic condition, such as:

- Pre-diabetes and diabetes
- High blood pressure
- Musculoskeletal (joint, muscle or nerve) pains
- Arthritis

Support includes:

- Creating a specific treatment plan with achievable goals
- Monitoring your condition with regular calls and assessments
- Reviewing the next course of action if medically necessary*

Feel reassured thanks to second medical opinions

Decision Support programme

This service provides advice and recommendations on your individual diagnosis, and includes:

- Access to leading medical experts for second medical opinions
- Initial contact within 48 hours of receiving your medical history
- A medical report containing the medical expert's opinion on your treatment plan
- Additional answers and explanations to questions you may have

* This programme is available regardless of a medical exclusion being applied to your policy related to a chronic condition. However a physical treatment may not be covered for that condition if it is part of the medical exclusion.

Managing Your Policy

Did you know?

You can access your online Customer Area via www.cignaglobal.com and clicking the 'Member Login' button at the top right of the page.

As a Cigna Global Health Options customer, you have access to a wealth of information wherever you are in the world through your secure online Customer Area.

To access your secure online Customer Area, click here.

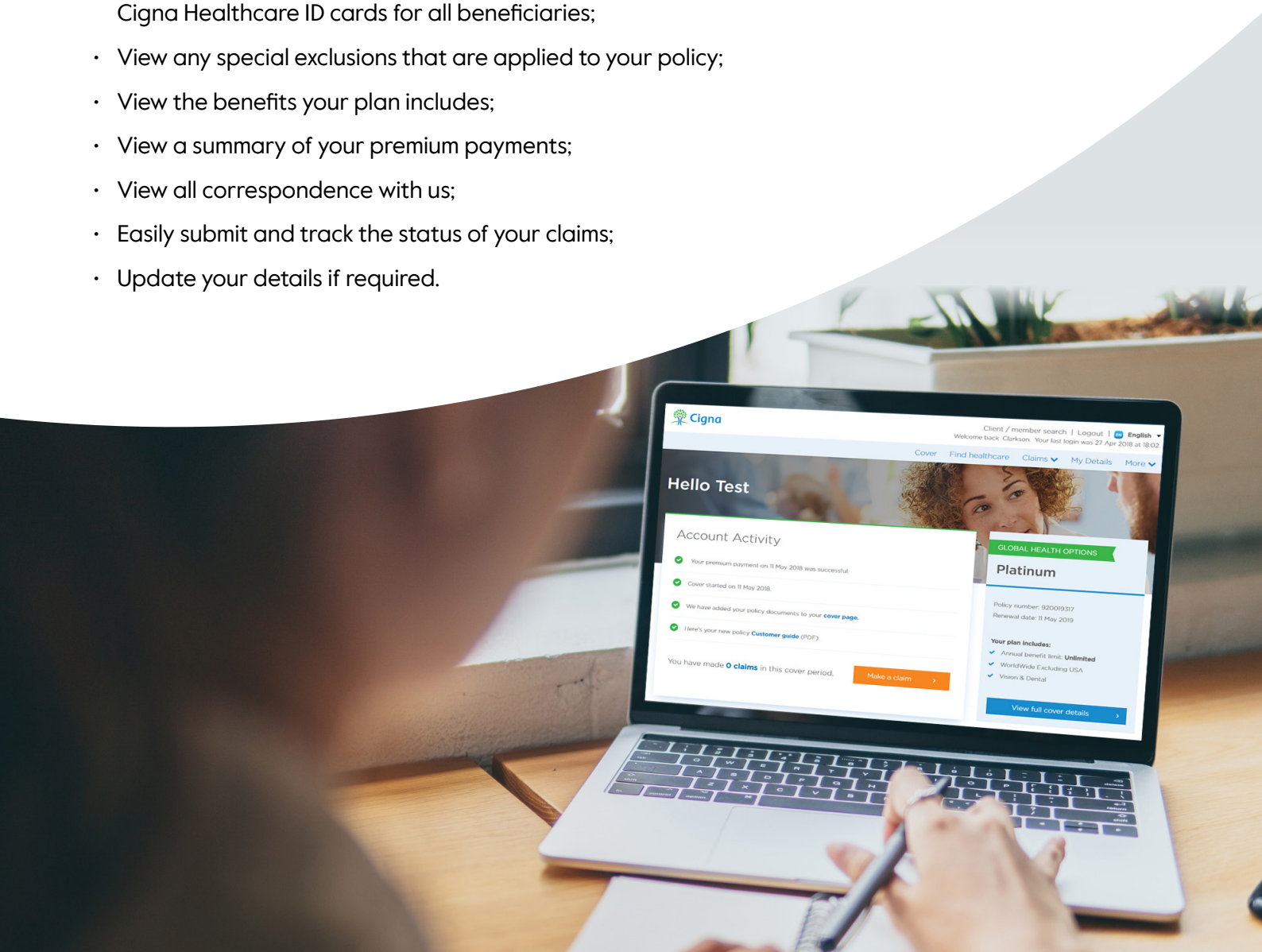
Select **'Global Individual Policy'** from the list and click **'Login'** button.

Enter 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. Contact details are provided on page 2.

Your secure online Customer Area is the easiest way for you to manage your policy and access all information relating to your plan. Here you can:

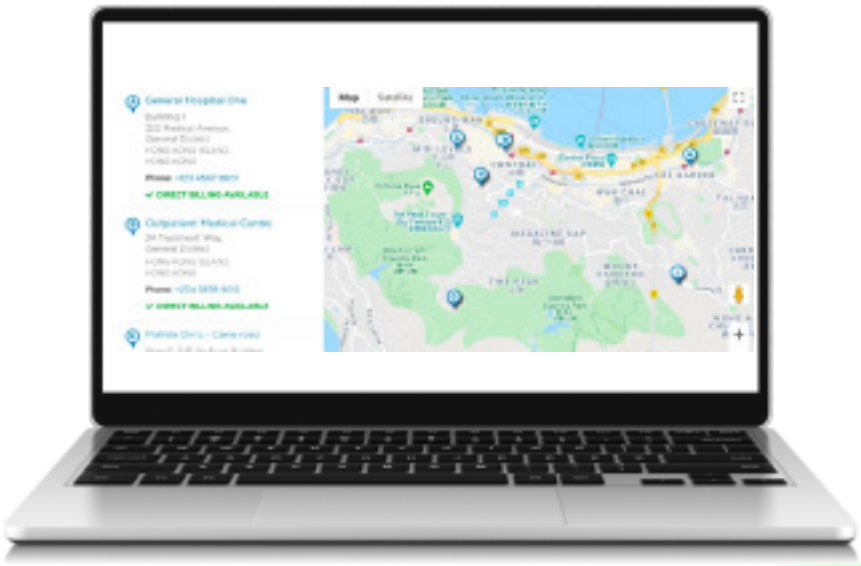
- View your policy documents, including your Certificate of Insurance and Cigna Healthcare ID cards for all beneficiaries;
- View any special exclusions that are applied to your policy;
- View the benefits your plan includes;
- View a summary of your premium payments;
- View all correspondence with us;
- Easily submit and track the status of your claims;
- Update your details if required.



Accessing Care

Our search tool provides you with an easy way to find medical providers in your location. You can refine your search by medical speciality, type of facility, or healthcare professional.

You will be given a clear list of providers with direct billing and a clear map showing where you are in relation to the providers.



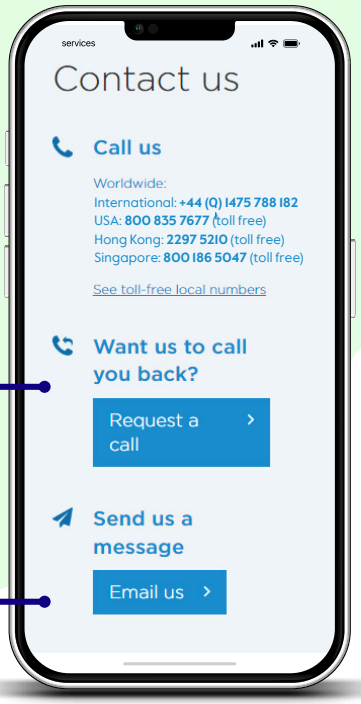
Contact us

Your secure online Customer Area also provides you with convenient methods to contact us that include live chat, sending us a direct message, or by letting us know a convenient time for you in which we will call you back.

Live chat

Request a call back

Message us



Arranging Treatment

What type of treatment or consultation do you need?

Inpatient or Daypatient treatment

- Long stay hospitalisation
- Hospital admission before and after surgery
- Same-day routine operation
- Scheduled ongoing treatment
- Admission to a specialist department
- Maternity care during childbirth

For example, if you require surgery following a heart attack. Any diagnostic tests, surgery and hospital charges are covered within inpatient and daypatient treatment. See page 11.

Outpatient treatment

- Doctor consultations
- Blood and other diagnostic tests
- X-rays and scans
- Physio appointment
- Acupuncture visit
- Minor procedure (for example stitches)
- Prescribed medication

For example, a diagnostic test, a flu vaccination or a mole removal. See page 12.

Do you need to contact Cigna Healthcare first?

Prior authorisation is required before receiving these treatments.

Please contact the Customer Service team as soon as possible to ensure your treatment is covered.

If no prior authorisation obtained:

- Delay in processing claims
- Payment reduction by 20%

In most cases, prior authorisation is not required.

There are a limited number of outpatient treatments which require prior authorisation and can be found on page 28.

Note: In case of emergency:

- Seek treatment first, not required to obtain prior authorisation before
- You or a family member to call us within 48hr of the initial treatment
- We confirm the treatment and arrange settlement with the provider
- If the provider is outside of Cigna Healthcare network, we may decide, with your consent, to continue treatment with a chosen provider.

Where can you receive treatment? Can you choose your preferred provider?

Provider Search

For inpatient or daypatient treatment, the Customer Service team can help you locate your nearest Cigna Healthcare network provider while you are requesting your prior authorisation.

Or you can use the Provider search in your online Customer Area.

Provider Choice

Outside the USA:
As you don't require prior authorisation for most outpatient treatments, you can select a provider of your choice.

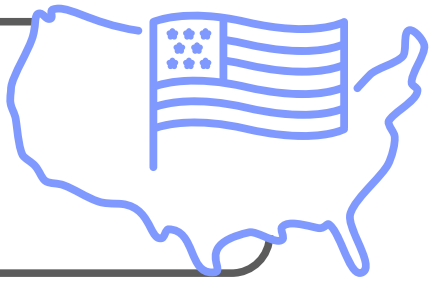
Inside the USA:
For any outpatient treatment, it is recommended to stay within the Cigna Healthcare network.

Treatment in the USA

If you choose an out-of-network provider, we will reduce the amount we pay by **20%.**

This payment reduction will not apply in the following instances:

- No Cigna Healthcare network provider within 30 miles/50 kilometres
- Treatment not available elsewhere
- Emergency treatment.



Do you need to pay for your treatment out of your pocket?

Guarantee of Payment

As part of the prior authorisation process, we will issue in most instance a Guarantee of Payment to you and/or the chosen provider. This means that we agree in advance to pay some or all the costs of a particular treatment with that provider based on the estimated fees.

Once we have given a guarantee of payment, we will pay the agreed amount to the provider on receipt of an appropriate request and a copy of the relevant invoice, once the treatment has been completed. Where there is a shortfall between the agreed Guarantee of Payment and the provider fees, we will review the difference as per our claim adjudication process.

Getting Treatment

For inpatient and daypatient treatment

After receiving the required prior authorisation and a guarantee of payment for the estimated cost of your treatment with the chosen provider – you can plan your hospital stay or book your treatment.

For outpatient and preventative treatments

As you don't require a prior authorisation for your day to day medical needs, we won't issue a guarantee of payment in these instances and you can directly visit your doctor or specialist.

Similarly, you can book an annual health check or a cancer screening without the need to contact our Customer care team first.

Receiving treatment – Remember to take a copy of your Cigna Healthcare ID with you. This is available to download in your online Customer Area.

How do you settle the medical bill(s) after your treatment?

For large bills, in most cases we will pay the provider directly

For most of the inpatient/daypatient treatments, we will pay your hospital, clinic or medical practitioner directly:

- through a direct billing agreement
- through the provision of a Guarantee of Payment

Notes:

- We will only pay the parts of the treatment costs incurred which are covered.
- You are responsible for paying any applicable deductible or cost share to the medical provider once we have settled the invoice. We will let you know the outstanding amount due.

If you have paid the provider

Submit your invoice and claims to us within 12 months from the date of treatment. You can submit claims online via your secure online Customer Area, or via email, fax, or post.

You can find details on how to submit a claim on page 13.

Notes:

- 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.

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

Important:

- In the event that we cannot pay a provider directly, you will be responsible for paying any treatment costs to your provider and Cigna Healthcare will reimburse you.
- In the event that the medical provider requests you to pay the applicable deductible or cost share at the time of treatment, you must obtain an invoice and **receipt for the amount paid** to avoid duplicate payment.
- We may, at our sole discretion and without notification, make changes to the Cigna Healthcare network from time to time by adding and/or removing hospitals, clinics, medical practitioners and pharmacies.

Example 1: Hospitalisation

Wondering how your policy will work for you?

The journey below shows an example of a customer who requires to be admitted to hospital for inpatient care and how Cigna Healthcare can assist them through this journey.

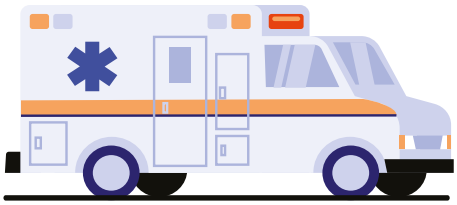
Did you know?

Inpatient means a patient who is admitted to hospital and who occupies a bed overnight or longer, for medical reasons. An example of inpatient treatment is undergoing surgery following a heart attack where they will recover in hospital overnight

Profile: Linda **Age:** 55 **Plan:** CGHO Silver

Linda is rushed to hospital following a suspected heart attack at home.

- **Benefit utilised:** Local ambulance services
- **Prior authorisation:** As this is an emergency, Linda is not required to call our Customer Service first.



Linda arrives at the hospital.

- **Treatment:** Linda is informed she requires surgery
- **Benefit utilised:** Hospital Charges
- **Prior Authorisation:** Required*
- **Guarantee Of Payment:** Provided as part of prior authorisation process

Following a successful operation, Linda requires rehabilitation treatment within hospital.

- **Benefit used:** Rehabilitation
- **Prior Authorisation:** Required
- **Guarantee of Payment:** Provided as part of prior authorisation process

Following a successful operation and follow-up rehabilitation treatment, Linda is sent home to fully recover.

- **Settlement:** As Linda has obtained the required prior authorisations, all her medical bills are taken care directly by Cigna Healthcare with the hospital.

*As Linda was unable to call customer services herself, her daughter, registered as a third party on Linda's policy was able to speak to a customer service representative to receive prior authorisation and guarantee of payment prior to any treatment being received.

Example 2: Out Of Hospital Care

Wondering how your policy will work for you?

The journey below shows an example of a customer who requires outpatient care and how Cigna Healthcare can assist them through this journey.

Did you know?

Outpatient means a patient who attends a hospital outpatient department, consulting room, or outpatient clinic for treatment but is not admitted as a daypatient or an inpatient and does not occupy a bed.

Profile: William **Age:** 65 **Plan:** CGHO Platinum
Additional cover selected: International Outpatient module

William feels unwell and visits his doctor to talk through his symptoms.

Benefit used: Consultations and outpatient procedures with medical practitioners

Prior Authorisation: Not required

Claim Reimbursement: Not required*

The doctor reviews William's symptoms and prescribes antibiotics.

Benefit: Prescribed drugs and dressings

Prior Authorisation: Not required

Claim Reimbursement: Required**

William also mentions a mole that he would like the doctor to investigate.

A follow-up appointment is scheduled.

Prior Authorisation: Not required

Two weeks after his initial consultation, William has the mole successfully removed at his doctor's surgery.

Benefit: Consultations with medical practitioners

Prior Authorisation: Not required

Claim Reimbursement: Not required*

One week later, William returns to have his stitches removed, and no additional follow-up consultations are required.

Benefit: Consultations with medical practitioners

Prior Authorisation: Not required

Claim Reimbursement: Not required*

*William uses the Provider search in his online Customer Area to locate his nearest doctor's clinic within Cigna Healthcare's network. As with most outpatient coverage, William does not need to obtain prior authorisation before seeking any treatment. As the doctor is within the Cigna provider network, Cigna Healthcare are billed directly in this instance, meaning William does not need to claim reimbursement for these in-network doctor visits.

**If the pharmacy to collect the prescription is not part of the Cigna Healthcare's network, William will have to pay upfront the cost of the medication and submit a claim for reimbursement . Currently, only in the USA, Cigna Healthcare customers will be able to access Cigna healthcare pharmacy network where verification and fulfilment are done automatically without the need to pay the medication out of their pocket.

How To Submit Claims

If you have paid for your treatment yourself, you can send your invoice and claim form to us. The easiest way to do this is via your secure online Customer Area.

You will need:

- The Invoice from your medical provider
- A completed Claims Form
- The Receipt from your payment

Please clearly state your policy number on any documentation you submit to us.

You can download your claims forms from your secure online Customer Area or at https://www.cignaglobal.com/individuals-families/members/help/claims-process.

You can submit your claims through:

- Your secure online **Customer Area** (see page 7)
- Email: **cghoclaims@cigna.com**
- Post: **For Treatment Incurred:**
- Fax: +44 (0) 1475 492 113 (Outside the USA); 855 358 6457 (Inside the USA)

Outside of the USA, Hong Kong, or Singapore	Cigna Global Health Options, Customer Service, 1 Knowe Road, Greenock Scotland PA15 4RJ
In the USA	Cigna International, PO Box 15964, Wilmington, Delaware 19850, USA
In Hong Kong	Cigna Worldwide General Insurance Company Ltd, Cigna Global Health Options, Customer Service, 16/F, International Trade Tower, 348 Kwun Tong Road, Kwun Tong, Kowloon, Hong Kong SAR
In Singapore	Business Services Team, Cigna Europe Insurance Company S.A.-N.V. - Singapore Branch, Cigna Global, Health Singapore, 152 Beach Road, #33-05/06, The Gateway East, Singapore 189721

Important information

- You and all beneficiaries must comply with the claims procedures set out in this Customer Guide.
- We can reimburse you using bank wire transfer.
- 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 claims forms and invoices as soon as possible after any treatment. If the claim and invoice is not submitted to us within 12 months of the date of treatment, the claim will not qualify for payment or reimbursement by us.

Subject to the terms of this policy, 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.
- 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.
- If you exceed any individual benefit sub limit, or the overall annual benefit maximum, we will seek reimbursement from you to cover the costs where you have exceeded your limit.

Cigna Wellbeing® App

Our Cigna Wellbeing® App provides you with a host of tools and features to help you manage your health and wellbeing.

Did you know?

You can speak to a doctor at any time by scheduling a virtual appointment via Global Telehealth on the Cigna Wellbeing® App.

Access care, anytime, anywhere

The Cigna Wellbeing® App is the easiest way to access Global Telehealth. Use the same email address and password as your online Customer Area to access the Cigna Wellbeing® App services.

REQUEST AN APPOINTMENT

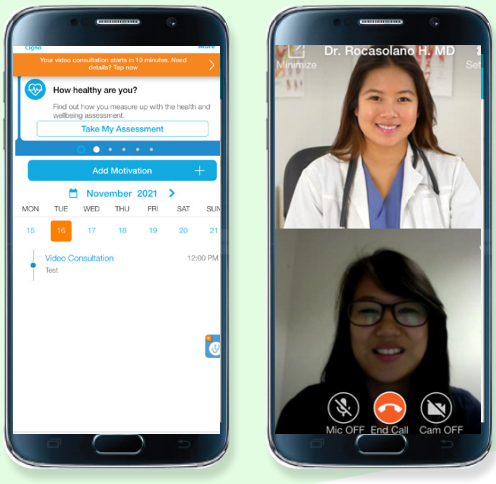
Use the Cigna Wellbeing® App to make an appointment with a doctor anytime, anywhere.

SPEAK WITH A DOCTOR

The initial consultation will be with a General Practitioner by phone or video.

FEEL BETTER

Get the right advice for you. Includes prescription services and referrals for treatment if you require further care.



Why use Global Telehealth?

It's convenient.
There's no need to leave the house or workplace.

It's available 24/7.
That's around the clock access to doctors, usually within 24 hours (depending on language preference).

It's affordable.
It's an alternative to doctor office or clinic visits - with no deductibles or cost share payments and no limits to the number of consultations arranged.

Click below for free download

GET IT ON Google Play

Download on the App Store

Download the app for free to your mobile device today and let's get you started.

Your 24/7 GP available through the Cigna Wellbeing® app

Healthcare that fits into your life

- Access care, anytime, anywhere.
- Speak to a doctor and get your prescription delivered*

85% of our customers recommend this service**

76% of customers avoided taking time off of work**

Are you sitting comfortably?

No need to move – book and attend your appointment from wherever you are.

Are we speaking your language?

Service available in over 30 languages.

The best things in life are free...

No deductible applies to Telehealth consultations via our Cigna Wellbeing® app.

Why Use Telehealth?

- Access to experienced doctors
- Consultations from any location
- Shorter waiting times

* If you are covered by International Outpatient, prescriptions will be covered under this benefit. If not, prescriptions and delivery will be subject to charges. Delivery availability may be subject to location.

** Statistics provided by our partner Teladoc over more than 150,000 patient consultations from Cigna Wellbeing, Cigna International, Cigna Employees, Cigna Global Health Complete, Cigna GIH and Legacy Cigna UK in the overall lifetime number of cases from November 2015 up to October 2025.

Powered by Teladoc HEALTH

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Manage Your Health

Health Assessments

The confidential online Health Risk Assessment allows you to create your own unique report. The 360° view of your health will provide you with:

- **Your health score**
- **Your positive habits**
- **The areas for improvement**
- **Any risk areas**

The targeted assessments go deeper to assess if you're eating right, getting enough exercise, sleeping well and coping with stress.

Chronic Condition Management

This programme, led by our highly experienced nurses, will help you take control of your chronic condition, including but not limited to:

- **Diabetes**
- **High blood pressure**
- **Heart problems**

Please complete the Wellbeing Assessment and let us know if you would like to be contacted by us.

Change Behaviours

Track Biometrics

The Cigna Wellbeing® App allows you to continuously track:

- **Sleep**
- **Height/Weight**
- **Blood sugar**
- **Blood pressure**

Did you know?

You can access health assessments and track your health biometrics on the Cigna Wellbeing® App.

Health Content & Coaching Programmes

Discover articles, online coaching programmes, and videos designed to help you make better decisions relating to sleep, stress, nutrition and exercise.

- **Lifestyle**
- **General health**
- **Nutrition / weight**
- **Healthy recipes**
- **Physical activity**
- **Stress**

International Medical Insurance

Our plans comprise of 3 distinct levels of cover: Silver, Gold and Platinum.

International Medical Insurance is your essential cover for inpatient, daypatient and accommodation costs, as well as cover for cancer, mental health care and much more.

As per our definitions in your Policy Rules document:

- Inpatient means a patient who is admitted to hospital and who occupies a bed overnight or longer, for medical reasons. An example of inpatient treatment is undergoing surgery following a heart attack where they will recover in hospital overnight.
- Daypatient means a patient who is admitted to a hospital or daypatient unit or other medical facility for treatment or because they need a period of medically supervised recovery, but who does not occupy a bed overnight. An example of daypatient treatment would be attending hospital for chemotherapy as part of cancer treatment or receiving an endoscopy as part of diagnostic testing.
- Outpatient means a patient who attends a hospital outpatient department, consulting room, or outpatient clinic for minor treatment but is not admitted as a daypatient or an inpatient and does not occupy a bed. An example of outpatient treatment would be visiting an outpatient clinic to undergo a mole removal where you are not required to be admitted to hospital and do not require general anaesthetic for the procedure.

Some benefits (Extensive cancer care, Advanced Medical Imaging and Mental health care) included under the International Medical Insurance provide cover for treatment on inpatient, daypatient and outpatient basis. For all other benefits, you will need to add the optional International Outpatient module to be covered for outpatient treatment, as indicated in the benefit descriptions.

Important to note, **Prior authorisation** is required for all Inpatient and Daypatient treatments. Please refer to Page 9 for more information regarding Prior Authorisation and Page 2 for contact details. For all general exclusions please refer to your Policy Rules document found in your Customer Area.

Annual overall benefit maximum - per beneficiary per period of cover This includes claims paid across all sections of International Medical Insurance.	Silver	Gold	Platinum
	$1,000,000 €800,000 £650,000	**$2,000,000 €1,600,000 £1,300,000**	**Paid in full**

Hospital charges Up to the annual overall benefit maximum for your selected plan per beneficiary per period of cover. **This benefit requires prior authorisation.**	Silver	Gold	Platinum
	Paid in full Private room	**Paid in full Private room**	**Paid in full Private room**

- Nursing & accommodation for inpatient & daypatient treatment, and recovery room
- Operating theatre
- Prescribed medicines, drugs and dressings for inpatient or daypatient treatment only
- Pathology, radiology and diagnostic tests (excluding Advanced Medical Imaging. Advanced Medical Imaging are covered under a specific benefit)
- Intensive care: intensive therapy, coronary care and high dependency unit
- Surgeons' and anaesthetists' fees
- Inpatient and daypatient specialists' consultation fees
- Emergency inpatient dental treatment.

We will partner with you and your medical practitioner to ensure you receive the appropriate care and treatment in the right medical facility.

Important note:

- We will pay outpatient treatments relating to: cancer, mental health and MRI scans. Any other outpatient treatments will only be covered if the beneficiary has purchased the optional International Outpatient module.

Hospital accommodation for a parent or guardian

Up to the total limit shown for your selected plan per beneficiary per period of cover or, where "paid in full" is shown, this is up to the annual overall benefit maximum for your selected plan per beneficiary per period of cover.

This benefit requires prior authorisation.

Silver	Gold	Platinum
$1,000 €740 £665	**$2,000 €1,480 £1,330**	**Paid in full**

If a beneficiary who is under the age of 18 years old needs and requires inpatient treatment and has to stay in hospital overnight, we will also pay for hospital accommodation for a parent or legal guardian, if accommodation is available in the same hospital and the cost is reasonable.

We will only pay for hospital accommodation for a parent or legal guardian if the treatment which the beneficiary is receiving during their stay in hospital is covered under this policy.

Pandemics, epidemics and outbreaks of infectious illnesses

Up to the annual overall benefit maximum for your selected plan per beneficiary per period of cover.

This benefit requires prior authorisation.

Silver	Gold	Platinum
Paid in full	**Paid in full**	**Paid in full**

We will pay for medically necessary treatment for disease or illness resulting from a pandemic, epidemic or outbreak of infectious illness, as defined by the World Health Organisation (WHO).

The medically necessary treatment and related medical conditions will be covered on an inpatient and daypatient basis. We will pay for outpatient treatments only if the beneficiary has purchased the optional cover under the International Outpatient module.

Important note:

The medically necessary testing done on an outpatient basis (such as at home or in a diagnostic center) for pandemic, epidemic or outbreak of infectious illness will only be covered under the pathology, radiology and diagnostic tests benefit included in the International Outpatient module. These outpatient diagnostic tests, recommended according to the World Health Organisation (WHO) guidelines, will be covered in the same way as the diagnostics for other illnesses.

Inpatient cash benefit

Per night up to 30 days per beneficiary per period of cover.

Silver	Gold	Platinum
$100 €75 £65	**$150 €120 £95**	**$200 €150 £130**

We will make a cash payment directly to a beneficiary when they:

- receive treatment in hospital which is covered under this plan;
- stay in a hospital overnight; and
- the hospital does not charge any fees for the room, board and treatment costs to either the beneficiary, any Insurance company and/or any applicable local state or governmental authority.
- Can provide evidence of treatment, such as a medical report.

Accident and Emergency Room treatment

Up to the total limit shown for your selected plan per beneficiary per period of cover.

Silver	Gold	Platinum
$500 €370 £335	$1,000 €740 £665	$2,000 €1,600 £1,300

We will pay for necessary emergency treatment that is required on an outpatient basis only at an Accident and Emergency department in a hospital following an accident, sudden illness, and/or life threatening situations, and where the beneficiary does not occupy a bed overnight for medical reasons.

Important notes:

- If you have selected the International Outpatient option; this benefit and the limits are satisfied first and then the applicable International Outpatient benefits can be used thereafter.
- No deductible or cost share that you may have selected on the International Medical Insurance core cover and\or on the International Outpatient option will apply to this benefit for any of the three plans.

Transplant services

Up to the annual overall benefit maximum for your selected plan per beneficiary per period of cover.

This benefit requires prior authorisation.

Silver	Gold	Platinum
Paid in full	Paid in full	Paid in full

We will pay for inpatient and daypatient treatment directly associated with an organ transplant for a beneficiary if a transplant is medically necessary, and the organ to be transplanted has been donated by a verified and legitimate source. We will also pay for any anti-rejection medicines following a transplant.

If a beneficiary requires an organ transplant (regardless of whether or not the donor is covered for this policy) we will pay for:

- the harvesting of the organ or bone marrow;
- any medically necessary tissue matching tests or procedures;
- the donor's hospital costs; and
- any costs which are incurred if the donor experiences complications, for a period of 30 days after their procedure.

Kidney Dialysis

Up to the annual overall benefit maximum for your selected plan per beneficiary per period of cover.

This benefit requires prior authorisation.

Silver	Gold	Platinum
Paid in full	Paid in full	Paid in full

- Treatment for kidney dialysis will be covered if such treatment is available in the beneficiary's country of residence. We will pay for this on an inpatient, daypatient, or outpatient basis.
- We will pay for kidney dialysis treatment outside the beneficiary's country of habitual residence if the country where that treatment is provided is within the beneficiary's selected area of coverage. We will pay for this on a daypatient basis. Travel and accommodation expenses incurred in connection with such treatment will not be covered.

Advanced Medical Imaging (MRI, CT and PET scans)

Up to the total limit shown for your selected plan per beneficiary per period of cover or, where "paid in full" is shown, this is up to the annual overall benefit maximum for your selected plan per beneficiary per period of cover.

This benefit requires prior authorisation for any inpatient, daypatient and outpatient treatments.

Silver	Gold Updated	Platinum
$10,000 €7,400 £6,650	$30,000 €22,200 £19,200	Paid in full

We will pay for advanced medical imaging if it is recommended by a medical practitioner as a part of a beneficiary's inpatient, daypatient or outpatient treatment.

Important note:

This benefit is subject to any deductible or cost share that you may have selected on the International Medical Insurance core cover for any advanced medical imaging treatment, including MRI, CT and PET scans performed on an outpatient basis.

Rehabilitation

Up to the total limit shown for your selected plan per beneficiary per period of cover or, where "paid in full" is shown, this is up to the annual overall benefit maximum for your selected plan per beneficiary per period of cover.

This benefit requires prior authorisation.

Silver	Gold	Platinum
$5,000 €3,700 £3,325 Up to 30 days	**$10,000 €7,400 £6,650 Up to 60 days**	**Paid in full Up to 90 days**

We will pay for physical rehabilitation treatments including physiotherapy, occupational, cardiac, pulmonary, cognitive and speech therapies up to the benefit limits and day limit shown above. This benefit does not cover any mental health related treatment, which will instead be covered under the mental and behavioural health care benefit.

We will only pay for rehabilitation treatment immediately after surgery and/or a traumatic event. If the rehabilitation treatment is required in a residential rehabilitation centre, we will pay for accommodation and board, subject to medical necessity and in line with reasonable and customary charges for the location in which the treatment is provided.

In determining when the per day limit has been reached, we count each overnight stay during which a beneficiary receives inpatient and/or daypatient treatment as one day.

Important note:

We will only approve rehabilitation treatment if the treating specialist provides us with a report, explaining how long the beneficiary will need to stay in hospital, the diagnosis and the treatment which the beneficiary has received, or needs to receive.

Rehabilitation is physical, speech and occupational therapy for the purpose of treatment aimed at restoring the beneficiary to their previous state of health after an event.

Home nursing

Up to the total limit shown for your selected plan per beneficiary per period of cover or, where "paid in full" is shown, this is up to the annual overall benefit maximum for your selected plan per beneficiary per period of cover.

This benefit requires prior authorisation.

Silver	Gold	Platinum
$2,500 €1,850 £1,650 Up to 30 days	**$5,000 €3,700 £3,325 Up to 60 days**	**Paid in full Up to 120 days**

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

We will pay for a beneficiary to have home nursing if:

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

Acupuncture and Chinese medicine

Up to the total limit shown for your selected plan per beneficiary per period of cover or, where "paid in full" is shown, this is up to the annual overall benefit maximum for your selected plan per beneficiary per period of cover.

This benefit requires prior authorisation.

Silver	Gold	Platinum
$1,500 €1,100 £1,000	**$2,500 €1,850 £1,650**	**Paid in full**

We will only pay for acupuncture and Chinese medicine if it is not the primary treatment which the beneficiary is in hospital to receive.

The acupuncturist and the practitioner of Chinese medicine must be a properly qualified practitioner who holds the appropriate licence in the country where the treatment is received.

Palliative care

Silver	Gold	Platinum
$35,000 €25,900 £23,275	$60,000 €44,400 £38,400	Paid in full

Up to the total limit shown for your selected plan per beneficiary per period of cover or, where "paid in full" is shown, this is up to the annual overall benefit maximum for your selected plan per beneficiary per period of cover.

This benefit requires prior authorisation.

We will pay for palliative care if a beneficiary is given a terminal diagnosis and their life expectancy is less than six months, and there is no available treatment which will be effective in aiding recovery.

We will pay for:

- Home care;
- Inpatient and daypatient hospital or hospice care and accommodation;
- Prescribed medicines; and
- Physical and psychological care.

Prosthetic devices

Silver	Gold	Platinum
Paid in full	Paid in full	Paid in full

Up to the annual overall benefit maximum for your selected plan per beneficiary per period of cover.

This benefit requires prior authorisation.

We will pay for internal and external prosthetic devices which are necessary as part of a beneficiary's treatment, subject to the limitations explained below.

We will pay for:

- a prosthetic device which is a necessary part of the treatment immediately following surgery for as long as is required by medical necessity and/or is part of the recuperation process on a short-term basis;
- an initial external prosthetic device (but not any replacement devices) for beneficiaries aged 18 years old and over per period of cover.

We will pay for an initial external prosthetic device and up to two replacements for beneficiaries aged 17 years old or younger per period of cover.

If a beneficiary requires a replacement prosthetic device during the period of cover, we will require an appropriate medical report.

Important note:

A prosthetic device is an artificial limb or tool which is required for the purpose of, or in connection with surgery; or is a necessary part of the treatment immediately following surgery for as long as required by medical necessity; or which is medically necessary and is part of the recuperation process on a short-term basis.

Local ambulance & air ambulance services

Silver	Gold	Platinum
Paid in full	Paid in full	Paid in full

Up to the annual overall benefit maximum for your selected plan per beneficiary per period of cover.

This benefit requires prior authorisation.

Where it is medically necessary and related to a covered condition, we will pay for a local or air 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 and from hospital back home upon discharge

Important notes:

- We will only pay for a local air ambulance when appropriate, such as a helicopter, to transport a beneficiary to the nearest centre of medical excellence (accessed by road/ambulance within same country) when medically appropriate.
- This policy does not provide cover for mountain rescue services.
- Road or air ambulance is only for travel within the same country, For cross-border medical transportation, this would be covered under Medical Evacuation.
- Cover for medical evacuation or repatriation is only available if you have cover under the International Medical Evacuation option. Please refer to page 42 for details of that option.

Mental and Behavioural Health Care

Up to the total limit shown for your selected plan per beneficiary per period of cover or, where "paid in full" is shown, this is up to the annual overall benefit maximum for your selected plan per beneficiary per period of cover.

This benefit requires prior authorisation for inpatient and daypatient treatments. Prior authorisation is not required for any outpatient treatment under this benefit.

Silver	Gold	Platinum
$5,000 €3,700 £3,325 **Up to 30 days*** (Inpatient **and** Daypatient treatment)	**$10,000 €7,400 £6,650** **Up to 60 days*** (Inpatient **and** Daypatient treatment)	**Paid in full** **Up to 90 days*** (Inpatient **and** Daypatient treatment)

- We will pay for:
- Evidence-based and medically necessary treatment which is recommended by a medical practitioner. Please see FAQs for more information.
- Inpatient, daypatient or outpatient treatment carried out by a psychologist and/or psychiatrist who is licensed as such under the laws of that country. This includes outpatient mental health services for gender dysphoria.
- The diagnosis of addictions (including alcoholism).

Addiction treatment

- We will pay for one course or programme of addiction treatment at a specialist centre providing evidence-based treatment, if that treatment is medically necessary and recommended by a medical practitioner, up to the benefit limit.
- We pay for up to three attempts at detoxification, following which we will only pay for further detoxification treatment if the beneficiary completes a formal outpatient course or programme of addiction treatment.
- We will not pay for any other treatment related to alcoholism or addiction; or treatment of any related condition (such as depression, dementia or liver failure); where we reasonably believe that the condition which requires treatment was the direct result of alcoholism or addiction.

Autism and Attention Deficit Hyperactivity Disorder (ADHD)

We will pay for:

- Medical costs, including doctor and paediatrician visits related to Autism and Attention Deficit Hyperactivity Disorder (ADHD) on an outpatient basis only which are evidence-based treatment and medically necessary.
- Assessment and diagnostic testing for Autism and Attention Deficit Hyperactivity Disorder (ADHD) when symptoms are present.
- Behavioural therapy when medically necessary according to evidence-based treatment.

We will not pay for:

- Educational intervention, speech therapy and any devices to aid speech.
- Prescription drugs or medication prescribed on an outpatient basis for any of these conditions, unless you have purchased the International Outpatient option.

* The day limit only applies to inpatient and daypatient treatments.

Important note:
This benefit is subject to any deductible or cost share that you may have selected on the International Medical Insurance core cover for any mental and behavioural health care, including any mental health treatment taking place on an outpatient basis.

Treatment for Obesity

Up to the total limit shown for your selected plan per beneficiary per period of cover.

Available after the beneficiary has been covered for 24 months or more.

This benefit requires prior authorisation.

Silver	Gold	Platinum
No coverage	**70% refund up to: $20,000 €14,800 £13,300**	**80% refund up to: $25,000 €18,500 £16,500**

We will pay for obesity surgery for beneficiaries over the age of 18 years in circumstances where there is documented evidence that all other methods of weight loss, including but not limited to slimming classes, nutrition programmes, aids and drugs have been tried over the past 24 months. Please note, we will not cover any cost related to slimming classes, nutrition programmes, aids and drugs prior or post the surgery.

Important notes:

- The beneficiary must have a body mass index (BMI) of 40 or over and have been diagnosed as being morbidly obese and;
- The beneficiary can provide documented evidence of other methods of weight loss which have been tried over the past 24 months and;
- The beneficiary has been through a psychological assessment which has confirmed that it is appropriate for them to undergo the procedure

Cancer preventative surgery

Up to the total limit shown for your selected plan per beneficiary per period up to the total limit shown for your selected plan per beneficiary per period of cover. **Available once the beneficiary has been covered by the policy for 12 months or more.**

This benefit requires prior authorisation.

Silver	Gold	Platinum
$10,000 €7,400 £6,650	$18,000 €13,300 £12,000	$20,000 €14,800 £13,300

We will pay for preventative surgery when a beneficiary has a significant family history of a disease which is part of a hereditary cancer syndrome (such as ovarian cancer), and has undergone genetic testing which has established the presence of a hereditary cancer syndrome.

We will only pay for the genetic test if the beneficiary has cover under the International Outpatient option.

Extensive Cancer care

Up to the annual overall benefit maximum for your selected plan per beneficiary per period of cover.

This benefit requires prior authorisation for any inpatient, daypatient and outpatient treatments.

Silver Updated	Gold Updated	Platinum Updated
Paid in full	Paid in full	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, any required surgery (including reconstructive surgery), diagnostic tests and drugs, whether the beneficiary is staying in a hospital overnight or receiving treatment as a daypatient or outpatient.

For more information on what we offer as part of our Extensive Cancer benefit, please visit page 29.

Important notes:

- We will only pay for the genetic test if the beneficiary has cover under the International Outpatient option.
- Any outpatient treatments, including prescribed drugs, related to cancer care will be covered under this benefit included in your International Medical Insurance core cover, instead of any outpatient benefit included under the optional International Outpatient module.

Cancer related appliances

Up to the total limit shown per beneficiary per lifetime per cancer related appliance.

This benefit requires prior authorisation.

Silver	Gold	Platinum
$125 €100 £85	$250 €185 £165	$500 €370 £335

If a beneficiary receives a cancer diagnosis, we will pay for the purchase of:

- Wigs / headbands for cancer patients
- Mastectomy bras for cancer patients

Congenital conditions

Up to the total limit shown for your selected plan per beneficiary per period of cover.

This benefit requires prior authorisation.

Silver	Gold	Platinum
$5,000 €3,700 £3,325	$20,000 €14,800 £13,300	$50,000 €40,000 £33,000

We will pay for treatment of congenital conditions on an inpatient or daypatient basis that have manifested prior to a beneficiary's 18th birthday, regardless of the beneficiary's age at the time of the treatment.

Important notes:

Any treatment for congenital conditions within the first 90 days of a beneficiary's life will be covered under the Newborn Care benefit. Any treatment after these 90 days, so long as a diagnosis has been made prior to the beneficiaries 18th birthday will be covered under this benefit.

- If a congenital condition is diagnosed after the beneficiary's 18th birthday, the treatment will be covered under the applicable inpatient and daypatient benefits, instead of this specific benefit.

Out of Area Emergency Hospitalisation Cover

For beneficiaries who do not have Worldwide including USA coverage.

Up to the total limit shown for your selected plan per beneficiary per period of cover or, where "paid in full" is shown, this is up to the annual overall benefit maximum for your selected plan per beneficiary per period of cover.

This benefit requires prior authorisation.

Silver	Gold	Platinum
$100,000 €75,000 £65,000 (Inpatient **and** Daypatient **treatment)**	**$250,000 €200,000 £162,500** (Inpatient **and** Daypatient **treatment)**	**Paid in full** (Inpatient **and** Daypatient **treatment)**

Emergency treatment for inpatient and daypatient treatment during temporary short term business or leisure trips outside your area of coverage.

Important notes:

The beneficiary must have been treatment free, symptom and advice free of the medical condition requiring emergency treatment, prior to initiating the travel.

Coverage is limited to:

- a duration not exceeding 21 treatment days per trip; and
- a maximum of 60 treatment days in aggregate per period of cover for all trips combined.

- Only if the International Outpatient option has been purchased under your policy, will beneficiaries also be covered for emergency out of area Outpatient treatment. Cover will be subject to the overall outpatient annual maximum and the International Outpatient individual benefit limits. Please note this cover will be in addition to the Out of Area Emergency Hospitalisation Cover (for inpatient and daypatient treatment), described in this benefit.
- Charges relating to maternity, pregnancy, childbirth or any complications of pregnancy or childbirth are excluded from this Out of Area Emergency Hospitalisation Cover.
- This benefit is not applicable if you have selected the Worldwide including USA coverage option.
- We will require evidence of your entry and exit to the USA.
- This option is not available if your country of habitual residence is the USA.
- Receiving medical treatment must not have been one of the objectives of the trip.
- Emergency treatment is only applicable if you are not able to benefit from free state-provided healthcare in that country.

Emergency treatment refers to treatment which is medically necessary to prevent the immediate and significant effects of illnesses, injuries or conditions which, if left untreated, could result in a significant deterioration in health. We only cover medical treatment provided by a physician, medical practitioner, or hospital that starts within 24 hours of the emergency, or as soon as reasonably possible.

Global Telehealth

Global Telehealth with Teladoc

Up to the total limit shown per beneficiary per period of cover.

Silver	Gold	Platinum
Unlimited consultations	**Unlimited consultations**	**Unlimited consultations**

You have access to unlimited video and phone doctor consultations via the Cigna Wellbeing® App, or via a referral from our Customer Care team for non-emergency health issues. This includes but is not limited to:

- A diagnosis for non-emergency health issues ranging from acute conditions to complex chronic conditions
- Treating medical conditions like fever, rash, and pain
- Non-emergency paediatric care
- Making preparations for an upcoming consultation
- Discussing a medication plan and potential side effects
- Prescriptions for common health concerns, when medically necessary and permitted

Important notes

- You can access Global Telehealth via the Cigna Wellbeing® App. Please see page 14 for details on how to download the app and register. On the app home screen, click on the 'Get Care' icon and select 'Global Telehealth'. Once you have accepted the Terms and Conditions and Privacy Policy, select 'Schedule Consultation' and proceed to book your consultation by selecting either 'phone consultation' or 'video consultation' and then follow the steps.
- Where you 'Request a call for later' a doctor will typically phone you back on the same day, dependent on language availability. Where you request a video consultation, you can select the day and time to suit you. We recommend having the application open 10 minutes before the scheduled time.
- Prescribing medication is permissible only when the doctor is licensed to prescribe medication in the state or country of where the policy is underwritten. You must have purchased the optional International Outpatient module to receive coverage under the outpatient prescribed drugs and dressing benefit.
- If you have selected a deductible or cost share for outpatient treatment, you will be required to pay this if you are prescribed medication.

Parent and Baby Care

Routine maternity care
(Gold and Platinum plans only)

Up to the total limit shown for your selected plan per beneficiary per period of cover.

Available once the mother has been covered by the policy for 12 months or more.* (24 months or more in Singapore, Hong Kong and the UK)

This benefit requires prior authorisation.

Silver	Gold	Platinum
No coverage	$7,000 €5,500 £4,500	$14,000 €11,000 £9,000

We will pay for the following treatment, on an inpatient or daypatient basis as appropriate, if the mother has been a beneficiary under this policy for a continuous period of at least 12 months or more*:

- hospital, obstetricians' and midwives' fees for routine childbirth; and
- any fees as a result of post-natal care required by the mother immediately following routine childbirth. By routine, we mean any birth that can be categorised as low-risk, that does not require specialist medical intervention beyond standard care.

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

Important note:

* For treatment incurred in either the UK, Hong Kong or Singapore, this benefit is only available once the mother has been a beneficiary under this policy for a continuous period of at least 24 months or more.

Complications from maternity
(Gold and Platinum plans only)

Up to the total limit shown for your selected plan per beneficiary per period of cover.

Available once the mother has been covered by the policy for 12 months or more.* (24 months or more in Singapore, Hong Kong and the UK)

This benefit requires prior authorisation for both inpatient, daypatient and outpatient treatments.

Silver	Gold	Platinum
No coverage	$14,000 €11,000 £9,000	$28,000 €22,000 £18,000

We will pay for inpatient or outpatient treatment relating to complications resulting from childbirth if the mother has been a beneficiary under this policy for a continuous period of at least 12 months or more.*

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

- We will only pay for a Caesarean section, where it is medically necessary. If we cannot confirm that it was medically necessary, we will only pay up to the limit of the mother's routine maternity benefit care cover.

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

Important note:

* For treatment incurred in either the UK, Hong Kong or Singapore, this benefit is only available once the mother has been a beneficiary under this policy for a continuous period of at least 24 months or more.

Please note: it is not possible to claim under both the routine maternity care and the complications from maternity benefit during the same pregnancy.

Homebirths (Gold and Platinum plans only) Up to the total limit shown for your selected plan per beneficiary per period of cover. **Available once the mother has been covered by the policy for 12 months or more.* (24 months or more in Singapore, Hong Kong and the UK)** **This benefit requires prior authorisation.**	Silver	Gold	Platinum
	No coverage	**$500 €370 £335**	**$1,100 €850 £700**

We will pay midwives' and specialists' fees relating to routine home births if the mother has been a beneficiary under this policy for a continuous period of 12 months or more.*

- Please note that the Complications from maternity cover explained above does not include cover for home childbirth. This means that any costs relating to complications which arise in relation to home childbirth will only be paid in accordance with the home childbirth limits, as explained in the list of benefits.

Important note:

* For treatment incurred in either the UK, Hong Kong or Singapore, this benefit is only available once the mother has been a beneficiary under this policy for a continuous period of at least 24 months or more.

Newborn Care Up to the total limit shown for your selected plan per period of cover within the first 90 days following birth. **This benefit requires prior authorisation.**	Silver	Gold	Platinum
	$25,000 €18,500 £16,500	**$75,000 €55,500 £48,000**	**$156,000 €122,000 £100,000**

In order for any care or treatment to be provided to a newborn, the newborn must first be added to the policy, which will incur an additional premium, alongside the policyholder. Please note that any treatments incurred prior to the newborn being added to the policy will not be backdated, and that this benefit will be paid from the newborn's policy and no other beneficiaries. Please see below the eligibility criteria for adding a newborn.

Once the newborn has been added to the policy, we will pay for

- up to 10 days routine care for the baby following birth; and
- all inpatient and daypatient treatment required for the baby during the first 90 days after birth under this benefit instead of any other inpatient or daypatient benefit.

Important notes:

Adding the newborn to the policy:

- If at least one (1) parent has been covered by the policy for a continuous period of twelve (12) months or more* prior to the newborns birth, we will not require information about the newborn's health or a medical examination if an application is received by us to add the newborn to the policy within thirty (30) days of the newborn's date of birth. However, if an application is received by us more than thirty (30) days after the newborn's date of birth, the newborn will be subject to medical underwriting.
- If neither parent has been covered by the policy for a period of twelve (12) consecutive months or more* prior to the newborn's birth, the newborn will be subject to medical underwriting, and you can submit an application to add the newborn. If medical underwriting is required for the newborn, we will then tell you whether we will offer cover to the newborn and, if so, any special conditions and exclusions which would apply. Cover will begin no sooner than the date you accept our offered terms.
- Children who are born to a surrogate or have been adopted can be covered under this benefit but will be subject to medical underwriting, regardless of the length of cover under this policy by either of the parents. On completion of a medical health questionnaire, we will tell you whether we will offer cover to the newborn and, if so, any special conditions and exclusions which would apply. Cover will begin no sooner than the date you accept our offered terms.

Any treatment required for **congenital conditions** for a newborn will be covered under this benefit for the first 90 days following birth as per the terms of this benefit. If the **congenital conditions** is diagnosed after the first 90 days of the newborn's life, any treatment related to the **congenital conditions** will be covered under the 'Congenital conditions' benefit, as described on page 23, and is subject to the terms of adding the newborn to the policy as detailed above.

*For births that occur in either the UK, Hong Kong or Singapore, this is only available once either parent has been a beneficiary under this policy for a continuous period of at least 24 months or more.

Family building support with Carrot (Platinum plan only) **For more information on Carrot, please visit page 28**	Silver	Gold	Platinum New
	Not covered	**Not covered**	**Paid in full**

Carrot provides support and guidance across a wide range of areas:

- Fertility health, testing and preservation
- IVF and assisted reproduction
- Adoption and surrogacy
- Pregnancy, postpartum and parenting
- Menopause and low testosterone
- Return-to-work planning
- One-to-one expert telehealth chats and group sessions

Important notes:

Carrot is not available in certain countries. Check the site for current coverage.

No waiting period – access begins immediately upon registration.

Dependents under 18 are not eligible.

Carrot does not provide clinical or medical treatments. It offers support, education, and expert advice only.

Carrot's platform is available in 25+ languages and accessible via mobile app or desktop.

Your deductible and cost share options

Deductible 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 Cost share is the percentage of each claim not covered by your plan.	**First choose your cost share percentage:** **0% / 10% / 20% / 30%**		
Out of Pocket Maximum 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.	**Next, choose your out of pocket maximum:** **$2,000** **€1,480** **£1,330**	**or**	**$5,000** **€3,700** **£3,325**

Family-Building Support with Carrot

Because life's milestones deserve expert support.

Planning a family, navigating menopause, or returning to work after parental leave, Cigna Healthcare's partnership with Carrot Fertility ensures you have trusted guidance every step of the way.

This benefit is available exclusively to our Platinum members.

What Carrot Offers

Support across a wide range of life stages and needs:

- ✓ Fertility health, testing & preservation
- ✓ IVF and assisted reproduction
- ✓ Adoption & surrogacy
- ✓ Pregnancy, postpartum & parenting
- ✓ Menopause & low testosterone
- ✓ Return-to-work planning

Getting Started

Visit the website here

Create your personal account using your name and date of birth.

You can also add your partner/spouse during or after registration.

Real Stories, Real Support

Meet Rebecca, a Platinum member in Europe who used Carrot to take control of her menopause journey.

She began with Carrot Academy resources on perimenopause and menopause, then connected with a dedicated Carrot Companion to build a personalised plan.

From expert chats in her preferred language to virtual sessions on managing symptoms at work, Rebecca had support every step of the way.

Her Carrot Plan included tailored articles and group sessions, and she continues to access unlimited expert chats as she navigates her journey.

Provided by CARROT

Extensive Cancer Care

In the event of a cancer diagnosis, rest assured that we will do everything we can to support you and your family through this time. Everything included in our Extensive Cancer Care is fully covered, so you don't have to worry about any limits.

Included under all plans:

Cancer Treatment
Following a cancer diagnosis, we pay in full for costs of any treatment, including chemotherapy, radiotherapy, diagnostic tests and drugs on an inpatient, day-patient or outpatient basis.

Dedicated Cancer Case Manager & Care Co-ordinator
Being diagnosed with cancer can come with a lot of difficult emotions and questions, and this is where your assigned case manager can support you through your journey. Your care co-ordinator will be available to support you in locating a provider that suits your needs and in assisting you with booking appointments.

Patient and family counselling
We understand that a cancer diagnosis doesn't just impact you, it also impacts your family – that's why we want to offer you and your family members support through our counselling service.

Cancer dietician
You'll have the support of an oncological dietician who can help you understand what foods can help fuel your body, fight inflammation, and nourish your body.

Reconstructive surgery
We will cover the costs of reconstructive surgery, for example, after a mastectomy.

Robotic surgery
We will cover the cost of robotic surgery, when these surgeries have been determined to have improved patient outcomes over conventional surgical methods.

Additional cover under higher tier plans:

Home chemotherapy
Access chemotherapy from the comfort of your own home. Now available for Gold and Platinum members.

Fertility advice
We understand that certain cancer diagnoses and treatments can impact fertility, and this is where our partnership with Carrot, a fertility support service, can provide guidance. For Platinum members only.

Further Cancer Support

Cancer Related Appliances
For example for a wig, headband, or mastectomy bra.

Cancer Preventative Surgery
If you have confirmed presence of a hereditary cancer syndrome, we will pay for preventative surgery (12 month waiting period applies).

Cryopreservation
In the event your treatment may impact future fertility, we also offer cryopreservation based on medical necessity for our Platinum members.

Preventive Screenings
For members who have taken out the International Health & Wellbeing module, we offer cancer preventive screenings at frequencies that exceed World Health Organisation recommended guidelines.

The following pages detail the optional benefits you may have chosen to add to your core cover International Medical Insurance.

Take a look at your certificate of insurance to remind yourself exactly what cover you have.

International Outpatient

Optional Module

The International Outpatient optional module provides more comprehensive outpatient care where a hospital admission as a daypatient or inpatient is not required, including consultations with specialists, prescribed outpatient drugs and dressings, rehabilitation, genetic cancer testing and much more.

As per our definition, Outpatient means a patient who attends a hospital outpatient department, consulting room, or outpatient clinic for treatment but is not admitted as a daypatient or an inpatient and does not occupy a bed.

You do not require prior authorisation for most of the International Outpatient benefits. However, prior authorisation is required for the following outpatient benefits:

- Genetic Testing
- Infertility investigations and treatment
- Physiotherapy, chiropractic and osteopathy treatments when you have exceeded 10 sessions (Note: a prior authorisation is not required for the first 10 sessions referred by a medical practitioner).

For any other treatment under the International Outpatient module, you do not need to contact us for prior authorisation.

If you do not obtain a required prior authorisation from us, there may be delays in processing claims and we will reduce the amount which we will pay for that treatment by 20%.

Annual overall benefit maximum - per beneficiary per period of cover This includes claims paid across all sections of International Outpatient.	Silver	Gold	Platinum
	$15,000 €12,000 £9,650	**$35,000 €25,900 £23,275**	**Paid in full**

Consultations and outpatient procedures with medical practitioners and specialists Up to the total limit shown for your selected plan per beneficiary per period of cover or, where "paid in full" is shown, this is up to the annual overall benefit maximum for your selected plan per beneficiary per period of cover.	Silver	Gold	Platinum
	$2,500 €1,850 £1,650	**$7,500 €6,000 £4,825**	**Paid in full**

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

Important notes:

- Virtual consultation expenses should not exceed the cost of an equivalent face-to-face consultation. Expenses deemed to be excessive, unreasonable or unusual will not be covered or the amount of the benefit paid will be reduced.
- Virtual consultations can only be accessed where available and medically appropriate.

Prescribed drugs and dressings

Up to the total limit shown for your selected plan per beneficiary per period of cover or, where "paid in full" is shown, this is up to the annual overall benefit maximum for your selected plan per beneficiary per period of cover.

Silver	Gold	Platinum
$1,500 €1,100 £1,000	**$4,500 €3,300 £3,000**	**Paid in full**

We will pay for prescribed drugs and dressings which are prescribed by a medical practitioner on an outpatient basis. Please note that if the prescription exceeds three (3) months of supply or the treatment will require more than three (3) months of continuous prescription, prior authorisation will be required.

Important note:

Medication prescribed by a medical practitioner in the USA and/or delivered by a pharmacy in the USA are subject to our formulary drugs list.

Pathology, Radiology and diagnostic tests (excluding Advanced Medical Imaging)

Up to the total limit shown for your selected plan per beneficiary per period of cover or, where "paid in full" is shown, this is up to the annual overall benefit maximum for your selected plan per beneficiary per period of cover.

Silver	Gold	Platinum
$2,500 €1,850 £1,650	**$5,000 €3,700 £3,325**	**Paid in full**

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).

Important note:

We will pay under this benefit for medically necessary testing done on an outpatient basis for pandemic, epidemic or outbreak of infectious illnesses in line with the World Health Organisation (WHO) guidelines. These outpatient diagnostic tests will not be covered under the inpatient pandemics, epidemics and outbreak of infectious illnesses benefit.

Outpatient Rehabilitation

Up to the total limit shown for your selected plan per beneficiary per period of cover or, where "paid in full" is shown, this is up to the annual overall benefit maximum for your selected plan per beneficiary per period of cover.

This benefit requires prior authorisation*.

Silver	Gold	Platinum
$5,000 €3,700 £3,325	**$15,000 €12,000 £9,650**	**Paid in full**

We will pay for:

- Outpatient Physiotherapy;
- Outpatient Occupational therapy;
- Osteopathy and Chiropractic treatment;
- Speech therapy; and
- Cardiac and pulmonary rehabilitation.

Important notes:

Outpatient Physiotherapy, Osteopathy and Chiropractic treatment:

We will pay for this treatment if it 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.

* Prior-authorisation will be required from us after the initial 10 sessions to continue these outpatient treatments and will be reviewed by our clinical team based on medical necessity.

Speech therapy treatment:

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

Rehabilitation is physical, speech and occupational therapy for the purpose of treatment aimed at restoring the beneficiary to their previous state of health after an event.

Pre-natal and post-natal care
(Gold and Platinum plans only)

Up to the total limit shown for your selected plan per beneficiary per period of cover.

Available once the mother has been covered by the policy for 12 months or more.* (24 months or more in Singapore, Hong Kong and the UK)

Silver	Gold	Platinum
No coverage	**$3,500 €2,750 £2,250**	**$7,000 €5,500 £4,500**

- We will pay for medically necessary pre-natal and post-natal care on an outpatient basis if the mother has been a beneficiary under the International Outpatient option for a continuous period of 12 months or more.*
- Examples of pre-natal treatment and tests include:
  - Routine obstetricians' and midwives' fees;
  - All scheduled ultrasounds and examinations;
  - Prescribed medicines, drugs and dressings;
  - Routine pre-natal blood tests, if required;
  - Amniocentesis procedure (also referred to as amniotic fluid test or AFT) or chorionic villous sampling (also referred to as CVS); and
  - Non-invasive pre-natal testing (NIPT) for high risk individuals.

  Post-natal care:
  - Any fees, including prescribed drugs and dressings, as a result of post-natal care required by the mother immediately following routine childbirth.

Important note:

* For treatment incurred in either Hong Kong, Singapore, or the UK, this benefit is only available once the mother has been a beneficiary under this policy for a continuous period of at least 24 months or more.

Infertility Investigations and treatment

Up to the total limit shown for your selected plan per beneficiary per lifetime.

Available once the beneficiary has been covered by this option for 24 months or more.

This benefit requires prior authorisation.

Silver	Gold	Platinum
No coverage	No coverage	$10,000 €7,400 £6,650

We will pay for investigations into the cause of infertility if a specialist rules out any medical cause and the beneficiary was unaware of the existence of any infertility problem, and had not suffered any symptoms, when their cover under this policy commenced.

If necessary, we will pay a maximum of 4 attempts for Infertility treatment up to the total limit shown in aggregate, per lifetime of the policy. This benefit is available for beneficiaries up to 41 years old.

Important Notes:

- Prior authorisation is required for all infertility investigations and treatment. If you do not obtain a required prior authorisation from us, there may be delays in processing claims and we will reduce the amount which we will pay for that treatment by 20%.
- We will not pay for infertility investigations or treatment for anyone acting as a surrogate for a beneficiary.

Hormone Therapy

Up to the total limit shown for your selected plan per beneficiary per period of cover.

Silver	Gold	Platinum
$500 €370 £335	$1,000 €740 £665	$1,500 €1,100 £1,000

We will pay for Hormone Therapy when it is medically necessary to treat the symptoms of menopause, low testosterone and gender dysphoria.

Sleep Apnoea

Up to the total limit shown for your selected plan per beneficiary per period of cover.

Silver	Gold	Platinum
No coverage	$1,500 €1,100 £1,000	$2,000 €1,480 £1,330

Following a referral from your medical practitioner, we will pay for one sleep study or home sleep test to diagnose if you have sleep apnoea.

If it has been determined a beneficiary has sleep apnoea we will pay for the hire of a Continuous Positive Airway Pressure (CPAP) machine, or other appropriate oral appliances.

Once the beneficiary has been covered by this option for a continuous period of 12 months or more and if the hire of a CPAP machine is not available to the beneficiary, we will pay, when medically necessary, for the purchase of a CPAP machine up to the total limit of this benefit for your selected plan.

If it is medically appropriate, we will pay for surgery.

Genetic Testing

Up to the total limit shown for your selected plan per beneficiary per lifetime.

Available once the beneficiary has been covered by this option for 12 months or more.

This benefit requires prior authorisation.

Silver	Gold	Platinum
$1,000 €740 £665	$2,000 €1,480 £1,330	$4,000 €2,950 £2,650

We will pay for one genetic test for beneficiaries with an increased risk of conditions such as cancer, cystic fibrosis, gaucher disease and Rett syndrome, when medically necessary and in accordance with medical evidence.

Important Note:

- Prior authorisation is required for all genetic tests. If you do not obtain a required prior authorisation from us, there may be delays in processing claims and we will reduce the amount which we will pay for that treatment by 20%.
- The list of conditions above is for example purposes only. Genetic testing will be limited to testing for hereditary and multi-factorial conditions, where medically necessary and within Cigna Healthcare clinical guidance.

Acupuncture and Chinese medicine

Up to the total limit shown for your selected plan per beneficiary per period of cover or, where "paid in full" is shown, this is up to the annual overall benefit maximum for your selected plan per beneficiary per period of cover.

Silver	Gold	Platinum
$2,500 €1,850 £1,650	$5,000 €3,700 £3,325	Paid in full

We will pay for a combined maximum total of 15 consultations with an acupuncturist and practitioner of Chinese medicine, if those treatments are recommended by a medical practitioner. The treatment must be carried out by a properly qualified practitioner who holds the appropriate licence to practice in the country where the treatment is received.

Durable medical equipment

Up to the annual overall benefit maximum for your selected plan per beneficiary per period of cover.

Silver	Gold	Platinum
Paid in full	Paid in full	Paid in full

We will pay for the use of durable medical equipment if the use of that equipment is recommended by a specialist in order to support the beneficiary's treatment which is covered under this policy.

We will only pay for one type of medical equipment per period of cover 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.

Hearing Aids

Up to the total limit shown for your selected plan per beneficiary per period of cover.

Silver	Gold Updated	Platinum Updated
$500 €370 £335	$5,000 €3,700 £3,325	Paid in full

We will pay for one hearing aid appliance per period of cover which is medically necessary and is prescribed to support everyday living.

This includes the purchase of one original pair of hearing aids only and does not include a replacement pair within the same period of cover if the original pair is damaged or lost.

Adult vaccinations

Up to the total limit shown for your selected plan per beneficiary per period of cover or, where "paid in full" is shown, this is up to the annual overall benefit maximum for your selected plan per beneficiary per period of cover.

Silver	Gold	Platinum
$250 €185 £165	Paid in full	Paid in full

We will pay for certain vaccinations and immunisations that are clinically appropriate.

Dental accidents

Up to the total limit shown for your selected plan per beneficiary per period of cover or, where "paid in full" is shown, this is up to the annual overall benefit maximum for your selected plan per beneficiary per period of cover.

Silver	Gold	Platinum
$1,000 €740 £665	Paid in full	Paid in full

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.

Child and Adolescence Wellbeing Health

Up to the annual overall benefit maximum for your selected plan beneficiary per period of cover.

Silver	Gold	Platinum
Paid in full	Paid in full	Paid in full

We will pay for child and adolescence wellbeing health at appropriate age intervals, carried out by a medical practitioner for the following preventative care services:

- evaluating medical history;
- physical examinations;
- development assessment;
- anticipatory guidance; and
- appropriate immunisations, vaccinations and laboratory tests.

Important notes:

Mental health consultations with a psychiatrist or psychologist are covered under the Mental Health and Behavioural Care benefit under International Medical Insurance.

In addition, we will pay for:

- One school entry health check, to assess growth, hearing and vision, for each child at the first school entry date.
- Diabetic retinopathy screening for children who have diabetes.

Pre-Existing Condition Management

60+ Pre-Existing Condition Care

Up to the total limit shown for your selected plan per beneficiary per period of cover.

Silver	Gold Updated	Platinum Updated
$500 €370 £335	$1,500 €1,100 £1,000	$3,000 €2,220 £2,000

If a beneficiary is aged 60 years old and above, or turning 60 years old within the period of cover, and has one of the following conditions as declared on their medical questionnaire (and is a special exclusion as detailed on your Certificate of Insurance), we will pay for the medically necessary outpatient treatment costs associated with the maintenance of this condition: Hypertension, Type 2 Diabetes, Glaucoma, Arthritis, joint or back pain, Osteoporosis/ Osteopenia, migraine, high cholesterol, asthma, allergies, atherosclerosis/arteriosclerosis, coronary artery disease

Important notes:

- If, during the application stage you have selected the option to have one of the above conditions covered at an additional premium, whereby the condition is covered comprehensively on an inpatient and outpatient basis (if the International Outpatient option has been selected); this benefit will not be applicable.
- Examples of medically necessary treatment and tests include but are not limited to: consultations with medical practitioners, prescribed drugs and dressings, pathology and radiology, outpatient rehabilitation and acupuncture and Chinese medicine. Please note, this benefit excludes Advanced Medical Imaging.
- You are eligible to have the condition(s) covered (but not conditions, symptoms or complications arising from those conditions) on an outpatient basis, up to the total limits shown per period of cover.
- The benefit is subject to any cost shares or deductibles elected on your policy.

40-59 Pre-Existing Condition Care

Up to the total limit shown for your selected plan per beneficiary per period of cover.

Silver	Gold	Platinum New
No coverage	No coverage	$2,000 €1,480 £1,330

If a Platinum beneficiary is aged 40 - 59 years old, and has one of the following conditions as declared on their medical questionnaire (and is a special exclusion as detailed on your Certificate of Insurance), we will pay for the medically necessary outpatient treatment costs associated with the maintenance of this condition: Hypertension, Type 2 Diabetes, Glaucoma, Arthritis, joint or back pain, Osteoporosis/ Osteopenia, migraine, high cholesterol, asthma, allergies, atherosclerosis/arteriosclerosis, coronary artery disease

Important notes:

- If, during the application stage you have selected the option to have one of the above conditions covered at an additional premium, whereby the condition is covered comprehensively on an inpatient and outpatient basis (if the International Outpatient option has been selected); this benefit will not be applicable.
- Examples of medically necessary treatment and tests include but are not limited to: consultations with medical practitioners, prescribed drugs and dressings, pathology and radiology, outpatient rehabilitation and acupuncture and Chinese medicine. Please note, this benefit excludes Advanced Medical Imaging.
- You are eligible to have the condition(s) covered (but not conditions, symptoms or complications arising from those conditions) on an outpatient basis, up to the total limits shown per period of cover.
- The benefit is subject to any cost shares or deductibles elected on your policy.

Your deductible and cost share options

Deductible 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 Cost share is the percentage of each claim not covered by your plan.	**First choose** your cost share **percentage:** **0% / 10% / 20% / 30%**		
Out of Pocket Maximum 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.	**Next, choose** your out of pocket maximum: **$3,000** **€2,200** **£2,000**		

International Health & Wellbeing

Optional Module

We understand the importance of your overall wellbeing and living a balanced life. **The benefits listed below are available only to beneficiaries aged 18 years old and over.**

In addition, specific age eligibility will apply to the different cancer screenings.

Important Note:
Any follow-up test or additional screening required on an outpatient basis following an abnormal result will be covered under the pathology, radiology and diagnostics tests benefit included in the International Outpatient option. You must have purchased the International Outpatient option in order to have these additional diagnostic tests covered.

Routine adult physical examinations

Up to the total limit shown for your selected plan per beneficiary per period of cover.

Silver	Gold	Platinum
$325 €250 £220	$650 €500 £440	$2000 €1600 £1300

We will pay for routine adult physical examinations for persons aged 18 years or older. The health assessment may include but is not limited to:

- Height and weight measurements
- Waist circumference
- Body mass index (BMI)
- Body fat percentage
- Blood pressure
- Urine analysis
- Cholesterol test
- Full blood count
- Physiology and balance assessment
- Resilience to stressors measurement

In addition, for eligible beneficiaries of a Platinum policy, we will cover additional assessments, including but not limited to:

- Full biochemistry profile including liver and kidney function
- Lung function test
- Spinal assessment
- Chest X-ray (if clinically indicated)
- Advanced cardiovascular test (ECG or Aerobic fitness test)
- Body metabolism test (Resting Metabolic Rate (RMR) and VO2 test)
- Neurological examinations

Footcare by a Chiropodist or Podiatrist

Up to the total limit shown for your selected plan per beneficiary per period of cover.

Silver	Gold	Platinum Updated
$325 €250 £220 up to 5 sessions	$650 €500 £440 up to 10 sessions	$2,000 €1,600 £ 1,300 Up to 20 sessions

We will pay for the treatment of bunions, calluses, corns and fungal infection if it 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 podiatrist or chiropodist who holds the appropriate license to practice in the country where the treatment is received. This excludes any massage or sports medicine treatment.

Cervical cancer screening

Up to the total limit shown for your selected plan per beneficiary per period of cover.

Silver Updated	Gold Updated	Platinum Updated
$325 €250 £220	$650 €500 £440	Paid in full

For female beneficiaries from the age of 25 year old, we will provide cover every year for:

- 1 Papanicolaou test (pap smear) and
- 1 HPV DNA test.

Prostate cancer screening

Up to the total limit shown for your selected plan per beneficiary per period of cover.

Silver	Gold	Platinum
$325 €250 £220	$650 €500 £440	Paid in full

For male beneficiaries from the age of 50 year old, we will provide cover every year for:

- One prostate examination
- PSA testing

Breast cancer screening

Up to the total limit shown for your selected plan per beneficiary per period of cover.

Silver Updated	Gold Updated	Platinum Updated
$325 €250 £220	$650 €500 £440	Paid in full

For female beneficiaries from the age of 40 year old, we will provide cover for:

- 1 breast awareness consultation and Clinical Breast Exam (CBE) every year;
- 1 screening mammogram every year.

For female beneficiaries between the age of 25 and 39 year old if they have a prior history or an increased risk of breast cancer, we will provide cover for:

- 1 screening mammogram every year, when medically necessary.

Bowel cancer screening

Up to the total limit shown for your selected plan per beneficiary per period of cover.

Silver Updated	Gold Updated	Platinum Updated
$325 €250 £220	$650 €500 £440	Paid in full

For female and male beneficiaries from the age of 45 year old, we will provide cover for:

- 1 Fecal occult blood test (FOB) or 1 Fecal Immunochemical Test (FIT) every year
- 1 Colonoscopy every 5 years.

Skin cancer screening

Up to the total limit shown for your selected plan per beneficiary per period of cover.

Silver	Gold	Platinum
$325 €250 £220	$650 €500 £440	Paid in full

For female and male beneficiaries from the age of 18 year old, we will provide cover for:

- 1 skin cancer examination every year.

Lung cancer screening

Up to the total limit shown for your selected plan per beneficiary per period of cover.

Silver	Gold	Platinum
$325 €250 £220	$650 €500 £440	Paid in full

For female and male beneficiaries from the age of 45 year old we will provide cover for:

- 1 lung cancer examination every year.

Diabetes screening

Up to the total limit shown for your selected plan per beneficiary per period of cover.

Silver	Gold	Platinum
$325 €250 £220	$650 €500 £440	Paid in full

For female and male beneficiaries from the age of 18 year old, we will provide cover for:

- 1 AIC test or Fasting Blood Sugar test every year.

Bone densitometry Up to the total limit shown for your selected plan per beneficiary per period of cover.	Silver	Gold	Platinum
	$325 €250 £220	$650 €500 £440	Paid in full

We will pay for:

- I scan for women aged 65 years old or older;
- I scan for post-menopausal women younger than 65 years old when medically necessary; and
- I scan for men aged 50 years or older when medically necessary.

Dietetic consultations Up to the total limit shown for your selected plan per beneficiary per period of cover.	Silver	Gold	Platinum
	$325 €250 £220	$650 €500 £440	Paid in full

We provide coverage for an initial consultation with a dietitian without the need of a referral for any beneficiary seeking to enhance and improve their overall well-being, encompassing dietary modifications and preventative measures.

We provide additional coverage, when medically necessary, for up to 4 consultations in total per period of cover for beneficiaries in need of dietary advices related to a diagnosed conditions such as diabetes, pre-diabetes or eating disorders.

In addition to health screenings, tests and examinations; this module also empowers you and your family with the services and support to manage your own individual day-to-day health and wellbeing.

Your Wellness services, comprising of the Life Management Assistance, the Wellness Coaching and the Mental Health Support programmes, is available to help you and your eligible dependents stay healthy and well, both physically and mentally.

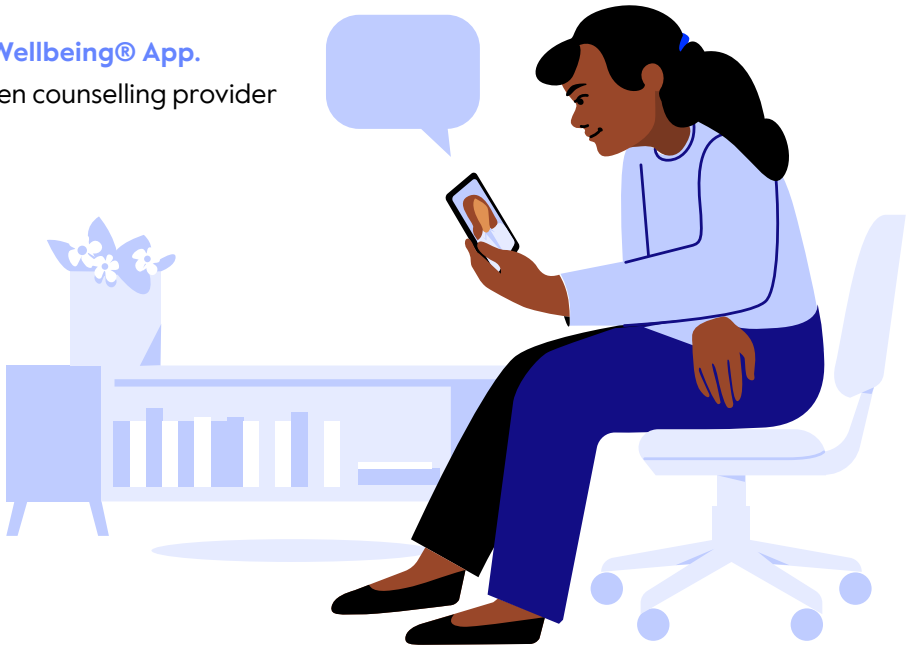
These services are available across all plan levels, providing you have purchased the optional International Health and Wellbeing module.

To access any of the Wellness services, please contact us through one of the following options:

Call us: +1 984 810 5338 (Line exclusively for Cigna Global Health Options customers). You can dial this number directly from the 'Mental Health Support' section of the Cigna Wellbeing® App.)

Live Chat: accessible through the website. To login, please enter 'assist' as the 'company code'. To access the Live Chat, click on 'LIVECONNECT' at the top of the home page.

Request a callback via the Cigna Wellbeing® App.
This service is provided by our chosen counselling provider



Life Management Assistance Programme

Silver	Gold	Platinum
Paid in full	Paid in full	Paid in full

At Cigna we see Body and Mind as equal parts in forming one's whole health. While most health solutions today only cover for physical health, our Life Management Assistance programme is a personal and confidential service offered to you and your family to help identify and solve problems they face in their everyday working and family lives.

All calls into our Life Management Assistance Programme are answered 24 hours a day, 7 days a week, 365 days a year. You will have access to the following services and tools:

Short-term counselling:

- Up to 6 counselling sessions via telephone, video, or face-to-face, per issue per period of cover. Common use cases include: managing anxiety and depression, couples' and family relationship support, bereavement, and more.

Behavioural health:

- Up to 6 sessions with a mindfulness coach via telephone per period of cover. Beneficial for individuals experiencing stress, and challenges with focus and concentration.
- An online self-help Cognitive Behavioural Therapy (CBT) programme to address mild to moderate anxiety, stress, and depression, with unlimited access to the programme for 6 months.

Career and workplace support:

- Life coaching telephonic sessions to assist with personal growth and career development at work.
- Telephonic sessions with a counsellor for managers to develop their people management skills.

Practical needs:

- Unlimited in the moment telephonic support for live assistance.
- Pre-qualified referrals and information to assist with your day to day demands, such as relocation logistics, child or eldercare, legal or financial services.

Important Notes:

This service is not suitable if:

- You are reporting imminent risk of harm to self or others;
- You have an addiction, such as substance or impulse control for example gambling;
- You have symptoms or a diagnosis or mental health issues other than anxiety or depression, for example Borderline Personality.

Wellness Coaching

Silver	Gold	Platinum
Paid in full	Paid in full	Paid in full

With so much time spent juggling work and home commitments, looking after yourself can sometimes take last priority. You may know what you want to change but don't quite know where to start. Our Wellness Coaching empowers you to create healthy behaviours for lasting lifestyle changes.

We will match you with your own personal qualified wellness coach who is specifically trained in health behaviour change. Your coach will partner with you to identify a specific wellness goal that is important to you, such as:

- Weight management
- Healthy eating
- Physical activity
- Sleep
- Stress management
- Tobacco cessation

You will have access to 6 confidential coaching sessions per focus area per period of cover. Your coach will provide personalised, goal-oriented guidance, wellness education, strategy development and encouragement. Coaching sessions can be scheduled according to time zone and language preferences, and the sessions can be delivered by telephone or video to suit.

Mental Health Support Programme Up to 20 face to face counselling sessions per condition per period of cover.	Silver	Gold	Platinum
	Paid in full	**Paid in full**	**Paid in full**

Being diagnosed with anxiety or depression can be overwhelming, and it can be difficult to know what steps to take next. At Cigna, we realize that anxiety and depression require more targeted support than milder mental health issues traditionally supported by the short-term counselling services offered through our Life Management Assistance Programme.

Our Mental Health Support Programme provides long-term psychological support in the areas of anxiety and depression, with up to 20 face to face counselling sessions per condition per period of cover.

This confidential counselling is provided in a one to one offline setting (the most traditional way of counselling), or video or phone sessions can also be considered as an alternative depending on your location.

The process to access this Mental Health Support Programme is as follows:

- **Reach out to the Life Management Assistance Programme (see above)**, by phone via our Customer Care Team or from the Cigna Wellbeing App.
- **Speak with a clinician** who will carry out an initial telephone-based assessment. If you have been diagnosed with moderate to severe depression or anxiety, the clinician will recommend referral to a CBT psychologist.
- **Receive initial counselling sessions** where a CBT psychologist will assess you over a maximum of 2 face to face sessions. Where in-person meetings are not possible, telephone or video meeting options can be made available.
- **Receive counselling support over a maximum of 20 sessions**. Psychometric testing is carried out at this stage and after every 6 sessions.
- **Start to feel the benefits** by achieving a happier, healthier state of wellbeing.
- **Monitor you progress**. A case manager will check in with you to ensure you're on track.

This programme offers you fast and easy access to CBT psychologist as our counsellors are often available in areas of the world where mental health services might be harder to access.

Important Notes:

This service is not suitable if:

- You are reporting imminent risk of harm to self or others;
- You have an addiction, such as substance or impulse control for example gambling;
- You have symptoms or a diagnosis or mental health issues other than anxiety or depression, for example Borderline Personality Disorder, Schizophrenia, Bi-Polar or OCD; or
- You are under 18 years old.

International Medical Evacuation

Optional Module

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

International Medical Evacuation

International Medical Evacuation Annual overall benefit maximum - per beneficiary per period of cover	Silver	Gold	Platinum
	Paid in full	Paid in full	Paid in full

Medical Evacuation	Silver	Gold	Platinum
	Paid in full	Paid in full	Paid in full

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

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

- to be taken to the nearest hospital where the necessary treatment is available (even if this is in another part of the country, or in another country); and
- to return to the place they were taken from, provided the return journey takes place not more than 14 days after the treatment is completed.

As regards to the return journey, we will pay:

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

We will only pay for taxi fares if:

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

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

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

Important notes:

- If you require to return to the hospital where you were evacuated for follow up treatment, we will not pay for travel costs or living allowance costs.
- In the event that evacuation services are not organised by us, we reserve the right to decline the costs.

Medical Repatriation

Silver	Gold	Platinum
Paid in full	Paid in full	Paid in full

If a beneficiary requires a medical repatriation as a result of a serious illness or after a traumatic event or surgery, we will pay:

- for them to be returned to their country of habitual residence or country of nationality; and
- to return them to the place they were taken from, provided the return journey takes place not more than 14 days after the treatment is completed.

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

As regards to the return journey, we will pay:

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

We will only pay for taxi fares if:

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

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

Important notes:

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

Repatriation of mortal remains

Silver	Gold	Platinum
Paid in full	Paid in full	Paid in full

If a beneficiary dies outside their country of habitual residence during the period of cover, the medical assistance service will arrange for their mortal remains to be returned to their country of habitual residence or country of nationality as soon as reasonably practicable, subject to airlines requirements and restrictions.

We will not pay any costs associated with burial or cremation or the transport costs for someone to collect or accompany the beneficiary's mortal remains.

Important note:

- In the event that repatriation services are not organised by us, we reserve the right to decline the costs.

Travel cost for an accompanying person	Silver	Gold	Platinum
	Paid in full	Paid in full	Paid in full

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

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

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

We will pay:

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

whichever is the lesser.

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

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

Important notes:

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

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

Compassionate visit - travel costs Up to a maximum of 5 trips per lifetime up to the total limit shown for your selected plan per beneficiary.	Silver	Gold	Platinum
	$1,200 €1,000 £800	$1,200 €1,000 £800	$1,200 €1,000 £800

Compassionate visit - living allowance costs Up to the total limit shown per day for each visit with a maximum of 10 days per visit.	Silver	Gold	Platinum
	$155 €125 £100	$155 €125 £100	$155 €125 £100

For each beneficiary we will pay for up to 5 compassionate visits over the lifetime of the cover. Compassionate visits must be approved in advance by our medical assistance service.

We will pay the cost of economy class return travel for a parent, spouse, partner, sibling or child to visit a beneficiary after an accident or sudden illness, if the beneficiary is in a different country and is anticipated to be hospitalised for 5 days or more, or has been given a short-term terminal prognosis.

We will also pay for living expenses incurred by a family member during a compassionate visit, for up to 10 days per visit while they are away from their country of habitual residence up to the limits shown in the list of benefits (subject to being provided with receipts in respect of the costs incurred).

Important note:

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

Medical Evacuation & Repatriation

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

Important notes

The services described in this section are provided or arranged by the medical assistance service under this policy.

The following conditions apply to both emergency medical evacuations and repatriations:

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

General conditions

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

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

International Vision & Dental

Optional Module

International Vision and Dental pays for the beneficiary's routine eye examination and pays costs for spectacles and lenses. It also covers a wide range of preventative, routine and major dental treatments.

Vision Care

Eye Test Up to the total limit shown for your selected plan per beneficiary per period of cover.	Silver	Gold	Platinum
	$100 €75 £65	$200 €150 £130	Paid in full

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

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

Expenses for: Up to the total limit shown for your selected plan per beneficiary per period of cover.	Silver	Gold Updated	Platinum
	$155 €125 £100	$200 €150 £130	$310 €245 £200

- Spectacle lenses.
- Contact lenses.
- Spectacle frames.
- Prescription sunglasses

when all are prescribed by an optometrist or ophthalmologist.

We will not pay for:

- sunglasses, unless medically prescribed, by an ophthalmologist or optometrist;
- glasses or lenses which are not medically necessary or not prescribed by an ophthalmologist or optometrist; or
- treatment or surgery, including treatment or surgery which aims to correct eyesight, such as laser eye surgery, refractive keratotomy (RK) or photorefractive keratectomy (PRK).

A copy of a prescription or invoice for corrective lenses will need to be provided to us in support of any claim for frames.

Dental Treatment

Overall annual Dental treatment benefit maximum Annual overall benefit maximum - per beneficiary per period of cover	Silver	Gold	Platinum
	$1,250 €930 £830	$2,500 €1,850 £1,650	$5,500 €4,300 £3,500

Preventative Up to the overall annual Dental treatment benefit maximum for your selected plan beneficiary per period of cover. **Available once the beneficiary has been covered by this option for 3 months.**	Silver	Gold	Platinum
	Paid in full	Paid in full	Paid in full

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

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

Routine

Up to the total limit shown for your selected plan per beneficiary per period of cover or, where "paid in full" is shown, this is up to the annual overall benefit maximum for your selected plan per beneficiary per period of cover.

Available once the beneficiary has been covered by this option for 3 months.

Silver	Gold	Platinum
80% refund	90% refund	Paid in full

We will pay treatment costs for the following routine dental treatment after the beneficiary has had International Vision and Dental 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;
- anaesthetics; and
- periodontal treatment.

Major restorative

Up to the total limit shown for your selected plan per beneficiary per period of cover or, where "paid in full" is shown, this is up to the annual overall benefit maximum for your selected plan per beneficiary per period of cover.

Available once the beneficiary has been covered by this option for 12 months.

Silver	Gold	Platinum
70% refund	80% refund	Paid in full

We will pay treatment costs for the following major restorative dental treatments after the beneficiary has had International Vision and Dental 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 International Vision and Dental cover for 12 months, we will pay 50% of the treatment costs.

Orthodontic treatment

Up to the total limit shown for your selected plan per beneficiary per period of cover or, where "paid in full" is shown, this is up to the annual overall benefit maximum for your selected plan per beneficiary per period of cover.

Available for beneficiaries aged 18 or younger, once they have been covered by this option for 18 months.

Silver	Gold	Platinum
40% refund	50% refund	50% refund

We will pay for orthodontic treatment for beneficiaries only under the age of 19 years old, if they have had International Vision and Dental cover for at least 18 months.

We will only pay for orthodontic treatment if:

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

Important Information

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 years of its original fitting unless:
  - it has been damaged beyond repair, whilst in use, as a result of a dental injury suffered by the beneficiary whilst they are covered under this policy; or
  - the replacement is necessary because the beneficiary requires the extraction of a sound natural tooth/teeth; or
  - the replacement is necessary because of the placement of an original opposing full denture.
- Acrylic or porcelain veneers.
- Crowns or pontics on, or replacing, the upper and lower first, second and third molars unless:
  - they are constructed of either porcelain; bonded-to-metal or metal alone (for example, a gold alloy crown); or
  - a temporary crown or pontic is necessary as part of routine or emergency dental treatment.
- Treatments, procedures and materials which are experimental or do not meet generally accepted dental standards.
- Treatment for dental implants directly or indirectly related to:
  - failure of the implant to integrate;
  - breakdown of osseointegration;
  - peri-implantitis;
  - replacement of crowns, bridges or dentures; or
  - any accident or emergency treatment including for any prosthetic device.
- Advice relating to plaque control, oral hygiene and diet.
- Services and supplies, including but not limited to mouthwash, toothbrush and toothpaste.
- Medical treatment carried out in hospital by an oral specialist may be covered under International Medical Insurance plan and/or International Outpatient, 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; or
  - diagnose or treat conditions or dysfunction of the temporomandibular joint; or
  - stabilise periodontally involved teeth; or
  - restore occlusion.

How Deductible And Cost Share Work

Our wide range of deductible and cost share options allow you to tailor your plan to suit your budget. You can choose to have a deductible and/or cost share on the International Medical Insurance and/or on the International Outpatient optional module.

If you have selected a deductible and/or cost share on your policy, this deductible and/or cost share will be required to be satisfied in full before you are able to claim for treatment or reimbursement for treatment costs. Please note, the deductible and/or cost share selected is not subtracted from the individual benefits limits available on your plan.

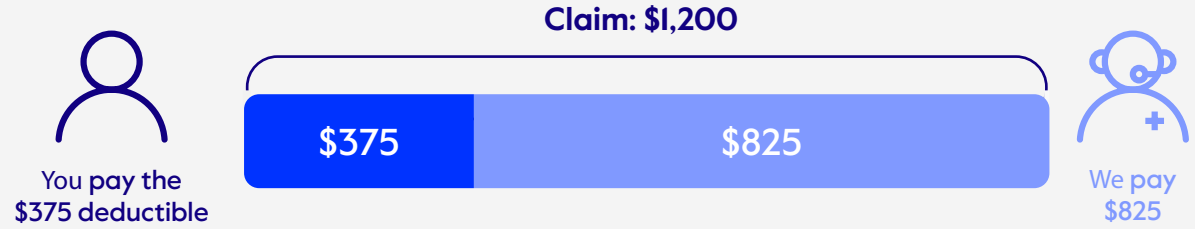
- **Deductible** - this is the amount you must pay towards your cost of treatment until the deductible for the period of cover is reached.
- **Cost Share** - this is the cost share percentage you must pay towards your cost of treatment. This applies once the deductible amount (if selected) has been calculated.
- **Out-of-Pocket Maximum** - this is the maximum amount of cost share you have to pay per period of cover. Only the amounts you pay related to the cost share are subject to the capping effect of the out of pocket maximum.

Example 1:

How the deductible works

Claim value: **$1,200**
Deductible: **$375**

Once the deductible amount has been reached, we pay for all subsequent treatment costs for that period of cover. In this example, the deductible amount has now been reached for this period of cover.

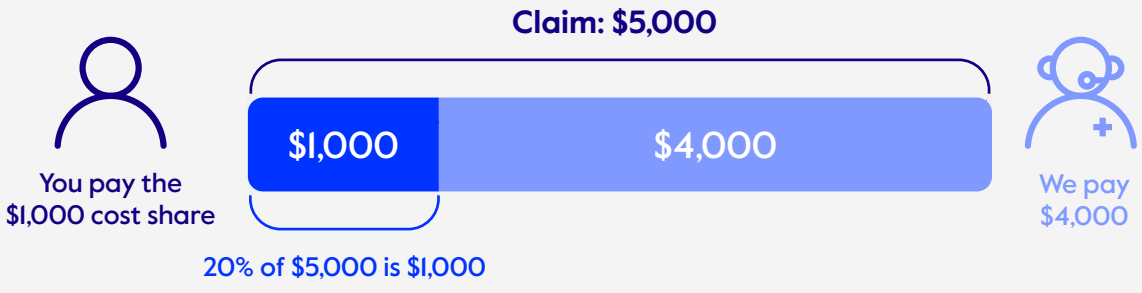


Example 2:

How the cost share works

Claim value: **$5,000**
Deductible: **$0**
Cost share: **20% = $1,000**
Out of Pocket Maximum: **$2,000**

The amount of cost share is subject to the capping effect of the out of pocket maximum. In this example, $1,000 has been paid towards the $2,000 out of pocket maximum for this period of cover.



Example 3:

How the cost share and out of pocket maximum works

Claim value: **$20,000**
Deductible: **$0**
Cost Share: **20% = $4,000**
Out of Pocket Maximum: **$2,000**

The out of pocket maximum protects you from large cost share amounts.

In this example, you have satisfied your out of pocket maximum and we will cover the rest for this period of cover.

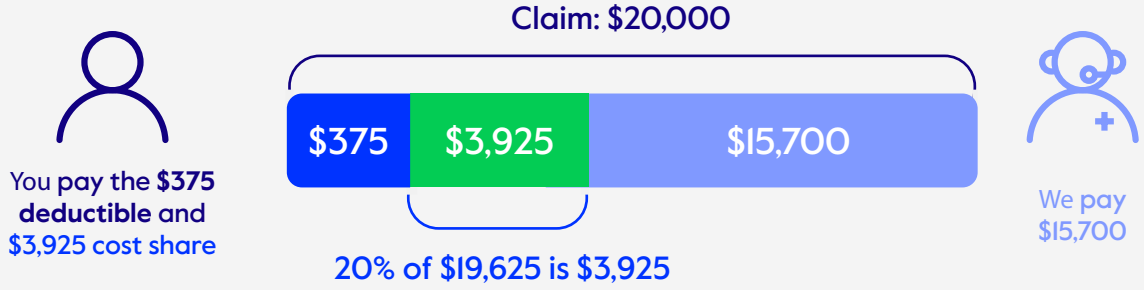
Example 4:

How the deductible and cost share work if you have selected both

Claim value: **$20,000**
Deductible: **$375**
Cost Share: **20% = $3,925**
Out of Pocket Maximum: **$5,000**

The deductible is due before the cost share is calculated.

In this example, your deductible of $375 is taken off the cost of treatment first and then the 20% cost share is calculated. $3,925 has been paid towards the $5,000 out of pocket maximum for this period of cover.



Important information

- You are responsible for paying the amount of any deductible and cost share due to the hospital, clinic, medical practitioner or pharmacy. We will let you know the outstanding charges that you need to pay once we have processed the invoice from the medical provider.
- The deductible, cost share, and out of pocket maximum is determined separately for each beneficiary and each period of cover.
- 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.
- You can request a change to the deductible and/or cost share and out of pocket maximum with effect from your annual renewal date each year. If you wish to remove or reduce your deductible, cost share or reduce your out of pocket maximum on your coverage, we may require you to provide us with more detailed medical information (including medical information of any beneficiaries if relevant) and we may apply new special restrictions or exclusions based on the information you provide us with.
- You can remind yourself of any deductible or cost shares you may have selected by checking your Certificate of Insurance which is available in your secure online Customer Area.

Did You Know?

Additional cover not included as standard

Cigna Global Health Options plans have four additional optional modules to enhance your health plan:

- International Outpatient
- International Health and Wellbeing
- International Medical Evacuation
- International Dental and Vision

You can add any of these modules during the enrolment, at renewal or during your period of cover. Your selection will be on your Certificate of Insurance. You can find this important document under 'Documents' in your online Customer Area.

Benefits with age restrictions:

Policyholders and any beneficiaries must be 18 years old or older to access any care and treatment within the International Health and Wellbeing optional module.

Core benefits included in every policy:

There are some outpatient treatments that are covered under every standard International Health Insurance plan:

- Mental and Behavioural Health Care
- Advanced Medical Imaging
- Accident and Emergency Room Treatment
- Kidney Dialysis
- Cancer Care
- Complications from maternity (only on Gold and Platinum plans)

Any deductible you may have chosen as part of your standard International Health Insurance plan will also apply to the outpatient treatments above, with the exception of the Accident and Emergency Room Treatment benefit, where no deductible is applied.

Additional benefits where deductible and cost share is not applied:

Deductibles and cost shares are not applied to the following benefits as per the terms and conditions in your Policy Rules document:

- Inpatient Cash Benefit
- Accident and Emergency Room Treatment
- Newborn Care
- Global Telehealth

Deductible and cost share options are not available to the following optional modules and their benefits:

- International Health and Wellbeing
- International Medical Evacuation
- International Dental and Vision

Frequently Asked Questions

How to speak to a doctor:

Global Telehealth

You have access to unlimited video and phone consultations with one of our chosen doctor through the Global Telehealth service. This service is available for non-emergency health issues via the Cigna Wellbeing® App, or via a referral from our Customer Service team.

Any treatment or prescriptions drugs following a Global Telehealth consultation will only be covered if you have purchased the optional International Outpatient Module as part of your plan.

How to speak to someone about your policy:

See page 2 for contact details for our Customer Service Team.

How to get access to treatment:

See page 8 to understand how to access treatment. If you have further questions, reach out to the Customer Service team.

How to pay for treatment:

See page 10 to understand if Cigna Healthcare will take care of the medical bill or if you need to seek reimbursement. If you need to submit a claim, please see further information on page 13.

How much do I pay towards the cost of my treatment claim?

You can check what deductible or cost share you've applied to your policy on your Certificate of Insurance.

Any deductible and/or cost-share chosen as part of your plan is applicable per person per policy year.

Remember: it is important to submit a claim even if you have paid for the treatment out of your pocket, as this amount will be included towards any deductible you may have applied to your policy.

See page 49 for how deductible and cost share works.

What happens at the end of my policy year?

You will receive an email 45 days in advance of your renewal date, including a renewal invite and a statement letter. These can also be found in your online Customer Portal.

If you wish to make any changes to your policy at that time, you can speak with a dedicated member of our customer loyalty team via the contact details in your renewal email.

You are not re-underwritten at renewal if you are not making material changes to your policy. We don't ask new or further medical questions if it's not required. We do not base your renewal premium on any claims you may or may not have made during your policy year.

What happens if I want to be reimbursed in a different currency?

We will reimburse your claim in the currency in which the expense was incurred. If you prefer, we can also reimburse you in the currency used to pay your policy premiums - just let us know.

You may request reimbursement in a different currency. If approved, a standard convenience fee of 3% will be applied to the exchange rate used.

What treatment isn't covered under the mental and behavioural health care benefit?

We will not cover treatment considered situational or lifestyle-based (for example, family or marital counselling) under this benefit. However, if a life event results in a clinically diagnosable condition, the recommended medically necessary treatment will be covered under this benefit. Note: Non-medically necessary counselling sessions for individual and group settings are available through our Life Management Assistance Programme within the optional Health and Wellbeing module.

Definitions

Unless otherwise specified, the words and phrases defined below when used throughout your Customer Guide, will have the following meanings. Unless otherwise provided, the singular includes the plural and the masculine includes the feminine and vice versa.

Annual Renewal Date
the anniversary of the start date.

Appropriate age intervals
child and adolescence age schedule up to age seventeen years old as set out by the American Academy of Pediatrics (AAP).

Benficiaries, beneficiary
anybody named in your Certificate of Insurance as being covered under this policy, including newborn children.

Congenital Condition(s)
any abnormality, deformity, disease, illness or injury present at birth, whether diagnosed or not.

Country of habitual residence
the country where a beneficiary habitually resides, as stated in your application.

Country of nationality
any country of which a beneficiary is a citizen, national or subject, as state in your application.

Daypatient
a patient who is admitted to a hospital or daypatient unit or other medical facility for treatment or because they need a period of medically supervised recovery, but who does not occupy a bed overnight.

An example of daypatient treatment would be attending hospital for chemotherapy as part of cancer treatment or receiving an endoscopy as part of diagnostic testing.

Dental Accident
treatment which is medically necessary as part of a beneficiary's recovery following a severe injury or accident which is aimed at restoring the beneficiary to their previous state of health after such an event.

Emergency treatment
treatment which is medically necessary to prevent the immediate and significant effects of illnesses, injuries or conditions which, if left untreated, could result in a significant deterioration in health. Only medical treatment through a physician, medical practitioner and hospitalisation that commences within twenty four (24) hours of the emergency event will be covered.

Evidence-based treatment
treatment which has been researched, reviewed and recognised by:

- the National Institute for Health and Clinical Excellence; or
- International Clinical Guidelines.

Formulary drugs list
A prescription drugs list applicable to all pharmacy claims in the USA. This list is developed by Cigna Healthcare with assistance from our Pharmacy and Therapeutics Committee and is updated twice a year. All the medications included in our formulary drugs list are approved by the U.S. Food and Drug Administration (FDA). Over-the-counter (OTC) medicines (those that do not require a prescription), except insulin, are excluded from our formulary drugs list, unless state or federal law requires coverage of such medicines. We will notify you of any change that affects the coverage of a medication that you are taking at the time of any update.

Guarantee of payment
a binding guarantee made by us to pay a provider the agreed costs associated with a particular treatment which we may give to a beneficiary or a medical facility or medical practitioner.

Inpatient
Inpatient means a patient who is admitted to a medical facility and who occupies a bed overnight or longer, for medical reasons.

An example of inpatient treatment is undergoing surgery following a heart attack where they will recover in hospital overnight.

Medical Assistance Service
a service which provides medical advice, evacuation, assistance and repatriation in accordance with International Clinical Guidelines. This service, provided by our partner International SOS, can be multilingual and assistance is available twenty four (24) hours per day.

Medically necessary/medical necessity
medically necessary covered services and supplies are those determined in accordance with International Clinical Guidelines by the medical team to be:

- required to diagnose or treat an illness, injury, disease or its symptoms;
- orthodox, and in accordance with generally accepted standards of medical practice;
- clinically appropriate in terms of type, frequency, extent, site and duration;
- not primarily for the convenience of the beneficiary, medical practitioner or medical facility; and
- rendered in the least intensive setting that is appropriate for the delivery of the services and supplies.

Where applicable, the medical team may compare the cost effectiveness of alternative services, settings or supplies when determining what the least intensive setting is.

Medical Facilties
this includes any organisation or institution which is registered or licensed as a medical or surgical clinic and/or hospital in the country in which it is located where the beneficiary is under the daily care or supervision of a medical practitioner or qualified nurse.

Medical Practitioners
a doctor, specialist, qualified nurse or therapist (including speech therapies, dietician or orthoptist), dental surgeon or dental pracittioner who is registered, suitably qualified or licensed to practice medicine or provide treatment under the laws of the

country, state or other regulated area in which the treatment is provided, and who is not covered under this policy, or a family member of someone covered under this policy.

Outpatient

Outpatient means a patient who attends a hospital outpatient department, consulting room, outpatient clinic or other outpatient medical facility for treatment but is not admitted as a daypatient or an inpatient and does not occupy a bed.

An example of outpatient treatment would be visiting an outpatient clinic to undergo a mole removal where you are not required to be admitted to hospital and do not require general anaesthetic for the procedure.

Period of cover

this policy has a minimum period of cover of three (3) and a maximum period of cover of twelve (I2) months renewable. The period of cover is from the start date to the end date as noted in the Certificate of Insurance or earlier if terminated in accordance with the Policy Rules

Policy

the Policy comprising of:

- the policyholder's Application and any declarations that they made during their enrolment for them and any beneficiaries in the application;
- the Policy Rules;
- this Customer Guide (which contains the list of benefits and claiming information);
- your Certificate of Insurance (shows the policy number, the annual premium, the start date, the deductible and/or cost share amount if selected, details of who is covered, any special exclusions that have been removed at an aditional premium and the heatlth plan and selected options where applicable), and;
- your Cigna Healthcare ID Card.

Pre-Existing Condition

Any disease, illness or injury, or symptoms present before the initial start date of your policy for which:

- medical advice or treatment has been sought or received; or
- the beneficiary knew about and did not seek medical advice or treatment.

Prior authorisation/prior approval

refers to the formal process of contacting us to obtain confirmation that the medical treatment will be covered and that the medical facility considered is a Cigna Healthcare approved medical provider that meets the Cigna Healthcare quality standards. The approval by us will be based on our medical necessity review process performed by our medical team and we may issue a guarantee of payment, if required, as part of that review. The medical treatment that requires prior authorisation are clearly indicated in the list of benefits in your customer guide. **Failure to obtain the required prior authorisation from us will result in reducing the amount which we will pay towards that treatment.**

Selected area of coverage

means either:

- Worldwide, including USA (every country throughout the world, excluding any country with whom, at the date of commencement of treatment, the Federal Government of the USA has prohibited trade to the extent that payments are illegal under applicable law.); or
- Worldwide, excluding USA (worldwide, with the exception of the USA) .
- Please note: For all US Territories, namely Puerto Rico, American Samoa, Guam, the Commonwealth of the Northern Mariana Islands and the US Virgin Islands, customers will be required to have US cover on their policy in order to utilise their coverage in these regions. However, there will be no penalty applied for 'out of network' provider use, as this is exclusive to the USA.

Treatment

any surgery or medical treatment controlled by a medical practitioner and takes place in a medical facility that is medically necessary to diagnose, cure or substantially relieve disease, illness or injury.

Improving the health and vitality of those we serve.

Want To Get 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.

Use your Customer Area
Live chat with us
Message us
Arrange a call back

Alternatively, you can email us at:
cignaglobal_customer.care@cigna.com

Call Us
International: **+44 (0) 1475 788 182**
USA: **800 835 7677** (toll free)
Hong Kong: **2297 5210** (toll free)
Singapore: **800 186 5047** (toll free)

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

If your policy is insured by Cigna Europe Insurance Company S.A.-N.V. Singapore Branch, the following statement applies:

Cigna Europe Insurance Company S.A.-N.V. Singapore Branch (Registration Number: T10FC0145E), is a foreign branch of Cigna Europe Insurance Company S.A.-N.V., registered in Belgium with limited liability, with its registered office at 152 Beach Road, #33-05/06 The Gateway East, Singapore 189721.

This policy is protected under the Policy Owners' Protection Scheme which is administered by the Singapore Deposit Insurance Corporation (SDIC). Coverage for your policy is automatic and no further action is required from you. For more information on the types of benefits that are covered under the scheme as well as the limits of coverage, where applicable, please contact us or visit the General Insurance Association (GIA) or SDIC websites (www.gia.org.sg or www.sdic.org.sg).

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