Cigna Close Care℠

Policy Rules

Terms, General Exclusions and Definitions relating to your plan

cigna healthcare

CONTENTS

Please read these *Policy Rules* along with *your Certificate of Insurance* and *your* Customer Guide as they all form part of *your* contract between *you* and *us*. If necessary seek expert advice should *you* need to determine if this *policy* is appropriate for *you*.

Words and phrases in *italics* have the meanings given to them in Section 3, 'Definitions'.

Please see below where to find all of the important information in relation to *your* Cigna Close Care℠ plan.

LEGAL AND REGULATORY INFORMATION

This insurance is provided by

Cigna Life Insurance Company of Europe S.A.-N.V.
Plantin en Moretuslei 309,
2140 Antwerpen,
Belgium

Cigna is regulated in Belgium by National Bank of Belgium (La Banque Nationale de Belgique/De Nationale Bank van België) for prudential supervision and the Financial Services and Markets Authority (L'Autorité des services et marchés financiers/De Autoriteit voor Financiële Diensten en Markten) for the integrity of the financial markets and fair treatment of financial consumers.

This *policy* does not replace any state health insurance scheme. *You* may wish to take appropriate advice before stopping contributions to any state health insurance scheme of which *you* are a member.

COMPLAINTS

Any complaint should in the first instance be sent to *us* at the address in the 'How to contact us' section below.

If the complaint is not resolved, the complaint may be referred to the Financial Ombudsman at:

The Financial Ombudsman Service
Exchange Tower
London
E14 9SR

Telephone: **0800 0 234 567**
or outside of the UK: **+44 (0) 2079 640 500**
Email: **complaint.info@financial-ombudsman.org.uk**

The Financial Ombudsman Service can adjudicate most (but not all) complaints. Its decision is binding on *us* but the person making the complaint may reject it without affecting their legal rights (including their right to bring court proceedings).

Unless specifically agreed to the contrary, this *policy* is governed by, and will be interpreted in accordance with, the law of England and Wales.

Any disputes about this *policy*, including disputes about its validity, formation and termination, will be determined exclusively in the courts of England and Wales.

HOW TO CONTACT US

To cancel this policy after your minimum period of cover of three (3) months, please email us at: **cignaglobal_customer.care@cigna.com.**

For full details, please see clause 6.7 of these *Policy Rules*. *You* will need to provide *your policy* number, full name and email address used in the *application* form.

You can also write to *us* at the following address:

Cigna Global Health Options
Customer Care Team
1 Knowe Road, Greenock
Scotland
PA15 4RJ
In other circumstances *you* can call *our* Customer Care Team 24/7* on:
+44 (0) 1475 788 182 or from inside the USA on: **0800 835 7677.**

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

SECTION 1: GENERAL TERMS AND CONDITIONS

1. Scope of cover and policy eligibility

1.1
This *policy* is only offered to *beneficiaries* who are *expatriates*. Therefore, this *policy* will only cover the costs of *treatment* in a *beneficiary's country of nationality* in circumstances where the *beneficiary* is temporarily resident in their *country of nationality*. Such circumstances may not exceed one hundred and eighty (180) days in aggregate per *period of cover*, and the *country of nationality* must be within the *area of coverage* (see clause 11 for full details).

The *area of coverage* for this *policy* is restricted to *your country of nationality* and *your country of habitual residence* only, unless covered under the Out of Area Emergency cover benefit. See clause 8.3 for more details.

1.2
Subject to the terms, conditions, limits, exclusions (and special exclusions as detailed in *your Certificate of Insurance*, if applicable) of this *policy*, *Cigna Healthcare* will cover *you* for medical and related expenses relating to *medically necessary treatment* which is recommended by a *medical practitioner*, and provided within the *area of coverage* for *injury* and sickness. The *treatment* must occur during the *period of cover* and deductibles, cost shares and limits of cover may apply. In some circumstances *we* may, at *our* absolute discretion, agree to remove an exclusion if *you* pay an additional premium. This will be agreed at the time *you* purchase *your policy*.

1.3
This *policy* is subject to a *condition* limit as detailed in the list of benefits. 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*. *We* will only pay for *outpatient* costs if the Outpatient and Wellness Care option has been selected, with the exception of *benefits* which include *outpatient treatment* as part of *your Core cover*.

We will not pay for any costs that exceed the overall *condition* limit as detailed in the list of benefits in the Customer Guide.

1.4
You must be eighteen (18) years old or over at the time of purchase in order to purchase this *policy*.

1.5
If there are any changes that occur between *your application* and the *initial start date* of *your policy* and any information that *you* provided to *us* in *your application* changes during this period, *you* must let *us* know. *We* reserve the right to cancel the *policy* or apply any additional premiums or exclusions as a result of any change to *your* state of health which *you* have notified *us* of before the *initial start date* of the *policy*. If *you* fail to inform *us* of any change to *your* state of health during this period, *we* may treat this as misrepresentation, which could affect coverage under *your policy* or payment of claims.

1.6
This *policy* will not cover any costs relating to *treatment* received before the cover starts, or after the cover ends (even if that *treatment* was approved by *us* before the cover ends).

2. When does cover begin and end

2.1
This policy is an annual renewable contract with a minimum period of cover of three (3) months and a maximum period of cover of twelve (12) months. This means that, unless it is terminated before the end date or automatically renewed, the period of cover will end one (1) year after the start date. Please see Clause 13 for more information on the policy renewal process at the end of your period of cover.

2.2
Subject to clause 4, if this policy ends within the first three (3) months of the initial start date,

any premium which has been paid for the first three (3) months of cover will not be refunded regardless if you have claimed or not during that period of cover. In addition, you will be liable to pay any remaining premium for that initial three (3) months period which hasn't been paid yet.

If this policy ends after the first three (3) months of the initial start date and before the end date, any premium which has been paid in relation to the period after cover has ended will be refunded on a pro rata basis, so long as no claims have been made or yet to be submitted and no guarantees of payment have been put in place during the period of cover.

If this policy ends after the first three (3) months of the initial start date and before the end date and you have made claims under it or you have received treatment not reimbursed yet, you will be liable for the remainder of any premium in respect of the policy which are unpaid.

2.3

If *you* die, cover will end for all *beneficiaries* unless a *beneficiary* contacts *us* within thirty (30) days of the date of death as shown in the Death Certificate. If any of the *beneficiaries* would like to continue coverage by becoming the *policyholder*, and subject to *our policy* terms, they must inform *us* within thirty (30) days and must provide *us* with a copy of the Death Certificate. If a *beneficiary* does not wish to continue coverage as the *policyholder*, all cover will end, and *we* will not make any payments in relation to *treatment* or services which are received on or after the date on which the cover ends.

3. The information you give us

In deciding whether to accept this *policy* and in setting the terms and premium, *we* have relied on the information that *you* have given to *us*. *You* must take care when answering any questions that *we* ask by ensuring that all information is accurate and complete.

If *we* determine on reasonable grounds that *you* deliberately or recklessly provided *us* with false or misleading information, it could adversely affect this *policy* and any claim. For example, *we* may:

- treat this *policy* as if it had never existed, refuse to pay all claims and return the premium paid. *We* will only do this if *we* provide *you* with insurance cover which *we* would not otherwise have offered;
- amend the terms of *your* insurance. *We* may apply these amended terms as if they were already in place if a claim has been adversely impacted by *your* carelessness; or
- terminate in accordance with 6.2.

We will notify *you* in writing if any of the above circumstances occur.

If *you* become aware that information *you* have given *us* is inaccurate, *you* must inform *us* as soon as possible using one of the options in the 'How to contact us' section on page 3 of these *Policy Rules*.

4. Free look period

You have a statutory right to cancel your policy within fourteen (14) days from the start date of your policy. If you wish to cancel this policy within this fourteen (14) day free look period and we have not paid a claim or issued a guarantee of payment, you will receive a full refund of your premium. Alternatively, if we have paid a claim, or issued a guarantee of payment, we will not refund any premium which has been paid. To cancel this policy, please contact us using one of the options in the 'How to contact us' section on page 3 of these Policy Rules.

If you do not exercise your right to cancel this policy during the free look period, it will continue in force for a minimum period of three (3) months, inclusive of the free look period, from the initial start date and you will be required to make any premium payments that are due to us.

For your termination rights outside of the fourteen (14) day statutory cooling off period, please refer to clause 6 of this policy.

5. Premium and other charges

5.1

Your Certificate of Insurance sets out the premium and any other charges (such as taxes)

which are payable, and states when and how they must be paid. As specified in Clause 2, you will be liable to pay the premium for a minimum period of cover of three (3) months regardless of the payment frequency selected.

Payments must be made in the currency and in the manner detailed in your Certificate of Insurance.

5.2

If *you*, or any *beneficiaries*, do not seek *prior approval* for the required *inpatient* and *daypatient* treatment, we will reduce the amount which we will pay towards that treatment by twenty (20) percent.

For medical expenses specifically in the *USA*, if *you*, or any *beneficiaries*, decide to receive treatment at a *hospital, clinic, medical practitioner* or pharmacy which is not part of the *Cigna Healthcare* network in the *USA*, we will reduce the amount which we will pay towards that medical expenses by twenty (20) percent. A list of *hospitals*, *clinics* and *medical practitioners within the Cigna Healthcare* network is available in *your* secure online Customer Area.

Please note, *we* may, at *our* sole discretion and without notification, make changes to the *Cigna Healthcare* network from time to time by adding and / or removing *hospitals, clinics, medical practitioners* and pharmacies.

5.3

In most cases we will pay directly the *hospital, clinic or medical practitioner* for *your* medical expenses. In the instance where *you*, or any *beneficiaries*, have to pay the *hospital, clinic or medical practitioner*, *you* should submit *your* invoice and claims form to us as soon as possible after any treatment. If the claim and invoice is not submitted to us within twelve (12) months of the date of treatment, the claim will not qualify for payment or reimbursement by *us*.

Any claim is subject to the applicable *deductible, cost shares* and limits of cover set out in these Policy Rules, the Customer Guide and *your Certificate of Insurance*.

5.3.1

Claims are reimbursed in the currency in which the claim was incurred or, upon request, the currency of the premiums paid on this policy and calculated using the applicable exchange rate.

You, or any beneficiaries, may submit a request to reimburse the claim in an alternative currency . Should we agree to provide a reimbursement consistent with an alternative currency request, we will apply a standard convenience charge of 3% over and above the applicable exchange rate.

The convenience charge will be added to the exchange rate of the requested currency and will impact the final amount reimbursed. This means that if an alternative currency request is made, subject to exchange rate fluctuations, the amount reimbursed may be less than the original amount claimed.

In the event a particular alternative currency request cannot be met, we will contact you to obtain your preference as to another alternative currency request or standard reimbursement.

You, or any beneficiaries, can contact us for the applicable exchange rate applied to any particular claim using one of the options in the ‘How to contact us’ section on page 3 of these Policy Rules. We reserve the right to withdraw or vary the convenience charge at any time on a sixty (60) days’ prior notice.

5.4

If *you* do not pay premium and/or any other charges when they are due, *we* will notify *you* by email immediately and suspend *your policy* i.e. cover for all *beneficiaries* will be suspended. If payment is made, the *policy* will be reinstated. *We* will not approve *treatment* while the *policy* is suspended. *We* will not settle any claim while any payment to *us* is outstanding until the outstanding amount is paid.

If after thirty (30) days the amount is still outstanding, *we* will write to *you* informing *you* that the *policy* is cancelled. The cancellation

date shall take effect on the date when the first outstanding payment was due.

If you settle the outstanding amount within thirty (30) days of when the first outstanding payment was due, *we* will reinstate *your* cover back to that date.

5.5
Subject to clause 13, *we* will inform *you* of the premium and any other charges which will apply during the next *period of cover*.

The premium and/or other charges will change each *period of cover*.

6. Termination

6.1
Subject to any conflicting legal or regulatory requirements *we* will terminate this *policy* for all *beneficiaries* immediately if:

6.1.1
any premium or other charge (including any relevant tax) is not paid in full within thirty (30) days of the date on which it is due. *We* will give *you* written notice if *we* are going to terminate the *policy* for this reason;

6.1.2
it becomes unlawful for *us* to provide any of the cover available under this *policy* or *we* are required to terminate the *policy* in any particular jurisdiction or territory at the direction of a regulator or authority with competent jurisdiction; or

6.1.3
any *beneficiary* is identified on any list imposing financial sanctions on targeted individuals or entities maintained by the United Nations Security Council, the European Union, the United States Office of Foreign Assets Control or any other applicable jurisdiction. Furthermore, *we* will not pay claims for services received in sanctioned countries if doing so would violate the requirements of the United Nations Security Council, the European Union or the United States Department of Treasury's Office of Foreign Assets Control.

6.2
Subject to clause 3, *we* will terminate this *policy* with immediate effect if, *we*, at *our* sole discretion determine, on reasonable grounds, that *you* have, in the course of applying for the *policy* or when making any claim under it, withheld information or knowingly or recklessly provided information which *you* know or believe to be untrue or inaccurate or failed to provide information which *we* have asked for, including medical information.

6.3
Subject to clause 11, *we* may terminate this *policy* if any *beneficiary* ceases to be an *expatriate* whether as a result of a change to a *beneficiary's country of nationality* or *country of habitual residence*.

6.4
We may terminate this *policy* if *we* reasonably believe *you* have travelled to a country outwith *your area of coverage* for *treatment*, unless covered under the terms of clause 8.3.

6.5
We may terminate this *policy* if any *beneficiary* relocates to a country which is not *your country of habitual residence*.

6.6
If *we* are no longer in the market to sell the *policy* or suitable alternative in *your* geographical area, *we* will notify *you* at least one (1) month before the *end date* to advise *you* that the *policy* will be terminated (and therefore unable to be renewed) with effect from the *end date*.

6.7
If you want to terminate this policy and end cover for all beneficiaries, you may only do so after the minimum period of cover of three (3) months from the initial start date by giving us at least fourteen (14) days' notice in writing. Termination of your policy will take effect fourteen (14) days after you, the policyholder, notifies us of the request by using one of the options in the 'How to contact us' section on page 3 of these Policy Rules.

6.7.1
If the *policy* is terminated in accordance with clause 6.7, before the *end date*, and *we* have paid a claim, covered a *treatment* or issued

a *guarantee of payment* during the *period of cover*, *you* will be liable for the remainder of any premiums in respect of the *policy* which are unpaid. If *your* annual premium is collected at intervals throughout the *policy* year, *you* will be responsible for making these payments for the remainder of the *period of cover* or alternatively, settle the outstanding premium amount.

6.8
In relation to the period after your cover has ended outside of the minimum period of cover of three (3) months, unless your policy is terminated in accordance with clause 6.2 and/or clause 7, then any premium which has been paid in relation to the period after cover has ended will be refunded to the extent that it does not relate to a period of time in which we have provided cover, so long as we have not paid any claim, or issued any guarantee of payment during the period of cover.

6.9
If *treatment* has been authorised, *we* will not be held responsible for any *treatment* costs if the *policy* ends or a *beneficiary* leaves the *policy* before *treatment* has taken place.

7. Fraud

7.1
If a *beneficiary* makes a fraudulent claim under this *policy*, *we*:

i. are not liable to pay the claim;

ii. may recover from the *beneficiary* any sums paid by *us* in respect of the claim; and

iii. may give notice to the *beneficiary* and treat the contract as having been terminated with effect from the time of the fraudulent act.

7.2
If *we* exercise *our* right under clause 7.1 (iii) above:

i. *we* shall not be liable to the *beneficiary* in respect of a relevant event occurring after the time of the fraudulent act. A relevant event is whatever gives rise to *our* liability under this *policy* (such as the occurrence of a loss, the submission of a claim, or the notification of a potential claim); and

ii. *we* do not need to return any of the premium paid.

7.3
If this *policy* provides cover for any *beneficiary* other than *you*, and a fraudulent claim is made under this *policy* on behalf of a *beneficiary* other than *you*, *we* may exercise the right set out in clause 7.1 above as if there were an individual insurance contract between *us* and that *beneficiary*. However, the exercise of any of those rights shall not affect the cover provided under the contract for any other *beneficiary*.

Nothing in this clause 7 is intended to vary the position under the Insurance Act 2015.

8. Coverage options

8.1
If a *beneficiary* does not have cover under the Outpatient and Wellness Care or Dental Care and Treatment options, *we* will not pay for any of the *treatments* which are available under those options.

8.2
The following changes to your policy cannot be requested during the *period of cover* and can only be made upon renewal:

- to modify your level of cover (for example moving from Cigna Close Care℠ to Cigna Global Health Options (CGHO) Silver plan or moving from CGHO Silver to Cigna Close Care℠),
- to modify your *deductible*, *cost share* or *out-of-pocket maximum*.

In order to proceed with such request, you should let us know in writing at least seven (7) days before your *annual renewal date*. Before making any of these changes, we may ask you to complete a new medical history questionnaire. If the request is accepted by us, we may apply new special restrictions or exclusions on your updated *policy* for the new *period of cover*. Once you accept our offered terms, these changes will become effective from your *annual renewal date*.

The following changes to your *policy* can be requested during the *period of cover* and will be reviewed by us:

- to add one or more of the optional modules at the same level of cover as your Cigna Close Care℠ core cover: Outpatient and Wellness Care, or Dental Care and Treatment options,
- to modify your *area of cover* by including *USA* cover (if applicable as your country of nationality or country of residency)

Before making any of such changes to your *policy* during the current period of cover, we may ask you to complete a new medical history questionnaire. If the request is accepted by us, we may apply new special restrictions or exclusions on your updated policy. These changes to your policy will begin no sooner than the date you accept our offered terms and will remain in place until at least your annual renewal date.

Any other changes to your *policy* in relation to coverage options will be reviewed by us and will be subject to medical underwriting.

8.3

Beneficiaries will be covered for *emergency treatment* on an *inpatient* or *daypatient* basis or provided on an *outpatient* basis (if the Outpatient and Wellness Care additional coverage option has been purchased under *your policy*) during temporary trips, even if those trips are outside *your area of coverage*. As with all *emergency treatment*, if *you* have not purchased the Outpatient and Wellness Care additional coverage option, *your emergency treatment* will only be covered if it results in an admission to the *hospital*. Please note, the health check and screenings under the Outpatient and Wellness Care option are not covered under the Out of Area Emergency cover *benefit*. This cover will be 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 and up to the overall annual limit of the Out of Area Emergency cover *benefit*. Any *cost shares* or *deductibles* elected on *your policy* will continue to apply.

To be eligible for this *benefit* the medical *condition* requiring *emergency treatment* must not have existed prior to the travel and the *beneficiary* must have been *treatment*-, symptom- and advice free of the medical *condition* prior to initiating the travel.

Receiving medical *treatment* must not have been one of the objectives of the trip. *Emergency treatment* is only applicable if *you* do not already have state-provided healthcare in that country. Proof of the date of entry into the country outside *your area of coverage* will also be required prior to *benefits* being paid under this cover. This cover will cease once the *treatment* provided results in a stabilised condition.

9. Deductible and Cost Share

9.1

If *you* have selected a deductible on the Core cover and/or Outpatient and Wellness Care option (if applicable), *you* will be responsible for paying the deductible amount directly to the *hospital*, *clinic*, *medical practitioner* or pharmacy. *We* will let *you* know what this amount is.

We will reduce the amount which *we* will pay towards the cost of *treatment* in respect of each claim which is made under the Core cover or Outpatient and Wellness Care option (if applicable) by the amount of any deductible until the deductible for the *period of cover* is reached.

9.2

If *you* have selected a cost share on the Core cover and/or Outpatient and Wellness Care option (if applicable), *we* will reduce the amount *we* pay towards the cost of *treatment* by that cost share percentage. *You* will be responsible for paying the cost share directly to the *hospital*, *clinic*, *medical practitioner* or pharmacy. The amounts *you* pay are subject to the capping effect of the applicable out of pocket maximum.

9.3

Only amounts *you* pay related to the cost share on the Core cover and/or Outpatient and Wellness Care option are subject to the capping effect of the out of pocket maximum. The following are not subject to the out of pocket maximum:

- Any amounts *you* pay due to a deductible;
- Due to exceeding limits of cover;

- For *treatment* not covered by the Core cover or Outpatient and Wellness Care option; or
- Due to penalties for not obtaining prior approval or using out of network providers in the *USA*.

Any amounts you pay to the deductible, cost share and out of pocket maximum where applicable, apply separately to each beneficiary, each coverage option and each period of cover.

9.4
No deductible applies to 'Inpatient cash benefit'.

10. Adding beneficiaries

10.1
If *you* would like to add a new *beneficiary* during the *policy* year, *you* must send *us* a completed *application* for that person. Acceptance of any new *beneficiary* is at *our* sole discretion. *We* will advise *you* of any special conditions or exclusions and any additional premium that will apply to the offer of cover. Cover for any new *beneficiary* will begin from the date on which *you* confirm *your* acceptance. *We* will send *you* an updated *Certificate of Insurance* confirming that the new *beneficiary* has been added.

The *beneficiary's area of coverage* must be the same as the *policyholder's*, otherwise the *beneficiary* must take out a separate *policy*, or an alternative *Cigna* plan.

10.2
If a *beneficiary* gives birth, *you* may apply to add the newborn as a *beneficiary* to *your* existing plan. The newborn will be subject to full medical underwriting and an additional premium will be due. *We* will tell *you* whether *we* will offer cover to the new *beneficiary*, and if so, any special conditions and exclusions which would apply. If *you* accept the offered terms, cover will begin from the date on which *you* confirm *your* acceptance. *We* will send *you* an updated *Certificate of Insurance* confirming that the new *beneficiary* has been added.

11. Changes to country of habitual residence, address and/or nationality

11.1
If any *beneficiary* changes their *country of habitual residence you* must inform *us* as soon as practicable and in any event within thirty (30) days. *We* reserve the right to ask *you* for further information about a change in *your* or any other *beneficiary's country of habitual residence* from time to time. Note that any change to *your* or any other *beneficiary's country of habitual residence* may result in an increase to *your* premium or additional tax becoming payable, meaning *you* may have to make an additional payment of premium or *your* monthly or quarterly payments may increase. If the premium increases, *we* will give *you* the right to cancel the *policy*, in accordance with clause 6.7, in which case clauses 6.7.1, 6.8 and 6.9 will apply. Please note that the insurance may be provided by another *Cigna* group company.

11.2
If a *beneficiary* returns to their *country of nationality* then the *treatment* which they can obtain will be limited to one hundred and eighty days (180) days in aggregate during the *policy* year.

11.2.1
We reserve the right to review all claims submitted by *beneficiaries* in their *country of nationality* and in circumstances where *we* know or reasonably believe the *beneficiary* is or intends to be resident in their *country of nationality* in excess of one hundred and eighty (180) days in aggregate per *period of cover*. In such circumstances *we* may no longer consider that *beneficiary* to be an *expatriate* as they have returned to their *country of nationality* for a sustained period and *we* may refuse payment of any claim or issuance of a *guarantee of payment*.

Please note, the *country of nationality* where *beneficiaries* can obtain *treatment* is the same as the *policyholder's country of nationality*.

11.3
If any *beneficiary* ceases to be an *expatriate* whether as a result of a change to a *beneficiary's*

country of nationality or *country of habitual residence*, then *you* can either:

11.3.1
leave the *policy* in force for the remainder of the *period of cover*. *You* must inform *us* upon renewal if *you* cease to be an *expatriate* and *we* will determine if *we* can offer *you* an alternative health plan provided by another *Cigna* group company; or

11.3.2
terminate the *policy* by giving written notice with the effect that cover will end for all *beneficiaries*. Any premium which has been paid in relation to the period after termination will be refunded to the extent that it does not relate to a period of time in which *we* have provided cover, so long as *we* have not paid claims or issued any *guarantees of payment* during the *period of cover*.

12. How we will communicate with you

We will send any communication and notices in relation to this *policy* electronically to the email address *you* have provided, and *we* will place *your policy documents* in *your* secure online Customer Area.

13. Policy renewal

13.1
If we determine to renew, we will write to you at least one (1) calendar month before the end date to invite you to automatically renew on the terms we offer you. We will inform you of any changes to the policy and premium for the forthcoming period of cover. If local law and/or regulation dictates, we may be required to offer you an alternative health plan. The minimum period of cover of three (3) month doesn't apply to renewed policies. This requirement applies only to the first year of your policy.

Subject to clause 7, any decision by Cigna Healthcare not to renew shall not be based on your claims history or any illness, injury or condition suffered by any beneficiaries.

13.2
If *you* accept the invitation to renew, please ensure *you* have read and understood the *policy documents* for the forthcoming *period of cover*. *Your* cover will be renewed for another twelve (12) months.

13.3
If *you* do not want to renew *your* cover, *you* must let *us* know in writing at least fourteen (14) days before *your policy end date*.

13.3.1
If *you* do not renew *your* cover, any *beneficiaries* who have been covered under the *policy* can apply for their own cover. *We* will consider their *applications* individually, and inform them whether, and on what terms, *we* are willing to offer them such cover.

13.4
Subject to clause 8.2, if you would like to make changes to your policy upon renewal, you must let us know in writing at least seven (7) days before your annual renewal date. We may apply new special restrictions, exclusions and/or adjust premium. If we do so we will send you an updated Certificate of Insurance.

13.5
If any special exclusion(s) have been applied to any *beneficiary* there may be occasions when *we* can review them at a future *annual renewal date*, to consider whether *we* are willing to remove the exclusion. If this is the case, *we* will show the exclusions review date in the *Certificate of Insurance*. At such date, *we* will also review the additional premium (if any) which *we* may have applied to cover a condition.

You should contact *us* upon receipt of the renewal notification, and at least fourteen (14) days before the *annual renewal date* if there is an exclusion which is due for review at that date.

We will then advise *you* of changes (if any) *we* have made and, where appropriate, issue an amended *Certificate of Insurance*. Amendments will be effective from the relevant *annual renewal date*. *We* do not guarantee that any special exclusion(s) or additional premium will be removed on renewal.

14. Data protection

14.1
In assessing *your application*, and administering the *policy* and the insurance provided to *you*, *we* will collect, process and share certain personal information about *you*. *We* take *your* privacy very seriously and *we* will always process *your* information in accordance with applicable data protection legislation, including the General Data Protection Regulation (EU 2016/679) and any other applicable legislation and any guidance or codes of practice issued in respect of protection of *personal data* from time to time. For more information please see *our* Data Protection Notice, which *we* may update from time to time.

14.2
Cigna Healthcare will for the purposes of administering any claim, ask a *beneficiary* to provide *special category data* relating to his or her medical condition, previous conditions, state of health and *treatments*.

15. Who can enforce this policy

Only *we* and *you* have legal rights in connection with this *policy*. A person who is not a party to this *policy* has no right under the Contracts (Rights of Third Parties) Act 1999 to enforce any term of this contract but this does not affect any right or remedy of a third party which exists or is available apart from that Act.

16. Our right to recovery from third parties

If a *beneficiary* requires *treatment* as a result of an accident or deliberate act for which a third party is at fault, *we* (or any person or company *we* nominate) will take on that *beneficiary's* right to recover the cost of that *treatment* from the third party at fault (or their insurance company). If *we* ask a *beneficiary* to do so, he or she must take all steps to include the amount of benefit claimed from *us* under this *policy* in any claim against the person at fault (or their insurance company).

The *beneficiary* will need to sign and deliver all documents or papers and take any other steps *we* require to secure *our* rights. The *beneficiary* must not take any action which could damage or affect these rights. *We* can take over and defend or settle any claim, or prosecute any claim, in a *beneficiary's* name for *our* own benefit. *We* will decide how to carry out any proceedings and settlement.

17. Other Insurance

If another insurer also provides cover, *we* will negotiate with them as regards to who pays what proportion of any claim. If a *beneficiary* is covered by other insurance, *we* may only pay part of the cost of *treatment*. If another person, organisation or public programme is responsible for paying the costs of *treatment*, *we* may claim back any of the costs *we* have paid.

18. Changes to this policy

18.1
No person other than an executive officer of *Cigna Healthcare* has authority to change this *policy* or to waive any of its provisions on *our* behalf, for example, sales representatives, brokers and other intermediaries cannot vary or extend the terms of the *policy*.

18.2
We reserve the right to make any changes to this *policy* that are necessary to comply with any changes to relevant laws and regulations. If this happens, *we* will write to *you* and tell *you* of the change.

19. Sanctions

It is *Cigna Healthcare's* global corporate policy to comply with the economic sanctions rules related to individuals, entities, and countries applicable to its global business operations, including but not limited to those imposed by the United Nations, the European Commission, the United States, and Canada. Therefore, *Cigna Healthcare* will not offer coverage or pay benefits to or on behalf of, any *beneficiaries* if doing so would violate these sanctions rules. In the event that *Cigna Healthcare* learns that a sanctioned individual or entity is enrolled under the *policy*, or that a *beneficiary* becomes sanctioned, *Cigna Healthcare* will take all appropriate action, which could include blocking, reporting, and terminating coverage. *Cigna Healthcare* is under no obligation to notify the *beneficiary* in advance

of taking these actions, or to obtain licenses from any government to enable the extension of coverage in compliance with sanctions laws.

In addition, restrictions will apply to claims incurred in sanctioned countries where there is no relevant, approved license from the U.S. Office of Foreign Assets Control. Among the restrictions, *Cigna Healthcare* will not cover: (I) elective or pre-scheduled *treatment* in sanctioned countries; or (2) *beneficiaries* considered "ordinarily resident" in a sanctioned country. *Beneficiaries* are considered ordinarily resident if they visit a sanctioned country for a period of longer than six (6) weeks over the course of any twelve (I2) month period.

20. Pandemics, Epidemics and Infectious Illnesses

20.1

We will cover *medically necessary treatment* for disease or illness resulting from a pandemic, epidemic or outbreak of infectious illness, as defined by the World Health Organisation (WHO). The *medically necessary treatment* and related medical conditions will be covered on an *inpatient, daypatient* and *outpatient* (if the Outpatient and Wellness Care option has been selected) basis as per the benefits of *your* plan and according to the terms of the *policy*. Where prescribed drugs cannot be accessed in the *beneficiary*'s current location as a result of a pandemic, epidemic or outbreak of infectious illness, *we* will cover the shipment cost in addition to the cost of the prescribed drugs under the terms of the prescribed drugs and dressings *outpatient* benefit.

20.2

We will cover *medically necessary* testing for pandemic, epidemic or outbreak of infectious illness, on an *outpatient* basis, in line with *policy* coverage for diagnostics for other illnesses, and according to the World Health Organisation (WHO) guidelines.

20.3

When an approved vaccine becomes available in a location through the local social security programmes or governmental agency, *we* recommend that local government advice is followed and the local health system or government programme is accessed where available.

If the vaccine needs to be delivered in an authorised private setting, and *your* plan includes coverage for clinically appropriate vaccines, then the vaccine will be covered on an *outpatient* basis according to the terms of the *policy*, and subject to the appropriate local regulatory authorities deeming the vaccine to be safe and efficient in the country where it will be administered.

We cannot guarantee the availability of a vaccine in any location and *Cigna Healthcare* cannot control how or when any vaccine is distributed.

SECTION 2: GENERAL EXCLUSIONS

We will not offer cover or pay claims when it is illegal for *us* to do so under applicable laws. Examples include but are not limited to, exchange controls, local licensing regulations or trade embargo.

In accordance with clause 19, *we* will not cover any *beneficiaries* or pay claims in jurisdictions when doing so would violate applicable trade restrictions, including but not limited to: restrictions imposed by the United States Department of Treasury's Office of Foreign Assets Control; the European Union Commission, or; the United Nations Security Council Sanctions Committees.

We cannot be held responsible for any loss, damage, illness and/or *injury* that may occur as a result of receiving medical *treatment* at a *hospital* or from a *medical practitioner*, even when *we* have approved the *treatment* as being covered.

The following exclusions apply to *your policy*. Please also refer to the list of benefits detailed in the Customer Guide, including the notes section for any further restrictions and exclusions that apply, in addition to the General Exclusions. Please also refer to *your Certificate of Insurance* for any special exclusions that may apply.

1. *Treatment* which is provided by:

a) a *medical practitioner* who is not recognised by the relevant authorities in the country where the *treatment* is received as having specialist knowledge of, or expertise in, the *treatment* of the disease, illness or *injury* being treated;
b) a *medical practitioner, therapist, hospital, clinic*, or facility to whom *we* have given written notice that *we* no longer recognise them as a *treatment* provider. Details of individuals, institutions and organisations to whom *we* have given such notice may be obtained by calling *our* Customer Care Team; or
c) a *medical practitioner, therapist, hospital, clinic*, or facility which, in *our* reasonable opinion, is either not properly qualified or authorised to provide *treatment*, or is not competent to provide *treatment*.

2. *Treatment* for:

a) a *pre-existing condition*; or
b) any condition or symptoms which result from, or are related to, a *pre-existing condition*.

We will not pay for *treatment* for a *pre-existing condition* of which the *policyholder* was (or should reasonably have been) aware at the date cover commenced, and in respect of which *we* have not expressly agreed to provide cover.

3. Preventative *treatment*, including but not limited to health screening, routine health checks and vaccinations (unless that *treatment* is available under one of the options under which a *beneficiary* has cover).

We will pay for preventative *surgery* when a *beneficiary*:

a) has a significant family history of a disease which is part of a hereditary cancer syndrome (such as ovarian cancer); and
b) has undergone genetic testing which has established the presence of a hereditary cancer syndrome. (Please note that *we* will not pay for the genetic testing).

4. *Treatment* which is provided by anyone who lives at the same address as the *beneficiary*, or who is a member of the *beneficiary's* family.

5. *Treatment* which is necessary as a result of conflict or disaster including but not limited to:

a) nuclear or chemical contamination;
b) war, invasion, acts of terrorism, rebellion (whether or not war is declared), civil war, commotion, military coup or other usurpation of power, martial law, riot, or the act of any unlawfully constituted authority;

c) any other conflict or disaster events;

where the *beneficiary* has:

i) put him or herself in danger by entering or remaining within a known area of conflict (as identified by a Government in *your country of nationality*, for example the British Foreign and Commonwealth Office);
ii) actively participated in the conflict; or
iii) displayed a blatant disregard for their own safety.

6. Any *treatment* outside *your country of habitual residence* or *country of nationality (area of coverage*), unless the *treatment* can be covered under the 'Out of Area Emergency cover' benefit as detailed in clause 8.3.

7. Travel costs for *treatment* including any fares such as taxis or buses, unless otherwise specified, and expenses such as petrol or parking fees.

8. Any expenses for ship to shore evacuations.

9. *Treatment* in nature cure *clinics*, health spas, nursing homes, or other facilities which are not *hospitals* or recognised medical *treatment* providers. Specifically, we would not cover the costs of nursing care (such as accommodations, meals and living expenses) or of any other form of treatment in a residential or elderly care facility even if the treatment is medically necessary and/or provided by a recognized medical practitioner.

10. Charges for residential stays in *hospital* which are arranged wholly or partly for domestic reasons or where *treatment* is not required or where the *hospital* has effectively become the place of domicile or permanent abode.

11. Costs of *hospital* accommodation for a deluxe, executive or VIP suite.

12. Any *prosthetic device* or appliance, including but not limited to hearing aids and spectacles, which is not *medically necessary* and/or does not fall within our definition of *prosthetic device(s)*.

13. Incidental costs including newspapers, telephone calls, guests' meals and hotel accommodation.

14. Costs or fees for filling in a claim form or other administration charges.

15. Non-medical admissions or stays in *hospital* which include:

a) *treatment* that could take place on a *daypatient* or *outpatient* basis;
b) convalescence;
c) admissions and stays for social or domestic reasons e.g. washing, dressing and bathing.

16. Life support *treatment* (such as mechanical ventilation) unless such *treatment* has a reasonable prospect of resulting in the *beneficiary's* recovery, or restoring the *beneficiary* to his or her previous state of health.

17. Foetal *surgery*, i.e. *treatment* or *surgery* undertaken in the womb before birth or *treatment* by way of the intentional termination of pregnancy, unless the pregnancy endangers a *beneficiary's* life or mental stability, and any other maternity *treatments* including complications arising from maternity.

18. Footcare by a Chiropodist or Podiatrist.

19. *Treatment* for, or in connection with, smoking cessation.

20. *Treatment* that arises from, or is in any way connected with attempted suicide, or any *injury* or illness that the *beneficiary* inflicts upon him or herself. *We* will cover *medically necessary* mental health care and behavioural health services, including but not limited to counselling and therapy with specialists.

21. Developmental problems, *treatment* for personality and/or character disorders, including but not limited to:

a) learning difficulties such as dyslexia;
b) physical development problems such as short height;
c) affective personality disorder;
d) schizoid personality disorder; or
e) histronic personality disorder.

22. Disorders of the temporomandibular joint (TMJ).

23. *Treatment* for a related condition resulting from addictive conditions and disorders.

24. *Treatment* for a related condition resulting from any kind of substance or alcohol use or misuse.

25. *Treatment* needed because of, or relating to, male or female birth control, including but not limited to:

a) surgical contraception, namely:
   - vasectomy, sterilisation or implants;

b) non-surgical contraception, namely:
   - pills or condoms;

c) family planning, namely:
   - meeting a *doctor* to discuss becoming pregnant or contraception.

26. *Treatment* for sexual dysfunction disorders (such as impotence) or other sexual problems regardless of the underlying cause.

27. *Treatment* which is intended to change the refraction of one or both eyes, including but not limited to laser *treatment*, refractive keratotomy and photorefractive keratectomy. Note that *we* will pay for *treatment* to correct or restore eyesight if it is needed as a result of a disease, illness or *injury* (such as cataracts or a detached retina).

28. Gender reassignment *surgery*, including elective procedures and any medical or psychological counselling in preparation for, or subsequent to, any such *surgery*, unless state or federal law requires such coverage. *We* will cover *medically necessary* behavioural health services, including but not limited to, counselling for gender dysphoria and related psychiatric conditions (such as anxiety and depression) and *medically necessary* hormonal therapy.

29. *Treatment* which is necessary because of, or is any way connected with, any *injury* or sickness suffered by a *beneficiary* as a result of:

a) taking part in a sporting activity at a professional level;
b) taking part in a hazardous sporting activity or hobby, including but not limited to off-piste winter sports (including skiing, ski-touring, snowboarding, heli-skiing or heliboarding), base or bungee jumping, sky diving, tombstoning or cliff jumping, mountaineering or rock climbing, free climbing (without harness or rope), potholing, fell or trail running, motorsports, equestrian sports (for instance horse racing, show jumping, or polo), hunting, bull riding or bull running, parkour, powerlifting, surfing or kitesurfing, white water rafting;
c) solo scuba-diving; or
d) scuba-diving at a depth of more than thirty (30) metres unless the *beneficiary* is appropriately qualified (namely PADI or equivalent) to scuba-dive at that depth.

Note: Winter sports performed on marked trails (on-piste) are not considered as hazardous sporting activities. Medically necessary treatment would not be excluded as a result of an incurred injury as long as on-piste winter sport activities are not performed at a competition or professional level.

Hill-walking, hiking and trekking performed on defined on-piste trails is not considered as a hazardous sporting activity as long as specialty equipment is not required (such as use of ropes, harness, karabiner, crampons and protective climbing equipment). Medically necessary treatments following any injury sustained during these non-hazardous activities will be covered under the appropriate inpatient, daypatient or outpatient benefit.

30. *Treatment* which (in *our* reasonable opinion) is experimental, or has not been proven to be effective. This includes but is not limited to:

a) *treatment* which is provided as part of a clinical trial;
b) *treatment* which has not been approved by the relevant public health authority in the country in which it is received; or
c) any drug or medicine which is prescribed for a purpose for which it has not been licensed or approved in the country in which it is prescribed.

31. Any form of *cosmetic* or reconstructive *treatment* and any complication thereof, the purpose of which is to alter or improve appearance even for psychological reasons, unless that *treatment* is *medically necessary* and

is a direct result of an illness or an *injury* suffered by the *beneficiary*, or as a result of *surgery*.

32. *Treatment* that is in any way caused by, or necessary because of, a *beneficiary* carrying out an illegal act.

33. Any expenses for:

a) weight loss drugs and slimming aids. These drugs are not covered even if they are prescribed for weight management by a medical practitioner or acknowledged as having therapeutic effects.

b) supplements (such as infant formula and cosmetic products) or substances that are available naturally, such as vitamins, minerals and organic substances, collected over-the-counter (OTC) or through a prescription.

We will cover, however, some supplements and vitamins in case of medical necessity to treat diagnosed vitamin deficiency syndromes, such as iron deficiency, anaemia, or folic acid during pregnancy.

34. Organ transplants and any related treatment or supervision. In addition, we would not cover the costs related to any cells, organisms or tissue donations for transplant or implanting purposes (regardless of where the donation comes from), such as:

a) mechanical or animal organs;
b) purchase of a donor organ from any source; or
c) harvesting and storage of stem cells, as a preventative measure against possible future disease.

35. Sleep disorders unless there are indications that the *beneficiary* is suffering from severe sleep apnoea. In these circumstances, *we* will only pay for:

a) one (1) sleep study; and
b) the hire of equipment such as a Continuous Positive Airway Pressure (CPAP) machine (only if the *beneficiary* has cover under the Outpatient and Wellness Care option).

If it is *medically necessary*, *we* will pay for surgery.

36. *Treatment* for obesity, or which is necessary because of obesity. This includes, but is not limited to, slimming classes, aids and drugs.

We will only pay for gastric banding or gastric bypass surgery if a *beneficiary*:

a) has a body mass index (BMI) of 40 or over and has been diagnosed as being morbidly obese;
b) can provide documented evidence of other methods of weight loss which have been tried over the past twenty-four (24) months; and
c) has been through a psychological assessment which has confirmed that it is appropriate for them to undergo the procedure.

37. *Treatment* relating to infertility (other than investigation to the point of diagnosis), fertility *treatment* of any sort, or *treatment* of complications arising as a result of such *treatment*. This includes, but is not limited to:

a) in-vitro fertilisation (IVF);
b) gamete intrafallopian transfer (GIFT);
c) zygote intrafallopian transfer (ZIFT);
d) artificial insemination (AI);
e) prescribed drug *treatment*;
f) embryo transportation (from one physical location to another); or
g) ovum and/or semen donation and related costs.

We will pay for investigations into the cause of infertility if:

a) the specialist wishes to rule out any medical cause;
b) the *beneficiary* has been covered under this *policy* for two (2) consecutive years before the investigations have commenced; and
c) the *beneficiary* was unaware of the existence of any infertility problem, and had not suffered any symptoms, when their cover under this *policy* commenced.

38. *Treatment* directly related to surrogacy.

39. *Treatment* directly or indirectly related to abnormalities, deformity, disease, illness or *injury* present at birth (congenital conditions) whether evident or not at the moment of childbirth.

SECTION 3: DEFINITIONS

The words and phrases set out below have the meanings specified. Where those words and phrases are used with those meanings, they will appear in italics in these *Policy Rules*, and in the Customer Guide, including the list of benefits.

Unless otherwise provided, the singular includes the plural and the masculine includes the feminine and vice versa.

Annual renewal date - the anniversary of the *start date*.

Application - the *policyholder's* application (whether they have sent in a form directly to *us* or through a broker or applied online or through *our* telemarketers), and any declarations that they made during their enrolment for them and any *beneficiaries* included in the application.

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

Area of coverage - *your country of habitual residence* and *your country of nationality*. For the avoidance of doubt this is the *policyholder's country of habitual residence* and *country of nationality*.

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

Certificate of Insurance - the certificate issued to the *policyholder*. This shows the *policy* number, the annual premium, the *start date*, *the* deductible amount (if selected), the cost share amount (if selected), the out of pocket maximum (if applicable), details of who is covered, any special exclusions or exclusions that have been removed at an additional premium and the health plan and selected options (if applicable) which apply.

Cigna, we, us, our, the insurer - see page 3 of these *Policy Rules* for details of the Cigna insurer providing *your policy*.

Clinic(s) - a health care facility which is registered or licensed in the country in which it is located, primarily to provide care for *outpatients* and where care or supervision is by a *medical practitioner*.

Condition(s) - any disease, illness or *injury* a *beneficiary* is diagnosed with.

Core cover - includes all aspects of *inpatient* and *daypatient treatment* included in the *list of benefits*. This does not include the optional modules which *you* may choose.

Cosmetic - services, procedures or items that are supplied primarily for aesthetic purposes and which are not necessary in order to maintain an acceptable standard of health.

Country of habitual residence - the country where all *beneficiaries* habitually reside, as stated in *your application*.

Country of nationality - the country of which *you* are a citizen, national or subject, as stated in *your application*.

Daypatient - a patient who is admitted to a *hospital* or daypatient unit or other medical facility for *treatment* or because they need a period of medically supervised recovery, but who does not occupy a bed overnight. This also includes surgical procedures carried out in a *doctor's* surgery.

Dentist - dental surgeon or dental practitioner who is registered or licensed as such under the laws of the country, state or other regulated area in which the *treatment* is provided.

Doctor - a medical professional who is registered and licensed under the laws of the country, state or regulated area to practice medicine in the country in which the *treatment* is provided.

Emergency treatment - *treatment* which is *medically necessary* to prevent the immediate and significant effects of illnesses, *injuries* or conditions which, if left

untreated, could result in a significant deterioration in health. Only medical *treatment* through a physician, *medical practitioner* and hospitalisation that commences within twenty four (24) hours of the emergency event will be covered.

End date - the date on which cover under this *policy* ends, as shown in the *Certificate of Insurance*.

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

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

Expatriate - means a *beneficiary* residing outside the country of which they are a national, in the *country of habitual residence* as stated in *your application*.

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

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

Hospital - any organisation or institution which is registered or licensed as a medical or surgical hospital in the country in which it is located and where the *beneficiary* is under the daily care or supervision of a *medical practitioner* or *qualified nurse*.

Initial start date - the first day the *beneficiary's* cover commenced on the *Core cover*.

Injury - a physical injury.

Inpatient - a patient who is admitted to *hospital* and who occupies a bed overnight or longer, for medical reasons.

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

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

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

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

Medical practitioner - a *doctor* or specialist who is registered or licensed to practice medicine under the laws of the country, state or other regulated area in which the *treatment* is provided, and who is not covered under this *policy*, or a family member of someone covered under this *policy*.

Outpatient - a patient who attends a *hospital*, consulting room, or outpatient *clinic* for *treatment* and is not admitted as a *daypatient* or an *inpatient*.

Period of cover - the twelve (12) months continuous period during which the *beneficiaries* are covered under this *policy*, being the period from the *start date* to the *end date* as noted

in the *Certificate of Insurance* or earlier if terminated in accordance with the *Policy Rules*.

Personal Data - any information relating to an identified or identifiable natural person.

Policy - the policy comprising these *Policy Rules*, the Customer Guide (which contains the list of benefits and claiming information), and *your Certificate of Insurance*.

Policy documents - the documentation relating to the *policy*, comprising of these *Policy Rules*, the Customer Guide, *your Certificate of Insurance* and *your Cigna* ID Card.

Policyholder - a person who is aged 18 years or older who has made an *application* to *us* which has been accepted in writing by *us*, and who pays the premium under the *policy*.

Policy Rules - the terms and conditions, general exclusions and defined terms that govern this *policy*.

Pre-existing condition - any disease, illness or *injury*, or symptoms present before the *initial start date* linked to such disease, illness or *injury* for which:

- medical advice or *treatment* has been sought or received; or
- the *beneficiary* knew about and did not seek medical advice or *treatment*.

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

Prosthetic device(s) - an artificial limb or tool which is required for the purpose of, or in connection with *surgery*; or is a necessary part of the *treatment* immediately following *surgery* for as long as required by *medical necessity*; or which is *medically necessary* and is part of the recuperation process on a short-term basis.

Qualified nurse - a nurse who is registered or licensed as such under the laws of the country, state or other regulated area in which the *treatment* is provided.

Rehabilitation - physical, speech and occupational therapy for the purpose of *treatment* aimed at restoring the *beneficiary* to their previous state of health after an event.

Special category data - *personal data* revealing racial or ethnic origin, political opinions, religious or philosophical beliefs or trade union membership, genetic data, biometric data for the purpose of uniquely identifying a natural person, data concerning health and data concerning a person's sex life or sexual orientation.

Spouse - a *beneficiary's* legal husband or wife, or unmarried or civil partner who *we* have accepted for cover under this *policy*.

Start date - the date on which coverage under this *policy* starts, as shown in the *Certificate of Insurance*.

Surgery - the branch of medicine that treats diseases, *injuries*, and deformities by operative methods which involves an incision into the body.

Therapist - a speech therapist, dietician or orthoptist who is suitably qualified and holds the appropriate license to practice in the country where *treatment* is received.

Treatment - any surgical or medical treatment controlled by a *medical practitioner* that is *medically necessary* to diagnose, cure or substantially relieve disease, illness or *injury*.

USA - the United States of America and US territories.

You, your - the *policyholder*.

Cigna Close Care℠ Policy Rules CLICE EXP EN 02/2025