AGREEMENT relating to the Cigna Care Connect Employee Healthcare Plan

BETWEEN

Cigna Europe Insurance Company S.A.-N.V. Singapore Branch
(Registration Number: T10FC0145E),
a foreign branch of Cigna Europe Insurance Company S.A.-N.V.,
registered in Belgium with limited liability,
152 Beach Road, #33-05/06 The Gateway East, Singapore 189721.

And

XXXXX

Group Policy Number	:	XXXXX
Policyholder	:	XXXXX
Start Date	:	XXXXX

This **Policy** document is a legal contract between **You** and **Us**. Whereas **You** have requested **Us** to grant the **Benefit**(s) and **We** hereby agree to pay to the **Insured Members** the **Benefit**(s) subject to all the terms and conditions of this **Policy**. This **Policy** is issued in consideration of payment of the **Premium** and shall take effect on the **Policy Start Date**.

This Policy document, the group insurance proposal form, enrolment form, the **Policy Schedule,** any **Endorsement**(s) or riders (made at the issue of this **Policy** document or subsequent to the issue of this **Policy** document) and/or the individual group health declaration forms submitted by the **Eligible Members** (if any), shall form the entire agreement ("**Policy**") between **You** and **Us**. Any modification or amendment to the terms and conditions of this **Policy** shall only be valid if it is approved by **Us** and evidenced by **Endorsement**(s) issued and signed by **Us**.

Welcome to **Your** Cigna **Policy**.

SECTION A – Our agreement

1. This **Policy** document is a legal contract between **You** and **Us** and we agree to provide you with the **Benefit**(s) stated in the **Policy Schedule** in consideration for the **Premium** paid by **You**.

2. This Policy document, the group insurance proposal form, enrolment form, the **Policy Schedule,** any **Endorsement**(s) or riders (made at the issuance of this **Policy** document or subsequent to the issuance of this **Policy** document) and/or the individual group health declaration forms submitted by the **Eligible Members** (if any), shall form the entire agreement ("**Policy**") between **You** and **Us**.

3. **We** have relied on the information provided to **Us** in the group insurance proposal form, enrolment form, individual group health declaration forms and any other correspondence for this **Policy** to determine whether or not to grant the insurance coverage. Such information provided to **Us** in the aforesaid documents shall be the basis of and shall form part of the **Policy**. **You** are responsible for the accuracy and completeness of the information in any document provided by **You** to **Us** and for compliance with the conditions of this **Policy** document. The **Eligible Member** is also responsible for providing accurate and complete information in the individual group health declaration forms.

4. This **Policy** may be void if **You** do not disclose to **Us** fully and faithfully the facts **You** know or ought to know, or if **You** do not comply with the terms and conditions of this **Policy**. On a similar basis, coverage of the **Insured Member** may be void if the **Insured Member** does not disclose to **Us** fully and faithfully the facts the **Insured Member** knows or ought to know, or if the **Insured Member** does not comply with the conditions of this **Policy**.

5. The **Premium** and **Benefit**(s) are payable in Singapore dollars.

6. This **Policy** shall be construed according to and governed by the laws of Singapore. The parties to this **Policy** agree to be subject to the exclusive jurisdiction of the courts of Singapore.

7. A person who is not a party to this **Policy** has no rights under the Contracts (Rights of Third Parties) Act, Cap. 53B to enforce any of the terms and conditions of this **Policy**.

8. This **Policy** may at any time be amended by written agreement between **You** and **Us**. Any amendments to this agreement shall be binding on all **Insured Members** whether insured under this **Policy** prior to or on or after the **Effective Date** of the amendment. In response to any regulatory requirements imposed by law or to any of **Our** operational developments, **We** may amend the terms and conditions of this **Policy** and inform you of the relevant changes and the date upon which such changes will become effective.

SECTION B – Definitions

Accident means a sudden, unforeseen, and unexpected physical event during the **Policy Year** that is the sole and direct cause of bodily injury and excludes all **Illnesses** or diseases.

An **Employee** shall be considered to be in **Active Service** if he/she is:
(a) employed by **You** or **Your Affiliates** on a full-time permanent basis;
(b) reporting for work at **Your** business establishment or location, performing all the regular duties of his/her employment in the customary manner; and
(c) on paid sick leave; or actively working on any day which is one of **Your** or **Your Affiliates'** scheduled work days or on a regular paid vacation or on a regular non-working day; provided that he/she satisfies the requirements in (a) and (b) above on the day before such paid sick leave, vacation or non-working day.

Employees on no pay leave, for whatever reasons shall not be considered to be in **Active Service**.

Accident & Emergency Department means a medical treatment facility specializing in emergency medicine and the acute care of patients, who present without prior appointment; either by their own means or that of an ambulance. The **Accident & Emergency Department** is usually found in a **Hospital** or other primary care center.

Affiliate means all entities now or in the future that **control**, are **controlled** by or are under common **control** with the **Policyholder**.

Age means the **Insured Member's** attained age as at the **Policy Start Date**.

Alternative Treatment means treatment relating only to chiropody, chiropractic treatment, osteopathy, homeopathy, and appropriate treatment received from a **Traditional Chinese Medical Practitioner** which is considered a reasonable alternative for the condition being treated. There must be general and widespread acceptance from the medical community that the given treatment is proven to alleviate symptoms and the treatment must be orthodox and adhere to the commonly accepted traditional practice of medicine.

Allied Health Services mean physiotherapy, occupational therapy, speech therapy and podiatry treatment rendered by licensed **Allied Health Professionals**.

Allied Health Professional means a person registered as an allied health professional with a local health authority or relevant local health council.

Annual Limit means the maximum **Benefit** payable by **Us** in a **Policy Year** as specified in the **Policy Schedule**.

Area of Cover means the geographical area that **We** cover the **Insured Members** as specified in the **Policy Schedule**.

Benefit(s) means the amount(s) payable by **Us** in accordance with the terms and conditions of this **Policy**.

Cancer means a malignant tumour positively diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells with invasion and destruction of normal tissue. The term malignant tumour includes leukemia, lymphoma and sarcoma.

Cigna Emergency Assistance means emergency assistance service provider appointed by Cigna to provide the International Emergency Benefit.

Cigna Medical Team means Cigna's medical director.

Community Hospital means an institution that is designated as a community hospital by a local health authority. For avoidance of doubt, hospices, convalescent centres, **Hospitals** and homes are not community hospitals.

Congenital Conditions means a genetic (including hereditary condition), physical or biochemical defect, disease, malformation or anomaly, present at birth and whether or not manifest, diagnosed or known about at birth.

Control/Controlled means with respect to any entity, means the possession, directly or indirectly, of the power to direct or cause the direction of the management or policies of such entity, whether through ownership of voting securities or other ownership interests, by contract or otherwise.

Co-Insurance means the percentage of a claim (being the amount that is in excess of the **Deductible**, if any) which has to be borne by the **Insured Member** before the relevant **Benefits** are payable under this **Policy**.

Co-Payment means the amount of a claim (being the amount that is in excess of the **Deductible**, if any) which has to be borne by the **Insured Member** before the relevant **Benefits** are payable under this **Policy**.

Country of Residence means the country in which the **Insured Member** is residing and which will be shown as the **Insured Member**'s country of residence in **Our** records.

Day Surgery means **Surgery** that does not require and/or involve overnight stay in a **Hospital**.

Deductible means the amount shown in the **Policy Schedule** (and before the application of any **Co-Insurance** or **Co-Payment**) which has to be borne by the **Insured Member** for a claim before any **Benefits** becomes payable under this **Policy**.

Dentist means a person qualified by a degree in Western dentistry to practise dentistry and is duly licensed and registered with the relevant statutory dental board or council to provide dental treatment and who is practising within the scope of his/her licence and training in the geographical area of practice. However, this excludes a dentist who is the **Insured Member** himself/herself or a member of the **Insured Member's** immediate family.

Dependant means the following:

(a) the **Employee's Spouse** (who is not him/herself an **Insured Member** under this Policy), whose name has been provided to **Us** prior to the **Effective Date** of the **Policy** coverage, but only if those persons are below age seventy-five (75) during the **Policy Year**; and

(b) the **Employee's** unmarried child(ren) or child(ren) who is in full-time education , whose names have been provided to **Us** prior to the **Effective Date** of the **Policy** coverage, but only if those persons are below age twenty-six (26) during the **Policy Year**. The term "child" or "children" means a child born to the **Employee** or a child legally adopted by the **Employee**. It also includes a stepchild from a legal marriage.

Eligible Costs/Charges means all costs/charges that are approved and covered by **Us** subject to the **Benefit** limit as specified in the **Policy Schedule**, and taking into account of any **Co-Payment, Co-Insurance** and/or **Deductible** that is applicable.

Eligible Member means an **Employee and/or Dependant** who has not been disqualified by any other provisions of this **Policy** and is entitled to participate in the insurance coverage provided by this **Policy**.

Emergency Treatment means urgent remedial treatment to avoid death, or impairment to the **Insured Member's** immediate or long-term health prospects.

Emergency Dental Treatment means the **Treatment** required for the **Insured Member** due to an **Accident** resulting in loss of or damage to the **Insured Member's** sound natural teeth.

Employee(s) means any member of staff employed full-time by **You** or **Your Affiliates**, who is in **Active Service** and within the age limit as specified in the **Policy Schedule.**

Endorsement means any supplementary document **We** issue to the **Policyholder** to record and confirm changes to the **Policy**.

Effective Date means the date the coverage under this **Policy** starts for the **Employees** and their **Dependants**.

Experimental means an unproven **Treatment** that is not generally accepted by the medical community as effective and proven; not recognised by professional medical organisations as conforming to accepted medical practice; not approved by the Food and Drug Administration (FDA) or Health Sciences Authority (HSA) in Singapore; are in clinical trials or need further study even if the **Singapore Government Restructured Hospitals** provide such services, **Treatment** and/or **Prescription Drug**; or are rarely used, novel, or unknown and lack authoritative evidence of safety and efficacy.

Gene Therapy or Genetic Therapy means **Treatment** or services that seeks to modify or manipulate the expression of a gene or to alter the biological properties of living cells for therapeutic use. Gene therapy is a technique that modifies a person's genes to treat or cure disease. Gene therapies can work by several mechanisms: replacing a disease-causing gene with a healthy copy of the gene, inactivating a disease-causing gene that is not functioning properly or introducing a new or modified gene into the body to help treat a disease.

General Practitioner means a **Physician** who conducts medical services in an outpatient clinic setting and not at a specialist level, and who is neither an **Insured Member** himself/herself, nor a relative, sibling, parent or **Dependant** of the **Insured Member**.

Grace Period means a period of sixty (60) days after the date on which a **Premium** is due. If **We** do not receive the **Premium** within sixty (60) days, services will be suspended until receipt of payment. **We** reserve the right to terminate the **Policy** in the case of non-payment. **You** will be liable to **Us** for any unpaid **Premium** for the period the **Policy** was in force.

Home Nursing means visits from a **Qualified Nurse** to the **Patient's** home to give expert nursing services:
(a) immediately after **Hospital Treatment** for as long as is **Medically Necessary**;
(b) the **Treatment** is one which would normally be provided in a **Hospital**; and
(c) the **Specialist** who treated the **Insured Member** must have recommended these services.

Hospital means an establishment duly constituted and licensed in the geographical area in which it is located as a medical and surgical hospital for the care and treatment of sick and injured persons as bed paying patients, and which:
(a) provides facilities for diagnosis, treatment and minor or major **Surgery**;
(b) provides twenty-four (24) hours nursing services by registered nurses;
(c) is supervised by a full-time staff of **Physicians** at all times;
(d) is not primarily a clinic, a mental hospital or institution, a place for custodial care or facility for alcoholics or drug addicts, a spa, or hydro clinic or hospices, nursing or rest or home for the aged, convalescent home or similar establishment; and
(e) is not a **Community Hospital**.

Hospitalisation/Hospitalised means when an **Insured Member** is confined in a **Hospital** or when the **Hospital** makes a charge for **Room and Board** for the **Treatment** of an **Illness** or **Injury**.

Illness means a physical or mental condition marked by a pathological deviation from the normal healthy state.

Injury means a bodily injury which is sustained by an **Insured Member** during the **Policy Year** and is caused solely and directly by an **Accident** and does not include any **Illness** and is independent of any other causes.

Inpatient means admission and confinement of an **Insured Member** in a **Hospital** for **Treatment** of an **Illness** or **Injury** for which the **Hospital** charges the daily **Room and Board** costs.

Insured Member(s) means an **Eligible Member** who has been approved by **You** and **Us** for coverage under this **Policy**.

Intensive Care Unit (ICU) means a section, ward, or wing within a **Hospital** which is under the constant supervision of an Intensive Care Unit **Specialist**, and which is specially equipped for the **Treatment** of the **Patient** who:

(a) is in a critical condition; or
(b) requires life support facilities;

and requires a level of care and supervision which is considerably more sophisticated and intensive than in the ordinary and high care wards.

Medically Necessary/Medical Necessity

Medically necessary means any healthcare services, supplies or expenses which are ordered by a **Physician** or **Dentist** for the diagnosis or treatment of an **Injury** or **Illness** of the **Insured Member**, and which are:

(a) not provided only as a convenience to the **Insured Member** or **Physician**;
(b) consistent with the symptoms and findings or diagnosis and customary **Treatment** for the **Insured Member's Illness** or **Injury**;
(c) according to the standards of good medical practice, consistent with current standard of professional medical care in the location where the **Treatment** is given at the time of the commencement of the procedure or **Treatment**;
(d) does not exceed (in scope, duration or intensity) the level of care that is necessary to provide safe, adequate and appropriate diagnosis or **Treatment**;
(e) not **Experimental**; and
(f) not a matter of personal choice.

Non-Panel means a **Physician** clinic who is not on **Our** approved **Panel** list.

Non-Panel Dentist means a **Dentist** (dental clinic) who is not on **Our** approved **Panel Dentist** list.

Outpatient means **Treatment** given at a **Hospital**, **Physician's** office or outpatient clinic where the **Insured Member** does not stay overnight or as a day-case to receive **Treatment** of the **Illness** or **Injury**.

Panel means the group of **Physician** clinics in Singapore designated and approved by **Us** to provide **Treatment** to the **Insured Member**.

Panel Dentist means the group of **Dentists** (dental clinics) in Singapore designated and approved by **Us** to provide **Treatment** to the **Insured Member**.

Patient means the **Employee** or **Dependant** who undergoes **Treatment**.

Physician means a person qualified as a medical practitioner by a medical degree in Western medicine and duly licensed and registered with the relevant statutory medical board or council to practise medicine and is practising within the scope of his/her licence and training in the geographical area of practice. A reference to a "**Physician**" in this **Policy** shall be construed to mean, wherever appropriate, a **General Practitioner** and/or a **Specialist**. However, this excludes a **Physician** who is the **Insured Member** himself/herself or a member of the **Insured Member's** immediate family.

Policyholder means the owner of this **Policy** as named in the **Policy Schedule**.

Policy Period means the period of cover as shown in the **Policy Schedule**.

Policy Schedule means the schedule to this **Policy** which sets out the details of the **Benefits** under the **Policy**.

Policy Year means the twelve (12) months period of a **Policy** beginning from the **Start Date** specified in the **Policy Schedule**.

Premium means amount paid or payable by the **Policyholder** in return for **Benefits** provided by **Us**.

Premium Schedule means the amount of the **Premium** and the initial agreed **Policy Period** as stated in the **Policy Schedule**. The payment of the **Premium** is made on the date specified in the **Premium Schedule**.

Pre-Existing Condition means any condition, prior to the **Effective Date** on which an **Insured Member** is first covered under the **Policy**:

(a) for which **Treatment**, medication or advice has been sought or received by the **Insured Member**;
(b) which the **Insured Member** should reasonably, based on **Our** appointed **Physician's** opinion, have known about; or
(c) for which the **Insured Member** has experienced symptoms even if the **Insured Member** has not consulted a **Physician** previously.

Prescription Drugs means drugs which are **Medically Necessary** as prescribed by a **Physician or Dentist** for the **Treatment** of an **Illness** or **Injury**.

'Prohibited Persons, Entities or Countries' or **'Prohibited Persons or Entities'** or **'Prohibited Countries'** means any persons, entities and/or countries (as the case may be) restricted, sanctioned or prohibited under any relevant laws and regulations.

Psychiatric/Psychiatry means an **Illness** or medical condition relating to mental or emotional disorders as medically recognised by the relevant **Specialist**.

Qualified Nurse means a nurse who is registered or licensed as such under the laws of the geographical area of practice in which the **Treatment** is provided.

Reasonable and Customary Charges means charges paid for medical services or **Treatment** which are appropriate and consistent with the diagnosis and according to accepted medical standards, and which could not have reasonably been avoided without negatively affecting the **Insured Member's** medical condition. These expenses must not be more than the general level of charges made by other medical service suppliers of similar standing in Singapore for such services and supplies for similar medical services or **Treatment**. Singapore Ministry of Health published data on procedures at the seventy-fifth (75^{th}) percentile of the respective class ward may be used to establish the upper range of reasonable charges for such published procedures.

Referral Letter means an official letter prescribed by the **Physician** for the **Insured Member** to seek further **Treatment** with a **Specialist**.

Renewal Date means the date immediately following the last day of any **Policy Period** as stated in the **Policy Schedule**.

Room and Board means actual **Standard Room** accommodation charges including meals, and general nursing care incurred per day while the **Insured Member** is confined in a **Hospital**.

Short-Stay Ward means a ward where emergency department patients stay for up to twenty-four (24) hours for observation by a **Physician**.

Singapore Government Restructured Hospital means a **Hospital** in Singapore that:
(a) is run as a private company owned by the Singapore Government; and
(b) is governed by broad policy guidance from the Singapore Government through Ministry of Health of Singapore.

Specialist means a **Physician** who specialises in specific area(s) in the medical field, but it excludes a specialist who is an **Insured Member** himself/herself, or a relative, sibling, parent, or **Dependant** of the **Insured Member**. This excludes **Allied Health Professionals**.

Spouse means the **Employee's** legal husband or wife, or unmarried, or civil partner that **We** have accepted for cover under the **Policy**.

Standard Room means the class of hospital ward, which is categorised as standard by the **Hospital** in which the **Insured Member** is confined as an **Inpatient** and shall not include luxury suites or other special rooms that exist at the **Hospital** in addition to the standard room.

Start Date means the date on which the insurance cover commences as set forth in **Your Policy Schedule**.

Surgeon means a **Specialist** who is qualified to perform **Surgery**.

Surgery means the following **Treatment**:
(a) incision, excision and suturing of wounds (excluding removal of suturing);
(b) electrocautery, cryocautery and laser techniques;
(c) reduction of a fracture and dislocation by manipulation; or
(d) any operative procedures performed by a **Physician** involving general or local anesthesia for the correction of deformities or defects, repair of **Injuries**, and the diagnosis or cure of certain diseases.

Surgical Appliances mean a metal or plastic appliance frequently constructed before or during a **Surgery** and used to immobilise or support tissue during the post-**Surgery** phase for rehabilitation and/or recuperation purpose.

Surgical Implants mean any medical device or tissue that is inserted by surgical or medical intervention, wholly or partially into the body of the patient; or by medical intervention, into a body orifice; and to remain in place after the procedure.

Traditional Chinese Medical Practitioner means a registered practitioner who is licensed to practise traditional Chinese medicine within the scope of his/her licence and training in the geographical area of practice who is neither an **Insured Member** himself, nor a relative, sibling, parent or **Dependant** of the **Insured Member**.

Treatment means any relevant consultation, diagnosis, procedure, care, or other medical services provided by a **Physician** or **Dentist** to diagnose, cure or substantially relieve acute or chronic conditions within the scope of the **Policy**.

Waiting Period means the period of time specified in the **Policy Schedule** that the **Insured Member** must fulfill before some or all of the insurance coverage can start.

We, Our, Us, and **Cigna Singapore** means Cigna Europe Insurance Company S.A.-N.V., Singapore Branch.

You, Your and **Yours** means the **Policyholder** referred to in the **Policy Schedule.**

SECTION C – Eligibility of coverage

1. Subject to Clause 5 of this Section C, unless otherwise specified by **Us,** all **Eligible Members** who are in **Active Service** at the **Policy Start Date** shall be covered under this **Policy**.

2. Unless otherwise specified by **Us**, All **Employees** who are not in **Active Service** at the **Policy Start Date** shall not be covered under this **Policy** and shall only be covered on the date they are in **Active Service**.

3. An **Insured Member** whose coverage under this **Policy** was terminated due to any cause and who re-applies for insurance coverage shall be considered as a new member and subject to **Waiting Period** (if any).

4. All **Dependants** are only eligible to be covered upon application of the **Dependants'** coverage by **You** and upon acceptance by **Us** in writing.

5. Any person who is a **Dependant** on the **Policy Start Date** shall be eligible at such **Effective Date**.

6. Written applications have to be submitted for an additional **Dependant** to be covered under this **Policy** within thirty-one (31) days from the date the **Dependant** becomes eligible.

SECTION D – Termination of Insured Members

1. The coverage for any **Insured Member** automatically terminates on the following dates, whichever is the earliest:

   (a) the date when **You** stopped paying the **Premium** due for the **Insured Members'** cover;

   (b) the end of the **Policy Year** when the **Insured Member** attains the maximum **Age** of coverage as specified in the **Policy Schedule**;

   (c) the date on which this **Policy** is terminated by either party pursuant to the terms and conditions of this **Policy**;

   (d) the date **We** inform **You** that the **Policy** terminates as a result of terrorism, war or an act of war. **We** shall have the sole and absolute discretion to determine such date;

   (e) the date the **Insured Member** dies;

   (f) the date the **Employee** ceases to be in **Active Service**;

   (g) the date when the **Dependant** no longer fulfils the conditions which qualify them as **Dependant**; or

   (h) the date on which **Dependant** enters into full-time military, naval or air-service.

SECTION E – Premium

1. Unless otherwise specified by **Us** in writing, **Premium** shall be paid to **Us** in advance on each **Premium** due date. The payment of any **Premium** shall not maintain the coverage under this **Policy** in force beyond the date when the next **Premium** becomes payable, except as stated in the provision of **Grace Period**. **We** reserve the right to change the rate at which the **Premium** is calculated on any **Renewal Date**; or when the risks being insured under this **Policy** have substantially increased provided that **We** notify **You** at least thirty (30) days in advance.

2. **Premium** adjustment can be administered based on named basis and headcount basis in the manner as set out below:

   (a) Named Basis:

   (b) **You** must furnish such information of all **Insured Members** who are covered under named basis at **Policy Start Date** and at each **Renewal Date**, or as and when **We** may require.

   (c) For new **Insured Member**, **You** must notify **Us** in writing within sixty (60) days after the new **Insured Member** is employed and in **Active Service** and pay the **Premium** for the new **Insured Member** from the **Effective Date** to the following **Renewal Date**.

   (d) For existing **Insured Member**, **You** must notify **Us** in writing within sixty (60) days from the date of the **Insured Member** ceases to be eligible under the **Policy**.

      (i) Any addition of the new **Insured Member** will be charged a pro-rated **Premium** corresponding to the unexpired **Policy Period**. Any termination of an **Insured Member** will be granted a pro-rated refund **Premium** paid in respect of that **Insured Member** corresponding to the unexpired **Policy Period**.

   (e) Headcount Basis:

      (i) **You** must furnish such information of all **Insured Members** who are covered under headcount basis at **Policy Start Date** and at each **Renewal Date** or as and when **We** may require. The information will form the basis of adjustment of the previous year.

      (ii) Adjustments to the **Premium** will be calculated as at the last day of the **Policy Period** by multiplying fifty percent (50%) of the difference between the headcount as at **Policy Start Date** and the headcount as at last day of the **Policy Period**; with the annual **Premium** rate.

      (iii) Unless otherwise endorsed, the administration of the **Policy** for **Employees** and **Dependants** will be on named basis.

SECTION F – Grace Period & Free Look Period

1. We shall not be liable under this **Policy** unless any **Premium** due is paid and received in full by **Us** within the time period as set out below ("**Grace Period**"):

   (a) where the **Premium** is payable on an annual basis, **Premium** is due on the later of:

   (i) sixty (60) days from **Policy Start Date** or **Renewal Date** of the **Policy**; or

   (ii) sixty (60) days from the date of the premium tax invoice issued by **Us**.

   (b) where the **Premium** is payable other than on annual basis:

   (i) Sixty (60) days from the **Policy Start Date** or **Renewal Date** of the **Policy** or sixty (60) days from the date of premium tax invoice issued by **Us**, whichever is the later, for the first instalment; and

   (ii) on the **Premium** payment dates as agreed between **You** and **us** for subsequent instalments.

   (c) **We** reserve the right to terminate this **Policy** from the **Renewal Date** in the event that any **Premium** is not paid to **Us** within the **Grace Period**, and **We** shall be discharged from all liability and obligations therefrom.

   (d) No claim incurred within the **Grace Period** shall be paid until **Premiums** due under this **Policy** relating to the respective **Policy Period** is received in full by **Us**.

   (e) You have a period of fourteen (14) days from the date you receive this **Policy** to review the terms and conditions of the **Policy** ("**Free Look Period**"). The **Policy** is deemed to have been received by **You** three (3) days after **We** dispatched it to **You**.

   (f) If **You** decide that the **Policy** is not suitable for **Your** needs, **You** may return the **Policy** to **Us** for cancellation within the **Free Look Period**. Where the **Policy** is cancelled within the **Free Look Period**:

   (i) any **Premium** paid will be refunded in full;

   (ii) the **Policy** shall be deemed to be voided from inception; and

   (iii) **We** shall not be liable for any claims occurring prior to the cancellation of the **Policy**.

SECTION G – Early Termination

1. This **Policy** may be terminated by either **You** or **Us** by giving thirty (30) days' notice in writing. **Termination** of this **Policy** by **You** or **Us** shall be without prejudice to any claims incurred prior to such **Termination**. A pro-rated **Premium** will be charged for the period the **Policy** was in force if the **Policy** is terminated by **Us**. However, if **You** terminate the **Policy**, **Premium** will be charged based on the following table:

Period of Cover	**Chargeable Premium**
Within 14 days	Not applicable
15 days – 60 days	150 days
61 days – 150 days	180 days
151 days – 210 days	240 days
Exceed 210 days	One (1) full year premium

SECTION H – Data Required

1. **You** shall furnish **Us** with all such data, information and evidence as **We** may reasonably require with regard to any matters pertaining to the **Policy**. All documents furnished to **You** by any **Insured Member** in connection with the **Policy**, and any other records that may have a bearing on the insurance coverage under this **Policy**, shall be made available for inspection by **Us** as may be reasonably required.

2. For avoidance of doubt, clerical errors in retaining the **Policyholder's** records shall not:

   (a) invalidate the insurance coverage which is otherwise validly in force; or

   (b) continue the insurance coverage, which is otherwise validly terminated.

   However, upon discovery of such errors, **We** shall provide for an equitable adjustment, the extent and timing of which shall be ascertained solely by **Us**.

SECTION I – Policy Renewal

1. This **Policy** shall be renewed automatically provided **We**:

   (a) offer **You** the renewal terms and conditions in writing;

   (b) **We** issue **You** a premium tax invoice for **Premium** due on the following **Policy Renewal Date**; and

   (c) receive the renewal premium within the **Grace Period**.

SECTION J – Misstatement

1. The correct facts and age will be used to determine the validity of the insurance coverage extended and if necessary, an equitable adjustment of **Premiums** will be made in the event the following should occur:

   (a) the date of birth, age or other relevant facts relating to an **Insured Member** is subsequently found to have been misstated; and

   (b) such misstatement affects the benefit level an **Insured Member** is entitled to or otherwise affects the terms and conditions of this **Policy**.

2. An **Insured Member's** insurance coverage shall be void in the following circumstances:

   (a) where a misstatement of age or other relevant facts has caused any **Insured Member** to be insured when they would otherwise not be eligible for any insurance coverage; or

   (b) where any statement has caused any **Insured Member** to remain insured when their insurance coverage would otherwise have been terminated in accordance with the terms and conditions of this **Policy**.

3. In any of the scenarios set out at Clause 2 of Section J above, **Premiums** paid in such instances shall be refunded except where there is fraud on **Your** part or on the part of the **Insured Member**.

SECTION K – Data Use

1. 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 at https://www.cigna.com.sg/assets/pdf/personal-data-protection-policy.pdf so that **You** will know and understand how **We** collect, use and disclose **Your** personal data.

SECTION L – Description of Benefits

A. Inpatient Benefit

1. Daily Hospital Room and Board

We will pay for the actual and **Eligible Charges** incurred for **Standard Room** accommodation (including meals and general nursing services) during the **Patient's Hospitalisation** stay, including high dependency ward charges.

2. Intensive Care Unit (ICU)

We will pay for the actual and **Eligible Charges** incurred for **ICU** confinement (including meals, **Room and Board,** and general nursing services) during the **Patient's Hospitalisation** stay in the **ICU** of the **Hospital**.

For avoidance of doubt, coronary care unit and such other similar units or sections in a **Hospital** shall be covered under this **Benefit**.

3. Short-Stay Ward

We will pay for the actual and **Eligible Charges** incurred for **Short-Stay Ward** confinement in a **Hospital** for the purpose of observation and/or **Treatment** of the **Patient**.

4. Hospital Miscellaneous Expenses

If **We** pay the Daily Hospital Room and Board **Benefit**, **We** will also pay the **Reasonable and Customary charges** incurred on **Hospital** miscellaneous expenses during the confinement for the following services:

(a) General nursing care including dressings, ordinary splints and plaster casts;

(b) Prescription drugs;

(c) Inpatient diagnostic procedures including X-rays, electrocardiograms, basal metabolism test and other laboratory tests;

(d) Inpatient physiotherapy by a qualified and registered physiotherapist upon the recommendation and approval of the attending **Physician** who furnishes specific instructions as to the type and duration of treatment;

(e) Intravenous infusion; and

(f) All **Medically Necessary** rehabilitation services.

5. In-Patient Physician's Visit

We will pay for the actual and **Eligible Charges** by the attending **Physician** for daily bedside visits after **Inpatient Treatment**.

6. Surgery

We will pay for the actual and **Eligible Charges** for **Surgery** by one or more **Surgeons** including the following:

(a) Use of the operation theatre and equipment;

(b) Surgeon's fees;

(c) Anesthetist's fees; and

(d) **Inpatient Surgery** and **Day Surgery**.

7. Pre-Hospitalisation Treatment

If the **Insured Member** needs **Hospitalisation** for **Treatment** due to an **Illness** or **Injury**, **We** will pay for the actual and **Eligible Charges** for any pre-**Hospitalisation Treatment** including **Specialist** consultations (**Prescription Drugs** included), diagnostic tests, x-rays or other laboratory tests that the **Insured Member** is required to undergo following the written recommendation or approval of the attending **Physician** provided they are done in connection with that **Hospitalisation** and within ninety (90) days prior to **Hospitalisation**.

If the **Insured Member** needs to be **Hospitalised** again due to the same **Illness** or **Injury** after the initial **Hospitalisation**, the ninety (90) days count will be based on the initial **Hospitalisation** admission date as long as the subsequent **Hospitalisation** admission date for the same **Illness** or **Injury** is no more than thirty (30) days after the initial **Hospitalisation** discharge date.

If the **Insured Member** needs to be **Hospitalised** again due to the same **Illness** or **Injury** after thirty (30) days from the initial **Hospitalisation** discharge date**,** the ninety (90) days count will refresh based on the current **Hospitalisation** admission date.

8. Post-Hospitalisation Treatment

If the **Insured Member** needs **Hospitalisation** for **Treatment** due to an **Illness** or **Injury**, **We** will pay for the actual and **Eligible Charges** for any post-**Hospitalisation Treatment** (including physiotherapy, speech therapy, and occupational therapy) that the **Insured Member** is required to undergo upon the written recommendation or approval of the **Physician** provided they are done in connection with that **Hospitalisation** and within ninety (90) days following the day of the **Hospitalisation** discharge date.

If the **Insured Member** needs to be **Hospitalised** again due to the same **Illness** or **Injury** from the initial **Hospitalisation**, the ninety (90) days count will still be based on the initial **Hospitalisation** discharge date as long as the subsequent **Hospitalisation** admission date for the same **Illness** or **Injury** is no more than thirty (30) days apart from the initial **Hospitalisation** discharge date.

If the **Insured Member** needs to be **Hospitalised** again due to the same **Illness** or **Injury** after thirty (30) days from the initial **Hospitalisation** discharge date, the ninety (90) days count will refresh based on the current **Hospitalisation** discharge date.

We do not reimburse for any routine medical check-up which is not related to the post-**hospitalisation Treatment** as recommended by the **Physician** and not related to the **Hospitalisation**.

9. Parental Accommodation

We will pay for the actual and **Eligible Charges** on the accommodation costs (including meal and bed), subject to the **Benefit** limit as specified in the **Policy Schedule**, for each night at a **Hospital** incurred by one (1) parent/legal guardian of an **Insured Member**, provided that:

(a) such **Insured Member** is under eighteen (18) years of **Age** at the date of **Hospitalisation**; and

(b) the **Insured Member** was receiving treatment for **Illness** or **Injury** as an **Inpatient** at a **Hospital**.

This **Benefit** is only payable up to a maximum of thirty (30) days per **Policy Year**, regardless of the number of **Hospitalisations** of the **Insured Member**.

10. Surgical Implants / Appliances

We will pay for the actual and **Eligible Charges** subject to the **Benefit** limit specified in the **Policy Schedule** for **Surgical Implants** or **Surgical Appliances** that are **Medically Necessary** including:

(a) a **Surgical Implant** that is inserted by surgical procedure into the body permanently; or

(b) a **Surgical Appliance** such as an artificial limb, prosthesis or device which is required for the purpose of or in connection with **Surgery**; or

(c) an artificial device or prosthesis which is a necessary part of the **Treatment** immediately following **Surgery** for short-term recuperation basis only.

For avoidance of doubt, durable or long-term medical equipment is not covered, such as but not limited to hospital bed and dialysis machine. We will cover the actual and eligible rental charges of such durable or long-term medical equipment for a period of no more than ninety (90) days post **Hospitalisation** of the **Insured Member** in relation to the specific **Treatment** of the **Illness** or **Injury** that requires such equipment.

11. Organ Transplant

We will pay for the actual and **Eligible Charges** on the **Treatment** costs incurred, subject to the **Benefit** limit as specified in the **Policy Schedule**, in respect of bone marrow, heart, kidney, corneas, pancreas, liver and lung transplants that are **Medically Necessary** (excluding the cost of acquisition of the organ and all costs incurred by the donor).

12. Inpatient Cancer Treatment

We will pay for the actual and **Eligible Charges** on the **Inpatient Treatment** costs incurred that are **Medically Necessary**, subject to the **Benefit** limit as specified in the **Policy Schedule**, in respect of **Cancer** as recommended by a **Physician** and incurred during the **Hospitalisation**. This **Benefit** extends to cover the maintenance phase of **Inpatient Cancer Treatment** by the **Insured Member's** attending **Physician**. This will include consultation, diagnostic tests or scans, medication prescribed by the attending **Physician** to keep the **Cancer** in remission or to prevent relapse of the **Cancer**, and other related **Treatments** that are FDA or HSA approved during the **Hospitalisation**. Pre-**Hospitalisation Treatment** and Post- **Hospitalisation Treatment** costs are not covered under this **Benefit**.

13. Outpatient Cancer Treatment

We will pay for the actual and **Eligible Charges** on the **Outpatient Treatment** costs incurred that are **Medically Necessary**, subject to the **Benefit** limit as specified in the **Policy Schedule**, in respect of **Cancer** as recommended by a **Physician**. This **Benefit** extends to cover the maintenance phase of **Outpatient Cancer Treatment** by the **Insured Member's** attending **Physician**. This will include consultation, diagnostic tests or scans, medication prescribed by the attending **Physician** to keep the **Cancer** in remission or to prevent relapse of the **Cancer**, and other related **Outpatient Treatments** that are FDA or HSA approved.

14. Inpatient Kidney Dialysis

We will pay for the actual and **Eligible Charges** on the **Inpatient Treatment** costs incurred that are **Medically Necessary**, subject to the **Benefit** limit as specified in the **Policy Schedule**, for kidney dialysis as recommended by a **Physician**. This benefit includes kidney dialysis charges incurred during **Hospitalisation**, subject to the **Benefit** limit. This benefit extends to cover the maintenance phase of **Inpatient** kidney dialysis **Treatment** by the **Insured Member's** attending **Physician**. This will include consultation (including **Prescription Drug**), diagnostic tests or scans, hemodialysis, peritoneal dialysis, erythropoietin treatment, and all other related **Inpatient Treatment** costs. Pre-**Hospitalisation Treatment** and Post- **Hospitalisation Treatment** costs are not covered under this **Benefit**.

15. Outpatient Kidney Dialysis

We will pay for the actual and **Eligible Charges** on the **Outpatient Treatment** costs incurred that are **Medically Necessary**, subject to the **Benefit** limit as specified in the **Policy Schedule**, for kidney dialysis as recommended by a **Physician**. This benefit extends to cover the maintenance phase of **Outpatient** kidney dialysis **Treatment** by the **Insured Member's** attending **Physician**. This will include consultation (including **Prescription Drug**), diagnostic tests or scans, hemodialysis, peritoneal dialysis, erythropoietin treatment, and all other related **Outpatient Treatment** costs.

16. Inpatient Congenital Conditions

We will pay for the actual and **Eligible Charges** on the **Treatment** costs incurred that are **Medically Necessary**, subject to the **Benefit** limit as specified in the **Policy Schedule,** for all **Congenital Conditions** of the **Insured Member** resulting from **Hospitalisation** and **Surgery**. Pre-**Hospitalisation Treatment** and post-**Hospitalisation Treatment** costs are not covered under this **Benefit**.

17. Inpatient Psychiatric Treatment

We will pay for the actual and **Eligible Charges** on the **Treatment** costs incurred that are **Medically Necessary**, subject to the **Benefit** limit as specified in the **Policy Schedule**, for **Psychiatric Treatments** incurred during the **Hospitalisation**. Pre-**Hospitalisation Treatment** and Post-**Hospitalisation Treatment** costs are not covered under this **Benefit**.

18. Miscarriage or Ectopic Pregnancy

We will pay for the actual and **Eligible Charges** on the **Treatment** costs incurred that are **Medically Necessary**, subject to the **Benefit** limit as specified in the **Policy Schedule**, arising from the **Emergency Treatment** by a **Physician** for miscarriage suffered by the **Insured Member** including elective and non-elective abortion due to medical reason or **Accident** that threatens the life of the **Insured Member** or the unborn fetus, as well as ectopic pregnancy, provided such **Treatment** is not due to a voluntary or malicious act by such **Insured Member**.

19. Outpatient Emergency Treatment (Due to Accident only)

We will pay for the actual and **Eligible Charges** on the **Treatment** costs incurred that are **Medically Necessary**, subject to the **Benefit** limit as specified in the **Policy Schedule**, arising from the **Emergency Treatment** of an **Insured Member** for an **Injury**, which is performed at a **Hospital** or by a **Physician** within twenty-four (24) hours following the date of the **Accident**, and any follow up **Treatment** up to thirty-one (31) days from the date of the **Accident.** Any short-term appliances, such as crutches and walker, **Prescribed** by the **Physician** shall be paid under this **Benefit**.

20. Emergency Dental Treatment (Due to Accident only)

We will pay for the actual and **Eligible Charges** on the **Treatment** costs incurred that are **Medically Necessary**, subject to the **Benefit** limit as specified in the **Policy Schedule**, for **Treatment** received within 24 hours of a **Dental Emergency** and any follow up **Treatment** up to thirty-one (31) days from the date of the **Accident**. This **Benefit** does not include dental implants, crowning, bridges or dentures, and root canal **Treatments**.

21. Home Nursing (Up to 180 Days)

We will pay for the actual and **Eligible Charges** incurred that are **Medically Necessary**, subject to the **Benefit** limit as specified in the **Policy Schedule**, for charges incurred for the nursing services of a registered nurse licensed in the geographical area of practice attending to the **Insured Member** (excluding consumables), provided that such home attendance:

(a) is prescribed by a **Physician** for **Medical Necessity**;

(b) is necessary as without which the **Insured Member** would require **Hospitalisation**;

(c) is carried out in the **Insured Member's** own home; and

(d) immediately follows the date of discharge of the **Insured Member** from **Hospitalisation**.

22. Community Hospital Confinement (Up to 90 Days)

We will pay for the actual and **Eligible Charges** incurred that are **Medically Necessary**, subject to the **Benefit** limit as specified in the **Policy Schedule**, for all charges incurred arising from the confinement in the **Community Hospital** including accommodation, meals and general nursing as a bed-paying patient in the **Community Hospital**, provided:

(a) this confinement is immediately following the date of discharge of the **Insured Member's Hospitalisation** as approved by **Us**; and

(b) recommended with a written approval from the attending **Physician**.

23. Ambulance Services

We will pay for the actual and **Eligible Charges** incurred, subject to the **Benefit** limit as specified in the **Policy Schedule**, for emergency domestic ambulance services to the **Hospital**, leading to the **Insured Member's Hospitalisation**, or confinement in **Short-Stay Ward**, or resulting in Emergency **Outpatient Treatment** (due to **Accident** only) excluding **Emergency Dental Treatment Benefit**.

24. Hospital Cash Allowance for Admission to Singapore Government Restructured Hospitals Only

(a) If the **Insured Member** is **Hospitalised** at a **Singapore Government Restructured Hospital**, **We** will pay a cash allowance subject to the **Benefit** limit as specified in the **Policy Schedule**.

(b) **We** will not pay this **Benefit** if any one of the following situations occur:

(i) If the **Insured Member** does not stay in the same class of ward during the entire **Hospitalisation**; or

(ii) If the **Hospitalisation** is less than twenty-four (24) hours.

25. International Emergency Benefit

(a) Subject to the **Benefit** limit as specified in the **Policy Schedule** and fulfillment of the additional conditions as set out below, the following emergency assistance services are provided to an **Insured Member** and we shall pay directly to **Cigna Emergency Assistance** the covered expenses incurred by **Cigna Emergency Assistance** in providing the emergency assistance services:

(i) Emergency Medical Evacuation

(aa) If during **Policy Period**, the **Insured Member** suffers an **Illness** or **Injury** while overseas and it is determined by the **Cigna Medical Team** or **Cigna Emergency Assistance** that: (1) it is **Medically Necessary** to prevent the immediate and significant effects of **Illness**, **Injury** or conditions which if left untreated could result in a significant deterioration of health and represent a threat to life or limb; and (ii) the **Treatment** is not available locally; **Cigna Emergency Assistance** will arrange for the transport of the **Insured Member** to the nearest **Hospital** offering the necessary **Treatment** by way or air and/or surface transportation such as an appropriately medically equipped specialty aircraft, commercial airline, train or ambulance depending upon the medical needs and available transportation specific to each case, under accompaniment of medical supervision of a qualified health care professional during the entire warranted evacuation.

(bb) **Cigna Medical Team** or **Cigna Emergency Assistance** shall have absolute discretion to decide whether the **Insured Member**'s medical condition warrants an emergency medical evacuation based on **Medical Necessity**. For the avoidance of doubt, the seriousness of the medical condition will be determined taking into consideration the nature of the medical emergency, the local availability of appropriate medical care or facilities and the **Insured Member**'s geographical location. All decisions as to the means or methods by which such evacuation will be carried out as well as the final destination to which the **Insured Member** shall be evacuated will be made by **Cigna Medical Team** or **Cigna Emergency Assistance** having regard to all the facts and circumstances of which they are aware of at the relevant time.

(cc) The covered expenses under this benefit are **Medically Necessary** expenses for services provided and/or arranged by **Cigna Emergency Assistance** for the **Insured Member**'s transportation and shall include any

medical services, medical supplies and any usual ancillary charges incurred as a result of the emergency medical evacuation.

(ii) Medical Repatriation

(aa) If during **Policy Period**, the **Insured Member** suffers an **Illness** or **Injury** while overseas and it is determined by the **Cigna Medical Team** or **Cigna Emergency Assistance** that it is **Medically Necessary** for the **Insured Member** to be returned to his/her **Country of Residence** following an emergency medical evacuation to a place outside his/her country of residence to prevent any immediate and significant effects of **Illness**, **Injury** or conditions which if left untreated could result in a significant deterioration of health and represent a threat to life or limb; **Cigna Emergency Assistance** will arrange for the transport of the **Insured Member** to return to his/her **Country of Residence** by way or air and/or surface transportation such as an appropriately medically equipped specialty aircraft, commercial airline, train or ambulance depending upon the medical needs and available transportation specific to each case, under accompaniment of medical supervision of a qualified health care professional during the entire warranted evacuation.

(bb) **Cigna Medical Team** or **Cigna Emergency Assistance** shall have absolute discretion to decide whether the **Insured Member**'s medical condition warrants a medical repatriation based on **Medical Necessity**. For the avoidance of doubt, the seriousness of the medical condition will be determined taking into consideration the nature of the medical emergency, the local availability of appropriate medical care or facilities and the **Insured Member**'s geographical location. All decisions as to the means or methods by which such repatriation will be carried out will be made by **Cigna Medical Team** or **Cigna Emergency Assistance** having regard to all the facts and circumstances of which they are aware of at the relevant time.

(cc) The covered expenses under this benefit are **Medically Necessary** expenses for services provided and/or arranged by **Cigna Emergency Assistance** for the **Insured Member**'s transportation and shall include any medical services, medical supplies and any usual ancillary charges incurred as a result of the medical repatriation in returning the **Insured Member** to his/her **Country of Residence**.

(dd) In addition, Cigna reserves the right, after **Treatment** has commenced following emergency medical evacuation to the nearest **Hospital**, to request the repatriation of the **Insured Member** to a **Hospital** in the **Insured Member**'s **Country of Residence**, where a **Physician** named by **Cigna Medical Team** or **Cigna Emergency Assistance**, after speaking with a local attending **Physician**, decides that the **Insured Member** is fit to undertake the journey.

(iii) Repatriation of Mortal Remains

(aa) If during **Policy Period**, in the event of the death of the **Insured Member** outside his/her **Country of Residence** resulting from any **Illness** or **Injury** sustained while overseas, **Cigna Emergency Assistance** will arrange as soon as reasonably practicable for the return of the **Insured Member**'s mortal remains to the **Country of Residence** or home country of the deceased.

(bb) The covered expenses under this benefit are the expenses reasonably and unavoidably incurred by **Cigna Emergency Assistance** for the transportation of the **Insured Member**'s mortal remains from the place of death to the **Country of Residence** or the **Insured Member**'s home country. For the avoidance of doubt, we will only pay any associated reasonable expenses incurred overseas for services and supplies provided by mortician or undertaker necessary for the purpose of transportation of the **Insured Member**'s mortal remains from the place of death to the **Country of Residence** or the **Insured Member**'s home country, such as the costs of a basic casket and embalmment. We do not cover the cost of cremation or local burial at the place of death if so elected.

(b) Additional Conditions Applicable to Emergency Assistance Services

(i) The **Insured Member**'s journey is not undertaken against the advice of a **Physician**.

(ii) The emergency medical evacuation or repatriation must be pre-authorised by **Cigna Medical Team** or **Cigna Emergency Assistance**. **Insured Member** should contact **Cigna Emergency Assistance** immediately to obtain prior approval for any emergency medical evacuation or repatriation. Where it is not possible for pre-authorisation to be sought before the evacuation or repatriation takes place due to the **Insured Member**'s location in a remote or primitive areas where **Cigna Emergency Assistance** cannot be contacted in advance, this must be sought as soon as possible thereafter. In all cases (except for the foregoing), failure to obtain pre-authorisation from **Cigna Medical Team** or **Cigna Emergency Assistance** will result in the claim being declined.

B. Outpatient Benefit

1. Panel General Practitioner Services

(a) **We** will pay for the actual and **Eligible Charges** incurred that are **Medically Necessary**, subject to the **Benefit** limit as specified in the **Policy Schedule**, for all consultation, **Prescription Drugs** and/or diagnostic tests as prescribed by the **General Practitioner** in the **Panel**.

(b) The **Insured Member** must present their valid membership card when visiting a **Panel General Practitioner**.

(c) The **Panel General Practitioner** will provide **Treatment** to the **Insured Member** without requiring any payment from the **Insured Member**, except if this **Policy** has a **Co-Payment**, **Co-Insurance**, and/or **Deductible** provisions. If the **Policy** has a **Co-Payment**, **Co-Insurance**, and/or **Deductible** provisions, the **Insured Member** will then need to pay the clinic the amount as specified in the **Policy Schedule**.

(d) If the **Panel General Practitioner** clinic is GST (Goods and Services Tax) registered, the **Insured Member** must bear the relevant GST costs on the **Co-Payment, Co-Insurance** and/or **Deductible** amount.

(e) If an **Insured Member** seeks **Treatment** at a government polyclinic in Singapore and pays the fee and charges for the **Treatment**, **We** will reimburse the actual and **Eligible Charges** subject to the **Benefit** limit as specified in the **Policy Schedule**.

(f) If an **Insured Member** did not present their valid membership card whilst seeking **Treatment**, this will be considered as a **Non-Panel General Practitioner Services** and subject to the **Benefit** limit as specified in the **Policy Schedule**.

(g) **Panel General Practitioner** services include Cigna Virtual Clinic, where **Treatment** will be provided to the **Insured Member** through video or telephone consultations. Cigna Virtual Clinic services include but are not limited to:

- diagnosis of non-emergency health issues, ranging from acute conditions to chronic conditions;
- treating medical conditions such as fevers, rashes and pain;
- prescriptions for common health concerns, when Medically Necessary; and delivery of medications; and/or
- discussion relating to medication plan and potential side effects.

2. Non-Panel General Practitioner Services (where applicable)

We will pay for the actual and **Eligible Charges** incurred that are **Medically Necessary**, subject to the **Benefit** limit as specified in the **Policy Schedule,** for all consultation, **Prescription Drugs** and/or diagnostic tests as prescribed by the **General Practitioner** that is not in the **Panel**.

3. Alternative Treatment

We will pay for the actual and **Eligible Charges** incurred for **Alternative Treatment** arising from an **Illness** or **Injury**, subject to the **Benefit** limit as specified in the **Policy Schedule.**

4. Allied Health Services

We will pay for the actual and **Eligible Charges** incurred for the **Allied Health Services** that are **Medically Necessary** arising from an **Illness** or **Injury**, subject to the **Benefit** limit as specified in the **Policy Schedule.**

5. Treatment at Accident and Emergency Department

If the **Insured Member** visits an **Accident and Emergency Department** in any **Hospital** and incurs the fees and charges for the **Treatment** that is **Medically Necessary**, **We** will reimburse the actual and **Eligible Charges** subject to the **Benefit** limit as specified in the **Policy Schedule**.

6. Panel Specialist Services

(a) **We** will pay for the actual and **Eligible Charges** incurred that are **Medically Necessary**, subject to the **Benefit** limit as specified in the **Policy Schedule**, for all consultation, **Prescription Drugs** and/or diagnostic tests as prescribed by the **Specialist** in the **Panel**.

(b) A **Referral Letter** from a **Physician** is required for all **Specialist** visits except for an **Insured Member** who is below seven (7) years old seeking **Treatment** from paediatrician.

(c) The **Insured Member** must present their valid membership card when visiting a **Panel Specialist**. The **Panel Specialist** will provide **Treatment** to the **Insured Member** without requiring any payment from the **Insured Member**, except if this **Policy** has a **Co-Payment**, **Co- Insurance**, and/or **Deductible** provisions. If the **Policy** has a **Co-Payment**, **Co-Insurance**, and/or **Deductible** provision, the **Insured Member** will then need to pay the clinic the amount as specified in the **Policy Schedule**.

(d) If the **Panel Specialist** clinic is GST (Goods and Services Tax) registered, the **Insured Member** must bear the relevant GST costs on the **Co-Payment, Co-Insurance** and/or **Deductible** amount.

(e) If an **Insured Member** did not present their valid membership card whilst seeking **Treatment**, this will be considered as a **Non-Panel Specialist** services and subject to the corresponding **Non-Panel Specialist** Services **Benefit** limit as specified in the **Policy Schedule**.

7. Non-Panel Specialist Consultation (where applicable)

We will pay for the actual and **Eligible Charges** incurred that are **Medically Necessary**, subject to the **Benefit** limit as specified in the **Policy Schedule**, for all consultation and/or **Prescription Drugs** as prescribed by the **Specialist** that is not in the **Panel**.

A **Referral Letter** from a **General Practitioner** is required for all **Specialist** visits except for an **Insured Member** who is below seven (7) years old seeking **Treatment** from **Non-Panel** pediatrician.

8. Non-Panel Laboratory and Radiology (where applicable)

We will pay for the actual and **Eligible Charges** incurred that are **Medically Necessary**, subject to the **Benefit** limit as specified in the **Policy Schedule**, for all standard laboratory tests, advanced imaging and other radiology diagnostic scans as prescribed by the **Physician** that is not in the **Panel**.

A **Referral Letter** from a **Physician** is required for all laboratory and radiology visits except for an **Insured Member** who is below seven (7) years old seeking **Treatment** from a **Non-Panel** pediatrician.

C. Maternity Benefit

1. Routine Maternity

We will pay for the actual and **Eligible Charges** incurred, subject to the **Benefit** limit and **Waiting Period** as specified in the **Policy Schedule,** for all aspects of routine pregnancy or childbirth (pre and post natal) for the eligible female **Insured Member**, excluding **Dependant** children. The **Eligible Charges** include:

(a) Consultation and **Prescription Drugs** (including supplements as prescribed by the **Physician**);

(b) Diagnostic tests and scans as prescribed by the **Physician** that are **Medically Necessary**;

(c) Vaginal delivery (including assisted delivery) and related **Eligible Costs** including water birth;

(d) Elective caesarean section delivery;

(e) Post-natal costs up to ninety (90) days from the date of delivery; and

(f) Intentional termination of pregnancy if certified by the **Physician** that the pregnancy would endanger the life or mental stability of the mother.

The actual and **Eligible Charges** of the standard nursery care for the newborn upon delivery is subject to the Routine Maternity **Benefit** limit as specified in the **Policy Schedule**. If the newborn requires **Hospitalisation** due to medical reasons unrelated to standard nursery care, and the newborn is an **Insured Member** in the **Policy**, then all such **Eligible Costs** will be paid under the **Dependant's Benefit** limit as specified in the **Policy Schedule**.

2. Complicated Maternity

We will pay for the actual and **Eligible Charges** incurred, subject to the **Benefit** limit and **Waiting Period** as specified in the **Policy Schedule,** for all aspects of complicated pregnancy or childbirth (pre and post natal) for the eligible female **Insured Member**, excluding **Dependant** children, which includes one of the following pregnancy complications:

(a) Ectopic pregnancy, pre-eclampsia or eclampsia

(b) Disseminated intravascular coagulation (DIC)

(c) Miscarriage

(d) Still birth / intra-uterine Death

(e) Acute fatty liver pregnancy

(f) Choriocarcinoma and hydatidiform mole and molar pregnancy evidenced by histological report

(g) Severe intra-uterine growth retardation

(h) Placenta previa

(i) Oligohydramnios

(j) Polyhydramnios

(k) Diabetes gravidarum

(l) Fetal abnormalities

(m) Mother suffering from severe disease (heart disease, diabetes, epilepsy, kidney disease, severe infections during pregnancy)

(n) Intentional termination of pregnancy if certified by the **Physician** that the pregnancy would endanger the life or mental stability of the mother. For avoidance of doubt, payment of any **Benefit** arising out of intentional termination of pregnancy will only be made under this Complicated Maternity section, where the **Insured Member** is covered under for both Routine Maternity and Complicated Maternity Benefit

(o) Threatened abortion

(p) Premature contractions (before thirty-five (35) weeks)

(q) Cervical insufficiency needing cerclage

(r) Breech delivery

The **Eligible Charges** for this **Benefit** include:

(i) Consultation and **Prescription Drug** (including supplements as prescribed by the **Physician**);

(ii) Diagnostic tests and scans as prescribed by the **Physician** that are **Medically Necessary**;

(iii) Non-elective caesarean section delivery and related **Eligible Costs**; and

(iv) Post-natal costs up to ninety (90) days from the date of delivery.

In the event the pregnancy is determined by the attending **Physician** to be a complicated pregnancy or childbirth (and regardless of the stage of the pregnancy), all subsequent actual and **Eligible Charges** incurred in respect of such pregnancy or childbirth will be subject to the Complicated Maternity Benefit limit as specified in the Policy Schedule.

The actual and **Eligible Charges** of the standard nursery care for the newborn upon delivery is subject to the Complicated Maternity **Benefit** limit as specified in the **Policy Schedule**. If the newborn requires **Hospitalisation** due to medical reasons unrelated to standard nursery care, and the newborn is an **Insured Member** in the **Policy**, then all such **Eligible Costs** will be paid under the **Dependant's Benefit** limit as specified in the **Policy Schedule**.

D. Dental Benefit

1. Preventive Services

We will pay for the actual and **Eligible Charges** incurred, subject to the **Benefit** limit as specified in the **Policy Schedule**, for all aspects of dental preventive services. The **Eligible Charges** include:

(a) Dental examination

(b) Scraping and scaling

(c) Cleaning and polishing

(d) X-Ray

We will only pay for maximum 2 visits per **Policy Year**.

2. Dental Treatment

We will pay for the actual and **Eligible Charges** incurred, subject to the **Benefit** limit as specified in the **Policy Schedule**, for all aspects of Dental **Treatment Benefit** that is **Medically Necessary**. The **Eligible Charges** include:

(a) Composite fillings and simple non-surgical extraction

(b) Minor gum treatment

(c) Surgical extraction including wisdom tooth

(d) Root canal treatment

(e) Dental amalgam

(f) X-ray needed to support major restorative gum treatment

(g) Periodontal treatment

(h) Crowning

(i) Dentures – acrylic/synthetic, metal and metal/acrylic, crowns, inlays, mouth guard or occlusal splint

(j) **Eligible Cost** to supply fit and repair crowns, bridges, and dentures

(k) All dental **Surgery** and related **Eligible Charges** (including anesthetics) to the Dental Treatment

3. Panel Dentist

(a) If any **Insured Member** shall visit a **Panel Dentist** for dental preventive services or dental **Treatment**, the **Insured Member** must present their valid membership card when visiting a **Panel Dentist**.

(b) The **Panel Dentist** will provide **Treatment** to the **Insured Member** without requiring any payment from the **Insured Member**, except if this **Policy** has a **Co-Payment**, **Co-Insurance**, and/or **Deductible** provisions. If the **Policy** has a **Co-Payment**, **Co-Insurance**, and/or **Deductible** provisions, the **Insured Member** will then need to pay the clinic the amount as specified in the **Policy Schedule**.

(c) If the **Panel Dentist** is GST (Goods and Services Tax) registered, the **Insured Member** must bear the relevant GST costs on the **Co-Payment, Co-Insurance** and/or **Deductible** amount (where applicable).

(d) If an **Insured Member** did not present their valid membership card whilst seeking **Treatment**, this will be considered as a **Non-Panel Dentist** and subject to the **Benefit** limit as specified in the **Policy Schedule**.

4. Non-Panel Dentist (where applicable)

If an **Insured** Member incurs expenses for dental preventive services or dental **Treatment** performed by a **Non-Panel Dentist**, we will pay for the actual and **Eligible Charges** incurred that are **Medically Necessary**, subject to the **Benefit** limit and **Co-Insurance** as specified in the **Policy Schedule**. The **Insured Member** will need to pay the clinic the amount in relation to the **Co-Insurance** as specified in the **Policy Schedule**. If the **Panel Dentist** is GST (Goods and Services Tax) registered, the **Insured Member** must bear the relevant GST costs on the **Co-Insurance** amount.

E. Preventive Care Benefit

1. Health Screening

We will pay for the actual and **Eligible Charges** incurred based on **Reasonable and Customary Charges**, subject to the **Benefit** limit as specified in the **Policy Schedule**, for all aspects of routine health screening.

2. Immunisation

We will pay for the actual and **Eligible Charges** incurred based on **Reasonable and Customary Charges**, subject to the **Benefit** limit as specified in the **Policy Schedule**, for all aspects of immunisation services as follows:

(a) DPT (Diphtheria, Pertussism and Tetanus)

(b) MMR (Measles, Mumps and Rubella)

(c) HiB (Haemophilus influenza Type B)

(d) Polio

(e) Influenza

(f) Hepatitis A

(g) Hepatitis B

(h) Meningitis

(i) Pneumococcal Disease

(j) Human Papilloma Virus from nine (9) years to twenty-six (26) years old

(k) Rotavirus Vaccine

(l) Varicella Vaccine

(m) Tetanus

(n) Rabies

(o) Cholera

(p) Yellow fever

(q) Japanese encephalitis

(r) Typhoid

(s) Malaria (including tablet form)

F. Wellness Services

We offer different Wellness Services for buy-up from the **Policy** including the following services:

1. **Telemedicine** – tele/video consultation with **General Practitioner** including **Prescription Drugs** subject to the **Benefit** limits as specified in the **Policy Schedule**;

2. **Home Care** – home care post-**Hospitalisation** for basic daily living assistance and nursing care; and

3. Other services as offered by **Us** and specified in the **Policy Schedule**.

SECTION M – Policy Exclusions

We shall not provide any cover, and shall not pay any **Benefits** under this **Policy** if the cost/expense/charge arises directly or indirectly out of any one of the following:

1. All **Pre-Existing Conditions** unless endorsed by **Us** in the **Policy**.

2. Routine or preventative physical examinations, investigation, medical check-up, vaccinations, treatments or follow-up consultations, unless specified in the **Policy Schedule**.

3. Any **Injury** or **Illness** caused directly or indirectly by intentional self-infliction or self-destruction, abuse of drugs or alcohol or **Injuries** sustained as a result of criminal act or attempted suicide whether the **Insured Member** is sane or insane.

4. Any **Treatment** for conditions relating to physiological or natural cause such as aging, menopause, or puberty and which are not due to any underlying **Illness** or **Injury**.

5. **Congenital Conditions** or genetic defects including hereditary conditions existing from the time of birth regardless of the time of discovery of such anomalies or defects, unless specified in the **Policy**.

6. **Outpatient Treatment**, traditional Chinese medicine and its related treatment, unless specified in the **Policy**.

7. Rest cares, sanatoria care, nature cure clinics, health spa, nursing home, or stay in any similar healthcare establishment for social or non-medical reasons.

8. Hormone replacement therapy, nutritional and dietary supplements including, but not limited to, vitamins (except for prenatal vitamins if maternity benefit is covered), minerals, herbs, meal supplements, sports nutrition products, natural food supplements, and other related products used to boost the nutritional content of the diet. Toiletries including, but not limited to, moisturiser, cream, gel, lotion, whether prescribed or not are not covered under this **Policy**.

9. Cryopreservation, or harvesting or storage of stem cells as a preventive measure against possible future disease/**Illness** or **Injury**.

10. Administrative expenses (including bank charges, where applicable), medical report charges, and non-medical personal service and other ineligible non-medical items.

11. Dental care and its related **Treatment** unless it is necessary to treat or replace sound natural teeth damaged or lost as a result of **Accident**, or as specified in the **Policy**.

12. Any **Treatment** relating to temporomandibular joint disorder.

13. Pregnancy, childbirth, intentional termination of pregnancy, miscarriage, pre and post natal care, and all complications arising therefrom unless specified in the **Policy.**

14. Birth control measures, assisted reproduction, abortion including infertility treatment, sterilisation (or its reversal) or any events arising out of or in connection thereto.

15. Home birth, including all consequence of it.

16. Circumcision unless **Medically Necessary**, impotence or any consequence of it.

17. Any **Treatment** which arises from, or is in any way attributable to, sex change.

18. Any costs in relation to dental implants, orthodontics for **Insured Members** aged eighteen (18) years old and above, or cosmetic **Treatments** including but not limited to dental whitening and dental veneer.

19. Eye tests, refractive errors of the eyes, spectacles and contact lenses, as well as any costs relating to **Surgery** for correction of squint or other eye misalignment.

20. Any **Treatment** needed as a result of engaging in or taking part in acts of terrorism, nuclear contamination, biological contamination or chemical contamination.

21. Any **Treatment** arising from any consequence of direct participation in declared or undeclared war, act of foreign enemy, invasion, civil war, riot, rebellion, insurrection, revolution, overthrow of a legally constituted government, explosions of war weapons.

22. All types of learning disorders, educational problems, behavioral problems, physical development, or psychological development, including assessment or grading of such problems.

23. Any costs related to **Experimental Treatment**.

24. Any costs related to robotic **Treatment**, except for prostate cancer.

25. Any conditions relating to skin including but not limited to mole, acne, pigmentation, scars, xanthelasma, or vitiligo.

26. Any conditions relating to hair.

27. Any conditions relating to enhancement of bodily function or appearance including but not limited to plastic surgery, cosmetic treatment or treatment for beautification purposes, except for plastic surgery which is **Medically Necessary** arising from an **Illness** or **Injury** while the **Insured Member** is covered under this **Policy**.

28. Any costs related to **Gene Therapy or Genetic Therapy**; cell, tissue or gene therapy products (as defined under the Health Products Act of Singapore) and its related **Treatment**, including but not limited to bone graft, amniotic membrane, gene modified cells, vectors with therapeutic gene and Xeno-based products.

29. Any genetic tests, nor for any counselling made necessary following genetic tests, even when those tests are undertaken to establish whether or not the **Insured member** may be genetically disposed to the development of a medical condition in the future.

30. Any **Treatment** of obesity or any medical condition which arises from, or is related to, obesity in any way including but not limited to the use of gastric banding or stapling, the removal of fat or surplus tissue from any part of the body whether or not it is needed for medical or psychological reasons; weight improvement; supplements or medications for weight loss or weight improvement.

31. All types of sleep disorder including snoring, insomnia, obstructive sleep apnea or sleep study test unless followed by **Surgery** as prescribed by the **Physician**.

32. Purchase of all durable or long-term medical equipment.

33. Transport-related services including emergency evacuation, medical repatriation and repatriation of mortal remains.

34. All costs relating to immunisation unless specified in the **Policy**.

35. All non-**Medically Necessary Treatments** and related costs.

36. Full-time military, naval or air service personnel, except national reservist duty pursuant to relevant local laws.

37. **Injury** or **Illness** arising from violation or any attempted violation of the law or resistance or attempted resistance to lawful arrest.

38. **Injury** or **Illness** covered or coverable under a workmen's compensation insurance contract or any legislation or corresponding insurance relating to occupational death, injury, illness or disease.

SECTION N – Claims

1. Making Claims

   (a) The **Insured Member** must notify **Us** in writing within ninety (90) days after the happening of any event likely to give rise to a claim under this **Policy**. The claim will not be invalidated if it can be proved that it was not reasonably possible for the **Insured Member** to notify us within this period.

   (b) In the event the **Insured Member's** claim is denied and the **Insured Member** wishes to appeal against such claim denial, **We** reserve the right to ask the **Insured Member** to provide, at their own expense, more documents or evidence to help **Us** to reassess the **Insured Member**'s claim and to appoint a **Physician** to re-examine the **Insured Member**. In the event of any differences in opinions between **Our** appointed **Physician** and the **Insured Member**'s **Physician**, **Our** appointed **Physician**'s opinion shall prevail.

   (c) If the **Insured Member** can claim medical expenses from another insurance policy, **We** will reimburse the **Insured Member** only for the amount not covered by the other insurance up to the amounts shown on the **Policy Schedule**. Certified true copy of bills and proof of settlement by the previous insurer must be submitted for our processing.

2. Payment of **Benefits**

   (a) All **Benefits** shall be payable only when the claim has been proven to **Our** satisfaction and the total amount of payment shall have been agreed upon by **You** and **Us**.

   (b) Unless **You** notify **Us** otherwise in writing, any amount payable under this **Policy** will be paid by cheque or bank transfer to the **Insured Member** to whom such **Benefits** relate. Any payment made to the **Insured Member** shall effectively discharge **Us** from any further liability in respect thereof.

   (c) In the event the medical bills submitted for reimbursement of **Benefits** under this **Policy** are not expressed in Singapore currency, **We** will convert the relevant amount of bills into Singapore currency at the rate of exchange as determined by **Us.**

   (d) All **Benefits** shall be payable only if the claims are incurred in the **Area of Cover**. Notwithstanding the foregoing, **We** will pay for **Emergency Treatment** costs which are **Medically Necessary** and incurred in the USA within the first thirty (30) days of each trip to the USA, whether the purpose of travel is for business or pleasure, regardless of the number of trips to the USA per **Policy Year**, where the **Insured member** does not travel to USA wholly or partly to have **Treatment**.

3. Fraudulent Claims

   If any claims under this **Policy** is in any respect, fraudulent or if any fraudulent means or devices shall be used by **You** or an **Insured Member** or any one acting on behalf of **You** or an **Insured Member** to obtain a **Benefit** under this **Policy**, **We** shall be under no liability in respect of such claims and shall be entitled to recover any payment made before the discovery of fraud.

SECTION O – Policy Owners' Protection Scheme

1. 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 web-sites (www.gia.org.sg or www.sdic.org.sg).

SECTION P – Company Not Liable

1. **We** shall not be liable or be held responsible as a party in any way whatsoever to any legal proceeding for any losses, damages or otherwise, which may be brought by any **Insured Member** arising out of or in connection with any **Treatment** by any providers for reasons of malpractice, neglect or other causes arising from acts or omissions in such **Treatment** or examination of the **Insured Member**.

SECTION Q – Variations

1. No person other than **Us** is authorised to:

   (a) extend the **Grace Period** for **Premium** payment;

   (b) waive any notice of claim required by this **Policy**;

   (c) extend the date for claim submission; or

   (d) amend any terms and conditions of the **Policy**.

2. Any amendment to the terms and conditions of this **Policy** shall only be valid if it is:

   (a) approved by **Us**; and

   (b) evidenced by **Endorsement(s)** issued by **Us**.

SECTION R – Exclusion of coverage/Payment limitation

1. This **Policy** shall not provide any insurance coverage or oblige **Us** to make any payments to or on behalf of any **Prohibited Persons, Entities or Countries**.

2. Should any **Prohibited Person or Entity** be found to have been enrolled under this **Policy**, or if any **Insured Member** or the **Policyholder** becomes a **Prohibited Person or Entity**, **We** will take any actions as we deem necessary at our sole discretion in compliance with relevant laws, regulations, guidelines, directions, ordinances, decrees, orders, codes and/or requirements imposed by relevant authorities, which could include suspension of services and payments, reporting to the relevant authorities and terminating insurance coverage for such person or entity with immediate effect. Any unearned **Premiums** paid in respect of such terminated person or entity shall be refunded to the **Policyholder** only if approval is given by the relevant authorities, such as the US Office of Foreign Assets Control (where applicable). For the avoidance of doubt, **We** are under no obligation to notify the **Insured Member** or the **Policyholder** in advance of taking these actions, or to obtain licenses from any relevant authorities to enable the extension of insurance coverage.

3. Should any claim for payment of any nature be submitted by any **Prohibited Persons or Entities** under this **Policy**, no such payment will be made towards the claim.

4. Should any claim be incurred in a **Prohibited Country** where there is no relevant, approved license from relevant authorities, such as the US Office of Foreign Assets Control, restrictions may be applied, in particular **We** will not cover (i) elective or pre-scheduled **Treatment** in such **Prohibited Country**; or (ii) **Insured Members** who are ordinarily resident in a **Prohibited Country** (i.e. **Insured Member** visits a **Prohibited Country** for a period of longer than six weeks over the course of any twelve month period).

POLICY SCHEDULE

Name of Policyholder	:	
Group Policy Number	:	
Policy Period	:	
Eligibility Cover	:	
Maximum Age	:	110
Area of Cover	:	Worldwide excluding USA
Start Date	:	
Waiting Period	:	
Premium Payment Frequency	:	
Premium (before GST)	:	

Table of Benefits

PREMIUM SCHEDULE
Annual Premium Rates

ENDORSEMENT NO. 1 (WHERE APPLICABLE)