Global Health Options

CIGNA CLOSE CARE℠

Individual Plan

Together, all the way.℠

A HEALTH INSURANCE PLAN SPECIFICALLY DESIGNED WITH YOU IN MIND

CIGNA - THERE FOR YOU WHEN YOU NEED US MOST

At Cigna, we are always thinking about the needs of our customers. The Cigna Close Care[SM] plan has been specifically designed to meet the needs of individuals who want the reassurance of a trusted global health insurer but don't require global coverage.

If you are planning on relocating to a new country and only need your health care covered in that country, as well as temporary trips home to visit family and friends – this is the plan for you.

Perhaps you are a student embarking on a new adventure away from home, or looking to enjoy your retirement in a new country, or; you are embarking on an expatriate work assignment. Rest assured, Cigna will cover you comprehensively when you need us most. What's more, you have the added comfort of our Out of Area Emergency care benefit which covers you for any unexpected medical needs when you are on a short trip outside your area of coverage.

You will also have access to our Global Health Assist Service. This is provided by our Clinical Team who offer you expert help and information through your treatment journey and time with Cigna, ensuring you have clinical guidance and support every step of the way.

CONTENTS

Why choose the Cigna Close Care[SM] plan	4
Why we are your best choice	5
Our Global Health Assist Service	6
Your Cigna Close Care[SM] plan explained	7
How to create your plan	8
How deductible, cost share and out of pocket maximum work	9
Your benefits explained	11
Secure Online Customer Area	23
What you can expect from us	24
We're waiting to hear from you	25

WHY CHOOSE THE CIGNA CLOSE CARE℠ PLAN

Our mission

Our passion and our mission is to help the people we serve to improve their health, wellbeing, and sense of security.

Why choose the Cigna Close Care℠ plan:

- You are looking for health insurance, but do not need worldwide coverage
- You only require coverage in your country of residence and when you return home for visits
- The quality of your local country's healthcare system does not meet your standards or needs
- You want access to our network of trusted hospitals, physicians and other healthcare professionals, allowing you to visit any hospital, medical practitioner or clinic of your choice in many countries
- You would like the flexibility to tailor a cost-effective plan to suit your individual needs
- Our Customer Care Team is always available to speak with you day and night, 24/7 with multi-language capabilities
- Our Global Health Assist Service which is provided by our expert Clinical team, will offer advice, help and guidance throughout your treatment journey and time with Cigna.

WHY WE ARE YOUR BEST CHOICE

Cigna's experience

We've provided global health insurance for many years. Today we have over 95 million customer relationships in over 200 countries and jurisdictions. Looking after them is an international workforce of 37,000 people, plus a medical network comprising of over 1 million partnerships, including 180,700 behavioral health care professionals, and 13,900 facilities and clinics.

Put your health in the right hands

Decision on your application within 24 hours

Flexibility to tailor a plan to suit your needs

Direct billing with a provider in many cases

Access to a hospital, medical practitioner or clinic of your choice (excluding the USA)

Secure online Customer Area where all of your Policy documents will be stored in a central location

CIGNA IS A GREAT OPTION FOR EXPATS AND STUDENTS ABROAD. THERE'S NOTHING BETTER THAN THE PEACE MIND WHICH COMES FROM KNOWING YOU'RE COVERED FOR EMERGENCIES AND WHEN YOU VISIT BACK HOME.

Customer Satisfaction Survey, May 2017.

OUR GLOBAL HEALTH ASSIST SERVICE

With the Cigna Close Care℠ plan, you will have access to our dedicated team of doctors and nurses who will work hand in hand with you to provide you with the full medical support you deserve. We are dedicated to helping you live a happier, healthier life with our expert level of clinical expertise. Through this service, our Clinical team will offer you:

> Medical network/ preferred provider information
> Help with arranging your hospital visits and navigating the healthcare system
> Detailed coverage information of your Cigna Close Care℠ plan
> Personalised support and Case Management throughout your time with Cigna

GUARANTEE OF PAYMENT

Our Clinical Team can make your treatment journey even easier by issuing a guarantee of payment prior to receiving treatment. This means that we will agree in advance to pay some or all of the cost of a particular treatment which you are due to receive. Where we have approved a guarantee of payment, we will pay the beneficiary, medical practitioner or clinic the agreed amount on receipt of an appropriate request and a copy of the relevant invoice after the treatment has been provided. This provides you with added security enabling you to gain easier access to treatment.

COMPLEX CASE MANAGEMENT

As you go through treatment, you can find confidence in the fact that if you require treatment which is more complex, our nurses can take over management of the case and provide you with clinical guidance and reassurance through our complex case management. In addition, you will have a dedicated nurse as your main point of contact throughout your entire treatment, allowing you to concentrate on getting better as we liaise directly with the hospitals, medical practitioners and providers for you.

CHRONIC CONDITION SUPPORT

What's more, our Global Health Assist Service works with a proactive and personalised approach to manage chronic health conditions. Our qualified nurses from the Clinical team will immediately contact customers suffering from pre-existing conditions or serious illnesses and confirm a personalised and dedicated point of contact for the customer. Even if you have a pre-existing condition which was evident prior to taking out your Cigna Close Care℠ plan which is excluded from your policy, we can still offer you guidance, support and information to help you control your condition and maintain a healthy lifestyle.

YOUR CIGNA CLOSE CARE℠ PLAN EXPLAINED

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 in and when you return home for temporary visits.

Out of Area Emergency cover

For additional peace of mind, when you are visiting a location outwith your area of coverage, the Cigna Close Care℠ plan includes emergency medical coverage. This is covered on an inpatient or daypatient basis, or outpatient basis (if the Outpatient and Wellness Care option has been purchased under the policy) during temporary trips, even if those trips are outside the area of coverage. Coverage is limited to a maximum period of twenty one (21) days per trip and a maximum of forty five (45) days per period of cover for all trips combined.

Condition limit

Following the diagnosis of a medical condition, your Cigna Close Care℠ plan has a condition limit of $250,000/€200,000/£165,000 per beneficiary per policy year. This includes all claims paid in relation to the medical condition. For the avoidance of doubt, this excludes any pre-existing condtions. For full details please refer to the list of benefits on page 11.

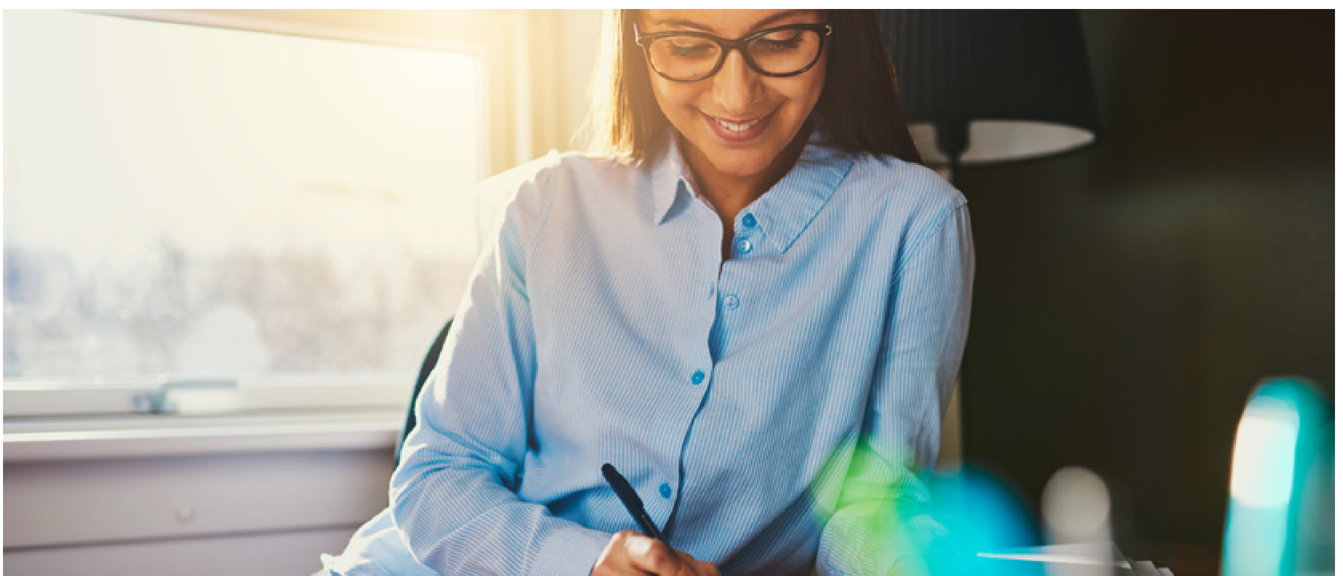
How to create your plan

Creating a comprehensive, tailored plan with Cigna is simple. Your Core cover will cover you comprehensively for inpatient and daypatient treatment.

In addition, you can select optional benefits, including Outpatient and Wellness Care and Dental Care and Treatment. This enables you the flexibility to create a health insurance plan that suits your unique needs.

As well as this, we offer a wide range of cost shares and deductible options on your Core cover and Outpatient and Wellness Care option, allowing you to tailor a plan to suit your budget.

The diagram on the next page shows you how the Cigna Close Care℠ plan works.



HOW TO CREATE YOUR PLAN

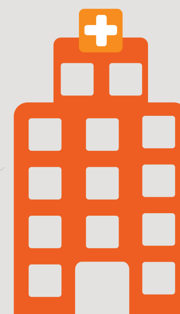
1 YOUR CORE COVER

Our core plan covers you for essential hospital stays and treatments, including but not limited to:

- > Surgeon & consultation fees
- > Hospital accommodation
- > Cancer treatment

Your area of cover:

> Your country of habitual residence and country of nationality



Annual benefits

Up to the maximum amount per beneficiary per period of cover

$500,000 / €400,000 / £325,000

2 ADD OPTIONAL MODULES

Outpatient and Wellness Care

Outpatient and Wellness Care covers you more comprehensively for outpatient care and medical emergencies that may arise where a hospital admission as a daypatient or inpatient is not required. As well as this, this option will cover you for consultations with specialists and medical practitioners, prescribed drugs and dressings, physiotherapy and osteopathic and chiropractic treatments. You will also be covered for pre-cancer screenings, and adult physical exams.

Dental Care and Treatment

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.

3 MANAGE YOUR PREMIUM

Choose if you would like to add a deductible or cost share*.

Please see page 9 for a full description and example of how the deductible and cost share work.

*the voluntary amount you have chosen to pay that's not covered by your plan.

4 PAY FOR YOUR PLAN

You can choose to pay for your premiums on a monthly, quarterly, or annual basis. You can make payments by debit or credit card, or alternatively if you pay annually, you can pay by bank wire transfer.

HOW THE DEDUCTIBLE, COST SHARE AND OUT OF POCKET MAXIMUM WORK

Our wide range of deductible and cost share options allow you to tailor your plan to suit your needs.

You can choose to have a deductible and/or cost share on the Core cover and/or Outpatient and Wellness Care option.

You will be responsible for paying the amount of any deductible and cost share directly to the hospital, clinic or medical practitioner. We will let you know what this amount is. If you select both a deductible and a cost share, the amount you will need to pay due to the deductible is calculated before the amount you will need to pay due to the cost share. The out of pocket maximum is the maximum amount of cost share any beneficiary must pay per period of cover.

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

EXAMPLE 1: DEDUCTIBLE

(also known as 'excess')

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

Claim value:	**$1,200**
Deductible:	**$500**

YOU PAY..
Deductible of $500

WE PAY...
$700

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

EXAMPLE 2: COST SHARE AND OUT OF POCKET MAXIMUM AFTER DEDUCTIBLE

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

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

Claim value:	**$5,000**
Deductible:	**$0**
20% cost share:	**$1,000**
Out of pocket maximum:	**$2,000**

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

WE PAY...
$4,000

WHAT THIS MEANS FOR YOU...
Your cost share is 20% of $5,000 ($1,000). This is less than your out of pocket maximum, so you pay $1,000 and we cover the rest.

Please note:
The deductible, cost share after deductible, and out of pocket maximum is determined separately for each beneficiary and each period of cover.

EXAMPLE 3: COST SHARE AND OUT OF POCKET MAXIMUM AFTER DEDUCTIBLE

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

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

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

YOU PAY..

The out of pocket maximum of

$2,000

WE PAY...

$18,000

WHAT THIS MEANS FOR YOU...

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

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

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

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

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

YOU PAY..

The deductible of **$375** and the cost share of

$3,925

WE PAY...

$15,700

WHAT THIS MEANS FOR YOU...

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

Please note:

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

YOUR CORE COVER

The Core cover is your essential cover 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).

LIST OF BENEFITS
INPATIENT AND DAYPATIENT BENEFITS

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

Benefit	Limit
Annual 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**

Benefit	Limit
Condition limit Up to the maximum amount 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.

Benefit	Limit
Out of area emergency cover Up to the maximum amount per period of cover.	**$40,000** **€29,600** **£26,600**

- Emergency inpatient, daypatient and outpatient medical treatment during temporary trips outside your country of habitual residence or country of nationality.
- This is limited to 21 days per trip and a maximum of 45 days per policy year.
- Emergency outpatient treatment is included 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 10.6 for terms relating to this overall benefit limit.

Hospital charges for:

Nursing and accommodation for inpatient and daypatient treatment and recovery room.

Paid in full for a semi-private room

- We will pay for nursing care and accommodation whilst a beneficiary is receiving inpatient or daypatient treatment; or the cost of a treatment room while a beneficiary is undergoing outpatient surgery, if one is required.
- We will only pay these costs if:
  - it is medically necessary for the beneficiary to be treated on an inpatient or daypatient basis;
  - they stay in hospital for a medically appropriate period of time;
  - the treatment which they receive is provided or managed by a specialist; and
  - they stay in a semi-private room with shared bathroom.
- If a hospital's fees vary depending on the type of room which the beneficiary stays in, then the maximum amount which we will pay is the amount which would have been charged if the beneficiary had stayed in a standard semi-private room with shared bathroom or equivalent.
- If the treating medical practitioner decides that the beneficiary needs to stay in hospital for a longer period than we have approved in advance, or decides that the treatment which the beneficiary needs is different to that which we have approved in advance, then that medical practitioner must provide us with a report, explaining: how long the beneficiary will need to stay in hospital; the diagnosis (if this has changed); and the treatment which the beneficiary has received, and needs to receive.

Hospital charges for:

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

Paid in full

Operating theatre costs:

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

Medicines, drugs and dressings:

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

Intensive care:

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

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

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

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.

Kidney Dialysis

$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.

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

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.

Advanced Medical Imaging (MRI, CT and PET scans)

Up to the maximum amount shown per period of cover.

$2,500
€1,850
£1,650

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

Physiotherapy and complementary therapies

Up to the maximum amount shown per period of cover.

$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, homeopaths, and practitioners of Chinese medicine) if these therapies are recommended by a specialist as part of the beneficiary's hospital stay for inpatient or daypatient treatment (but is not the primary treatment which they are in hospital to receive).

Rehabilitation

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

$2,000
€1,480
£1,330

- We will pay for rehabilitation treatments (physical, occupational and speech therapies), which are recommended by a specialist and are medically necessary after a traumatic event such as a stroke or spinal injury.
- If the rehabilitation treatment is required in a residential rehabilitation centre we will pay for accommodation and board for up to 30 days for each separate condition that requires rehabilitation treatment.

  In determining when the 30 days limit has been reached:

  - we count each overnight stay during which a beneficiary receives inpatient treatment as 1 day; and
  - we count each day on which a beneficiary receives outpatient and daypatient treatment as 1 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 pay for rehabilitation treatment if it is needed after, or as a result of, treatment which is covered by this policy and it begins within 30 days of the end of that original treatment.
- All rehabilitation treatment must be approved by us in advance. We will only approve rehabilitation treatment if the treating specialist provides us with a report, explaining:

  i) how long the beneficiary will need to stay in hospital;

  ii) the diagnosis; and

  iii) the treatment which the beneficiary has received, or needs to receive.

Hospice and palliative care

Up to the maximum amount shown per lifetime.

$2,500
€1,850
£1,650

- If a beneficiary is given a terminal diagnosis, and there is no available treatment which will be effective in aiding recovery, we will pay for hospital or hospice care and accommodation, nursing care, prescribed medicines, and physical and psychological care.

Internal prosthetic devices/surgical and medical appliances

Up to the maximum amount shown per period of cover.

Paid in full

- We will pay for internal prosthetic implants, devices or appliances which are put in place during surgery as part of a beneficiary's treatment.
- A surgical appliance or a medical appliance can mean:
  - an artificial limb, prosthesis or device which is required for the purpose of or in connection with surgery;
  - an artificial device or prosthesis which is a necessary part of the treatment immediately following surgery for as long as required by medical necessity; or
  - a prosthesis or appliance which is medically necessary and is part of the recuperation process on a short-term basis.

External prosthetic devices/surgical and medical appliances

Up to the maximum amount shown per period of cover.

$2,500
€1,850
£1,650

- We will pay for external prosthetics, devices or appliances which are necessary as part of a beneficiary's treatment (subject to the limitations explained below).
- We will pay for:
  - a prosthetic device or appliance which is a necessary part of the treatment immediately following surgery for as long as is required by medical necessity; 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. We do not pay for any replacement prosthetic devices for beneficiaries who are aged 18 and over.
- We will pay for an initial external prosthetic device and up to 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

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 treatment which a beneficiary needs to receive in hospital. Where it is medically necessary.
- This policy does not provide cover for mountain rescue services.
- Cover for a medical evacuation or repatriation is not available.

Emergency inpatient dental treatment

$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.

Treatment for mental health conditions and disorders

Up to the maximum amount shown per period of cover.

$3,000
€2,200
£2,000

- Subject to the limits explained below we will pay for the treatment of mental health conditions and disorders on an inpatient, daypatient or outpatient basis.

Important notes

- We will not pay for the treatment and diagnosis of addictions (including alcoholism) or any facilities specialised in addictions treatments.
- For treatment of mental health conditions and disorders, we will only pay for evidence-based, medically necessary treatment and which is recommended by a medical practitioner.
- We will pay for up to a combined maximum total of 60 days of treatment for mental health conditions and disorders in any 1 period of cover, including a maximum of 30 days of inpatient treatment.
- We will pay for up to a combined maximum total of 90 days of treatment for mental health conditions and disorders in any 5 year period of cover. For example, if a beneficiary uses 30 days of mental health treatment in 1 period of cover and 60 days of mental health treatment in the following period of cover, we will not pay for any further mental health treatment for the next 3 consecutive years of cover.
- In determining when these 30, and 90 day limits have been reached:
  - we count each overnight stay during which a beneficiary received inpatient treatment as 1 day; and
  - we count each day on which a beneficiary received outpatient and daypatient treatment as 1 day.
- We will not pay for prescription drugs or medication prescribed on an outpatient basis for any of these conditions, unless you have purchased the Outpatient and Wellness Care option.

Cancer care

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.

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

THE FOLLOWING PAGES DETAIL THE OPTIONAL BENEFITS AVAILABLE TO ADD TO YOUR **CORE COVER**.

YOU CAN CHOOSE TO ADD ANY OF THE OPTIONAL BENEFITS AS YOU WISH, TO BUILD A PLAN THAT SUITS YOUR NEEDS.

OUTPATIENT AND WELLNESS CARE

Outpatient and Wellness Care covers you more comprehensively for outpatient care and medical emergencies that may arise where a hospital admission as a daypatient or inpatient is not required. As well as this, this benefit will cover you for consultations with specialists and medical practitioners, prescribed drugs and dressings, physiotherapy and osteopathic and chiropractic treatments. You will also be covered for pre-cancer screenings, and routine adult physical exams.

YOUR OVERALL LIMIT

Benefit	Limit
Annual 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**

YOUR STANDARD MEDICAL BENEFITS

Benefit	Limit
Consultations with medical practitioners and specialists Up to the maximum amount shown per period of cover.	**$100/€75/£65 per visit. Up to 8 visits per year.**

- We will pay for consultations or meetings with a medical practitioner which are necessary to diagnose an illness, or to arrange or receive treatment up to the maximum number of visits shown in the benefit table.
- We will pay for non-surgical treatment on an outpatient basis, which is recommended by a specialist as being medically necessary.

Benefit	Limit
Pathology, radiology and diagnostic tests (excluding Advanced Medical Imaging) Up to the maximum amount shown 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).

Benefit	Limit
Physiotherapy Up to the maximum amount shown per period of cover.	**$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 license to practice in the country where the treatment is received. This excludes any sports medicine treatment.
- We will require a medical report and treatment plan prior to approval.

Osteopathy and chiropractic treatment

Up to the maximum amount shown per period of cover.

$100/€75/£65 per visit. Up to 8 visits per year.

- We will pay up to a combined maximum total of 8 visits in any 1 period of cover for osteopathy and chiropractic treatment which is evidence-based treatment, medically necessary and recommended by a treating specialist, if a medical practitioner recommends the treatment and provides a referral. The treatment must be carried out by a properly qualified practitioner who holds the appropriate license to practice in the country where the treatment is received. This excludes any sports medicine treatment.
- We will require a medical report and treatment plan prior to approval.

Acupuncture, Homeopathy and Chinese medicine

Up to a combined maximum of 15 visits per period of cover.

$100/€75/£65 per visit. Up to 15 visits per year.

- We will pay for a combined maximum total of 15 consultations with acupuncturist, homeopaths and practitioners of Chinese medicine for each beneficiary in any 1 period of cover, if those treatments are recommended by a medical practitioner. The treatment must be carried out by a properly qualified practitioner who holds the appropriate license to practice in the country where the treatment is received.
- We will require a medical report and treatment plan prior to approval.

Prescribed drugs and dressings

Up to the maximum amount shown 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.

Rental of durable equipment

Up to the maximum of 45 days 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 the rental of durable medical equipment which:
  - is not disposable, and is capable of being used more than once;
  - serves a medical purpose;
  - is fit for use in the home; and
  - is of a type only normally used by a person who is suffering from the effect of a disease, illness or injury.

Adult vaccinations

Up to the maximum amount shown per period of cover.

$250
€185
£165

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

Dental accidents

Up to the maximum amount shown per period of cover.

$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.

Well child tests

$1,000
€740
£665

- Payable for children at appropriate age intervals up to the age of 6.
- We will pay for well child routine tests at any of the appropriate age intervals (birth, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 2 years, 3 years, 4 years, 5 years and 6 years) and for a medical practitioner to provide preventative care consisting of:
  - evaluating medical history;
  - physical examinations;
  - development assessment;
  - anticipatory guidance; and
  - appropriate immunisations and laboratory tests; for children aged 6 or younger.

  We will pay for 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.
- In addition, we will pay for:
  - 1 school entry health check, to assess growth, hearing and vision, for each child aged 6 or younger; and
  - diabetic retinopathy screening for children over the age of 12 who have diabetes.

Child immunisations

$1,000
€740
£665

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

Annual eye and hearing test for children aged 15 and younger

Paid in full

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

Benefit	Limit
Routine adult physical examination Up to the maximum amount shown per period of cover. › We will pay for 1 routine adult physical examination (including but not limited to: height, weight, bloods, urinalysis, blood pressure, lung function etc.) for persons aged 18 or older.	**$100 €75 £65**

Benefit	Limit
Pap smear Up to the combined maximum amount shown per period of cover. › We will pay for 1 papanicolaou test (pap smear) for female beneficiaries.	**Combined aggregate limit of $400 €300 £260**
Prostate cancer screening Up to the combined maximum amount shown per period of cover. › We will pay for 1 prostate examination (prostate specific antigen (PSA) test) for male beneficiaries aged 50 or over.	
Mammograms for breast cancer screening Up to the combined maximum amount shown per period of cover. › We will pay for: • Aged 35-39: 1 baseline mammogram for asymptomatic women. • Aged 40-49: 1 mammogram for asymptomatic women every 2 years. • Aged 50 or older: 1 mammogram each year.	
Bowel cancer screening Up to the combined maximum amount shown per period of cover. › We will pay for 1 bowel cancer screening for beneficiaries aged 55 or older.	
Bone densitometry Up to the combined maximum amount shown per period of cover. › We will pay for 1 scan to determine the density of the beneficiaries bones.	

Item	Options
Deductible (various) A deductible is the amount which you must pay before any claims are covered by your plan.	$0 / $150 / $500 / $1,000 / $1,500 €0 / €110 / €370 / €700 / €1,100 £0 / £100 / £335 / £600 / £1,000
Cost share after deductible and out of pocket maximum Cost share is the percentage of each claim not covered by your plan. The out of pocket maximum is the maximum amount of cost share you would have to pay in a period of cover. The cost share amount is calculated after the deductible is taken into account. Only amounts you pay related to cost share contribute to the out of pocket maximum.	First, choose your cost share percentage: 0% / 10% / 20% / 30% Next, choose your out of pocket maximum: $3,000 €2,200 £2,000

DENTAL CARE AND TREATMENT

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

YOUR STANDARD DENTAL BENEFITS

Preventative dental treatment

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

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 or thopantomogram (OPG);
- scaling and polishing including topical fluoride application when necessary (2 per period of cover);
- 1 mouth guard per period of cover;
- 1 night guard per period of cover; and
- fissure sealant.

Routine dental treatment

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

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.

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.

SECURE ONLINE CUSTOMER AREA

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

- View your policy documentation, including your Certificate of Insurance and Cigna ID cards for all the beneficiaries covered under your plan
- Check the policy rules that apply to your policy
- Check your coverage for you and your beneficiaries
- Submit claims online
- Search for healthcare facilities and professionals near your location
- View our quarterly customer magazine

WHAT YOU CAN EXPECT FROM US

In addition to your Cigna Close Care℠ plan, there are a few more things you might like to know about us and the service you can expect as a customer of Cigna.

Comprehensive welcome pack

Once you have joined Cigna, we will send your policy documents electronically within twenty four (24) hours. Your policy documents are all available in your secure online Customer Area.

Please read through all your policy documents when you receive them and make sure you check the details of your policy on the certificate of insurance. You will need to show your Cigna ID card when you require treatment so your doctor knows who you are (it's not used for payment). It also has all the contact numbers you'll need. You can view and print your Cigna ID card in your secure online Customer Area.

Getting treatment

Prior approval should be obtained from us for all treatment. This will help ensure your claims are covered under the policy. Our Customer Care Team will help you find a high quality hospital or doctor near you. Wherever possible, we will pay them directly, saving you the inconvenience of paying for your treatment yourself and claiming a refund later.

On the rare occasion you do pay for treatment yourself, we'll aim to process your claim within five (5) working days after receiving all necessary documentation. The Customer Guide in your welcome pack will tell you everything you need to know about getting treatment and making a claim.

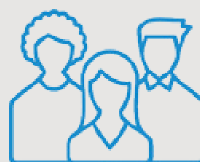
Your policy documents include the following:

Customer Guide

How your plan works and your guide to the benefits.

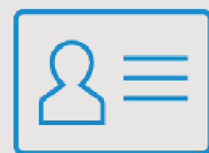
Policy Rules

The terms and conditions, general exclusions and definitions of your policy in one handy booklet.



Certificate of Insurance

A record of the plan you chose, the premium and what and who it covers.



ID Card

Proof of your identity and cover for when you need treatment.

WE'RE WAITING TO HEAR FROM YOU

If you have any questions about the Cigna Close Care[SM] plan and how it works for you, you can reach us at:

Call:
Inside the USA: 877.539.6295 or outside the USA: +44 (0) 1475 492 119
Our sales lines are open between 8am - 8pm GMT Monday to Friday.

Email:
cignaglobal_sales.team@cigna.com

Post:
Cigna Global Health Options, The Grosvenor Building,
72 Gordon Street, Glasgow, Scotland G1 3RS

NOTES

Together, all the way.℠

Important note: This document serves only as a reference and does not form part of a legal contract. The information herein is believed accurate as of the date of publication and is subject to change. This material is intended for informational purposes only and contains a partial and general description of benefits. We recommend that you examine your (product) policy in detail to be certain of precise terms, conditions and coverage. Coverage and benefits are available except where prohibited by applicable law.

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