CIGNA GLOBAL HEALTH OPTIONS

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

Cigna Global Health Options Customer Guide effective from 15th February 2026.

Please be aware that some of the benefits, terms and/or wording within your Customer Guide have been updated and will take effect from your annual renewal date. Not all changes detailed below are applicable to your policy and will depend on the optional modules you may have selected. Please see your Certificate of Insurance for details of your plan coverage.

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

In the event of a discrepancy between the Customer Guide document and this document, the Customer Guide document will prevail. Please note,

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

See below for changes to benefit limits for CGHO Customer Guide 02/2026:

Benefit name	Cigna Global Health Options 2025 (current)	Cigna Global Health Options 2026 (updated)
International Medical Insurance Core Module		
Advanced Medical Imaging	Current Benefit Limit for Gold: $15,000 / €12,000 / £9,650	Increased Benefit Limit for Gold: $30,000/ €22,200/ £19,200
International Outpatient Optional Module		
60+ Care (now 60+ Pre-Existing Condition Care)	Current benefit limits: Gold: $1,000/€740/£665 Platinum: $2,000/€1,480/£1,330	Increased Benefit limits: Gold: $1,500/ €1,100/ £1,000 Platinum: $3,000/ €2,220/ £2,000
NEW: 40-59 Pre Existing Condition Care	-	Benefit limit for Platinum: $2,000/ €1,480/ £1,330
Hearing Aids	Current benefit limits: Gold: $1,000/ €740/ £665 Platinum: $2,000 / €1,480 / £1,330	Increased benefit limits: Gold: $5,000/ €3,700/ £3,325 Platinum: Paid in full
International Health & Wellbeing Optional Module		
Footcare by a Chiropodist or Podiatrist	Current benefit limits for Platinum: $900 / €660 / £600 (up to 15 sessions)	Increased benefit limits for Platinum: Platinum: $2,000/ €1,600/ £1,300 (up to 20 sessions)
International Dental & Vision Optional Module		
Vision Expenses	Current benefit limits: Gold: $155/ €125/ £100	Increase benefit limits: Gold: $200/ €150/ £130

Benefit name & Page number	Current benefits, terms and/ or wording [CGHO Customer Guide 02/2025]	Updated benefits, terms and / or wording [CGHO Customer Guide 02/2026]
INTERNATIONAL MEDICAL INSURANCE		
Understanding Your Health Insurance p.4	Current wording Throughout this document, we've highlighted some key terms in bold. You can find further explanation of these key terms in the Definitions section.	Updated wording At the end of this document, we have explained the meaning of some key terms in the Definitions section.
Getting Treatment p.10	Current wording You are responsible for paying any deductible or cost share directly to the hospital, clinic, medical practitioner or pharmacy at the time of treatment.	Updated wording You are responsible for paying any applicable deductible or cost share to the medical provider once we have settled the invoice. We will let you know the outstanding amount due.
	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.	In the event that we cannot pay a provider directly, you will be responsible for paying any treatment costs to your provider and Cigna Healthcare will reimburse you.
	-	In the event that the medical provider requests you to pay the applicable deductible or cost share at the time of treatment, you must obtain an invoice and receipt for the amount paid to avoid duplicate payment.
How to Submit Claims p.10	Current wording You can download your claims forms from your secure online Customer Area or at www.cignaglobal.com/help/claim.	Updated wording You can download your claims forms from your secure online Customer Area or at https://www.cignaglobal.com/individualsfamilies/members/help/claims-process.
International Medical Insurance p.17	Current benefit wording 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) are included under the International Medical Insurance provide cover for treatment on inpatient, daypatient and outpatient basis.	Updated wording Outpatient means a patient who attends a hospital outpatient department, consulting room, or outpatient clinic for minor treatment but is not admitted as a daypatient or an inpatient and does not occupy a bed. An example of outpatient treatment would be visiting an outpatient clinic to undergo a mole removal where you are not required to be admitted to hospital and do not require general anaesthetic for the procedure. Some benefits (Extensive Cancer care, Advanced Medical Imaging and Mental health care) included under the International Medical Insurance provide cover for treatment on inpatient, daypatient and outpatient basis.

Inpatient Cash Benefit p.18	Current wording 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.	Added wording We will make a cash payment directly to a beneficiary when they: • receive treatment in hospital which is covered under this plan; • stay in a hospital overnight; and • the hospital does not charge any fees for the room, board and treatment costs to either the beneficiary, any Insurance company and/or any applicable local state or governmental authority. • Can provide evidence of treatment, such as a medical report.
Rehabilitation p.20	Current wording We will pay for physical rehabilitation treatments including physiotherapy, occupational, cardiac, pulmonary, cognitive and speech therapies up to the benefit limits and day limit shown above. We will only pay for rehabilitation treatment immediately after surgery and/or a traumatic event. If the rehabilitation treatment is required in a residential rehabilitation centre, we will pay for accommodation and board, subject to medical necessity and in line with reasonable and customary charges for the location in which the treatment is provided. In determining when the per day limit has been reached, we count each overnight stay during which a beneficiary receives inpatient and/or daypatient treatment as one day.	Updated wording We will pay for physical rehabilitation treatments including physiotherapy, occupational, cardiac, pulmonary, cognitive and speech therapies up to the benefit limits and day limit shown above. This benefit does not cover any mental health related treatment, which will instead be covered under the mental and behavioural health care benefit. We will only pay for rehabilitation treatment immediately after surgery and/or a traumatic event. If the rehabilitation treatment is required in a residential rehabilitation centre, we will pay for accommodation and board, subject to medical necessity and in line with reasonable and customary charges for the location in which the treatment is provided. In determining when the per day limit has been reached, we count each overnight stay during which a beneficiary receives inpatient and/or daypatient treatment as one day.
Local ambulance & air ambulance services p.21	Current wording (i) from their home to a hospital. (ii) Cover for medical evacuation or repatriation is only available if you have cover under the International Evacuation & Crisis Assistance Plus® option. Please refer to page 40 of this Customer Guide for details of that option.	Updated wording - (i) from their home to a hospital and from hospital back home upon discharge (ii) Cover for medical evacuation or repatriation is only available if you have cover under International Medical Evacuation. Please refer to page 42 of this Customer Guide for details of that option.
Mental and Behavioural Health Care p.22	Current wording 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. This includes outpatient mental health services for gender dysphoria. • The diagnosis of addictions (including alcoholism).	Updated wording We will pay for: • Evidence-based and medically necessary treatment which is recommended by a medical practitioner. Please see FAQs for more information. • Inpatient, daypatient or outpatient treatment carried out by a psychologist and/or psychiatrist who is licensed as such under the laws of that country. This includes outpatient mental health services for gender dysphoria. • The diagnosis of addictions (including alcoholism).
Cancer Care p.23	Current benefit wording 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. Important notes: • We will only pay for the genetic test if the beneficiary has cover under the Gold or Platinum International Outpatient option.	Updated benefit wording Following a diagnosis of cancer, we will pay for costs for the treatment of cancer if the treatment is considered by us to be active treatment and evidence-based treatment. This includes chemotherapy, radiotherapy, any required surgery (including reconstructive surgery), diagnostic tests and drugs, whether the beneficiary is staying in a hospital overnight or receiving treatment as a daypatient or outpatient. For more information on what we offer as part of our Extensive Cancer benefit, please visit page 29. Important notes:

	• Any outpatient treatments, including prescribed drugs, related to cancer care will be covered under this benefit included in your International Medical Insurance core cover, instead of any outpatient benefit included under the optional International Outpatient module.	• We will only pay for the genetic test if the beneficiary has cover under the International Outpatient option. • Any outpatient treatments, including prescribed drugs, related to cancer care will be covered under this benefit included in your International Medical Insurance core cover, instead of any outpatient benefit included under the optional International Outpatient module.
Congenital Conditions p.23	Current benefit wording Important notes: • We cover the treatment of congenital conditions only under this specific benefit, and not under any other benefits listed, unless it is diagnosed within the first 90 days of a newborn care (see newborn care inpatient benefit) or after the 18th birthday. • If a congenital condition is diagnosed after the beneficiary's 18th birthday, the treatment will be covered under the applicable inpatient and daypatient benefits, instead of this specific benefit.	Updated benefit wording Important notes: • Any treatment for congenital conditions within the first 90 days of a beneficiary's life will be covered under the Newborn Care benefit. Any treatment after these 90 days, so long as a diagnosis has been made prior to the beneficiaries 18th birthday will be covered under this benefit. • If a congenital condition is diagnosed after the beneficiary's 18th birthday, the treatment will be covered under the applicable inpatient and daypatient benefits, instead of this specific benefit.
Routine Maternity Care p.25	Current benefit wording (Gold and Platinum plans only) Up to the total limit shown for your selected plan per beneficiary per period of cover. Available once the mother has been covered by the policy for 12 months or more.* This benefit requires prior authorisation. We will pay for the following treatment, on an inpatient or daypatient basis as appropriate, if the mother has been a beneficiary under this policy for a continuous period of at least 12 months or more*: • hospital, obstetricians' and midwives' fees for routine childbirth; and • any fees as a result of post-natal care required by the mother immediately following routine childbirth. We will not pay for surrogacy or any related treatment. We will not pay for maternity care or treatment for a beneficiary acting as a surrogate, or anyone acting as a surrogate for a beneficiary. Important note: * For treatment incurred in either Hong Kong or Singapore, this benefit is only available once the mother has been a beneficiary under this policy for a continuous period of at least 24 months or more.	Updated benefit wording (Gold and Platinum plans only) Up to the total limit shown for your selected plan per beneficiary per period of cover. Available once the mother has been covered by the policy for 12 months or more.* (24 months or more in Singapore, Hong Kong and the UK) This benefit requires prior authorisation. We will pay for the following treatment, on an inpatient or daypatient basis as appropriate, if the mother has been a beneficiary under this policy for a continuous period of at least 12 months or more*: • hospital, obstetricians' and midwives' fees for routine childbirth; and • any fees as a result of post-natal care required by the mother immediately following routine childbirth. By routine, we mean any birth that can be categorised as low-risk, that does not require specialist medical intervention beyond standard care. We will not pay for surrogacy or any related treatment. We will not pay for maternity care or treatment for a beneficiary acting as a surrogate, or anyone acting as a surrogate for a beneficiary. Important note: * For treatment incurred in either the UK, Hong Kong or Singapore, this benefit is only available once the mother has been a beneficiary under this policy for a continuous period of at least 24 months or more.
Complications from maternity p.25	Current benefit wording (Gold and Platinum plans only) Up to the total limit shown for your selected plan per beneficiary per period of cover. Available once the mother has been covered by the policy for 12 months or more.* This benefit requires prior authorisation. We will pay for inpatient or outpatient treatment relating to complications resulting from pregnancy or childbirth if the mother has been a beneficiary under this policy for a continuous period of at least 12 months or more.* This is limited to conditions which can only arise as a direct result of pregnancy or childbirth, including miscarriage and ectopic pregnancy. • This part of the policy does not provide cover for home births. • We will only pay for a Caesarean section, where it is medically necessary. If we cannot confirm that it was medically necessary, we will only pay up to the limit of the mother's routine maternity benefit care cover.	Updated benefit wording (Gold and Platinum plans only) Up to the total limit shown for your selected plan per beneficiary per period of cover. Available once the mother has been covered by the policy for 12 months or more.* (24 months or more in Singapore, Hong Kong and the UK) This benefit requires prior authorisation. We will pay for inpatient or outpatient treatment relating to complications resulting from childbirth if the mother has been a beneficiary under this policy for a continuous period of at least 12 months or more.* • This part of the policy does not provide cover for home births. • We will only pay for a Caesarean section, where it is medically necessary. If we cannot confirm that it was medically necessary, we will only pay up to the limit of the mother's routine maternity benefit care cover. We will not pay for surrogacy or any related treatment. We will not pay for maternity benefit care or treatment for a beneficiary acting as a surrogate or anyone acting as a surrogate for a beneficiary. Important note:

	We will not pay for surrogacy or any related treatment. We will not pay for maternity benefit care or treatment for a beneficiary acting as a surrogate or anyone acting as a surrogate for a beneficiary. Important note: * For treatment incurred in either Hong Kong or Singapore, this benefit is only available once the mother has been a beneficiary under this policy for a continuous period of at least 24 months or more.	* For treatment incurred in either the UK, Hong Kong or Singapore, this benefit is only available once the mother has been a beneficiary under this policy for a continuous period of at least 24 months or more. Please note: it is not possible to claim under both the routine maternity care and the complications from maternity benefit during the same pregnancy.
Homebirths p.26	Current benefit wording (Gold and Platinum plans only) Up to the total limit shown for your selected plan per beneficiary per period of cover. Available once the mother has been covered by the policy for 12 months or more.* This benefit requires prior authorisation. * For treatment incurred in either Hong Kong or Singapore, this benefit is only available once the mother has been a beneficiary under this policy for a continuous period of at least 24 months or more.	Updated benefit wording (Gold and Platinum plans only) Up to the total limit shown for your selected plan per beneficiary per period of cover. Available once the mother has been covered by the policy for 12 months or more.* (24 months of more in Singapore, Hong Kong and the UK) This benefit requires prior authorisation. * For treatment incurred in either the UK, Hong Kong or Singapore, this benefit is only available once the mother has been a beneficiary under this policy for a continuous period of at least 24 months or more.
Newborn Care p.26	Current benefit wording Up to the total limit shown for your selected plan per period of cover within the first 90 days following birth. Available once either parent has been covered by the policy for 12 months or more.* This benefit requires prior authorisation. In order for any care or treatment to be provided to a newborn, the newborn must first be added to the policy, which will incur an additional premium, alongside the policyholder. Please see below the eligibility criteria for adding a newborn. Once the newborn has been added to the policy, we will pay for • up to 10 days routine care for the baby following birth; and • all inpatient and daypatient treatment required for the baby during the first 90 days after birth instead of any other inpatient or daypatient benefit. Important notes: Adding the newborn to the policy: • If at least one (1) parent has been covered by the policy for a continuous period of twelve (12) months or more* prior to the newborns birth, we will not require information about the newborn's health or a medical examination if an application is received by us to add the newborn to the policy within thirty (30) days of the newborn's date of birth. However, if an application is received by us more than thirty (30) days after the newborn's date of birth, the newborn will be subject to medical underwriting. • If neither parent has been covered by the policy for a period of twelve (12) consecutive months or more* prior to the newborn's birth, the newborn will be subject to medical underwriting, and you can submit an application to add the newborn. If medical underwriting is required for the newborn, we will then tell you whether we will offer cover to the newborn and, if so, any special conditions and exclusions which would apply. Cover will begin no sooner than the date you accept our offered terms. • Children who are born to a surrogate or have been adopted can be covered under this benefit but will be subject to medical underwriting, regardless of the length of cover under this policy by either of the parents. On completion of a medical health questionnaire, we will tell you whether we will offer cover to the newborn and, if so, any special conditions and	Updated benefit wording Up to the total limit shown for your selected plan per period of cover within the first 90 days following birth. This benefit requires prior authorisation. In order for any care or treatment to be provided to a newborn, the newborn must first be added to the policy, which will incur an additional premium, alongside the policyholder. Please note that any treatments incurred prior to the newborn being added to the policy will not be backdated, and that this benefit will be paid from the newborn's policy and no other beneficiaries. Please see below the eligibility criteria for adding a newborn. Once the newborn has been added to the policy, we will pay for • up to 10 days routine care for the baby following birth; and • all inpatient and daypatient treatment required for the baby during the first 90 days after birth under this benefit instead of any other inpatient or daypatient benefit. Important notes: Adding the newborn to the policy: • If at least one (1) parent has been covered by the policy for a continuous period of twelve (12) months or more* prior to the newborns birth, we will not require information about the newborn's health or a medical examination if an application is received by us to add the newborn to the policy within thirty (30) days of the newborn's date of birth. However, if an application is received by us more than thirty (30) days after the newborn's date of birth, the newborn will be subject to medical underwriting. • If neither parent has been covered by the policy for a period of twelve (12) consecutive months or more* prior to the newborn's birth, the newborn will be subject to medical underwriting, and you can submit an application to add the newborn. If medical underwriting is required for the newborn, we will then tell you whether we will offer cover to the newborn and, if so, any special conditions and exclusions which would apply. Cover will begin no sooner than the date you accept our offered terms. • Children who are born to a surrogate or have been adopted can be covered under this benefit but will be subject to medical underwriting, regardless of the length of cover under this policy by either of the parents. On completion of a medical health questionnaire, we will tell you whether we will offer cover to the newborn and, if so, any special conditions and exclusions which

	exclusions which would apply. Cover will begin no sooner than the date you accept our offered terms. Any treatment required for congenital conditions for a newborn will be covered under this benefit for the first 90 days following birth as per the terms of this benefit. If the congenital conditions is diagnosed after the first 90 days of the newborn, any treatment related to the congenital conditions will be covered under the 'Congenital conditions' benefit, as described on page 22, and is subject to the terms of adding the newborn to the policy as detailed above. *For treatment incurred in either Hong Kong or Singapore, this benefit is only available once either parent has been a beneficiary under this policy for a continuous period of at laast 24 months or more.	would apply. Cover will begin no sooner than the date you accept our offered terms. Any treatment required for congenital conditions for a newborn will be covered under this benefit for the first 90 days following birth as per the terms of this benefit. If the congenital conditions is diagnosed after the first 90 days of the newborn, any treatment related to the congenital conditions will be covered under the 'Congenital conditions' benefit, as described on page 22, and is subject to the terms of adding the newborn to the policy as detailed above. *For treatment incurred in either the UK, Hong Kong or Singapore, this benefit is only available once either parent has been a beneficiary under this policy for a continuous period of at laast 24 months or more.
Family building support with Carrot p.27		New wording Carrot provides support and guidance across a wide range of areas: For more information on Carrot, please visit page 28 • Fertility health, • Fertility health, testing and preservation • IVF and assisted reproduction • Adoption and surrogacy • Pregnancy, postpartum and parenting • Menopause and low testosterone • Return-to-work planning • One-to-one expert telehealth chats and group sessions Important notes: Carrot is not available in certain countries. Check the site for current coverage. No waiting period – access begins immediately upon registration. Dependents under 18 are not eligible. Carrot does not provide clinical or medical treatments. It offers support, education, and expert advice only. Carrot's platform is available in 25+ languages and accessible via mobile app or desktop.
	INTERNATIONAL OUTPATIENT OPTIONAL MODULE	
Prescribed Drugs and Dressings p.31	Current wording We will pay for prescribed 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.	Updated wording We will pay for prescribed drugs and dressings which are prescribed by a medical practitioner on an outpatient basis. Please note that if the prescription exceeds three (3) months of supply or the treatment will require more than three (3) months of continuous prescription, prior authorisation will be required. Important note: Medication prescribed by a medical practitioner in the USA and/or delivered by a pharmacy in the USA are subject to our formulary drugs list.
Pre-natal and Post-natal Care p.32	Current wording Up to the total limit shown for your selected plan per beneficiary per period of cover. Available once the mother has been covered by the policy for 12 months or more.* • We will pay for medically necessary pre-natal and post-natal care on an outpatient basis if the mother has been a beneficiary under the International Outpatient option for a continuous period of 12 months or more.* • Examples of pre-natal treatment and tests include: • Routine obstetricians' and midwives' fees; • All scheduled ultrasounds and examinations; • Prescribed medicines, drugs and dressings; • Routine pre-natal blood tests, if required;	Updated wording Up to the total limit shown for your selected plan per beneficiary per period of cover. Available once the mother has been covered by the policy for 12 months or more.* (24 months or more in Singapore, Hong Kong and the UK) • We will pay for medically necessary pre-natal and post-natal care on an outpatient basis if the mother has been a beneficiary under the International Outpatient option for a continuous period of 12 months or more.* • Examples of pre-natal treatment and tests include: • Routine obstetricians' and midwives' fees; • All scheduled ultrasounds and examinations; • Prescribed medicines, drugs and dressings; • Routine pre-natal blood tests, if required;

	• Amniocentesis procedure (also referred to as amniotic fluid test or AFT) or chorionic villous sampling (also referred to as CVS); and • Non-invasive pre-natal testing (NIPT) for high risk individuals. Post-natal care: • Any fees, including prescribed drugs and dressings, as a result of post-natal care required by the mother immediately following routine childbirth. Important note: * For beneficiaries whose country of habitual residence is either Hong Kong or Singapore, this benefit is only available once the mother has been a beneficiary under this policy for a continuous period of at least 24 months or more.	• Amniocentesis procedure (also referred to as amniotic fluid test or AFT) or chorionic villous sampling (also referred to as CVS); and • Non-invasive pre-natal testing (NIPT) for high risk individuals. Post-natal care: • Any fees, including prescribed drugs and dressings, as a result of post-natal care required by the mother immediately following routine childbirth. Important note: * For treatment incurred in either Hong Kong, Singapore, or the UK, this benefit is only available once the mother has been a beneficiary under this policy for a continuous period of at least 24 months or more.
Sleep Apnoea p.33	Current benefit limit Silver - $1,000, €740, £665	New benefit limit Removed – printing error in previous version Silver – No coverage
60+ Care (now 60+ Pre-Existing Condition Care) p.35	Current wording Silver - $500 €370 £335 Gold - $1,000 €740 £665 Platinum - $2,000 €1,480 £1,330 If a beneficiary is aged 60 years old and above, or turning 60 years old within the period of cover, and has one of the following conditions as declared on their medical questionnaire (and is a special exclusion as detailed on your Certificate of Insurance), we will pay for the medically necessary outpatient treatment costs associated with the maintenance of this condition: Hypertension, Type 2 Diabetes, Glaucoma, Arthritis, joint or back pain, Osteoporosis/Osteopenia.	Updated wording Silver - $500 €370 £335 Gold - $1,500 €1,100 £1,000 Platinum - $3,000 €2,220 £2,000 If a beneficiary is aged 60 years old and above, or turning 60 years old within the period of cover, and has one of the following conditions as declared on their medical questionnaire (and is a special exclusion as detailed on your Certificate of Insurance), we will pay for the medically necessary outpatient treatment costs associated with the maintenance of this condition: Hypertension, Type 2 Diabetes, Glaucoma, Arthritis, joint or back pain, Osteoporosis/Osteopenia, migraine, high cholesterol, asthma, allergies, atherosclerosis/arteriosclerosis, coronary artery disease
40-59 Pre-Existing Condition Care p.35	-	New wording Platinum - $2,000 €1,480 £1,330 If a Platinum beneficiary is aged 40-59 years old and above, and has one of the following conditions as declared on their medical questionnaire (and is a special exclusion as detailed on your Certificate of Insurance), we will pay for the medically necessary outpatient treatment costs associated with the maintenance of this condition: Hypertension, Type 2 Diabetes, Glaucoma, Arthritis, joint or back pain, Osteoporosis/Osteopenia. Important notes: • If, during the application stage you have selected the option to have one of the above conditions covered at an additional premium, whereby the condition is covered comprehensively on an inpatient and outpatient basis (if the International Outpatient option has been selected); this benefit will not be applicable. • Examples of medically necessary treatment and tests include but are not limited to: consultations with medical practitioners, prescribed drugs and dressings, pathology and radiology, outpatient rehabilitation and acupuncture and Chinese medicine. Please note, this benefit excludes Advanced Medical Imaging. • You are eligible to have the condition(s) covered (but not conditions, symptoms or complications arising from those conditions) on an outpatient basis, up to the total limits shown per period of cover. • The benefit is subject to any cost shares or deductibles elected on your policy.
INTERNATIONAL HEALTH AND WELLBEING		
International Health & Wellbeing introductory text p.37	Current wording 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.	Updated wording 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. Important Note:

		Any follow-up test or additional screening required on an outpatient basis following an abnormal result will be covered under the pathology, radiology and diagnostics tests benefit included in the International Outpatient option. You must have purchased the International Outpatient option in order to have these additional diagnostic tests covered.
Cervical Cancer Screening p.38	Current wording 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.	Updated wording For female beneficiaries from the age of 25 year old, we will provide cover every year for: • I Papanicolaou test (pap smear) and • I HPV DNA test.
Prostate Cancer Screening p.38	Current wording Important Note: Any follow-up test or additional screening required on an outpatient basis following an abnormal result will be covered under the pathology, radiology and diagnostics tests benefit included in the International Outpatient option. You must have purchased the International Outpatient option in order to have these additional diagnostic tests covered.	Updated wording This has been moved to the introductory text and removed from this specific benefit, as statement applies to all benefits.
Breast Cancer Screening p.38	Current wording For female beneficiaries from the age of 40 year old, we will provide cover for: • I breast awareness consultation and Clinical Breast Exam (CBE) every year; • I screening mammogram every 2 year. For female beneficiaries between the age of 25 and 39 year old if they have a prior history or an increased risk of breast cancer, we will provide cover for: • I screening mammogram every year, when medically necessary.	Updated wording For female beneficiaries from the age of 40 year old, we will provide cover for: • I breast awareness consultation and Clinical Breast Exam (CBE) every year; • I screening mammogram every year. For female beneficiaries between the age of 25- and 39-year-old if they have a prior history or an increased risk of breast cancer, we will provide cover for: • I screening mammogram every year, when medically necessary.
Bowel Cancer Screening p.38	Current wording 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.	Updated wording 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 5 years.
INTERNATIONAL MEDICAL EVACUATION		
International Evacuation & Crisis Assistance Plus (now International Medical Evacuation) – introductory text p.42	Current wording International Evacuation & Crisis Assistance Plus® Optional Module International Medical Evacuation provides coverage for reasonable transportation costs to the nearest centre of medical excellence in the event that the treatment is not available locally in an emergency. This option also includes medical repatriation coverage as a result of a serious illness or after a traumatic event or surgery, and compassionate visits for a parent, spouse, partner, sibling or child to visit a beneficiary after an accident or sudden illness and the beneficiary has not been evacuated or repatriated.	Updated Wording International Medical Evacuation Optional Module International Medical Evacuation provides coverage for reasonable transportation costs to the nearest centre of medical excellence in the event that the treatment is not available locally in an emergency. This option also includes medical repatriation coverage as a result of a serious illness or after a traumatic event or surgery, and compassionate visits for a parent, spouse, partner, sibling or child to visit a beneficiary after an accident or sudden illness and the beneficiary has not been evacuated or repatriated.

	Peace of mind for you and your family, particularly while travelling globally, is very important to us. As well as providing coverage for medical evacuation events, this option also includes the Crisis Assistance Plus® programme providing 24/7 time-sensitive advice and coordinated in-country crisis response services in the event of a travel or security risk that may occur while you and your family are travelling globally.	
Crisis Assistance Plus Programme		Page has been removed – service no longer offered.
DEDUCTIBLE AND COST SHARE		
Deductible and Cost Share – Important Information p.49	Current wording 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.	Updated wording Important information • You are responsible for paying the amount of any deductible and cost share due to the hospital, clinic, medical practitioner or pharmacy. We will let you know the outstanding charges that you need to pay once we have processed the invoice from the medical provider. • The deductible, cost share, and out of pocket maximum is determined separately for each beneficiary and each period of cover. • If you select both a deductible and a cost share, the amount you will need to pay due to the deductible is calculated before the amount you will need to pay due to the cost share. • You can request a change to the deductible and/or cost share and out of pocket maximum with effect from your annual renewal date each year. If you wish to remove or reduce your deductible, cost share or reduce your out of pocket maximum on your coverage, we may require you to provide us with more detailed medical information (including medical information of any beneficiaries if relevant) and we may apply new special restrictions or exclusions based on the information you provide us with. • You can remind yourself of any deductible or cost shares you may have selected by checking your Certificate of Insurance which is available in your secure online Customer Area.
FURTHER INFORMATION		
Frequently Asked Questions p.52		New wording What treatment isn't covered under the mental and behavioural health care benefit? We will not cover treatment considered situational or lifestyle-based (for example, family or marital counselling) under this benefit. However, if a life event results in a clinically diagnosable condition, the recommended medically necessary treatment will be covered under this benefit. Note: Non-medically necessary counselling sessions for individual and group settings are available through our Life Management Assistance Programme within the optional Health and Wellbeing module.
Definitions p.53	Current wording 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.	Updated wording Medical Assistance Service a service which provides medical advice, evacuation, assistance and repatriation in accordance with International Clinical Guidelines. This service, provided by our partner International SOS, can be multilingual and assistance is available twenty four (24) hours per day.

	Current wording Selected area of coverage means either: • Worldwide, including USA (every country throughout the world, excluding any country with whom, at the date of commencement of treatment, the Federal Government of the USA has prohibited trade to the extent that payments are illegal under applicable law.); or • Worldwide, excluding USA (worldwide, with the exception of the USA) .	Updated wording Selected area of coverage means either: • Worldwide, including USA (every country throughout the world, excluding any country with whom, at the date of commencement of treatment, the Federal Government of the USA has prohibited trade to the extent that payments are illegal under applicable law.); or • Worldwide, excluding USA (worldwide, with the exception of the USA) Please note: For all US Territories, namely Puerto Rico, American Samoa, Guam, the Commonwealth of the Northern Mariana Islands and the US Virgin Islands, customers will be required to have US cover on their policy in order to utilise their coverage in these regions. However, there will be no penalty applied for 'out of network' provider use, as this is exclusive to the USA.
	-	New wording Pre-existing condition - any disease, illness or injury, or symptoms present before the initial start date of your policy for which: > medical advice or treatment has been sought or received; or > the beneficiary knew about and did not seek medical advice or treatment.