Important Information

The product information in this section does not contain the full terms of the policy and the full terms can be found in the policy documents.

1. FREE LOOK PERIOD - You have a right to cancel your policy within twenty one (21) days from the date you receive this policy. If you wish to cancel this policy and we have not paid a claim or issued a guarantee of payment, you will receive a full refund of your premium and levy. Alternatively, if we have paid a claim, or issued a guarantee of payment, we will not refund any premium which has been paid.

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

For your cancellation rights outside of the twenty one (21) day cooling off period, please refer to clause 6 of this policy.

2. CANCELLATION - 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 fourteen (14) days' notice in writing.

Please contact us at Cignaglobal_customer.care@cigna.com

If this policy ends before the normal date, any premium and levy which has been paid in relation to the period after cover has ended will be refunded on a pro rata basis, so long as no claims have been made or yet to be submitted and no guarantees of payment 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 or you have received treatment not reimbursed yet, you will be liable for the remainder of any premiums in respect of the policy which are unpaid. For full details, please refer to the Policy Rules.

3. SCOPE OF COVER - Subject to the terms, conditions, limits, exclusions (and special exclusions as detailed in your Certificate of Insurance, if applicable) of this policy, Cigna Healthcare will cover you for medical and related expenses relating to medically necessary treatment which is recommended by a medical practitioner, and provided within the 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. 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.

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).

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

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

We reserve the right to make any changes to this policy that are necessary to comply with any changes to relevant laws and regulations. We also reserve the right to make changes to the terms of cover at the time of renewal. If local law and/or regulation dictates, we may be required to offer you an alternative health plan.

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

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

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

5. NON-GUARANTEED PREMIUM - Premium rates are not guaranteed and may be adjusted upon renewal based on future experience. Factors leading to premium adjustment may include but are not limited to our experience in claims and expenses incurred by and/or in relation to this product overall and not directly related to individual policies.

We will inform you of the premium and any other charges which will apply during the next period of cover. The premium and/or other charges will change each period of cover.

6. TERMINATION - Subject to any conflicting legal or regulatory requirements we may terminate this policy for all beneficiaries immediately if:

6.1 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

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

6.3 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

6.4 We, at our sole discretion determine, on reasonable grounds, that you have, in the course of applying for the policy or when making any claim under it, withheld information or knowingly or recklessly provided information which you know or believe to be untrue or inaccurate or failed to provide information which we have asked for, including medical information; or

6.5 Subject to the terms and conditions of the policy, we may terminate the policy if any beneficiary ceases to be an expatriate whether as a result of a change to a beneficiary's country of nationality or country of habitual residence.

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

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

If the policy is terminated in accordance with clause 6.5 of the Policy Rules, before the end date, and we have paid a claim, covered a treatment or issued a guarantee of payment during the period of cover, you will be liable for the remainder of any premiums in respect of the policy which are unpaid. If your annual premium is collected at intervals throughout the policy year, you will be responsible for making these payments for the remainder of the period of cover or alternatively, settle the outstanding premium amount.

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

7. WAITING PERIOD - The cover will begin on the start date shown on the first Certificate of insurance which

we send to you. 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.

The following benefits have a Waiting Period:

International Medical Insurance

- **Treatment for Obesity** (Gold and Platinum plans only)
  - A twenty four (24) month* waiting period applies.
- **Cancer preventative surgery**
  - A twelve (12) month waiting period applies
  - Available once the beneficiary has been covered by the policy for 12 months or more.
- **Routine maternity benefit and childbirth cover on an inpatient and daypatient basis** (Gold and Platinum plans only)
  - A twenty four (24) month* waiting period applies for parent and baby care and treatment.
  - Available once the mother has been covered by the policy for a continuous period of at least twenty four (24) months or more*.
- **Complications from Maternity** (Gold and Platinum plans only)
  - A twenty four (24) month* waiting period applies for complications resulting from pregnancy or childbirth.
  - Available once the mother has been covered by the policy for a continuous period of at least twenty four (24) months or more*.
- **Homebirths** (Gold and Platinum plans only)
  - A twenty four (24) month* waiting period applies for Homebirths.
  - Available once the mother has been covered by the policy for a continuous period of twenty four (24) months or more*.
- **Newborn care**
  - A twenty four (24) month* waiting period applies.
  - Available once either parent has been covered by the policy for a continuous period of twenty four (24) months or more* prior to the newborn's birth.

* For treatment incurred outside of either Hong Kong or Singapore, this benefit is available once the mother has been a beneficiary under this policy for a continuous period of at least 12 months or more.

International Outpatient optional module

- **Pre-natal and post-natal care on an outpatient basis** (Gold and Platinum plans only)
  - A twenty four (24) month* waiting period applies for Pre-natal and post-natal care.
  - Available once the mother has been covered under the International Outpatient optional module for a continuous period of at least twenty four (24) months or more*.
- **Infertility Investigations and treatment** (Platinum plan only)
  - A twenty four (24) month waiting period applies for Infertility Investigations and treatment.
- **Genetic Testing**
  - A twelve (12) month waiting period applies for Genetic Testing.

* For treatment incurred outside of either Hong Kong or Singapore, this benefit is available once the mother has been a beneficiary under this policy for a continuous period of at least 12 months or more.

International Vision and Dental optional module

Dental Treatment:

- Preventative & Routine dental treatment
  - A three (3) month waiting period applies for Preventative and Routine dental treatment in the International Vision and Dental optional module.
- Major Restorative dental treatment
  - A twelve (12) month waiting period applies for Major restorative dental treatment in the International Vision and Dental optional module.
  - If the beneficiary needs major restorative dental treatment before they have had International Vision and Dental cover for twelve (12) months, we will pay 50% of the treatment costs.
- Orthodontic treatment
  - An eighteen (18) month waiting period applies for Orthodontic treatment in the International Vision and Dental optional module.

8. REASONABLE AND CUSTOMARY CHARGES - We will pay reasonable and customary costs for treatment, and services related to treatments which are shown in the list of benefits. We will pay for such treatment costs in line with the appropriate fees in the location of treatment and according to established clinical and medical practice.

9. MEDICALLY NECESSARY TREATMENT - We will cover treatment which is medically necessary and clinically appropriate for the beneficiary. Medically necessary covered services and supplies are those determined in accordance with International Clinical Guidelines by the medical team to be:

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

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

10. AREA OF COVER - You may choose between two (2) options, which determine where in the world beneficiaries will be covered. The options are: Worldwide including USA and Worldwide excluding USA.

11. CLAIMS - Please contact our Customer Care Team as soon as possible before you receive treatment using the following numbers:

Inside Hong Kong 2297 5210

International +44 1475 788182 (overseas)

Prior authorisation is required for all Inpatient and Daypatient treatments. It is not required for Outpatient treatments with the exception of the treatments listed on page 27 of the Customer Guide.

We can help you arrange your treatment plan, and point you in the right direction, saving you the time and hassle of looking for a hospital, clinic or medical practitioner yourself. We can liaise directly with your treatment provider to ensure the treatment that you are about to undertake is covered under your policy and issue a prior authorisation. We can also liaise directly with your treatment provider to arrange direct billing by issuing a guarantee of payment.

We appreciate that there will be times when it will not be practical or possible to contact us prior to treatment in an emergency and the priority is to get treatment as soon as possible. In circumstances like these, we ask that you or the affected beneficiary get in touch with us within 48 hours of receiving the treatment. This will allow us to

confirm whether your treatment is covered and arrange settlement with your treatment provider. We may ask for further information, such as a medical report in order for us to approve treatment. We will confirm approval, and where applicable, the number of treatments approved.

If a beneficiary has been taken to a hospital, medical practitioner or clinic which is not part of our network, then we may make arrangements (with the beneficiary's consent) to move the beneficiary to a Cigna Healthcare network hospital, medical practitioner or clinic to continue treatment, once it is medically appropriate to do so.

For full details of our Claims process please refer to the Customer Guide.

12. RISKS & LIMITATIONS INVOLVED IN SWITCHING YOUR POLICY - If you intend to switch from your other health insurance policy to this replacement policy, do take note that:

(a) you may not be insurable at standard terms;

(b) you may have to pay a different premium;

(c) the terms and conditions may defer; or

(d) there may be fee or charge you would have to bear.

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.

13. STANDARD EXCLUSIONS - There are certain conditions under which no benefits will be payable. These are stated as exclusions in the Policy Rules. You are advised to read the Policy Rules for the full list of exclusions. The following is a list of some of the exclusions for the Policy:

- Treatment for a pre-existing condition or any conditions or symptoms which result from, or are related to, a pre-existing condition. We will not pay for treatment for which 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.
- Congenital anomalies or defects, except in the instance where we can provide cover under the 'Congenital conditions' benefit within the International Medical Insurance plan.
- Routine maternity and childbirth cover, Complications from maternity and Homebirths cover benefits are excluded from our Silver plan. These benefits are included in the Gold and Platinum plan.