PROTECTING YOU AND YOUR FAMILY WHEN LIVING ABROAD
YOUR CIGNA GLOBAL PLAN

Thank you for choosing a Cigna Global plan to protect you and your family. It’s our mission to help improve your health, wellbeing and sense of security - and everything we do is designed to achieve this.

Please read this Customer Guide, along with your Certificate of Insurance and your Policy Rules as they all form part of your contract between you and us for this period of cover.

You have chosen a plan to meet your own unique needs, so as you look through your Customer Guide and discover the full extent of the cover we provide, you may see some terms that are in italics. These terms are clearly defined in your Policy Rules so as to avoid any confusion.

In the meantime, we hope you enjoy the peace of mind that comes from knowing you and your family have quick access to the quality medical treatment you need, whenever and wherever you need it.

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OUR CUSTOMER PROMISE

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

> you can speak to our highly experienced Customer Care Team 24 hours a day;

> you will have quick and easy access to healthcare facilities and professionals around the world through our extensive network;

> we will reimburse your treatment provider directly in most cases. On the rare occasion that you have to pay for treatment yourself, we aim to process your claim within 5 working days after receiving all necessary documentation;

> you can receive payment in over 135 currencies.

How this is delivered

Customer Service centres with multi-language assistance and support.

A medical network comprising of over 1 million partnerships, including 89,000 behavioural health care professionals, and 11,400 facilities and clinics.

A simple claims system that enables you to access treatment without paying in many cases, simply by calling our Customer Care Team first.
GETTING IN TOUCH

If you have any questions about your policy, need to get approval for treatment, or for any other reason, please contact our Customer Care Team 24 hours a day, 7 days a week, 365 days a year.

📞 Call: +44 (0) 1475 788 182
📠 Fax: +44 (0) 1475 492 113
✉️ Email: cignaglobal_customer.care@cigna.com

Inside the USA:
Call: 800 835 7677
Fax: 855 358 6457

Inside Hong Kong:
Call: 2297 5210

Inside Singapore:
Call: 800 186 5047
YOUR ONLINE CUSTOMER AREA

As a Cigna customer you have access to a wealth of information wherever you are in the world through your secure online Customer Area. Here you will be able to effectively manage your policy including:

> View your policy documents, including your Certificate of Insurance and Cigna ID cards for all the people covered under your plan

> Check the Policy Rules that apply to your policy

> Check your coverage for you and your family

> Submit claims online

> Search for healthcare facilities and professionals near your location

> Access the Health and Wellbeing site

> Download the Cigna Wellbeing™ app

> Download the Safe Travel app (Platinum and Gold plan customers only)

To access your secure online Customer Area, please log on to www.cignaglobal.com then:

Click on the ‘Customer Area Login’ button at the top right of the page

Next, click on the ‘Log into the Customer Area’ button to access the Customer Area Login page

In the User ID field type the email address that you provided us with and then your password

If you have any problems accessing the Customer Area, please contact our Customer Care Team.
Prior approval

Please contact our Customer Care Team prior to treatment. We can help you arrange your treatment plan, and point you in the right direction, saving you the time and hassle of looking for a hospital, clinic or medical practitioner yourself. What’s more, in most cases we can arrange direct payment with your treatment provider, cutting down the hassle and letting you focus on your health.

If we cannot arrange direct payment with the provider, we will advise you of the nearest billing provider when you call for approval. There may be instances when we cannot arrange direct payments with a provider, and in such instances, we will let you know.

Our experts are available 24/7 to discuss your treatment plan and liaise directly with your treatment provider to arrange guarantee of payment, and ensure the treatment that you are about to undertake is covered under your policy.

We may ask for further information, such as a medical report in order for us to approve treatment. We will confirm approval, and where applicable, the number of treatments approved.

Emergency Treatment

We appreciate that there will be times when it will not be practical or possible for a beneficiary to contact us for prior approval (for example, emergencies, or when a family member is suddenly sick and the priority is to get treatment for them as soon as possible). In circumstances like these, we ask that you or the affected beneficiary get in touch with us within 48 hours after treatment has been sought, so that we can confirm whether treatment is covered and arrange settlement with your provider. This will also allow us to make sure that you or the affected beneficiary is making the best use of the cover.

In the event of emergency treatment we will ask for an explanation of why the treatment was needed urgently, and may ask for evidence of this. If we agree that it was not reasonably possible or practical to seek prior approval, we will cover the cost of the initial treatment (including any prescribed medication) which was urgent (within the terms of this policy).

If a beneficiary has been taken to a hospital, medical practitioner or clinic which is not part of the Cigna network, then we may make arrangements (with the beneficiary’s consent) to move the beneficiary to a Cigna network hospital, medical practitioner or clinic to continue treatment, once it is medically appropriate to do so.

Important note

Prior approval should be obtained from us for all treatment. This will help ensure your claim is covered under the policy. If you do not get prior approval from us, there may be delays in processing claims, or we may decline to pay all or part of the claim.

We will reduce the amount which we will pay by:

- 50% if you did not obtain prior approval when it was required for treatment inside the USA;
- 20% if you did not obtain prior approval for treatment outside the USA.
Getting Treatment

Please remember to take your Cigna ID card with you when you go for treatment and ask your hospital, medical practitioner or clinic about direct billing if this has not already been confirmed. We will give the provider a guarantee of payment, if required. A copy of your Cigna ID card is available in your secure online Customer Area.

Important note

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

Guarantee of payment

In some circumstances, we may give a beneficiary or a hospital, medical practitioner or clinic a guarantee of payment. This means that we agree in advance to pay some or all of the cost of a particular treatment. Where we have given a guarantee of payment we will pay the beneficiary or hospital, medical practitioner or clinic the agreed amount on receipt of an appropriate request and a copy of the relevant invoice, after the treatment has been provided.

Getting treatment in the USA

If prior approval is obtained, but the beneficiary decides to receive treatment at a hospital, medical practitioner or clinic which is not part of the Cigna network, we will reduce any amount which we will pay by 20%. A list of Cigna network hospitals, clinics and medical practitioners is available in your secure online Customer Area or you can contact our Customer Care Team for more information.

We realise that there may be occasions when it is not reasonably possible for treatment to be provided by a Cigna network hospital, medical practitioner or clinic. In these cases, we will not apply any reduction to the payments we will make. Examples include, but are not limited to;

> when there is no Cigna network hospital, medical practitioner or clinic within 30 miles/50 kilometres of the benefit beneficiary’s home address; or

> when the treatment the beneficiary needs is not available from a local Cigna network hospital, medical practitioner or clinic.
How we will pay claims after treatment

We pay your hospital clinic or medical practitioner directly

Some hospitals, medical practitioners or clinics are willing to invoice us directly. If the treatment is covered, the hospital, medical practitioner or clinic should send us the original invoice and we will pay them directly.

If your hospital, clinic or medical practitioner gives you an invoice

If a hospital, medical practitioner or clinic invoices a beneficiary directly, and the hospital, medical practitioner or clinic has not been paid, the beneficiary must send the original invoice and we will make any payment under this policy to that hospital, medical practitioner or clinic directly.

If you have paid your hospital, clinic or medical practitioner

If the hospital, medical practitioner or clinic invoices a beneficiary directly, and the invoice is paid, the beneficiary may send us the original invoice, receipt and claim form for the payment which has been made to the hospital, medical practitioner or clinic as soon as possible. We will then reimburse the beneficiary for any portion of the cost of the treatment which is covered.

In each case, we will only pay the parts of the costs incurred which are covered. We will let you know if we believe that any part of the cost incurred is not covered. We can reimburse you using bank wire transfer or cheque.

You can submit claims online via your secure online Customer Area, email, fax or send them in the post. Please see page 10 on how to submit claims for your specific region.

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

Important note

We may need to ask for extra information to help us process a claim, for example; medical reports or other information about the beneficiary’s condition or the results of any independent medical examination that we may ask and pay for.

Beneficiaries should submit claim forms and invoices as soon as possible after any treatment. If the claim and invoice is not submitted to us within 12 months of the date of treatment, the claim will not qualify for payment or reimbursement by us.

We will pay for the following costs related to your claim:

- Costs as described in the list of benefits section of this Customer Guide as applicable on the date(s) of the beneficiary’s treatment.

- Costs for treatment which have taken place, however, we will not cover future treatment costs that require payment deposits or payment in advance.

- Treatment which is medically necessary and clinically appropriate for the beneficiary.

- 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.
SUBMITTING YOUR CLAIM

If you’ve paid for your treatment yourself, you can send your invoice and claim form to us using any of the following methods. Please clearly state your policy number on all documentation.

Online Customer Area: www.cignaglobal.com
Email: cignaglobal_customer.care@cigna.com
Fax: +44 (0) 1475 492 113
Post:

Treatment incurred outside the USA, Hong Kong and Singapore
Cigna Global Health Options
Customer Service
1 Knowe Road
Greenock
Scotland PA15 4RJ

Treatment incurred in the USA
Cigna International
PO Box 15964
Wilmington
Delaware 19850
USA

Treatment incurred 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

Treatment incurred in Singapore
Cigna Europe Insurance Company S.A.-N.V. - Singapore Branch
Cigna Global Health Options
152 Beach Road
#33-05/06 The Gateway East
Singapore 189721

Inside the USA:
Fax: 855 358 6457
SUMMARY OF YOUR GUIDE TO GETTING TREATMENT

The diagram below summarises how the treatment and claiming process works:

- Before getting treatment call our Customer Care Team. Please see relevant contact details on page 5.
- If it's an emergency and you can't call us before treatment, contact us in the next 48 hours.
- In most cases we will pay your hospital, clinic or medical practitioner directly.
- If you've chosen a deductible and/or cost share option, you pay this amount directly to your hospital, clinic or medical practitioner and we will pay the rest.

Claim Submission:

You and all beneficiaries must comply with the claims procedures set out in this Customer Guide.
OUR GLOBAL HEALTH ASSIST PROGRAMME

Our unique Global Health Assist programme is carried out by our dedicated team of doctors and nurses, who work hand in hand with customers with serious or complex health conditions to bring them the full medical support they deserve.

We are dedicated to helping you and your family live happier, healthier lives with an unparalleled level of clinical expertise, which grants all beneficiaries access to:

DECISION SUPPORT PROGRAMME

We provide our customers with access to speak with a doctor or nurse. This can offer an international second opinion service or simple reassurance to our customers at what can often be a sensitive and potentially emotional time. Included within this service may be an independent view on their diagnosis or treatment plan.

NURSE COMPLEX CASE MANAGEMENT

When treatment is more complex, our nurses can take over the case providing clinical guidance and reassurance. In addition, that nurse can become the beneficiary’s dedicated point of contact throughout the treatment process.

Our Global Health Assist service works with a proactive and personalised approach to manage complex health conditions.

Our qualified nurses from the Clinical team will immediately contact customers suffering from pre-existing conditions or serious illnesses and confirm a personalised and dedicated point of contact for the customer, and you will receive personalised support and information about:

- Our decision support programme;
- Medical network/preferred provider information;
- Hospital visits and accessing the right level of healthcare;
- Detailed coverage information;
- Personalised support and case management and;
- Global Care On Demand.
HELPFUL INFORMATION

What your exclusions mean

Exclusions are costs or treatments that are not covered by your plan. Please refer to your Policy Rules to see the list of General Exclusions that apply to all coverage and options under Cigna Global Health Options. If you have any special exclusions applied to your individual policy, they’ll be on your Certificate of Insurance. For some special exclusions, we may have agreed to remove the special exclusion at an additional premium, details of which will be on your Certificate of Insurance.

Don’t understand some words and terms?

If you’re not sure what any of the terms in this guide mean, don’t worry. You’ll find a handy list of definitions in your Policy Rules.

Paying your premiums

You can choose to pay for your premiums on a monthly, quarterly or annual basis. You can make payments by debit or credit card, or alternatively if you pay annually, you can pay by bank wire transfer. Please let us know if your credit card has expired or if you get a new credit card so that we can update your card number and expiry date.

Renewing your policy

We will contact you at least one calendar month prior to the end of your period of cover to see whether you want to renew your policy. We will inform you of any changes (if any) to your benefits and policy terms and conditions which will apply on renewal. Your policy documentation for the forthcoming period of cover will be available in your secure online Customer Area, including your schedule of insurance which details your premium. If you have chosen to receive printed copies of your policy documents, we will send them to the postal address you gave us. If you decide to renew, you don’t need to do anything, and your cover will be renewed automatically for another 12 months. We will issue a Certificate of Insurance for your new period of cover on your annual renewal date.

Changing your beneficiaries

Unless there has been a relevant qualifying life event, you can only add or remove a beneficiary when your cover is being renewed at the end of the annual period of cover. If there has been a relevant qualifying life event, such as marriage, divorce, or the birth of a child, you can add or remove a beneficiary at any time during your annual period of cover. If you would like to add, remove or change a beneficiary, just call the Customer Care Team, and they will be happy to help you.

Making changes to your plan

If you want to make any changes to your plan, this can be done when your cover is being renewed at the end of the annual period of cover. Please contact the Customer Care Team who will be happy to help, and discuss the various options and any additional premiums payable.

Cancelling your policy

If you choose to terminate your policy and end cover for all beneficiaries, you can do so at any time by giving us at least seven days’ notice in writing.
Our wide range of deductible and cost share options allow you to tailor your plan to suit your needs.

You can choose to have a deductible and/or cost share on the International Medical Insurance and/or International Outpatient option. No deductible applies to inpatient cash benefits or newborn care benefits.

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

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

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

**EXAMPLE 1: DEDUCTIBLE**  
(also known as ‘excess’)

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

<table>
<thead>
<tr>
<th>Claim value:</th>
<th>$1,200</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible:</td>
<td>$500</td>
</tr>
</tbody>
</table>

**YOU PAY..**  
Deductible of $500

**WE PAY...**  
$700

**WHAT THIS MEANS FOR YOU...**
You only pay the deductible amount and we pay the rest.

**EXAMPLE 2: COST SHARE AND OUT OF POCKET MAXIMUM AFTER DEDUCTIBLE**  
(when your cost share after deductible amount is under the out of pocket maximum)

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

<table>
<thead>
<tr>
<th>Claim value:</th>
<th>$5,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible:</td>
<td>$0</td>
</tr>
<tr>
<td>20% cost share:</td>
<td>$1,000</td>
</tr>
<tr>
<td>Out of pocket maximum:</td>
<td>$2,000</td>
</tr>
</tbody>
</table>

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

**WE PAY...**  
$4,000

**WHAT THIS MEANS FOR YOU...**
Your cost share is 20% of $5,000 ($1,000). This is less than your out of pocket maximum, so you pay $1,000 and we cover the rest.
**EXAMPLE 3: COST SHARE AND OUT OF POCKET MAXIMUM AFTER DEDUCTIBLE**

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

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

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

YOU PAY.. The out of pocket maximum of $2,000

WE PAY... $18,000

**WHAT THIS MEANS FOR YOU...**

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

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

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

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

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

YOU PAY.. The deductible of $375 and the cost share of $3,925

WE PAY... $15,700

**WHAT THIS MEANS FOR YOU...**

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

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⚠️ **Please note:**

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

When building your tailored Cigna Global plan, you may have chosen optional benefits to add to your core cover – International Medical Insurance. In this section we detail exactly what cover you can look forward to with each option. To remind yourself of which benefits you’ve chosen, take a look at your Certificate of Insurance. Your Certificate of Insurance will also detail the area of coverage you have selected for your plan, either Worldwide including USA or Worldwide excluding USA.

The benefit tables detail what is covered in your plan. The Platinum plan provides unlimited cover for International Medical Insurance and the International Outpatient option, with the exception of any benefits which have individual limits. The Gold and Silver plans, along with the Dental options, have annual maximums. These are the maximum amounts we will pay for per beneficiary per period of cover.

The benefits under International Outpatient, International Medical Evacuation, International Health and Wellbeing and the International Vision and Dental options will only be available if you have purchased these in addition to your core level of cover - International Medical Insurance. Please read the additional accompanying notes applicable to each benefit in the benefit tables.

The International Outpatient option includes treatments which take place at a hospital, consulting room or outpatient clinic when an admission as an inpatient or daypatient is not required. This means that emergency treatment that does not require an admission as an inpatient or daypatient will only be covered if you have purchased the International Outpatient option.

The benefits and any additional options chosen are provided subject to all of the terms, conditions, limits and exclusions of this policy (including the General Exclusions found in the Policy Rules, specific exclusions set out in the list of benefits and any special exclusions set out in your Certificate of Insurance). The list of benefits in this Customer Guide shows any limits which apply to the benefits. Benefits that are ‘paid in full’ are subject to the overall annual benefit maximum, where applicable. There are some benefits which have waiting periods, meaning you can only submit a claim for treatments incurred after the duration of the waiting period has been satisfied.

The benefit limits are displayed in USD, EUR and GBP. The currency in which you have chosen to pay your premium is the currency that applies to your plan benefits.

Out of Area Emergency cover - for customers who have Worldwide excluding USA area of coverage.

For additional peace of mind, your plan includes emergency short-term medical coverage when you are visiting a location outside of your selected area of coverage.

Beneficiaries will be covered for emergency treatment on an inpatient or daypatient basis, or outpatient basis (if the International Outpatient additional coverage option has been purchased under your policy) during temporary business or holiday trips, even if those trips are outside your selected area of coverage. Coverage is limited to a maximum period of three (3) weeks per trip and a maximum of sixty (60) days per period of cover for all trips combined. Please read the full terms and conditions relating to this benefit in clause 10.6.1 of your Policy Rules.
INTERNATIONAL MEDICAL INSURANCE

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

Your chosen level of cover is detailed in the table below. All amounts apply per beneficiary and per period of cover (except where otherwise noted).

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. Our Gold and Platinum plans also give you cover for inpatient and daypatient maternity care.

YOUR OVERALL LIMIT

<table>
<thead>
<tr>
<th>Annual benefit - maximum per beneficiary per period of cover. This includes claims paid across all sections of International Medical Insurance.</th>
<th>Silver</th>
<th>Gold</th>
<th>Platinum</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,000,000</td>
<td>$2,000,000</td>
<td>Unlimited</td>
<td></td>
</tr>
<tr>
<td>€800,000</td>
<td>€1,600,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>£650,000</td>
<td>£1,300,000</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

YOUR STANDARD MEDICAL BENEFITS

Hospital charges for:
Nursing and accommodation for inpatient and daypatient treatment and recovery room.

<table>
<thead>
<tr>
<th>Silver</th>
<th>Gold</th>
<th>Platinum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paid in full for a semi-private room</td>
<td>Paid in full for a private room</td>
<td>Paid in full for a private room</td>
</tr>
</tbody>
</table>

› We will pay for nursing care and accommodation whilst a beneficiary is receiving inpatient or daypatient treatment; or the cost of a treatment room while a beneficiary is undergoing outpatient surgery, if one is required.

› We will only pay these costs if:
  - it is medically necessary for the beneficiary to be treated on an inpatient or daypatient basis;
  - they stay in hospital for a medically appropriate period of time;
  - the treatment which they receive is provided or managed by a specialist; and
  - they stay in a standard single room with a private bathroom or equivalent (applicable on the Gold and Platinum plans only).
  - they stay in a semi-private room with shared bathroom (applicable on the Silver plan only).

› If a hospital’s fees vary depending on the type of room which the beneficiary stays in, then the maximum amount which we will pay is the amount which would have been charged if the beneficiary had stayed in a standard single room with a private bathroom or equivalent (applicable on the Gold and Platinum plans only), or a semi-private room with shared bathroom or equivalent (applicable on the Silver plan only).

› If the treating medical practitioner decides that the beneficiary needs to stay in hospital for a longer period than we have approved in advance, or decides that the treatment which the beneficiary needs is different to that which we have approved in advance, then that medical practitioner must provide us with a report, explaining: how long the beneficiary will need to stay in hospital; the diagnosis (if this has changed); and the treatment which the beneficiary has received, and needs to receive.
Hospital charges for:
› operating theatre.
› prescribed medicines, drugs and dressings for inpatient or daypatient treatment.
› treatment room fees for outpatient surgery.

Operating theatre costs
› We will pay any costs and charges relating to the use of an operating theatre, if the treatment being given is covered under this policy.

Medicines, drugs and dressings
› We will pay for medicines, drugs and dressings which are prescribed for the beneficiary whilst he or she is receiving inpatient or daypatient treatment.
› We will only pay for medicines, drugs and dressings which are prescribed for use at home if the beneficiary has cover under the International Outpatient option (unless they are prescribed as part of cancer treatment).

Intensive care:
› intensive therapy.
› coronary care.
› high dependency unit.

› We will pay for a beneficiary to be treated in an intensive care, intensive therapy, coronary care or high dependency facility if:
  • that facility is the most appropriate place for them to be treated;
  • the care provided by that facility is an essential part of their treatment; and
  • the care provided by that facility is routinely required by patients suffering from the same type of illness or injury, or receiving the same type of treatment.

Surgeons’ and anaesthetists’ fees

› We will pay for inpatient, daypatient or outpatient costs for:
  • surgeons’ and anaesthetists’ surgery fees; and
  • surgeons’ and anaesthetists’ fees in respect of treatment which is needed immediately before or after surgery (i.e. on the same day as the surgery).

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

Specialists’ consultation fees

› We will pay for regular visits by a specialist during stays in hospital including intensive care by a specialist for as long as is required by medical necessity.

› We will pay for consultations with a specialist during stays in a hospital where the beneficiary:
  • is being treated on an inpatient or daypatient basis;
  • is having surgery; or
  • where the consultation is a medical necessity.
**Hospital accommodation for a parent or guardian**

Up to the maximum amount shown per period of cover.

<table>
<thead>
<tr>
<th>Silver</th>
<th>Gold</th>
<th>Platinum</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,000</td>
<td>$1,000</td>
<td>Paid in full</td>
</tr>
<tr>
<td>€740</td>
<td>€740</td>
<td></td>
</tr>
<tr>
<td>£665</td>
<td>£665</td>
<td></td>
</tr>
</tbody>
</table>

› If a beneficiary who is under the age of 18 years old needs 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.

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**Transplant services for organ, bone marrow and stem cell transplants**

<table>
<thead>
<tr>
<th>Silver</th>
<th>Gold</th>
<th>Platinum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paid in full</td>
<td>Paid in full</td>
<td>Paid in full</td>
</tr>
</tbody>
</table>

› We will pay for inpatient treatment directly associated with an organ transplant, for the beneficiary if:

- the transplant is medically necessary, and the organ to be transplanted has been donated by a member of the beneficiary’s family or comes from a verified and legitimate source.

› We will pay for anti-rejection medicines following a transplant, when they are given on an inpatient basis.

› We will pay for inpatient treatment directly associated with a bone marrow or peripheral stem cell transplant if:

- the transplant is medically necessary; and
- the material to be transplanted is the beneficiary’s own bone marrow or stem cells, or bone marrow taken from a verified and legitimate source.

› We will not pay for bone marrow or peripheral stem cell transplants under this part of this policy if the transplants form part of cancer treatment. The cover which we provide in respect of cancer treatment is explained in other parts of this policy.

› If a person donates bone marrow or an organ to a beneficiary, 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; whether or not the donor is covered by this policy.

› The amount which we will pay towards a donor’s medical costs will be reduced by the amount which is payable to them in relation to those costs under any other insurance policy or from any other source.

› We will not pay for outpatient treatment for either the beneficiary or donor, unless the beneficiary has cover under the International Outpatient option for the specific outpatient treatment required.

› If a beneficiary donates an organ for a medically necessary transplant, we will cover the medical costs incurred by the beneficiary associated with this donation up to any policy limits. However, we will only pay for the harvesting of the donated organ if the intended recipient is also a beneficiary under this plan.

› We will consider all medically necessary transplants. Other transplants (such as transplants which are considered to be experimental procedures) are not covered under this policy. This is because of conditions or limitations to coverage which are explained elsewhere in this policy.

**Important note**

› A beneficiary must contact us and get approval in advance before they incur any costs relating to organ, bone marrow or stem cell donation or transplant.
Kidney dialysis

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.

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

Where investigations are provided on an inpatient or daypatient basis.

We will pay for:
- blood and urine tests;
- X-rays;
- ultrasound scans;
- electrocardiograms (ECG); and
- other diagnostic tests (excluding advanced medical imaging);

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

Advanced Medical Imaging (MRI, CT and PET scans)

Up to the maximum amount shown per period of cover.

We will pay for the following scans if they are recommended by a specialist as a part of a beneficiary’s inpatient, daypatient or outpatient treatment:
- magnetic resonance imaging (MRI);
- computed tomography (CT); and / or
- positron emission tomography (PET);

We may require a medical report in advance of a magnetic resonance imaging (MRI) scan.

Physiotherapy and complementary therapies

Up to the maximum amount shown per period of cover.

Where treatment is provided on an inpatient or daypatient basis.

We will pay for treatment provided by physiotherapist and complementary therapists; (acupuncturists, homeopaths, and practitioners of Chinese medicine) if these therapies are recommended by a specialist as part of the beneficiary’s hospital stay for inpatient or daypatient treatment (but are not the primary treatment which they are in hospital to receive).
**Home nursing**
Up to 30 days and the maximum amount shown per period of cover.

- We will pay for a beneficiary to have up to 30 days of home nursing care per period of cover 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.

**Important note**
- 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.

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

- We will pay for rehabilitation treatments (physical, occupational and speech therapies), which are recommended by a specialist and are medically necessary after a traumatic event such as a stroke or spinal injury.

- If the rehabilitation treatment is required in a residential rehabilitation centre we will pay for accommodation and board for up to 30 days for each separate condition that requires rehabilitation treatment.

  In determining when the 30 day limit has been reached:
  - we count each overnight stay during which a beneficiary receives inpatient treatment as one day
  - we count each day on which a beneficiary receives outpatient and daypatient treatment as one day.

- Subject to prior approval being obtained, prior to the commencement of any treatment, we will pay for rehabilitation treatment for more than 30 days, if further treatment is medically necessary and is recommended by the treating specialist.

**Important note**
- We will only pay for rehabilitation treatment if it is needed after, or as a result of, treatment which is covered by this policy and it begins within 30 days of the end of that original treatment.

- All rehabilitation treatment must be approved by us in advance. We will only approve rehabilitation treatment if the treating specialist provides us with a report, explaining:
  i) how long the beneficiary will need to stay in hospital;
  ii) the diagnosis; and
  iii) the treatment which the beneficiary has received, or needs to receive.

---

**Hospice and palliative care**
Up to the maximum amount shown per lifetime.

- If a beneficiary is given a terminal diagnosis, and there is no available treatment which will be effective in aiding recovery, we will pay for hospital or hospice care and accommodation, nursing care, prescribed medicines, and physical and psychological care.
Internal prosthetic devices / surgical and medical appliances
Up to the maximum amount shown per period of cover.

› We will pay for internal prosthetic implants, devices or appliances which are put in place during surgery as part of a beneficiary’s treatment.

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

External prosthetic devices / surgical and medical appliances
Up to the maximum amount shown per period of cover.

› We will pay for external prosthetics, devices or appliances which are necessary as part of a beneficiary’s treatment (subject to the limitations explained below).

› We will pay for:
  • a prosthetic device or appliance which is a necessary part of the treatment immediately following surgery for as long as is required by medical necessity;
  • a prosthetic device or appliance which is medically necessary and is part of the recuperation process on a short-term basis.

› We will pay for an initial external prosthetic device for beneficiaries aged 18 or over per period of cover. We do not pay for any replacement prosthetic devices for beneficiaries who are aged 18 and over.

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

› By an external ‘prosthetic device’, we mean an external artificial body part, such as a prosthetic limb or prosthetic hand which is medically necessary as part of treatment immediately following the beneficiary’s surgery or as part of the recuperation process on a short-term basis.
Local ambulance and air ambulance services

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› 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
  • have not been charged for their room, board and treatment costs.

Important notes

› Air ambulance cover is subject to the following conditions and limitations:
  • In some situations it will be impossible, impractical or unreasonably dangerous for an air ambulance to operate. In these situations, we will not arrange or pay for an air ambulance. This policy does not guarantee that an air ambulance will always be available when requested, even if it is medically appropriate.
  • We will only pay for a local air ambulance, such as a helicopter, to transport a beneficiary for distances up to 100 miles (160 kilometres) and we will only pay for an air ambulance where its use relates to treatment which a beneficiary needs to receive in hospital.

› This policy does not provide cover for mountain rescue services.

› Cover for medical evacuation or repatriation is only available if you have cover under the International Medical Evacuation option. Please refer to the relevant section of this Customer Guide for details of that option.

Inpatient cash benefit
Per night up to 30 nights per period of cover.

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› 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
  • have not been charged for their room, board and treatment costs.

Emergency inpatient dental treatment

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

› We will pay for emergency dental treatment which is required by a beneficiary while they are in hospital as an inpatient, if that emergency inpatient dental treatment is recommended by the treating medical practitioner because of a dental emergency (but is not the primary treatment which the beneficiary is in hospital to receive).

› This benefit is paid instead of any other dental benefits the beneficiary may be entitled to in these circumstances.
Treatment for mental health conditions and disorders and addiction treatment

Up to the maximum amount shown per period of cover.

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› Subject to the limits explained below we will pay for:
   • the treatment of mental health conditions and disorders; and
   • 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.

› 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.

Important notes

› Following a diagnosis of cancer, we will pay for costs for the treatment of cancer if the treatment is considered by us to be active treatment and evidence-based treatment. This includes chemotherapy, radiotherapy, oncology, diagnostic tests and drugs, whether the beneficiary is staying in a hospital overnight or receiving treatment as a daypatient or outpatient.

› We do not pay for genetic cancer screening.
**PARENT AND BABY CARE**

**Routine maternity benefit care (Gold and Platinum plans only)**
Up to the maximum amount shown per period of cover. Available once the mother has been covered by the policy for twelve (12) months or more.

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- We will pay for the following parent and baby care and 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 twelve (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.

- 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.

**Complications from maternity (Gold and Platinum plans only)**
Up to the maximum amount shown per period of cover. Available once the mother has been covered by the policy for twelve (12) months or more.

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- We will pay for inpatient or outpatient treatment relating to complications resulting from pregnancy or childbirth if the mother has been a beneficiary under this policy for a continuous period of at least twelve (12) months or more. This is limited to conditions which can only arise as a direct result of pregnancy or childbirth, including miscarriage and ectopic pregnancy.

- 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.

**Homebirths (Gold and Platinum plans only)**
Up to the maximum amount shown per period of cover. Available once the mother has been covered by the policy for twelve (12) months or more.

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- 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 twelve (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.
Newborn care
Up to the maximum amount shown for treatment within the first 90 days following birth. Available once at least one parent has been covered by the policy for 12 months or more.

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<td>€48,000</td>
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› Provided the newborn is added to the policy, we will pay for:
• up to 10 days routine care for the baby following birth; and
• all treatment required for the baby during the first 90 days after birth instead of any other benefit; if at least one parent has been covered by the policy for a continuous period of 12 months or more prior to the newborn’s 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 30 days of the newborn’s date of birth. If an application is received after 30 days of the newborn’s date of birth, the newborn will be subject to medical underwriting and we will require the completion of a medical health questionnaire whereby we may apply special restrictions or exclusions.

› We will pay for:
• up to 10 days routine care for the baby following birth; and
• all treatment required for the baby during the first 90 days after birth instead of any other benefit; if neither parent has been covered by the policy for a continuous period of 12 months or more prior to the newborn’s birth and an application is received by us to add the newborn to the policy as a beneficiary.

The newborn will be subject to medical underwriting and we will require the completion of a medical health questionnaire. Cover for the newborn will be subject to medical underwriting whereby we may apply special restrictions or exclusions.

› The newborn care benefits explained above are not available for children who are born following fertility treatment (such as IVF), are born to a surrogate, or have been adopted. In these circumstances children can only be covered by the policy when they are 90 days old. Cover for the baby will be subject to completion of a medical health questionnaire whereby we may apply special restrictions or exclusions.

Congenital conditions
Up to the maximum amount shown per period of cover.

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<td>$5,000</td>
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<td>€3,700</td>
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<td>£3,325</td>
<td>€13,300</td>
<td>£25,000</td>
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› We will pay for treatment of congenital conditions on an inpatient or daypatient basis which manifest themselves before the beneficiary’s 18th birthday if:
• at least one parent has been covered by the policy for a continuous period of 12 months or more prior to the newborn’s birth and the newborn is added to the policy within 30 days of the birth.
• they were not evident at policy inception.

YOUR DEDUCTIBLE AND COST SHARE OPTIONS

Deductible (various)
A deductible is the amount which you must pay before any claims are covered by your plan.

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<td>€5,000</td>
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Cost share after deductible and out of pocket maximum
Cost share is the percentage of each claim not covered by your plan.

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

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

First, choose your cost share percentage:
• 0% / 10% / 20% / 30%

Next, choose your out of pocket maximum:
• $2,000 or $5,000
• €1,480 or €3,700
• £1,330 or £3,325
THE FOLLOWING PAGES DETAIL THE OPTIONAL BENEFITS YOU MAY HAVE CHOSEN TO ADD TO YOUR CORE COVER – INTERNATIONAL MEDICAL INSURANCE.

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

International Outpatient covers you more comprehensively for outpatient care and medical emergencies that may arise where a hospital admission as a daypatient or inpatient is not required. As well as this, consultations with specialists and medical practitioners, prescribed outpatient drugs and dressings, pre-natal and post-natal outpatient care, physiotherapy, osteopathy, chiropractic and much more.

YOUR OVERALL LIMIT

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<td>Annual benefit</td>
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<td>€7,400</td>
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<td>£6,650</td>
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This includes claims paid across all sections of International Outpatient.

YOUR STANDARD MEDICAL BENEFITS

Consultation with medical practitioners and Specialists

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› We will pay for consultations or meetings with a medical practitioner which are necessary to diagnose an illness, or to arrange or receive treatment up to the maximum number of visits shown in the benefit table.

› We will pay for non-surgical treatment on an outpatient basis, which is recommended by a specialist as being medically necessary.

› Subject to prior approval and provided the medical practitioner is within your selected area of coverage, we may pay for consultations that take place by use of electronic means or telephone.

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

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› 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 optional benefit for a continuous period of at least 12 months or more.

Examples of such 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);
- Non-invasive pre-natal testing (NIPT) for high risk individuals; and
- Any fees as a result of post-natal care required by the mother immediately following routine childbirth.
Pathology, radiology and diagnostic tests (excluding Advanced Medical Imaging)
Up to the maximum amount shown per period of cover.

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We will pay for the following tests where they are medically necessary and are recommended by a specialist as part of a beneficiary’s outpatient treatment:

- blood and urine tests;
- X-rays;
- ultrasound scans;
- electrocardiograms (ECG); and
- other diagnostic tests (excluding advanced medical imaging).

Physiotherapy treatment
Up to the maximum amount shown per period of cover.

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We will pay for physiotherapy treatment on an outpatient basis that is medically necessary and restorative in nature to help you to carry out your normal activities of daily living. The treatment must be carried out by a properly qualified practitioner who holds the appropriate license to practice in the country where the treatment is received. This excludes any sports medicine treatment.

We will require a medical report and treatment plan prior to approval.

Osteopathy and chiropractic treatment
Up to the maximum amount shown per period of cover.

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We will pay up to a combined maximum total of visits in any one period of cover for osteopathy and chiropractic treatment which is evidence-based treatment, medically necessary and recommended by a treating specialist, if a medical practitioner recommends the treatment and provides a referral. The treatment must be carried out by a properly qualified practitioner who holds the appropriate license to practice in the country where the treatment is received. We will require a medical report and treatment plan prior to approval. This excludes any sports medicine treatment.

Acupuncture, Homeopathy, and Chinese medicine
Up to a combined maximum of 15 visits per period of cover.

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We will pay for a combined maximum total of 15 consultations with acupuncturists, homeopaths and practitioners of Chinese medicine for each beneficiary in any one period of cover, if those treatments are recommended by a medical practitioner. The treatment must be carried out by a properly qualified practitioner who holds the appropriate license to practice in the country where the treatment is received.
### Restorative speech therapy

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

<table>
<thead>
<tr>
<th></th>
<th>Silver</th>
<th>Gold</th>
<th>Platinum</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$2,500</td>
<td>$5,000</td>
<td>Paid in full</td>
</tr>
<tr>
<td>€1,850</td>
<td>€3,700</td>
<td></td>
<td></td>
</tr>
<tr>
<td>£1,650</td>
<td>£3,325</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- 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);
  - it is confirmed by a *specialist* to be *medically necessary* on a *short-term* basis.

### Important notes

- We will only pay for speech therapy if the aim of that therapy is to restore impaired speech function.

- We will not pay for speech therapy which:
  - aims to improve speech skills which are not fully developed;
  - is educational in nature;
  - is intended to maintain speech communication;
  - aims to improve speech or language disorders (such as stammering); or
  - is as a result of learning difficulties, developmental problems (such as dyslexia), attention-deficit hyperactivity disorder or autism.

### Prescribed drugs and dressings

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

<table>
<thead>
<tr>
<th></th>
<th>Silver</th>
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<th>Platinum</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>$500</td>
<td>$2,000</td>
<td>Paid in full</td>
</tr>
<tr>
<td>€370</td>
<td>€1,480</td>
<td></td>
<td></td>
</tr>
<tr>
<td>£330</td>
<td>£1,330</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

### Rental of durable equipment

Up to a maximum of 45 days in the **period of cover**.

<table>
<thead>
<tr>
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<th>Silver</th>
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<th>Platinum</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Paid in full</td>
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</tbody>
</table>

- We will pay for the rental of durable medical equipment for up to 45 days per **period of cover**, if the use of that equipment is recommended by a *specialist* in order to support the *beneficiary’s treatment*.

- We will only pay for the rental of durable medical equipment which:
  - is not disposable, and is capable of being used more than once;
  - serves a medical purpose;
  - is fit for use in the home; and
  - is of a type only normally used by a person who is suffering from the effect of a disease, illness or *injury*.

### Adult vaccinations

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

<table>
<thead>
<tr>
<th></th>
<th>Silver</th>
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<th>Platinum</th>
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<tbody>
<tr>
<td></td>
<td>$250</td>
<td></td>
<td>Paid in full</td>
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<tr>
<td>€185</td>
<td></td>
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<tr>
<td>£165</td>
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</tr>
</tbody>
</table>

- We will pay for certain vaccinations and immunisations that are clinically appropriate namely:
  - Influenza (flu);
  - Tetanus (once every 10 years);
  - Hepatitis A;
  - Hepatitis B;
  - Meningitis;
  - Rabies;
  - Cholera;
  - Yellow Fever;
  - Japanese Encephalitis;
  - Polio booster;
  - Typhoid; and
  - Malaria (in tablet form, either daily or weekly).
Dental accidents
Up to the maximum amount shown per period of cover.

- If a beneficiary needs dental treatment as a result of injuries which they have suffered in an accident, we will pay for outpatient dental treatment for any sound natural tooth/teeth damaged or affected by the accident, provided the treatment commences immediately after the accident and is completed within 30 days of the date of the accident.
- In order to approve this treatment, we will require confirmation from the beneficiary’s treating dentist of:
  - the date of the accident; and
  - the fact that the tooth/teeth which are the subject of the proposed treatment are sound natural tooth/teeth.
- We will pay for this treatment instead of any other dental treatment the beneficiary may be entitled to under this policy, when they need treatment following accidental damage to a tooth or teeth.
- We will not pay for the repair or provision of dental implants, crowns or dentures under this part of this policy.

Well child tests
Payable for children at appropriate age intervals up to the age of 6.

- We will pay for well child routine tests at any of the appropriate age intervals (birth, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 2 years, 3 years, 4 years, 5 years and 6 years) and for a medical practitioner to provide preventative care consisting of:
  - evaluating medical history;
  - physical examinations;
  - development assessment;
  - anticipatory guidance; and
  - appropriate immunisations and laboratory tests; for children aged 6 or younger.
- We will pay for one visit to a medical practitioner at each of the appropriate age intervals (up to a total of 13 visits for each child) for the purposes of receiving preventative care services.
- In addition, we will pay for:
  - one school entry health check, to assess growth, hearing and vision, for each child aged 6 or younger.
  - diabetic retinopathy screening for children over the age of 12 who have diabetes.

Child immunisations
We will pay for the following immunisations for children aged 17 or younger:
- DPT (Diphtheria, Pertussis and Tetanus);
- MMR (Measles, Mumps and Rubella);
- HiB (Haemophilus influenza type b);
- Polio;
- Influenza;
- Hepatitis B;
- Meningitis; and
- Human Papilloma Virus (HPV).
We will pay for the following routine tests for children aged 15 or younger:

- one eye test; and
- one hearing test.

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, we will pay for the medically necessary outpatient treatment costs associated with the maintenance of this condition:

- Arthritis, joint or back pain
- Glaucoma
- Hypertension
- Osteoporosis / Osteopenia
- Type 2 Diabetes

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 and specialists; pathology and radiology; physiotherapy; prescribed drugs and dressings, osteopathy and chiropractic treatment and acupuncture, homeopathy 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 maximum amounts 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 (various)**
A deductible is the amount which you must pay before any claims are covered by your plan.

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<thead>
<tr>
<th></th>
<th>Silver</th>
<th>Gold</th>
<th>Platinum</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0 / $150 / $500 / $1,000 / $1,500</td>
<td>€0 / €110 / €370 / €700 / €1,100</td>
<td>£0 / £100 / £335 / £600 / £1,000</td>
<td></td>
</tr>
</tbody>
</table>

**Cost share after deductible and out of pocket maximum**
Cost share is the percentage of each claim not covered by your plan.

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

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

First, choose your cost share percentage:

- 0% / 10% / 20% / 30%

Your out of pocket maximum is:

- $3,000
- €2,200
- £2,000
INTERNATIONAL MEDICAL EVACUATION

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 repatriation coverage, allowing the beneficiary to return to their country of habitual residence or country of nationality to be treated in a familiar location. It also includes 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.

YOUR OVERALL LIMIT

<table>
<thead>
<tr>
<th>Annual benefit - maximum per beneficiary per period of cover</th>
<th>Silver</th>
<th>Gold</th>
<th>Platinum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paid in full</td>
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</tbody>
</table>

YOUR STANDARD MEDICAL BENEFITS

<table>
<thead>
<tr>
<th>Medical Evacuation</th>
<th>Silver</th>
<th>Gold</th>
<th>Platinum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paid in full</td>
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</tbody>
</table>

› 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 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 note
› 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.
If a beneficiary requires a medical repatriation, 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 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.

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.
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 and;
- 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.

<table>
<thead>
<tr>
<th>Compassionate visits - travel costs</th>
<th>Silver</th>
<th>Gold</th>
<th>Platinum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to a maximum of 5 trips per lifetime.</td>
<td>$1,200</td>
<td>$1,200</td>
<td>$1,200</td>
</tr>
<tr>
<td>Up to the maximum amount shown per period of cover.</td>
<td>€1,000</td>
<td>€1,000</td>
<td>€1,000</td>
</tr>
<tr>
<td>£800</td>
<td>£800</td>
<td>£800</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Compassionate visits - living allowance costs</th>
<th>Silver</th>
<th>Gold</th>
<th>Platinum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to the maximum amount shown per day for each visit with a maximum of 10 days per visit.</td>
<td>$155</td>
<td>$155</td>
<td>$155</td>
</tr>
<tr>
<td>Up to the maximum amount shown per period of cover.</td>
<td>€125</td>
<td>€125</td>
<td>€125</td>
</tr>
<tr>
<td>£100</td>
<td>£100</td>
<td>£100</td>
<td></td>
</tr>
</tbody>
</table>

- 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 five 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.
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 HEALTH AND WELLBEING

International Health and Wellbeing covers the beneficiary for screenings, tests, examinations and counselling support for a range of life crises and tailored advice and support through our online health education and health risk assessment, helping the beneficiary to take control and manage their health the way they want.

During each period of cover we will pay for the following tests to be carried out by a medical practitioner.

<table>
<thead>
<tr>
<th>Test</th>
<th>Silver</th>
<th>Gold</th>
<th>Platinum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine adult physical examinations</td>
<td>$225</td>
<td>€165</td>
<td>£150</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$450</td>
<td>€330</td>
</tr>
<tr>
<td></td>
<td></td>
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<td>£300</td>
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<td></td>
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<td>€440</td>
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<td></td>
<td></td>
<td></td>
<td>£400</td>
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<tr>
<td>› We will pay for routine adult physical examinations (including but not limited to: height, weight, bloods, urinalysis, blood pressure, lung function etc), for persons aged 18 or older.</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Test</th>
<th>Silver</th>
<th>Gold</th>
<th>Platinum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pap smear</td>
<td>$225</td>
<td>€165</td>
<td>£150</td>
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<tr>
<td></td>
<td></td>
<td>$450</td>
<td>€330</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>£300</td>
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<tr>
<td>› We will pay for one papanicolaou test (pap smear) for female beneficiaries.</td>
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<thead>
<tr>
<th>Test</th>
<th>Silver</th>
<th>Gold</th>
<th>Platinum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prostate cancer screening</td>
<td>$225</td>
<td>€165</td>
<td>£150</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$450</td>
<td>€330</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>£300</td>
</tr>
<tr>
<td>› We will pay for one prostate examination (prostate specific antigen (PSA) test) for male beneficiaries aged 50 or over.</td>
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<table>
<thead>
<tr>
<th>Test</th>
<th>Silver</th>
<th>Gold</th>
<th>Platinum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mammograms for breast cancer screening</td>
<td>$225</td>
<td>€165</td>
<td>£150</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$450</td>
<td>€330</td>
</tr>
<tr>
<td>› We will pay for:</td>
<td></td>
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<tr>
<td>• Aged 35-39: one baseline mammogram for asymptomatic women.</td>
<td></td>
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<tr>
<td>• Aged 40-49: one mammogram for asymptomatic women every two years.</td>
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<tr>
<td>• Aged 50 or older: one mammogram each year.</td>
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</tbody>
</table>
Bowel cancer screening
Up to the maximum amount shown per period of cover.

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<tr>
<th></th>
<th>Silver</th>
<th>Gold</th>
<th>Platinum</th>
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<tbody>
<tr>
<td></td>
<td>$225</td>
<td>$450</td>
<td>Paid in full</td>
</tr>
<tr>
<td></td>
<td>€165</td>
<td>€330</td>
<td></td>
</tr>
<tr>
<td></td>
<td>£150</td>
<td>£300</td>
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</table>

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

Bone densitometry
Up to the maximum amount shown per period of cover.

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<thead>
<tr>
<th></th>
<th>Silver</th>
<th>Gold</th>
<th>Platinum</th>
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<tbody>
<tr>
<td></td>
<td>$225</td>
<td>$450</td>
<td>Paid in full</td>
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<tr>
<td></td>
<td>€165</td>
<td>€330</td>
<td></td>
</tr>
<tr>
<td></td>
<td>£150</td>
<td>£300</td>
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</table>

› We will pay for one scan to determine the density of the beneficiary’s bones.

Dietetic consultations

<table>
<thead>
<tr>
<th></th>
<th>Silver</th>
<th>Gold</th>
<th>Platinum</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Not covered</td>
<td>Not covered</td>
<td>Paid in full</td>
</tr>
</tbody>
</table>

› We will pay for up to 4 consultations with a dietician per period of cover, if the beneficiary requires dietary advice relating to a diagnosed disease or illness such as diabetes (Platinum plan only).

Life management assistance programme

<table>
<thead>
<tr>
<th></th>
<th>Silver</th>
<th>Gold</th>
<th>Platinum</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Paid in full</td>
<td>Paid in full</td>
<td>Paid in full</td>
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</tbody>
</table>

› Our Life Management service is available 24 hours a day, 7 days a week, 365 days a year. Professionals are ready to assist you with any issue that matters to you.

› We will pay for up to 5 counselling sessions per issue per period of cover. This could be telephonic or face to face counselling support.

› Unlimited in the moment telephonic support for live assistance.

› Provides information, resources and counselling on any work, life, personal, or family issue that matters to you.

› Information services provide support including assistance for day to day demands or the logistics of relocating. The information specialists can offer assistance over the phone and perform research and provide pre-qualified referrals to local resources.

Please contact us for approval. The service is provided by our chosen counselling provider.

Online health education, health assessments and web-based coaching programmes

<table>
<thead>
<tr>
<th></th>
<th>Silver</th>
<th>Gold</th>
<th>Platinum</th>
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<tbody>
<tr>
<td></td>
<td>Paid in full</td>
<td>Paid in full</td>
<td>Paid in full</td>
</tr>
</tbody>
</table>

› Access to our health and wellbeing section is available in your secure online Customer Area.
# INTERNATIONAL VISION AND DENTAL

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

<table>
<thead>
<tr>
<th>Eye examination</th>
<th>Silver</th>
<th>Gold</th>
<th>Platinum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum per beneficiary per period of cover.</td>
<td>$100</td>
<td>€75</td>
<td>£65</td>
</tr>
<tr>
<td></td>
<td>$200</td>
<td>€150</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$300</td>
<td>€200</td>
<td>£150</td>
</tr>
</tbody>
</table>

- 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.

<table>
<thead>
<tr>
<th>Expenses for:</th>
<th>Silver</th>
<th>Gold</th>
<th>Platinum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spectacle lenses;</td>
<td>$155</td>
<td>€125</td>
<td>£100</td>
</tr>
<tr>
<td>Contact lenses;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spectacle frames;</td>
<td>$155</td>
<td>€125</td>
<td>£100</td>
</tr>
<tr>
<td>Prescription sunglasses;</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

when all are prescribed by an optometrist or ophthalmologist.

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

- 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

### YOUR OVERALL LIMIT

<table>
<thead>
<tr>
<th>Annual benefit - maximum per beneficiary per period of cover</th>
<th>Silver</th>
<th>Gold</th>
<th>Platinum</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$1,250</td>
<td>€930</td>
<td>£830</td>
</tr>
<tr>
<td></td>
<td>$2,500</td>
<td>€1,850</td>
<td>£1,650</td>
</tr>
<tr>
<td></td>
<td>$5,500</td>
<td>€4,300</td>
<td>£3,500</td>
</tr>
</tbody>
</table>
Preventative dental treatment  
After the beneficiary has been covered on this option for 3 months.

- 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:
  - two 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);
  - one mouth guard per period of cover;
  - one night guard per period of cover; and
  - Fissure sealant.

Routine dental treatment  
After the beneficiary has been covered on this option for 3 months.

- 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;
  - occasional treatment;
  - anaesthetics; and
  - periodontal treatment.

Major restorative dental treatment  
After the beneficiary has been covered on this option for 12 months.

- 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  
After the beneficiary has been covered on this option for 18 months.

- We will pay for orthodontic treatment for beneficiaries aged 18 years old or younger, 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.
Other dental treatment

If a beneficiary requires a form of dental treatment which is not provided for in this Customer Guide, they may contact us (before the treatment is received) to enquire whether we will provide cover for that treatment. We will consider the request, and will decide, at our discretion:
• whether we will pay for the treatment;
• if so, whether we will pay all or part of the cost; and
• which of the areas of cover it will come within (for the purposes of calculating when limits of cover are reached).
• prior approval should be obtained before any treatment is received.

Dental exclusions

The following exclusions apply to dental treatment, in addition to those set out elsewhere in this policy and in your Certificate of Insurance.

› We will not pay for:
  • Purely cosmetic treatments, or other treatments which are not necessary for continued or improved oral health.
  • The replacement of any dental appliance which is lost or stolen, or associated treatment.
  • The replacement of a bridge, crown or denture which (in the reasonable opinion of a dentist of ordinary competence and skill in the beneficiary’s country of habitual residence) is capable of being repaired and made usable.
  • The replacement of a bridge, crown or denture within five 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.
  • Orthodontic treatment for anyone after their 19th birthday.
  • 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.
Details of the Cigna company who provides the cover under your policy can be found in your Policy Rules and on your Certificate of Insurance.