PRODUCT SUMMARY

PRODUCT INFORMATION

INTERNATIONAL MEDICAL INSURANCE

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

Choose your level of cover from 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

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

YOUR STANDARD MEDICAL BENEFITS

	Silver	Gold	Platinum
Hospital charges for: Nursing and accommodation for inpatient and daypatient treatment and recovery room.	Paid in full for a semi-private room	Paid in full for a private room	Paid in full for a private room

- We will pay for nursing care and accommodation whilst a beneficiary is receiving inpatient or daypatient treatment; or the cost of a treatment room while a beneficiary is undergoing outpatient surgery, if one is required.
- We will only pay these costs if:
  - it is medically necessary for the beneficiary to be treated on an inpatient or daypatient basis;
  - they stay in hospital for a medically appropriate period of time;
  - the treatment which they receive is provided or managed by a specialist; and
  - they stay in a 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:	Silver	Gold	Platinum
› operating theatre. › prescribed medicines, drugs and dressings for inpatient or daypatient treatment. › treatment room fees for outpatient surgery.	Paid in full	Paid in full	Paid in full

Operating theatre costs

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

Medicines, drugs and dressings

› We will pay for medicines, drugs and dressings which are prescribed for the beneficiary whilst he or she is receiving inpatient or daypatient treatment.

› 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:	Silver	Gold	Platinum
› intensive therapy. › coronary care. › high dependency unit.	Paid in full	Paid in full	Paid in full

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

Surgeons' and anaesthetists' fees	Silver	Gold	Platinum
	Paid in full	Paid in full	Paid in full

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

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

Specialists' consultation fees	Silver	Gold	Platinum
	Paid in full	Paid in full	Paid in full

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

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

Hospital accommodation for a parent or guardian Up to the maximum amount shown per period of cover.	Silver	Gold	Platinum
	$1,000 €740 £665	$1,000 €740 £665	Paid in full

- 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.

Transplant services for organ, bone marrow and stem cell transplants	Silver	Gold	Platinum
	Paid in full	Paid in full	Paid in full

- 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	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.

Pathology, radiology and diagnostic tests (excluding Advanced Medical Imaging)	Silver	Gold	Platinum
	Paid in full	Paid in full	Paid in full

- Where investigations are provided on an inpatient or daypatient basis.
- We will pay for:
  - blood and urine tests;
  - X-rays;
  - ultrasound scans;
  - electrocardiograms (ECG); and
  - other diagnostic tests (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.	Silver	Gold	Platinum
	$5,000 €3,700 £3,325	$10,000 €7,400 £6,650	Paid in full

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

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

- 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.

Rehabilitation Up to 30 days and the maximum amount shown 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 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.	Silver	Gold	Platinum
	$2,500 €1,850 £1,650	$5,000 €3,700 £3,325	Paid in full

- 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.	Silver	Gold	Platinum
	Paid in full	Paid in full	Paid in full

- We will pay for internal prosthetic implants, devices or appliances which are put in place during surgery as part of a beneficiary's treatment.
- A surgical appliance or a medical appliance can mean:
  - an artificial limb, prosthesis or device which is required for the purpose of or in connection with surgery; 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.	Silver	Gold	Platinum
	For each prosthetic device $3,100 €2,400 £2,000	For each prosthetic device $3,100 €2,400 £2,000	For each prosthetic device $3,100 €2,400 £2,000

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

- Where it is medically necessary, we will pay for a local ambulance to transport a beneficiary:
  - from the scene of an accident or injury to a hospital;
  - from one hospital to another; or
  - from their home to a hospital.

- We will only pay for a local road ambulance where its use relates to treatment which a beneficiary needs to receive in hospital. Where it is medically necessary, we will pay for an air ambulance to transport the beneficiary from the scene of an accident or injury to a hospital or from one hospital to another.

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.	Silver	Gold	Platinum
	$100 €75 £65	$100 €75 £65	$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
  - have not been charged for their room, board and treatment costs.

Emergency inpatient dental treatment	Silver	Gold	Platinum
	Paid in full	Paid in full	Paid in full

- 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.	Silver	Gold	Platinum
	$5,000 €3,700 £3,325	$10,000 €7,400 £6,650	Paid in full

- 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

- For treatment of mental health conditions and disorders and addiction treatment, we will only pay for evidence-based, medically necessary treatment and recommended by a medical practitioner.
- We will pay for up to a combined maximum total of 90 days of treatment for mental health conditions and disorders and addiction treatment in any one period of cover, including up to 30 days of inpatient treatment.
- We will pay for up to a combined maximum total of 180 days of treatment for mental health conditions and disorders; and addiction treatment in any five year period. For example, if a beneficiary uses 90 days of mental health or addiction treatment in one period of cover, and 90 days of mental health or addiction treatment in the following period of cover, we will not pay for any further mental health or addiction treatment for the next three consecutive years of cover.
- In determining when these 30, 90 and 180 day limits have been reached:
  - we count each overnight stay during which a beneficiary received inpatient treatment as one day; and
  - we count each day on which a beneficiary receives outpatient and daypatient treatment as one day.
- We will not pay for prescription drugs or medication prescribed on an outpatient basis for any of these conditions, unless you have purchased the International Outpatient option.
- 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.

Cancer care	Silver	Gold	Platinum
	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, 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.	Silver	Gold	Platinum
	Not covered	$7,000 €5,500 £4,500	$14,000 €11,000 £9,000

- 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.	Silver	Gold	Platinum
	Not covered	$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 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.	Silver	Gold	Platinum
	Not covered	$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 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.

	Silver	Gold	Platinum
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.	$25,000 €18,500 £16,500	$75,000 €55,500 £48,000	$156,000 €122,000 £100,000

- 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.

	Silver	Gold	Platinum
Congenital conditions Up to the maximum amount shown per period of cover.	$5,000 €3,700 £3,325	$20,000 €14,800 £13,300	$39,000 €30,500 £25,000

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

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

	Silver	Gold	Platinum
Annual benefit - maximum per beneficiary per period of cover This includes claims paid across all sections of International Outpatient.	$10,000 €7,400 £6,650	$25,000 €18,500 £16,625	Unlimited

YOUR STANDARD MEDICAL BENEFITS

	Silver	Gold	Platinum
Consultation with medical practitioners and Specialists Up to the maximum amount shown per period of cover.	$125/€90/£80 limit per visit. Up to 15 visits per year.	$250/€185/£165 limit per visit. Up to 30 visits per year.	Paid in full

- 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.

	Silver	Gold	Platinum
Pre-natal and post-natal care **(Gold and Platinum plans only)** Up to the maximum amount shown per period of cover. Available once the mother has been covered on this option for twelve (12) months or more.	*Not covered*	$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 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.	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).

Physiotherapy treatment Up to the maximum amount shown 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 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.	Silver	Gold	Platinum
	Paid in full up to 15 visits	Paid in full up to 15 visits	Paid in full up to 30 visits

- 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.	Silver	Gold	Platinum
	Paid in full	Paid in full	Paid in full

- 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.

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

- 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.

Silver	Gold	Platinum
$500 €370 £330	$2,000 €1,480 £1,330	Paid in full

- 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.

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

- 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.

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

- 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.	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.

Well child tests	Silver	Gold	Platinum
	Paid in full	Paid in full	Paid in full

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

- 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).

	Silver	Gold	Platinum
Annual routine tests	Paid in full	Paid in full	Paid in full

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

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.	$0 / $150 / $500 / $1,000 / $1,500 €0 / €110 / €370 / €700 / €1,100 £0 / £100 / £335 / £600 / £1,000
Cost share after deductible and out of pocket maximum Cost share is the percentage of each claim not covered by your plan. The out of pocket maximum is the maximum amount of cost share you would have to pay in a period of cover. The cost share amount is calculated after the deductible is taken into account. Only amounts you pay related to cost share contribute to the out of pocket maximum.	First, choose your cost share percentage: 0% / 10% / 20% / 30% 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. 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

	Silver	Gold	Platinum
Annual benefit - maximum per beneficiary per period of cover	Paid in full	Paid in full	Paid in full

YOUR STANDARD MEDICAL BENEFITS

	Silver	Gold	Platinum
Medical Evacuation	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 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.

Medical repatriation	Silver	Gold	Platinum
	Paid in full	Paid in full	Paid in full

- 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.

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.

	Silver	Gold	Platinum
Travel costs for an accompanying person	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 and; 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.

	Silver	Gold	Platinum
Compassionate visits - travel costs Up to a maximum of 5 trips per lifetime. Up to the maximum amount shown per period of cover.	$1,200 €1,000 £800	$1,200 €1,000 £800	$1,200 €1,000 £800
Compassionate visits - living allowance costs Up to the maximum amount shown per day for each visit with a maximum of 10 days per visit. Up to the maximum amount shown per period of cover.	$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 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.

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.

	Silver	Gold	Platinum
Routine adult physical examinations Up to the maximum amount shown per period of cover.	$225 €165 £150	$450 €330 £300	$600 €440 £400

› 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.

	Silver	Gold	Platinum
Pap smear Up to the maximum amount shown per period of cover.	$225 €165 £150	$450 €330 £300	Paid in full

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

	Silver	Gold	Platinum
Prostate cancer screening Up to the maximum amount shown per period of cover.	$225 €165 £150	$450 €330 £300	Paid in full

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

	Silver	Gold	Platinum
Mammograms for breast cancer screening Up to the maximum amount shown per period of cover.	$225 €165 £150	$450 €330 £300	Paid in full

› We will pay for:
- Aged 35-39: one baseline mammogram for asymptomatic women.
- Aged 40-49: one mammogram for asymptomatic women every two years.
- Aged 50 or older: one mammogram each year.

	Silver	Gold	Platinum
Bowel cancer screening Up to the maximum amount shown per period of cover.	$225 €165 £150	$450 €330 £300	Paid in full

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

	Silver	Gold	Platinum
Bone densitometry Up to the maximum amount shown per period of cover.	$225 €165 £150	$450 €330 £300	Paid in full

- We will pay for one scan to determine the density of the beneficiary's bones.

	Silver	Gold	Platinum
Dietetic consultations	*Not covered*	*Not covered*	Paid in full

- 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)*.

	Silver	Gold	Platinum
Life management assistance programme	Paid in full	Paid in full	Paid in full

- 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.

	Silver	Gold	Platinum
Online health education, health assessments and web-based coaching programmes	Paid in full	Paid in full	Paid in full

- 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

	Silver	Gold	Platinum
Eye examination Maximum per beneficiary per period of cover.	$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.

	Silver	Gold	Platinum
Expenses for: › Spectacle lenses; › Contact lenses; › Spectacle frames; › Prescription sunglasses; when all are prescribed by an optometrist or ophthalmologist. Up to the maximum amount shown per period of cover.	$155 €125 £100	$155 €125 £100	$310 €245 £200

- 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

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

Preventative dental treatment

After the beneficiary has been covered on 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:
  - 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.

Silver	Gold	Platinum
80% refund per period of cover	90% refund per period of cover	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;
  - occasional treatment;
  - anaesthetics; and
  - periodontal treatment.

Major restorative dental treatment

After the beneficiary has been covered on this option for 12 months.

Silver	Gold	Platinum
70% refund per period of cover	80% refund per period of cover	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

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

Silver	Gold	Platinum
40% refund per period of cover	50% refund per period of cover	50% refund per period of cover

- 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.

KEY PRODUCT PROVISIONS

The following are key product provisions found in our Policy contracts. This is only a brief summary, intended for guidance and information. You are advised to also refer to the Policy Rules, which will prevail in the event of a conflict between the two documents and which contains the terms and conditions, definitions and general exclusions. The Customer Guide also shows the limits which apply to benefits. Please consult your insurance advisor or Cigna should you require further explanation.

1. CANCELLATION CLAUSE - Subject to any conflicting legal or regulatory requirements we may terminate this policy if:

1.1 Any premium or other charge (including any relevant tax) is not paid in full within thirty (30) days of the date on which it is due. We will give you written notice if we are going to terminate the policy for this reason; or

1.2 It becomes unlawful for us to provide any of the cover available under this policy; or

1.3 Any beneficiary is identified on any list imposing financial sanctions on targeted individuals or entities maintained by the United Nations Security Council, the European Union, the United States Office of Foreign Assets Control or any other applicable jurisdiction. Furthermore, we will not pay claims for services received in sanctioned countries if doing so would violate the requirements of the United Nations Security Council, the European Union or the United States Department of Treasury's Office of Foreign Assets Control; or

1.4 We determine, you have knowingly or recklessly provided information which you know or believe to be untrue or inaccurate or failed to provide information which we have asked for. This could affect payment of claims under your policy and may result in us terminating your cover; or

1.5 We are no longer in the market to sell the policy or a suitable alternative in your geographical area.

If this policy ends before the normal end date, any premium which has been paid in relation to the period after cover has ended will be refunded on a pro rata basis, so long as no claims have been made and no guarantees of payment or prior approvals have been put in place during the period of cover. If your policy is terminated in accordance with clause 14.1.4 of the Policy Rules, we may not refund any premiums you paid nor pay any claims you have made under your policy.

If the policy ends before the normal end date and you have made claims under it, you will be liable for the remainder of any premiums in respect of the policy which are unpaid.

If treatment has been authorised, Cigna will not be held responsible for any treatment costs if the policy ends or a beneficiary leaves the policy before treatment has taken place.

We will wherever possible, write to you at least one month before the end date to give you written notice that the policy will not be renewed with effect from the end date.

2. TERMS OF RENEWAL - This policy is an annual contract. This means that, unless it is terminated earlier or renewed, the cover will end one year after the start date.

We will write to you at least one calendar month before the end date and ask you whether you want to renew the cover you currently have. We will also inform you of any changes to the premiums, definitions, benefits and terms and conditions which will apply on renewal. We will give you at least one (1) calendar month's notice of such changes.

If you choose to renew, you do not need to do anything, and your cover will be renewed automatically for another twelve (12) months. Renewal is subject to the definitions, benefits and terms and conditions of the Policy Rules in force at the time of renewal. If you do not want to renew your cover, you must let us know at least seven (7) days before your policy end date.

If you do not renew your cover, any beneficiaries who have been covered under the policy can apply for their own cover. We will consider their applications individually, and inform them whether, and on what terms, we are willing to offer them such cover.

3. NON-GUARANTEED PREMIUM - We will write to you at least one (1) calendar month before the end date and ask you whether you want to renew the cover you currently have. Premiums may change if you request to change coverage options at the annual renewal date. We will inform you of any changes to the premiums or terms and conditions which would apply on your renewal. The premium and/or other charges may vary from year to year.

4. STANDARD EXCLUSIONS - There are certain conditions under which no benefits will be payable. You are advised to read the Policy Rules for the full list of exclusions. Please find below some important exclusions.

- Treatment for a pre-existing condition or any conditions or symptoms which result from, or are related to, a pre-existing condition. We will not pay for treatment for which a pre-existing condition of which the policyholder was (or should reasonably have been aware) at the date cover commenced, and in respect of which we have not expressly agreed to provide cover.
- Congenital anomalies or defects, except new-borns who are eligible to join the plan without medical underwriting. who exhibit such conditions which manifest themselves before the beneficiary's 18th birthday, or were not evident at policy inception.
- Routine maternity and childbirth cover, Complications from maternity and Homebirths benefit cover is excluded from our Silver plan. The benefits are included in the Gold and Platinum plan.
- We will not cover or pay claims when it is illegal for us to do so under applicable laws. Examples include but are not limited to, exchange controls, local licensing regulations or trade embargo.
- We will not pay a claim which we have reasonable grounds to suppose has been made fraudulently.
- We cannot be held responsible for any loss, damage, illness and/or injury that may occur as a result of receiving medical treatment at a hospital or from a medical practitioner, even when we have approved the treatment as being covered.
- We will not pay for treatments which are necessary as a result of conflict or disaster including but not limited to:

a) nuclear or chemical contamination;

b) war, invasion, acts of terrorism, rebellion (whether or not war is declared), civil war, commotion, military coup or other usurpation of power, martial law, riot, or the act of unlawfully constituted authority;

c) any other conflict or disaster events;

where the beneficiary has:

- put him or herself in danger by entering a known area of conflict (as identified by a Government in your Country of nationality, for example the British Foreign and Commonwealth Office);
- actively participated in the conflict; or
- displayed a blatant disregard for their own safety.

We will not pay for treatments which are provided by:

a) a medical practitioner who is not recognised by the relevant authorities in the country where the treatment is received as having specialist knowledge of, or expertise in, the treatment of the disease, illness or injury being treated;

b) a medical practitioner, therapist, hospital, clinic, or facility to whom we have given written notice that we no longer recognise them as a treatment provider; or

c) a medical practitioner, therapist, hospital, clinic, or facility which, in our reasonable opinion, is either not properly qualified or authorized to provide treatment, or is not competent to provide treatment.

5. WAITING PERIOD - The cover will begin on the start date shown on the first Certificate of insurance which we send to you. If you choose to buy cover for any additional beneficiaries, their cover will begin on the start date shown on the first Certificate of insurance on which they are listed.

The following benefits have a Waiting Period:

> **Routine maternity benefit and childbirth cover on an inpatient and daypatient basis** (Benefit only available in Gold and Platinum plans) A 12 month waiting period applies for parent and baby care and treatment.

- The mother has been covered by the policy for a continuous period of at least 12 months or more.

> **Pre-natal and post-natal care** (Benefit only available in Gold and Platinum plans) on an outpatient basis if the mother has been covered under the International Outpatient benefit for a continuous period of at least 12 months or more.

> **Complications from Maternity** (Benefit only available in Gold and Platinum plans)

- A 12 month waiting period applies for complications resulting from pregnancy or childbirth
- The mother has been covered by the policy for a continuous period of at least 12 months or more.

> **Homebirths** (Benefit only available in Gold and Platinum plans)

- A 12 month waiting period applies for Homebirths.
- Available once the mother has been covered by the policy for a continuous period of 12 months or more.

> **Newborn care**

- A 12 month waiting period applies.
- 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.

International Vision and Dental Care optional module

Dental Treatment:

> **Preventative & Routine treatment**

- International Vision and Dental cover for at least 3 months

> **Major Restorative treatment**

- International Vision and Dental cover for at least 12 months. If the beneficiary needs major restorative dental treatment before they have had International Vision and Dental cover for 12 months, will pay 50% of the treatment costs.

> **Orthodontic treatment**

- International Vision and Dental cover for at least 24 months.

6. REASONABLE AND CUSTOMARY CHARGES - We will pay 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.

7. AREA OF COVER - You may choose between two options, which determine where in the world beneficiaries will be covered. The two options are: Worldwide including USA and Worldwide excluding USA.

8. FREE LOOK PERIOD - If the policy does not meet your needs, or has not been issued in accordance with your intention, you may ask us to cancel it within fourteen (14) days of the date of receipt of the policy. If no claims have been made, and no guarantees of payment or prior approvals have been put in place, we will refund any premium that has been paid.

9. TERMINATIONS - If you want to terminate this policy and end cover for all beneficiaries, you may do so at any time by giving us at least seven (7) days' notice in writing.

Please contact us at **Cignaglobal_customer.care@cigna.com**

If this policy ends before the normal date, any premium which has been paid in relation to the period after cover has ended will be refunded on a pro rata basis, so long as no claims have been made and no guarantees of payment or prior approvals have been put in place during the period

of cover. If the policy ends before the normal end date and you have made claims under it, you will be liable for the remainder of any premiums in respect of the policy which are unpaid.

For full details, please refer to the Policy Rules.

10. CLAIMS - Please contact our Customer Care Team for prior approval for all treatment using the following numbers:

Singapore Toll free 800 186 5047
International +44 1475 788182 (overseas)

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.

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.

For full details of our Claims process please refer to the Customer Guide.

11. CHANGE OF OCCUPATION - No requirement for you to inform us of a change of occupation.

12. DEFERMENT PERIOD - Not applicable to our products.

13. SURVIVAL PERIOD - No benefit payable.

14. DISTRIBUTION COSTS – Cigna pays a remuneration to your sales representative and/or insurance brokers when we issue and renew your policy. Whilst the type and value of this remuneration varies, it normally constitutes a commission of 10-15% of the value of the policy premium. If you require more information about remuneration we pay, we can share this upon request.

SWITCHING

Buying an Accident and Health policy can be a long term commitment. You should consider carefully before terminating the policy or switching to a new one as there may be disadvantages in doing so. The new policy may cost more or have fewer benefits at the same cost.

MEDISHIELD LIFE

If you are a citizen or permanent resident of Singapore, you are covered by MediShield Life for life, for treatments in Singapore, regardless of pre-existing medical conditions or other circumstances that you face. For more details on your coverage, please visit www.medishieldlife.sg

Not Medisave-approved Policy

This policy is not a Medisave-approved policy and you may not use Medisave to pay the premium for this policy.

Renewable Short-term Accident and Health Policy

This is a short-term accident and health policy and the insurer is not required to renew this policy. The insurer may terminate this policy by giving you 30 days' notice in writing.

You may wish to seek advice from a qualified adviser before making a commitment to purchase this product. In the event that you choose not to seek advice from a qualified adviser, you should consider whether the product in question is suitable for you. Buying health insurance products that are not suitable for you may impact your ability to finance your future healthcare needs. If you decide that the policy is not suitable after purchasing it, you may terminate the policy in accordance with the free-look provision, if any, and we may recover from you any expense incurred by us in underwriting the policy.

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).

Together, all the way.[SM]

Cigna®