

# Child Plan

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Policy Terms and Conditions



CIGNA

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Welcome to this explanation of how **your plan** works. Please read these pages carefully as they tell **you** what is covered under **your plan**, **your rights**, and what **you** need to do when making a claim. To make things clearer for **you**, **we** have defined certain words in Section 17. They appear in **bold** in this document and the **list of benefits**. Alongside this information about **your plan** you also need to read the current **list of benefits** and **guide to claiming**.

If **you** don't understand anything, please phone **us** on the CIGNA helpline number.

### 1. What does the plan cover?

It covers the costs of medically necessary **treatment** and services detailed in the current **list of benefits** for **acute** conditions so long as **you** and **your dependants** covered under the **plan** live permanently in the **United Kingdom** and are referred to a **specialist** by **your GP**, an optician for eye **treatment** or an occupational health physician in the case of psychiatric conditions.

**You** may refer **your dependants** for physiotherapy but this must be to **our preferred providers** only.

The **plan** also covers costs for certain specified **diagnostic tests** if **your dependants** are referred by their GP, or

by a **doctor** following a health screen. **You** should note that there is a pre-defined list of tests and procedures that **we** will cover for this. Please contact **us** for advice on what is covered.

Please note that the **plan** does not cover **treatment**, supervision or care for **chronic** conditions.

### 2. When does cover start for my children?

To become a **policyholder**, **you** need to complete the CIGNA application form and let **us** know the names of the **dependants** **you** want to be covered under the **plan**. **We'll** let **you** know the terms that apply to **your dependant's** cover. If no exclusions apply, **we** will issue **you** with a **membership certificate** and cover for **your dependant** will start on the first day of the month after **we** receive **your** application. If exclusions do apply, **we'll** issue **you** with two copies of **your membership certificate**. **You** must sign and return one copy to **us**. Cover will then start on the first day of the month after **we** have received a signed copy of **your membership certificate**.

If **your dependants** are not covered under **our** normal terms or **we** decide not to cover them, **we're** under no obligation to explain why.

Your unmarried children are eligible to join the **plan** if they:

- live permanently in the **United Kingdom**
- are aged under 18 on the **start date**.

If **you** have another child at a later date, they will be accepted as a **dependant** and will be covered, so long as **we** receive **your** application within 30 days of birth. For stepchildren and adopted children, please provide evidence such as a copy of the adoption certificate.

**We** aren't responsible for applications lost or delayed in the post. Proof of posting the application doesn't provide proof of **us** receiving it.

**Your** covered **dependants** are eligible for benefit from the **start date**.

### 3. What costs will my children be covered for?

#### a) Healthcare benefits

**We** will refund the costs of **your dependant's** medically necessary **treatment** and services detailed in the current **list of benefits**, and the cost of certain specified **diagnostic tests** if referred by **your dependant's GP**. **Treatment** could

take place in the **United Kingdom** or abroad subject to the conditions below.

In any one **year of insurance**, we will pay up to the amount shown in the **list of benefits**, so long as **treatment** is recommended by a **specialist** and meets the following conditions:

- **Home nursing:** cover may be provided instead of **hospital treatment**, if the **treatment** is medically necessary and covered by **your plan** as well as being recommended by **your dependant's specialist**. We pay for up to 180 days in any one **year of insurance**, depending on any relevant monetary limit shown in the **list of benefits**.
- A parent staying with a child: if an eligible child under 12 goes into **hospital** as an **inpatient**, we'll pay for **you, your spouse** or the child's legal guardian to stay with them for up to 30 days in any one **year of insurance**. This cover will stop on the child's 12th birthday. We only pay if:
  - **you** or the other parent or guardian stays with **your child**

- **your child's treatment** is covered by the **plan** and
- the cost of **hospital accommodation** is reasonable.
- Private ambulance: we'll pay up to the amount shown in the current **list of benefits** in any one **year of insurance**.
- Chiropractic **treatment** or osteopathy: if **your dependant's GP** refers **your dependant**, we'll pay up to the amount shown in the current **list of benefits** in any one **year of insurance**.
- Physiotherapy:
  - for a self referral to **our preferred physiotherapy providers**, we'll pay the costs of an initial assessment followed by a maximum of three further sessions if required, as long as prior approval has been obtained from **us**. If further consultations or physiotherapy are needed, **you** must contact **our nurses** with details of **your dependant's proposed treatment plan**

from the physiotherapist to receive prior approval.

- for a referral to a physiotherapist from **your dependant's GP**, we'll pay the cost of an initial assessment only, as long as prior approval has been obtained from **us**. If further consultations or physiotherapy are needed, **you** must contact **our nurses** with details of **your dependant's proposed treatment plan** from the physiotherapist, before incurring costs. We'll pay costs of **evidence based treatment** only.
- **Treatment** of psychiatric conditions, other mental disorders, addictions and alcoholism: these fees will be paid subject to **medical necessity**, provided we approve the **treatment** as **evidence based treatment**. The only payments we make for addictions and alcoholism are to cover diagnosis and the first time the **patient** is referred by a **GP for treatment** at a specialist centre providing **evidence based treatment** i.e. the first alcohol or addictions programme after

diagnosis. We may cover up to three attempts at **detoxification** before starting a formal **outpatient** addictions programme. We won't pay for any more claims for recovery programmes for addictions, alcoholism or a **related condition** e.g. depression, dementia or liver failure, where after considering the medical evidence, we reasonably believe that the condition was the direct result of the addiction.

- **Cancer:** We'll pay costs for the **treatment** of a primary **cancer** if the **treatment** is considered by us to be **active** and **evidence based treatment**.

We'll also pay costs for the first course of **active** and **evidence based treatment** for **cancer** that has spread from its original site (known as secondary **cancer** or metastatic spread).

In all cases, if **treatment** becomes **symptomatic** (just to alleviate symptoms), no cover will be available.

- **Complementary medicine:** we'll pay for **treatment** involving **complementary medicine** - for example, homeopathy or acupuncture - if recommended by a medical **specialist** (not a specialist in complementary medicine).
- **NHS Cash Benefit:** we'll pay a cash amount to **you** for each night **your dependant** spends in an NHS **hospital** for NHS **inpatient treatment** instead of **us** making a payment for **treatment** provided under the **plan**. An overnight stay must start before midnight.
- **Claims for treatment** abroad: if **your dependant** claims for this **you** must also send **us** proof of how long **your dependant** spent abroad which should be no more than a total of 90 days in any one **year of insurance** (or longer if **we** agree in writing). If any terms in the **policy** only relate to the **United Kingdom**, **we'll** use those **we** believe are the closest in meaning to the foreign term. **Inpatient treatment** received overseas will be limited to a cumulative total of 90 nights in any one **year of insurance**. Costs, including accommodation charges

will be paid only up to limits in the **list of benefits** and will be paid in pounds sterling using a suitable exchange rate chosen by **us**. The **CIGNA fee schedule** will apply to Surgeons' and Anaesthetists' fees. If the Foreign and Commonwealth Office has advised against travel to a particular country or area, or if **your dependant** is already there but has been advised to leave, **we** won't pay for **treatment** whilst there unless **you** received prior written authority from **us**.

We pay up to the limits in the **CIGNA fee schedule** for surgeons' and anaesthetists' fees. This is available for **you** to view at [www.cigna.co.uk](http://www.cigna.co.uk). **We** will not pay any amounts which are higher than the fees listed and **you** will be responsible for paying the difference (the shortfall) directly to the surgeon or anaesthetist. To reduce the risk of this happening **we** recommend that **you** contact **us** before **treatment** takes place to check the fees and any potential shortfall.

b) **Cash Sum**

A **cash sum** is paid in addition to the benefits paid for **treatment** or **NHS cash benefit** if the **qualifying operation** is:

- carried out on a **day patient** or **inpatient** basis in **hospital**
- covered under this **plan**
- deemed medically necessary by a **specialist**, and
- an invasive procedure which may involve a surgical incision.

The amount of **cash sum** we'll pay will depend on the nature and severity of the **qualifying operation**. The **qualifying operations** are divided into five levels. The levels, the amount we'll pay and some examples of the **qualifying operations** covered by each level are set out below.

Level 1 - £300

Removal of tonsils, D&C, insertion of grommets.

Level 2 - £500

Hysterectomy, repair of inguinal hernia.

Level 3 - £800

Removal of thyroid gland, angioplasty, removal of spleen.

Level 4 - £1,200

Decompression of spinal disc, hip replacement

Level 5 - £3,000

Repair of heart valve, heart bypass.

The above list gives only examples of the **qualifying operations** covered. We can send you a full **qualifying operations list** on request. Not all surgical procedures will be treated as **qualifying operations**.

Any **cash sum** will be paid by us by cheque to the **policyholder** not the **dependant**.

The following rules apply to the payment of the **cash sum**:

- If **your dependant** has more than one **qualifying operation** during one stay in **hospital** for which a **cash sum** would be paid, we'll only pay the **cash sum** for the higher classification of **qualifying operation**.

- If **your dependant** has more than one **qualifying operation** on the same part of the body during different stays in **hospital**, we'll pay the **cash sum** for each **qualifying operation**, if **your dependant's specialist** confirms that more than one **qualifying operation** during different stays in **hospital** was medically necessary.

- If **your dependant** has more than one **qualifying operation** but on different parts of the body during different stays in **hospital**, we'll pay the **cash sum** for each **qualifying operation**.

We have the right to change the **qualifying operations list**. You can ask us for details of any changes at any time.

No **cash sum** will be paid if a claim arises from an **operation** which is carried out for or as a result of complications caused by any of the exclusions set out in Section 4.

## Excess

There may be an excess to pay under this **policy**, which will apply to **you** if **you** make a claim on behalf of **your dependant**. If so, we'll agree this amount with **you** at the **start date** and **you** can find out what it is by looking on **your membership certificate**. Any excess is due from the first time **you** make a claim. The amount will be deducted from the cost of **treatment** for each claim **you** make until the excess limit for the **year of insurance** is reached. **You** will need to pay any deducted excess amount directly to **your** provider. **We** will let **you** know what this amount is. At each **annual renewal date**, we'll agree any new excess level with **you**.

The excess doesn't apply to any **NHS cash benefit** which we might pay to **you** as an alternative to paying for **treatment** under this **plan** or to any **cash sum** we may pay for a **qualifying operation**.

### 4. What isn't covered by this plan?

**We** will not pay claims for the following conditions, **treatments** and incidental costs where **your** claim is:

4.1 for the following conditions that are not **acute** medical conditions i.e.

- a. Pregnancy or childbirth, unless it's affected by an **acute** medical condition or requires a **specified obstetric procedure**.
  - b. Termination of pregnancy.
  - c. Any **treatment** needed because of male or female birth control.
  - d. Infertility or any type of fertility **treatment**.
  - e. Sex change operations or any associated **treatment** needed before or after (for example, psychological counselling).
  - f. Expenses for any plastic or reconstructive surgery, even for psychological reasons, unless it's medically necessary as the result of an accident or because of other surgery covered under the **plan**.
- 4.2 based on a referral route, place of **treatment** or type of **treatment** that is not covered by the **plan** i.e.
- a. Any **treatment** that hasn't been referred by **your dependant's GP**, an optician for eye **treatment**, or an occupational health physician for psychiatric conditions. However, any emergency **treatment your dependant** receives is still covered.
  - b. **Diagnostic tests** where **your dependant** has been referred by their **GP** or a **doctor**

following a health screen, that have not been approved by **us**.

- c. **Treatment** outside the **United Kingdom** if one of the reasons **your dependant** went abroad was for that **treatment**.
  - d. **Treatments** that are not **evidence based treatment**.
- 4.3 for the following specific types of **treatment** or **treatment** settings that are not covered by the **plan** i.e.
- a. Dental or orthodontic **treatment**, except for any surgical procedures included in the **CIGNA Fee Schedule** which are specifically covered.
  - b. Transplants (apart from skin and corneal grafts) and any related **treatment** or supervision.
  - c. Bone marrow donations whether using **your dependant's** own bone marrow or someone else's.
  - d. Removing, storing and reintroducing very early cells (or stem cells) that produce blood cells, and any associated **treatment**.
  - e. Any **treatment** to change the refraction of one or both eyes.

- f. **Treatment** in any way linked to a Human Immunodeficiency Virus (HIV) infection or a related illness.
- g. **Treatment** linked to a sexually-transmitted disease.
- h. Charges for **treatment** which has not yet taken place.
- i. **Treatment** connected to injuries **your dependant** causes themselves.
- j. **Treatment** caused by injuries or illness resulting from **your dependant** behaving illegally.
- k. Injury or disability that has been caused or exacerbated by war, invasion, terrorist or military activity, or while at work for the army, naval or air services.
- l. **Treatment** in nature cure clinics, health hydros or similar establishments or private beds registered as a nursing home in these places.
- m. **Home nursing** or living in a **hospital** where it is not a medical necessity, unless **we** agreed to this.
- n. **Treatment** for any **pre-existing condition** that **you** knew about or suspected before the **start date**. The exception is if **you** disclosed all relevant information in **your** application form and **we** didn't specifically exclude the condition on **your membership certificate**.
- o. **Treatment** of a psychiatric condition which existed before the **start date**.
- 4.4 for the following diagnostics and **treatment** of genetic and developmental conditions that are not covered by the **plan** i.e.
- a. Any genetic screening.
- b. **Treatment** for abnormalities from birth, except for emergency operations carried out on babies within 14 days of birth.
- c. **Treatment** related to learning disorders or delay in **your dependant's** development.
- d. **Treatment** related to tongue-tie or cleft lip palates.
- e. **Treatment** related to pes planus (flat feet).
- 4.5 for a **chronic** condition i.e.
- a. **Treatment**, supervision or care for a **chronic** condition.
- b. Any **treatment** required as a result of a relapse of a **chronic** condition.
- c. Supportive **treatment** for chronic kidney failure, including dialysis.
- 4.6 for **cancer** that has spread from its original site (known as secondary **cancer** or metastatic spread) for which **your dependant** has already received the first course of **active treatment**.
- 4.7 for the following specific charges and fees:
- a. Private prescriptions or dressings that **your dependant** needs as an **outpatient**.
- b. Expenses for **your dependant's** GP's fees, including consultations or fees for filling in a claim form.
- c. Expenses for any sterilisation or contraception, including vasectomy.
- d. Expenses for appliances (including spectacles and hearing aids) which don't fall within **our** definition of **surgical appliance**.
- e. Extra costs including newspapers, taxi fares, phone calls and guests' meals.
- f. Expenses for routine examinations or tests including eye tests, health screens, medical examinations and hearing tests.
- g. Charges incurred by **your dependant** for missed or cancelled appointments.

4.8 for any expenses which **you** have claimed or can claim from another source or insurance (see Section 12 for more information on this).

#### 5. [How and when do I make a claim?](#)

For all consultations, investigations and **treatment**, it's vital that **you** follow the claiming process described below. If **you** don't **we** will only pay 80% of the cost of the claim and **you** will be responsible for the remaining 20% of the cost of the claim. In addition, no **NHS cash benefit** or **cash sum** will be paid. Before **you** make a claim, please refer to the **guide to claiming**.

##### a) [Claiming Process](#)

**You** must get an authorisation number from **us** - without this, **you** will be responsible for paying 20% of the cost of the claim. **You** must take great care to follow this procedure:

- If **your dependant's GP** refers **your dependant** for a consultation with a **specialist** or for investigations, **you** must call **us** before this takes place. **We'll** check **your** cover details and confirm that the consultation or investigations are covered.

- After the consultation and before any **treatment**, call **us** again and tell **us** what the **specialist** has recommended. At this point, **we'll** confirm cover, provide information and tell **you** what benefits **you** can claim.

- **You** must contact **our** Customer Services team regularly at each stage of **treatment** - especially if there is any change in **treatment**.

If **you** don't keep to the claiming process, **you** will be responsible for 20% of the cost of each claim and no **NHS cash benefit** or **cash sum** will be paid.

If **you** have chosen one of **our** excess options, the amount of the excess will be deducted from any claims **you** make until the excess limit is reached in every **year of insurance**.

##### b) [When to send in your claim form](#)

Please send **us** **your** completed claim together with all bills and invoices within six months of the **treatment's** start date. **We** can't accept photocopies - only original bills. If **you** don't submit **your** claim and invoices within this time, **your** claim will be denied. If **your dependant** must have **treatment** that continues for

longer than six months **you** should send **us** interim claims for every six month period. **We** may ask for a medical report if **we** need more information, which may mean that **your dependant** needs to have an independent medical examination. **We'll** pay for both of these.

#### 6. [When does cover end?](#)

6.1 Cover under the **policy** will end:

- if **you** die. We may then allow **dependants** covered by **your plan** to join one of **our** individual healthcare plans. **We** will write to **your spouse**, or the nominated guardian of **your dependant** to ask if cover is to be continued.
- if **you** don't pay the required premiums. **We'll** only cover expenses incurred before the due date of any unpaid premium.

6.2 Cover will end for a **dependant**:

- if they die
- at the **annual renewal date** for any children after their 18th birthday or if they marry, at the **annual renewal date** on or immediately after the date on which the marriage takes place. **We** may then allow

the **dependant** to join one of our individual healthcare plans.

**Your dependant** or the guardian must apply to **us** within 30 days of the date that cover ends under sections 6.1 and 6.2 above if they wish to continue cover or join a **CIGNA** individual healthcare plan. The conditions **we** set for our individual healthcare plans may be different from those detailed for this **plan**.

6.3 Please note that even if **treatment** has been authorised, **we** won't be responsible for any costs if the **plan** ends before **treatment** has taken place.

7. **Who is responsible for providing the information for administering the plan?** **You** must give **us** all the information **we** need, in writing, to work out the premium. **You** are responsible for making sure **we** have enough information to pay **your** claims. Remember to tell **us** about any changes to **your** circumstances, name or address, to ensure **our** records are up to date.

8. **How is the policy renewed?**  
**We'll** send **you** a letter at least one month before **your annual renewal date** asking **you** if **you** want to renew **your** cover. If **you** don't cancel the **policy**, it will be automatically renewed for another 12 months from **your annual renewal date**.

9. **Will there be any changes to my plan's conditions?**  
**We** can end the **policy** or change any of its conditions. If the **policy** changes because of new laws, **we'll** write and tell **you**. Otherwise, **we'll** give the following notice:

- For changes to the **list of benefits**, **we** will give **you** at least 28 days' notice in writing. The effective date of the changes will be shown on the notice and the new **list of benefits** will apply after this time.
- For changes to the conditions or if **we** end the **plan**, **we** will give **you** at least 28 days' notice in writing. The change will take place or the **plan** will end on an **annual renewal date**.

**We** can end or change **your dependants'** cover at any time if either of the following happens:

- If **you** or any of **your dependants** have given misleading information, have kept something from **us** or have broken the conditions of the **policy**.
- If **you** or any of **your dependants** no longer live full time in the **United Kingdom**.

10. **Premiums**  
**We'll** tell **you** in writing before the **annual renewal date** of changes in premium rates for the next **year of insurance**.

Premiums must be paid monthly by direct debit and within the **days of grace**.

11. **How should payments be made?**  
**You** must make any payments in pounds sterling to **our** administration office, 1 Knowe Road, Greenock, Scotland PA15 4RJ.

12. **Other insurance and CIGNA's right of subrogation explained**  
**You** must tell **us** in writing as soon as possible about any claim or right of legal action against any other person that arises from a claim under this **plan**. **You** must keep **us** fully informed of any developments. If another insurer provides

cover, **we'll** negotiate with them to make sure we both pay our share of the claim. If **we** ask **you**, **you** must take all steps to include the amount of benefit **you** are claiming from **us** under this **plan** in **your** claim against the other person. **We** can take over and defend or settle any claim, or prosecute any claim in **your** or **your dependant's** name for **our** own benefit. **We** will decide how to carry out any proceedings and settlement.

### 13. What should I do if I want to complain?

If **you** have any cause for complaint, please contact **CIGNA** in the first instance at 1 Knowe Road, Greenock, Scotland PA15 4RJ. If the complaint is not resolved to **your** satisfaction, **you** may refer **your** complaint to the Financial Ombudsman Service (FOS) at:

The Financial Ombudsman Service  
South Quay Plaza  
183 Marsh Wall  
London E14 9SR

The FOS can adjudicate most (but not all) complaints. Their decision is binding on **us** but **you** may reject it without affecting **your** legal rights.

### 14. Regulatory information

CIGNA Life Insurance Company of Europe S.A.-N.V., 4th Floor, 45 London Road, Reigate, Surrey RH2 9PY (UK branch) is regulated by the Banking, Finance and Insurance Commission, (Commission Bancaire, Financiere et des Assurances – CBFA) of Belgium and is subject to limited regulation by the Financial Services Authority (FSA) for the conduct of insurance business in the UK. Details of the extent of **our** regulation by the Financial Services Authority are available from **us** on request.

**Our** FSA register number is 202845.

**You** can check this on the FSA's register by going to their website [www.fsa.gov.uk/register](http://www.fsa.gov.uk/register) or by contacting them at:

The Financial Services Authority  
25 The North Colonnade  
Canary Wharf  
London E14 5HS

### 15. What about data protection?

Telephone calls to and from **our** organisation are recorded to help **us** monitor and improve the service **we** provide **you**.

Under the Data Protection Act 1998, **we** act as the Data Controller for the personal information **we** hold about **you**. This will be processed by **us** to carry out **our** obligations and **we** may need to share it with authorised third parties. If **you'd** like a copy of the information **we** hold about **you**, please write to **us** quoting **your** membership number. Please note that **we** may charge a fee to provide this information.

Please ensure **our** records are up to date by telling **us** about any changes to **your** circumstances, name or address.

From time to time **we'd** like to tell **you** about other products or services that may interest **you**. However, if **you** don't want to hear from **us**, please just write to **us**.

To help **us** detect and prevent fraud, **we** may need to share **your** personal information with other insurers or organisations.

## 16. Law and interpretation

The **policy** is governed by English Law. Please note that the words and phrases in **bold** all have special meanings which are defined below in Section 17.

No person other than the **insurer** or the **policyholder** may enforce this **policy** by virtue of the Contracts (Rights of Third Parties) Act 1999. Only the **policyholder** and **CIGNA** have legal rights under the agreement relating to **your policy**. This means that only the **policyholder** and **CIGNA** may enforce the agreement, although **CIGNA** will allow anyone who is covered under the **policy** access to **our** complaints process.

## 17. What do these words mean?

### 17 What do these words mean?

We, us, our, **CIGNA**, the insurer - **CIGNA** Life Insurance Company of Europe S.A.-N.V., 1 Knowe Road, Greenock, Scotland PA15 4RJ

You, your - the **policyholder** and any **dependants**, if they're eligible.

17.1 '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.

17.2 'Acute' - a disease, illness or injury that is likely to respond quickly to **treatment** which aims to return **your dependant** to the state of health they were in immediately before suffering the disease, illness or injury, or which leads to their full recovery.

17.3 'Annual renewal date' - the anniversary of this **plan's start date**.

17.4 'Cancer' – a malignant tumour, tissues or cells, characterised by the uncontrolled growth and spread of malignant cells and invasion of tissue.

17.5 'Cash sum' – a cash sum we pay to the **policyholder** if a **dependant** has a **qualifying operation**. This is different from the **NHS cash benefit** defined in 17.23.

17.6 'Chronic' - a disease, illness or injury which has one or more of the following characteristics:

- It needs ongoing or long-term monitoring through consultations, examinations, check-ups, and/or tests.
- It needs ongoing or long-term control or relief of symptoms.

- It requires **your dependant's** rehabilitation or for them to be specially trained to cope with it.

- It continues indefinitely.

- It has no known cure.

- It comes back or is likely to come back.

17.7 'CIGNA Fee Schedule' – the current schedule of interventional procedures and reimbursement limits approved by **us**, using the codes and narratives from the Clinical Classification and Schedule Development Group.

17.8 'Day patient' - a **patient** who is admitted to a **hospital** or day patient unit because they need a period of medically supervised recovery but does not occupy a bed overnight.

17.9 'Days of grace' - a period of 14 days after the date on which a premium is due. **We** will not pay any claims received during this period until **we** have received the premium owed.

17.10 'Dependant' – **your** dependent children aged under 18 on the **start date** of the **plan** who **you** have included in **your** application for cover and have been accepted in writing by **us** for cover under the **plan**.

17.11 'Detoxification' - **treatment** for withdrawal symptoms after **your dependant** has been abusing drugs, alcohol or both. It includes the rest, medication, fluids and changes in diet needed to stabilise **your** body.

17.12 'Diagnostic tests' - investigations, such as x-rays or blood tests, to find or to help to find the cause of **your dependant's** symptoms.

17.13 'Doctor' - a medical practitioner registered under the Medical Act 1983 (as amended) and has a license to practice.

17.14 'Evidence based treatment' - **treatment** which has been researched, reviewed and approved by:

- the National Institute for Health and Clinical Excellence or
- CIGNA's Medical Advisory Panel or

- another national or international source recognised by **us**.

17.15 'General practitioner' (GP) - a registered and licensed **doctor** in general practice.

17.16 'Guide to claiming' – information available to **you** which sets out the steps **you** need to take and tells **you** who **you** need to contact when making a claim.

17.17 'Home nursing' - expert nursing services provided to **your dependant** at home by a **nurse**, following hospital **treatment**.

17.18 'Hospital'-

- NHS hospital - a national health service hospital, as defined in Section 128 of the National Health Service Act 1977 or in any future law.

- Private hospital - an independent hospital registered under The Registered Homes Act (1984) or any future law. It may also include a private bed in an NHS hospital.

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

17.20 'Inpatient treatment'- **treatment** which, for medical reasons, means that **your dependant** has to stay in **hospital** overnight or longer.

17.21 'List of benefits' - **our** latest list of benefits payable for different **treatment** and service items.

17.22 'Medical necessity' – health care services necessary to evaluate, diagnose, or treat an illness, injury, disease or its symptoms, which are:

- in line with generally accepted standards of medical practice
- clinically appropriate, in terms of type, frequency, extent, site and duration, and thought to be effective for the **patient's** illness, injury or disease
- not chiefly for the **patient's** or **specialist's** convenience, and
- not more costly than an alternative service(s) at least as likely to produce the same therapeutic or diagnostic results.

- 17.23 'Membership Certificate' - the certificate issued to the **policyholder**. It shows the **policy number**, **start date**, the amount of excess, if one is applied, that **you** would need to pay if **you** make a claim, details of who is covered and any individual exclusions which apply.
- 17.24 'NHS Cash Benefit' – a cash amount paid to the **policyholder** for each night a **dependant** spends in an NHS **hospital** for NHS **inpatient treatment** instead of **us** making a payment for **treatment** provided under the **plan**. An overnight stay must start before midnight.
- 17.25 'Nurse' - a qualified nurse who is on the register of the Nursing and Midwifery Council (NMC) and holds a valid NMC personal identification number.
- 17.26 'Operation' and 'Oro-surgical procedure' - operations described this way in the **CIGNA Fee Schedule**.
- 17.27 'Outpatient' - a **patient** who attends a **hospital**, consulting room or outpatient clinic and is not admitted as a **day patient** or **inpatient**.
- 17.28 'Outpatient treatment' – **treatment** given at a **hospital**, consulting room or outpatient clinic where **you** do not go in for **day patient** or **inpatient treatment**.
- 17.29 'Patient' – the **policyholder's dependant** while having **treatment**.
- 17.30 'Plan' – **your CIGNA Child Plan Healthcare Policy**.
- 17.31 'Policy' – the documents **we** send to **you** which includes these policy conditions, the **list of benefits** and **membership certificate**.
- 17.32 'Policyholder' – the adult who is responsible for paying the premium who has made an application to **us** which has been accepted in writing by **us**.
- 17.33 'Pre-existing condition' - any disease, illness or injury for which:
- a **dependant** has received medication, advice or **treatment**, or
  - a **dependant** has experienced symptoms
- whether the condition has been diagnosed or not in the ten years before the start of **your** cover.
- 17.34 'Preferred providers' - **our** list of preferred physiotherapy providers as updated from time to time.
- 17.35 'Private ambulance' - a purpose-built vehicle run by a recognised private ambulance service.
- 17.36 'Qualifying operation' – an operation in the **qualifying operations list**.
- 17.37 'Qualifying operations list' – a list of **qualifying operations** for which a **cash sum** is paid.
- 17.38 'Related condition' - any symptom, disease, illness, or injury which is medically considered to be associated with another symptom, disease, illness or injury.
- 17.39 'Specialist' – a **doctor** who:
- is a medical practitioner registered under the Medical Act 1983 (as amended) and has a licence to practise as a specialist in the **treatment** for which **your dependant** is referred; or

- has valid admitting rights as approved by the Medical Advisory Committee from the independent **hospital** they intend to practice from; or
- has a certificate of Higher Specialist Training in their speciality from the Higher Specialist Training Committee of the appropriate Royal College or Faculty; or
- is or has been a National Health Service consultant; or
- is a chartered or state-registered physiotherapist and only a specialist for the purpose of physiotherapy as outlined in the **list of benefits**; or
- has a Diploma and practices in Osteopathy or Chiropractic; or
- has been recognised as a specialist by CIGNA.

17.40 'Specified obstetric procedure' – includes:

- When there's a complication to a pregnancy and caesarean section becomes inevitable. Cover starts when **you're** admitted to **hospital** for the caesarean. Scans and any ante-natal care received before the admission are not covered under the **plan**, without prior authorisation from one of **our nurses**.
- Transfusion to the foetus in the womb.
- Removing the placenta or other foetal products from the womb.
- Delivering a baby by forceps or vacuum extraction.
- Ectopic pregnancies.
- Hydatidiform moles (abnormal changes in a fertilised egg that make the placenta grow abnormally).

17.41 'Start date' - the date the **plan** started as shown in the **membership certificate**.

17.42 'Surgical appliance' –

- An artificial limb, body part or device inserted during surgery.
- An artificial device or an artificial body part which **your dependant** needs immediately after surgery - for example, a knee brace after ligament surgery. This doesn't include wheel chairs, crutches and other similar appliances.

17.43 'Symptomatic' - **treatment** that no longer attempts to alter **cancer** growth or progression but is given to alleviate symptoms.

17.44 'Treatment' - surgical or medical services (including **diagnostic tests**) that are needed to diagnose, relieve or cure a disease, illness or injury.

17.45 'United Kingdom' - England, Scotland, Wales and Northern Ireland.

17.46 'Year of insurance' - the 12 months from the **start date** or **annual renewal date** during which time this **policy** is valid.

## **CIGNA HealthCare**

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CIGNA HealthCare is a trading name. The following companies are part of that group:

CIGNA Life Insurance Company of Europe S.A.-N.V., registered in Belgium with limited liability (Brussels trade register no. 4421 437 284), Avenue de Cortenbergh 52, 1000 Brussels, Belgium.

Regulated by the Banking, Finance and Insurance Commission (Commission Bancaire, Financière et des Assurances - CBFA) of Belgium and subject to limited regulation by the Financial Services Authority. Details of the extent of our regulation by the Financial Services Authority are available from us on request.

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