POLICY RULES

Terms, General Exclusions, and Definitions relating to your plan
POLICY RULES

Please read the Policy Rules along with your Certificate of Insurance and your Customer Guide as they all form part of your contract between you and us.

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This policy is designed for expatriates. It does not provide any cover for the cost of treatment in a country of which a beneficiary is a national at the time of treatment (for example, the cover does not cover the costs of a German national obtaining any treatment in Germany) except where the beneficiary is on a visit to that country, all such visits during the period of cover last for a total of less than ninety (90) days, and the country is within the selected area of coverage. See clause 17 for full details.

If you do not fully understand the terms and conditions of this policy, then you should contact us within fourteen (14) days of the start date shown on your Certificate of Insurance.

If the policy does not meet your needs, or has not been issued in accordance with your intention, you may ask us to cancel it within fourteen (14) days of the start date shown on your Certificate of Insurance. If no claims have been made, and no guarantees of payment or prior approvals have been put in place, we will refund any premium which has been paid.

Words and phrases in italics have the meanings given to them in section 3, ‘Definitions’.

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.
1. **Scope of cover**

Subject to the terms, conditions, limits and exclusions set out in this policy, Cigna shall reimburse medical and related expenses relating to treatment provided within the selected 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.

2. **Policy documents**

These Policy Rules, your application, your Certificate of Insurance and the Customer Guide constitute the entire contract between you and us. You should read these documents carefully.

3. **Policy eligibility**

You must be eighteen (18) years old or over to purchase a policy.

4. **When does the cover begin?**

4.1 The cover will begin on the start date shown on the first Certificate of Insurance which we send to you. The renewal date will fall on this date each year.

4.2 If you choose to buy cover for any additional beneficiaries, their cover will begin on the start date shown on the first Certificate of Insurance on which they are listed.

4.3 Where there is a delay between your application and the initial start date of your policy and your state of health changes during the period of delay, you must let us know. We reserve the right to cancel the policy or apply additional premiums or exclusions as a result of any change to your state of health notified to us. If you fail to inform us of any change to your state of health during the period of delay, we may treat this as a misrepresentation, which could affect coverage under your policy or payment of claims.

5. **When does the cover end?**

5.1 This policy is an annual contract. This means that, unless it is terminated earlier or renewed, the cover will end one (1) year after the start date. For example, if the start date is 1 January, the final day of cover will be 31 December.

5.2 Cover will automatically end for any beneficiary if:

5.2.1 the beneficiary dies (although any benefits which may be payable after death, such as repatriation of mortal remains, will still be paid); or

5.2.2 the policy is terminated. The circumstances in which you or we can terminate the policy are explained in clause 14.
5.3 If you die, cover will end for all beneficiaries. If this happens, we will try to contact any other beneficiaries who are covered under this policy, and offer them the opportunity to continue the cover until the end date, with one of them taking over as policyholder. If the beneficiary does wish to continue the cover, they must respond, in writing, within thirty (30) days, to confirm their acceptance. If they do not do so, 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.

5.4 If this policy ends before the normal 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 and no guarantees of payment or prior approvals have been put in place during the period of cover.

If the policy ends before the normal end date and you have made claims under it, you will be liable for the remainder of any premiums in respect of the policy which are unpaid.

6. How is the policy renewed?

6.1 We will write to you at least one (1) calendar month before the end date and ask you whether you want to renew the cover you currently have. We will also inform you of any changes to the premiums, definitions, benefits and terms and conditions which will apply on renewal.

6.2 If you choose to renew, you do not need to do anything, and your cover will be renewed automatically for another twelve (12) months. If you do not want to renew your cover, you must let us know at least seven (7) days before your policy end date. Renewal is subject to the definitions, benefits and terms and conditions of the Policy Rules in force at the time of renewal. If we are unable to renew your cover for the reasons detailed in clause 14.1, we will give you notice as described in clause 14.5.

6.3 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.

7. Who is covered?

7.1 You may add certain persons (e.g. family members) as beneficiaries to your policy. This is at our absolute discretion. In order to do so, you must include them in your application. If we agree to cover them, we will include their names on your Certificate of Insurance. Additional premium may be payable, and special exclusions may be applied in relation to them.

7.2 You may, if we give permission, take out cover for certain people (e.g. minor children or other dependents) while not taking out cover for yourself. In this situation, you will be the policyholder, and will be responsible for payment of premiums and all other obligations under the policy, but will not be covered. All applications will be subject to medical underwriting and we will let the policyholder know the terms that will apply to any beneficiary named on the Certificate of Insurance.
8. Can I add or remove beneficiaries part way through the period of cover?

8.1 Unless there has been a relevant qualifying life event, you may add or remove a beneficiary only when you are renewing the cover at the end of an annual period of cover. For example, if the start date shown on your Certificate of Insurance is 1 January, you may only add or remove a new beneficiary with effect from 1 January the following year.

8.2 If there has been a relevant qualifying life event, you may add or remove the other person involved in that qualifying life event as a beneficiary part way through the period of cover. If you would like to add a new beneficiary on this basis, you must send us a completed application for that person.

We will then tell you whether we will offer cover to that person and, if so, any special conditions or exclusions and any additional premium which would apply. Cover for the new beneficiary will begin from the date on which you confirm your acceptance.

We will send you an updated Certificate of Insurance to confirm that the new beneficiary has been added.

8.3 If you or your spouse gives birth, you may apply to add the newborn as a beneficiary to your existing plan:

8.3.1 If at least one parent has been covered by the policy for a continuous period of twelve (12) months or more prior to the newborn’s birth and the application is received by us within thirty (30) days of the newborn’s date of birth, the newborn will not be subject to medical underwriting, we will not require information regarding the newborn’s health or a medical examination, and cover will begin when we confirm receipt of the application. We will send you an updated Certificate of Insurance confirming that the new beneficiary has been added.

8.3.2 If at least one parent has been covered by the policy for a continuous period of twelve (12) months or more prior to the newborn’s birth and the application is received by us more than thirty (30) days after the newborn’s date of birth, the newborn will be subject to medical underwriting. We will then tell you whether we will offer cover to the newborn and, if so, any special conditions and exclusions which would apply. If you accept the offered terms, cover will begin when we confirm receipt of the application. We will send you an updated Certificate of Insurance confirming that the new beneficiary has been added.

8.3.3 If neither parent has been covered by the policy for a period of twelve (12) consecutive months or more prior to the newborn’s birth, the newborn will be subject to medical underwriting. We will then tell you whether we will offer cover to the newborn and, if so, any special conditions and exclusions which would apply. If you accept the offered terms, cover will begin when we confirm receipt of the application. We will send you an updated Certificate of Insurance confirming that the new beneficiary has been added.
9. What is covered?

9.1
This policy covers certain costs of services or supplies which are recommended by a medical practitioner, and which are medically necessary for the care and treatment of an injury or sickness, as determined by us.

9.2
The costs which are covered are set out in the Customer Guide. These costs are subject to the limits and exclusions which are set out in these Policy Rules, the Customer Guide, and your Certificate of Insurance.

9.3
In addition to prior approval for treatment; further approval may be required for any treatment incurred in relation to the maternity and childbirth benefit if at the time of treatment:

9.3.1
the mother is intending to be outside her country of habitual residence; or

9.3.2
the mother is intending to be in her country of nationality.

9.4
Special exclusions, imposed on an individual basis, may apply. Details of these special exclusions will be shown on your Certificate of Insurance. 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.

9.5
Any claim is subject to the applicable deductible, cost share and limits of cover set out in these Policy Rules, the Customer Guide, and your Certificate of Insurance.

9.6
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).

10. Coverage options

10.1
The International Medical Insurance plan is provided to every beneficiary. The benefits which are available (subject to the applicable terms, conditions, limits and exclusions) are set out in ‘Your Benefits in Detail’ in the Customer Guide.

10.2
You may (if you pay additional premium) add to the cover provided under the International Medical Insurance plan by choosing one or more from the following extra coverage options. If you do, the extra coverage will apply to all beneficiaries under your policy:

10.2.1
International Outpatient;

10.2.2
International Medical Evacuation;

10.2.3
International Health and Wellbeing; and

10.2.4
International Vision and Dental.

10.3
Details of the extra coverage options are set out in ‘Your Benefits in Detail’ in the Customer Guide.

10.4
Coverage options cannot be changed at your request during the period of cover. If you want to add or remove coverage
options, you should let us know before the annual renewal date.

10.5
If you want to add new coverage options, we may ask for a completed medical history questionnaire, and we may apply new special restrictions or exclusions on the new coverage options.

10.6
You may (unless your country of habitual residence is the USA) choose between two options (Worldwide excluding USA and Worldwide including USA) to determine where in the world beneficiaries will be covered.

10.6.1
The Worldwide excluding USA option provides cover, subject to the terms of the policy, for treatment anywhere in the world except the USA. This option is not available if your country of habitual residence is the USA.

Beneficiaries will be covered for emergency treatment on an inpatient or daypatient basis or provided on an outpatient basis (if the International Outpatient additional coverage option has been purchased under your policy) during temporary business or holiday trips even if those trips are outside your selected area of coverage. As with all emergency treatment, if you have not purchased the International Outpatient additional coverage option, your emergency treatment will only be covered if it results in an admission to the hospital. This cover will be limited to a maximum period of three (3) weeks per trip and a maximum of sixty (60) days per period of cover for all trips combined.

Coverage continues to be subject to the maximum benefit amounts stated in your Customer Guide; 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. Charges relating to maternity, pregnancy, childbirth or any complications of pregnancy or childbirth are excluded from this benefit.

Proof of the date of entry into the country outside your selected 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.

10.6.2
The Worldwide including USA option provides cover, subject to the terms of the policy, for treatment anywhere in the world (including the USA).

11. Premium and other charges

11.1
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.

11.2
Payments must be made in the currency and in the manner detailed on your Certificate of Insurance.
11.3 We may apply certain penalties if any beneficiaries do not seek prior approval for treatment or receive treatment in the USA at a hospital, clinic or medical practitioner which is not part of the Cigna network. A list of Cigna network of hospitals, clinics and medical practitioners is available in your secure online Customer Area.

11.4 You are responsible for paying the premium and any other charges as detailed on your Certificate of Insurance, and are also responsible for making sure these payments are made on time.

11.5 If you do not pay premium and 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 at 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.

11.6 The premium and / or other charges may vary from year to year. We will write to you before the annual renewal date to tell you about the premium and or other charges which will apply during the next period of cover.

12. Deductible

12.1 We will reduce the amount which we will pay towards the cost of treatment in respect of each claim which is made under the International Medical Insurance or International Outpatient option (if applicable) by the amount of any deductible until the deductible for the period of cover is reached.

12.2 The deductible applies separately to each beneficiary, each coverage option, and each period of cover.

12.3 You can choose to have a deductible on the International Medical Insurance or International Outpatient option. If you do so, your premium will be lower than it otherwise would be. If you would like to apply a deductible, you should tell us so in your application.

12.4 No deductible applies to ‘Inpatient Cash Benefits’ or ‘Newborn Care Benefits’.

12.5 You will be responsible for paying the amount of any deductible directly to the hospital, clinic or medical practitioner. We will let you know what this amount is.

12.6 You can request a change to the deductible with effect from your annual renewal date each year. If you wish to remove or reduce your deductible, we may require a medical history questionnaire, and we may apply new special restrictions or exclusions.
13. Cost share

13.1 If a cost share is selected on the International Medical Insurance plan, we will reduce the amount we pay towards the cost of treatment by the cost share percentage. The cost share percentage results in a proportion of the costs of treatment not being covered by us; these costs will be capped by the out of pocket maximum you have chosen for any one period of cover.

13.2 If a cost share is selected on the International Outpatient option, we will reduce the amount we pay towards the cost of treatment by the cost share percentage. The cost share percentage results in a proportion of costs of treatment not being covered by us; these costs will be capped by the out of pocket maximum you have chosen for any one period of cover.

13.3 Only amounts you pay related to the cost share on the International Medical Insurance or International Outpatient plan are subject to the capping effect of 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 International Medical Insurance plan or International Outpatient option; or due to penalties for not obtaining proper pre-authorisation or using out of network providers in the USA, are not subject to the out of pocket maximum.

13.4 The out of pocket maximum and the cost share apply separately to each beneficiary and each period of cover.

13.5 You can choose to have a cost share on the International Medical Insurance plan or International Outpatient option. If you do so, your premium will be lower than it otherwise would be. If you would like to apply a cost share, you should tell us so in your application. Additionally, if you choose to have a cost share, you also select a corresponding out of pocket maximum.

13.6 If you select both a deductible and a cost share, the amount you will need to pay due to the deductible is calculated before the amount you will need to pay due to the cost share. Refer to clause 12 for more information relating to deductibles.

13.7 You will be responsible for paying the amount of any cost share directly to the hospital, clinic or medical practitioner. We will let you know what this amount is.

13.8 You can request a change to the cost share and out of pocket maximum with effect from your annual renewal date each year. If you wish to remove or reduce your cost share or reduce your out of pocket maximum, we may require a medical history questionnaire and we may apply new special restrictions or exclusions.

14. Termination of cover

14.1 Subject to any conflicting legal or regulatory requirements we may terminate this policy if:

14.1.1 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; or

14.1.2 it becomes unlawful for us to provide any of the cover available under this policy; or
14.1.3 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; or

14.1.4 we determine, on reasonable grounds, that you have, in the course of applying for the policy or when making any claim under it, 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; or

14.1.5 we are no longer in the market to sell the policy or a suitable alternative in your geographical area.

14.2 If you want to terminate this policy and end cover for all beneficiaries, you may do so at any time by giving us at least seven (7) days’ notice in writing.

14.3 If this policy ends before the normal 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 and no guarantees of payment or prior approvals have been put in place during the period of cover. If your policy is terminated in accordance with clause 14.1.4, however, we may not refund any premiums you have paid and payment of any claims you have made under your policy may also not be made.

If the policy ends before the normal end date and you have made claims under it, you will be liable for the remainder of any premiums in respect of the policy which are unpaid.

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

14.5 We will wherever possible, write to you at least one (1) month before the end date to give you written notice that the policy will not be renewed with effect from the end date.

15. Your duty of reasonable care

You must take reasonable care to answer all questions from us honestly, accurately and in full. If you fail to do so, or if you deliberately or recklessly provide us with information which you know or believe to be untrue or inaccurate, this could result in us cancelling your policy, reducing the value of any claims payment which you are due, or in refusing to pay a claim or claims altogether.

16. Fraud

Any beneficiary who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information which has been asked for, commits a fraudulent insurance act, which is a crime.
17. Expatriates and nationals

17.1
This policy does not cover any costs of treatment in a country of which the beneficiary receiving treatment is a national, except where the beneficiary is on a visit to that country, all such visits during the period of cover last for a total of less than ninety (90) days and the country is within the selected area of coverage.

17.2
If any beneficiary is not, or ceases to be, an expatriate (whether as a result of a change of nationality or a change of habitual residence), then you may:

17.2.1
leave the policy in force. Cover will remain unaffected for any beneficiary who is an expatriate and for any beneficiary who is not an expatriate but obtains treatment outside their country of nationality; or

17.2.2
terminate the policy in accordance with clause 14.2, in which case clauses 14.3 and 14.4 will apply.

17.3
In some instances, we may need to end the cover if a change of country of habitual residence would make it unlawful for us to provide you with cover or would result in a breach of regulations governing the provision of healthcare cover to local nationals, residents or citizens.

17.4
We reserve the right to ask you for further information about a change in your country of habitual residence. A change to your country of habitual residence may result in an increase to your premium or additional tax becoming payable, meaning you 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, in accordance with clause 14.2, in which case clauses 14.3 and 14.4 will apply.

18. Change of address and nationality

18.1
We will send any communication and notices in relation to this policy to the postal address or email address you have provided. If you have chosen to receive your policy documents electronically, we will place them in your secure online Customer Area.

18.2
You must tell us if any beneficiaries change address, country of habitual residence, or country of nationality. We will then send you an updated Certificate of Insurance by the means which you have chosen (postal address you have provided or placing in your secure online Customer Area).

19. Contacting you

If we need to contact you in relation to this policy, or if we need to give you notice that we are going to amend or terminate this policy, we will write to you at the postal address or email address you have given us.
20. Contacting us

In some circumstances, which are explained in these rules, you may need to contact us in writing. If so, you should write to us at:

Cigna Global Health Options
Customer Care Team
1 Knowe Road
Greenock
Scotland
PA15 4RJ

or email us at:
cignaglobal_customer.care@cigna.com

In other circumstances you can call our Customer Care Team 24/7 on: +44 (0) 1475 788 182 or from inside the USA on 800 835 7677.

21. Changes to this policy

21.1
No person other than an executive officer of Cigna 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.

21.2
We reserve the right to change this policy to comply with any changes to relevant laws and regulations. If this happens, we will write and tell you of the change.

21.3
We also reserve the right to make changes to the terms of cover on renewal. We will give you at least one (1) calendar month’s notice of such changes and the changes will take effect from the annual renewal date.

21.4
If 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 on the Certificate of Insurance. At such date, we will also review the additional premium (if any) which we 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 premiums will be removed on renewal.

22. Who can enforce this policy?

Only we and you have legal rights in connection with this insurance. This means that only we or you may enforce the agreement (although we will allow anyone who is covered under this policy to use our complaints process).

23. 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.

24. Other insurance

If another insurer also provides cover, we will negotiate with them as regards who pays what proportion of any claim.

25. Data protection

25.1
Cigna needs to collect and process your personal information relating to you, for example your name, address, date of birth, telephone numbers and sensitive information such as details of health information relating to you, for the purposes of administering this policy and providing the insurance. You consent to Cigna collecting and processing all personal and sensitive information relating to you to the extent reasonably necessary for these purposes.

25.2
Telephone calls to and from Cigna may be recorded, for quality control.

This data will be processed by us to carry out our obligations, and we may need to share it, in certain circumstances, with third parties (such as healthcare providers or suppliers) who assist us in carrying out our obligations to you which may mean in certain instances we need to transfer data outside the European Economic Area (EEA). Where we do this, we take appropriate steps to ensure your data is secure and protected.

If you would like a copy of the information we hold about you, please write to us quoting your policy number. Please note that we may charge a reasonable fee to provide this information.

25.3
To help us detect and prevent fraud, we may need to share information with other insurers or organisations. If we need to share information for this reason, we will only share information which is required to enable the prevention or detection of fraud or attempted fraud, and will not share information about any beneficiary which is not necessary for these purposes.

26. Language

You have asked for all of the policy documents and all communications in relation to this policy to be provided in English. All such documents and communications will be provided in English only.

27. Regulatory information

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
28. Complaints

28.1 Any complaint should in the first instance be sent to us at:

Cigna Global Health Options
Customer Care Team
1 Knowe Road
Greenock
Scotland
PA15 4RJ

28.2 If the complaint is not resolved, you may complain to one of the following complaints bodies:

Ombudsman des Assurances
Square de Meeûs 35, boîte 6
1000 Bruxelles

Ombudsman van de Verzekeringen
de Meeûssquare 35, bus 6
1000 Brussel

Telephone: +32 (2) 547 58 71
Fax: +32 (2) 547 59 75
Email: info@ombudsman.as

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

29. Applicable law and jurisdiction

29.1 This policy is governed by, and will be interpreted in accordance with, English law.

29.2 Any disputes about this policy, including disputes about its validity, formation and termination, will be determined in the courts of England and Wales.
SECTION 2: GENERAL EXCLUSIONS

These are your General Exclusions. 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. Cover under this policy is subject to the following general exclusions:

1.1 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.

1.2 We will not cover you or pay claims 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.

1.3 We will not pay a claim which we have reasonable grounds to suppose has been made fraudulently.

1.4 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.

1.5 If a beneficiary does not have cover under the International Outpatient, International Medical Evacuation, International Health and Wellbeing, or International Vision and Dental options, we will not pay for any of the treatments or other benefits which are available under those options.

1.6 The following exclusions apply to the International Medical Insurance plan and to all of the extra coverage options.

Where, in the exclusions which are set out below, we have stated that we will pay for treatment in some circumstances, this is subject to the beneficiary having cover under the appropriate coverage option or options.

1.7 We will not pay for:

1.7.1 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.

1.7.2 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.

1.7.3 Treatment for a condition which is the subject of a special exclusion. Special exclusions are set out in your Certificate of Insurance.

1.7.4 Non-medical admissions or stays in hospital which include:

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

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

1.7.6 Donor organs:

a) mechanical or animal organs, except where a mechanical appliance is temporarily used to maintain bodily function whilst awaiting transplant;

b) purchase of a donor organ from any source; or

c) harvesting and storage of stem cells, when a preventative measure against possible future disease.

1.7.7 Foetal surgery, i.e. treatment or surgery undertaken in the womb before birth, unless this is resulting from complications arising through maternity and shall be subject to the limits detailed in the ‘Complicated Maternity’ section of your policy, where covered.

1.7.8 Footcare by a Chiropodist or Podiatrist.

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

- one sleep study;
- the hire of equipment such as a Continuous Positive Airway Pressure (CPAP) machine (only if the beneficiary has cover under the International Outpatient option).

If it is medically appropriate, we will pay for surgery.

1.7.10 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.
1.7.11 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.

1.7.12 Treatment for, or in connection with, smoking cessation.

1.7.13 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:
   > put him or herself in danger by entering a known area of conflict (as identified by a Government in your Country of nationality, for example the British Foreign and Commonwealth Office);
   > actively participated in the conflict; or
   > displayed a blatant disregard for their own safety.

1.7.14 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.

1.7.15 Treatment for or in connection with speech therapy that is not restorative in nature, or if such therapy is:
   a) used to improve speech skills that have not fully developed;
   b) can be considered educational; or
   c) is intended to maintain speech communication.

1.7.16 Developmental problems including:
   a) learning difficulties such as dyslexia;
   b) autism or attention deficit disorder (ADHD);
   c) physical development problems such as short height.

1.7.17 Disorders of the temporomandibular joint (TMJ).

1.7.18 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:
   > has a body mass index (BMI) of 40 or over and has been diagnosed as being morbidly obese;
   > can provide documented evidence of other methods of weight loss which have been tried over the past 24 months;
   > has been through a psychological assessment which has confirmed that it is appropriate for them to undergo the procedure.
1.7.19
*Treatment* in nature cure *clinics*, health spas, nursing homes, or other facilities which are not *hospitals* or recognised medical *treatment* providers.

1.7.20
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.

1.7.21
*Treatment* for a related condition resulting from addictive conditions and disorders.

1.7.22
*Treatment* for a related condition resulting from any kind of substance or alcohol use or misuse.

1.7.23
*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.

1.7.24
*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.

1.7.25
*Treatment* by way of the intentional termination of pregnancy, unless the pregnancy endangers a *beneficiary’s* life or mental stability.

1.7.26
*Treatment* directly related to surrogacy. *We* will not pay *maternity benefits*:

a) to a *beneficiary* who acts as a surrogate; or

b) to anyone else acting as a surrogate for a *beneficiary*. 
1.7.27 ‘Newborn Care Benefits’ for children born as a result of fertility treatment, such as IVF, or for children born to a surrogate, or who have been adopted. These children can only join once they are ninety (90) days old, and will be subject to medical underwriting.

1.7.28 Nursery care for a newborn in hospital, unless the mother is required to remain in hospital due to medical necessity for treatment that is covered by this policy.

1.7.29 Treatment for more than ninety (90) continuous days for a beneficiary who has suffered permanent neurological damage and/or is in a persistent vegetative state (PVS).

1.7.30 Treatment for personality and/or character disorders, including but not limited to:

- a) affective personality disorder;
- b) schizoid personality disorder; or
- c) histrionic personality disorder.

1.7.31 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).

Under the International Medical Insurance plan, the limits of cover for preventative surgery in respect of congenital conditions will apply, other than for cancer.

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

1.7.33 Treatment in the USA, unless the beneficiary has purchased Worldwide including USA cover under this policy, or the treatment can be covered under the Out of Area Emergency cover conditions.

1.7.34 Treatment in the USA (where the Worldwide including USA cover was purchased) if we know or reasonably suspect that the cover was purchased and the beneficiary travelled to the USA for the purpose of receiving treatment.

1.7.35 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.

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).
1.7.36
Any treatment outside your selected area of coverage, unless the treatment can be covered under the Out of Area Emergency cover conditions.

1.7.37
Travel costs for treatment including any fares such as taxis or buses, unless otherwise specified, and expenses such as petrol or parking fees.

1.7.38
Any expenses for international emergency services which were not approved in advance by the medical assistance service, where applicable.

1.7.39
International services expenses for emergency evacuation, medical repatriation and transportation costs for third parties where the treatment needed is not covered under this policy.

1.7.40
Any expenses for ship-to-shore evacuations.

1.7.41
Gender reassignment surgery, including elective procedures and any medical or psychological counselling in preparation for, or subsequent to, any such surgery.

1.7.42
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 on a professional basis;

b) solo scuba-diving; or
c) 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.

1.7.43
Treatment which (in our reasonable opinion) is experimental, is not orthodox, 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.

1.7.44
Any form of plastic, cosmetic or reconstructive treatment, 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. This includes but is not limited to:

a) facelifts (rhytidectomy);

b) nose reshaping (rhinoplasty);

c) liposuction and other procedures which remove fat tissue;

d) hair transplants; and
e) surgery to change the shape of, enhance or reduce breasts (other than breast reconstruction following treatment for cancer).
We will only pay for plastic, cosmetic or reconstructive treatment if the illness, injury or surgery as a result of which the treatment is required took place during the beneficiary’s current continuous period of cover and is itself covered under the policy.

1.7.45
Appliances, including but not limited to hearing aids and spectacles (unless the International Vision & Dental option is selected) which do not fall within our definition of surgical appliances and/or medical appliances.

1.7.46
Incidental costs including newspapers, taxi fares, telephone calls, guests’ meals and hotel accommodation.

1.7.47
Costs or fees for filling in a claim form or other administration charges.

1.7.48
Costs that have been or can be paid by another insurance company, person, organisation or public programme. 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.

1.7.49
Treatment that is in any way caused by, or necessary because of, a beneficiary carrying out an illegal act.
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.

A

‘Active treatment’ - treatment which is intended to shrink a cancer, stabilise it or slow down the spread of the disease. This excludes treatment given solely to relieve symptoms.

‘Acute’ - a disease, illness or injury that is likely to respond quickly to treatment which aims to return the beneficiary to the state of health he or she was in immediately before suffering the disease, illness or injury, or which leads to his or her full recovery.

‘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’ - birth, two (2) months, four (4) months, six (6) months, nine (9) months, twelve (12) months, fifteen (15) months, eighteen (18) months, two (2) years, three (3) years, four (4) years, five (5) years and six (6) years.

B

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

‘Benefit(s)’ - any benefit(s) shown in the list of benefits.

C

‘Cancer’ - a malignant tumour, tissues or cells, characterised by the uncontrolled growth and spread of malignant cells and invasion of tissue.

‘Certificate of Insurance’ - the certificate issued to the policyholder. This shows the policy number, 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 benefits which apply.

‘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.

‘Complementary therapist’ - an acupuncturist, homeopath or practitioner of Chinese medicine who is appropriately qualified and entitled to practise in the country where treatment is given.

‘Congenital condition’ - any abnormality, deformity, disease, illness or injury present at birth, whether diagnosed or not.

‘Cost share after deductible’, ‘cost share(s)’ - is the percentage of each claim which a beneficiary must pay themselves after any deductible has been paid. A separate cost share may apply to the International Medical Insurance plan and International Outpatient option. These will be shown in the Certificate of Insurance if selected.

‘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 a beneficiary habitually resides, as stated on your application.

‘Country of nationality’ - any country of which a beneficiary is a citizen, national or subject, as stated on your application.

‘Customer Guide’ - contains the list of benefits and claiming information and forms part of the policy.

‘Daypatient treatment’ - care involving admission to hospital and using a bed but not staying overnight. In respect of USA based admissions, this also includes surgical procedures carried out in the doctor’s surgery.

‘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.

‘Deductible(s)’ - is the amount of any claim which a beneficiary must pay themselves. This will be shown in the Certificate of Insurance if selected.

‘Dental emergency’ - where either severe pain which is not amenable to relief by painkillers or facial swelling or uncontrollable bleeding after an extraction is being suffered and it is either outside the business hours of a beneficiary’s usual dentist or the beneficiary is staying at a place which is away from the dental practice he or she usually visits. The treatment covered in such an instance is to purely stabilise the problem and relieve severe pain.

‘Dental injury’ - injury to a sound natural tooth caused by extra-oral impact. Treatment for dental implants, crowns or dentures is not covered unless you have purchased the International Vision and Dental option and subject to the conditions outlined in the policy.
‘Dental treatment’ - any dental procedure or service which:

> is needed for continued oral health; and

> is carried out or personally controlled by a dentist, including procedures provided by a hygienist; and

> is included in the list of benefits, or, though not included in the list of benefits, is accepted by us as a procedure or service meeting common dental standards as upheld by a respectable, responsible and substantial body of dental opinion, experienced in the particular field of dentistry.

‘Dentist’ - a 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.

‘Detoxification’ - treatment for withdrawal symptoms after a beneficiary has been abusing drugs, alcohol or both. It includes the rest, medication, fluids and changes in diet needed to stabilise the body.

‘Diagnostic tests’ - investigations such as x-rays or blood tests to find or to help to find the cause of the beneficiary’s symptoms.

‘Doctor’ - a medical professional who holds an appropriate doctoral degree, 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.

‘Eligible female’ - a female policyholder or beneficiary.

‘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

> the Cigna Medical Team; or

> another source recognised by the Cigna Medical Team.

‘Guarantee of payment’ - a guarantee to pay agreed costs associated with particular treatment which we may give to a beneficiary or a hospital, clinic or medical practitioner.
‘Home nursing’ - visits from a qualified nurse to the beneficiary’s home to give expert nursing services for up to 30 days:

> immediately after hospital treatment as required by medical necessity; and

> visits for treatment which would normally be provided in a hospital.

Home nursing is only covered when the specialist who treated the beneficiary has recommended such services.

‘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 International Medical Insurance plan.

‘Injury’ - a physical injury.

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

‘Insurance’ - the coverage which is provided by us to the beneficiaries subject to the terms, conditions, limits and exclusions set out in these Policy Rules, the Customer Guide, and your Certificate of Insurance.

‘Intensive care’ - a specialised department in a hospital that provides intensive care treatment, for example an intensive care unit, critical care unit, intensive therapy unit, or intensive treatment unit.

‘International services’ - services arranged by the medical assistance service.

‘List of benefits’ - the list of benefits detailed in your Customer Guide, including any notes.

‘Maternity benefit’ - benefits available in relation to all aspects of pregnancy or childbirth under the International Medical Insurance and International Outpatient option, including any complications, for any eligible female covered under this policy, but excluding:

> treatment by way of the intentional termination of pregnancy unless the pregnancy endangers the life or mental stability of the mother; and

> nursery care for a newborn in hospital, unless the mother is required to remain in hospital due to medical necessity for treatment that is covered by this policy.

‘Medical assistance service’ - a service which provides medical advice, evacuation, assistance and repatriation. 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 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.

‘Medical team’ - means our clinical team and / or the medical assistance service.

‘Operation(s)’ - any procedure described as an operation in the schedule of surgical procedures.

‘Oral health’ - for a patient, a reasonable standard of oral health of the teeth, their supporting structures and other tissues of the mouth, and of dental efficiency, according to a standard acceptable to a dentist of ordinary competence and skill in the patient’s country of habitual residence which will safeguard his or her general health.

‘Orthodox’ - when used in relation to a procedure or treatment, ‘orthodox’ means that the procedure or treatment in question is medically accepted in the country where it takes place at the time of the commencement of the procedure or treatment, that complies with a respectable, responsible and substantial body of medical opinion, held and expressed by medical practitioners experienced in the particular field of medicine in question.

‘Out of pocket maximum’ - is the maximum amount of cost share under the International Medical Insurance plan or International Outpatient option any beneficiary must pay per period of cover. This will be shown in the Certificate of Insurance if applicable. This applies only to amounts paid relating to cost share on the International Medical Insurance plan or International Outpatient option.

Any amounts paid due to a deductible; due to exceeding limits of cover; for treatment not covered by your plan; or due to penalties for not obtaining proper pre-authorisation or using out of network providers in the USA, are not subject to the out of pocket maximum.
‘Outpatient’ - a patient who attends a hospital, consulting room, or outpatient clinic for treatment and is not admitted as a daypatient or an inpatient.

‘Palliative care’ - treatment that does not cure or substantially improve a condition but is given in order to alleviate symptoms.

‘Period of cover’ - the twelve (12) month continuous period during which the beneficiaries are covered under this policy, being the period from the start date to the end date as noted on the Certificate of Insurance or earlier if terminated in accordance with the Policy Rules.

‘Persistent vegetative state’ - a beneficiary who is in a vegetative state for at least ninety (90) consecutive days. A persistent vegetative state means a condition caused by injury, disease or illness in which the beneficiary has suffered a loss of consciousness, with no behavioural evidence of awareness of self or surroundings, other than reflex activity of muscles and nerves for low level conditioned response, and from which to a reasonable degree of medical probability, there can be no recovery.

‘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, the Cigna claim form, and your Cigna ID Card.

‘Policyholder’ - a person 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 governing the policy, detailing ‘General Exclusions’ and ‘Definitions’.

‘Pre-existing condition’ - any disease, illness or injury, or symptoms 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;

before the initial start date.

‘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.

‘Qualifying life event’ means:

> marriage or civil partnership;

> commencing cohabitation with a partner;

> divorce or separation;

> birth of a child;

> legal adoption of a child; or

> death of a spouse, partner or child.

We may require evidence of the above event.
‘Rehabilitation’ - physical, speech and occupational therapy for the purpose of treatment aimed at restoring the beneficiary to their previous state of health after an acute event.

‘Surgical appliance(s)’, ‘Medical appliance(s)’ - means either:

> an artificial limb, prosthesis or device which is required for the purpose of or in connection with surgery; or

> an artificial device or prosthesis which is a necessary part of the treatment immediately following surgery for as long as required by medical necessity; or

> a prosthesis or appliance which is medically necessary and is part of the recuperation process on a short-term basis.

‘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.

‘Worldwide including USA’ - every country throughout the world and at sea, 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.

‘Worldwide excluding USA’ - worldwide, with the exception of the USA.

‘You, your’ - the policyholder.