Cigna Global Health Options

Policy Rules

Terms, General Exclusions and Definitions relating to your plan

CONTENTS

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

Unless otherwise specified, words and phrases included in Section 3, 'Definitions', when used throughout these Policy Rules, and your Customer Guide (including the Table of Benefits section on pages 17-47), will have the meanings given to them in that Section.

The following sections contain important information relating to your Cigna Global Health Options plan.

LEGAL AND REGULATORY INFORMATION

This insurance is provided by:
Cigna Europe Insurance Company S.A.-N.V., Singapore Branch
Cigna Global Health Options
152 Beach Road
#33-05/06 The Gateway East
Singapore 189721

Cigna Healthcare is regulated by the Monetary Authority of Singapore and is also subject to supervision by the regulatory authorities in Belgium which includes the National Bank of Belgium and the Financial Services and Markets Authority.

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

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

Cigna Healthcare does not provide any personal recommendation to you with respect to you entering into this policy.

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.

This policy is protected under the Policy Owners' Protection Scheme which is administered by the Singapore Deposit Insurance Corporation (SDIC). Coverage for your policy is automatic and no further action is required from you. For more information on the types of benefits that are covered under the scheme as well as the limits of coverage, where applicable, please contact us or visit the General Insurance Association (GIA) or SDIC websites (**www.gia.org.sg** or **www.sdic.org.sg**).

COMPLAINTS

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

If the complaint is not resolved, the complaint may be referred to the Financial Industry Disputes Resolution Centre at:

Financial Industry Disputes Resolution Centre (FIDReC)
36 Robinson Road, #15-01 City House
Singapore, 068877

Telephone: **(65) 6327 8878**
Website: **www.fidrec.com.sg/contact-us**

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.

HOW TO CONTACT US

To contact us if you have any questions regarding your policy, please email us at:
cignaglobal_customer.care@cigna.com.

Alternatively, you can call our Customer Care Team, available 24/7, on: **+44 (0) 1475 788 182**
From inside Singapore on: **800 186 5047** or from inside the USA on: **800 835 7677.**

You can also write to us at the following address:
Cigna Global Health Options, Customer Care Team
1 Knowe Road, Greenock
Scotland, PA15 4RJ

You will need to provide your policy number, full name and email address used in the application form to be identified. For full details about your termination rights, please see clause 6 of these Policy Rules.

SECTION 1: GENERAL TERMS AND CONDITIONS

1. Scope of cover and policy eligibility

1.1
This policy is only offered to beneficiaries who are Singapore citizens and expatriates residing in Singapore. For expatriates the policy will only cover the costs of treatment in a beneficiary's country of nationality in circumstances where the beneficiary is temporarily resident in their country of nationality. Such circumstances may not exceed one hundred and eighty (180) days in aggregate per period of cover, and the country of nationality must be within the selected area of coverage (see clause II for full details). For the avoidance of any doubt, a Singaporean citizen shall not be subject to the one hundred and eighty (180) days rule during any period of time when they are habitually resident in Singapore, however if at any time a Singaporean citizen is considered as an expatriate then this limitation will apply.

1.2
Subject to the terms, conditions, limits, exclusions (and special exclusions as detailed in your Certificate of Insurance, if applicable) of this policy, Cigna Healthcare will cover you, and any other beneficiary under your policy, 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 be approved and, unless otherwise agreed with us, must occur during the period of cover and deductibles, cost shares and limits of cover may apply in accordance with clause 9.

1.3
In some circumstances we may, at our absolute discretion, agree to remove a medical exclusion related to you or any beneficiary included in your policy if you pay an additional premium. This will be agreed during the application process and before the policy start date.

1.4
You must be eighteen (18) years old or over at the time of purchase in order to purchase this policy. We reserve the right to cancel the policy if at any time there is no beneficiary on cover who is eighteen (18) years old or over.

1.5
You must let us know as soon as possible if any of the information that you provided to us in your application changes before the initial start date of your policy (please see Clause II for changes that occur during the period of cover).

We reserve the right to cancel the policy or to apply any additional premiums or exclusions as a result of any material change to your state of health or any other personal information which you have notified us of before the initial start date of the policy.

It is your responsibility to ensure that all information you provide to us is accurate and, in the event of any uncertainty, make the enquiries necessary to get that information. If you fail to inform us of any material changes during this period – either deliberately or carelessly - we may treat this as misrepresentation, which could affect coverage under your policy or payment of claims. Please see Clause 3 for more information.

1.6
This policy will not cover any costs relating to:

i. treatment received before the cover starts; or

ii. unless expressly agreed by us, treatment received after the cover ends (even if that treatment was approved by us before the cover ends).

2. When does cover begin and end

2.1
This policy is an annual renewable contract. 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 Clauses 2, 3, 4 and 6 for more information on how this policy may be terminated before the end date. Please see Clause 13 for more

information on the policy renewal process at the end of your period of cover.

2.2

Unless cancelled under Clause 4, if this policy ends within the first three (3) months (the minimum period) following the initial start date - any premium which has been paid for the first three (3) months of cover will not be refunded, regardless if you have claimed or not during that period of cover. In addition, you will be liable to pay any remaining premium for that initial three (3) months period which has not yet been paid.

If this policy ends after the minimum period (so more than three (3) months after the initial start date but before the end date), any premium which has been paid in relation to the period after the policy terminates and cover ends will be refunded, so long as no claims have been made or will be made and no guarantees of payment have been put in place during the period of cover.

If this policy ends at any time prior to the end date and you have made claims under it, received a guarantee of payment, or treatment not yet reimbursed you will not be refunded any premiums that you have paid in relation to the period after the policy terminates. If your annual premium is collected at intervals throughout the policy year, you will be liable to pay the remaining annual premium for the full twelve (12) months either by making these scheduled payments or by settling directly the whole outstanding premium amount.

2.3

If you die, cover will end for all beneficiaries unless a beneficiary contacts us within thirty (30) days of the date of death as shown in the death certificate (or equivalent) and notifies us that they would like to take over as policyholder. If any of the beneficiaries would like to continue coverage by becoming the policyholder, and subject to our policy terms, they must inform us within thirty (30) days and must provide us with a copy of the Death Certificate. The beneficiary must meet the policy eligibility conditions set out in Clause 1 to become a policyholder.

If a beneficiary does not wish to continue coverage as the policyholder, all cover will end, and we will not make any payments in relation to treatment or services which are received on or after the date on which the policy terminates. In this circumstance, clause 6.5 will not apply and you will be entitled to a refund of any paid premiums in relation to the period after the policy terminates.

3. The information we require from you

3.1 During the application process

In deciding whether to accept this policy and in setting the terms and premium, we have relied on the information that you have given to us. You must take all reasonable care when answering any questions that we ask and ensure that all information is accurate and complete. We require you to provide a complete overview of your medical history as of the date of the application and any medical symptoms or any other medical information which may be relevant to us in determining whether to provide cover.

If you do not, and we determine on reasonable grounds following an underwriting investigation, that you provided us with inaccurate, false or misleading information, and/or carelessly, recklessly or deliberately failed to disclose or to provide us with relevant medial information, including comprehensively answering the medical questionnaire in the application form, we may treat it as qualifying misrepresentation, and it could adversely affect this policy and any claim.

3.1.1

Where we determine the misrepresentation was careless, we reserve the right to:

i. treat this policy as if it had never existed, refuse to pay all claims and return the premium paid. We will only do this in circumstances where, if we had we been aware of the full facts or circumstances we would not have provided you with insurance cover; or

ii. amend the terms of your policy including but not limited to applying a medical exclusion to your policy; and/or

iii. in circumstances where we would have charged a higher premium but for the misrepresentation, we may refuse or proportionately reduce the amount to be paid on a claim.

3.1.2
Where we determine the misrepresentation was deliberate or reckless, we reserve the right to:

i. treat this policy as if it had never existed, refuse to pay all claims and retain the premium paid; or

ii. terminate your policy in accordance with clause 6.2.

We may apply these amended terms retrospectively from the start of your policy if a submitted claim has adversely impacted us by your misrepresentation.

We will notify you in writing if any of the above circumstances occur within 14 days of either having received updated and accurate information from you or as a result of our underwriting investigation based on reasonable grounds.

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

3.2 During the prior authorisation process

To cover any inpatient and day patient treatment under International Medical Insurance for any beneficiary under your policy, you are required to obtain prior authorisation from us. In order to approve the treatment, a medical necessity review by our medical team will take place and we require that you provide all the necessary information, including medical report, treatment plan, medical examination or any other relevant information related to a specific condition.

As per our medical necessity review, we may require access to additional information supplied by your medical practitioner or treatment provider. As such, we require:

i. that you give us access to the medical practitioner or facility, and;

ii. that you authorise us to enquire about a specific treatment or service provided to any beneficiary under your policy. In certain circumstances, we may require accessing the medical records of any beneficiary under your policy from your authorised physician.

If you, your medical practitioner, or treatment provider fail or delay in providing us with the required information, we reserve the right to exercise one or more of the following remedies:

i. delay the approval of the treatment;

ii. deny the approval of the treatment;

iii. reduce the amount which we will pay towards that treatment by twenty (20) percent;

iv. refuse to pay fully or partially a related claim if the medical necessity cannot be determined by our clinical team;

v. amend the terms of your policy.

As part of the prior authorisation process, we will in most instances issue a guarantee of payment to you and/or your chosen provider. This means that we agree in advance to pay some or all the costs of a particular treatment with that provider based on the estimated fees provided by you and approved by us according to established clinical practice and appropriate medical costs.

3.3 During the claim reimbursement process

In the instance where you, or any beneficiaries, have paid the hospital, clinic, medical practitioner or pharmacy for any eligible treatment directly, you should submit your invoice, receipt and claims form to us as soon as possible after such treatment has taken place. In order to process your reimbursement, we may require that you provide additional information including the medical report, treatment plan, medical examination or any other relevant information related to a specific condition. In certain circumstances, we may require access to additional information supplied by your medical practitioner or treatment provider. As such, we require that you give us access to the medical practitioner or facility and that you authorise us to enquire about a specific treatment or service provided to any beneficiary under your policy.

If you fail or delay in providing us with the requested information, we reserve the right to exercise one or more of the following remedies:

i. delay the claim reimbursement;

ii. deny the claim reimbursement; or

iii. amend the terms of your policy.

In assessing your claim, we may review the reasonable and customary costs of comparable treatment and services. We will only pay for such treatment costs where we are satisfied that they are not excessive in line with customary fees in the location of treatment and according to established clinical and medical practice.

4. Free look period

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

If you do not exercise your right to cancel this policy during the free look period, it will continue in force for one (1) year from the initial start date and you will be required to make any premium payments that are due to us for that period.

Subject to the terms of Clause 2.2, we and you have also have other termination rights outside of the fourteen (14) day statutory free look period, which are set out in Clause 6.

5. Premium and other charges

5.1

Your Certificate of Insurance sets out the premium and any other charges (such as taxes) which are payable, and states when and how they must be paid. As specified in Clause 2, unless you cancel during the free look period, you will be liable to pay the premium for the minimum period of three (3) months, regardless of the payment frequency selected or when the cover is terminated.

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

5.2

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

We will not apply the reduction in circumstances where we are satisfied that the costs related to medically necessary emergency treatment. No prior authorisation is required where an emergency treatment is required (for example where there is a threat to life), but you, or someone acting on your behalf, must contact us within 48 hours of the emergency treatment being administered, or if not practicable in the circumstances, as soon as reasonably possible.

5.3

Treatment in the USA should ordinarily be obtained from a hospital, clinic, medical practitioner or pharmacy which is part of the Cigna Healthcare network in the USA. A full list of hospitals, clinics and medical practitioners within the Cigna Healthcare network can be accessed in your secure online customer area. Should you or any beneficiary seek treatment in the USA from a provider that is not part of the Cigna Healthcare network, we will reduce the amount which we will pay towards that any medical expenses or treatment costs by twenty (20) percent.

However, we will not reduce the amount which we will pay or reimburse if you can demonstrate that:

i. there is or was no Cigna Healthcare network provider within 30 miles/50 kilometres of your location at the time treatment was sought, or;

ii. the relevant treatment is deemed medically necessary but is not available from a Cigna Healthcare provider, or;

iii. the relevant treatment is or was required in the event of an emergency.

Please note, we may, at our sole discretion and without notification, make changes to the Cigna Healthcare network from time to time by adding and / or removing hospitals, clinics, medical practitioners and pharmacies. We will update the medical provider list in your secure online Customer Area to reflect any changes.

5.4
In most cases we will pay the hospital, clinic or medical practitioner directly for your medical expenses. In the instance where you, or any beneficiaries, are required to pay the hospital, clinic or medical practitioner, you must submit your invoice and fully completed claims form to us as soon as possible after incurring costs for any treatment. All claims, including invoices, must be submitted to us within twelve (12) months of the date that treatment or costs were incurred. We will not pay or reimburse any claim submitted to us by you or a medical provider more than twelve (12) months after the date of treatment.

5.5
All claims are subject to the applicable deductible, cost shares and limits of cover set out in these Policy Rules, the Customer Guide and your Certificate of Insurance.

5.5.1
Claims are reimbursed in the currency in which the claim was incurred or, upon request, the currency of the premiums paid on this policy and calculated using our applicable exchange rate.

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

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

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

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

5.6
If you do not pay premium and/or any other charges when they are due, we will notify you by email as soon as possible and suspend your policy from the date when payment was due i.e. cover for all beneficiaries will be suspended. If payment is made within thirty (30) days of when the payment was due, the suspension will be lifted and cover under the policy will be reinstated back to the date the payment was due.

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 thirty (30) days after payment is due the amount is still outstanding, we will write to you informing you that the policy is cancelled. The cancellation shall take effect on the date when the first outstanding payment was due.

5.7
Subject to clause 13, we will inform you of the premium and any other charges which will apply during the next period of cover.

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

6. Termination

6.1
We will give you written notice if we are going to terminate the policy for all beneficiaries immediately, subject to any conflicting legal or regulatory requirements, if:

6.1.1
any premium or other charge (including any relevant tax) is not paid in full within thirty (30) days of the date on which it is due, as set out in Clause 5.6;

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

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

6.2

Subject to clause 3, we reserve the right to terminate this policy for any or all beneficiaries with immediate effect if, we, at our sole discretion determine, on reasonable grounds, that you have, in the course of applying for the policy, requesting prior authorisation, or when making any claim under it, withheld information or deliberately 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.

In these circumstances, we reserve the right to exercise all or any of the following remedies:

i. refuse to pay any claim; and/or

ii. recover from you any sums in respect of the claims paid by us; and/or

iii. retain any of the premium paid.

6.3

Subject to clause II, if any beneficiary ceases to be an expatriate whether as a result of a change to the beneficiary's country of nationality or country of habitual residence, we reserve the right to remove said beneficiary from the policy as per the terms outlined in Clause I0.

6.4

If we are no longer in the market to offer this policy, we will notify you at least one (I) month before the end date to advise you that the policy will be terminated (and therefore unable to be renewed) with effect from the policy end date. We will endeavour, but will not be obliged, to find a suitable alternative to provide continuity of cover in such circumstances.

6.5

If you want to terminate this policy and end cover for all beneficiaries, you may do so by giving us at least fourteen (I4) days' notice in writing using one of the following options:

i. If you may send us an email to the address indicated in the 'How to contact us' section on page 3 of these Policy Rules.

ii. you may contact in writing your dedicated account manager.

iii. you may log into your secure online customer area and click on the button 'Need to cancel your policy?', and indicate your termination date, to trigger a notification to the appropriate team.

Termination of your policy will take effect fourteen (I4) days after you notify us of the request. It is important to note that regardless of when you terminate your policy, a minimum of at least three (3) months premium is payable, as set out in Clause 2.

6.6

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, covered any treatment or issued any guarantee of payment during the period of cover.

If we have paid a claim, covered a treatment or issued a guarantee of payment during the period of cover and your annual premium is collected at intervals throughout the policy year, you will be liable to pay the remaining annual premium for the full twelve (12) months either by making these scheduled payments or by settling directly the whole outstanding premium amount.

6.7
Unless expressly agreed, we will not be held responsible for any treatment costs if the policy ends or a beneficiary leaves the policy before the treatment has taken place, even if the treatment has been authorised by us, and you or the medical provider will be responsible for all such treatment costs.

7. Fraud

7.1
If we determine that a beneficiary has made a fraudulent claim under this policy, we:

i. are not liable to pay the claim;

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

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

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

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

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

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

8. Coverage options

8.1
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 which are available under those options.

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

i. to modify your level of cover (for example moving up from the Silver level to the Gold level or moving down from the Platinum level to the Gold level for the International Medical Insurance cover); and\or
ii. to modify your deductible, cost share or out-of-pocket maximum.

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

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

i. to add one or more of the optional modules at the same level of cover as your International Medical Insurance core

cover: International Outpatient, International Medical Evacuation, International Health and Wellbeing or International Vision and Dental options; and\or

ii. to modify your area of cover by including USA cover (i.e. changing from Worldwide excluding the USA to Worldwide including the USA).

These changes to your policy will begin no sooner than the date you accept our offered terms and will remain in place until at least your annual renewal date.

8.2.1

Such changes are subject to our discretion and before making any of such changes to your policy, we may ask you to complete a new medical history questionnaire. If the requested change is accepted by us, we may apply new special restrictions or exclusions to your updated policy.

Any other changes to your policy in relation to coverage options will be subject to our absolute discretion and will be subject to medical underwriting.

8.3

It is important to note that there is no cover for maternity benefits ('Parent and Baby Care' section in the Customer Guide) on the Silver plan, and therefore in the case of an upgrade from the Silver level to the Gold level or the Silver level to the Platinum level, any beneficiary on the Silver plan will not have access to maternity benefits until they have satisfied the twelve (12) month waiting period (twenty-four (24) months in the UK, Hong Kong or Singapore) for the maternity benefits on the Gold or Platinum plan. Once any beneficiary has been covered under the Gold or Platinum plan for twelve (12) months or more (twenty-four (24) months in the UK, Hong Kong or Singapore), they will then have access to the maternity benefits.

For maternity benefits in the case of an upgrade from the Gold level to the Platinum level upon your renewal, any beneficiary will only have access to the benefit limits of the Gold plan for maternity benefits until they have satisfied the twelve (12) month (twenty-four (24) months in the UK, Hong Kong or Singapore) waiting period on the Platinum plan. Once any beneficiary has been covered under the Platinum plan for 12 months or more (twenty-four (24) months in the UK, Hong Kong or Singapore), then they will have access to the Platinum limits for the maternity benefits.

9. Deductible and Cost Share

9.1

If you have selected a deductible on the International Medical Insurance plan and/or International Outpatient option (if applicable), your chosen deductible will apply as per the treatment date and any deductible amount paid will be considered as a claim towards your policy, regardless if the deductible amount paid has covered fully or partially the cost of your claim.

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

Settling an invoice with medical providers when a deductible applies

Where direct billing arrangements are in place with the selected medical provider, we will issue a guarantee of payment to the medical provider, which will include the applicable deductible amount. Upon receipt of the invoice from the medical provider, we will first settle the eligible charges directly with the medical provider. We will then let you and the medical provider know any outstanding amount at your charge and you will be responsible to pay that deductible amount directly to the hospital, clinic, medical practitioner or pharmacy.

In circumstances where the medical provider requests you to pay the applicable deductible directly to the medical provider at the time of treatment, you must obtain and retain a valid invoice and receipt evidencing payment of the deductible, to prevent duplication of payment and to facilitate accurate claim reconciliation.

Furthermore, where the total cost of treatment falls below the deductible threshold, and you have paid that deductible amount directly to the medical provider, it must be noted that the deductible shall not be deemed satisfied unless you submit a claim. For the avoidance

of doubt, for the deductible to be applied and recorded appropriately, you are required to submit all eligible claims, irrespective of whether reimbursement is sought. Failure to do so may result in the deductible remaining outstanding and applicable to future claims.

9.2

If you have selected a cost share on the International Medical Insurance plan and/or International Outpatient option (if applicable), we will reduce the amount we pay towards the cost of treatment by that cost share percentage. Upon receipt of the invoice from the medical provider, we will first settle the eligible charges directly with the medical provider, you will then be responsible for paying the cost share to the hospital, clinic, medical practitioner or pharmacy. The amounts you pay are subject to the capping effect of the applicable out of pocket maximum.

Your chosen cost share applies as per the treatment date and any cost share amount paid will be considered as a claim towards your policy regardless if the cost share amount paid has covered fully or partially the cost of your claim.

9.3

Only amounts you pay related to the cost share on the International Medical Insurance and/or International Outpatient option are subject to the capping effect of the out of pocket maximum. The following are not subject to the out of pocket maximum:

i. Any amounts you pay due to a deductible;
ii. Where the limit of cover has been exceeded;
iii. Where the treatment is not covered by the International Medical Insurance plan; or
iv. Where you have received a penalty for not obtaining prior authorisation or using medical providers not in the Cigna Healthcare network.

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

9.4

No deductible or cost share apply to 'Inpatient cash benefit,' 'Newborn Care' benefit, 'Accident and Emergency Room Treatment,' or 'Global Telehealth with Teledoc' within the International Medical Insurance plan.

No deductible or cost share apply to benefits within the following optional modules: International Health and Wellbeing, International Medical Evacuation, or International Vision and Dental.

9.5

For the following outpatient treatments, which are covered under the International Medical Insurance plan, the chosen inpatient deductible applies:

i. Any outpatient treatment under the 'Kidney Dialysis' benefit.
ii. Any Advanced Medical Imaging (MRI, CT and PET scans) benefit on an outpatient basis.
iii. Any outpatient treatment under the 'Mental and Behavioural Health Care' benefit, including counselling.
iv. Any outpatient treatment under the 'Extensive Cancer Care' benefit.
v. Any outpatient treatment covered under the 'Complications from maternity' benefit.

10. Adding or removing beneficiaries

10.1

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

10.2

If a beneficiary gives birth, you may apply to add the newborn as a beneficiary to your existing plan, subject to the following:

10.2.1

If at least one (1) parent has been covered by the policy for a continuous period of twelve (12) months (twenty-four (24) months for births that occur in the UK, Hong Kong or Singapore) or more prior to the newborns

birth, we will not require information about the newborn's health or a medical examination if an application is received by us to add the newborn to the policy within thirty (30) days of the newborn's date of birth. However, if an 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.

10.2.2
If neither parent has been covered by the policy for a period of twelve (12) consecutive months (twenty-four (24) months for births that occur in the UK, Hong Kong or Singapore) or more prior to the newborn's birth, the newborn will be subject to medical underwriting, and we may apply special restrictions or exclusions.

10.2.3
If a beneficiary has a child via a surrogate or an adoption, the newborn can be added as a beneficiary to your existing plan by submitting an application. The newborn will be subject to medical underwriting whereby we may apply special restrictions or exclusions in respect of the newborn.

If medical underwriting is required for the newborn, we will then tell you whether we will offer cover to the newborn and, if so, any special conditions and exclusions which would apply. Cover will begin no sooner than the date you accept our offered terms.

We will send you an updated Certificate of Insurance confirming that the new beneficiary has been added. Please refer to the 'Newborn Care' benefit in your Customer Guide for further details.

Please note that the amount specified for the Newborn Care benefit cover expenses only relates to the added newborn, and no other beneficiary can claim under that benefit.

10.3
Except during the free look period, if you would like to remove a beneficiary during the policy year, you must notify us by giving us at least fourteen (14) days' notice in writing. The removal of said beneficiary from your policy will take effect fourteen (14) days after you, the policyholder, notify us of the request by using one of the options in the 'How to contact us' section on page 3 of these Policy Rules.

Subject to clause 2.2, you will be entitled to a refund of any paid premiums for the remainder of the period of cover for said beneficiary, so long as we have not paid a claim, covered a treatment, or issued a guarantee of payment for that beneficiary.

If we have paid a claim, covered a treatment or issued a guarantee of payment for said beneficiary during the period of cover, you will be liable for the remainder of the premiums for the period of cover which are unpaid.

11. Changes to any personal information you have provided

11.1
During the period of cover, if there is any change to a beneficiary's:

i. country of habitual residence; and/or

ii. country of nationality; and/or

iii. occupation; and/or

iv. participation in hazardous activities (as outlined in General Exclusion 29);

then you must inform us as soon as practicable and in any event within thirty (30) days.

We reserve the right to ask you from time to time for further information about any changes to the information you have provided us. Note that any change to your or any other beneficiary's personal information may result in a change to your premium or the application of an exclusion. This may mean 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 the policy, in accordance with Clause 6.5, in which case Clauses 6.6 and 6.7 will apply. Please note that the insurance may be provided by another Cigna Healthcare company.

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

11.2.1
We reserve the right to review all claims submitted by beneficiaries in their country of nationality In circumstances where we know or reasonably believe the beneficiary is or intends to be resident in their country of nationality in excess of one hundred and eighty (180) days in aggregate per period of cover, we may, at our sole discretion:

i. no longer consider that beneficiary to be an expatriate as they have returned to their country of nationality for a sustained period and exercise our right to remove the beneficiary from the policy in accordance with Clause 6.3; and/or

ii. we may refuse payment of any claim or issuance of a guarantee of payment.

11.3
We may request proof of expatriate status at any time for any beneficiary. If you fail to provide us with the requested information within thirty (30) days, we reserve the right to remove the beneficiary in question from the policy in accordance with Clause 6.3.

11.4
If you, the policyholder, cease to be an expatriate whether as a result of a change to a beneficiary's country of nationality or country of habitual residence, then you can either:

11.4.1
leave the policy in force for the remainder of the period of cover; or

11.4.2
terminate the policy by giving written notice with the effect that cover will end for all beneficiaries. Any premium which has been paid in relation to the period after termination will be refunded to the extent that it does not relate to a period of time in which we have provided cover, so long as we have not paid claims, covered treatment or issued any guarantees of payment during the period of cover.

If you do elect to leave the policy in force in accordance with Clause 11.4.1, treatment may be limited in accordance with Clause 11.2. You must inform us in advance of the policy renewal if you cease to be an expatriate and we will determine if we can offer you an alternative health plan provided by another Cigna Healthcare company, otherwise we may determine to not renew or to terminate your policy.

12. How we will communicate with you

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

You agree that we will primarily communicate with you in English.

13. Policy renewal

13.1
This policy will automatically renew unless we decide not to renew, or you notify us (in accordance with clause 13.4) that you do not wish for the policy to renew and you instead wish to terminate the policy.

13.2
We will write to you at least one (1) calendar month before the end date to inform you that the policy shall automatically renew and inform you of any changes to the policy and premium for the forthcoming period of cover.

The minimum payment of three (3) months premium does not apply to renewed policies. This requirement applies only to the first year of your policy.

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

13.3
If you do not inform us of your wish to not renew or to cancel the policy, your policy will renew automatically. In such circumstances, please ensure you have read and understood the policy documents for the forthcoming period of cover. Your cover will be renewed for another twelve (12) months.

13.4
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 by following the process to terminate this policy under Clause 6.5.

13.4.1
If you do not renew your cover, any eligible 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. Please note at least one (1) beneficiary must be at least eighteen (18) years old, as per the policy eligibility conditions set out in Clause 1, to become a policyholder.

13.5
Subject to clause 8.2, if you would like to make changes to your policy upon renewal, you must let us know in writing at least seven (7) days before your annual renewal date. We may apply new special restrictions, exclusions and/or adjust premium. If we do so we will send you an updated Certificate of Insurance.

13.6
If any special exclusion(s) have been applied to any beneficiary there may be occasions when we can review them at a future annual renewal date, to consider whether we are willing to remove the exclusion. If this is the case, we will show the exclusions review date in the Certificate of Insurance. At such date, we will also review the additional premium (if any) which we may have applied to cover a condition.

You should contact us upon receipt of the renewal notification, and at least seven (7) days before the annual renewal date if there is an exclusion which is due for review at that date.

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

14. Data protection

We would like you to be kept informed of how we manage your personal data as required under the Personal Data Protection Act (No. 26 of 2012) of Singapore. Your personal data and privacy are important to us, and we would urge you to read our Personal Data Protection Policy which is available in your secure online Customer Area, so that you will know and understand how we collect, use and disclose your personal data.

Telephone calls to and from Cigna Healthcare may be recorded, for quality control. We act as the data controller for the personal and sensitive information we hold about you and any beneficiaries. This data will be processed by us to carry out our obligations, and we may need to share it with authorized third parties, such as your broker.

15. Who can enforce this policy

Only we and you have legal rights in connection with this insurance. A person who is not a party to this policy has no right under the Contracts (Rights of Third Parties) Act 2001 to enforce any of the terms and conditions of this policy.

16. Our right to recovery from third parties

Subrogation refers to the rights which Cigna Healthcare can exercise to recover any expenses or costs from another insurance company, national health insurance scheme or any source linked to the reimbursement of treatment insured under this policy.

If Cigna Healthcare agrees to indemnify a beneficiary under the policy, we shall immediately be subrogated to any rights of recovery, contractual or otherwise, which the beneficiary may have against a liable third-party, to the extent permitted by law and shall automatically

have a lien upon the proceeds of any recovery by a beneficiary from such third-party to the extent of any benefits paid under the policy.
The beneficiary must execute all documents as may be required, and do everything necessary to secure and preserve such rights as to enable Cigna Healthcare to bring proceedings in the name of the beneficiary. The beneficiary will not prejudice Cigna Healthcare's interests or its potential or actual rights of recovery and will give Cigna Healthcare such information and co-operation as it may reasonably require. We may ask for a medical report from the medical practitioner who has carried out the treatment, if it needs more information.

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.

In respect of any expenses for which the beneficiary has been or can be reimbursed from any other insurance or source, Cigna Healthcare will apply the normal principles of equitable contribution and indemnity in accordance with the conditions set forth under this policy and reserves the right of subrogation and reimbursement to recover such expenses from any source.

Cigna Healthcare is also granted the right of reimbursement from the proceeds of any recovery whether by settlement, judgment, or otherwise. This right of reimbursement is cumulative with and not exclusive of the subrogation rights granted in this policy, but only to the extent of the benefits provided by the policy.

In the event a beneficiary shall fail or refuse to honor its obligations hereunder, then Cigna Healthcare shall be entitled to recover any costs incurred in enforcing the terms hereof including, but not limited to, lawyers or attorney's fees, litigation, court costs, and other expenses. Cigna Healthcare shall also be entitled to offset the reimbursement obligation against any entitlement to future medical benefits hereunder until the beneficiary has fully complied with his reimbursement obligations hereunder, regardless of how those future medical benefits are incurred.

No beneficiary shall make any settlement, which specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided by the policy.

17. Other Insurance

If you make a claim under this policy which may be covered by another insurer under a separate policy, you must notify us of this as soon as possible, providing details of the other insurance and the insurer. You will not be entitled to double recovery. We will contact the other insurer to discuss the claim and we will negotiate with them with regards to who pays what proportion of any claim, or, where appropriate, we may claim back from them any of the costs we have already paid.

When an overpayment has been made by Cigna Healthcare, we reserve the right to;

i. recover that overpayment from the person to whom or on whose behalf it was made; or

ii. offset the amount of that overpayment from a future claim reimbursement.

18. Changes to this policy

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

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

19. Sanctions

It is Cigna Healthcare's global corporate policy to comply with the economic sanctions rules related to individuals, entities, and countries applicable to its global business operations,

including but not limited to those imposed by the United Nations, the European Commission, the United States, and Canada. Therefore, Cigna Healthcare will not offer coverage or pay benefits to or on behalf of, any beneficiaries if doing so would violate these sanctions rules. In the event that Cigna Healthcare learns that a sanctioned individual or entity is enrolled under the policy, or that a beneficiary becomes sanctioned, Cigna Healthcare will take all appropriate action, which could include blocking, reporting, and terminating coverage. Cigna Healthcare is under no obligation to notify the beneficiary in advance of taking these actions, or to obtain licenses from any government to enable the extension of coverage in compliance with sanctions laws.

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

20. Pandemics, Epidemics and Infectious Illnesses

20.1

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

20.2

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

20.3

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

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

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

SECTION 2: GENERAL EXCLUSIONS

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

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

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

The following exclusions apply to the International Medical Insurance plan and to all of the extra coverage options. 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. Unlicensed or unrecognised treatment facilities, providers and practitioners

Treatment which is provided by:

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

2. Pre-existing conditions

Unless otherwise agreed, treatment for:

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

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

3. Preventative treatments

Preventative treatment, including but not limited to health screening, routine health checks and vaccinations (unless that treatment is available under the International Medical Insurance plan or one of the options for which a beneficiary has cover).

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

4. Treatment by family members or co-habitants

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

5. Conflicts, disaster or high-risk behaviour

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

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

c) any other conflict or disaster events;

where the beneficiary has:

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

6. Treatment outside selected coverage area

Any treatment outside your selected area of coverage, unless the treatment can be covered under the 'Out of Area Emergency Hospitalisation Cover' conditions.

7. Travel costs

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

8. Ship to shore evacuations

Any expenses for ship to shore evacuations.

9. Nursing homes, health spas, and nature clinics

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

10. Hospital stays for non-medical reasons

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

11. Reasonable hospital accommodation

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

12. Prosthetic devices

Any prosthetic device or appliance, including but not limited to spectacles (unless the International Vision & Dental module is selected) which is not medically necessary and/or does not fall within our definition of prosthetic device(s).

13. Incidental expenses

Incidental costs including, but not limited to, newspapers, telephone calls, guests' meals and hotel accommodation.

14. Administration costs

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

15. Non-medical hospital admissions

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

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

16. Artificial life maintenance

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

17. Foetal surgery

Foetal surgery, i.e. treatment or surgery undertaken in the womb before birth, unless this is resulting from complications arising through maternity and shall be subject to the limits detailed in the Complications from Maternity benefit under the International Medical Insurance plan.

18. Smoking cessation

Treatment for, or in connection with, smoking cessation.

19. Self-inflicted injury or attempted suicide

While we will cover medically necessary mental health care and behavioural health services, including but not limited to counselling and therapy with specialists, we will not otherwise cover 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. unless state or federal law requires such coverage.

20. Developmental and personality disorders

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

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

21. Temporomandibular joint disorders (TMJ)

Disorders of the temporomandibular joint (TMJ).

22. Addictive conditions and disorders

Treatment for a related condition resulting from addictive conditions and disorders. However, one course or programme of addiction treatment at a specialist centre providing evidenced-based treatment (where such treatment is medically necessary and recommended by a medical practitioner) and up to three attempts at detoxification is covered under this policy to the extent detailed under the Mental and Behavioural Health Care benefit.

23. Substance and alcohol misuse

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

24. Contraception

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

a) surgical contraception, namely:
   - vasectomy, sterilisation or implants;
b) non-surgical contraception, namely:
   - pills or condoms;
c) family planning, namely:
   - meeting a doctor to discuss becoming pregnant or contraception.

25. Intentional termination of a pregnancy

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

26. Sexual dysfunction disorders

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

27. Refractive eye surgery

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

We do not cover treatment in the event of physiological presbyopia - vision loss that can be attributed to the normal change in vision that arises as a result of ageing.

28. Gender reassignment surgery

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

29. Hazardous and professional sporting activities

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

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

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

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

30. Experimental or unapproved treatments

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

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

Any complications arising as a result of experimental or unapproved treatments will also not be covered.

31. Cosmetic treatments

Any form of cosmetic or reconstructive treatment and any complication thereof, the purpose of which is to alter or improve appearance even for psychological reasons, unless that treatment is medically necessary and is a direct result of an illness or an injury suffered by the beneficiary, or as a result of surgery.

32. Illegal Act

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

33. Weight-loss drugs and other supplements

Any expenses for:

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

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

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

SECTION 3: DEFINITIONS

Unless otherwise specified, the words and phrases defined below when used throughout these Policy Rules, and your Customer Guide (including the Table of Benefits section on pages **17-47**), will have the following meanings.

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

Annual renewal date - the anniversary of the start date.

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

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

Cigna Healthcare - the insurer of this policy.

Cigna Healthcare network - the network of hospitals, clinics, pharmacies, and medical practitioners that are authorised partners of the Cigna Group.

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

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

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

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

Daypatient - a patient who is admitted to a hospital or daypatient unit or other medical facility for treatment or because they need a period of medically supervised recovery, but who does not occupy a bed overnight.

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

Emergency treatment - treatment which is medically necessary to prevent the immediate and/or 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, or as soon as reasonably possible, will be covered.

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

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

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

Executive Officer - a senior leader within Cigna Healthcare who is responsible for policy or decision making.

Expatriate - a beneficiary residing outside of their country of nationality.

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

requires coverage of such medicines. We will notify you of any change that affects the coverage of a medication that you are taking at the time of any update

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

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

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

International Medical Insurance - refers to the mandatory core cover of your Cigna Healthcare policy. It forms the foundation of your policy and is primarily comprised of inpatient and daypatient benefits. For the full list of benefits covered under International Medical Insurance, please refer to the table of benefits in your Customer Guide.

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

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

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

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

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

Medical practitioner - a doctor, specialist, qualified nurse or therapist (including speech therapies, dietician or orthoptist), dental surgeon or dental practitioner who is registered, suitably qualified or licensed to practice medicine or provide treatment under the laws of the country, state or other regulated area in which the treatment is provided, and who is not covered under this policy, or a family member of someone covered under this policy.

Minimum period - refers to the first three consecutive months from the initial start date of your policy (inclusive of the free look period) for which you are obligated to pay premiums, regardless of whether you have claimed under the policy or not.

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

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

Period of cover - this policy has a period of cover of twelve (12) months. The period of cover is from the start date to the end date as noted in the Certificate of Insurance or earlier if terminated in accordance with the Policy Rules. The policy is automatically renewed at the end of the period of cover, unless expressed otherwise by you or us.

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

Policy - the policy comprising of:

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

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

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

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

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

Selected area of coverage - means either:

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

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

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

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

'We', 'Us' and 'Our' - when we use the terms 'we', us' and 'our', we refer to Cigna Healthcare, the insurer of this policy. Please refer to page 3 of this Policy Rules document for details of the Cigna Healthcare legal entity providing your policy.

'You', 'your' - the policyholder.

CGHO Policy Rules Singapore EN 02/2026