CIGNA GLOBAL HEALTH OPTIONS

Notification of amendments to Policy Rules for policies insured by the following operating subsidiaries: Cigna Global Insurance Company Limited, Cigna Life Insurance Company of Europe S.A.-N.V., Cigna Europe Insurance Company S.A.-N.V. and Cigna Worldwide General Insurance Company Limited.

Cigna Global Health Options Policy Rules effective from 15th February 2025.

Please be aware that some of the terms and/or wording within your Policy Rules have been updated and will take effect from your annual renewal date. Not all changes detailed below are applicable to your policy. Please see the foot of the back page of the Policy Rules for the forthcoming policy year, where you will find your specific Policy Rules name, including; CLICE EXP 02/2025, CLICE EU 02/2025, CEIC UK 02/2025, CGIC 02/2025, CGIC NA 02/2025, Singapore 02/2025 and Hong Kong 02/2025.

Please read the changes carefully. If you have any questions, please contact our Customer Care Team on + 44 (0) 1475 788 182 or email: **cignaglobal_customer.care@cigna.com**

In the event of a discrepancy between the Policy Rules document and this document, the Policy Rules document will prevail.

Please note,

- All headlines communicating the current vs. updated changes will be marked in orange and,
- the actual content changes will be marked in blue.

The following changes apply to all Cigna Global Health Options Policy Rules		
Current Terms, General Exclusions and/or Definitions [CGHO Policy Rules 02/2024]		Updated Terms, General Exclusions and/or Definitions [CGHO Policy Rules 02/2025
The following change relates to “How to Contact Us”		
	Current wording To cancel this policy, please email us at: cignaglobal_customer.care@cigna.com.	Updated wording To cancel this policy after your minimum period of cover of three (3) months, please email us at: cignaglobal_customer.care@cigna.com
The following changes relate to the General Terms and Condition section		
All Policy Rules Section 1: General Terms and Conditions	Current General Terms and Conditions Clause 2 2.1 This policy is an annual contract. This means that, unless it is terminated earlier, the cover will end one (1) year after the start date. 2.2 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 or yet to be submitted and no guarantees of payment 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 or you have received treatment not reimbursed yet, you will be liable for the remainder of any premium in respect of the policy which are unpaid.	Updated current wording of General Terms and Conditions Clause 2 2.1 This policy is an annual renewable contract with a minimum period of cover of three (3) months and a maximum period of cover of twelve (12) months. This means that, unless it is terminated before the end date or automatically renewed, the period of cover will end one (1) year after the start date. Please see Clause 13 for more information on the policy renewal process at the end of your period of cover. 2.2 Subject to clause 4, if this policy ends within the first three (3) months of the initial start date, any premium which has been paid for the first three (3) months of cover will not be refunded regardless of if you have claimed or not during that period of cover. In addition, you will be liable to pay any remaining premium for that initial three (3) months period which hasn't been paid yet. If this policy ends after the first three (3) months of the initial start date and before the 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 or yet to be submitted and no guarantees of payment have been put in place during the period of cover. If this policy ends after the first three (3) months of the initial start date and before the end date and you have made claims under it or you have received treatment not reimbursed yet, you will be liable for the remainder of any premium in respect of the policy which are unpaid.

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All Policy Rules Section 1: General Terms and Conditions	Current General Terms and Conditions Clause 4 You have a statutory right to cancel your policy within fourteen (14) days from the date you receive this policy. If you wish to cancel this policy and we have not paid a claim or issued a guarantee of payment, you will receive a full refund of your premium. Alternatively, if we have paid a claim, or issued a guarantee of payment, we will not refund any premium which has been paid. To cancel this policy, please contact us using one of the options in the 'How to contact us' section on page 3 of these Policy Rules. If you do not exercise your right to cancel this policy, it will continue in force, and you will be required to make any premium payments that are due to us. For your cancellation rights outside of the fourteen (14) day statutory cooling off period, please refer to clause 6 of this policy.	Updated current wording of General Terms and Conditions Clause 4 You have a statutory right to cancel your policy within fourteen (14) days from the start date of your policy. If you wish to cancel this policy within this fourteen (14) day free look period and we have not paid a claim or issued a guarantee of payment, you will receive a full refund of your premium. Alternatively, if we have paid a claim, or issued a guarantee of payment, we will not refund any premium which has been paid. To cancel this policy, please contact us using one of the options in the 'How to contact us' section on page 3 of these Policy Rules. If you do not exercise your right to cancel this policy during the free look period, it will continue in force for a minimum period of three (3) months, inclusive of the free look period, from the initial start date and you will be required to make any premium payments that are due to us. For your termination rights outside of the fourteen (14) day statutory cooling off period, please refer to clause 6 of this policy.
	Current General Terms and Conditions Clause 5 5.1 Your Certificate of Insurance sets out the premium and any other charges (such as taxes) which are payable, and states when and how they must be paid. Payments must be made in the currency and in the manner detailed in your Certificate of Insurance.	Updated current wording of General Terms and Conditions Clause 5 5.1 Your Certificate of Insurance sets out the premium and any other charges (such as taxes) which are payable, and states when and how they must be paid. As specified in Clause 2, you will be liable to pay the premium for a minimum period of cover of three (3) months regardless of the payment frequency selected. Payments must be made in the currency and in the manner detailed in your Certificate of Insurance. 5.3.1 Claims are reimbursed in the currency in which the claim was incurred, or, upon request, the currency of the premiums paid on this policy and calculated using the applicable exchange rate. You, or any beneficiaries, may submit a request to reimburse the claim in an alternative currency. Should we agree to provide a reimbursement consistent with an alternative currency request, we will apply a standard convenience charge of 3 % over and above the applicable exchange rate. The convenience charge will be added to the exchange rate of the requested currency and will impact the final amount reimbursed. This means that if an alternative currency request is made, subject to exchange rate fluctuations, the amount reimbursed may be less than the original amount claimed. In the event a particular alternative currency request cannot be met, we will contact you to obtain your preference as to another alternative currency request or standard reimbursement. You, or any beneficiaries, can contact us for the applicable exchange rate applied to any particular claim using one of the options in the 'How to contact us' section on page 3 of these Policy Rules. We reserve the right to withdraw or vary the convenience charge at any time on a sixty (60) days' prior notice.
	Current General Terms and Conditions Clause 6 6.5 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 fourteen (14) days' notice in writing. Termination of your policy will take effect fourteen (14) days after you, the policyholder, notifies us of the request by using one of the options in the 'How to contact us' section on page 3 of these Policy Rules. 6.6 In relation to the period after your cover has ended, unless your policy is terminated in accordance with clause 6.2 and/or clause 7, then any premium which has been paid in relation to the period after cover has ended will be refunded to the extent that it does not relate to a period of time in which we have provided cover, so long as we have not paid any claim, or issued any guarantee of payment during the period of cover.	Updated current wording of General Terms and Conditions Clause 6 6.5 If you want to terminate this policy and end cover for all beneficiaries, you may only do so after the minimum period of cover of three (3) months from the initial start date by giving us at least fourteen (14) days' notice in writing. Termination of your policy will take effect fourteen (14) days after you, the policyholder, notifies us of the request by using one of the options in the 'How to contact us' section on page 3 of these Policy Rules. 6.6 In relation to the period after your cover has ended outside of the minimum period of cover of three (3) months, unless your policy is terminated in accordance with clause 6.2 and/or clause 7, then any premium which has been paid in relation to the period after cover has ended will be refunded to the extent that it does not relate to a period of time in which we have provided cover, so long as we have not paid any claim, or issued any guarantee of payment during the period of cover.
	Current General Terms and Conditions Clause 8.2 8.2 The following changes to your policy cannot be requested during the period of cover and can only be made upon renewal:	Updated current wording of General Terms and Conditions Clause 8.2 8.2 The following changes to your policy cannot be requested during the period of cover and can only be made upon renewal:

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All Policy Rules Section I: General Terms and Conditions	> to modify your level of cover (for example moving up from the Silver level to the Gold level or moving down from the Platinum level to the Gold level for the International Medical Insurance cover), > to modify your deductible, cost share or outof-pocket maximum. In order to proceed with such request, you should let us know in writing at least seven (7) days before your annual renewal date. Before making any of these changes, we may ask you to complete a new medical history questionnaire. If the request is accepted by us, we may apply new special restrictions or exclusions on your updated policy for the new period of cover. Once you accept our offered terms, these changes will become effective from your annual renewal date. The following changes to your policy can be requested during the period of cover and will be reviewed by us: > to add one or more of the optional modules at the same level of cover as your International Medical Insurance core cover: International Outpatient, International Evacuation & Crisis Assistance Plus™, International Health and Wellbeing or International Vision and Dental options, > to modify your area of cover by including USA cover (i.e. changing from Worldwide excluding the USA to Worldwide including the USA). Before making any of such changes to your policy during the current period of cover, we may ask you to complete a new medical history questionnaire. If the request is accepted by us, we may apply new special restrictions or exclusions on your updated policy. These changes to your policy will begin no sooner than the date you accept our offered terms and will remain in place until at least your annual renewal date. Any other changes to your policy in relation to coverage options will be reviewed by us and will be subject to medical underwriting.	> to modify your level of cover (for example moving up from the Silver level to the Gold level or moving down from the Platinum level to the Gold level for the International Medical Insurance cover), > to modify your deductible, cost share or outof-pocket maximum. In order to proceed with such request, you should let us know in writing at least seven (7) days before your annual renewal date. Before making any of these changes, we may ask you to complete a new medical history questionnaire as some changes may be subject to medical underwriting. If the request is accepted by us, we may apply new special restrictions or exclusions on your updated policy for the new period of cover. Once you accept our offered terms, these changes will become effective from your annual renewal date. The following changes to your policy can be requested during the period of cover and will be reviewed by us: > to add one or more of the optional modules at the same level of cover as your International Medical Insurance core cover: International Outpatient, International Evacuation & Crisis Assistance Plus®, International Health and Wellbeing or International Vision and Dental options, > to modify your area of cover by including USA cover (i.e. changing from Worldwide excluding the USA to Worldwide including the USA). Before making any of such changes to your policy during the current period of cover, we may ask you to complete a new medical history questionnaire. If the request is accepted by us, we may apply new special restrictions or exclusions on your updated policy. These changes to your policy will begin no sooner than the date you accept our offered terms and will remain in place until at least your annual renewal date. Any other changes to your policy in relation to coverage options will be reviewed by us and will be subject to medical underwriting. Please note, there is no access to maternity benefits on the Silver plan, and therefore in the case of an upgrade from Silver to Gold or Silver to Platinum, the beneficiary will not have any access to maternity benefits until they have satisfied the 12 month waiting period for maternity benefits on the Gold or Platinum plan. Once the beneficiary has been covered under the Gold or Platinum plan for 12 months or more, then they will have access to the maternity benefits. For maternity benefits in the case of an upgrade from Gold to Platinum, the beneficiary will only have access to the benefit limits of the Gold plan for maternity benefits until they have satisfied the 12 month waiting period on the Platinum plan. Once the beneficiary has been covered under the Platinum plan for 12 months or more, then they will have access to the Platinum limits for the maternity benefits.
	Current General Terms and Conditions Clause 9 9.1 If you have selected a deductible on the International Medical Insurance plan and/or International Outpatient option (if applicable), you will be responsible for paying the deductible amount directly to the hospital, clinic, medical practitioner or pharmacy. We will let you know what this amount is. We will reduce the amount which we will pay towards the cost of treatment in respect of each claim which is made under the International Medical Insurance or International Outpatient option (if applicable) by the amount of any deductible until the deductible for the period of cover is reached. 9.2 If you have selected a cost share on the International Medical Insurance plan and/or International Outpatient option (if applicable), we will reduce the amount we pay towards the cost of treatment by that cost share percentage. You will be responsible for paying the cost share directly to the hospital, clinic, medical practitioner or pharmacy. The amounts you pay are subject to the capping effect of the applicable out of pocket maximum. 9.3 Only amounts you pay related to the cost share on the International Medical Insurance and/or International Outpatient option are subject to the capping effect of the out of pocket maximum. The following are not subject to the out of pocket maximum: > Any amounts you pay due to a deductible; > Due to exceeding limits of cover;	Updated current wording of General Terms and Conditions Clause 9 9.1 If you have selected a deductible on the International Medical Insurance plan and/or International Outpatient option (if applicable), you will be responsible for paying the deductible amount directly to the hospital, clinic, medical practitioner or pharmacy. We will let you know what this amount is. Your chosen deductible applies from the treatment date. We will reduce the amount which we will pay towards the cost of treatment in respect of each claim which is made under the International Medical Insurance or International Outpatient option (if applicable) by the amount of any deductible until the deductible for the period of cover is reached. 9.2 If you have selected a cost share on the International Medical Insurance plan and/or International Outpatient option (if applicable), we will reduce the amount we pay towards the cost of treatment by that cost share percentage. You will be responsible for paying the cost share directly to the hospital, clinic, medical practitioner or pharmacy. The amounts you pay are subject to the capping effect of the applicable out of pocket maximum. Your chosen cost share applies as per the treatment date and any cost share amount paid will be considered as a claim towards your policy regardless if the cost share amount paid has covered fully or partially the cost of your claim . 9.3 Only amounts you pay related to the cost share on the International Medical Insurance and/or International Outpatient option are subject to the capping effect of the out of pocket maximum. The following are not subject to the out of pocket maximum: > Any amounts you pay due to a deductible; > Due to exceeding limits of cover; > For treatment not covered by the International Medical Insurance plan or International Outpatient option; or

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All Policy Rules Section 1: General Terms and Conditions	> For treatment not covered by the International Medical Insurance plan or International Outpatient option; or > Due to penalties for not obtaining prior approval or using out of network providers in the USA. Any amounts you pay to the deductible, cost share and out of pocket maximum where applicable, apply separately to each beneficiary, each coverage option and each period of cover. 9.4 No deductible applies to 'Inpatient cash benefit' or 'Newborn Care' benefit.	> Due to penalties for not obtaining prior approval or using out of network providers in the USA. Any amounts you pay to the deductible, cost share and out of pocket maximum where applicable, apply separately to each beneficiary, each coverage option and each period of cover. 9.4 No deductible applies to 'Inpatient cash benefit,' 'Newborn Care' benefit, 'Accident and Emergency Room Treatment,' or 'Global Telehealth with Teladoc' within the International Medical Insurance plan. No deductible applies to benefits within the following optional modules: International Health and Wellbeing, International Evacuation and Crisis Assistance Plus®, or International Vision and Dental. 9.5 For the following outpatient benefits, which are covered under the International Medical Insurance plan, the chosen inpatient deductible applies: > Any outpatient treatment under the 'Kidney Dialysis' benefit. > Advanced Medical Imaging (MRI, CT and PET scans). > Any outpatient treatment under the 'Mental and Behavioural Health Care' benefit, including counselling. > Any outpatient treatment under the 'Cancer Care' benefit. > Any outpatient treatment covered under the 'Complications from maternity' benefit.
All Policy Rules Section 1: General Terms and Conditions	Current General Terms and Conditions Clause 13.1 If we determine to renew, we will write to you at least one (1) calendar month before the end date to invite you to renew on the terms we offer you. We will inform you of any changes to the policy and premium for the forthcoming period of cover. If local law and/or regulation dictates, we may be required to offer you an alternative health plan. Subject to clause 7, any decision by Cigna Healthcare not to renew shall not be based on your claims history or any illness, injury or condition suffered by any beneficiaries.	Updated current wording of General Terms and Conditions Clause 13.1 If we determine to renew, we will write to you at least one (1) calendar month before the end date to invite you to automatically renew on the terms we offer you. We will inform you of any changes to the policy and premium for the forthcoming period of cover. If local law and/or regulation dictates, we may be required to offer you an alternative health plan. The minimum period of cover of three (3) month doesn't apply to renewed policies. This requirement applies only to the first year of your policy. Subject to clause 7, any decision by Cigna Healthcare not to renew shall not be based on your claims history or any illness, injury or condition suffered by any beneficiaries.
The following changes relate to Section 2: General Exclusions		
All Policy Rules Section 2: General Exclusions	Current General Exclusion 5 5. Treatment which is 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 any unlawfully constituted authority; c) any other conflict or disaster events; where the beneficiary has i) 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); ii) actively participated in the conflict; or iii) displayed a blatant disregard for their own safety.	Updated General Exclusion 5 5. Treatment which is 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 any unlawfully constituted authority; c) any other conflict or disaster events; where the beneficiary has i) put him or herself in danger by entering or remaining within a known area of conflict (as identified by a Government in your country of nationality, for example the British Foreign and Commonwealth Office); ii) actively participated in the conflict; or iii) displayed a blatant disregard for their own safety.
	Current General Exclusion 29 29. Treatment which is necessary because of, or is any way connected with, any injury or sickness suffered by a beneficiary as a result of: a) taking part in a sporting activity at a professional level; b) taking part in a hazardous sporting activity or hobby, including but not limited to off-piste winter sports (including skiing, ski-touring, snowboarding, heli-skiing or heliboarding), base or bungee jumping, sky diving, tombstoning or cliff jumping, mountaineering or rock climbing, free climbing (without harness or rope), potholing, fell or trail running, motorsports, equestrian sports (for instance horse racing, show jumping, or polo), hunting, bull riding or bull running, parkour, powerlifting, surfing or kitesurfing, white water rafting; c) solo scuba-diving; or	Updated General Exclusion 29 29. Treatment which is necessary because of, or is any way connected with, any injury or sickness suffered by a beneficiary as a result of: a) taking part in a sporting activity at a professional level; b) taking part in a hazardous sporting activity or hobby, including but not limited to off-piste winter sports (including skiing, ski-touring, snowboarding, heli-skiing or heliboarding), base or bungee jumping, sky diving, tombstoning or cliff jumping, mountaineering or rock climbing, free climbing (without harness or rope), potholing, fell or trail running, motorsports, equestrian sports (for instance horse racing, show jumping, or polo), hunting, bull riding or bull running, parkour, powerlifting, surfing or kitesurfing, white water rafting; c) solo scuba-diving; or d) scuba-diving at a depth of more than thirty (30) metres unless the beneficiary is appropriately qualified (namely PADI or equivalent) to scuba-dive at that depth.

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	d) scuba-diving at a depth of more than thirty (30) metres unless the beneficiary is appropriately qualified (namely PADI or equivalent) to scuba-dive at that depth. Note: Winter sports performed on marked trails (on-piste) are not considered as hazardous sporting activities. Medically necessary treatment would not be excluded as a result of an incurred injury as long as on-piste winter sport activities are not performed at a competition or professional level..	Note: Winter sports performed on marked trails (on-piste) are not considered as hazardous sporting activities. Medically necessary treatment would not be excluded as a result of an incurred injury as long as on-piste winter sport activities are not performed at a competition or professional level. Hill-walking, hiking and trekking performed on defined on-piste trails is not considered as a hazardous sporting activity as long as specialty equipment is not required (such as use of ropes, harness, karabiner, crampons and protective climbing equipment). Medically necessary treatments following any injury sustained during these non-hazardous activities will be covered under the appropriate inpatient, daypatient or outpatient benefit.
The following change relates to Section 3: Definitions		
All Policy Rules Section 3: Definitions	Current definition. Cosmetic - services, procedures or items that are supplied primarily for aesthetic purposes and which are not necessary in order to maintain an acceptable standard of health.	Amendment of definition. Cosmetic: services, procedures or items that are supplied primarily for aesthetic purposes and which are not medically necessary in order to maintain an acceptable standard of health.
	Current definition. Inpatient: a patient who is admitted to hospital and who occupies a bed overnight or longer, for medical reasons.	Amendment of definition. Inpatient: a patient who is admitted to hospital and who occupies a bed overnight or longer, for medical reasons. An example of inpatient treatment is undergoing surgery following a heart attack where they will recover in hospital overnight.
	Current definition. Daypatient: a patient who is admitted to a hospital or daypatient unit or other medical facility for treatment or because they need a period of medically supervised recovery, but who does not occupy a bed overnight. This also includes surgical procedures carried out in a doctor's surgery.	Amendment of definition. Daypatient : a patient who is admitted to a hospital or daypatient unit or other medical facility for treatment or because they need a period of medically supervised recovery, but who does not occupy a bed overnight. An example of daypatient treatment would be attending hospital for chemotherapy as part of cancer treatment or receiving an endoscopy as part of diagnostic testing.
	Current definition. Outpatient : a patient who attends a hospital, consulting room, or outpatient clinic for treatment and is not admitted as a daypatient or an inpatient and doies not occupy a bed.	Amendment of definition. Outpatient: a patient who attends a hospital outpatient department, consulting room, or outpatient clinic for treatment but is not admitted as a daypatient or an inpatient and does not occupy a bed. An example of outpatient treatment would be visiting an outpatient clinic to undergo a mole removal where you are not required to be admitted to hospital and do not require general anaesthetic for the procedure.
	Current definition. Guarantee of payment: a binding guarantee made by us to pay a provider the agreed costs associated with a particular treatment which we may give to a beneficiary or a hospital, clinic or medical practitioner.	Amendment of definition. Guarantee of payment: a binding guarantee made by us to pay a provider the agreed costs associated with a particular treatment which we may give to a beneficiary or a medical facility or medical practitioner.
	Current definition. Medically necessary/ medical necessity medically necessary covered services and supplies are those determined in accordance with International Clinical Guidelines by the medical team to be: > required to diagnose or treat an illness, injury, disease or its symptoms; > orthodox, and in accordance with generally accepted standards of medical practice; > clinically appropriate in terms of type, frequency, extent, site and duration; > not primarily for the convenience of the beneficiary, physician or other hospital, clinic or medical practitioner; and > rendered in the least intensive setting that is appropriate for the delivery of the services and supplies.	Amendment of definition. Medically necessary/medical necessity: medically necessary covered services and supplies are those determined in accordance with International Clinical Guidelines by the medical team to be: > required to diagnose or treat an illness, injury, disease or its symptoms; > orthodox, and in accordance with generally accepted standards of medical practice; > clinically appropriate in terms of type, frequency, extent, site and duration; > not primarily for the convenience of the beneficiary, medical practitioner or medical facility; and > rendered in the least intensive setting that is appropriate for the delivery of the services and supplies. Where applicable, the medical team may compare the cost effectiveness of alternative services, settings or supplies when determining what the least intensive setting is.
	Current definition. Medical practitioner : a doctor or specialist who is registered or licensed to practice medicine under the laws of the country, state or other regulated area in which the treatment is provided, and who is not covered under this policy, or a family member of someone covered under this policy.	Amendment of definition. Medical Practitioner(s): a doctor, specialist, qualified nurse or therapist (including speech therapies, dietician or orthoptist), dental surgeon or dental practitioner who is registered, suitably qualified or licensed to practice medicine or provide treatment under the laws of the country, state or other regulated area in which the treatment is provided, and who is not covered under this policy, or a family member of someone covered under this policy.

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<tr>
<td rowspan="7">All Policy Rules Section 3: Definitions</td>
<td>Current definition.

Period of cover:
the twelve (12) months continuous period during which the beneficiaries are covered under this policy, being the period from the start date to the end date as noted in the Certificate of Insurance or earlier if terminated in accordance with the Policy Rules</td>
<td>Amendment of definition.

Period of cover:
this policy has a minimum period of cover of three (3) months and a maximum period of cover of twelve (12) months renewable. The period of cover is from the start date to the end date as noted in the Certificate of Insurance or earlier if terminated in accordance with the Policy Rules.</td>
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<td>Current definition.

Policy:
the policy comprising these Policy Rules, the Customer Guide (which contains the list of benefits and claiming information), and your Certificate of Insurance</td>
<td>Amendment of definition.

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

Pre-existing condition:
any disease, illness or injury, or symptoms present before the initial start date linked to such disease, illness or injury for which:
> medical advice or treatment has been sought or received; or
> the beneficiary knew about and did not seek medical advice or treatment.</td>
<td>Amendment of definition.

Pre-existing condition:
any disease, illness or injury, or symptoms present before the initial start date of your policy for which:
> medical advice or treatment has been sought or received; or
> the beneficiary knew about and did not seek medical advice or treatment.</td>
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<td>Current definition.

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

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

Selected area of coverage means either:
> Worldwide, including USA; or
> Worldwide, excluding USA.</td>
<td>Amendment of definition.

Selected area of coverage means either:
> Worldwide, including USA (every country throughout the world, excluding any country with whom, at the date of commencement of treatment, the Federal Government of the USA has prohibited trade to the extent that payments are illegal under applicable law.); or
> Worldwide, excluding USA (worldwide, with the exception of the USA) .</td>
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<td>Current definition.

Treatment:
any surgical or medical treatment controlled by a medical practitioner that is medically necessary to diagnose, cure or substantially relieve disease, illness or injury</td>
<td>Amendment of definition.

Treatment:
any surgical or medical treatment controlled by a medical practitioner and takes place in a medical facility that is medically necessary to diagnose, cure or substantially relieve disease, illness or injury.</td>
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<td>Not currently defined.

Medical Facilities</td>
<td>New definition.

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