



Cigna Close CareSM

Policy Rules

Terms, General Exclusions and
Definitions relating to your plan



CONTENTS

Please read these Policy Rules along with your Certificate of Insurance, your Customer Guide and your application 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.

Unless otherwise specified, words and phrases included in Section 3, 'Definitions', when used throughout these Policy Rules, and your Customer Guide (including the Table of Benefits section on pages 17-34), will have the meanings given to them in that Section..

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

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LEGAL AND REGULATORY INFORMATION

This insurance is provided by:

Cigna Europe Insurance Company S.A.-N.V., UK branch
(Financial Services Register No. 207198)

Having its UK place of establishment at:

13th Floor, 5 Aldermanbury Square
London EC2V 7HR

Cigna Europe Insurance Company S.A. – N.V., UK branch is authorised and regulated by the National Bank of Belgium. Authorised by the Prudential Regulation Authority. Subject to regulation by the Financial Conduct Authority and limited regulation by the Prudential Regulation Authority. Details about the extent of our regulation by the Prudential Regulation Authority are available from us on request.

Cigna Europe Insurance Company S.A. – N.V., is a private limited liability company regulated in Belgium by the National Bank of Belgium and registered in the Brussels Trade Registry (number 0474.624.562) at Plantin en Moretuslei 309, 2140 Antwerpen, Belgium.

This policy is administered by Cigna European Services (UK) Limited (Financial Services Register No. 788765), a company registered in England and Wales at 13th Floor, 5 Aldermanbury Square, London EC2V 7HR. VAT registration No 740445451 (Company Number 00199739), and which is an Appointed Representative of Cigna Europe Insurance Company S.A.-N.V. UK branch.

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 6.6 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 (Mon to Fri 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 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.

6.6.1

If the policy is terminated in accordance with clause 6.6, 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.

6.7

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.

6.8

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 CareSM to Cigna Global Health Options (CGHO) Silver plan or moving from CGHO Silver to Cigna Close CareSM),
- > 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 CareSM 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 6.6, in which case clauses 6.6.I, 6.7 and 6.8 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 legislation enacted by the UK and any

guidance or codes of practice issued in respect of protection of personal data by any UK data protection regulator 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: (1) 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 (12) 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 I9, 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.

I. Unlicensed or unrecognised treatment facilities, providers and practitioners

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. Pre-existing conditions

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 treatments

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 by family members or co-habitants

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. Conflicts, disaster or high-risk behaviour

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. Treatment outside selected coverage area

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

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

8. Ship to shore evacuations

Any expenses for ship to shore evacuations.

9. Nursing homes, health spas, and nature clinics

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. Hospital stays for non-medical reasons

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. Reasonable hospital accommodation

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

12. Prosthetic devices

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 expenses

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

14. Administration costs

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

15. Non-medical hospital admissions

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. Artificial life maintenance

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

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

Footcare by a Chiropodist or Podiatrist.

19. Smoking cessation

Treatment for, or in connection with, smoking cessation.

20. Self-inflicted injury or attempted suicide

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 and personality disorders

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) histrionic personality disorder.

22. Temporomandibular joint disorders (TMJ)

Disorders of the temporomandibular joint (TMJ).

23. Addictive conditions and disorders

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

24. Substance and alcohol misuse

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

25. Contraception

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. Sexual dysfunction disorders

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

27. Refractive eye surgery

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

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. Hazardous and professional sporting activities

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. Experimental or unapproved treatments

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. Cosmetic treatments

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. Illegal Act

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

33. Weight-loss drugs and other supplements

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 transplant and related procedures

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

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. Obesity

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. Infertility

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. Surrogacy

Treatment directly related to surrogacy.

39. Congenital Conditions

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

Unless otherwise specified, the words and phrases defined below when used throughout these Policy Rules, and your Customer Guide (including the Table of Benefits section on pages 17-34), will have the following meanings.

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.

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

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

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

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

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

Country of nationality - any country of which a beneficiary is a citizen, national or subject, as 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.

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

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 of their country of nationality.

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

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

Initial start date - the first day the beneficiary's cover commenced on the International Medical Insurance plan.

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

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

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

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

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

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

Medical practitioner - a doctor, specialist, qualified nurse or therapist (including speech therapies, dietician or orthoptist), dental surgeon or dental practitioner who is registered, suitably qualified or licensed to practice medicine or

provide treatment under the laws of the country, state or other regulated area in which the treatment is provided, and who is not covered under this policy, or a family member of someone covered under this policy.

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

An example of outpatient treatment would be visiting an outpatient clinic to undergo a mole removal where you are not required to be admitted to hospital and do not require general anaesthetic for the procedure.

Period of cover - this policy has a minimum period of cover of three (3) months and a maximum period of cover of twelve (12) months renewable. The period of cover is from the start date to the end date as noted in the Certificate of Insurance or earlier if terminated in accordance with the Policy Rules.

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

Policy - the policy comprising of:

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

Policyholder - 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.

Pre-existing condition - any disease, illness or injury, or symptoms present before the initial start date of your policy for which:

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

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

Selected area of coverage - means either:

- Worldwide, including USA (every country throughout the world, excluding any country with whom, at the date of commencement of treatment, the Federal Government of the USA has prohibited trade to the extent that payments are illegal under applicable law.); or
- Worldwide, excluding USA (worldwide, with the exception of the USA) .

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..

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

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



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