cigna healthcare

Cigna Close Care℠

Customer Guide

Everything you need to know about your plan

Want To Get In Touch?

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

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

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

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

* For certain queries, our Customer Service team may direct you to our in-house team of specialists who are available during the working hours of Monday to Friday from 8am to 8pm CET.

Contents

Understanding Your Health Insurance

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

Throughout this document, we've highlighted some key terms in **bold**. You can find further explanation of these key terms in the Definitions section.

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

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

When we use the terms 'we,' 'us' and 'our', we refer to Cigna Healthcare, the insurer of this policy. Please refer to page 3 of the Policy Rules document for details of the Cigna Healthcare legal entity providing your policy.

Welcome To Cigna Healthcare

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

We put people first

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

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

We are your whole health partner

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

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

We have global expertise

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

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

Your Cigna Close Care℠ plan

Area of coverage

- The Cigna Close Care℠ plan covers *you* in *your country of habitual residence* and *your country of nationality*. This means *you* only pay for coverage where *you* need it most, in the country *you* will be living and when *you* return home for temporary visits.
- These temporary visits may not exceed 180 days per *period of cover*, and the *country of nationality* must be within the *area of coverage*.
- *USA area of coverage* is only permitted if either of the following options apply:
  - *USA* coverage is included if the *country of habitual residence* is the USA.
  - *USA* nationals can choose to purchase *USA* coverage. If the policyholder does not elect to purchase *USA* coverage, then *beneficiaries* do not have coverage on visits home.

Out of area emergency cover

- For additional peace of mind, when visiting a location outwith *your area of coverage*, *your* plan includes emergency medical coverage.
- *Beneficiaries* will be covered for emergency *treatment* on an *inpatient* or *daypatient* basis, as well as on an *outpatient* basis (only if the Outpatient and Wellness Care option has been purchased under *your policy*) during temporary trips, outside *your area of coverage*.
- Coverage is limited to a maximum period of twenty one (21) treatment days per trip and a maximum of forty five (45) treatment days per *period of cover* for all trips combined. Please read the full terms and conditions relating to this benefit in clause 8.3 of *your Policy Rules*.

Your benefit cover

- *Your* Core cover will cover *you* comprehensively for *inpatient* and *daypatient treatment*.
- When building *your* tailored Cigna Close Care℠ plan, *you* may have chosen the following optional benefits to add to *your* Core cover : the Outpatient and Wellness Care module and the Dental Care and Treatment module.
- To remind yourself of which benefits you've chosen, take a look at *your Certificate of Insurance*, available on *your* online Customer Area.

Condition limit

- *Your* Cigna Close Care℠ plan has a *condition* limit of $250,000/€200,000/£165,000 per *beneficiary*, per *period of cover*.
- This includes all claims paid across all sections of *inpatient*, *daypatient* and *outpatient treatment* in relation to the primary condition.
- For the avoidance of doubt, this excludes any *pre-existing conditions*. For full details please refer to the list of benefits on page 17.

Our Clinical Support

Did you know?

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

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

Feel supported on your medical journey

Case Management

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

Chronic Condition Management

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

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

Support includes:

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

Feel reassured thanks to second medical opinions

Decision Support programme

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

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

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

Managing Your Policy

Did you know?

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

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

To access your secure online Customer Area, click here.

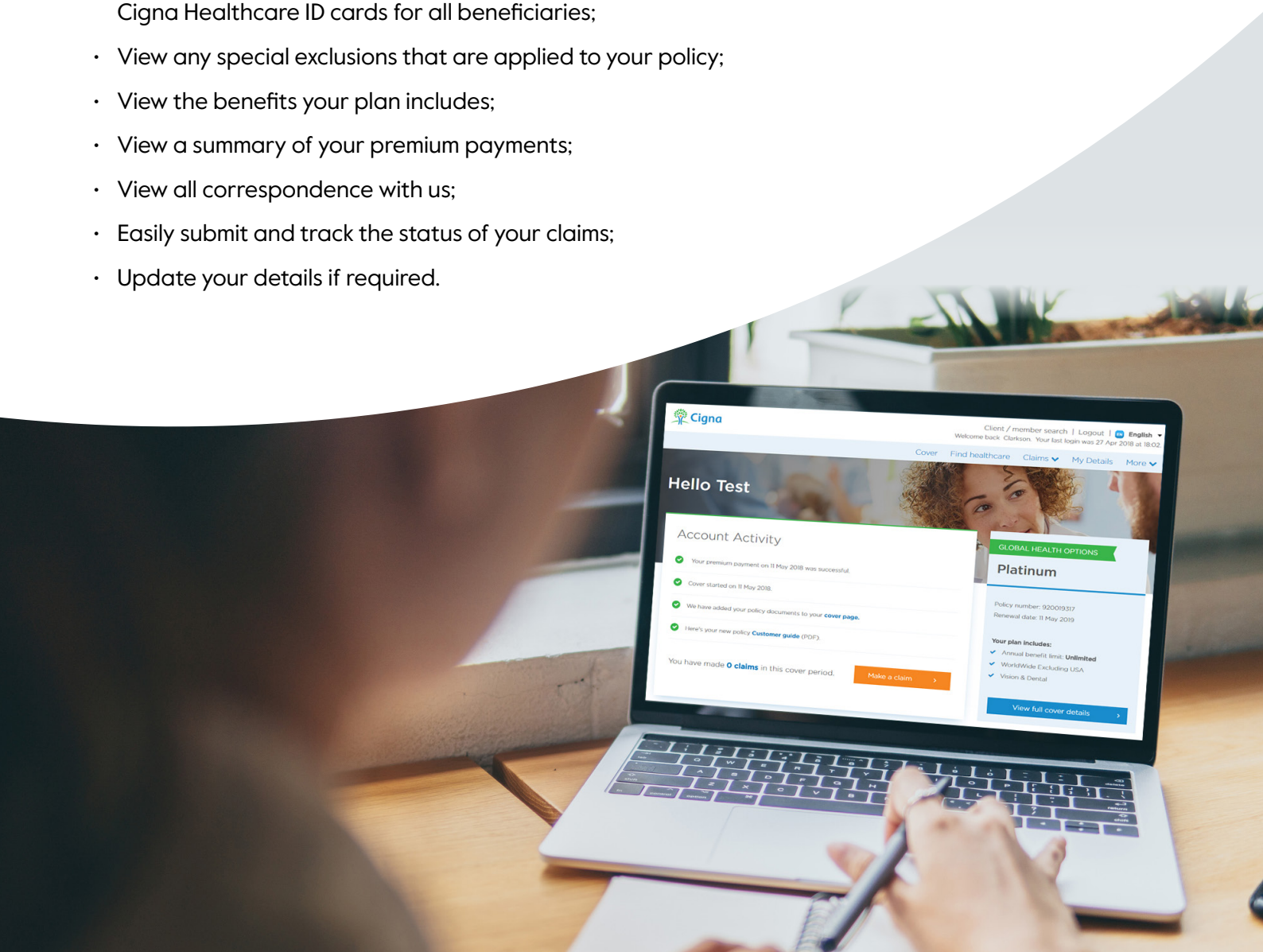
Select **'Global Individual Policy'** from the list and click **'Login'** button.

Enter the email **address that** you **provided** us **with** and then your password.

If you have any problems accessing the Customer Area, please contact our Customer Care team. Contact details are provided on page 2.

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

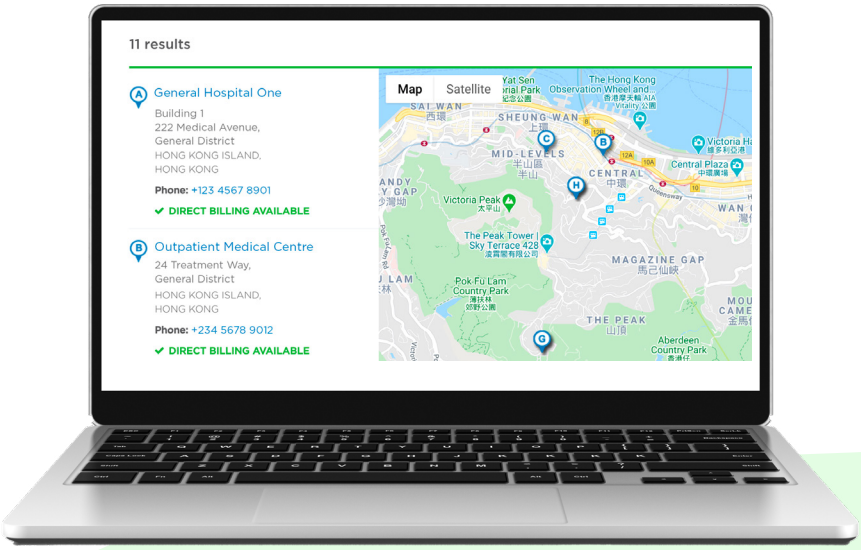
- View your policy documents, including your Certificate of Insurance and Cigna Healthcare ID cards for all beneficiaries;
- View any special exclusions that are applied to your policy;
- View the benefits your plan includes;
- View a summary of your premium payments;
- View all correspondence with us;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



Accessing Care

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

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



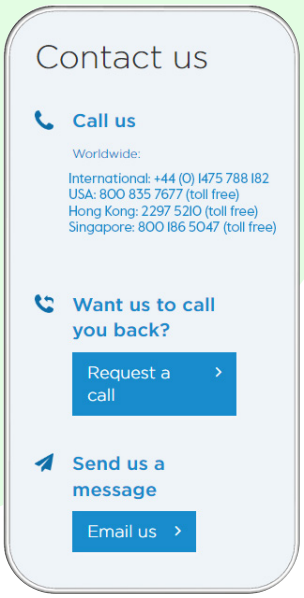
Contact us

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

Live chat

Request a call back

Message us



Arranging Treatment

What type of treatment or consultation do you need?

Inpatient or Daypatient treatment

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

For example, if you require surgery following a heart attack. Any diagnostic tests, surgery and hospital charges are covered within inpatient and daypatient treatment. See page 12.

Outpatient treatment

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

For example, a diagnostic test, a flu vaccination or a mole removal. See page 13.

Do you need to contact Cigna Healthcare first?

Prior authorisation is required before receiving these treatments.

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

If no prior authorisation obtained:

- Delay in processing claims
- Payment reduction by 20%

In most cases, prior authorisation is not required.

There are a limited number of outpatient treatments which require prior authorisation and can be found on page 27.

Note: In case of emergency:

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

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

Provider Search

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

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

Provider Choice

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

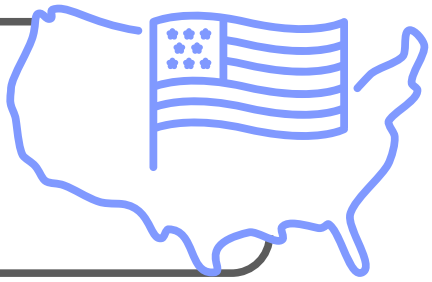
Inside the USA:
For any outpatient treatment, it is recommended to stay within the Cigna Healthcare network.

Treatment in the USA

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

This payment reduction will not apply in the following instances:

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



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

Guarantee of Payment

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

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

Getting Treatment

For inpatient and daypatient treatment

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

For outpatient and preventative treatments

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

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

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

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

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

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

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

Notes:

- We will only pay the parts of the treatment costs incurred which are covered.
- You are responsible for paying any deductible or cost share directly to the hospital, clinic, medical practitioner or pharmacy at the time of treatment.

If you have paid the provider

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

You can find details on how to submit a claim on page 14.

Notes:

- We will reimburse you (less your applicable deductible and/or cost share option).
- We aim to process your claim within 5 working days after receiving all necessary documentation.

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

Important:

- There may be certain countries where we are unable to pay a provider directly. In this instance, you will be responsible for paying any treatment costs to your provider and Cigna Healthcare will reimburse you.
- We may, at our sole discretion and without notification, make changes to the Cigna Healthcare network from time to time by adding and/or removing hospitals, clinics, medical practitioners and pharmacies.

Example 1: Hospitalisation

Wondering how your policy will work for you?

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

Did you know?

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

Profile: Linda **Age:** 55 **Plan:** Cigna Close Care℠

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

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

Linda arrives at the hospital.

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

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

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

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

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

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

Example 2: Out Of Hospital Care

Wondering how your policy will work for you?

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

Did you know?

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

Profile: William **Age:** 65 **Plan:** Cigna Close Care℠
Additional cover selected: Outpatient and Wellness Care module

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

Benefit used: Consultations and outpatient procedures with medical practitioners

Prior Authorisation: Not required

Claim Reimbursement: Not required*

The doctor reviews William's symptoms and prescribes antibiotics.

Benefit: Prescribed drugs and dressings

Prior Authorisation: Not required

Claim Reimbursement: Required**

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

A follow-up appointment is scheduled.

Prior Authorisation: Not required

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

Benefit: Consultations and outpatient procedures with medical practitioners and specialists

Prior Authorisation: Not required

Claim Reimbursement: Not required*

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

Benefit: Consultations and outpatient procedures with medical practitioners and specialists

Prior Authorisation: Not required

Claim Reimbursement: Not required*

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

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

How To Submit Claims

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

You will need:

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

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

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

You can submit your claims through:

- Your secure online **Customer Area** (see page 8)
- Email: cghoclaims@cigna.com
- Post: For Treatment Incurred:
- Fax: +44 (0) 1475 492 113 (Outside the *USA*); 855 358 6457 (Inside the *USA*)

Outside of the *USA*, Hong Kong, or Singapore	Cigna Global Health Options, Customer Service, 1 Knowe Road, Greenock Scotland PA15 4RJ
In the *USA*	Cigna International, PO Box 15964, Wilmington, Delaware 19850, USA

Important information

- You and all beneficiaries must comply with the claims procedures set out in this Customer Guide.
- We can reimburse you using bank wire transfer or cheque.
- We may need to ask for extra information to help us process a claim, for example: medical reports or other information about the beneficiary's condition or the results of any independent medical examination that we may ask and pay for.
- Beneficiaries should submit claims forms and invoices as soon as possible after any treatment. If the claim and invoice is not submitted to us within 12 months of the date of treatment, the claim will not qualify for payment or reimbursement by us.

Subject to the terms of this policy, we will pay for the following costs related to your claim:

- Costs as described in the list of benefits section of this Customer Guide as applicable on the date(s) of the beneficiary's treatment.
- Costs for treatment which have taken place, however, we will not cover future treatment costs that require payment deposits or payment in advance.
- Treatment which is medically necessary and clinically appropriate for the beneficiary.
- Reasonable and customary costs for treatment, and services related to treatments which are shown in the list of benefits. We will pay for such treatment costs in line with the appropriate fees in the location of treatment and according to established clinical and medical practice.
- If you exceed any individual benefit sub limit, or the overall annual benefit maximum, we will seek reimbursement from you to cover the costs where you have exceeded your limit.

Cigna Wellbeing® App

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

Did you know?

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

Access care, anytime, anywhere

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

REQUEST AN APPOINTMENT

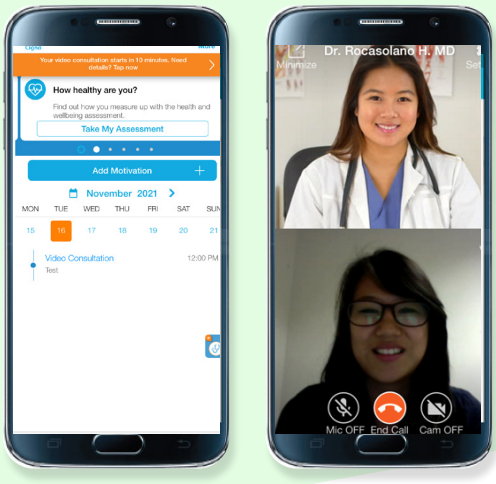
Use the Cigna Wellbeing® App to make an appointment with a *doctor* anytime, anywhere.

SPEAK WITH A DOCTOR

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

FEEL BETTER

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



Why use Global Telehealth?

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

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

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

GET IT ON Google Play

Download on the App Store

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

Manage Your Health

Health Assessments

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

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

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

Chronic Condition Management

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

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

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

Change Behaviours

Track Biometrics

The Cigna Wellbeing® App allows you to continuously track:

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

Did you know?

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

Health Content & Coaching Programmes

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

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

Your core cover

Your Core cover is detailed in the table below. This is your essential cover for inpatient, daypatient and accommodation costs, as well as cover for cancer, mental health care and much more. All amounts apply per beneficiary and per period of cover (except where otherwise noted).

Inpatient and Daypatient benefits

As per our definitions in your Policy Rules document:

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

Some benefits (Cancer care, Advanced Medical Imaging and Mental health care) that are included under your Core Cover provide cover for treatment on inpatient, daypatient and outpatient basis.

For all other benefits, you will need to add the optional Outpatient and Wellness Care module to be covered for outpatient treatment, as indicated in the benefit descriptions.

Important to note, **Prior authorisation** is required for all Inpatient and Daypatient treatments. Please refer to Page 10 for more information regarding Prior Authorisation and Page 2 for contact details. For all general exclusions please refer to your Policy Rules document found in your Customer Area.

Area of Coverage

- The *area of coverage* is limited to *your country of habitual residence* and *country of nationality*.
- *USA* coverage is included if the *country of habitual residence* is the *USA*.
- *USA* nationals can choose to purchase *USA* coverage (if the *policyholder* does not elect to purchase *USA* coverage, then *beneficiaries* do not have coverage on visits home).
- *USA area of coverage* is not permitted if either of the options above do not apply.

YOUR OVERALL LIMIT

Annual overall benefit maximum - per *beneficiary* per *period of cover*. This includes claims paid across all sections of *inpatient* and *daypatient benefits*.	**$500,000 €400,000 £325,000**
***Condition* limit** Up to the total limit shown per *beneficiary* per *period of cover*.	**$250,000 €200,000 £165,000**

This is the annual amount *we* will pay towards all costs of *treatment* following the diagnosis of a *condition*. This includes all claims paid across *inpatient*, *daypatient* and *outpatient* in relation to the primary *condition*. This applies to each *beneficiary* per *period of cover*.

Important notes

- *We* will only pay up to the maximum amount in aggregate per *period of cover* as detailed in the *list of benefits*.
- The costs do not include any evacuation or repatriation services.
- Any further costs directly related to the medical *condition*, that exceed the *benefit* limit, will not be covered by *us*.
- In determining when this limit has been reached, *our medical team* will take into account and review all of the relevant medical *treatment* and care received.
- *We* will only pay for *outpatient* costs if the Outpatient and Wellness Care option has been selected, with the exception of certain *benefits* which include *outpatient treatment* as part of *your Core cover*.

Out of area emergency cover

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

This benefit requires *prior authorisation*.

$40,000
€29,600
£26,600

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

Important notes

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

Coverage is limited to:

- a duration not exceeding 21 treatment days per trip; and
- a maximum of 45 treatment days in aggregate per period of cover for all trips combined.

Emergency outpatient treatment may also be included and only up to $2,500/€1,850/£1,650. This is only available if you have selected the Outpatient and Wellness Care option. Please refer to Policy Rules clause 8.3 for terms relating to this overall benefit limit.

Hospital charges for:

- operating theatre.
- prescribed medicines, drugs and dressings for *inpatient or daypatient treatment*.
- *treatment* room fees for *outpatient surgery*.

Up to the annual overall benefit maximum per *beneficiary per period of cover*.

This benefit requires *prior authorisation*.

Paid in full for a semi-private room

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.
- Medicines, drugs and dressings which are prescribed for use at home will be covered under the limits of the prescribed drugs and dressing limit in the Outpatient and Wellness Care benefits (unless they are prescribed as part of cancer treatment).

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 semi-private room with shared bathroom.

Important Notes:

- If a Semi-Private Room is not available either because a Private Room is standard for that hospital, or the hospital is at maximum occupancy and does not have semi-private rooms available, then the maximum amount that we will pay is the amount that would have been charged if the beneficiary had stayed in a standard semi-private room with shared bathroom or the hospital's equivalent of such.
- 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.

Pandemics, epidemics and outbreaks of infectious illnesses

Up to the annual overall benefit maximum per *beneficiary* per *period of cover*.

This benefit requires *prior authorisation*.

Paid in full

- *We* will pay for *medically necessary treatment* for disease or illness resulting from a pandemic, epidemic or outbreak of infectious illness, as defined by the World Health Organisation (WHO).
- The *medically necessary treatment* and related medical conditions will be covered on an *inpatient and daypatient* basis. We will only pay for *outpatient* treatments if the *beneficiary* has purchased the optional Outpatient and Wellness module.

Important notes

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

Inpatient cash benefit

Per night up to 30 days per *beneficiary* per *period of cover*.
Any deductible chosen under your core cover will not apply to this benefit, as per policy rules

$100
€75
£65

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

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

Intensive care:

- intensive therapy.
- coronary care.
- high dependency unit.

Up to the annual overall benefit maximum per *beneficiary* per *period of cover*.

This benefit requires *prior authorisation*.

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

Up to the annual overall benefit maximum per *beneficiary* per *period of cover*.

This benefit requires *prior authorisation*.

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 Outpatient and Wellness Care option (unless the treatment is given as part of *cancer treatment*).

Specialists' consultation fees

Up to the annual overall benefit maximum per *beneficiary* per *period of cover*.

This benefit requires *prior authorisation*.

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*.

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

Up to the annual overall benefit maximum per *beneficiary* per *period of cover*.

This benefit requires *prior authorisation*.

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*;

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

Kidney Dialysis

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

This benefit requires *prior authorisation*.

$5,000
€3,700
£3,325

- *Treatment* for kidney dialysis will be covered if such *treatment* is available in the *beneficiary's country of habitual residence*. *We* will pay for this on an *inpatient*, *daypatient*, or *outpatient* basis.
- *We* will not pay for kidney dialysis *treatment outside the beneficiary's area of coverage* unless it is covered under the terms of the out of area emergency cover *benefit*
- We will pay for this on a daypatient basis. Travel and accommodation expenses incurred in connection with such treatment will not be covered..

Advanced Medical Imaging (MRI, CT and PET scans)

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

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

$2,500
€1,850
£1,650

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

Important note:

This benefit is subject to any deductible or cost share that you may have selected on your Core Cover for any advanced medical imaging treatment, including MRI, CT and PET scans performed on an outpatient basis.

Physiotherapy and complementary therapies

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

This benefit requires *prior authorisation*.

$2,000
€1,480
£1,330

- Where *treatment* is provided on an *inpatient* or *daypatient* basis.
- *We* will pay for *treatment* provided by physiotherapist and *complementary therapists*; (acupuncturists 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 is not the primary *treatment* which they are in *hospital* to receive). The Acupuncturist and the practitioner of Chinese medicine must be a properly qualified practitioner who holds the appropriate licence in the country where the *treatment* is received.

Rehabilitation

Up to 30 days and the total limit shown per *beneficiary* per *period of cover*.

This benefit requires *prior authorisation*.

$2,000
€1,480
£1,330

- We will pay for rehabilitation treatments including occupational, cardiac, pulmonary, cognitive and speech therapies up to the benefit limits and day limit shown above.
- We will only pay for rehabilitation treatment immediately after surgery and/or a traumatic event. If the rehabilitation treatment is required in a residential rehabilitation centre, we will pay for accommodation and board.
- In determining when the 30 day limit has been reached, we count each overnight stay during which a beneficiary receives inpatient and/or 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 notes

- We will only approve rehabilitation treatment if the treating specialist provides us with a report, explaining how long the beneficiary will need to stay in hospital, the diagnosis and the treatment which the beneficiary has received, or needs to receive.
- Rehabilitation is physical, speech and occupational therapy for the purpose of treatment aimed at restoring the beneficiary to their previous state of health after an event.

Mental and Behavioural Health Care

Up to the total limit shown per *beneficiary* per *period of cover*.
Up to 60 days (*inpatient* and *outpatient* combined).
Up to 30 days (*inpatient* only).

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

$3,000
€2,200
£2,000

We will pay for:

- *Evidence-based and medically necessary treatment which is recommended by a medical practitioner.*
- *Inpatient, daypatient or outpatient treatment carried out by a psychologist and/or psychiatrist who is licensed as such under the laws of that country.*
- The diagnosis of addictions (including alcoholism);

Addiction treatment

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

Autism and Attention Deficit Hyperactivity Disorder (ADHD)

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

Important notes

This benefit is subject to any deductible or cost share that you may have selected on the inpatient core cover for any mental and behavioral health care, including any mental health treatment taking place on an outpatient basis.

We will not pay for:

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

Cancer care

Up to the annual overall benefit maximum per *beneficiary* per *period of cover*.

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

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.
- Any outpatient treatments, including prescribed drugs, related to cancer care will be covered under this benefit included in your Core Cover, instead of any outpatient benefit included under the optional Outpatient and Wellness Care module.

Cancer related appliances

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

This benefit requires *prior authorisation*.

$125
€100
£85

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

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

Hospice and Palliative care

Up to the maximum amount shown per lifetime.

This benefit requires *prior authorisation*.

$2,500
€1,850
£1,650

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

We will pay for:

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

Internal *prosthetic devices*

Up to the annual overall benefit maximum per *beneficiary* per *period of cover*.

This benefit requires *prior authorisation*.

Paid in full

- *We* will pay for internal *prosthetic devices* which are necessary as part of a *beneficiary's treatment*.
- A *prosthetic device* means:
  - an artificial limb, prosthesis or device which is required for the purpose of or in connection with *surgery*;
  - 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*

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

This benefit requires *prior authorisation*.

$2,500
€1,850
£1,650

- *We* will pay for external *prosthetic devices* which are necessary as part of a *beneficiary's treatment* (subject to the limitations explained below).
- *We* will pay for:
  - a *prosthetic device* or appliance which is a necessary part of the *treatment* immediately following *surgery* for as long as is required by *medical necessity*; or
  - a *prosthetic device* or appliance which is *medical 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*. *If a beneficiary requires a replacement prosthetic device during the period of cover, we will require an appropriate medical report.*
- *We* will pay for an initial external prosthetic device and up to 2 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 services

Up to the annual overall benefit maximum per *beneficiary* per *period of cover*.

This benefit requires *prior authorisation*.

Paid in full

- Where it is *medically necessary*, *we* will pay for a local road 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 *medically necessary treatment* which a *beneficiary* needs to receive in *hospital*.
- This *policy* does not provide cover for mountain rescue services.
- This benefit is only for travel within the same country, For cross-border medical transportation, this would be covered under Medical Evacuation.

Emergency *inpatient dental treatment*

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

This benefit requires *prior authorisation*.

$2,500
€1,850
£1,650

- *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.

Global Telehealth with Teladoc

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

Unlimited consultations

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

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

Important notes

- You can access Global Telehealth via the Cigna Wellbeing® App. Please see page 15 for details on how to download the app and register. On the app home screen, click on the 'Get Care' icon and select 'Global Telehealth'. Once you have accepted the Terms and Conditions and Privacy Policy, select 'Schedule Consultation' and proceed to book your consultation by selecting either 'phone consultation' or 'video consultation' and then follow the steps.
- Where you 'Request a call for later' a doctor will typically phone you back on the same day, dependent on language availability. Where you request a video consultation, you can select the day and time to suit you. We recommend having the application open 10 minutes before the scheduled time.
- Prescribing medication is permissible only when the *doctor* is licensed to prescribe medication in the state or country of where the policy is underwritten. *You* must have purchased the optional Outpatient and Wellness Care module to receive coverage under the outpatient prescribed drugs and dressing benefit.
- If *you* have selected a deductible or cost share for outpatient *treatment*, *you* will be required to pay this if *you* are prescribed medication.

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

Medical Evacuation

Any deductible chosen under your core cover will not apply to this benefit.

$50,000
€37,000
£33,250

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

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

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

As regards to the return journey, *we* will pay:

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

We will only pay for taxi fares if:

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

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

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

Important notes:

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

Medical Repatriation

Any deductible chosen under your core cover will not apply to this benefit.

$100,000
€74,000
£66,500

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

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

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

As regards to the return journey, *we* will pay:

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

We will only pay for taxi fares if:

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

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

Important notes:

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

Repatriation of Mortal Remains Any deductible chosen under your core cover will not apply to this benefit.	$25,000 €18,500 £16,500

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

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

Important note:

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

The following important notes and general conditions apply to all the cover which is provided under the benefits of Medical Evacuation, Medical Repatriation and Repatriation of Mortal Remains.

Important notes

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

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

- all evacuations and repatriations must be approved in advance by the *medical assistance* service, which is contactable through the Customer Care Team (Please refer to page 2 for contact details);
- the *treatment* for which, or following which, the evacuation or repatriation is required must be recommended by a *qualified nurse* or *medical practitioner*;
- evacuation and repatriation services are only available under this *policy* if the *beneficiary* is being treated (or needs to be treated) on an *inpatient* or *daypatient* basis;
- the *treatment* because of which the evacuation or repatriation service is required must:
  - be *treatment* for which the *beneficiary* is covered under this *policy*; and
  - not be available in the location from which the *beneficiary* is to be evacuated or repatriated;
  - the *beneficiary* must already have cover under the Close Care℠ core cover, before they need the evacuation or repatriation service;
  - the *beneficiary* must have cover in the *selected area of coverage* which includes the country where the *treatment* will be provided after the evacuation or repatriation (*treatment* in the USA is excluded unless the *beneficiary* has purchased the *USA cover as country of habitual residence, or country of nationality)*.
- *We* will only pay for evacuation or repatriation services if all arrangements are approved in advance by *our medical assistance service*. Before that approval will be given, *we* must be provided with any information or proof that *we* may reasonably request;
- *We* will not approve or pay for an evacuation or repatriation if, in *our* reasonable opinion, it is not appropriate, or if it is against medical advice. In coming to a decision as to whether an evacuation or repatriation is appropriate, *we* will refer to established clinical and medical practice;
- From time to time *we* may carry out a review of this cover and reserve the right to contact *you* to obtain further information when it is reasonable for *us* to do so.

General conditions

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

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

How Medical Evacuation, Repatriation and Out of Area Emergency cover works:

You are residing in Spain and your country of nationality is France.

Example I:

You require emergency treatment following a stroke at home; however, your treatment is not available to you locally. We will pay for you to be taken to the nearest hospital where this treatment is available; this may be within Spain, or over the border in Portugal.

If you are transferred to a hospital within Portugal, any emergency treatment would be included within the Out of Area Emergency Cover benefit up to $40,000 / €29,600/ £26,600. The medical evacuation to Portugal would be covered under medical evacuation benefit up to $50,000 / €37,000 / £33,250. If you receive treatment locally within Spain (county of cover), treatment costs would be covered under your core inpatient cover.

Example 2:

You require emergency treatment, following surgery for a heart attack, whilst on holiday in Thailand **(Out of Area)**. We will pay for you to be repatriated to either France or Spain (countries of cover) following surgery. Emergency treatment following a heart attack would be covered under the out of area emergency benefit up to $40,000 / €29,600 / £26,600. Repatriation to France or Spain would be covered up to $100,000 / €74,000 / $66,500.

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

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

Outpatient and Wellness Care

Optional Module

Outpatient and Wellness Care provides more comprehensive outpatient care where a hospital admission as a daypatient or inpatient is not required, including consultations with specialists, prescribed outpatient drugs and dressings, physiotherapy and osteopathic and chiropractic treatments.

As your whole health partner, you will also be covered for a range of pre-cancer screenings, routine adult physical exams, and have access to our Life Management Assistance Programme and our Wellness Coaching programme.

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

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

- Physiotherapy, chiropractic and osteopathy treatments when you have exceeded 10 sessions (Note: a prior authorisation is not required for the first 10 sessions referred by a medical practionner).
- Prescribed drugs and dressings for more than 3 months.

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

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

YOUR OVERALL LIMIT

Annual overall benefit maximum - per *beneficiary* per *period of cover* This includes claims paid across all sections of Outpatient and Wellness Care.	**$5,000** **€3,700** **£3,325**

Consultations and outpatient procedures with *medical practitioners* and specialists

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

$650
€500
£425

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

Important notes:

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

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

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

$1,000
€740
£665

- *We* will pay for the following tests where they are *medically necessary* and are recommended by a specialist as part of a *beneficiary's outpatient treatment*:
  - blood and urine tests;
  - X-rays;
  - ultrasound scans;
  - electrocardiograms (ECG); and
  - other *diagnostic tests* (excluding advanced medical imaging).

Important note

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

Physiotherapy

Up to the total limit shown per *beneficiary* per *period of cover*.
This benefit requires prior *authorisation.**

$1,000
€740
£665

- *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 licence to practice in the country where the *treatment* is received. This excludes any sports medicine *treatment*.

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

Osteopathy and chiropractic *treatment*

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

This benefit requires prior *authorisation.**

$650
€500
£425

- *We* will pay 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 licence to practice in the country where the *treatment* is received. This excludes any sports medicine *treatment*.

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

Acupuncture and Chinese medicine

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

$650
€500
£425

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

Prescribed drugs and dressings

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

$500
€370
£330

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

Important note

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

Rental of durable medical equipment

Up to 45 days and the total limit shown per *beneficiary* per *period of cover*.

$1,500
€1,100
£1,000

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

Adult vaccinations

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

$250
€185
£165

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

Dental accidents

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

$500
€370
£330

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

Child wellbeing tests

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

$1,000
€740
£665

- Payable for children at *appropriate age intervals* up to the age of 6.
- *We* will pay for child routine wellbeing tests at any of the *appropriate age intervals* and carried out by 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 1 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.

  Mental health consultations with a psychiatrist or psychologist are covered under the Mental Health and Behavioural Care benefit under your Core Cover

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

Child immunisations

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

$1,000
€740
£665

- *We* will pay for certain vaccinations and immunisations that are clinically appropriate for children aged 17 or younger.

Annual eye and hearing test for children aged 15 and younger

Up to the annual overall benefit maximum per *beneficiary* per *period of cover*.

Paid in full

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

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*.

Choose your cost share percentage:

0% / 10% / 20% / 30%

and your applicable out of pocket maximum is:

$3,000
€2,200
£2,000

YOUR WELLNESS CARE BENEFITS

We understand the importance of your overall wellbeing and living a balanced life. **The benefits listed below are available only to beneficiaries aged 18 year old and over.** In addition, specific age eligibility will apply to the different cancer screenings.

Any chosen deductible by Policyholder and all beneficiaries, apply to only Outpatient benefits. Deductible will not apply to any Wellness Care benefits noted from page 31.

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

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

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

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

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

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

Request a callback via the Cigna Wellbeing® App.

This service is provided by our chosen counselling provider

Life Management Assistance Programme

Deductible does not apply.

Included

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

All calls into our Life Management Assistance Programme are answered 24 hours a day, 7 days a week,, 365 days a year.

You will have access to the following services and tools:

Short-term counselling:

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

Behavioural health:

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

Career and workplace support:

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

Practical needs:

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

Important Notes:

This service is not suitable if:

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

Wellness Coaching

Deductible does not apply.

Included

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

We will match you with your own personal qualified wellness coach who is specifically trained in health behaviour change.

Your coach will partner with you to identify a specific wellness goal that is important to you, such as:

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

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

Routine adult physical examination

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

Deductible does not apply.

$225
€165
£150

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

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

Any deductible chosen under the optional outpatient and wellness care module, will not apply to the benefits listed below.

Cervical cancer screening

Up to the per screening limit and the combined aggregate limit shown per *beneficiary* per *period of cover*.

For female *beneficiaries* from the age of 25 year old, we will provide cover every 3 year for:

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

Prostate cancer screening

Up to the per screening limit and the combined aggregate limit shown per *beneficiary* per *period of cover*.

- *We* will pay for I prostate examination (prostate specific antigen (PSA) test) for male *beneficiaries* aged 50 or over.

Important Note:

Any follow-up test or additional screening required on an outpatient basis following an abnormal result will be covered under the pathology, radiology and diagnostics tests benefit included in the Outpatient option.

Breast cancer screening

Up to the per screening limit and the combined aggregate limit shown per *beneficiary* per *period of cover*.

- *We* will pay for:
  - Aged 35-39: I baseline mammogram for asymptomatic women.
  - Aged 40-49: I mammogram for asymptomatic women every 2 years.
  - Aged 50 or older: I mammogram each year.

Bowel cancer screening

Up to the per screening limit and the combined aggregate limit shown per *beneficiary* per *period of cover*.

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

- I Fecal occult blood test (FOB) or I Fecal Immunochemical Test (FIT) every year
- I Colonoscopy every 7 years.

Skin cancer screening

Up to the per screening limit and the combined aggregate limit shown per *beneficiary* per *period of cover*.

- For female and male beneficiaries from the age of 18 year old, we will provide cover for:
- I skin cancer examination every year.

Lung cancer screening

Up to the per screening limit and the combined aggregate limit shown per *beneficiary* per *period of cover*.

- For female and male beneficiaries from the age of 45 year old who are current or past smokers, we will provide cover for:
- I lung cancer examination every year.

Bone densitometry

Up to the per screening limit and the combined aggregate limit shown per *beneficiary* per *period of cover*.

- *We* will pay for I scan to determine the density of the *beneficiaries* bones when *medically necessary*.

Per screening limit
$225
€165
£150

Combined aggregate limit of $400
€300
£260

Dental Care and Treatment

Optional Module

Maintain *your* oral health with the Dental Care and Treatment option. This option covers *you* for a wide range of preventative, routine and major dental treatments.

YOUR OVERALL LIMIT

Annual overall benefit maximum - per *beneficiary* per *period of cover*.	**$750 €550 £500**

Preventative dental treatment

After the beneficiary has been covered on this option for 3 months.
Up to the annual overall benefit maximum per *beneficiary* per *period of cover*.

Paid in full

- *We* will pay for the following preventative dental treatment recommended by a *dentist* after a *beneficiary* has had Dental Care and Treatment cover for at least 3 months:
  - 2 dental check-ups per *period of cover*;
  - X-rays, including bitewing, single view, and orthopantomogram (OPG);
  - scaling and polishing including topical fluoride *application* when necessary (2 per *period of cover*);
  - I mouth guard per *period of cover*;
  - I night guard per *period of cover*; and
  - fissure sealant.

Routine dental treatment

After the beneficiary has been covered on this option for 3 months.
Up to the annual overall benefit maximum per *beneficiary* per *period of cover*.

80% refund per *period of cover*

- *We* will pay *treatment* costs for the following routine dental treatment after the *beneficiary* has had Dental Care and Treatment 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.
Up to the annual overall benefit maximum per *beneficiary* per *period of cover*.

70% refund per *period of cover*

- *We* will pay *treatment* costs for the following major restorative dental treatments after the *beneficiary* has had Dental Care and Treatment 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 the Dental Care and Treatment option for 12 months, *we* will pay 50% of the *treatment* costs.

Dental exclusions

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

We will not pay for:

- Purely *cosmetic treatments*, or other *treatments* which are not necessary for continued or improved oral health.
- The replacement of any dental appliance which is lost or stolen, or associated *treatment*.
- The replacement of a bridge, crown or denture which (in the reasonable opinion of a *dentist* of ordinary competence and skill in the *beneficiary's country of habitual residence*) is capable of being repaired and made usable.
- The replacement of a bridge, crown or denture within five (5) years of its original fitting unless:
  - it has been damaged beyond repair, whilst in use, as a result of a dental *injury* suffered by the *beneficiary* whilst they are covered under this *policy*;
  - the replacement is necessary because the *beneficiary* requires the extraction of a sound natural tooth/teeth; or
  - the replacement is necessary because of the placement of an original opposing full denture.
- Acrylic or porcelain veneers.
- Crowns or pontics on, or replacing, the upper and lower first, second and third molars unless:
  - they are constructed of either porcelain; bonded-to-metal or metal alone (for example, a gold alloy crown); or
  - a temporary crown or pontic is necessary as part of routine or emergency dental treatment.
- *Treatments*, procedures and materials which are experimental or do not meet generally accepted dental standards.
- *Treatment* for dental implants directly or indirectly related to:
  - failure of the implant to integrate;
  - breakdown of osseointegration;
  - peri-implantitis;
  - replacement of crowns, bridges or dentures; or
  - any accident or *emergency treatment* including for any prosthetic device.
- Advice relating to plaque control, oral hygiene and diet.
- Services and supplies, including but not limited to mouthwash, toothbrush and toothpaste.
- Medical *treatment* carried out in *hospital* by an oral specialist may be covered under *your core cover* and/or Outpatient and Wellness Care option, if this option has been bought, except when dental treatment is the reason for *you* being in *hospital*.
- Bite registration, precision or semi-precision attachments.
- Any *treatment*, procedure, appliance or restoration (except full dentures) if its main purpose is to:
  - change vertical dimensions;
  - diagnose or treat *conditions* or dysfunction of the temporomandibular joint;
  - stabilise periodontally involved teeth; or
  - restore occlusion.

How Deductible And Cost Share Work

Our wide range of deductible and cost share options allow you to tailor your plan to suit your budget. You can choose to have a deductible and/or cost share on your core cover for inpatient and daypatient benefits and/or Outpatient and Wellness Care optional module.

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

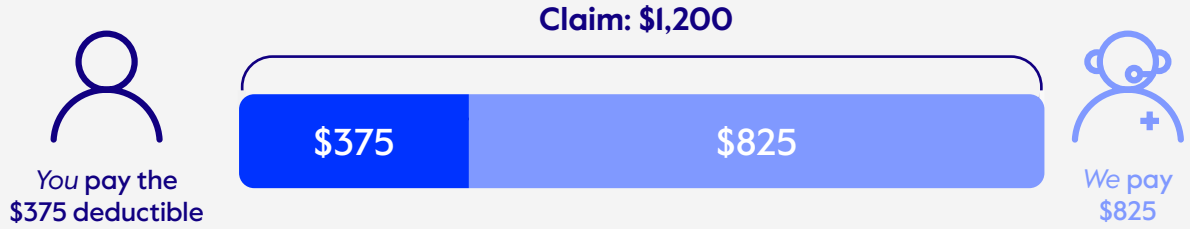
- **Deductible** - this is the amount you must pay towards your cost of treatment until the deductible for the period of cover is reached.
- **Cost Share** - this is the cost share percentage you must pay towards your cost of treatment. This applies once the deductible amount (if selected) has been calculated.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

Example 1:

How the **deductible** works

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

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

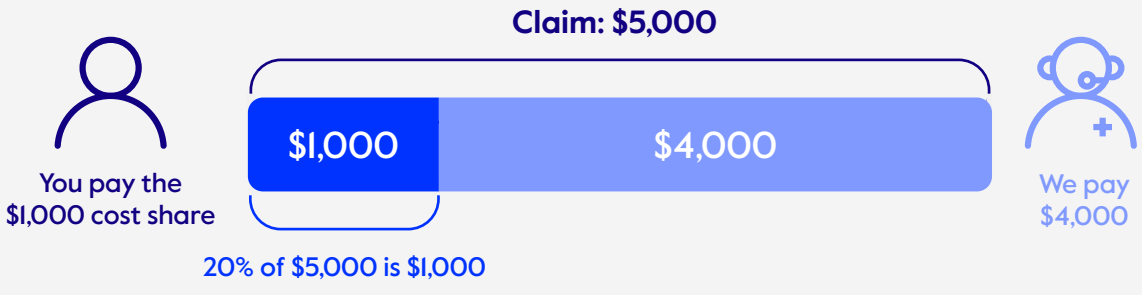


Example 2:

How the **cost share** works

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

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



Example 3:

How the cost share and out of pocket maximum works

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

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

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

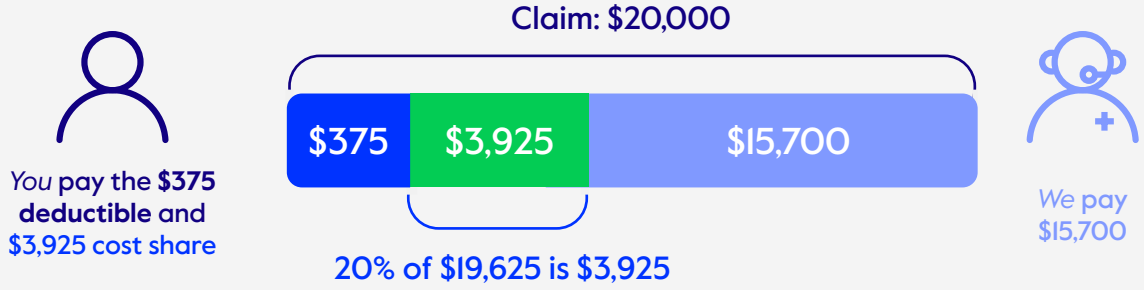
Example 4:

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

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

The deductible is due before the cost share is calculated.

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



Important information

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

Did You Know?

Additional cover not included as standard

Cigna Close Care℠ has two additional optional modules to enhance your health plan:

- Outpatient and Wellness Care
- Dental Care and Treatment

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

Benefits with age restrictions:

Policyholders and any beneficiaries must be 18 years old or older to access any care and treatment within the Wellness Care Benefits within the Outpatient and Wellness Care optional module.

Core benefits included in every policy:

There are some outpatient treatments that are covered under every standard core plan:

- Mental and Behavioural Health Care
- Advanced Medical Imaging
- Kidney Dialysis
- Cancer Care

Any deductible you may have chosen as part of your standard core cover will also apply to the outpatient treatments above.

Additional benefits where deductible is not applied:

Deductibles are not applied to the following benefits as per your policy rules:

- Inpatient Cash Benefit
- Global Telehealth

Deductibles are not applied to the following optional modules and their benefits:

- Wellness Care Benefits as part of Outpatient and Wellness Care*
- Dental Care and Treatment

**Please note, any chosen deductibles as part of Outpatient and Wellness Care module, will apply to all benefits under Outpatient only. They will not apply to any benefits under Wellness Care.*

Frequently Asked Questions

How to speak to a doctor:

Global Telehealth

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

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

How to speak to someone about your policy:

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

How to get access to treatment:

See page 10 to understand how to access treatment. If you have further questions, reach out to the Customer Service team.

How to pay for treatment:

See page 11 to understand if Cigna Healthcare will take care of the medical bill or if you need to seek reimbursement. If you need to submit a claim, please see further information on page 14.

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

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

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

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

See page 36 for how deductible and cost share works.

What happens at the end of my policy year?

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

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

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

Definitions

Annual Renewal Date
the anniversary of the start date.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Medical Practitioners
a doctor, specialist, qualified nurse or therapist (including speech therapies, dietician or orthoptist), dental surgeon or dental pracittioner who is registered, suitably qualified or licensed to practice medicine or provide treatment under the laws of the country, state or other regulated area in which the treatment is provided, and who is not covered under this policy, or a family member of someone covered under this policy.

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

An example of outpatient treatment would be visiting an

outpatient clinic to undergo a mole removal where you are not required to be admitted to hospital and do not require general anaesthetic for the procedure.

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

Policy
the Policy comprising of:

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

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

Selected area of coverage
means your country of habitual residence and your country of nationality. This means you only pay for coverage where you need it most, in the country you will be living and when you return home for temporary visits.

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

Improving the health and vitality of those we serve.

Want To Get In Touch?

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

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

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

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

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

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

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

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

* For certain queries, our Customer Service team may direct you to our in-house team of specialists who are available during working hours (Monday to Friday from 8am to 8pm CET).

For policies arranged through our Dubai International Finance Centre office, under insurance license Cigna Global Insurance Company Limited, the underwriting agent is Cigna Insurance Management Services (DIFC) Limited which is regulated by the Dubai Financial Services Authority.

200593 Close Care Customer Guide 10/2025

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