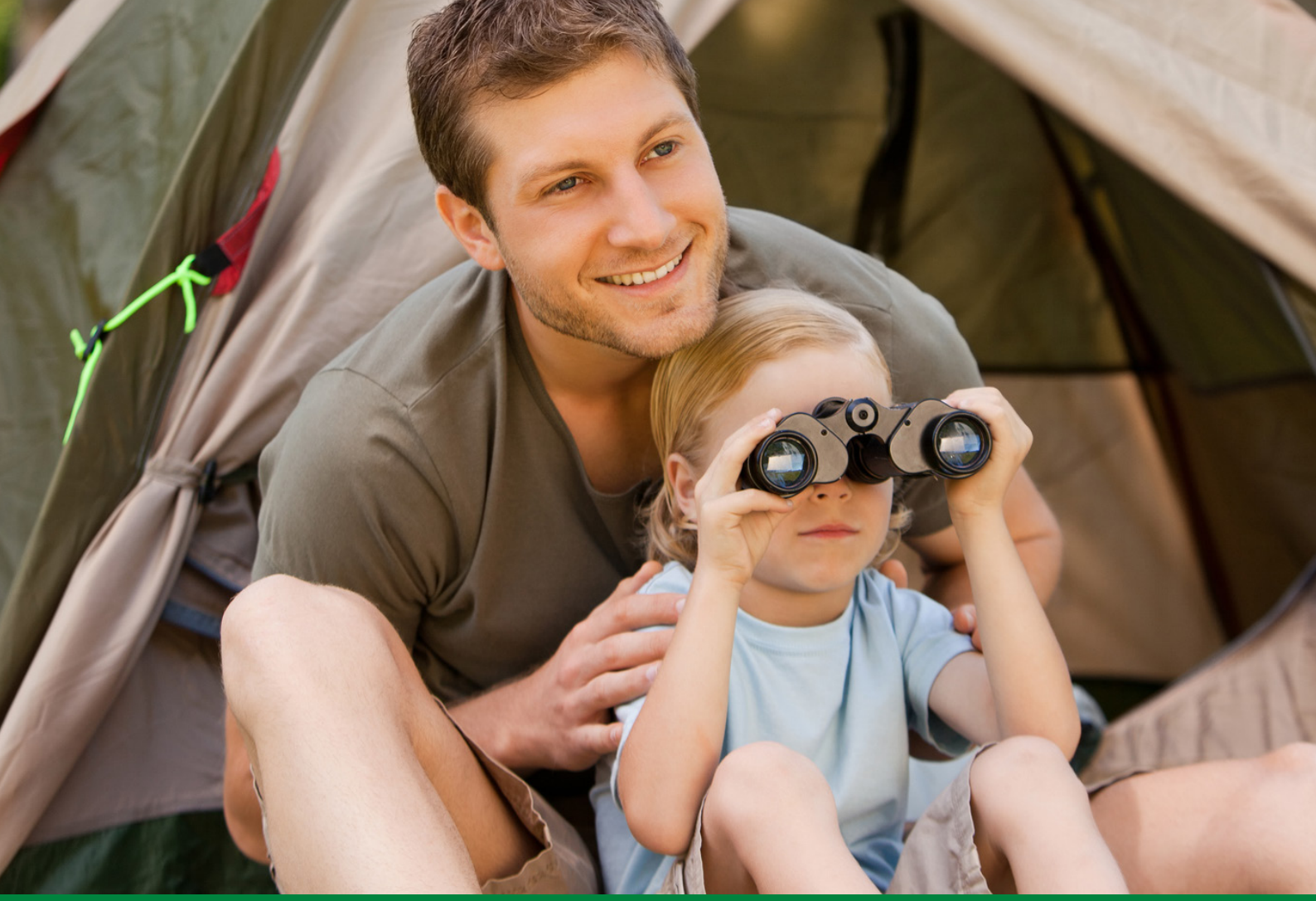
Global Health Options

CIGNA HORIZON℠ CORE PLAN

For individuals leaving a Cigna Global Health Benefits group plan

Together, all the way.℠

Cigna®

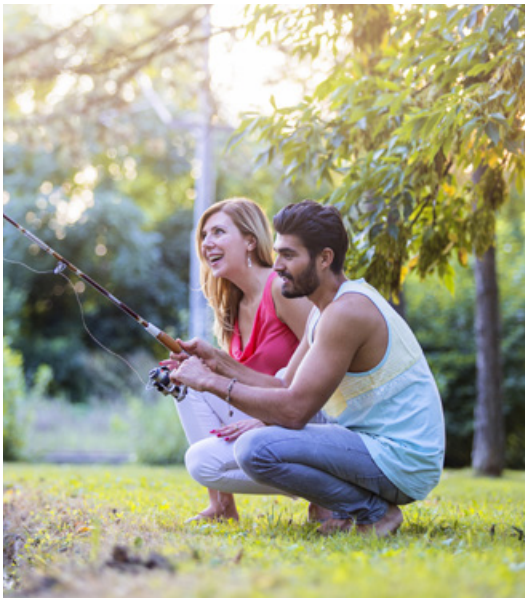


LOOKING AFTER YOU AND YOUR FAMILY WHEN LIVING ABROAD

A seamless solution for Cigna Global Health Benefits group customers.

A HEALTHY PARTNERSHIP

Any change in the professional career brings a wealth of opportunities as well as a few uncertainties. It's important at that time to secure peace of mind in the health and wellbeing of your family. That's why we have specifically designed a tailored solution for Cigna Global Health Benefits customers. We offer a seamless approach for individuals like you who are leaving their employer and their group plan but still require individual international health coverage.



At Cigna, we currently provide health insurance for customers in over 200 countries, and take great pride in being able to support the globally mobile population with a medical network of over 1 million hospitals and medical professionals worldwide. With the Cigna Horizon℠ Core plan, you benefit from a comprehensive international medical insurance with a host of additional options selectable. Read on to find out more about what we have to offer.

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WHY CHOOSE THE CIGNA HORIZON^{SM} CORE 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 us

Our customers choose us because Cigna gives them all of the following:

- Access to our network of trusted hospitals, physicians and other healthcare professionals.
- The flexibility to tailor an affordable plan to suit their individual needs.
- Access to our Customer Care Team that is always available to speak with you day and night.
- The reassurance of our experience in delivering international healthcare.
- Access to our unique Global Health Assist service to provide full medical support.

Why you may need us

There are lots of different reasons you might need the Cigna Horizon^{SM} Core plan. Here are a few:

- The assurance there will be no gap in your health cover.
- No change to the way we cover your medical history.
- Your family members will transfer as well to the new policy and can remain on your plan as long as required.
- A seamless transition thanks to a straightforward application process.

A ONE CIGNA CUSTOMER APPROACH

No further medical underwriting or additional medical declarations required

No need to start over with new waiting periods for certain benefits

Choose to add optional modules to suit your needs

No deductible or cost share applicable

Peace of mind that you and your family can continue to enjoy the benefits of the One Cigna approach

It is important to note that the benefit limits and terms and conditions do differ from group health plans, and eligibility criteria will apply.

> **QUICK AND EASY TO SET UP A POLICY. ANY QUESTIONS WERE CLEARED UP BY THE AGENT. IDEAL INSURANCE FOR MY SITUATION, PLENTY OF FLEXIBILITY. PAPERLESS COMMUNICATION.**
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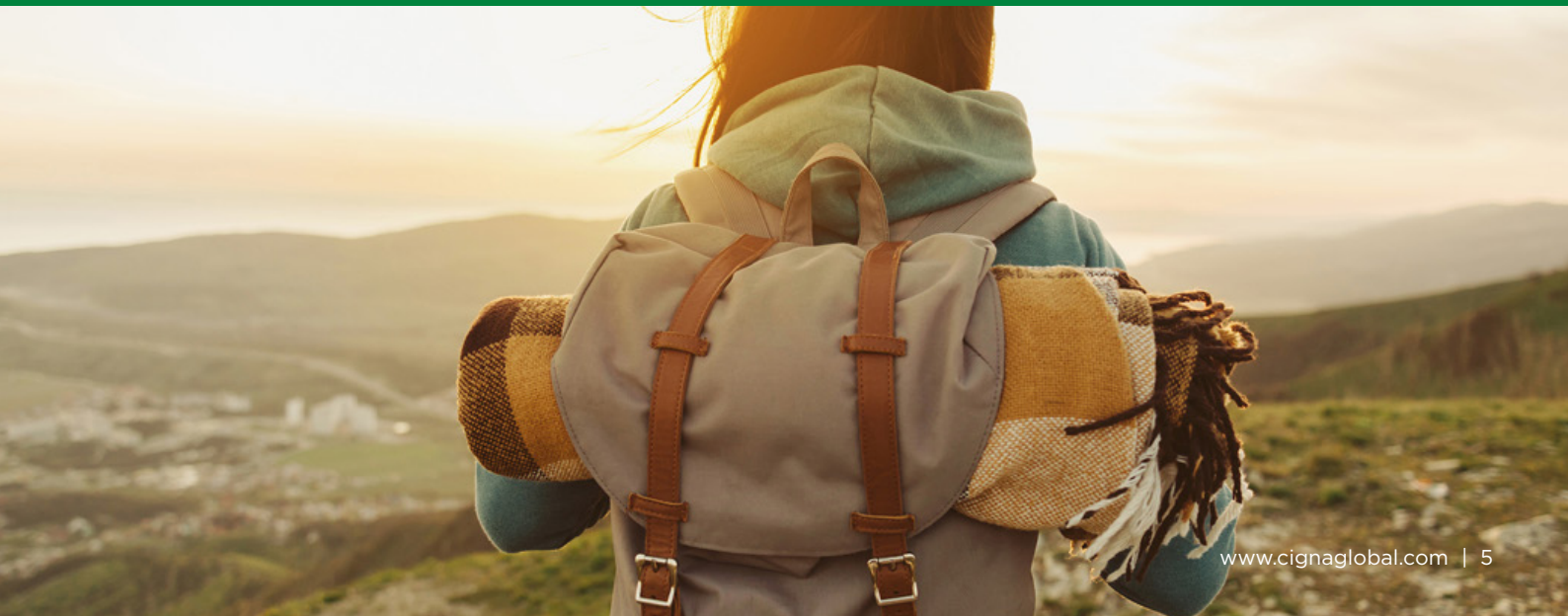
> Customer Satisfaction Survey,
> February 2017 communication.



WHAT IS INCLUDED IN YOUR PLAN

The Cigna Horizon℠ Core plan is designed to cover for inpatient, daypatient, accommodation costs, outpatient care and treatments, as well as cover for cancer, mental health care and much more.

The outpatient benefits include treatments which take place at a hospital, consulting room or outpatient clinic when an admission as an inpatient or daypatient is not required.

In addition, you can select optional modules, including:

- International Medical Evacuation;
- International Health and Wellbeing; and
- International Vision and Dental

which enables you the flexibility to create a health insurance plan that suits your unique needs.

As a former Cigna Global Health Benefits member, there will be no changes to the way we cover your medical history. That means if you or a family member have been previously covered for treatment relating to pre-existing conditions or chronic illnesses, we will keep covering that treatment, subject to the terms and conditions of this plan.

INTERNATIONAL MEDICAL INSURANCE

International Inpatient & Daypatient

Cover for hospital stays and treatments, such as:

- Surgeon & consultation fees
- Hospital accommodation
- Cancer treatment

International Outpatient

More extensive outpatient care that doesn't require an overnight stay in hospital, including:

- Pathology, radiology and diagnostic tests
- Physiotherapy and complementary therapies
- Consultations with medical practitioners and specialists
- Prescribed drugs and dressings

OPTIONAL MODULES

International Medical Evacuation

Medical evacuation in the event that treatment is not available locally in an emergency, as well as repatriation, allowing the beneficiary to return to their country of habitual residence or nationality.

International Health & Wellbeing

Proactively manage your own health. Screen against disease, test against common illnesses and get reassurance with routine physical exams.

International Vision & Dental

Vision care including an eye test and a wide range of preventative, routine and major dental treatments.

OUR GLOBAL HEALTH ASSIST PROGRAM

Our unique Global Health Assist program is carried out by our dedicated team of doctors and nurses, who work hand in hand with customers with serious or complex health conditions to bring them the full medical support they deserve.

We are dedicated to helping you and your family live happier, healthier lives with an unparalleled level of clinical expertise, which grants all beneficiaries access to:

MEDICAL SECOND OPINION SERVICE

We provide our customers with access to speak with a doctor or nurse. This can offer an international second opinion service or simple reassurance to our customers at what can often be a sensitive and potentially emotional time. Included within this service may be an independent view on their diagnosis or treatment plan.

NURSE COMPLEX CASE MANAGEMENT

When treatment is more complex, our nurses can take over the case providing clinical guidance and reassurance. In addition, that nurse can become the beneficiary's dedicated point of contact throughout the treatment process.

Our Global Health Assist service works with a proactive and personalised approach to manage complex 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, and you will receive personalised support and information about;

- Our second medical opinion program;
- Medical network/preferred provider information;
- Hospital visits and navigating the "Healthcare Maze";
- Detailed coverage information and;
- Personalised support and case management.
- Global Care On Demand

INTERNATIONAL MEDICAL INSURANCE

The level of cover for the Cigna Horizon℠ Core plan is detailed in the table below.

All benefits detailed as 'Paid in full' are subject to the overall annual benefit limit. All amounts apply per beneficiary and per period of cover (except where otherwise noted).

International Medical Insurance is your core cover for inpatient, daypatient, accommodation costs, outpatient care and treatments, as well as cover for cancer, mental health care and much more.

LIST OF BENEFITS

INPATIENT AND DAYPATIENT BENEFITS

YOUR OVERALL 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**

YOUR STANDARD MEDICAL BENEFITS

Hospital charges for: Nursing and accommodation for inpatient and daypatient treatment and recovery room. Up to the overall annual inpatient and daypatient benefit limit.	**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.

Up to the overall annual inpatient and daypatient benefit limit.

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; and
- 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 Outpatient benefits (unless they are prescribed as part of cancer treatment).

Intensive care:

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

Up to the overall annual inpatient and daypatient benefit limit.

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 overall annual inpatient and daypatient benefit limit.

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).

Specialists' consultation fees

Up to the overall annual inpatient and daypatient benefit limit.

Paid in full

- We will pay for regular visits by a specialist during stays in hospital including intensive care by a specialist for as long as is required by medical necessity.
- We will pay for consultations with a specialist during stays in a hospital where the beneficiary:
  - is being treated on an inpatient or daypatient basis;
  - is having surgery; or
  - where the consultation is a medical necessity.

Hospital accommodation for a parent or guardian

Up to the maximum amount shown per period of cover.

$1,000
€740
£665

- If a beneficiary who is under the age of 18 years old needs inpatient treatment and has to stay in hospital overnight, we will also pay for hospital accommodation for a parent or legal guardian, if:
  - accommodation is available in the same hospital; and
  - the cost is reasonable.
- We will only pay for hospital accommodation for a parent or legal guardian if the treatment which the beneficiary is receiving during their stay in hospital is covered under this policy.

Transplant services for organ, bone marrow and stem cell transplants

Up to the overall annual inpatient and daypatient benefit limit.

Paid in full

- We will pay for inpatient treatment directly associated with an organ transplant, for the beneficiary if:
  - the transplant is medically necessary, and the organ to be transplanted has been donated by a member of the beneficiary's family or comes from a verified and legitimate source.
- We will pay for anti-rejection medicines following a transplant, when they are given on an inpatient basis.
- We will pay for inpatient treatment directly associated with a bone marrow or peripheral stem cell transplant if:
  - the transplant is medically necessary; and
  - the material to be transplanted is the beneficiary's own bone marrow or stem cells, or bone marrow taken from a verified and legitimate source.
- We will not pay for bone marrow or peripheral stem cell transplants under this part of this policy if the transplants form part of cancer treatment. The cover which we provide in respect of cancer treatment is explained in other parts of this policy.
- If a person donates bone marrow or an organ to a beneficiary, we will pay for:
  - the harvesting of the organ or bone marrow;
  - any medically necessary tissue matching tests or procedures;
  - the donor's hospital costs; and
  - any costs which are incurred if the donor experiences complications, for a period of 30 days after their procedure;

  whether or not the donor is covered by this policy.
- The amount which we will pay towards a donor's medical costs will be reduced by the amount which is payable to them in relation to those costs under any other insurance policy or from any other source.
- If a beneficiary donates an organ for a medically necessary transplant, we will cover the medical costs incurred by the beneficiary associated with this donation up to any policy limits. However, we will only pay for the harvesting of the donated organ if the intended recipient is also a beneficiary under this plan.
- We will consider all medically necessary transplants. Other transplants (such as transplants which are considered to be experimental procedures) are not covered under this policy. This is because of conditions or limitations to coverage which are explained elsewhere in this policy

Important notes:

- A beneficiary must contact us and get approval in advance before they incur any costs relating to organ, bone marrow or stem cell donation or transplant.

Kidney Dialysis

Up to the overall annual inpatient and daypatient benefit limit.

Paid in full

- Treatment for kidney dialysis will be covered if such treatment is available in the beneficiary's country of residence. We will pay for this on an inpatient, daypatient, or outpatient basis.
- We will pay for kidney dialysis treatment outside the beneficiary's country of habitual residence if the country where that treatment is provided is within the beneficiary's applicable area of coverage. We will pay for this on a daypatient basis. Travel and accommodation expenses incurred in connection with such treatment will not be covered.

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

Up to the overall annual inpatient and daypatient benefit limit.

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.

$5,000
€3,700
£3,325

- 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.

$2,500
€1,850
£1,650

- 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).

Home nursing

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

$2,500
€1,850
£1,650

- We will pay for a beneficiary to have up to 30 days of home nursing care per period of cover if:
  - it is recommended by a specialist following inpatient or daypatient treatment which is covered by this policy;
  - it starts immediately after the beneficiary leaves hospital; and
  - it reduces the length of time for which the beneficiary needs to stay in hospital.

Important notes:

- We will only pay for home nursing if it is provided in the beneficiary's home by a qualified nurse and it comprises medically necessary care that would normally be provided in a hospital. We will not pay for home nursing which only provides non-medical care or personal assistance.

Rehabilitation

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

$2,500
€1,850
£1,650

- 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
  - 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 overall annual inpatient and daypatient benefit limit.

Paid in full

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

External prosthetic devices / surgical and medical appliances

Up to the maximum amount shown per period of cover.

For each prosthetic device
$3,100
€2,400
£2,000

- We will pay for external prosthetics, devices or appliances which are necessary as part of a beneficiary's treatment (subject to the limitations explained below).
- We will pay for:
  - a prosthetic device or appliance which is a necessary part of the treatment immediately following surgery for as long as is required by medical necessity;
  - a prosthetic device or appliance which is 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 and air ambulance services

Up to the overall annual inpatient and daypatient benefit limit.

Paid in full

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

Important notes

- Air ambulance cover is subject to the following conditions and limitations:
  - in some situations it will be impossible, impractical or unreasonably dangerous for an air ambulance to operate. In these situations, we will not arrange or pay for an air ambulance. This policy does not guarantee that an air ambulance will always be available when requested, even if it is medically appropriate.
  - we will only pay for a local air ambulance, such as a helicopter, to transport a beneficiary for distances up to 100 miles (160 kilometres) and we will only pay for an air ambulance where its use relates to treatment which a beneficiary needs to receive in hospital.
- This policy does not provide cover for mountain rescue services.
- Cover for medical evacuation or repatriation is only available if you have cover under the International medical Evacuation option detailed below. Please refer to the relevant section of this document for details of that option.

Inpatient cash benefit

Per night up to thirty (30) nights per period of cover.

$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
  - have not been charged for their room, board and treatment costs.

Emergency inpatient dental treatment

Up to the overall annual inpatient and daypatient benefit limit.

Paid in full

- We will cover dental treatment in hospital after a serious accident, subject to the conditions set out below.
- We will pay for emergency dental treatment which is required by a beneficiary while they are in hospital as an inpatient, if that emergency inpatient dental treatment is recommended by the treating medical practitioner because of a dental emergency (but is not the primary treatment which the beneficiary is in hospital to receive).
- This benefit is paid instead of any other dental benefits the beneficiary may be entitled to in these circumstances.

Treatment for mental health conditions and disorders and addiction treatment

Up to the maximum amount shown per period of cover.

$5,000
€3,700
£3,325

- Subject to the limits explained below we will pay for:
  - the treatment of mental health conditions and disorders; and
  - the diagnosis of addictions (including alcoholism);

Addiction treatment

- We will pay for 1 course or programme of addiction treatment at a specialist centre providing evidence-based treatment, if that treatment is medically necessary and recommended by a medical practitioner.
- We pay for up to 3 attempts at detoxification, following which we will only pay for further detoxification treatment if the beneficiary completes a formal outpatient course or programme of addiction treatment.
- We will not pay for any other treatment related to alcoholism or addiction; or treatment of any related condition (such as depression, dementia or liver failure); where we reasonably believe that the condition which requires treatment was the direct result of alcoholism or addiction.

Important notes

- For treatment of mental health conditions and disorders and addiction treatment, we will only pay for evidence-based, medically necessary treatment and recommended by a medical practitioner.
- We will pay for up to a combined maximum total of 90 days of treatment for mental health conditions and disorders and addiction treatment in any one period of cover, including up to 30 days of inpatient treatment.
- We will pay for up to a combined maximum total of 180 days of treatment for mental health conditions and disorders and addiction treatment in any 5 year period of cover. For example, if a beneficiary uses 90 days of mental health or addiction treatment in one period of cover, and 90 days of mental health or addiction treatment in the following period of cover, we will not pay for any further mental health or addiction treatment for the next 3 consecutive years of cover.
- In determining when these 30, 90 and 180 day limits have been reached:
  - we count each overnight stay during which a beneficiary received inpatient treatment as 1 day; and
  - we count each day on which a beneficiary received outpatient and daypatient treatment as 1 day.
- Prescription drugs or medication prescribed on an outpatient basis is paid under the prescribed drugs and dressings benefit.
- Subject to prior approval and provided the medical practitioner is within your applicable area of coverage, we may pay for consultations that take place by use of electronic means or telephone.

Cancer care

Up to the overall annual inpatient and daypatient benefit limit.

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.

Newborn Care

Up to the maximum amount shown for treatment within the first ninety (90) days following birth. Available once the mother has been covered under the International Medical Insurance for twelve (12) months unless she was covered under the Cigna Global Health Benefits plan for twelve (12) months or more.

$25,000
€18,500
£16,500

- Provided the newborn is added to the policy, we will pay for:
  - up to 10 days routine care for the baby following birth; and
  - all treatment required for the baby during the first 90 days after birth instead of any other benefit; if the mother has been covered under the International Medical Insurance for 12 months unless she was covered by the Cigna Global Health Benefits policy for a continuous period of 12 months or more prior to the newborn's birth.
- We will not require information about the newborn's health or a medical examination if an application is received by us to add the newborn to the policy within 30 days of the newborn's date of birth.
- The newborn will not be eligible to be added to this policy if the application is received by us more than 30 days after the newborn's date of birth.
- The newborn care benefits explained above are not available for children who are born following fertility treatment (such as IVF), are born to a surrogate, or have been adopted. In these circumstances children can only be covered by the policy when they are 90 days old.

Congenital conditions

Up to the maximum amount shown per period of cover.
Available once the mother has been covered under the International Medical Insurance for twelve (12) months unless she was covered under the Cigna Global Health Benefits plan for twelve (12) months or more.

$5,000
€3,700
£3,325

- We will pay for treatment of congenital conditions and birth defects on an inpatient or daypatient basis which manifest themselves before the beneficiary's 18th birthday If:
  - the mother has been covered under the International Medical Insurance for 12 months unless she was covered by the Cigna Global Health Benefits policy for a continuous period of 12 months or more prior to the newborn's birth and the newborn is added to the policy within 30 days of the birth.
  - they were not evident at policy inception.

OUTPATIENT BENEFITS

The benefits below provide cover for outpatient care and medical emergencies that may arise where a hospital admission as a daypatient or inpatient is not required. As well as this, consultations with specialists and medical practitioners, prescribed outpatient drugs and dressings, physiotherapy, osteopathy, chiropractic and much more.

YOUR OVERALL LIMIT

Annual benefit - maximum per beneficiary per period of cover This includes claims paid across all of the outpatient benefits outlined below.	**$10,000** **€7,400** **£6,650**

YOUR STANDARD MEDICAL BENEFITS

Consultations with medical practitioners and specialists Up to the maximum amount shown per period of cover.	**$125** **€90** **£80** **limit per visit. Up to 15 visits per year.**

- We will pay for consultations or meetings with a medical practitioner which are necessary to diagnose an illness, or to arrange or receive treatment up to the maximum number of visits shown in the benefit table.
- We will pay for non-surgical treatment on an outpatient basis, which is recommended by a specialist as being medically necessary.
- Subject to prior approval and provided the medical practitioner is within your applicable area of coverage, we may pay for consultations that take place by use of electronic means or telephone.

Pathology, radiology and diagnostic tests (excluding Advanced Medical Imaging) Up to the maximum amount shown per period of cover.	**$2,500** **€1,850** **£1,650**

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

Physiotherapy treatment Up to the maximum amount shown per period of cover.	**$2,500** **€1,850** **£1,650**

- 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 a combined maximum of fifteen (15) visits per period of cover. Up to the overall annual outpatient benefit limit.	**Paid in full**

- We will pay up to a combined maximum total of visits in any one period of cover for osteopathy and chiropractic treatment which is evidence-based treatment, medically necessary and recommended by a treating specialist, if a medical practitioner recommends the treatment and provides a referral. The treatment must be carried out by a properly qualified practitioner who holds the appropriate license to practice in the country where the treatment is received. 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 fifteen (15) visits per period of cover.
Up to the overall annual outpatient benefit limit.

Paid in full

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

Restorative speech therapy

Up to the maximum amount shown per period of cover.

$2,500
€1,850
£1,650

› We will pay for restorative speech therapy if:

- it is required immediately following treatment which is covered under this policy (for example, as part of a beneficiary's follow-up care after they have suffered a stroke);
- it is confirmed by a specialist to be medically necessary on a short-term basis.

Important notes

› We will only pay for speech therapy if the aim of that therapy is to restore impaired speech function.

› We will not pay for speech therapy which:

- aims to improve speech skills which are not fully developed;
- is educational in nature;
- is intended to maintain speech communication;
- aims to improve speech or language disorders (such as stammering); or
- is as a result of learning difficulties, developmental problems (such as dyslexia), attention-deficit hyperactivity disorder or autism.

Prescribed drugs and dressings

Up to the maximum amount shown per period of cover.

$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 forty-five (45) days in the period of cover.
Up to the overall annual outpatient benefit limit.

Paid in full

› We will pay for the rental of durable medical equipment for up to 45 days per period of cover, if the use of that equipment is recommended by a specialist in order to support the beneficiary's treatment.

› We will only pay for the rental of durable medical equipment which:

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

Adult vaccinations

Up to the maximum amount shown per period of cover.

$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.

$1,000
€740
£665

- 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

Up to the overall annual outpatient benefit limit.

Paid in full

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

  We will pay for 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.
  - diabetic retinopathy screening for children over the age of 12 who have diabetes.

Child immunisations

Up to the overall annual outpatient benefit limit.

Paid in full

- 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 routine tests

Up to the overall annual outpatient benefit limit.

Paid in full

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

THE FOLLOWING PAGES DETAIL THE OPTIONAL BENEFITS AVAILABLE TO ADD TO YOUR CORE COVER – **INTERNATIONAL MEDICAL INSURANCE**.

YOU CAN ADD AS MANY OPTIONAL BENEFITS AS YOU WISH TO BUILD A PLAN THAT SUITS YOUR NEEDS.

INTERNATIONAL MEDICAL EVACUATION

International Medical Evacuation provides coverage for reasonable transportation costs to the nearest centre of medical excellence in the event that the treatment is not available locally in an emergency. This option also includes repatriation coverage, allowing the beneficiary to return to their country of habitual residence or country of nationality to be treated in a familiar location. It also includes compassionate visits for a parent, spouse, partner, sibling or child to visit a beneficiary after an accident or sudden illness and the beneficiary has not been evacuated or repatriated.

YOUR OVERALL LIMIT

Annual benefit - maximum per beneficiary per period of cover.	**Paid in full**

YOUR STANDARD MEDICAL BENEFITS

Medical Evacuation	**Paid in full**

- Transfer to the nearest centre of medical excellence if the treatment the beneficiary needs is not available locally in an emergency.
- If a beneficiary requires emergency treatment, we will pay for medical evacuation for them:
  - to be taken to the nearest hospital where the necessary treatment is available (even if this is in another part of the country, or in another country); and
  - to return to the place they were taken from, provided the return journey takes place not more than 14 days after the treatment is completed.
- As regards 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 note

- If you require to return to the hospital where you were evacuated for follow up treatment, we will not pay for travel costs or living allowance costs.

Medical repatriation

Paid in full

- If a beneficiary requires a medical repatriation, we will pay:
  - for them to be returned to their country of habitual residence or country of nationality; and
  - to return them to the place they were taken from, provided the return journey takes place not more than 14 days after the treatment is completed.
- The above journey must be approved in advance by our medical assistance service and to avoid doubt all transportation costs are required to be reasonable and customary.
- As regards 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.

Repatriation of mortal remains

Paid in full

- If a beneficiary dies outside their country of habitual residence during the period of cover, the medical assistance service will arrange for their mortal remains to be returned to their country of habitual residence or country of nationality as soon as reasonably practicable, subject to airlines requirements and restrictions.
- We will not pay any costs associated with burial or cremation or the transport costs for someone to collect or accompany the beneficiary's mortal remains.

Travel costs for an accompanying person

Paid in full

- If a beneficiary needs a parent, sibling, child, spouse or partner, to travel with them on their journey in conjunction with a medical evacuation or repatriation, because they:
  - need help getting on or off an aeroplane or other vehicle;
  - are travelling 1000 miles (or 1600km) or further;
  - are severely anxious or distressed, and are not being accompanied by a nurse, paramedic or other medical escort and; or
  - are very seriously ill or injured;

  we will pay for a relative or partner to accompany them. The journeys (for the avoidance of doubt shall mean 1 outbound and 1 return) must be approved in advance by the medical assistance service and the return journey must take place not more than 14 days after the treatment is completed.

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

  If it is appropriate, considering the beneficiary's medical requirements, the family member or partner who is accompanying them may travel in a different class.

  If it is medically necessary for a beneficiary to be evacuated or repatriated, and they are going to be accompanied by their spouse or partner, we will also pay the reasonable travel costs of any children aged 17 or under, if those children would otherwise be left without a parent or guardian.

Important notes

- We will not pay for a third party to accompany a beneficiary if the original purpose of the evacuation was to enable the beneficiary to receive outpatient treatment.
- We will not pay for any other costs relating to third party travel costs, such as accommodation or local transportation.

Compassionate visits

If you have purchased this option, we will also make available the provision below for compassionate visits to you by immediate family members.

Compassionate visits - travel costs

Up to a maximum of five (5) trips per lifetime.
Up to the maximum amount shown per period of cover.

$1,200
€1,000
£800

Compassionate visits - living allowance costs

Up to the maximum amount shown per day for each visit with a maximum of ten (10) days per visit.

Up to the maximum amount shown per period of cover.

$155
€125
£100

- For each beneficiary we will pay for up to 5 compassionate visits over the lifetime of the cover. Compassionate visits must be approved in advance by our medical assistance service.
- We will pay the cost of economy class return travel for a parent, spouse, partner, sibling or child to visit a beneficiary after an accident or sudden illness, if the beneficiary is in a different country and is anticipated to be hospitalised for 5 days or more, or has been given a short-term terminal prognosis.
- We will also pay for living expenses incurred by a family member during a compassionate visit, for up to 10 days per visit while they are away from their country of habitual residence up to the limits shown in the list of benefits (subject to being provided with receipts in respect of the costs incurred).

Important note

- We will not pay for a compassionate visit when the beneficiary has been evacuated or repatriated. If an evacuation or repatriation takes place during a compassionate visit, we will not pay any further third party transportation costs.

INTERNATIONAL HEALTH AND WELLBEING

International Health and Wellbeing covers the beneficiary for screenings, tests, examinations and counselling support for a range of life crises and tailored advice and support through our online health education and health risk assessment, helping the beneficiary to take control and manage their health the way they want.

During each period of cover we will pay for the following tests to be carried out by a medical practitioner.

Routine adult physical examinations Up to the maximum amount shown per period of cover.	**$225** **€165** **£150**
› We will pay for routine adult physical examinations (including but not limited to: height, weight, bloods, urinalysis, blood pressure, lung function etc.) for persons aged 18 or older.	

Pap smear Up to the maximum amount shown per period of cover.	**$225** **€165** **£150**
› We will pay for 1 papanicolaou test (pap smear) for female beneficiaries.	

Prostate cancer screening Up to the maximum amount shown per period of cover.	**$225** **€165** **£150**
› 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 maximum amount shown per period of cover.	**$225** **€165** **£150**
› 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 maximum amount shown per period of cover.	**$225** **€165** **£150**
› We will pay for 1 bowel cancer screening for beneficiaries aged 55 or older.	

Bone densitometry Up to the maximum amount shown per period of cover.	**$225** **€165** **£150**
› We will pay for 1 scan to determine the density of the beneficiary's bones.	

Life management assistance programme

Paid in full

- Our Life Management service is available 24 hours a day, 7 days a week, 365 days a year. Professionals are ready to assist you with any issue that matters to you.
- We will pay for up to 5 counselling sessions per issue per period of cover. This could be telephonic or face to face counselling support.
- Unlimited in the moment telephonic support for live assistance.
- Provides information, resources and counselling on any work, life, personal, or family issue that matters to you.
- Information services provide support including assistance for day to day demands or the logistics of relocating. The information specialists can offer assistance over the phone and perform research and provide pre-qualified referrals to local resources.

Please contact us for approval. The service is provided by our chosen counselling provider.

Online health education, health assessments and web-based coaching programmes

Paid in full

- Access to our health and wellbeing section is available in your secure online Customer Area.

INTERNATIONAL VISION AND DENTAL

International Vision and Dental pays for the beneficiary's routine eye examination and pays costs for spectacles and lenses. It also covers a wide range of preventative, routine and major dental treatments.

VISION CARE

Eye examination Maximum per beneficiary per period of cover.	**$100** **€75** **£65**

- We will pay for 1 routine eye examination per period of cover, to be carried out by either an ophthalmologist or optometrist.
- We will not pay for more than 1 eye examination in any one period of cover.

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

- We will not pay for:
  - sunglasses, unless medically prescribed, by an ophthalmologist or optometrist;
  - glasses or lenses which are not medically necessary or not prescribed by an ophthalmologist or optometrist; or
  - treatment or surgery, including treatment or surgery which aims to correct eyesight, such as laser eye surgery, refractive keratotomy (RK) or photorefractive keratectomy (PRK).
- A copy of a prescription or invoice for corrective lenses will need to be provided to us in support of any claim for frames.

DENTAL TREATMENT

YOUR OVERALL LIMIT

Annual benefit - maximum per beneficiary per period of cover.	**$1,250** **€930** **£830**

YOUR STANDARD DENTAL BENEFITS

Preventative dental treatment After the beneficiary has been covered on this option for three (3) months unless he was covered on the dental option under the Cigna Global Health Benefits plan for three (3) months. Up to the overall annual dental treatment benefit limit.	**Paid in full**

- We will pay for the following preventative dental treatment recommended by a dentist after a beneficiary has had International Vision and Dental cover for at least 3 months unless already covered under the dental option of the Cigna Global Health Benefits plan for 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 three (3) months unless he was covered on the dental option under the Cigna Global Health Benefits plan for three (3) months. Up to the overall annual dental treatment benefit limit.

80% refund per period of cover

- We will pay treatment costs for the following routine dental treatment after the beneficiary has had International Vision and Dental cover for at least 3 months unless already covered under the dental option of the Cigna Global Health Benefits plan for 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 twelve (12) months unless he was covered on the dental option under the Cigna Global Health Benefits plan for twelve (12) months. Up to the overall annual dental treatment benefit limit.

70% refund per period of cover

- We will pay treatment costs for the following major restorative dental treatments after the beneficiary has had International Vision and Dental cover for at least 12 months unless already covered under the dental option of the Cigna Global Health Benefits plan for 12 months:
  - dentures (acrylic/synthetic, metal and metal/acrylic);
  - crowns;
  - inlays; and
  - placement of dental implants.
- If a beneficiary needs major restorative dental treatment before they have had International Vision and Dental cover for 12 months, we will pay 50% of the treatment costs.

Orthodontic treatment

After the beneficiary has been covered on this option for eighteen (18) months unless he was covered on the dental option under the Cigna Global Health Benefits plan for eighteen (18) months. Up to the overall annual dental treatment benefit limit.

40% refund per period of cover

- We will pay for orthodontic treatment for beneficiaries aged 18 years old or younger, if they have had International Vision and Dental cover for at least 18 months unless already covered under the dental option of the Cigna Global Health Benefits plan for 18 months.
- We will only pay for orthodontic treatment if:
  - the dentist or orthodontist who is going to provide the treatment provides us, in advance, with a detailed description of the proposed treatment (including X-rays and models), and an estimate of the cost of treatment; and
  - we have approved the treatment in advance.

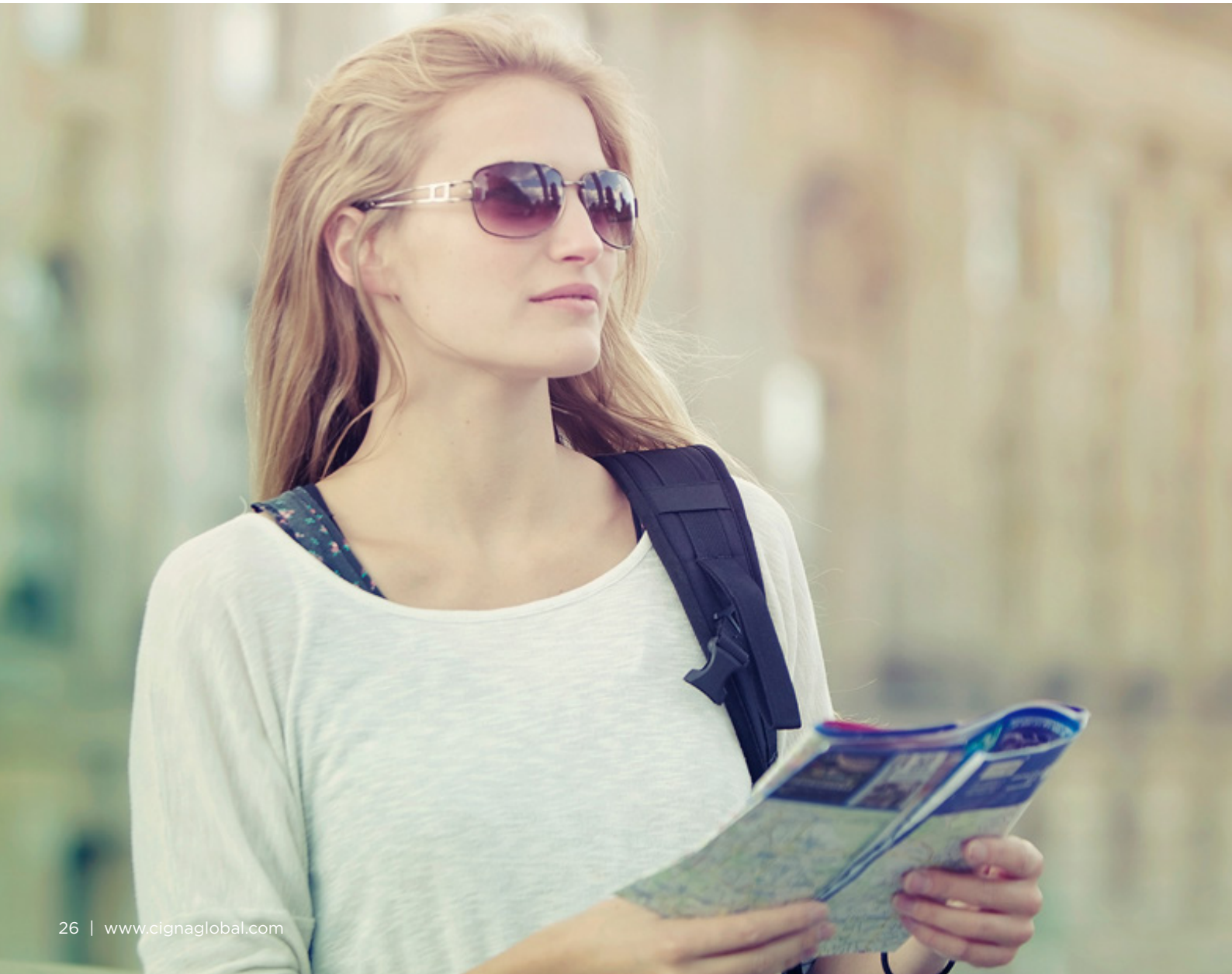
WE HAVE YOU COVERED

Pre-existing conditions

Our Cigna Horizon℠ Core plan provides cover for pre-existing and chronic conditions for former Cigna Global Health Benefits members. That means no further medical underwriting or additional medical declarations are required when you join our plan. It is important to note that the benefit limits and terms and conditions do differ from Cigna Global Health Benefits group plans, and eligibility criteria will apply.

USA emergency cover

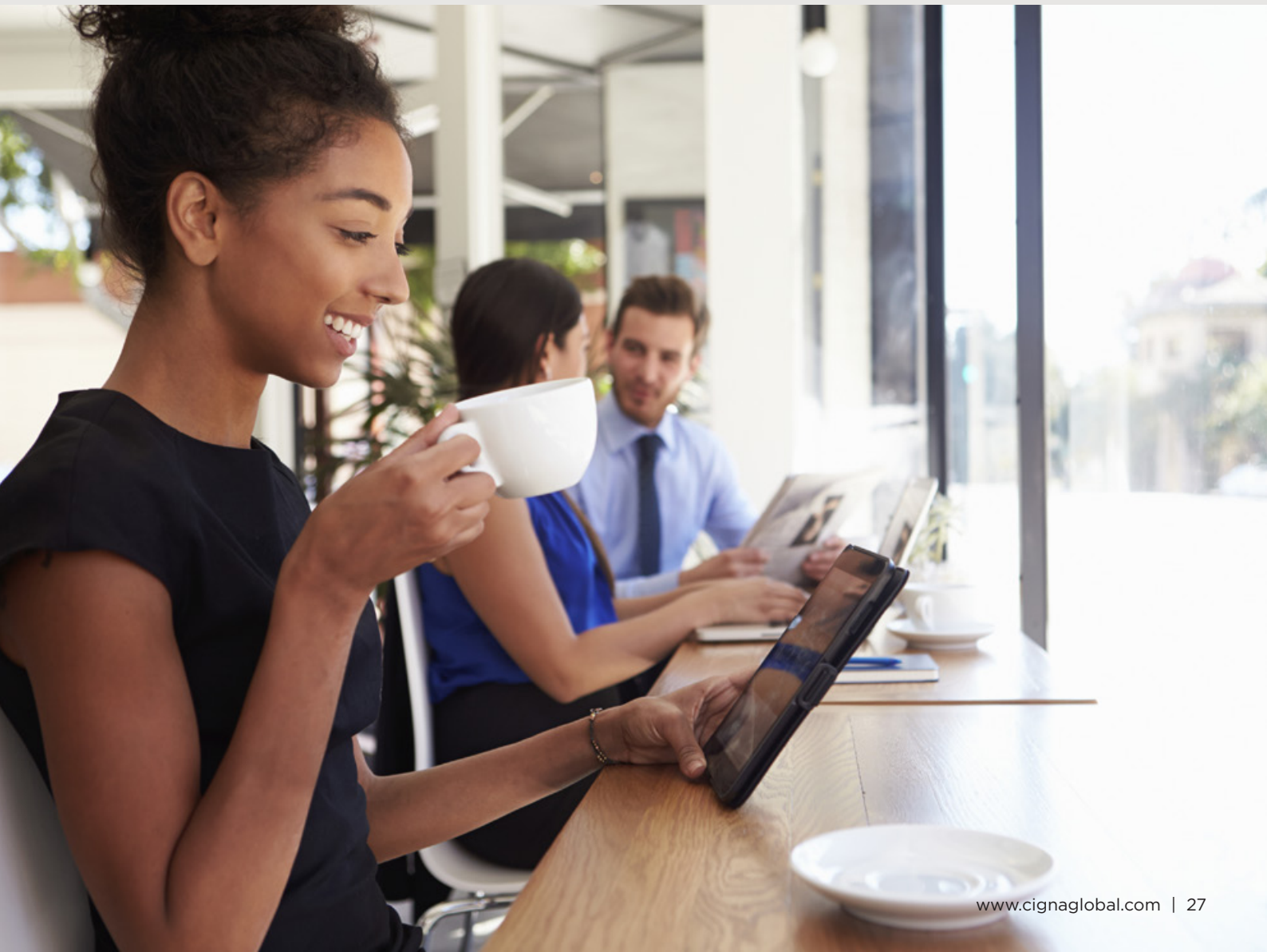
For additional peace of mind, our Cigna Horizon℠ Core plan include emergency short-term medical coverage when you are visiting the USA. So you will be covered for emergency treatment on an inpatient or daypatient basis, or outpatient basis during temporary business or holiday trips to the USA. Coverage is limited to a maximum period of three (3) weeks per trip and a maximum of sixty (60) days per period of cover for all trips combined. Please read our policy documentation for the full terms and conditions relating to this benefit. This benefit is not applicable if your country of habitual residence is the USA.



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 family
- 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 Horizon℠ Core plan, there are a few more things you might like to know about us and the service you can continue to expect as a customer of Cigna.

Comprehensive welcome pack

Once you join the Cigna Horizon℠ Core plan, we will send your policy documents electronically within twenty four (24) hours. Your policy documents are all available in your secure online Customer Area also. If you have requested to receive printed copies of your policy documents, we will send them to the postal address you gave us.

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.

NOTES

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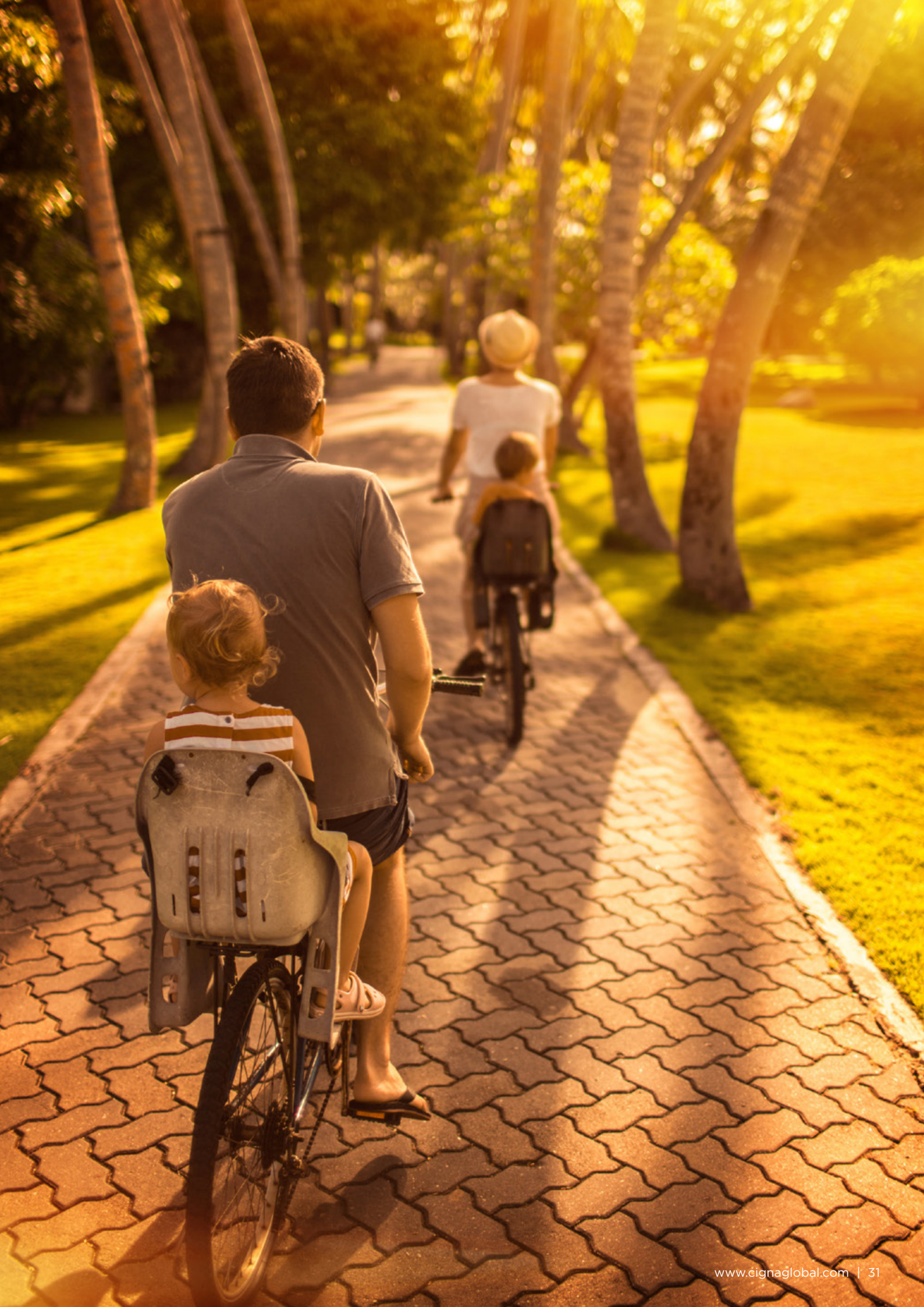

Together, all the way.[SM]

Cigna Horizon[SM] Core Sales Brochure 05/2018