CIGNA HEALTHGUARD℠ CUSTOMER HANDBOOK

Everything you need to know about your health plan. For individuals holding a resident visa and residing in the Emirate of Dubai or the Northern Emirates.

Together, all the way.℠

Cigna®

PROTECTING YOU AND YOUR FAMILY

YOUR CIGNA HEALTHGUARD℠ PLAN

THANK YOU FOR CHOOSING CIGNA HEALTHGUARD℠. IT'S OUR MISSION TO HELP IMPROVE YOUR HEALTH, WELLBEING AND PEACE OF MIND – AND EVERYTHING WE DO IS DESIGNED TO ACHIEVE THIS.

Please read this *Customer Handbook*, along with *your Certificate of Insurance*, and *your Medical ID cards* (including *your application*) which together form the contract between *you* and *us* for this *period of cover*. If there is anything *you* are unsure of or have any questions regarding *your policy*, *we* will be happy to help *you*.

GETTING IN TOUCH

Please contact our Customer Care Team 24 hours a day, 7 days a week, 365 days a year.

Call: Inside the UAE - 800 55 33, Outside of the UAE - 00971 4 317 8499

Email: **service.healthguard@cigna.com**

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A PLAN TAILORED TO YOUR NEEDS

You have chosen a plan to meet *your* own unique needs, so please read through this *Customer Handbook* to confirm the full extent of the cover *we* provide including the *list of benefits* included in *your* plan on page 18 onwards. Any words or phrases which appear in italics are defined in the Definitions section from page 68 onwards.

This *policy* is underwritten by:
Cigna Insurance Middle East S.A.L
The Offices 3 at One Central
Dubai World Trade Centre
Office No. 111, Level 1
Po Box 3664
Dubai
United Arab Emirates

***Our* Middle East partner administrator:**
Neuron LLC
TPA001 (eClaim Link ID)

We have partnered with Neuron to give *you* the best possible access to *healthcare providers* in the *UAE*, based on a tiered network of *healthcare providers*.

Neuron is one of the leading third party administrators (TPA) in the Middle East region delivering quality healthcare administrative services and business solutions amongst regional and international insurance companies and several multi-national self-funded organisations. Moreover, their experience in the healthcare sector in the region for over a decade has resulted in an extensive provider network.

Our partnership combines a comprehensive regional provider access with Cigna international network, which ensures access to uninterrupted and quality healthcare services during *your* travel outside the *UAE*.

If *you* do not fully understand the terms and conditions of *your policy*, then *you* should contact *us* within thirty (30) days from the date of receipt of the *policy* document. Please contact our Customer Care Team on 800 55 33 who will be happy to answer any questions *you* have in relation to *your policy*.

We will permit you to immediately cancel your policy within thirty (30) days from the date of receipt of the policy document. If you wish to cancel this policy within the first 30 days and we have not paid a claim, made a guarantee of payment or provided a prior authorisation, you will receive a pro-rata refund of your premium from the effective date of your cancellation. Alternatively, if we have paid a claim, made a guarantee of payment or provided a prior authorisation, in respect of your claims we will not refund any premium which has been paid for your cover.

If *you* do not exercise *your* right to cancel this *policy*, it will continue in force and *you* will be required to make any premium payments that are due to us.

For the notice required to terminate after *your* termination rights outside of the first thirty (30) days statutory cooling off period, please, please refer to Clause 19 of this policy.

OUR PROMISE

We pride ourselves in offering *you* exceptional customer service. This is *our* promise to *you*:

- A product specifically designed for *you* and *your* family if *you* are living or working in the Emirate of Dubai or the Northern Emirates;
- Quick and easy access to healthcare facilities and professionals around the world through *our* extensive network 24 hours a day, 7 days a week, 365 days a year;
- Claims settlement on a direct billing basis with a *healthcare provider* in most cases. On occasions where *you* have to pay for *treatment* yourself, *we* aim to process *your* claim within 5 working days after receiving all necessary documentation.

YOUR ONLINE CUSTOMER AREA

As a *Cigna* customer *you* have access to a wealth of information wherever *you* are in the world through *your* secure online Customer Area. Here *you* will be able to effectively manage *your policy* including;

- View *your policy documents*, including *your Certificate of Insurance* listing all the people covered under *your plan*
- Review the Terms and Conditions, included in the *Customer Handbook*, that apply to *your policy*
- Check *your* coverage for *you* and *your* family
- Submit claims online
- Search for healthcare facilities and professionals near *your* location
- Access the Health and Wellbeing site
- Download the Cigna Wellbeing™ app
- Download the Safe Travel app (International and International Plus plan customers only)

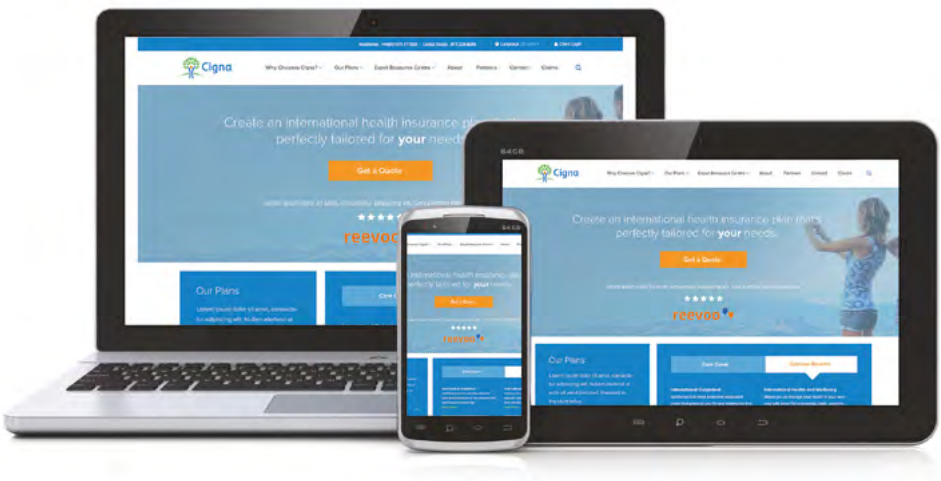
***Note: *You* will need to register online through the Customer Area before *you* can access the Cigna Wellbeing App.**

To access *your* secure online Customer Area, please log on to **www.cignaglobal.com** then;

Click on the 'Customer Area Login' button at the top right of the page

Next, click on the 'Log into the Customer Area' button to access the Customer Area Login page

In the User ID field type the email address that *you* provided *us* with and then *your* password



If *you* have any problems accessing the Customer Area, please contact *our* Customer Care Team.

YOUR GUIDE TO GETTING TREATMENT

We want to make sure that getting *treatment* is as stress free as possible for *you* and *your* family.

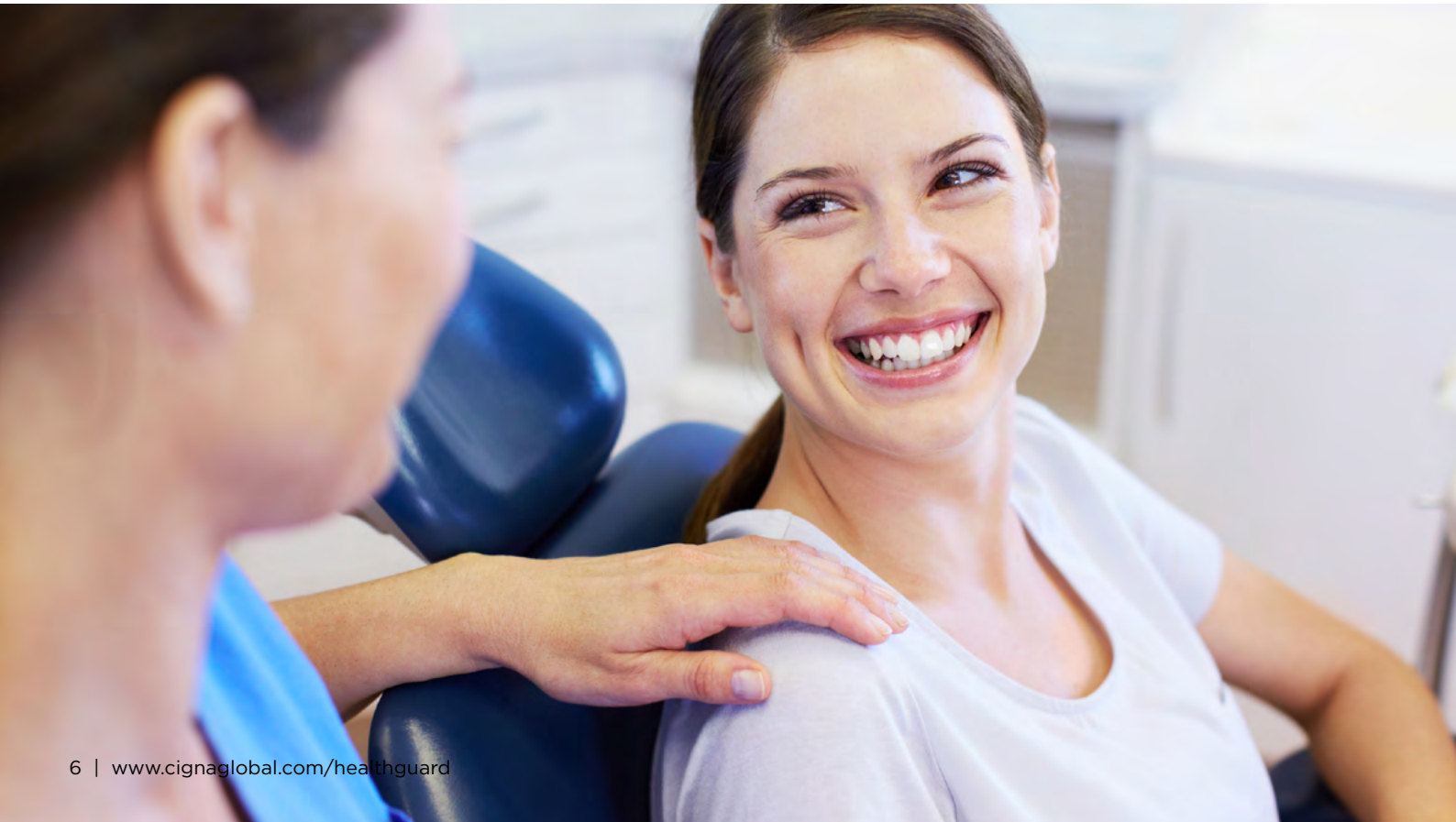
We have a medical network comprising of over 1 million partnerships, including 122,000 behavioural healthcare professionals and 14,000 facilities and *clinics*.

Our extensive network allows direct billing with a *healthcare provider* in most cases for *inpatient* and *outpatient treatments* (other types of *treatments* such as *dental treatment* may be subject to reimbursement in some cases).

The Healthguard Regional plan covers *you* for *treatment* including the countries of the *GCC*, other countries in the Middle East and Asia (with the exception of Hong Kong, China and Singapore). Page 75 of this *Customer Handbook* provides a full list of all the countries included under the terms of *your policy*.

Our Healthguard International and International Plus plans covers *you* for *treatment* (under the terms of *your policy*), everywhere with the exception of the *USA* (except where *you* have selected *Worldwide including the USA* cover). *Your Certificate of Insurance* will detail the area of coverage *you* have selected.

In all cases, access to *treatment* in a particular country or jurisdiction and/or provision of cover to individuals based on their *country of nationality* will be conditional on *our* ability to provide cover in that country or jurisdiction in compliance with applicable laws, regulations and international trade sanctions and restrictions including those of the *UAE*.



GETTING TO KNOW YOUR MEDICAL ID CARD

Each *beneficiary* will receive two *Medical ID cards* for *treatment* as detailed below. The first card should be used for all *treatment* that takes place in *UAE* and the other one is for *treatment* that takes place elsewhere in the world, including the *USA* (subject to the terms and coverage of *your policy*).

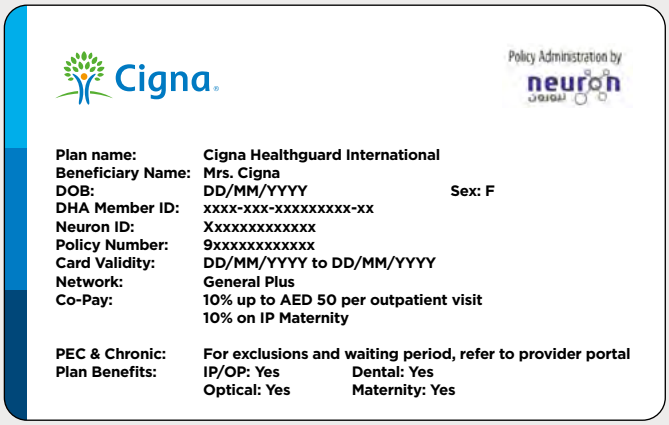
Please carry *your Medical ID Cards* with *you*, as this is important to allow *you* to access care within *our healthcare provider* network.

Before *you* get *treatment you* will need to present the *healthcare provider* with *your Medical ID card*.

When *you* receive *your Medical ID Cards*, please check that all the information is correct. If something needs to be changed, contact *us* using the 'Getting in touch' details on page 3.

If *you* lose a *Medical ID Card*, please inform *us* as soon as possible and *we* will arrange a replacement card to be sent to *you*.

1 **This card is for treatment that takes place in the *UAE***



2 **This card is for treatment that takes place in all other countries.**

ACCESSING CARE

We have arrangements with designated *healthcare providers* in the *UAE* allowing *you* to seek *treatment* on a direct billing basis. *Your* Certificate of Insurance indicates the healthcare provider network tier *you* have selected and have access to in the *UAE*.

Please contact *our* Customer Care team to locate a *healthcare provider* that is available within the limits of *your* plan.

Important note

If *you* receive *treatment* in the *UAE* that is not within the selected *healthcare provider* network provided under the terms of *your* plan, *you* will be responsible to pay 20% of the *treatment* costs directly to that healthcare provider.

If *we* cannot arrange direct payment with *your* chosen *healthcare provider*, *we* will advise *you* of the nearest *healthcare provider* who can accept direct payments when *you* call for approval. There may be instances when *we* cannot arrange direct payments with a *healthcare provider*, and in such instances, *we* will let *you* know and any approved costs incurred by *you* will be subject to reimbursement.

Please note that the *healthcare providers* included in *our* network tier may be updated during *your period of cover*. *We* will only cover costs related to *your* claim detailed in page 11:

- *Reasonable and customary* costs
- *Medically necessary*
- In relation to the *list of benefits* as detailed in *your policy*
- In line with *our* claims procedure

WHEN YOU NEED TREATMENT

We want to make sure *you* are getting the right *treatment* when *you* need it. *Our* experts are available 24 hours a day, 7 days a week, 365 days a year and can help *you* arrange *your treatment* plan, and point *you* in the right direction, saving *you* the time and effort of looking for a *healthcare provider* yourself. What's more, in most cases *we* can arrange direct payment with *your healthcare provider*, cutting down the hassle and letting *you* focus on *your* health.

GETTING PRIOR AUTHORISATION FOR TREATMENT

Prior authorisation is required for the following:

- All *inpatient* and *daypatient treatment* and care;
- Ambulance services;
- All cancer *treatment*;
- *Home nursing*;
- Prescription drugs more than two months' supply, regardless of the cost;
- Evacuation and repatriation services; and
- Dental and optical *treatment*.
- Maternity antenatal
- Physiotherapy
- *Outpatient* pathology, radiology and *diagnostic tests*

For prior approvals for *treatment*, please email *us* at: **Service.healthguard@cigna.com**.

If *you* do not get prior approval from *us*, there may be delays in processing claims, or *we* may decline to pay all or part of the claim.

We will reduce the amount which *we* will pay by:

- 50% if *you* did not obtain prior approval when it was required for *treatment* inside the *USA*
- 20% if *you* did not obtain prior approval for *treatment* outside the *USA*.

There are a number of *treatments* and consultations that do not require *prior authorisation*. *Prior authorisation* is not required for certain *outpatient treatments* less than AED 2,000.

Prior authorisation for *treatment* in the *UAE* is valid for a maximum of 14 days from the date of approval. If a *beneficiary* does not obtain *treatment* within that 14 day period, the *prior authorisation* will automatically lapse and a new *prior authorisation* will be required.

HOW WE WILL PAY CLAIMS AFTER TREATMENT

***We* pay *your healthcare provider* directly**

If the *treatment* is covered, the *healthcare provider* should send *us* the original invoice and *we* will pay them directly.

As mentioned, *we* have arrangements with many of the designated *healthcare providers* worldwide, allowing *you* to receive medical *treatment* on a direct billing basis with the *healthcare provider* (subject to any *benefit* limits that may apply) for eligible *inpatient*, *daypatient* and *outpatient treatment* costs.

You will however be responsible for reimbursing *us* in respect of all claims paid by *us* to a *healthcare provider* under the following conditions:

- Any matter which is subject to one or more of the *General Exclusions* including *excluded treatments*;
- Any *Co-Pay* (mandatory and optional);
- Claims paid for *beneficiaries* who are no longer subject to or eligible for cover;
- Fraudulent use of *Medical ID Cards* by any of the *beneficiaries*;
- Fraudulent claims submitted by or on behalf of any of the *beneficiaries*;
- *Unauthorised Claims*.

In each of the foregoing circumstances *we* will have the right to seek recovery from *you* in respect of any sums paid by *us* to the *healthcare provider*. Should *you* fail to reimburse *us* within 15 days of our first request, *we* may, at *our* discretion (subject to local law and regulation), cease to make any further payments in relation to claims under *your policy*, withdraw any *prior authorisation* for *treatment* and/or terminate this *policy* in respect of *you* or any relevant *beneficiary*.

If *your healthcare provider* gives *you* an invoice

If a *healthcare provider* invoices a *beneficiary* directly for approved *treatment* and the *healthcare provider* has not been paid by the *beneficiary*, the *beneficiary* must send: the original invoice report; test results; receipt; and importantly, a clear diagnosis by a *medical practitioner* to *us* as soon as possible. On receipt of the required documents, *we* will make any payment under this *policy* to that *healthcare provider* directly.

Please note; the Healthguard plans are direct payment only in the *UAE.*

If *you* have paid *your healthcare provider*

If the *healthcare provider* invoices a *beneficiary* directly, and the invoice is paid by the *beneficiary*, the *beneficiary* must send *us*: the original invoice; reports; test results; receipt; a claim form for the payment which has been made to the *healthcare provider*; and importantly; a clear diagnosis by a *medical practitioner*, as soon as possible.

We will only reimburse the *beneficiary* for any portion of the cost of the *treatment* which is covered by this *policy*. *We* will

let *you* know if *we* believe that any part of the cost incurred is not covered. Reimbursement for *treatment* in the *UAE* will be in *UAE* Dirhams (AED) where settlement is to a bank account of the *beneficiary* in the *UAE*. *We* may reimburse international claims in other currencies.

GETTING TREATMENT IN THE USA

Applicable only on the International and International Plus plans and if *Worldwide including the USA* coverage has been selected.

If prior approval is obtained, but the *beneficiary* decides to receive *treatment* at a *healthcare provider* which is not part of *our* international network in the *USA*, *you* will be responsible to pay 20% of the *treatment* costs directly to that *healthcare provider*. Please contact *our* Customer Care team for information on the list of network *healthcare providers* in the *USA*.

We realise that there may be occasions when it is not reasonably possible for *treatment* to be provided by *our* international network of *healthcare providers*. In these cases, *we* may at *our* discretion, determine not to apply any reduction to the payments *we* will make. Examples include, but are not limited to;

- where there is no international network provider within 30 miles/50 kilometres of the *beneficiary's* residential address; or
- when the *treatment* the *beneficiary* needs is not available from a local network *healthcare provider*.

EMERGENCY TREATMENT

We appreciate that there will be times when it will not be practical or possible for a *beneficiary* or a *healthcare provider* to contact *us* for *prior authorisation* (for example, emergencies, or when a family member is suddenly sick and the priority is to get *treatment* for them as soon as possible). In circumstances like these, *we* ask that *you* or the affected *beneficiary* get in touch with *us* within 48 hours after *treatment* has been sought, so that *we* can confirm whether *treatment* is covered and if *we* can arrange settlement with *your healthcare provider*. This will also allow *us* to make sure that *you* or the affected *beneficiary* is making the best use of the cover. In the event of *emergency treatment we* will require an explanation of why the *treatment* was needed urgently, and may ask for additional evidence to support this. If *we* agree that it was not reasonably possible or practical to seek prior approval, *we* will cover the cost of the initial *treatment*, including any prescribed medication which was urgent, provided that such *treatment* falls within the terms of this *policy*.

If a *beneficiary* has been taken to a *healthcare provider* which is not part of *our* network, then *we* may make arrangements (with the *beneficiary's* consent) to move the *beneficiary* to one of *our* network *healthcare providers* to continue *treatment*, once it is *medically appropriate* to do so.

Important note

We may need to ask for extra information to help *us* process a claim, for example: medical reports, health records or other information about the *beneficiary's* medical *condition* or the results of any independent medical examination that *we* may ask and pay for. *Beneficiaries* should submit claim forms and invoices as soon as possible after any *treatment*. If the claim and invoice is not submitted to *us* within 6 months of the date of *treatment*, the claim will not qualify for payment or reimbursement by *us*.

We will pay for the following costs related to *your* claim:

- Costs as described in the *list of benefits* section of this *Customer Handbook* as applicable on the date(s) of the *beneficiary's treatment*;
- Costs for *treatment* which have taken place; however, *we* will not cover future *treatment* costs that require payment deposits or payment in advance;
- *Treatment* which is *medically necessary* and clinically appropriate for the *beneficiary*;
- *Reasonable and customary costs* for *treatment*, and services related to *treatments* which are shown in the *list of benefits*. *We* will pay for such *treatment* costs in line with the appropriate fees in the location of *treatment* and according to established clinical and medical practice.

PRE-EXISTING CONDITIONS

It is very important that *you* have told *us* about any *pre-existing conditions* or any pre-existing chronic conditions as part of *your* application. Any *pre-existing conditions* will be reviewed by *us*. The outcome of *our* decision will be communicated to *you* during the application process in *our underwriting summary form*.

We will, except in a number of limited circumstances, apply an annual cumulative *benefit* limit of AED 150,000 per *beneficiary* per *period of cover* for the cover of all *pre-existing conditions*.

We also reserve the right, at *our* sole discretion, to apply an additional premium to cover the *treatment* of the *pre-existing conditions*.

Any *pre-existing conditions* and/or any pre-existing chronic conditions subject to the annual cumulative *benefit* limit and/or to an additional premium for the *pre-existing conditions* for each *beneficiary* will be detailed on *your Certificate of Insurance*.

Subject to local regulation, *we* reserve the right, exercisable at *our* sole discretion, to reduce, withhold, deny payment of a claim or to terminate *your policy* in accordance with Clause 19.1.4 in circumstances where *we* have evidence or reasonable grounds to believe that *treatment* obtained was in respect of any *pre-existing condition* that was not disclosed to *us* during the *application* stage.

Where *we* become aware of, or reasonably expect there to be, an undisclosed *pre-existing condition(s)*, whether intentionally or not, except in case of *policy* termination in accordance with Clause 19.1.4, *you* will be presented with two (2) options:

(1) Apply the additional premium identified by *us* as payable to cover any *pre-existing conditions* subject to the annual cumulative *benefit* limit of AED 150,000 for the remaining *period of cover*; or

(2) Exclude the *pre-existing conditions* and all related *treatments* for the remaining *period of cover*.

You must confirm to *us your* selected option within thirty (30) days of these options being presented to *you*. Please note *we* will not pay any claims related to any *pre-existing conditions* until *you* confirm *your* selected option. A new *Certificate of Insurance* will be issued detailing the changes related to the *pre-existing conditions*.

Upon renewal *you* will be required to submit an updated *application* form including a fully completed medical questionnaire that will be reviewed by *us*. *We* may apply an additional premium and/or the annual cumulative *benefit* limit of AED 150,000 for *pre-existing conditions* at this time. Any decision will be communicated to *you* through the *underwriting summary form* and a new *Certificate of Insurance* will be issued detailing the changes related to any *pre-existing condition* cover.

Important note

Please note that where an individual *benefit* limit is identified within the *list of benefits*, this is the limit that will apply for that *benefit* irrespective of the annual cumulative *benefit* limit which is applied for the cover of all *pre-existing conditions*. Any individual *benefit* limit will form part of the annual cumulative *benefit* limit for the cover of all *pre-existing conditions*.

The following examples show how an individual *benefit* limit applies in conjunction with the annual cumulative *benefit* limit for the cover of all *pre-existing conditions*.

EXAMPLE 1: HEALTHGUARD REGIONAL PLAN – *PRE-EXISTING CONDITION* COVER

***WE* PAY AED 9,000**

***YOU* PAY AED 1,000**

Treatment: Claim for prescribed drugs for a *pre-existing condition* - total AED 10,000

Benefit applicable: Prescribed drugs and dressings - paid up to AED 9,000

Remaining available of the annual cumulative *benefit* limit for *pre-existing conditions* - AED 141,000

WHAT THIS MEANS FOR *YOU*...

We will cover the costs for *your* prescribed drugs and dressings for the *treatment* of all *your pre-existing conditions*, up to the total limit shown for *your* selected plan per *beneficiary* per *period of cover*, in this case AED 9,000.

As *we* applied, in this instance, the annual cumulative *benefit* limit for the *treatment* of all *your pre-existing conditions*, the remaining costs available to *you* to cover all *your pre-existing conditions* is AED 141,000 for the *period of cover*.

EXAMPLE 2: HEALTHGUARD INTERNATIONAL PLAN – *PRE-EXISTING CONDITION* COVER

***WE* PAY AED 7,500**

***YOU* PAY AED 500**

Treatment: Claim for non-emergency mental health care for a pre-existing condition - total AED 8,000

Benefit applicable: Non-emergency mental health care on an *inpatient*, *daypatient* or *outpatient* basis - paid up to AED 7,500

Remaining available of the annual cumulative *benefit* limit for *pre-existing conditions* - AED 142,500

WHAT THIS MEANS FOR *YOU*...

We will cover the costs for *your* non-emergency mental health care for the *treatment* of all *your pre-existing conditions*, up to the total limit shown for *your* selected plan per *beneficiary* per *period of cover*, in this case AED 7,500.

As *we* applied, in this instance, the annual cumulative *benefit* limit for the *treatment* of all *your pre-existing conditions*, the remaining costs available to *you* to cover all *your pre-existing conditions* is AED 142,500 for the *period of cover*.

SUBMITTING YOUR CLAIM

If you've paid for *your treatment* yourself, *you* can send *your* invoice and claim form to *us* using any of the following methods. Please clearly state *your policy* number on all documentation.

We aim to process *your* claims within 5 working days after receiving *your* claim with all the necessary documentation.

Email: **Claims.healthguard@cigna.com**

Post: Cigna Insurance Middle East S.A.L
The Offices 3 at One Central
Dubai World Trade Centre
Office No. 111, Level 1
Po Box 3664
Dubai
United Arab Emirates

If *you* require claims forms, please contact *our* Customer Care Team.

We provide the following reimbursement option:

- Electronic transfer of funds into *your* bank account.

Reimbursement for *treatment* in the *UAE* will be in *UAE* Dirhams (AED) where settlement is to *your* bank account in the *UAE*. *We* may reimburse international claims in other currencies.

Important note

Beneficiaries should submit claim forms and invoices as soon as possible after any *treatment*. If the claim and invoice is not submitted to *us* within 6 months of the date of *treatment*, the claim will not qualify for payment or reimbursement by *us*.

OUR GLOBAL HEALTH ASSIST PROGRAMME

***Our* unique Global Health Assist programme is carried out by *our* dedicated team of doctors and nurses, who work hand in hand with customers with serious or complex health conditions to bring them the full medical support they deserve.**

We are dedicated to helping *you* and *your* family live happier, healthier lives with an unparalleled level of clinical expertise, which grants all *beneficiaries* access to:

DECISION SUPPORT PROGRAMME

We provide *our* customers with access to speak with a *doctor* or nurse. This can offer an international second opinion service or simple reassurance to *our* customers at what can often be a sensitive and potentially emotional time. Included within this service may be an independent view on their diagnosis or *treatment* plan.

NURSE COMPLEX CASE MANAGEMENT

When *treatment* is more complex, *our* nurses can take over the case providing clinical guidance and reassurance. In addition, that nurse can become the *beneficiary's* dedicated point of contact throughout the *treatment* process.

Our Global Health Assist service works with a proactive and personalised approach to manage complex health conditions.

Our qualified nurses from the Clinical team will immediately contact customers suffering from *pre-existing conditions* or serious illnesses and confirm a personalised and dedicated point of contact for the customer, and *you* will receive personalised support and information about:

- *Our* decision support programme;
- Medical network/preferred provider information;
- *Hospital* visits and accessing the right level of healthcare;
- Detailed coverage information;
- Personalised support and case management and;
- Global Care On Demand.

HELPFUL INFORMATION

RENEWING YOUR POLICY

Your policy is not automatically renewed; *we* may or may not offer *you* the opportunity to renew *your policy*. If *we* choose to renew, *we* will contact *you* in writing forty-five (45) days prior to *your annual renewal date* to see whether *you* want to renew *your policy*.

We will inform *you* of any changes (if any) to *your benefits* and *policy* terms and conditions which will apply on renewal.

As part of *your* renewal invitation, *we* will provide *you* with *your policy* documentation for the forthcoming *period of cover*, including *your* Schedule of Insurance which details *your* premium and *we* will send them to the postal address or email address *you* gave *us* on *application*.

If *you* choose to renew, *you* should let *us* know in writing at least thirty (30) days prior to *your policy end date* and *your* cover will be renewed automatically for another twelve (12) months. *We* will issue a *Certificate of Insurance* for *your* new *period of cover* on *your annual renewal date* once *your* premium has been received.

If *you* do not want to renew *your* cover, *you* must let *us* know at least thirty (30) days before *your policy end date*.

CHANGING YOUR BENEFICIARIES

If there has been a relevant *qualifying life event*, such as marriage, divorce, or the birth of a child, *you* can add or remove a *beneficiary* at any time. If *you* would like to add, remove or change a *beneficiary*, please contact the Customer Care Team, and they will be happy to help *you*.

MAKING CHANGES TO YOUR POLICY

If *you* want to make any changes to your *policy,* this can be done during the first 30 days of *your policy* or when *your* cover is being renewed at the *annual renewal* date.

Please contact the Customer Care Team they will be happy to help, and discuss the various options and any additional premiums payable. No changes can be made after the first 30 days of the *policy.*

CANCELLING YOUR POLICY

Your policy is an annual contract. If you choose to terminate *your policy* and end cover for all *beneficiaries,* you can do so at any time by giving *us* thirty (30) days' notice in writing. Please see Clause 19.2 of the *policy* terms and conditions section of this Customer Handbook. Note that *you* will be liable for any premium due up to the effective date of cancellation. In addition, if any claim has been made under the *policy, you* will remain liable to pay the whole annual premium (a failure to do so may result in us withholding payment in respect of any claims). To terminate this *policy* in respect of *you* or another *beneficiary,* we may require *you* to provide supporting evidence that *you* or the other *beneficiary,* as the case may be, are no longer required to have medical *insurance* in Dubai or the Northern Emirates or have alternative private medical *insurance* in place to provide continuous cover in Dubai or the Northern Emirates (for example, cancelled visa, or *certificate of insurance* from another provider).

OUT OF AREA EMERGENCY COVER

For additional peace of mind, *your policy* includes emergency *short-term* medical coverage when *you* or a *beneficiary* are visiting a location on a temporary trip outside of *your selected area of coverage*.

Cover is limited to a maximum period of thirty (30) days per trip and a maximum of sixty (60) days per *period of cover* for all trips combined. Please read the full terms and conditions relating to this *benefit* in Clause 16 of the *policy* terms and conditions section of this *Customer Handbook*.

HOW CO-PAY ON OUTPATIENT VISITS WORKS

Co-Pay is the percentage of each *outpatient visit* which a *beneficiary* must pay themselves. *You* will be responsible for paying the amount of *Co-Pay* directly to the *healthcare provider*. The *healthcare provider* will let *you* know what this amount is. *Your Certificate of Insurance* and *Medical ID Cards* will detail any *Co-Pay* applicable.

For *your* added protection, there is a limit on the *Co-Pay* amount *you* will pay for every *outpatient visit*. If *you* have selected a 10% *Co-Pay*, the maximum amount *you* will pay for an *outpatient visit* is AED 50. If *you* have selected a 20% *Co-Pay*, the maximum amount *you* will pay for an *outpatient visit* is AED 100.

Please see how the optional *Co-Pay* in relation to *outpatient visits* will apply for the following examples. For further details, please refer to Clause 18 in this *Customer Handbook*.

EXAMPLE 1: HEALTHGUARD REGIONAL PLAN – *OUTPATIENT VISIT*

YOU PAY AED 100 | **WE PAY AED 1,430**

Co-Pay Selected: 20% up to a maximum of AED 100 per visit

Visit to a provider for the following *Outpatient* benefits on the same day:

- consultation with *medical practitioner* (AED 350)
- multiple *diagnostic tests* (AED 1,180)

Total Visit value: AED 1,530

WHAT THIS MEANS FOR YOU...

Your selected *Co-Pay* is 20% which means the amount *you* would normally pay for this visit is AED 306. However, the amount *you* pay for each *outpatient visit* is capped at AED 100, so that *your* contribution is limited at AED 100.

EXAMPLE 2: HEALTHGUARD INTERNATIONAL PLAN – *OUTPATIENT VISITS*

YOU PAY AED 200 | **WE PAY AED 1,330**

Co-Pay Selected: 20% up to a maximum of AED 100 per visit

Visit to a provider for the following *Outpatient benefits* on the same day:

- consultation with *medical practitioner* (AED 350)
- multiple *diagnostic tests* (AED 300)

Next visit to the same provider for further *Outpatient benefits* on a different day:

- multiple *diagnostic tests* (AED 880)

Total Visits value: AED 1,530

WHAT THIS MEANS FOR YOU...

Your selected *Co-Pay* is 20% which means the amount *you* would normally pay for these visits is AED 306. However, the amount *you* pay for each *outpatient visit* is capped at AED 100, so that *your* contribution is limited at AED 200 (2 * AED 100).

EXAMPLE 3: HEALTHGUARD INTERNATIONAL PLUS PLAN – *OUTPATIENT VISITS*

YOU PAY AED 500 | **WE PAY AED 5,850**

Co-Pay Selected: 10% up to a maximum of AED 50 per visit

Visit to a provider for the following *Outpatient benefits* on the same day:

- consultation with *medical practitioner* (AED 350)
- 1st physiotherapy session (AED 600)

9 visits to the same provider for further *Outpatient benefits* on different days:

- 9 physiotherapy sessions (AED 5400)

Total Visits value: AED 6,350

WHAT THIS MEANS FOR YOU...

Your selected *Co-Pay* is 10% which means the amount *you* would normally pay for these visits is AED 635. However, the amount *you* pay for each *outpatient visit* is capped at AED 50, so that *your* contribution is limited at AED 500 (10 * AED 50).

Important note:

A mandatory *Co-Pay* of 10% applies to routine maternity, *medically necessary* caesarean and complications arising from maternity and childbirth (non-life threatening) *benefits* across all plans. These *treatments* covered on an *inpatient* and *daypatient* basis are not subject to the associated limit of AED 50 applicable for the optional *Co-Pay* in relation to *outpatient visits*.

A mandatory *Co-Pay* also applies to some of the dental *benefits* in the optional Healthy Connect module. The *Co-Pay* applicable to major restorative *dental treatment* and orthodontic *treatment benefits* are not limited to a specific amount for these *treatments*.

YOUR BENEFITS IN DETAIL

When building *your* tailored plan, *you* may have chosen the Healthy Connect optional module. If *you* have chosen this option, this will be set out in *your Certificate of Insurance* which will also detail the area of coverage *you* have selected for *your policy*.

The *list of benefits* detail what is covered in *your policy* and any important information related to each *benefit*. The Healthguard International Plus plan provides unlimited cover for *inpatient*, *daypatient* and *outpatient treatment*, with the exception of any *benefits* which have individual limits.

The *list of benefits* in the Healthguard International plan and the Healthguard Regional plan include an overall *benefit* maximum. These are the maximum amounts *we* will pay for per *beneficiary* per *period of cover*.

HEALTHY CONNECT OPTION

In addition to the core medical offering, our Healthy Connect optional module includes a wide range of benefits that will help *you* take control and pro-actively manage the health and wellbeing of *you* and *your* family. The *benefits* range from comprehensive *dental treatment*, eye examination, enhanced health screenings and tests, life management assistance and dietetic consultations. What's more, *we* understand that there are times when *you* would prefer to have *treatment* in familiar surroundings with family members close by; for those *beneficiaries* whose *country of nationality* is not the *UAE*, Healthy Connect also includes a return home cash benefit, making it possible to return home, should the need arise.

The optional module can only be purchased in conjunction with the Core plan and is required to be purchased for all *beneficiaries*.

Important note

The *benefits* and any additional options chosen are provided subject to all of the terms, conditions, limits and exclusions of this *policy* (including the *General Exclusions* and specific exclusions set out in the *list of benefits* in this *Customer Handbook*). The *list of benefits* shows any limits which apply to the *benefits*. *Benefits* that are 'paid in full' are subject to the overall annual *benefit* maximum, where applicable. Please read the additional accompanying notes applicable to each *benefit* in the *list of benefits*. There are some *benefits* which have waiting periods, meaning *you* can only submit a claim for *treatments* incurred after the duration of the waiting period has been satisfied. Some benefits have a mandatory *Co-Pay*, which means, *we* will only pay the cost of *treatment* less the *Co-Pay* amount *you* need to pay.

HEALTHGUARD PLAN BENEFITS

Our Healthguard plans comprise of three levels of cover. The Regional plan provides coverage within the countries of the Gulf Cooperation Council (*GCC*), other Middle East countries and Asia (excluding Singapore, Hong Kong and China).

The International and International Plus plans provide cover *Worldwide excluding the USA* as standard, however, *you* may select the *Worldwide including the USA* coverage additional option.

The table below details the level of cover *you* can choose. All *benefits* detailed as 'Paid in full' are subject to the overall annual *benefit* maximum with the exclusion of the Medical Evacuation and Repatriation service *benefits*. All the *outpatient benefits* detailed as 'Paid in full' are also subject to any *Co-Pay* amounts if *you* have selected an optional *Co-Pay* in relation to any *outpatient benefit*.

All amounts apply per *beneficiary* per *period of cover* (except where otherwise noted).

Our plans are designed to cover for *inpatient*, *daypatient*, accommodation costs, *outpatient* care and *treatments*, as well as cover for *cancer*, maternity, mental health care and much more.

Please note *benefit* limits displayed in USD ($) are for illustrative purposes only and have been rounded.

LIST OF BENEFITS

YOUR OVERALL MAXIMUM

Annual overall *benefit* - maximum per *beneficiary* per *period of cover* Includes all *inpatient*, *daypatient* and *outpatient treatment*.	REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
	AED 2,750,000 ($750,000)	AED 7,350,000 ($2,000,000)	Unlimited

YOUR NETWORK AND AREA OF COVERAGE

	REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
Healthcare provider network in the *UAE*	Select *your* Network Tier from the 4 choices: General General Plus Comprehensive excluding American *Hospital* Dubai (AHD) Comprehensive		

A full list of *our* network of *healthcare providers* is available in *your* online Customer Area.

Please note, in the following circumstances direct payment to the provider may not be possible and a reimbursement will apply, up to the maximum amount per *benefit* per *period of cover*:

- No network exists within area of coverage
- *Emergency treatment*
- The *treatment* required is not available in the network of *healthcare providers*.

Network of *healthcare providers*	REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
	Direct payment to providers in the *UAE* Out of network penalty in the *UAE* - 20%*	Direct payment to providers in the *UAE* Out of network penalty in the *UAE* and the *USA* - 20% *	

If a *beneficiary* receives *treatment* in the *UAE* or the *USA* (if applicable) and the provider is not part of the *healthcare provider* network, *we* will reduce any amount *we* pay by 20%.

*Please note there are occasions when this may not apply, including:

- Where there is no *Cigna* network of *healthcare providers* within 30 miles / 50 kilometres of the *beneficiaries* home address.
- When the *treatment* the *beneficiary* needs is not available from a local network *hospital*, *medical practitioner* or *clinic*.
- In the event *emergency treatment* is required at a *hospital*, *medical practitioner* or *clinic* that is not part of the *Cigna* network.
- The *Cigna* network of *healthcare providers* is used outside of the *UAE* or the *USA* (if applicable).

USA area of coverage option	REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
	Not applicable	*Worldwide excluding the USA* or; *Worldwide including the USA*	

Choose to include the *USA* area of coverage (International and International Plus plans only)

Out of Area Emergency Cover Up to the total limit shown for *your* selected plan per *beneficiary* per *period of cover*.	REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
	AED 180,000 ($50,000)	AED 280,000 ($75,000) Not applicable if *you* have selected the *Wordwide including the USA* coverage option.	AED 500,000 ($135,000)

Emergency *inpatient*, *daypatient* or *outpatient* medical *treatment* during temporary business or leisure trips outside *your* area of coverage.

Important notes:

- The medical condition requiring *emergency treatment* must not have existed prior to the travel and the *beneficiary* must have been *treatment*, symptom, and advice free of the medical condition prior to initiating the travel.
- Coverage is limited to a maximum period of 30 days per trip and a maximum of 60 days per *period of cover* for all trips combined.
- Charges relating to maternity, pregnancy, childbirth or any complications of pregnancy or childbirth are excluded from this Out of Area Emergency Cover.

YOUR STANDARD MEDICAL BENEFITS

INPATIENT & DAYPATIENT BENEFITS

Please note, there are some *benefits* detailed below that include *outpatient treatment*. Therefore, a *Co-Pay* (if selected) will apply for such *treatments*.

Hospital charges for: nursing care, accommodation on a private room basis for *inpatient* and *daypatient treatment* and recovery room including *emergency treatment*. Up to the annual overall benefit maximum for *your* selected plan per *beneficiary* per *period of cover*.	REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
	Paid in full Standard private room	Paid in full Standard private room	Paid in full Standard private room

- *We* will pay for nursing care and accommodation whilst a *beneficiary* is receiving *inpatient* or *daypatient treatment*; or the cost of a *treatment* room while a *beneficiary* is undergoing *outpatient surgery*, if one is required.
- *We* will only pay these costs if:
  - it is *medically necessary* for the *beneficiary* to be *treated* on an *inpatient* or *daypatient* basis;
  - they stay in *hospital* for a *medically appropriate* period of time;
  - the *treatment* which they receive is provided or managed by a *specialist*.
- If a *hospital's* fees vary depending on the type of room which the *beneficiary* stays in, the maximum amount which *we* will pay is *reasonable and customary costs* in line with appropriate costs in that area, based on a standard single room with a private bathroom or equivalent.
- If the treating *medical practitioner* decides that the *beneficiary* needs to stay in *hospital* for a longer period than *we* have approved in advance, or decides that the *treatment* which the *beneficiary* needs is different to that which *we* have approved in advance, then that *medical practitioner* must provide *us* with a report, explaining: how long the *beneficiary* will need to stay in *hospital*; the diagnosis (if this has changed); and the *treatment* which the *beneficiary* has received, and needs to receive.

Hospital charges for: operating theatre, prescribed medicines, drugs and dressings and surgeons' and anaesthetists' fees on an *inpatient* and *daypatient* basis. Up to the annual overall benefit maximum for *your* selected plan per *beneficiary* per *period of cover*.	REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
	Paid in full	Paid in full	Paid in full

Operating theatre costs:

- Costs and charges relating to the use of an operating theatre, if the *treatment* being given is covered under this *policy*.

Medicines, drugs and dressings:

- Medicines, drugs and dressings which are prescribed for the *beneficiary* whilst he or she is receiving *inpatient* or *daypatient treatment*.
- Medicines, drugs and dressings which are prescribed for use at home will be covered under the limits of the prescribed drugs and dressing limit in *Outpatient* benefits (unless they are prescribed as part of *cancer treatment*).

Intensive care: including intensive therapy, coronary care and high dependency unit. Up to the annual overall benefit maximum for *your* selected plan per *beneficiary* per *period of cover*.	REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
	Paid in full	Paid in full	Paid in full

Treatment in an *intensive care*, intensive therapy, coronary care or high dependency facility if:

- that facility is the most appropriate place for them to be treated;
- the care provided by that facility is an essential part of their *treatment*; and
- the care provided by that facility is routinely required by patients suffering from the same type of illness or *injury*, or receiving the same type of *treatment*.

Surgeons' and Anaesthetists' fees

Up to the annual overall benefit maximum for *your* selected plan per *beneficiary* per *period of cover*.

REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
Paid in full	Paid in full	Paid in full

Inpatient or *daypatient* costs for:

- surgeons' and anaesthetists' *surgery* fees; and
- surgeons' and anaesthetists' fees in respect of *treatment* which is needed immediately before or after *surgery* (i.e. on the same day as the *surgery*).

Specialists' consultation fees

Up to the annual overall benefit maximum for *your* selected plan per *beneficiary* per *period of cover*.

REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
Paid in full	Paid in full	Paid in full

Regular visits by a *specialist* during stays in *hospital* including *intensive care* by a *specialist* for as long as is required by medical necessity.

We will pay for consultations with a *specialist* during stays in a *hospital* where the *beneficiary*:

- is being treated on an *inpatient* or *daypatient* basis;
- is having *surgery*; or
- where the consultation is a medical necessity.

Companion Accommodation (per night)

Up to the total limit shown per night for *your* selected plan per *beneficiary* per *period of cover*.

REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
AED 100 ($28)	AED 100 ($28)	AED 200 ($56)

- The cost of accommodation of a person accompanying an *inpatient beneficiary* in the same room in cases of medical necessity at the recommendation of the treating *doctor*.

Hospital accommodation for a parent or legal guardian (per night)

Up to the total limit shown per night for *your* selected plan per *beneficiary* per *period of cover* or where "paid in full" is shown this is up to the annual overall benefit maximum for *your* selected plan per *beneficiary* per *period of cover*.

REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
AED 500 ($135)	AED 1,000 ($270)	Paid in full

If a *beneficiary* who is under the age of 18 years old needs *inpatient treatment* and has to stay in *hospital* overnight, *we* will also pay for *hospital* accommodation for a parent or legal guardian, if:

- accommodation is available in the same *hospital*; and
- the cost is reasonable.

We will only pay for *hospital* accommodation for a parent or legal guardian if the *treatment* which the *beneficiary* is receiving during their stay in *hospital* is covered under this *policy*.

Transplant services for organ, bone marrow and stem cell transplants

Up to the annual overall benefit maximum for *your* selected plan per *beneficiary* per *period of cover*.

REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
Paid in full	Paid in full	Paid in full

We will pay for *inpatient treatment* directly associated with an organ transplant, for the *beneficiary* if:

- the transplant is *medically necessary*, and the organ to be transplanted has been donated by a member of the *beneficiary's* family or comes from a verified and legitimate source.

We will pay for anti-rejection medicines following a transplant, when they are given on an *inpatient* basis.

We will pay for *inpatient treatment* directly associated with a bone marrow or peripheral stem cell transplant if:

- the transplant is *medically necessary*; and
- the material to be transplanted is the *beneficiary's* own bone marrow or stem cells, or bone marrow taken from a verified and legitimate source.

We will not pay for bone marrow or peripheral stem cell transplants under this part of this *policy* if the transplants form part of cancer *treatment*. The cover which *we* provide in respect of *cancer treatment* is explained in other parts of this *policy*.

If a person donates bone marrow or an organ to a *beneficiary*, *we* will pay for:

- the harvesting of the organ or bone marrow;
- any *medically necessary* tissue matching tests or procedures;
- the donor's *hospital* costs; and
- any costs which are incurred if the donor experiences complications, for a period of 30 days after their procedure; whether or not the donor is covered by this *policy*.

The amount which *we* will pay towards a donor's medical costs will be reduced by the amount which is payable to them in relation to those costs under any other insurance *policy* or from any other source.

If a *beneficiary* donates an organ for a *medically necessary* transplant, *we* will cover the medical costs incurred by the *beneficiary* associated with this donation up to any *policy* limits. However, *we* will only pay for the harvesting of the donated organ if the intended recipient is also a *beneficiary* under this plan.

We will consider all *medically necessary* transplants. Other transplants (such as transplants which are considered to be experimental procedures) are not covered under this *policy*.

Important note:

A *Co-Pay* (if selected) will apply for all *outpatient treatment* related to this *benefit*.

A *beneficiary* must contact *us* and get approval in advance before they incur any costs relating to organ, bone marrow or stem cell donation or transplant.

Kidney dialysis

Up to the annual overall benefit maximum for *your* selected plan per *beneficiary* per *period of cover*.

REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
Paid in full	Paid in full	Paid in full

Treatment for kidney dialysis will be covered if such *treatment* is available.

- *We* will pay for this on an *inpatient* or *daypatient* basis.
- *We* will pay for kidney dialysis *treatment* outside the *beneficiary's* country of habitual residence if the country where that *treatment* is provided is within the *beneficiary's* selected area of coverage. *We* will pay for this on a *daypatient* basis. Travel and accommodation expenses incurred in connection with such *treatment* will not be covered.

Pathology, radiology and *diagnostic tests*

Up to the annual overall benefit maximum for *your* selected plan per *beneficiary* per *period of cover*.

REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
Paid in full	Paid in full	Paid in full

Tests which are *medically necessary* and are recommended by a *specialist* as part of a *beneficiary's hospital* stay for *inpatient* or *daypatient treatment*, including:

- blood and urine tests;
- X-rays;
- ultrasound scans;
- electrocardiograms (ECG); and
- other *diagnostic tests*.

Advanced medical imaging

Up to the annual overall benefit maximum for *your* selected plan per *beneficiary* per *period of cover*.

REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
Paid in full	Paid in full	Paid in full

We will pay for the following scans if they are recommended by a *specialist* as a part of a *beneficiary's inpatient* or *daypatient treatment*:

- magnetic resonance imaging (MRI);
- computed tomography (CT); and/or
- positron emission tomography (PET).

Rehabilitation

Up to thirty (30) days and to the total limit shown for *your* selected plan per *beneficiary* per *period of cover* or where "paid in full" is shown this is up to the annual overall benefit maximum for *your* selected plan per *beneficiary* per *period of cover*.

REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
AED 9,000 ($2,500)	AED 18,000 ($5,000)	Paid in full

We will pay for *rehabilitation* on an *inpatient*, *daypatient* or *outpatient* basis immediately following *treatment* that is covered under the *policy*.

We will pay for *rehabilitation treatment*s (physical, occupational and speech therapies), which are recommended by a *specialist* and are *medically necessary* after a traumatic event such as a stroke or spinal *injury*.

If the *rehabilitation treatment* is required in a residential *rehabilitation* centre *we* will pay for accommodation and board for up to 30 days for each separate condition that requires *rehabilitation treatment*.

In determining when the 30 day limit has been reached:

- *we* count each overnight stay during which a *beneficiary* receives *inpatient treatment* as one day
- *we* count each day on which a *beneficiary* receives *outpatient* and *daypatient treatment* as one day.

Subject to prior approval being obtained, prior to the commencement of any *treatment*, *we* will pay for *rehabilitation treatment* for more than 30 days, if further *treatment* is *medically necessary* and is recommended by the treating *specialist*.

Important notes:

We will only pay for *rehabilitation treatment* if it is needed after, or as a result of, *treatment* which is covered by this *policy* and it begins within 30 days of the end of that original *treatment*.

All *rehabilitation treatment* must be approved by *us* in advance. *We* will only approve *rehabilitation treatment* if the treating *specialist* provides *us* with a report, explaining:

- how long the *beneficiary* will need to stay in *hospital*;
- the diagnosis; and
- the *treatment* which the *beneficiary* has received, or needs to receive.

A *Co-Pay* (if selected) will apply for all *outpatient treatment* related to this *benefit*.

Home nursing

Up to thirty (30) days and to the total limit shown for *your* selected plan per *beneficiary* per *period of cover* or where "paid in full" is shown this is up to the annual overall benefit maximum for *your* selected plan per *beneficiary* per *period of cover*.

REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
AED 9,000 ($2,500)	AED 18,000 ($5,000)	Paid in full

We will pay for a *beneficiary* to have up to 30 days of *home nursing* care per *period of cover* if:

- it is recommended by a *specialist* following *inpatient* or *daypatient treatment* which is covered by this *policy*;
- it starts immediately after the *beneficiary* leaves *hospital*; and
- it reduces the length of time for which the *beneficiary* needs to stay in *hospital*.

Important notes:

- *We* will only pay for *home nursing* if it is provided in the *beneficiary's* home by a qualified nurse and it comprises *medically necessary* care that would normally be provided in a *hospital*. *We* will not pay for *home nursing* which only provides non-medical care or personal assistance.

Physiotherapy

Up to the annual overall benefit maximum for *your* selected plan per *beneficiary* per *period of cover*.

REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
Paid in full	Paid in full	Paid in full

- Where *treatment* is provided on an *inpatient* or *daypatient basis*.
- *We* will pay for *treatment* provided by physiotherapist if it is recommended by a *specialist* as part of the *beneficiary's hospital* stay for *inpatient* or *daypatient treatment* (but is not the primary *treatment* which they are in *hospital* to receive).

Local road and air ambulance services

Up to the annual overall benefit maximum for *your* selected plan per *beneficiary* per *period of cover*.

REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
Paid in Full (Road only)	Paid in full	Paid in full

Where it is *medically necessary*, *we* will pay for a local ambulance to transport a *beneficiary*:

- from the scene of an accident or *injury* to a *hospital*;
- from one *hospital* to another; or
- from their home to a *hospital*.

We will only pay for a local road ambulance where its use relates to *treatment* which a *beneficiary* needs to receive in *hospital*. Where it is *medically necessary*, *we* will pay for an air ambulance to transport the *beneficiary* from the scene of an accident or *injury* to a *hospital* or from one *hospital* to another.

Important notes:

Air ambulance cover is subject to the following conditions and limitations:

- In some situations it will be impossible, impractical or unreasonably dangerous for an air ambulance to operate. In these situations, *we* will not arrange or pay for an air ambulance. This *policy* does not guarantee that an air ambulance will always be available when requested, even if it is *medically appropriate*.
- *We* will only pay for a local air ambulance, such as a helicopter, to transport a *beneficiary* for distances up to 100 miles (160 kilometres) and *we* will only pay for an air ambulance where its use relates to *treatment* which a *beneficiary* needs to receive in *hospital*.

This *policy* does not provide cover for mountain rescue services.

Hospice and *palliative care*

Up to the annual overall benefit maximum for *your* selected plan per *beneficiary* per *period of cover*.

REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
Paid in full	Paid in full	Paid in full

- If a *beneficiary* is given a terminal diagnosis, and there is no available *treatment* which will be effective in aiding recovery, *we* will pay for *hospital* or hospice care and accommodation, nursing care, prescribed medicines, and physical and psychological care.

Internal prosthetic devices/ *surgical and medical appliances*

Up to the total limit shown for *your* selected plan per *beneficiary* per *period of cover* or where "paid in full" is shown this is up to the annual overall benefit maximum for *your* selected plan per *beneficiary* per *period of cover*.

REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
AED 150,000 ($41,000)	Paid in full	Paid in full

Medically necessary internal prosthetic implants, devices or appliances which are put in place during *surgery* as part of a *beneficiary's treatment*.

A *surgical appliance* or a *medical appliance* can mean:

- a prosthesis or device which is required for the purpose of, or in connection with, *surgery* or;
- an artificial device or prosthesis which is a necessary part of the *treatment* immediately following *surgery* for as long as required by medical necessity.

External prosthetic devices/ *surgical and medical appliances*

REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
AED 10,000 ($2,700)	AED 15,000 ($4,100)	Paid in full

Up to the total limit shown for *your* selected plan per *beneficiary* per *period of cover* or where "paid in full" is shown this is up to the annual overall benefit maximum for *your* selected plan per *beneficiary* per *period of cover*.

External prosthetics, devices or appliances which are necessary as part of a *beneficiary's treatment* (subject to the limitations explained below).

We will pay for:

- a prosthetic device or appliance which is a necessary part of the *treatment* immediately following *surgery* for as long as is required by medical necessity;
- a prosthetic device or appliance which is *medically necessary* and is part of the recuperation process on a *short-term* basis.

We will pay for an initial external prosthetic device for *beneficiaries* aged 18 or over per *period of cover*. *We* do not pay for any replacement prosthetic devices for *beneficiaries* who are aged 18 and over.

We will pay for an initial external prosthetic device and up to two replacements for *beneficiaries* aged 17 or younger per *period of cover*.

By an external 'prosthetic device', *we* mean an external artificial body part, such as a prosthetic limb or prosthetic hand which is *medically necessary* as part of *treatment* immediately following the *beneficiary's surgery* or as part of the recuperation process on a *short-term* basis.

Inpatient cash *benefit* (per night)

REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
AED 400 ($100)	AED 600 ($150)	AED 900 ($250)

Up to thirty (30) nights and to the total limit shown per night for *your* selected plan per *beneficiary* per *period of cover*.

Cash payment directly to a *beneficiary* when they:

- receive *treatment* in *hospital* which is covered under this plan;
- stay in a *hospital* overnight; and
- have not been charged for their room, board and *treatment* costs.

Emergency dental and gum *treatment*

REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
Paid in full	Paid in full	Paid in full

Up to the annual overall benefit maximum for *your* selected plan per *beneficiary* per *period of cover*.

Dental or gum *treatment*, in the case of a medical emergency immediately after damage to *sound natural teeth* or gums on an *inpatient* or *daypatient* basis, subject to the conditions set out below.

- *We* will pay for *emergency treatment* which is required by a *beneficiary* while they are in *hospital* as an *inpatient*, if that emergency *inpatient* dental *treatment* is recommended by the treating *medical practitioner* because of a *dental emergency* (but is not the primary *treatment* which the *beneficiary* is in *hospital* to receive).
- This *benefit* is paid instead of any other dental *benefits* the *beneficiary* may be entitled to in these circumstances.

Emergency mental health care

REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
Paid in full	Paid in full	Paid in full

Up to the annual overall benefit maximum for *your* selected plan per *beneficiary* per *period of cover*.

Treatment for emergency mental health conditions and disorders and addiction *treatment* on an *inpatient*, *daypatient* and *outpatient* basis. *We* will only pay for *evidence-based*, *medically necessary treatment* and recommended by a *medical practitioner*.

- Prescription drugs or medication prescribed on an *outpatient* basis is paid under the prescribed drugs and dressings benefit.
- A *Co-Pay* (if selected) will apply for all *outpatient treatment* related to this *benefit*.

Non-emergency mental health care

Up to the total limit shown for *your* selected plan per *beneficiary* per *period of cover*.

REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
AED 10,000 ($2,720)	AED 12,000 ($3,265)	AED 12,000 ($3,265)

Subject to the limits explained below *we* will pay for the following *treatment* on an *inpatient*, *daypatient* or *outpatient* basis:

- the *treatment* of mental health conditions and disorders; and
- the diagnosis of addictions.

Addiction *treatment*

- *We* will pay for one course or programme of addiction *treatment* at a *specialist* centre providing *evidence based treatment*, if that *treatment* is *medically necessary* and recommended by a *medical practitioner*.
- *We* pay for up to three attempts at detoxification, following which *we* will only pay for further detoxification *treatment* if the *beneficiary* completes a formal *outpatient* course or programme of addiction *treatment*.
- *We* will not pay for any *treatment* related to alcoholism or controlled substances addiction; or *treatment* of any related condition (such as depression, dementia or liver failure); where *we* reasonably believe that the *condition* which requires *treatment* was the direct result of alcoholism or controlled substances addiction.
- Prescription drugs or medication prescribed on an *outpatient* basis is paid under the prescribed drugs and dressings *benefit*.

Cancer care

Up to the annual overall benefit maximum for *your* selected plan per *beneficiary* per *period of cover*.

REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
Paid in full	Paid in full	Paid in full

- Following a diagnosis of *cancer*, *we* will pay for costs for the *treatment* of *cancer* if the *treatment* is considered by *us* to be active *treatment* and *evidence-based treatment*. This includes chemotherapy, radiotherapy, oncology, *diagnostic tests* and drugs, whether the *beneficiary* is staying in a *hospital* overnight or receiving *treatment* as a *daypatient* or *outpatient*.
- Cover for genetic cancer screening is only available if *you* selected the Healthy Connect optional module detailed in this *Customer Handbook*.
- No *Co-Pay* will apply for *outpatient treatment*, including drugs.

Important note:

- Any treatment or costs, for or relating to, *Gene Therapy or Genetic Therapy* is not covered.

Cancer preventative *surgery*

Up to the total limit shown for *your* selected plan per *beneficiary* per *period of cover*.

REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
AED 36,500 ($10,000) 30% *Co-Pay* applies	AED 66,000 ($18,000) 20% *Co-Pay* applies	AED 66,000 ($18,000) 10% *Co-Pay* applies

We will pay for preventative *surgery* for breast and ovarian *cancer* when the *surgery* is considered *medically necessary* for the *treatment* of individuals at high risk of developing breast or ovarian *cancer* according to *Cigna* medical guidelines.

Routine maternity, childbirth and elective caesarean

10% mandatory *Co-Pay* applies.
Up to the total limit shown for *your* selected plan per *beneficiary* per *period of cover*.

REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
AED 10,000 ($2,720)	AED 10,000 ($2,720)	AED 10,000 ($2,720)

We will pay for routine maternity care, childbirth and elective caesarean costs on an *inpatient* or *daypatient* basis including:

- *hospital*, obstetricians' and midwives' fees for routine childbirth;
- any fees as a result of post-natal care required by the mother immediately following routine childbirth.

We will not pay for surrogacy or any related *treatment*. *We* will not pay for maternity *benefit* care or *treatment* for a *beneficiary* acting as a surrogate or anyone acting as a surrogate for a *beneficiary*.

Important notes:

- A 10% mandatory *Co-Pay* applies to this *benefit*.
- The *benefit* is payable outside of the *UAE* once the mother has been covered by the *policy* for 12 months or more.

Medically necessary caesarean and complications arising from maternity and childbirth (non-life threatening) 10% mandatory *Co-Pay* applies. Up to the total limit shown for *your* selected plan per *beneficiary* per *period of cover*.	REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
	AED 10,000 ($2,700)	AED 10,000 ($2,700)	AED 10,000 ($2,700)

We will pay for *medically necessary* caesarean and complications arising from maternity and childbirth on an *inpatient* or *daypatient basis* including:

- *hospital*, obstetricians' and midwives' fees for complicated (non-life threatening) childbirth;
- any fees as a result of post-natal care required by the mother immediately following complicated (non-life threatening) childbirth.

We will not pay for surrogacy or any related *treatment*. *We* will not pay for maternity *benefit* care or *treatment* for a *beneficiary* acting as a surrogate or anyone acting as a surrogate for a *beneficiary*.

The plan *benefit* limits for routine maternity in the *benefit* above and a *medically necessary* caesarean, does not result in a combined aggregate limit payable.

Important notes:

- A 10% mandatory *Co-Pay* applies to this benefit.
- The *benefit* is payable outside of the *UAE* once the mother has been covered by the *policy* for 12 months or more.

Complications arising from maternity and childbirth (*Treatment* for life threatening maternity conditions) and *medically necessary* termination Up to the annual overall benefit maximum for *your* selected plan per *beneficiary* per *period of cover*.	REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
	Paid in full	Paid in full	Paid in full

We will pay for all *treatment* as a result of complications of pregnancy, including a *medically necessary* termination, ectopic pregnancy and pre-eclampsia.

Newborn Care Up to thirty (30) days from newborn's birth and to the total limit shown for *your* selected plan per *beneficiary* per *period of cover*.	REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
	AED 150,000 up to and including 30 days from newborn's birth.	AED 150,000 up to and including 30 days from newborn's birth.	AED 150,000 up to and including 30 days from newborn's birth.

We will pay for the following:

- Any illness or defect detected (congenital or otherwise) during pregnancy or evident at or arising up to and including 30 days from birth.
- BCG, Hepatitis B, Vit K and other neo-natal screening tests, including; Phenylketonuria, Congenital Hypothyroidism, Sickle cell screening, Congenital adrenal hyperplasia, G6PD and hearing tests.

Congenital conditions and birth defects (life threatening) Up to the total limit shown for *your* selected plan per *beneficiary* per *period of cover*.	REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
	AED 150,000 ($41,000)	AED 150,000 ($41,000)	AED 150,000 ($41,000)

- *We* will pay for *treatment* for life threatening *congenital conditions* and birth defects on an *inpatient*, *outpatient* and *daypatient basis* which are life threatening.

Important note:

- Any treatment or costs, for or relating to, *Gene Therapy or Genetic Therapy* is not covered.

OUTPATIENT BENEFITS

A *Co-Pay* (if selected) applies to all *outpatient* care *benefits*	REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
	Choose *your Co-Pay* option for *Outpatient visits*: 0% 10% up to a maximum of AED 50 ($14) per visit 20% up to a maximum of AED 100 ($28) per visit		

Co-Pay is the percentage of each *outpatient visit* that is not covered by *your* plan. For additional peace of mind, our *Co-Pay* options include a maximum amount for each *outpatient visit*.

Consultations with *medical practitioners* and *specialists* Up to the annual overall benefit maximum for *your* selected plan per *beneficiary* per *period of cover*.	REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
	Paid in full	Paid in full	Paid in full

- Consultations or meetings with a *medical practitioner* which are necessary to diagnose an illness, or to arrange or receive *treatment*;
- Non-surgical *treatment* on an *outpatient* basis, which is recommended by a *specialist* as being *medically necessary*.

Surgeons' and Anaesthetists' fees Up to the annual overall benefit maximum for *your* selected plan per *beneficiary* per *period of cover*.	REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
	Paid in full	Paid in full	Paid in full

Outpatient costs for:

- surgeons' and anaesthetists' *surgery* fees; and
- surgeons' and anaesthetists' fees in respect of *treatment* which is needed immediately before or after *surgery* (i.e. on the same day as the *surgery*).

Outpatient maternity Up to the annual overall benefit maximum for *your* selected plan per *beneficiary* per *period of cover*.	REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
	Paid in full Maximum of 8 visits to obstetrician.	Paid in full Maximum of 8 visits to obstetrician.	Paid in full Maximum of 8 visits to obstetrician.

- All care provided for low risk or *specialist* obstetrician for high risk referrals.
- All blood tests required during one of the visits to an obstetrician including, initial investigations such as:
  - FBC and Platelets;
  - Blood group, rhesus status and antibodies;
  - VDRL, MSU and urinalysis;
  - Rubella serology;
  - GTT (for high risk patients);
  - FBS, random s or A1.
- 3 ante-natal ultrasound scans;
- Appointment(s) for and tests such as the CTG and Bishops score and a membrane sweep; and
- All visits including reviews, checks and tests in accordance with ante-natal protocols for high risk patients.

Important notes:

- A *Co-Pay* (if selected) will apply for all *outpatient treatments* related to this *benefit*.
- All post-natal *treatment* (other than immediately following delivery and complications) is covered under the applicable *outpatient* care benefit.
- The *benefit* is payable outside of the *UAE* once the mother has been covered by the *policy* for 12 months or more.

Kidney dialysis

Up to the annual overall benefit maximum for *your* selected plan per *beneficiary* per *period of cover*.

REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
Paid in full	Paid in full	Paid in full

Treatment for kidney dialysis will be covered if such *treatment* is available.

- *We* will pay for this on an *outpatient* basis.
- *We* will pay for kidney dialysis *treatment* outside the *beneficiary's* country of habitual residence if the country where that *treatment* is provided is within the *beneficiary's* selected area of coverage.

Pathology, radiology and *diagnostic tests*

Up to the annual overall benefit maximum for *your* selected plan per *beneficiary* per *period of cover*.

REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
Paid in full	Paid in full	Paid in full

Tests where they are *medically necessary* and are recommended by a *specialist* as part of a *beneficiary's outpatient treatment*, including:

- blood and urine tests;
- X-rays;
- ultrasound scans;
- electrocardiograms (ECG); and
- other *diagnostic tests*.

Advanced medical imaging

Up to the annual overall benefit maximum for *your* selected plan per *beneficiary* per *period of cover*.

REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
Paid in full	Paid in full	Paid in full

We will pay for the following scans on an *outpatient* basis if they are recommended by a *specialist* part of *beneficiary's outpatient treatment*:

- magnetic resonance imaging (MRI);
- computed tomography (CT); and/or
- positron emission tomography (PET).

Physiotherapy *treatment*

Up to the annual overall benefit maximum for *your* selected plan per *beneficiary* per *period of cover*.

REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
Paid in full Maximum of 15 visits	Paid in full Maximum of 30 visits	Paid in full

- Physiotherapy *treatment* on an *outpatient* basis that is *medically necessary* and restorative in nature to help *you* to carry out *your* normal activities of daily living. The *treatment* must be carried out by a properly qualified practitioner who holds the appropriate license to practice in the country where the *treatment* is received. This excludes any sports medicine *treatment*.

Osteopathy and chiropractic *treatment*

Up to the annual overall benefit maximum for *your* selected plan per *beneficiary* per *period of cover*.

REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
Paid in full up to a combined maximum of 10 visits	Paid in full up to a combined maximum of 15 visits	Paid in full

- *Treatment* includes a combined maximum total of visits in any one *period of cover* for osteopathy and chiropractic *treatment* which is *evidence-based treatment*, *medically necessary* and recommended by a treating *specialist*, if a *medical practitioner* recommends the *treatment* and provides a referral. The *treatment* must be carried out by a properly qualified practitioner who holds the appropriate license to practice in the country where the *treatment* is received. *We* will require a medical report and *treatment* plan prior to approval. This excludes any sports medicine *treatment*.

Acupuncture

Up to the total limit shown for *your* selected plan per *beneficiary* per *period of cover* or where "paid in full" is shown this is up to the annual overall benefit maximum for *your* selected plan per *beneficiary* per *period of cover*.

REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
AED 3,500 ($1,000)	Paid in full	Paid in full

- *Treatment* administered by a registered Acupuncturist, when those *treatments* are recommended by a *medical practitioner*. The *treatment* must be carried out by a properly qualified practitioner who holds the appropriate license to practice in the country where the *treatment* is received.
- *We* will not pay for any other types of alternate therapies or *treatment*, including but not limited to Naturopathy, Herbal Medicine, Reiki or Hypnotism.

Emergency dental and gum *treatment*

Up to the annual overall benefit maximum for *your* selected plan per *beneficiary* per *period of cover*.

REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
Paid in full	Paid in full	Paid in full

- Dental or gum *treatment*, in the case of a medical emergency immediately after damage to *sound natural teeth* or gums on an *outpatient* basis.
- This *benefit* is paid instead of any other dental *benefits* the *beneficiary* may be entitled to in these circumstances.

Restorative speech therapy

Up to the total limit shown for *your* selected plan per *beneficiary* per *period of cover* or where "paid in full" is shown this is up to the annual overall benefit maximum for *your* selected plan per *beneficiary* per *period of cover*.

REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
AED 9,000 ($2,500)	AED 18,000 ($5,000)	Paid in full

Restorative speech therapy if:

- it is required immediately following *treatment* which is covered under this *policy* (for example, as part of a *beneficiary's* follow-up care after they have suffered a stroke);
- it is confirmed by a *specialist* to be *medically necessary* on a *short-term* basis.

Important notes:

- *We* will only pay for speech therapy if the aim of that therapy is to restore impaired speech function.
- *We* will not pay for speech therapy which:
  - aims to improve speech skills which are not fully developed;
  - is educational in nature;
  - is intended to maintain speech communication;
  - aims to improve speech or language disorders (such as stammering); or
  - is as a result of learning difficulties, developmental problems (such as dyslexia), attention-deficit hyperactivity disorder or autism.

Prescribed drugs and dressings

Up to the total limit shown for *your* selected plan per *beneficiary* per *period of cover* or where "paid in full" is shown this is up to the annual overall benefit maximum for *your* selected plan per *beneficiary* per *period of cover*.

REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
AED 9,000 ($2,500)	AED 18,000 ($5,000)	Paid in full

- Prescription drugs and dressings which are prescribed by a *medical practitioner* on an *outpatient* basis.

Important note:

- Any treatment or costs, for or relating to, *Gene Therapy or Genetic Therapy* is not covered.

Rental of durable equipment

Up to the total limit shown for *your* selected plan per *beneficiary* per *period of cover* or where "paid in full" is shown this is up to the annual overall benefit maximum for *your* selected plan per *beneficiary* per *period of cover*.

REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
AED 9,000 ($2,500)	AED 18,000 ($5,000)	Paid in full

- Rental of durable medical equipment for up to 45 days per *period of cover*, if the use of that equipment is recommended by a *specialist* in order to support the *beneficiary's treatment*.
- *We* will only pay for the rental of durable medical equipment which:
  - is not disposable, and is capable of being used more than once;
  - serves a medical purpose;
  - is fit for use in the home; and
  - is of a type only normally used by a person who is suffering from the effect of a disease, illness or *injury*.

Adult vaccinations

Up to the total limit shown for *your* selected plan per *beneficiary* per *period of cover* or where "paid in full" is shown this is up to the annual overall benefit maximum for *your* selected plan per *beneficiary* per *period of cover*.

REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
AED 2,000 ($550)	AED 7,500 ($2,000)	Paid in full

- The following vaccinations and immunisations that are clinically appropriate, namely:
  - Influenza (flu);
  - Tetanus (once every 10 years);
  - Hepatitis A;
  - Hepatitis B;
  - Meningitis;
  - Rabies;
  - Cholera;
  - Yellow Fever;
  - Japanese Encephalitis;
  - Polio booster;
  - Typhoid; and
  - Malaria (in tablet form, either daily or weekly).
  - Adult Pneumococcal Conjugate Vaccine

Well child tests

Up to the total limit shown for *your* selected plan per *beneficiary* per *period of cover* or where "paid in full" is shown this is up to the annual overall benefit maximum for *your* selected plan per *beneficiary* per *period of cover*.

REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
AED 9,000 ($2,500)	Paid in full	Paid in full

Payable for children at *appropriate age intervals* up to the age of 6.

We will pay for well child routine tests at any of the *appropriate age intervals* (birth, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 2 years, 3 years, 4 years, 5 years and 6 years) and for a *medical practitioner* to provide preventative care consisting of:

- evaluating medical history;
- physical examinations;
- development assessment;
- anticipatory guidance; and
- appropriate laboratory tests for children aged 6 or younger.

We will pay for one visit to a *medical practitioner* at each of the *appropriate age intervals* (up to a total of 13 visits for each child) for the purposes of receiving preventative care services.

In addition, *we* will pay for:

- one school entry health check, to assess growth, hearing and vision, for each child aged 6 or younger.
- diabetic retinopathy screening for children over the age of 12 and up to age 17 years who have diabetes.

Child vaccinations and immunisations

Up to the annual overall benefit maximum for *your* selected plan per *beneficiary* per *period of cover*.

REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
Paid in full	Paid in full	Paid in full

The following vaccinations and immunisations as appropriate, for children aged 17 or younger:

- DPT (Diphtheria, Pertussis and Tetanus);
- MMR (Measles, Mumps and Rubella);
- HiB (Haemophilus influenza type b);
- Polio;
- Influenza;
- Hepatitis B;
- Meningitis; and
- Human Papilloma Virus (HPV).

Important note:

The *benefit* includes vaccinations and immunisations as per the guidelines set by the Dubai Ministry of Health.

Annual routine tests for children aged 15 or younger

Up to the total limit shown for *your* selected plan per *beneficiary* per *period of cover* or where "paid in full" is shown this is up to the annual overall benefit maximum for *your* selected plan per *beneficiary* per *period of cover*.

REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
AED 9,000 ($2,500)	Paid in full	Paid in full

We will pay for the following routine tests for children aged 15 or younger:

- 1 eye examination; and
- 1 hearing test.

Routine adult physical examination

Up to the total limit shown for *your* selected plan per *beneficiary* per *period of cover*.

REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
AED 550 ($150)	AED 1,100 ($300)	AED 1,650 ($450)

- Routine adult physical examination (including: height, weight, body mass index, skin check, blood test (cholesterol, glucose level), urinalysis, blood pressure, cardiac examination, neurological examinations and vital organ functions) for persons aged 18 or older.

Diabetes screening

Up to the annual overall benefit maximum for *your* selected plan per *beneficiary* per *period of cover*.

REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
Paid in full	Paid in full	Paid in full

- Diabetes screening coverage every 3 years for low risk individuals from age 30 years, and also for high risk individuals annually from age 18 years.

Cancer screening

Up to the annual overall benefit maximum for *your* selected plan per *beneficiary* per *period of cover*.

REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
Paid in full	Paid in full	Paid in full

1 annual screening/test for each of the following if applicable

- Breast *Cancer* screening:
  - Asymptomatic Women Aged 40-69: Breast awareness consultation, Clinical Breast Exam (CBE) every year, Mammography every 2 years
- Cervical *Cancer* screening:
  - Asymptomatic Women Aged 25-49: Papanicolaou test (pap smear) every 3 years
  - Asymptomatic Women Aged 50-65: Papanicolaou test (pap smear) every 5 years
- Bowel *Cancer* screening:
  - Asymptomatic Men and Women Aged 40-75: Colonoscopy every 10 years; or Fecal Immunochemical Test (FIT) every 2 years.
  - Eligible population must be offered colonoscopy screening first, as baseline. In case of refusal, the patient should be offered a Fecal Immunochemical Test (FIT).
- Prostate *Cancer* screening:
  - Asymptomatic Men Aged 50-75: Prostate examination (prostate specific antigen (PSA) test) every year

Hepatitis B & C Virus screening

Up to the annual overall benefit maximum for *your* selected plan per *beneficiary* per *period of cover*.

REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
Paid in full	Paid in full	Paid in full

- We pay for Hepatitis B & C screening and *treatment* in accordance with Dubai Health Authority (DHA) Hepatitis B & C guidelines.

Treatment for accidental hearing loss

Up to the annual overall benefit maximum for *your* selected plan per *beneficiary* per *period of cover*.

REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
Paid in full	Paid in full	Paid in full

- *We* will pay for *treatment* for accidental hearing loss as a result of a medical emergency or as a result of a life threatening condition.

Hearing and vision aids and vision correction by surgeries and laser in a medical emergency

Up to the annual overall benefit maximum for *your* selected plan per *beneficiary* per *period of cover*

REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
Paid in full	Paid in full	Paid in full

- *We* will pay for hearing and vision aids, and vision correction by *surgery* and laser as a result of a medical emergency or as a result of a life threatening condition.

Preventative dental *treatment*

Three (3) months waiting period applies.

Up to the total limit shown for *your* selected plan per *beneficiary* per *period of cover*.

REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
AED 550 ($150)	AED 1,100 ($300)	AED 1,650 ($450)

We will pay for the following preventative *dental treatment* recommended by a *dentist*:

- 2 dental check-ups per *period of cover* including scaling and polishing (topical fluoride application if required).

Homeopathy, Ayurveda and Chinese medicine

Up to the total limit shown for *your* selected plan per *beneficiary* per *period of cover* or where "paid in full" is shown this is up to the annual overall benefit maximum for *your* selected plan per *beneficiary* per period of cover.

REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
AED 3,500 ($1,000)	Paid in full	Paid in full

Treatment administered by a registered Homeopath, Ayurvedic & Chinese medicine practitioner, when those *treatments* are recommended by a *medical practitioner.* The *treatment* must be carried out by a properly qualified practitioner who holds the appropriate license to practice in the country where the *treatment* is received.

MEDICAL EVACUATION BENEFITS

Medical Evacuation and Repatriation service provides coverage for reasonable transportation costs to the nearest centre of medical excellence in the event that the *treatment* is not available locally in an emergency. This service also includes repatriation coverage. It also includes compassionate visits for a parent, *spouse*, partner, sibling or child to visit a *beneficiary* after an accident or sudden illness and the *beneficiary* has not been evacuated or repatriated.

Medical Evacuation	REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
	Paid in full	Paid in full	Paid in full

Transfer to the nearest centre of medical excellence if the *treatment* the *beneficiary* needs is not available locally in an emergency.

If a *beneficiary* requires *emergency treatment*, *we* will pay for medical evacuation for them:

- to be taken to the nearest *hospital* where the necessary *treatment* is available (even if this is in another part of the country, or in another country); and
- to return to the place they were taken from, provided the return journey takes place not more than 14 days after the *treatment* is completed.

As regards to the return journey, *we* will pay:

- the price of an economy class air ticket; or
- the reasonable cost of travel by land or sea; whichever is lesser.

We will only pay for taxi fares if:

- it is medically preferable for the *beneficiary* to travel to the airport by taxi, rather than by ambulance; and
- approval is obtained in advance from the *medical assistance service*.

We will pay for evacuation (but not repatriation) if the *beneficiary* needs *diagnostic tests* or *cancer treatment* (such as chemotherapy) if, in the opinion of our *medical assistance service*, evacuation is appropriate and *medically necessary* in the circumstances.

We will not pay any other costs related to an evacuation (such as accommodation costs).

Important note:

If *you* require to return to the *hospital* where *you* were evacuated for follow up *treatment*, *we* will not pay for travel costs or living allowance costs.

Medical repatriation	REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
	Paid in full	Paid in full	Paid in full

If a *beneficiary* requires a medical repatriation, *we* will pay:

- for them to be returned to their country of habitual residence or *country of nationality*; and
- to return them to the place they were taken from, provided the return journey takes place not more than 14 days after the *treatment* is completed.

The above journey must be approved in advance by *our medical assistance service* and to avoid doubt all transportation costs are required to be *reasonable and customary*.

As regards to the return journey, *we* will pay:

- the price of an economy class air ticket; or
- the reasonable cost of travel by land or sea; whichever is lesser.

We will only pay for taxi fares if:

- it is medically preferable for the *beneficiary* to travel to the airport by taxi, rather than by ambulance; and
- approval is obtained in advance from the *medical assistance service*.

We will not pay any other costs related to a repatriation (such as accommodation costs).

Important notes:

- If *you* require to return to the *hospital* where *you* were repatriated for follow up *treatment*, *we* will not pay for travel costs or living allowance costs.
- If a *beneficiary* contacts the *medical assistance service* to ask for prior approval for repatriation, but the *medical assistance service* does not consider repatriation to be *medically appropriate*, *we* may instead arrange for the *beneficiary* to be evacuated to the nearest *hospital* where the necessary *treatment* is available. *We* will then repatriate the *beneficiary* to his or her specified *country of nationality* or country of habitual residence when his or her condition is stable, and it is *medically appropriate* to do so.

Repatriation of mortal remains	REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
	Paid in full	Paid in full	Paid in full

- If a *beneficiary* dies outside their country of habitual residence during the *period of cover*, the *medical assistance service* will arrange for their mortal remains to be returned to their country of habitual residence or *country of nationality* as soon as reasonably practicable, subject to airlines requirements and restrictions.
- *We* will not pay any costs associated with burial or cremation or the transport costs for someone to collect or accompany the *beneficiary's* mortal remains.

Travel costs for accompanying person	REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
	Paid in full	Paid in full	Paid in full

If a *beneficiary* needs a parent, sibling, child, *spouse* or partner, to travel with them on their journey in conjunction with a medical evacuation or repatriation, because they:

- need help getting on or off an aeroplane or other vehicle;
- are travelling 1000 miles (or 1600km) or further;
- are severely anxious or distressed, and are not being accompanied by a nurse, paramedic or other medical escort; or
- are very seriously ill or injured;

we will pay for a relative or partner to accompany them. The journeys (for the avoidance of doubt shall mean one outbound and one return) must be approved in advance by the *medical assistance service* and the return journey must take place not more than 14 days after the *treatment* is completed.

We will pay:

- the price of an economy class air ticket; or
- the reasonable cost of travel by land or sea; whichever is the lesser.

If it is appropriate, considering the *beneficiary's* medical requirements, the family member or partner who is accompanying them may travel in a different class. If it is *medically necessary* for a *beneficiary* to be evacuated or repatriated, and they are going to be accompanied by their *spouse* or partner, *we* will also pay the reasonable travel costs of any children aged 17 or under, if those children would otherwise be left without a parent or guardian.

Important notes:

We will not pay for a third party to accompany a *beneficiary* if the original purpose of the evacuation was to enable the *beneficiary* to receive *outpatient treatment*.

We will not pay for any other costs relating to third party travel costs, such as accommodation or local transportation.

Compassionate visits - travel costs	REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
Up to a maximum of 5 trips per lifetime. Up to the total limit shown for *your* selected plan per *beneficiary* per *period of cover*	AED 3,500 ($1,000)	AED 4,500 ($1,250)	AED 4,500 ($1,250)

Compassionate visits - living allowance costs	REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
Up to the total limit shown per day for each visit with a maximum of 10 days per visit	AED 600 ($150)	AED 750 ($200)	AED 750 ($200)

- For each *beneficiary we* will pay for up to 5 compassionate visits over the lifetime of the cover. Compassionate visits must be approved in advance by *our medical assistance service*.
- *We* will pay the cost of economy class return travel for a parent, spouse, partner, sibling or child to visit a *beneficiary* after an accident or sudden illness, if the *beneficiary* is in a different country and is anticipated to be *hospitalised* for 5 days or more, or has been given a *short-term* terminal prognosis.
- *We* will also pay for living expenses incurred by a family member during a compassionate visit, for up to 10 days per visit while they are away from their country of habitual residence up to the limits shown in the *list of benefits* (subject to being provided with receipts in respect of the costs incurred).

Important note:

We will not pay for a compassionate visit when the *beneficiary* has been evacuated or repatriated. If an evacuation or repatriation takes place during a compassionate visit, *we* will not pay any further third party transportation costs.

IMPORTANT NOTES

The following important notes and general conditions apply to all of the cover which is provided under the Medical Evacuaton and Repatriation service benefits.

The Medical Evacuation and Repatriation service *benefits* detailed as 'Paid in Full' are not subject to the overall annual *benefit* maximum.

The services described in this section are provided or arranged by the *medical assistance service under* this *policy*. The following conditions apply to both emergency medical evacuations and repatriations:

- all evacuations and repatriations must be approved in advance by the *medical assistance service*, which is contactable through the Customer Care Team;
- the *treatment* for which, or following which, the evacuation or repatriation is required must be recommended by a *qualified nurse* or *medical practitioner*;
- evacuation and repatriation services are only available under this *policy* if the *beneficiary* is being treated (or needs to be treated) on an *inpatient* or *daypatient basis*;
- the *treatment* because of which the evacuation or repatriation service is required must:
    - be *treatment* for which the *beneficiary* is covered under this *policy*; and
    - not be available in the location from which the *beneficiary* is to be evacuated or repatriated;
- the *beneficiary* must have cover in the *selected area of coverage* which includes the country where the *treatment* will be provided after the evacuation or repatriation.
- *We* will only pay for evacuation or repatriation services if all arrangements are approved in advance by *our medical assistance service*. In order for *us* to provide approval, *we* must be provided with any information or proof that *we* may reasonably request;
- *We* will not approve or pay for an evacuation or repatriation if, in *our* reasonable opinion, it is not appropriate, or if it is against medical advice. In coming to a decision as to whether an evacuation or repatriation is appropriate, *we* will refer to established clinical and medical practice;
- From time to time *we* may carry out a review of this cover and reserve the right to contact *you* to obtain further information when it is reasonable for *us* to do so.

GENERAL CONDITIONS

- Where local conditions make it impossible, impractical, or unreasonably dangerous to enter an area, for example because of political instability or war, *we* may not be able to arrange evacuation or repatriation services. This *policy* does not guarantee that evacuation or repatriation services will always be available when requested, even if they are *medically appropriate*.
- *We* will only pay for *hospital* accommodation for as long as the *beneficiary* is being treated. *We* will not pay for *hospital* accommodation if a *beneficiary* is no longer being treated but is waiting for a return flight.
- Any medical *treatment* which a *beneficiary* receives before or after an evacuation or repatriation will be paid from the *inpatient*, *daypatient* or *outpatient benefits* provided that the *treatment* is covered under this *policy.*

- *We* cannot be held liable for any delays or lack of availability of evacuation or repatriation services which result from adverse weather conditions, technical or mechanical problems, conditions or restrictions imposed by public authorities, or any other factor which is beyond *our* reasonable control.
- *We* will only pay for evacuation, repatriation and third party transportation if the *treatment* for which, or because of which, the evacuation or repatriation is necessary is covered under this *policy*.
- All decisions as to:
    - the medical necessity of evacuation or repatriation;
    - the means and timing of any evacuation or repatriation;
    - the medical equipment and medical personnel to be used; and
    - the destination to which the *beneficiary* should be transported;

    will be made by *our medical team*, after consultation with the *medical practitioners* who are treating the *beneficiary,* taking into account all of the relevant medical factors and considerations.

OPTIONAL COVERAGE

HEALTHY CONNECT

HEALTHY CONNECT

In addition to the core medical offering, *our* Healthy Connect optional module includes a wide range of *benefits* that will help *you* take control and pro-actively manage the health and wellbeing of *you* and *your* family. The *benefits* range from comprehensive *dental treatment*, eye examination, enhanced health screenings and tests, life management assistance and dietetic consultations. What's more, *we* understand that there are times when *you* would prefer to have *treatment* in familiar surroundings with family members close by; for those *beneficiaries* whose *country of nationality* is not the *UAE*, Healthy Connect also includes a Return home cash *benefit*, making it possible to return home, should the need arise.

Healthy Connect can only be purchased at the inception of *your policy,* during the first 30 days or at Renewal, in conjunction with the Core plan and is required to be purchased for all *beneficiaries*.

WELLNESS

Enhanced adult physical examination

Up to the total limit shown for *your* selected plan per *beneficiary* per *period of cover*.

REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
AED 1,500 ($400)	AED 2,000 ($550)	AED 3,500 ($1,000)

- 1 enhanced adult physical examinations (including: full biochemistry profile (liver and kidney function), lung function test, spinal assessment, advanced cardiovascular test (ECG or Aerobic fitness test), body metabolism test (Resting Metabolic rate (RMR), VO2 max test), chest X-Ray (if clinically indicated)), for persons aged 18 or older.

Screening and tests

Up to the total limit shown for *your* selected plan per *beneficiary* per *period of cover*.

REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
AED 2,750 ($750)	AED 5,500 ($1,500)	AED 11,000 ($3,000)

1 screening/test for each of the following if applicable:

- Genetic *cancer* screening as per Cigna medical guidelines:
  - 1 genetic test per lifetime for *beneficiaries* aged 25 and over with an increased risk of breast and ovarian *cancer*, including BRCA1 and BRCA2 where a direct family (bloodline) history exists.
- Bone densitometry:
  - 1 scan to determine the density of the *beneficiary's* bones.
- Allergy Test:
  - 1 series of tests with a qualified *specialist* to determine common allergies if *medically necessary* in accordance to *Cigna* medical guidelines.

Dietetic consultations

Up to the total limit shown for *your* selected plan per *beneficiary* per *period of cover* or where "paid in full" is shown this is up to the annual overall benefit maximum for *your* selected plan per *beneficiary* per *period of cover*.

REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
AED 1,500 ($400)	AED 2,000 ($550)	Paid in full

- Up to 4 consultations with a dietician per *period of cover*, if the *beneficiary* requires dietary advice relating to a diagnosed disease or illness such as diabetes.

Life management assistance programme

REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
Paid in full	Paid in full	Paid in full

- *Our* Life management assistance programme is available 24 hours a day, 7 days a week, 365 days a year meaning *you* can contact the service for access to free, confidential assistance with any work, life, personal or family issue that matters to *you* at a time that is suitable for *you*.
- This service covers *short-term* counselling, in-the-moment telephone support, and information about local resources:
  - *We* will pay for up to 6 counselling sessions per issue per *period of cover*. This could be telephonic or face to face counselling support.
  - *You* have access to unlimited in the moment telephonic support for live assistance.
  - Provides information, resources and counselling on any work, life, personal, or family issue that matters to *you*.
- The information service can provide support and resources to assist with *your* day to day demands such as childcare arrangements or relocation logistics. The information *specialists* can perform research and provide pre-qualified referrals for local resources in the domain of legal, financial or family care services.

Please contact *us* for approval. The service is provided by *our* chosen counselling provider.

VISION CARE

Routine eye examination Up to the annual overall benefit maximum for *your* selected plan per *beneficiary* per *period of cover*.	REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
	Paid in full	Paid in full	Paid in full

› 1 routine eye examination per *period of cover* to be carried out by either an ophthalmologist or optometrist.

We will not pay for more than 1 eye examination in any one *period of cover*.

Expenses for: › Spectacle lenses; › Contact lenses; › Spectacle frames; › Prescription sunglasses; when all are prescribed by an optometrist or ophthalmologist. Up to the total limit shown for *your* selected plan per *beneficiary* per *period of cover*.	REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
	AED 600 ($150)	AED 900 ($250)	AED 2,000 ($550)

› *We* will not pay for:
- sunglasses, unless medically prescribed by an ophthalmologist or optometrist;
- glasses or lenses which are not *medically necessary* or not prescribed by an ophthalmologist or optometrist; or
- *treatment* or *surgery*, including *treatment* or *surgery* which aims to correct eyesight, such as laser eye *surgery*, refractive keratotomy (RK) or photorefractive keratectomy (PRK).

› A copy of a prescription or invoice for corrective lenses will need to be provided to *us* in support of any claim for frames.

RETURN HOME CASH BENEFIT

Return home cash *benefit* Up to the total limit shown for *your* selected plan per *beneficiary* per *period of cover*.	REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
	AED 900 ($250)	AED 3,000 ($800)	AED 5,500 ($1,500)

If a *beneficiary* requests to travel back to their *country of nationality* for *medically necessary inpatient* or *daypatient treatment*, *we* will make a cash payment directly to the *beneficiary*:

› to receive *treatment* in a *hospital* which is covered under the limits of this plan and within the *beneficiary's selected area of coverage*.

› if it is *medically appropriate* for the *beneficiary* to travel back to their *country of nationality*.

As regards to the return journey, *we* will pay the price of reasonable costs for an economy class air ticket for the *beneficiary* requiring *treatment*.

Important notes:

› The *benefit* is not payable in respect of any *pre-existing conditions*;

› All *treatment* must be approved in advance by our customer care team;

› The air ticket excludes the cost of an air ambulance;

› The *beneficiary* will receive reimbursement once the *treatment* has been completed;

› Evidence of the air ticket and cost is required prior to any reimbursement;

› *We* will not pay for any other costs related to the journey home including; accommodation costs, other transport costs to and from the *hospital*, living allowance expenses or for anyone accompanying the *beneficiary* on the journey;

› *We* will not pay for *hospital* accommodation if a *beneficiary* is no longer being treated but is waiting for a return flight; and

› If the *beneficiary* is unable to return to their expatriate location following *treatment*, *we* may need to exercise *our* right to terminate the *policy*.

DENTAL CARE

Annual *benefit* - maximum per *beneficiary* per *period of cover*	REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
	AED 4,500 ($1,250)	AED 11,000 ($3,000)	AED 24,000 ($6,550)

Preventative *dental treatment*	REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
No waiting period applies. Up to the overall annual Dental Care benefit maximum.	Paid in full	Paid in full	Paid in full

We will pay for the following preventative *dental treatment* recommended by a *dentist*:

- 2 dental check-ups per *period of cover*;
- X-rays, including bitewing, single view, and orthopantomogram (OPG);
- scaling and polishing including topical fluoride application when necessary (2 per *period of cover*);
- 1 mouth guard per *period of cover*;
- 1 night guard per *period of cover*; and
- fissure sealant.

The dental *treatment* included in this *benefit* and the preventative dental *treatment* included in the core *outpatient benefits* are not cumulative and does not result in a combined aggregate limit payable.

Routine *dental treatment*	REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
After the *beneficiary* has been covered on the Healthy Connect module for three (3) months. Up to the overall annual Dental Care benefit maximum.	Paid in full	Paid in full	Paid in full

Treatment costs for the following routine *dental treatment* after the *beneficiary* has been covered on the Healthy Connect optional module for 3 months (if that *treatment* is necessary for continued oral health and is recommended by a *dentist*):

- dental fillings;
- root canal *treatment*;
- extractions;
- surgical procedures;
- occasional *treatment*;
- anaesthetics; and
- periodontal *treatment*.

Major restorative *dental treatment*	REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
After the *beneficiary* has been covered on the Healthy Connect module for twelve (12) months. Up to the overall annual Dental Care benefit maximum.	Paid in full 20% *Co-Pay* applies	Paid in full 20% *Co-Pay* applies	Paid in full 20% *Co-Pay* applies

Treatment costs for the following major restorative *dental treatment* after the *beneficiary* has been covered on the Healthy Connect option for 12 months:

- dentures (acrylic/synthetic, metal and metal/acrylic);
- crowns;
- inlays; and
- placement of dental implants.

If a *beneficiary* needs major restorative *dental treatment* before they have had Healthy Connect cover for 12 months, *we* will pay 50% of the *treatment* costs.

Orthodontic *treatment* After the *beneficiary* has been covered on the Healthy Connect module for eighteen (18) months. Up to the overall annual Dental Care *benefit* maximum.	REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
	Not covered	Paid in full 50% *Co-Pay* applies	Paid in full 50% *Co-Pay* applies

Treatment for *beneficiaries* aged 18 years old or younger after the *beneficiary* has been covered on the Healthy Connect option for 18 months.

We will only pay for orthodontic *treatment* if:

- the dentist or orthodontist who is going to provide the *treatment* provides us, in advance, with a detailed description of the proposed *treatment* (including X-rays and models), and an estimate of the cost of *treatment*; and
- *we* have approved the *treatment* in advance.

IMPORTANT NOTES

The following important notes and exclusions apply to the Dental care *benefits* within the Healthy Connect module.

If a *beneficiary* requires a form of *dental treatment* which is not provided for in the Healthy Connect optional module, they may contact *us* (before the *treatment* is received) to enquire whether *we* will provide cover for that *treatment*. *We* will consider the request, and will decide, at *our* discretion:

- whether *we* will pay for the *treatment*;
- if so, whether *we* will pay all or part of the cost; and
- which of the areas of cover it will come within (for the purposes of calculating when limits of cover are reached).
- prior approval should be obtained before any *treatment* is received.

DENTAL EXCLUSIONS

The following exclusions apply to *dental treatment*, in addition to those set out elsewhere in this *policy* and in *your Certificate of Insurance.*

- *We* will not pay for:
  - Purely *cosmetic treatments*, or other *treatments* which are not necessary for continued or improved *oral health*.
  - The replacement of any dental appliance which is lost or stolen, or associated *treatment*.
  - The replacement of a bridge, crown or denture which (in the reasonable opinion of a *dentist* of ordinary competence and skill in the *beneficiary's country of habitual residence*) is capable of being repaired and made usable.
  - The replacement of a bridge, crown or denture within five years of its original fitting unless:
    - it has been damaged beyond repair, whilst in use, as a result of a *dental injury* suffered by the *beneficiary* whilst they are covered under this *policy;* or
    - the replacement is necessary because the *beneficiary* requires the extraction of a *sound natural tooth/ teeth*; or
    - the replacement is necessary because of the placement of an original opposing full denture.
  - Acrylic or porcelain veneers.
  - Crowns or pontics on, or replacing, the upper and lower first, second and third molars unless:

    - they are constructed of either porcelain; bonded-to-metal or metal alone (for example, a gold alloy crown); or
    - a temporary crown or pontic is necessary as part of routine or emergency *dental treatment*.
- *Treatments*, procedures and materials which are experimental or do not meet generally accepted dental standards.
- *Treatment* for dental implants directly or indirectly related to:
    - failure of the implant to integrate;
    - breakdown of osseointegration;
    - peri-implantitis;
    - replacement of crowns, bridges or dentures; or
    - any accident or *emergency treatment* including for any prosthetic device.
- Advice relating to plaque control, oral hygiene and diet.
- Services and supplies, including but not limited to mouthwash, toothbrush and toothpaste.
- Medical *treatment* carried out in *hospital* by an oral *specialist* may be covered under *Your* Standard Medical Benefits, except when *dental treatment* is the reason for *you* being in *hospital*.
- Orthodontic *treatment* for anyone after their 19th birthday.
- Bite registration, precision or semi-precision attachments.
- Any *treatment*, procedure, appliance or restoration (except full dentures) if its main purpose is to:
    - change vertical dimensions; or
    - diagnose or treat *conditions* or dysfunction of the temporomandibular joint; or
    - stabilise periodontally involved teeth; or
    - restore occlusion.
    - major treatment on deciduous or baby teeth for dependant children.

OPTIONAL COVERAGE

MOTHER AND BABY CARE

MOTHER AND BABY CARE

Mother and Baby Care provides enhanced cover for the expectant mother during and after pregnancy; including pre and post natal tests and examinations, routine maternity and homebirth, as well as newborn care and non-life threatening *congenital conditions* and birth defects, ensuring both mother and baby have access to a more comprehensive cover. This module can only be purchased upon *policy* inception, within the first 30 days or renewal in conjunction with the Core plan and is only available to an *eligible female* aged between eighteen (18) and forty-three (43) years old.

MOTHER AND BABY CARE

Routine maternity, childbirth and elective Caesarean

Available once the mother has been covered on the Mother and Baby Care module for a continuous period of twelve (12) months or more.

Up to the total limit shown for *your* selected plan per *beneficiary* per *period of cover*.

REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
AED 18,000 ($5,000)	AED 25,500 ($7,000)	AED 51,500 ($14,000)

We will pay for routine maternity care, childbirth and elective caesaran costs on an *inpatient* or *daypatient basis* including:

- *hospital*, obstetricians' and midwives' fees for routine childbirth;
- any fees as a result of post-natal care required by the mother immediately following routine childbirth.

We will not pay for surrogacy or any related *treatment*. *We* will not pay for maternity benefit care or *treatment* for a *beneficiary* acting as a surrogate or anyone acting as a surrogate for a *beneficiary*.

Important note:

- A 10% mandatory *Co-Pay* applies to this *benefit*.

Medically necessary caesarean

Available once the mother has been covered on the Mother and Baby Care module for a continuous period of twelve (12) months or more.

Up to the total limit shown for *your* selected plan per *beneficiary* per *period of cover*.

REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
AED 18,000 ($5,000)	AED 36,500 ($10,000)	AED 73,500 ($20,000)

We will pay for *medically necessary* caesarean on an *inpatient* or *daypatient basis*. If *we* cannot confirm that the caesarean was *medically necessary*, *we* will only pay up to the limit of the mother's routine maternity *benefit*.

The plan *benefit* limits for routine maternity in the *benefit* above and a *medically necessary* caesarean, does not result in a combined aggregate limit payable.

Important note:

- A 10% mandatory *Co-Pay* applies to this *benefit*.

Complications arising from maternity and childbirth (non-life threatening)

Available once the mother has been covered on the Mother and Baby Care module for a continuous period of twelve (12) months or more.

Up to the total limit shown for *your* selected plan per *beneficiary* per *period of cover*.

REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
AED 150,000 ($41,000)	AED 150,000 ($41,000)	AED 150,000 ($41,000)

We will pay for complications cost arising from maternity and childbirth on an *inpatient* or *daypatient* basis including:

- *hospital*, obstetricians' and midwives' fees for complicated (non-life threatening) childbirth;
- any fees as a result of post-natal care required by the mother immediately following complicated (non-life threatening) childbirth.

Important note:

- A 10% mandatory *Co-Pay* applies to this *benefit*.

Homebirths

Available once the mother has been covered on the Mother and Baby Care module for a continuous period of twelve (12) months or more.

Up to the total limit shown for *your* selected plan per *beneficiary* per *period of cover*.

REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
AED 1,000 ($270)	AED 2,000 ($550)	AED 4,000 ($1,100)

We will pay midwives' and *specialists*' fees relating to routine home births.

Important note:

- Please note that the Complications from maternity cover explained above does not include cover for home childbirth. This means that any costs relating to complications which arise in relation to home childbirth will only be paid in accordance with the home childbirth limits, as explained in the *list of benefits*.

Newborn Care

Available once the mother has been covered on the Mother and Baby Care module for a continuous period of twelve (12) months or more.

Up to thirty (30) days and to the annual overall benefit maximum for *your* selected plan per *beneficiary* per *period of cover*

REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
Paid in full and up to and including 30 days from newborn's birth.	Paid in full and up to and including 30 days from newborn's birth.	Paid in full and up to and including 30 days from newborn's birth.

We will pay for the following:

- Any illness or defect detected (congenital or otherwise) during pregnancy or evident at or arising up to and including 30 days from birth.
- BCG, Hepatitis B, Vit K and other neo-natal screening tests, including; Phenylketonuria, Congenital Hypothyroidism, Sickle cell screening, Congenital adrenal hyperplasia, G6PD and hearing tests.

Congenital conditions and birth defects (non-life threatening)

Available once the mother has been covered on the Mother and Baby Care module for a continuous period of twelve (12) months or more.

Up to the total limit shown for *your* selected plan per *beneficiary* per *period of cover*.

REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
AED 36,500 ($10,000)	AED 73,500 ($20,000)	AED 140,000 ($39,000)

We will pay for *treatment* of *congenital conditions* and birth defects on an *inpatient*, *outpatient* and *daypatient basis* which are non-life threatening and manifest themselves before the *beneficiary's* 18th birthday if:

- the mother has been covered on the Mother and Baby Care module for a continuous period of 12 months or more prior to the newborn's birth and the newborn is added to the *policy* within 30 days of the birth.

Important note:

- Any treatment or costs, for or relating to, *Gene Therapy or Genetic Therapy* is not covered.

Outpatient Maternity

Available once the mother has been covered on the Mother and Baby Care module for a continuous period of twelve (12) months or more.

Up to the annual overall benefit maximum for *your* selected plan per *beneficiary* per *period of cover*.

REGIONAL	INTERNATIONAL	INTERNATIONAL PLUS
Paid in full Maximum of 8 visits to obstetrician	Paid in full Maximum of 12 visits to obstetrician	Paid in full

- All care provided for low risk or *specialist* obstetrician for high risk referrals.
- All blood tests required during one of the visits to an obstetrician including, initial investigations such as:
  - FBC and Platelets;
  - Blood group, rhesus status and antibodies;
  - VDRL, MSU and urinalysis;
  - Rubella serology;
  - GTT (for high risk patients);
  - FBS, random s or A1.
- 3 ante-natal ultrasound scans;
- Appointment(s) for and tests such as the CTG and Bishops score and a membrane sweep; and
- All visits including reviews, checks and tests in accordance with ante-natal protocols for high risk patients.

Important notes:

- A *Co-Pay* (if selected) will apply for all *outpatient treatments* related to this *benefit*.
- All post-natal *treatment* (other than immediately following delivery and complications) is covered under the applicable *outpatient* care *benefit*.

POLICY TERMS AND CONDITIONS

Words and phrases in italics have the meanings given to them in page 69, '**Definitions'**.

If *you* do not fully understand the terms and *conditions* of this *policy*, or there are any errors or omissions then *you* should contact *us* as soon as possible as this could affect the cover provided to *beneficiaries* by *us* under this *policy.*

The insurance is provided by:
Cigna Insurance Middle East S.A.L
The Offices 3 at One Central
Dubai World Trade Centre
Office No. 111, Level 1
Po Box 3664
Dubai
United Arab Emirates

1. Scope of cover

Subject to the terms, conditions, limits and exclusions set out in this *policy*, *Cigna* will reimburse medical and related expenses relating to *treatment* provided within the selected area of coverage for *injury* and *sickness*. The *treatment* must occur during the *period of cover* and *Co-Pays* and limits of cover may apply. In most circumstances (as outlined in this *policy*) the cost of any *treatments* will only be met or reimbursed in circumstances where they have been prior authorised and relate to *reasonable and customary treatments*.

2. Policy

This *Customer Handbook* (which includes *our Complaints Procedure*), *your application*, *your Certificate of Insurance,* and *your Medical ID Cards* constitute the entire contract between *you* and *us*. *You* should read these *policy documents* carefully.

3. Policy eligibility

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

The *policy* is designed for individuals holding a resident visa and residing in the Emirate of Dubai or the Northern Emirates. *Beneficiaries* may elect to have *treatment* in a country other than the *UAE*. To be covered under this *policy* for *treatment* in a country other than the *UAE,* the country must be in *your* selected area of coverage and *you* must seek our approval in advance. All such visits outside of the UAE during the *period of cover,* must last for a total of less than 180 days (in aggregate) during that *period of cover.*

If a *beneficiary* is outside the *UAE* for more than 180 days (in aggregate during any *period of cover*) *we* reserve the right to restrict cover and *treatment* under this *policy* for the remainder of the *period of cover* to *treatment* in the *UAE* only.

4. When does the cover begin?

4.1

The cover will begin on the *start date* shown on the first *Certificate of Insurance* which *we* send to *you* (or the date of birth for the newborn baby of a *beneficiary* where this occurs during a *period of cover*). The *annual renewal date* will fall on this date each year.

4.2

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

4.3

Where there is a delay between *your application* and the *initial start date* of *your policy* and *your* state of health changes during the period of delay, *you* must let *us* know. *We* may apply additional premiums

as a result of any change to *your* state of health notified to *us*. If *you* fail to inform *us* of any change to *your* state of health during the period of delay, *we* may treat this as a misrepresentation, which could affect coverage under *your policy* or payment of claims.

5. Treatment for pre-existing conditions

5.1

We will cover the costs of *pre-existing conditions* which *you* have disclosed for any *beneficiary* as part of *your* medical questionnaire during the *application* stage. Any *pre-existing conditions* will be reviewed by *us*. The outcome of *our* decision will be communicated to *you* during the *application* process in *our underwriting summary form*.

We will, except in a number of limited circumstances, apply an annual cumulative *benefit* limit of AED 150,000 per *beneficiary* per *period of cover* for the cover of all *pre-existing conditions*.

Please note that where an individual *benefit* limit is identified within the *list of benefits*, this is the limit that will apply for that *benefit* irrespective of the annual cumulative benefit limit which is applied for the cover of all *pre-existing conditions*. Any individual *benefit* limit will form part of the annual cumulative limit for the cover of all *pre-existing conditions*.

We also reserve the right, at *our* sole discretion, to apply an additional premium to cover the *treatment* of the *pre-existing conditions*. If we do so, this will be communicated to you as part of the underwriting summary form.

Any *pre-existing conditions* and/or any pre-existing chronic conditions subject to the annual cumulative *benefit* limit and/or to an additional premium for the *pre-existing conditions* for each *beneficiary* will be detailed on *your Certificate of Insurance*.

5.2 Non-disclosure of pre-existing conditions

If *you* fail to inform *us* about a *condition* which *we* reasonably believe to have existed prior to the *initial start date* of *your policy* (whether the *condition* was already present, or *you* had received *treatment*, tests or investigations or had signs or symptoms, or taken advice from a *medical practitioner*); this could (subject to local law and regulation) result in *us* reducing the amount of any claims payment, which *you* are due, refusing to pay a claim or claims related to such *condition* altogether or to terminate *your policy* in accordance with Clause 19.1.4.

Where *we* become aware of, or reasonably expect there to be, an undisclosed *pre-existing condition(s)*, whether intentionally or not, except in case of *policy* termination in accordance with Clause 19.1.4, *you* will be presented with two (2) options:

(1) Apply the additional premium identified by *us* as payable to cover any *pre-existing conditions* subject to the annual cumulative *benefit* limit of AED 150,000 for the remaining *period of cover*; or

(2) Exclude the *pre-existing conditions* and all related *treatments* for the remaining *period of cover*.

You must confirm to *us your* selected option within thirty (30) days of these options being presented to *you*. Please note *we* will not pay any claims related to any *pre-existing conditions* until *you* confirm *your* selected option. A new *Certificate of Insurance* will be issued detailing the changes related to the *pre-existing conditions*.

Upon renewal *you* will be required to submit an updated *application* form including a fully completed medical questionnaire that will be reviewed by *us*. *We* may apply an additional premium and/or the annual cumulative *benefit* limit of AED 150,000 for *pre-existing conditions* at this time. Any decision will be communicated to *you* through the *underwriting summary form*

and a new *Certificate of Insurance* will be issued detailing the changes related to any *pre-existing condition* cover.

6. When does the cover end?

6.1

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

6.2

Cover will automatically end for any *beneficiary* if:

6.2.1

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

6.2.2

the *policy* is terminated. The circumstances in which *you* or *we* can terminate the *policy* are explained more fully in Clause 19.

6.3

If *you* die, cover will end for all *beneficiaries*. If this happens, *we* will try to contact any other *beneficiaries* who are covered under this *policy*, and offer them the opportunity to continue the cover until the *end date*, with one of them taking over as *policyholder*. If the *beneficiary* does wish to continue the cover, they must respond, in writing, within thirty (30) days, to confirm their acceptance. If they do not do so, all cover will end, and *we* will not make any payments in relation to *treatment* or services which are received on or after the date on which the cover ends.

6.4

If this *policy* ends before the normal *end date*, any premium which has been paid in relation to the period after cover has ended will be refunded on a pro rata basis, so long as no claims have been made and no *guarantees of payment* or *prior authorisations* or other pre-approval have been put in place during the *period of cover*. However, if the *policy* ends before the normal *end date* and *you* or a *beneficiary* has made claims or received a *guarantee of payment* or *prior authorisation* under it, *you* will not (subject to local law and regulation and excluding any *beneficiaries* who have had their visa cancelled by their individual sponsor) be entitled to any refund of premium and will be liable to pay *us* the premium for the whole period *of cover*.

7. How is the policy renewed?

7.1

If *we* determine to renew the *policy* then *we* will write to *you* forty-five (45) days before the *end date* and ask *you* whether *you* want to renew the cover *you* currently have. *We* will also inform *you* of any changes to the premiums, terms and *conditions*, definitions or *benefits*, which will apply on renewal.

7.2

If *you* choose to renew, *you* should let *us* know in writing at least thirty (30) days prior to *your policy end date* and *your* cover will be renewed automatically for another twelve (12) months. If *you* do not want to renew *your* cover, *you* must let *us* know at least thirty (30) days before *your policy end date*. Renewal is subject to the terms and conditions, exclusions, definitions and *benefits* of the current *Customer Handbook* in force at the time of renewal.

If *we* determine not to renew *your* cover (including for the reasons detailed in 19.1) *we* will give *you* notice as described in 19.5. Any decision by *Cigna* not to renew shall not be based on *your* claims history or any illness, *injury* or *condition* suffered by any *beneficiaries*.

7.3

If *you* do not renew *your* cover, any *beneficiaries* who have been covered under the *policy* and who meet the *policy* eligibility criteria 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.

8. Who is covered?

8.1

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

9. Can I add or remove beneficiaries part way through the period of cover?

9.1

Yes. If *you* would like to add a new *beneficiary* during the *period of cover*, *you* must send *us* a completed *application* for that person. *We* will then tell *you* any additional premium which would apply. Cover for the new *beneficiary* will begin from the date on which *you* confirm *your* acceptance. *We* will send *you* an updated *Certificate of Insurance* to confirm that the new *beneficiary* has been added.

9.2

If *you* or *your spouse* gives birth, *you* may apply to add the newborn as a *beneficiary* to *your* existing *policy.* If the *application* is received by *us* within thirty (30) days of the newborn's date of birth, *we* will not require information regarding the newborn's health or a medical examination, and cover will begin from birth. *We* will send *you* an updated *Certificate of Insurance* confirming that the new *beneficiary* has been added.

If the *application* is received by *us* more than thirty (30) days after the newborn's date of birth, the newborn will be subject to medical underwriting. *Pre-existing conditions* will be covered, following review by *us*, under the terms detailed in Clause 5 of this *Customer Handbook*.

If *you* accept the offered terms, cover will begin from the time of birth of the newborn. *We* will send *you* an updated *Certificate of Insurance* confirming that the new *beneficiary* has been added.

9.3

If *you* would like to remove a *beneficiary* from the *policy,* we may require *you to provide supporting evidence* that the *beneficiary* is no longer required to have medical insurance in Dubai or the Northern Emirates or has alternative private *medical insurance* in place to provide continuous cover in Dubai or the Northern Emirates (for example, cancelled visa, or *certificate of insurance* from another provider). *You* will be liable for the full annual premium of any *beneficiaries* removed from the *policy* with the exception of *yourself* where we will refund a pre-rata amount if *you*.

10. What is covered?

10.1

The *policy* is designed for individuals holding a resident visa and residing in the Emirate of Dubai or the Northern Emirates. This *policy* covers certain costs of services or supplies which are recommended by a *medical practitioner,* and which are *medically necessary* for the care and *treatment* of an *injury* or *sickness,* as determined by *us.*

10.2

The costs which are covered are set out in the *list of benefits*. These costs are subject to the limits and exclusions which are set

out in the *policy documents*.

10.3

Any claim is subject to the applicable *co-pay* and limits of cover set out in the *policy documents*.

10.4

This *policy* will not cover any costs relating to *treatment* received before the *initial start date*, or after the cover ends (even if that *treatment* was approved by *us* before the cover ends).

11. Return home cash benefit

If a *beneficiary* requests to travel back to their *country of nationality* for *medically necessary inpatient* or *daypatient treatment*, *we* will make a cash payment directly to the *beneficiary* (following conclusion of the *treatment*):

- to receive *treatment* in a *hospital* which is covered under the limits of this *policy* and within the *beneficiary's selected area of coverage*; and
- where *our medical team* determine it is *medically appropriate* for the *beneficiary* to travel back to their *country of nationality*.

As regards to the return journey, *we* will pay the price of reasonable costs for an economy class air ticket for the *beneficiary* requiring *treatment*.

The following conditions apply (*Return home cash benefit terms*):

- All *treatment* must be approved in advance by *our* customer care team as must the cost of any airfares;
- The cost of an airline ticket excludes the cost of an air ambulance;
- The *beneficiary* will only receive reimbursement once the approved *treatment* has been completed;
- This *benefit* excludes all *treatment* in relation to any *pre-existing conditions*;
- Evidence, to *our* satisfaction of the airline ticket and proof of purchase and cost is required prior to any reimbursement;
- *We* will not pay for any other costs related to the journey home including (but not limited to); accommodation costs, other transport costs to and from the *hospital*, living allowance expenses or for anyone accompanying the *beneficiary* on the journey, and;
- *We* will not pay for *hospital* accommodation if a *beneficiary* is no longer receiving *treatment* but is waiting for transportation including a return flight.

This *benefit* does not apply to *beneficiaries* whose *country of nationality* is the *UAE* or a country subject to international sanctions.

If the *beneficiary* is outside the *UAE* for a cumulative period in excess of one hundred and eighty (180) days during any *period of cover*, *we* may restrict *prior authorisation* or payment or reimbursement of claims for *treatment* in the *UAE* only for the remainder of the *period of cover.*

12. Prior authorisation for treatment

Prior authorisation is required for the following, including but not limited to:

- All *inpatient* and *daypatient treatment* and care;
- Ambulance services;
- All cancer *treatment*;
- *Home nursing*;
- Prescription drugs more than two months' supply, regardless of the cost;
- Evacuation and repatriation services; and
- Dental and optical *treatment*.
- Maternity antenatal;

- Physiotherapy;
- *Outpatient* pathology, radiology and *diagnostic tests*

If *prior authorisation* is required, the *healthcare provider* will contact *us* for approval.

There are a number of *outpatient treatments* and consultations that do not require *prior authorisation*. Where *prior authorisation* is not required for *outpatient treatments*, the value of the *treatment* must be less than AED 2,000.

A *prior authorisation* for *treatment* in the *UAE* is valid for a maximum of fourteen (14) days from the date of approval. If a *beneficiary* does not obtain *treatment* within that fourteen (14) days period the *prior authorisation* will automatically lapse and a new *prior authorisation* will be required.

13. Coverage options

13.1

The *policy* is provided to every *beneficiary*. The *benefits* which are available (subject to the applicable terms, conditions, limits and exclusions) are set out in the *list of benefits* in this *Customer Handbook*.

13.2

You may (if *you* pay an additional premium) add to the standard cover provided under the *policy* by choosing one (1) or more from the following extra coverage options. Details of the extra coverage options are set out in the *list of benefits* in this *Customer Handbook.*

13.2.1

Healthy Connect;

If *you* select the optional Healthy Connect module, this will apply to all eligible *beneficiaries* under *your policy.*

13.2.2

Mother and Baby Care;

If *you* select the optional Mother and Baby Care module, this will only apply to an *eligible female* under *your policy* that has chosen to add this module. Please see Clause 14 for further details.

13.3

If *you* want to add, continue or remove coverage options, *you* should let us know within 30 days of the *policy* inception or before the *annual renewal* date. Coverage options cannot be changed at *your* request outside of the above-mentioned *periods.*

Any waiting period included in any coverage option will apply when it is first added to the *policy* but will not apply where the coverage option is selected for any subsequent uninterrupted periods of cover. Should *you* choose to remove any coverage option from *your policy* for any reason but seek to add it again at a later *annual renewal date* the relevant waiting period will apply again as if it is the first time that the coverage option has been added to *your policy*.

13.4

If *you* want to add new coverage options, *we* may ask for a completed medical history questionnaire.

14. Maternity Care

Standard Maternity Care

14.1

For any married female *beneficiary*, *we* will cover the costs of any pregnancy which *you* have disclosed as part of *your* medical questionnaire during the *application* stage, up to the limits of the corresponding maternity *benefits* included as standard in *your* core cover as detailed in the *list of benefits* in this *Customer handbook*.

Inside the *UAE*: Any married female *beneficiary* can benefit from the maternity care included as standard in *your* core cover from the *initial start date* of *your policy*.

Outside the *UAE*: A mandatory twelve (12) month waiting period will apply from the *initial start date* of *your policy* before any married female *beneficiary* can benefit from the maternity care included as standard in *your* core cover, with the exception of *treatment* for life threatening maternity condition covered under the *benefit* 'Complications arising from Maternity and childbirth (*Treatment* for life threatening maternity conditions) and *medically necessary* termination'.

Optional Mother and Baby Care Module for enhanced Maternity Care

14.2

In addition to the standard maternity care outlined in 14.1, an *eligible female* can choose to add enhanced maternity care to the *policy* by selecting the optional Mother and Baby Care module. This optional module can only be selected for an *eligible female* if she is aged between eighteen (18) and forty-three (43) years old when this optional module is added to the *policy* for the first time or nineteen (19) and forty-four (44) years old for renewal.

14.3

If the optional module outlined in 14.2 is added to the *policy*, a mandatory waiting period of twelve (12) months from the date this module is first added to the *policy* (irrespective of whether this is added from the *initial start date* of *your policy* or at a later *renewal date*) will apply before an *eligible female* can benefit from the module. This means that an *eligible female* needs to have added this optional module to the *policy* for a minimum of two (2) consecutive *policy* years. However, the *eligible female* can start to benefit from the optional module from the beginning of the second year of the module being on the *policy* and during any subsequent uninterrupted *period of cover*.

14.4

If the optional module outlined in 14.2 is removed from the *policy* at any time for any reason and added again at a later *annual renewal date* this will be treated as the first time the optional module has been added to the *policy* and the twelve (12) month waiting period will apply on the same terms as outlined in 14.3.

14.5

During any mandatory waiting period applicable to the optional Mother and Baby Care module, an *eligible female* can continue to benefit from the maternity care included as standard in *your* core cover and as outlined in 14.1. However, please note that once the *eligible female* has satisfied the mandatory waiting period and is therefore eligible to benefit from the optional Mother and Baby Care module the *benefit* limits available as part of the standard maternity care will no longer be applicable and only the *benefit* limits outlined in the optional module will apply.

14.6

In accordance with Clause 14.2, the following age limits are applicable:

14.6.1

the maximum age an *eligible female* can be when the optional module is first added to the *policy* is forty-three (43); and

14.6.2

the maximum age an *eligible female* can be when the optional module is renewed on the *policy* is forty-four (44).

If an *eligible female* renews at forty-four (44) years old and turns forty-five (45) years old during that *policy* year the *eligible female* will be able to benefit from

the optional module for the remainder of that *policy* year. Please note that if the *policy* is renewed after the *eligible female* has turned forty-five (45) the Mother and Baby Care module and all the included *benefits* will not be included in any renewal as the *eligible female* would no longer be permitted to benefit from the optional module. This information will be detailed in the Schedule of Insurance and all the subsequent renewal communications.

14.7

In accordance with this Clause 14, if *you* fail to inform *us*, whether intentionally or not, about a pregnancy which *we* reasonably believe *you* were aware of prior to the *initial start date* of *your policy*; this could (subject to local law and regulation) result in *us* reducing the amount of any claims payment, which *you* are due or in refusing to pay a claim or claims related to the pregnancy altogether.

In the event of an undisclosed pregnancy at the *application* stage, *you* will be asked to submit an updated application form including a fully completed pregnancy questionnaire that will be reviewed by *us*.

Where an undisclosed pregnancy arises, whether intentionally or not, the eligible *beneficiary* will be presented with two (2) options:

(1) Apply the additional premium identified by *us* as payable to cover any *treatments* related to the pregnancy; or

(2) Exclude the pregnancy and all related *treatments* for the remaining *period of cover*.

You must confirm to *us your* selected option within thirty (30) days of these options being presented to *you*. Please note *we* will not pay any claims related to any undisclosed pregnancy until *you* confirm *your* selected option.

A new *Certificate of Insurance* will be issued detailing the changes related to the pregnancy cover.

15. Healthguard plans coverage

15.1 Healthguard Regional plan

Our Healthguard Regional plan provides coverage, subject to the terms of the *policy*, for *treatment* in any of the countries detailed on page 76 of this *Customer Handbook*.

15.2 Healthguard International and Healthguard International Plus plans

The Healthguard International and Healthguard International Plus plans provide coverage, subject to the terms of the *policy* for *treatment* anywhere in the world, except the *USA*. *You* may choose to include the *Worldwide including the USA* coverage, for an additional premium.

16. Out of area emergency treatment

Beneficiaries will be covered for *emergency treatment* during temporary business or holiday trips if those trips are outside *your* selected area of coverage. This cover will be subject to the maximum *benefit* amounts stated in the *list of benefits* table and any *Outpatient Co-Pay* selected on *your policy* will continue to apply. Coverage is also subject to a maximum period of thirty (30) days per trip and a maximum of sixty (60) days per *period of cover* for all trips combined.

To be eligible for this *benefit* the medical *condition* requiring *emergency treatment* must not have existed prior to the travel and the *beneficiary* must not have received *treatment*, had symptoms relating to the *condition* or received medical consultation in relation to the medical *condition* prior to initiating the travel. Receiving medical *treatment* must not have been one of the objectives of the trip. *Emergency treatment* is only applicable if *you* do not already have state-provided healthcare in that country.

Treatments relating to maternity, pregnancy, childbirth or any complications of pregnancy or childbirth are excluded from this *benefit*.

Proof of the date of entry into the country outside *your selected area of coverage* will also be required prior to *benefits* being paid under this cover. This cover will cease once the *treatment* provided results in a stabilised *condition*.

17. Premium and other charges

17.1

Your Certificate of Insurance sets out the premium and any other charges which are payable and states when and how they must be paid.

17.2

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

17.3

We may apply certain penalties if any *beneficiaries* do not seek *prior authorisation* for *treatment* as detailed in Clause 12 or receive *treatment* in the countries of the *UAE* or the *USA* at a *healthcare provider* which is not part of *our healthcare provider* network. Please refer to the section 'Your Guide to getting *treatment*' from page 6 in this *Customer Handbook*.

A list of *Cigna* network of *hospitals*, *clinics* and *medical practitioners* is available in *your* secure online Customer Area.

17.4

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

17.5

If *you* do not pay premium and other charges when they are due, *we* will notify *you* by email immediately and suspend *your policy* i.e. cover for all *beneficiaries* will be suspended. If payment is made, the *policy* will be reinstated. *We* will not approve *treatment* while the *policy* is suspended. *We* will not settle any claim while any payment to *us* is outstanding until the outstanding amount is paid. If at thirty (30) days the amount is still outstanding, *we* will write to *you* informing *you* that the *policy* is cancelled. The cancellation date shall take effect on the date when the first outstanding payment was due. If *you* settle the outstanding amount within thirty (30) days of when the first outstanding payment was due, *we* will reinstate *your* cover back to that date.

17.6

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

17.7

You can make payment by debit or credit card, or alternatively if *you* pay annually, *you* can pay by bank wire transfer. Unless the local regulations should require otherwise, payment of premiums must be in AED.

18. *Co-Pay*

18.1

A mandatory 10% *Co-Pay* applies to all routine maternity, *medically necessary* caesarean and complications arising from maternity and childbirth (non-life threatening) *benefits* whether it's part of *your* core cover or *you* have selected the optional Mother and Baby Care extra coverage.

A mandatory *Co-Pay* applies to the '*Cancer* preventative *surgery*' *benefit* as detailed in the *list of benefits*.

If *you* select the optional Healthy Connect extra coverage, a mandatory *Co-Pay* applies to certain dental *treatments* as detailed in the *list of benefits*.

18.2

You can select an optional *Co-Pay* in relation to *outpatient visits* of either 10% or 20% at *policy* inception or upon renewal. For *your* added protection, there is a limit on the optional *Co-Pay* amount *you* will pay for every *outpatient visit*. If *you* have selected the 10% *Co-Pay*, the maximum amount *you* will pay for every *outpatient visit* is AED 50. If *you* have selected the 20% *Co-Pay*, the maximum amount *you* will pay for every *outpatient visit* is AED 100.

This means the amount *we* pay towards the *outpatient visits* is reduced by the *Co-Pay* percentage. The *Co-Pay* percentage results in a proportion of the *outpatient* costs not being covered by *us*; these costs will be limited to the applicable maximum amount per *outpatient visit* per *beneficiary*.

Please consult page 16 of this *Customer Handbook* for further information on how the optional *Co-Pay* in relation to *outpatient visits* will apply.

Only the optional *Co-Pay* in relation to *outpatient visits* will be subject to the applicable maximum amount.

The mandatory *Co-Pay* detailed in Clause 18.1 are not subject to the applicable maximum amount.

If selected, the optional *Co-Pay* percentage in relation to o*utpatient visits* will be detailed on *your Certificate of Insurance* and *your Medical ID cards*.

18.3

Any *Co-Pay* detailed in Clause 18 shall apply separately to each *beneficiary* and each *period of cover*.

18.4

You will be responsible for paying the amount of any *Co-Pay* directly to the *healthcare provider*. The *healthcare provider* will let *you* know what this amount is.

18.5

You can request a change to the optional *Co-Pay* in relation to *outpatient visits* upon renewal, and such change will be effective from *your annual renewal date* each year. If *you* reduce *your* optional *Co-Pay* percentage selected, *we* may require *you* to complete a new medical history questionnaire which will be reviewed by *us* in accordance with Clause 5 of this *Customer Handbook*.

19. Termination of cover

19.1

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

19.1.1

any premium or other charge (including any relevant tax) is not paid in full within thirty (30) days of the date on which it is due. *We* will give *you* written notice if *we* are going to terminate the *policy* for this reason; or

19.1.2

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

19.1.3

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

violate the requirements of the United Nations Security Council, the European Union or the United States Department of Treasury's Office of Foreign Assets Control; or

19.1.4

we determine, on reasonable grounds, that *you* have, in the course of applying for the *policy* or when making any claim under it, knowingly or recklessly provided information which *you* know, or *we* reasonably believe, to be untrue or inaccurate or failed to provide information which *we* have asked for including but not limited to information in relation to *pre-existing conditions;* or

19.1.5

you fail to provide *us* all the required information, including any identification documentation required in accordance with all applicable legislation within thirty (30) days of the *initial start date* of *your policy* or *we* establish that *you* deliberately or recklessly provided *us* with false or misleading information; or

19.1.6

we are no longer in the market to sell the *policy* or a suitable alternative in the Emirate of Dubai and/or the Northern Emirates. If a *policy* is terminated in accordance with Clause 19.1.6 any termination will be effective from the normal *end date* of the *policy*; or

19.1.7

in respect of any *beneficiary* who ceases to be a resident of the Emirate of Dubai or the Northern Emirates, or who ceases to have the right to live in the Emirate of Dubai or the Northern Emirates.

19.2

If *you* want to terminate this *policy* and end cover for all *beneficiaries*, *you* may do so at any time by giving *us* at least thirty (30) days' notice in writing (including confirmation if there are any claims to be submitted by any *beneficiary* under the *policy*).

Cancellation will only be effective from the date that all *Medical ID cards* (for each *beneficiary*) have been returned and received by *us*.

Please send *your* cancellation request together with *your Medical ID cards* to the following address:

Cigna Insurance Middle East S.A.L
The Offices 3 at One Central
Dubai World Trade Centre
Office No. 111, Level 1
Po Box 3664
Dubai
United Arab Emirates

Please note that depending on *your* residency status, *you* may be required to maintain *insurance* coverage for thirty (30) days post cancelling *your* visa. *We* will endeavour to let *you* know if this applies to *you* but any requirement to maintain *insurance* coverage during the thirty (30) day grace period post cancelling *your* visa is *your* sole responsibility.

19.3

If this *policy* ends before the normal *end date*, any premium which has been paid in relation to any period after cover has ended will be refunded on a pro rata basis, provided that no claims have been made, no *guarantees of payment* or *prior authorisations* have been put in place during the *period of cover* and all *Medical ID cards* are returned to *us*. If *your policy* is terminated in accordance with Clause 19.1.4 or Clause 19.1.5, however, *we* may not refund any premiums *you* have paid and payment of any claims *you* have made under *your policy* may also not be made.

If the *policy* ends before the normal *end date* and *you* have made claims or received a *guarantee of payment* or *prior*

authorisation under it, *you* will be liable for the remainder of any premiums in respect of the *policy* which are unpaid.

19.4

If *treatment* has been authorised, *we* will not be held responsible for any *treatment* costs if the *policy* ends or is terminated or a *beneficiary* ceases to be covered by the *policy* before *treatment* has taken place.

19.5

We will wherever possible, write to *you* at least forty-five (45) days before the *end date* to give *you* written notice that the *policy* will not be renewed with effect from the *end date*.

20. The information you give us

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 care when answering any questions that *we* ask by ensuring that all information is accurate and complete. *You* have an obligation to provide all the required information to comply with all applicable legislation within thirty (30) days of the *initial start date* of *your policy*.

If *we* establish that *you* deliberately or recklessly provided *us* with false or misleading information, or *you* haven't provided the required information within thirty (30) days of the *initial start date* of *your policy*, it could adversely affect this *policy* and any claim. For example, *we* may:

- treat this *policy* as if it had never existed, refuse to pay all claims and return the premium paid. *We* will only do this if *we* provided *you* with insurance cover which *we* would not otherwise have offered;
- amend the terms of *your insurance*. *We* may apply these amended terms as if they were already in place if a claim has been adversely impacted by *your* carelessness; or
- cancel *your policy*.

We will write to *you* if *we*:

- intend to treat this *policy* as if it never existed; or
- need to amend the terms of *your policy*

If *you* become aware that information *you* have given *us* is inaccurate, *you* must inform *us* as soon as possible using the contact details that *we* have provided in this *Customer Handbook*.

21. Fraud

21.1

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

21.2

21.2.1

If a *beneficiary* makes a fraudulent claim under this *policy*, *we*:

a) are not liable to pay the claim; and

b) may recover from the *beneficiary* any sums paid by *us* in respect of the claim; and

c) may by notice to the *beneficiary* treat the contract as having been terminated with effect from the time of the fraudulent act.

21.2.2

If *we* exercise our right under this Clause 21.2.1 (c) above:

a) *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 making of a claim, or the notification of a potential claim); and

b) *we* do not need to return any of the premiums paid.

21.2.3

If this *policy* provides cover for any *beneficiary* other than *you* ("a covered person"), and a fraudulent claim is made under this *policy* on behalf of a covered person, *we* may exercise the right set out in Clause 21.2.1 above as if there were an individual *insurance* contract between *us* and that covered person. However, the exercise of any of those rights shall not affect the cover provided under the contract for any other *beneficiary*.

22. No longer a resident in the Emirate of Dubai or the Northern Emirates

If any *beneficiary* is not, or ceases to be a resident of the Emirate of Dubai or the Northern Emirates, please inform *us* immediately as cover will automatically cease in accordance with Clause 19.1.7. Please note that *we* might be able to offer *you* another insurance product provided by another *Cigna* group company.

23. Change of address and nationality

You must tell *us* if any *beneficiaries* change their residential address or change their *country of nationality. We* will, provided that *we* are able to continue to provide cover, then send *you* an updated *Certificate of Insurance*.

24. Contacting you

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

25. Contacting us

If *you* need to contact *us*, *you* should write to *us* at:

Cigna Insurance Middle East S.A.L
The Offices 3 at One Central
Dubai World Trade Centre
Office No. 111, Level 1
Po Box 3664
Dubai
United Arab Emirates

or email *us* at:
service.healthguard@cigna.com

You can also call *our* Customer Care Team 24/7 on:
Inside the *UAE*: 800 55 33
Outside of the *UAE*: 00971 4 317 8499

26. Changes to this policy

26.1

No person other than an authorised officer of *Cigna Insurance Middle East* 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*.

26.2

We reserve the right to change this *policy* at any time to comply with any changes to relevant laws and regulations if required, during the *period of cover*. If this happens, *we* will write and tell *you* of the change.

26.3

We also reserve the right to make changes to the terms of cover on renewal. *We* will give *you* forty-five (45) days' notice of such changes and the changes will take effect from the *annual renewal date.*

27. Who can enforce this policy?

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

28. Our right to recovery from third parties

If a *beneficiary* requires *treatment* as a result of an accident or deliberate act for which a third party is at fault, *we* (or any person or company *we* nominate) will take on that *beneficiary's* right to recover the cost of that *treatment* from the third party at fault (or their insurance company). If *we* ask a *beneficiary* to do so, he or she must take all steps to include the amount of *benefit* claimed from *us* under this *policy* in any claim against the person at fault (or their *insurance* company). The *beneficiary* will need to sign and deliver all documents or papers and take any other steps *we* require to secure *our* rights. The *beneficiary* must not take any action which could damage or affect these rights. *We* can take over and defend or settle any claim, or prosecute any claim, in a *beneficiary's* name for *our* own *benefit*. *We* will decide how to carry out any proceedings and settlement.

29. Other insurance

If another *insurer* also provides *you* or a *beneficiary* with healthcare cover during any *period of cover you* should inform *us* as soon as practical. Where *you* or a *beneficiary* makes a claim which is also covered by a *policy* of *insurance* issued by a third party *you* should confirm this to *us* at the relevant time of making the claim confirming what if any proportion of the claim has or will be settled by such third party. In these circumstances *you* consent to *us* contacting the other insurer and to

negotiating with them as regards who pays what proportion of any claim. *You* and any *healthcare provider* shall not be entitled to recover or be reimbursed more than once for any *treatment* or services related to such *treatment.*

30. Data protection

30.1

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

We will act as data controller for the personal information *we* hold about *you*. This data will be managed by *us* to carry out *our* obligations under the *policy* and *we* may need to share it with authorised third parties to fulfil the contract, such as emergency repatriation providers and reinsurers. *We* may also share *your* data with third parties who *we* subcontract to administer any aspects of *your policy*.

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

As the main point of contact for the *policy*, *you* will have administrative access to personal data held about *you* and *your beneficiaries*. In the event of a claim, this may include access to some limited sensitive personal data.

30.2

In assessing *your application*, and administering the *policy* and the *insurance* provided to *you*, *we* will collect, process and share certain personal information about *you*. *We* take *your* privacy very seriously and *we* will always process *your* information in accordance with applicable data protection legislation, including, where relevant, the General Data Protection Regulation (EU 2016/679) and any guidance or codes of practice issued in respect of protection of personal data from time to time.

30.3

Cigna will for the purposes of administering any claim, ask a *beneficiary* to provide sensitive personal data relating to his or her medical condition, previous conditions, state of health and *treatments*.

30.4

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

Note that *your* personal information and data may be transferred, processed and stored outside of the *UAE*.

By entering into this *policy you* and relevant *beneficiaries* consent to use of *your* data in the manner outlined in this Clause 30.

31. Language

The *policy documents* and all communications in relation to this *policy* is provided in English. The *Customer Handbook* and *Certificate of Insurance* are also available to *you* in Arabic upon request. Where there is any dispute between the two versions, the Arabic version will take precedence.

32. Regulatory Information

The insurance is provided by Cigna Insurance Middle East S.A.L (Dubai branch) which is registered and authorised by the *UAE* Insurance Authority as a branch of a foreign insurance company under registration No. 48 on 31 December 1984. Cigna Insurance Middle East S.A.L (Dubai branch) is regulated in the *UAE* by the Dubai Health Authority (DHA).

33. Complaints

If *you* wish to make a complaint, *you* can do so in accordance with the *Complaints Procedure* provided to *you* on page 77 of this *Customer Handbook* and forming part of the *policy*.

34. Applicable law and jurisdiction

34.1

This *policy* is governed by, and will be interpreted in accordance with the law of the *UAE*.

34.2

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

GENERAL EXCLUSIONS

These are *your General Exclusions*. Please also refer to the *list of benefits* detailed in this *Customer Handbook*, including the notes section for any further restrictions and exclusions that apply.

These General Exclusions may include, but are not limited to, any applicable exclusion listed by the Dubai Health Authority (DHA).

1. Cover under this *policy* is subject to the following *general exclusions*:

1.1

We will not offer cover or pay claims when it is illegal for *us* to do so under all applicable laws, rules and regulations to which *we* and this *policy* are subject. Examples include but are not limited to, exchange controls, local licensing regulations or trade embargo.

1.2

We will not cover *you* or pay claims when doing so would violate applicable trade restrictions, including but not limited to restrictions imposed by the United States Department of Treasury's Office of Foreign Assets Control, the European Union Commission or the United Nations Security Council Sanctions Committees.

1.3

We will not pay a claim which *we* have reasonable grounds to believe has been made fraudulently. Please see Clause 21 for further details.

1.4

We will not pay for any costs outside *your* area of coverage except under the Out of Area Emergency cover *benefit* terms detailed in the *list of benefits*.

1.5

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

1.6

If a *beneficiary* does not have cover under the Healthy Connect and/or the Mother and Baby Care extra coverage options, *we* will not pay for any of the *treatments* or other *benefits* which are available under those options.

1.7

The following exclusions apply to the *policy*. Where, in the exclusions which are set out below, *we* have stated that *we* will pay for *treatment* in some circumstances; this is subject to the *beneficiary* having cover under the appropriate coverage option(s).

We will not pay for:

1.7.1

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

1.7.2

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

- *treatment* that could take place on a *daypatient* or *outpatient* basis;
- time spent recovering from an illness or medical *treatment* (except where stated explicitly in this *policy*);
- admissions and stays for social or domestic reasons e.g. washing, dressing and bathing.

1.7.3

Costs of *hospital* accommodation for a deluxe, executive or VIP suite. *Hospital* accommodation costs that are more expensive than those of a standard private room which would not be deemed to be *reasonable and customary* in the country

where *treatment* is obtained.

1.7.4

Donor organs:

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

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

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

1.7.5

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 arising from Maternity and childbirth (*Treatment* for life threatening maternity conditions) and *medically necessary* termination' in the *list of benefits*.

1.7.6

Footcare by a Chiropodist or Podiatrist.

1.7.7

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

- one sleep study;
- the hire of equipment such as a Continuous Positive Airway Pressure (CPAP) machine

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

1.7.8

Treatment which is provided by:

i) 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;

ii) 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.

iii) a *medical practitioner*, *therapist*, *hospital*, *clinic*, or facility which, in *our* reasonable opinion, is either not properly qualified or authorised to provide *treatment*, or is not competent to provide *treatment*.

1.7.9

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

1.7.10

Treatment for, or in connection with smoking cessation.

1.7.11

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

a) nuclear or chemical contamination;

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

c) any other conflict or disaster events;

where the *beneficiary* has:

- put him or herself in danger by entering a known area of conflict (as identified by a Government in *your country of nationality*, for example the British Foreign and Commonwealth Office or the government of the *UAE*);
- actively participated in the conflict; or

- displayed a blatant disregard for their own safety.

1.7.12

Treatment that arises from, or is in any way connected with attempted suicide, or any *injury* or illness that the *beneficiary* inflicts upon him or herself.

1.7.13

Treatment for or in connection with speech therapy that is not restorative in nature, or if such therapy is:

a) used to improve speech skills that have not fully developed;

b) can be considered educational; or

c) is intended to maintain speech communication.

1.7.14

Developmental problems including:

a) learning difficulties such as dyslexia;

b) autism or attention deficit disorder (ADHD);

c) physical development problems such as short height.

1.7.15

Treatment for temporomandibular joint disorders, when administered by a certified oral and maxillofacial surgeon unless when the *Treatment* is considered *Medically Necessary.*

1.7.16

Treatment for obesity, or which is necessary because of obesity. This includes, but is not limited to, slimming classes, aids and drugs.

We will only pay for gastric banding or gastric bypass *surgery* if a *beneficiary*:

- has a body mass index (BMI) of 40 or over and has been diagnosed as being morbidly obese;
- can provide documented evidence of other methods of weight loss which have been tried over the past twenty-four (24) months;
- has been through a psychological assessment which has confirmed that it is appropriate for them to undergo the procedure.

1.7.17

Treatment in nature cure *clinics*, health spas, nursing homes, or other facilities which are not *hospitals* or recognised medical *treatment* providers.

1.7.18

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

1.7.19

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

1.7.20

Non-*emergency treatment* for a related *condition* resulting from any kind of substance or alcohol use or misuse.

1.7.21

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

a) *surgical* contraception namely:

- vasectomy, sterilisation or implants;

b) non-surgical contraception, namely:

- pills or condoms;

c) family planning namely:

- meeting a *doctor* to discuss becoming pregnant or contraception.

1.7.22

Treatment relating to infertility (other than investigation to the point of diagnosis), fertility *treatment* of any sort, or *treatment*

of complications arising as a result of such *treatment*. This includes, but is not limited to:

a) in-vitro fertilisation (IVF);

b) gamete intrafallopian transfer (GIFT);

c) zygote intrafallopian transfer (ZIFT);

d) artificial insemination (AI);

e) prescribed drug *treatment*;

f) embryo transportation (from one physical location to another); or

g) ovum and/or semen donation and related costs.

We will pay for investigations into the cause of infertility if:

a) the *specialist* wishes to rule out any medical cause;

b) the *beneficiary* has been covered under this *policy* for two (2) consecutive years before the investigations have commenced; and

c) the *beneficiary* was unaware of the existence of any infertility problem, and had not suffered any symptoms, when their cover under this *policy* commenced.

1.7.23

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

1.7.24

Treatment directly related to surrogacy.

1.7.25

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

1.7.26

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

1.7.27

Treatment (other than *emergency treatment*) for personality and/or character disorders, including but not limited to:

a) affective personality disorder;

b) schizoid personality disorder; or

c) histrionic personality disorder.

1.7.28

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

1.7.29

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

1.7.30

Treatment which is intended to change the refraction of one or both eyes, including but not limited to laser *treatment*, refractive keratotomy and photorefractive keratectomy.

We will pay for *treatment* to correct or restore eyesight if it is needed as a result of a disease, illness or *injury* (such as cataracts or a detached retina).

1.7.31

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

1.7.32

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

1.7.33

International services expenses for emergency medical evacuation, medical repatriation and transportation costs for

third parties where the *treatment* needed is not covered under this *policy*.

1.7.34

Any expenses for ship-to-shore evacuations.

1.7.35

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

1.7.36

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

a) taking part in a sporting activity on a professional basis;

b) taking part in a dangerous sporting activity or hobby;

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.

1.7.37

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

a) *treatment* which is provided as part of a clinical trial;

b) *treatment* which has not been approved by the relevant public health authority in the country in which it is received; or

c) any drug or medicine which is prescribed for a purpose for which it has not been licensed or approved in the country in which it is prescribed.

1.7.38

Any form of plastic, *cosmetic* or reconstructive *treatment*, the purpose of which is to alter or improve appearance even for psychological reasons, unless that *treatment* is *medically necessary* and is a direct result of a *condition* suffered by the *beneficiary*, or as a result of *surgery* and the principal purpose of the *cosmetic treatment* or *surgery* is to improve the physiological functioning of the affected body part. This includes but is not limited to:

a) facelifts (rhytidectomy);

b) nose reshaping (rhinoplasty);

c) liposuction and other procedures which remove fat tissue;

d) hair transplants; and

e) *surgery* to change the shape of, enhance or reduce breasts (other than breast reconstruction following *treatment* for *cancer*).

1.7.39

Appliances, including but not limited to hearing aids and spectacles (unless the Healthy Connect option is selected) which do not fall within *our* definition of *surgical appliances and/or medical appliances*.

1.7.40

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

1.7.41

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

1.7.42

Costs that have been or can be paid by another insurance company, person, organisation or public programme. If a *beneficiary* is covered by other insurance, *we* may only pay part of the cost of *treatment*. If another person, organisation or public programme is responsible for paying the costs of *treatment*, *we* may claim back any of the costs *we* have paid.

1.7.43

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

1.7.44

Treatment for a *pre-existing condition* of which the *policyholder was* (or should reasonably have been) aware at the *initial start date* but fail to inform *us,* and in respect of which *we* are not required to provide cover under local law and regulation.

1.7.45

*Treatment (*other than *emergency treatment*) for a long term psychological or mental illness (such as dementia or Alzheimer's disease).

1.7.46

Any *treatment* or costs, for or relating to, *Gene Therapy or Genetic Therapy* is not covered.

Definitions

The words and phrases set out below have the meanings specified. Where those words and phrases are used with those meanings, they will appear in italics in this *Customer Handbook*, including the *list of benefits*.

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

A

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

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

'Annual renewal date' - the anniversary of the *start date* each year.

'Application' - the *policyholder's application* (whether they have sent in a form directly to *us* or through a broker or applied online or through *our* telemarketers), and any declarations that they made during their enrolment for them and any *beneficiaries* included in the *application.*

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

B

'Beneficiaries'/ 'beneficiary' – anybody named on *your Certificate of Insurance* as

being covered under this *policy*, including newborn children.

'Benefit(s)' - any *benefit*(s) shown in the *list of benefits*.

C

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

'Certificate of Insurance' – the certificate issued to the *policyholder*. This shows the *policy* number, *start date*, the optional *Outpatient Co-Pay* (if applicable), details of who is covered and any conditions that are covered at an additional premium.

'Cigna' we', 'us', 'our' 'the insurer' - *the insurer* providing *your policy*;

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'Clinic(s)' - a health care facility which is registered or licensed in the country in which it is located, primarily to provide care for *outpatients* and where care or supervision is by a *medical practitioner*.

'Complaints procedure' – *our policy* and procedure for a *beneficiary* to make a complaint in relation to their *policy* contained in this *Customer handbook.*

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

'Condition'- any abnormality, deformity, disease, illness or *injury*;

'Congenital condition' – any *condition* present at birth, whether diagnosed or not.

'Co-Pay/Co-Pay(s)' - is the percentage of each claim which a *beneficiar*y must pay themselves. The optional *Outpatient Co-Pay* will be shown in the *Certificate of Insurance*, if applicable.

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

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

'Customer Handbook' – this document which contains claiming information, the *list of benefits*, the terms and conditions governing the *policy*, *General Exclusions* and Definitions which forms part of the *policy*.

D

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

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

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

'Dental injury' - *injury* to a sound natural tooth caused by extra-oral impact. *Treatment* for dental implants, crowns or dentures is not covered unless *you* have purchased the Healthy Connect option and subject to the *conditions* outlined in the *policy*.

'Dental treatment' - any dental procedure or service which:

- is needed for continued *oral health*; and
- is carried out or personally controlled by a *dentist*, including procedures provided by a hygienist; and
- is included in the *list of benefits*, or, though not included in the *list of benefits*, is accepted by *us* as a procedure or service meeting common dental standards as upheld by a respectable, responsible and substantial body of dental opinion, experienced in the particular field of dentistry.

'Dentist' - a *dentist*, dental surgeon or dental practitioner who is registered or licensed as such under the laws of the country, state or other regulated area in which the *treatment* is provided.

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

'Doctor' - a medical professional who holds an appropriate *doctora*l degree, is registered and licensed under the laws of the country, state or regulated area to practice medicine in the country in which the *treatment* is provided.

E

'Eligible female' - a married female on the *policy*, being either the *policyholder* or the *spouse* of the *policyholder*.

'Emergency treatment' – *treatment* administered by a *medical professional to* rescue or save a person's life or the elimination of a danger threatening that person's life. Examples of emergency *conditions* include but are not limited to, heart attack, poisoning, severe allergic reaction, convulsions, unconsciousness, and uncontrolled bleeding. Services received in a *doctor's* office or urgent care facility are not considered emergencies.

'End date' - the date on which cover under this *policy* ends, as shown in the *Certificate of Insurance* and *your UAE Medical ID card.*

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

- the National Institute for Health and Clinical Excellence; or
- the *Cigna Medical Team*; or
- another source recognised by the *Cigna Medical Team*.

'Excluded treatments' - means any *treatment* which is excluded under the terms of *your policy* including the *treatments* outlined under the *General Exclusions*.

G

'GCC'- Gulf Cooperation Council countries from time to time (which at the date of publication include; Saudi Arabia, *UAE*, Kuwait, Oman, Bahrain and Qatar.

'General Exclusions' - those matters, circumstances and *treatments* detailed in this *Customer Handbook* which are generally excluded and therefore not covered by *your policy*.

'Guarantee of payment' - a guarantee to pay agreed costs associated with particular *treatment* which *we* may give to a *beneficiary* or a *healthcare provider*.

'Gene Therapy or Genetic Therapy' - *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.

H

'Healthcare provider' - any organisation which is registered or licensed as a medical or surgical *hospital*, *clinic,* laboratory, pharmacies, physiotherapy centres and other paramedical institutions or individual licensed (including *medical practitioners*) to provide health care services in the country in which the *beneficiary* is located and where the patient is under the daily care or supervision of a *medical practitioner* or *qualified nurse*.

'Home nursing' - visits from a *qualified nurse* to the *beneficiary's* home to give expert nursing services for up to thirty (30) days:

- immediately after *hospital treatment* as required by medical necessity; and
- visits for *treatment* which would normally be provided in a *hospital*.

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

'Hospital' - any organisation or institution which is registered or licensed as a medical or surgical *hospital* in the country in which it is located and where the *beneficiary* is under the daily care or supervision of a *medical practitioner* or *qualified nurse*.

I

'Initial start date' - the first day the *beneficiary's* cover commenced.

'Injury' - a physical *injury*.

'Inpatient' - a patient who is admitted for *treatment* to *hospital* and who occupies a bed overnight or longer or who has received more than eight (8) hours continuous *treatment* or care in a *hospital* (where such patient has been registered as an admission), for medical reasons.

'Insurance' - the coverage which is provided by *us* to the *beneficiaries* subject to the terms, conditions, limits and exclusions set out in this *Customer Handbook, your Certificate of Insurance* and *Medical ID Card*(s).

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

'International services' – services arranged by the *medical assistance service*.

L

'List of benefits' - the list of *benefits* detailed in this *Customer Handbook*, including any notes.

M

'Maternity benefit' - *benefits* available in relation to all aspects of pregnancy or childbirth under the plan, including any complications, for any married female *beneficiary* covered under this *policy*, but excluding:

- *treatment* by way of the intentional termination of pregnancy unless this is a *medically necessary* termination as permitted by law; and
- nursery care for a newborn in *hospital*, unless the mother is required to remain in *hospital* due to medical necessity for *treatment* that is covered by this *policy*.

'Medically appropriate' - means appropriate with reference to locally and internationally recognised clinical guidelines of medical practice relative to a specific *condition.*

'Medical assistance service' - a service which provides medical advice, evacuation, assistance and repatriation. This service

can be multi-lingual and assistance is available twenty-four (24) hours per day.

'Medically necessary' – *treatment* and *medically necessary* covered services and supplies are those determined by the *medical team* to be:

- Necessary to meet the basic health needs of the *beneficiary*;
- Rendered in the most *medically appropriate* manner and type of setting appropriate for the delivery of the *treatment* taking into account both cost and quality of care;Consistent in type, frequency and duration of *treatment* with scientifically based guidelines of medical research or healthcare coverage organisations or governmental agencies that are accepted by *us*;
- Consistent with the diagnosis of the *condition*;
- Required for reasons other than the convenience of the *beneficiary* or *their medical practitioner;*
- Demonstrated through prevailing pre-reviewed medical literature to be either:
    - Safe and effective for treating or diagnosing the *condition* for which their use is proposed; or
    - Safe with promising effect for treating a life threatening *condition* in a clinically controlled research setting.

The fact that a *medical practitioner* has performed or prescribed a procedure or *treatment* or the fact that it may be the only *treatment* available for a particular *condition* does not mean that it is a *medically necessary treatment* as defined in this *policy.* The definition of *medically necessary* where used in this *policy* relates only to cover provided under this *policy* and differs from the way in which a *medical practitioner* may define *medically necessary*.

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

'Medical practitioner' - a *doctor* or *specialist* who is registered or licensed to practice medicine under the laws of the country, state or other regulated area in which the *treatment* is provided, and who is not a *beneficiary* under this *policy*, or a family member of a *beneficiary* under this *policy*.

'Medical ID cards' - the identity cards referenced on page 7 of this *Customer Handbook* issued to *beneficiaries* to access *treatment*. Each *beneficiary* will receive two ID cards. One for receiving *treatment* in the *UAE* region and the other one for *treatment* in all other countries, subject to the terms of *your policy*.

'Medical team' - means *our* clinical team and/or the *medical assistance service*.

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

'Oral health' - for a patient, a reasonable standard of *oral health* of the teeth, their supporting structures and other tissues of the mouth, and of dental efficiency, according to a standard acceptable to a *dentist* of ordinary competence and skill in the Emirate of Dubai and the Northern Emirates which will safeguard his or her general health.

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

'Outpatient' - a patient who attends a *hospital*, consulting room, or *outpatient clinic* for *treatment* and is not admitted as a *daypatient* or an *inpatient*.

'Outpatient visit' – a visit on an *outpatient* basis to receive an *outpatient benefit* or multiple *outpatient benefits*, as included in the *list of benefits*, on the same day and with the same *healthcare provider*. An *outpatient visit* also includes the collection or delivery of prescription drugs and dressings prescribed on an *outpatient* basis. Any visit to a different *healthcare provider* on the same day will be treated as a separate *outpatient* visit. Any *outpatient benefit(s)* received on a different day will also be treated as a separate *outpatient visit*.

P

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

'Period of cover' - the twelve (12) month continuous period during which the *beneficiaries* are covered under this *policy*, being the period from the *start date* to the *end date* as noted on the *Certificate of Insurance* or earlier if terminated in accordance with Clause 19 of the *Customer Handbook*.

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

'Policy' - the *policy* comprising this *Customer* Handbook (which includes the *complaints procedure*) and *your Certificate of Insurance*.

'Policy documents' - the documentation relating to the *policy*, comprising of this *Customer Handbook*, *your application*, *your Certificate of Insurance* and *your Medical ID Card (s)*.

'Policyholder' - a person who has made an *application* to *us* which has been accepted in writing by *us*, and who pays the premium under the *policy*.

'Prior authorisation' - a process through which a *beneficiary* or designated *healthcare provider* seeks approval from *us* prior to undergoing *treatment* to ensure that the proposed *treatment* falls within the scope of cover, subject to the terms of the *policy* and shall fall within the *healthcare providers* agreed rates.

'Pre-existing condition' - any *condition* (including any chronic *condition*) or symptoms linked to such *condition* for which:

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

before the *initial start date*.

Q

'Qualified nurse' - a nurse who is registered or licensed as such under the laws of the country, state or other regulated area in which the *treatment* is provided.

'Qualifying life event' means:

- marriage;
- divorce or separation;
- birth of a child;
- legal adoption of a child; or
- death of a *spouse*, partner or child.

We may require evidence of the above event.

R

'**Reasonable and customary costs**' - means those charges which *we or our medical team* consider as being *reasonable and customary* in the relevant territory for *treatment* provided by *medical practitioners* or *healthcare providers* outside of *our* network to the extent that they do not exceed the general level of charges being made by *healthcare providers* or *medical practitioners* of similar standing in the locality where the charges are incurred when providing comparable *treatment,* services or supplies to individuals of the same sex and of comparable age for a *condition.* The charges will be limited to the level of charges that would have been incurred by *us* should the *beneficiary* have received *treatment* at any *healthcare provider* in *our* applicable network;

'Rehabilitation' - physical, speech and occupational therapy for the purpose of *treatment* aimed at restoring the *beneficiary* to their previous state of health after an *acute* event.

'Return home cash benefit terms' – has the meaning given to it in Clause 11 of this *Customer Handbook*.

S

'Schedule of surgical procedures' - the current schedule of surgical procedures approved by *our* chief medical officer.

'Selected area of coverage' – means either:

- *GCC*, Middle East, Asia (excluding Singapore, Hong Kong and China)
- *Worldwide, including the USA*; or
- *Worldwide, excluding the USA*.

'Short-term' - means a period of time consistent with the recuperation time required for the *treatment* and as prescribed by the treating *medical practitioner* with the approval of *our* medical director.

'Sickness' - a physical or mental illness, including illness resulting from or relating to pregnancy.

'Sound natural tooth/teeth' - a tooth that functions normally for chewing and speech purposes and that is not a dental implant. Such natural tooth/teeth should not have experienced any of the following:

- decay or filling;
- gum disease associated with bone loss;
- root canal *treatment*.

'Specialist' - a *doctor* who is recognised, registered or licensed as such under the laws of the country, state or other regulated area in which the *treatment* is provided and only for the *treatment* which is being recommended.

'Spouse' - a *beneficiary's* legal husband or wife, who *we* have accepted for cover under this *policy*.

'Start date' - the date on which coverage under this *policy* starts, as shown in the *Certificate of Insurance* and *your UAE Medical ID card*.

'Surgery' - the branch of medicine that treats diseases, *injuries*, and deformities by operative methods which involves an incision into the body.

'Surgical appliance(s)', 'Medical appliance(s)' - means either:

- an artificial limb, prosthesis or device which is required for the purpose of or in connection with *surgery*; or
- an artificial device or prosthesis which is a necessary part of the *treatment* immediately following *surgery* for as long as required by medical necessity; or
- a prosthesis or appliance which is *medically necessary* and is part of the recuperation process on a *short-term* basis.

T

'**Therapist**' - a speech *therapist*, dietician or orthoptist who is suitably qualified and holds the appropriate license to practice in the country where *treatment* is received.

'**Treatment**' - any surgical or medical *treatment* controlled by a *medical practitioner* that is *medically necessary* to diagnose, cure or substantially relieve disease, illness or *injury*.

U

'**UAE**' – the United Arab Emirates.

'Unauthorised Claim' – a claim in relation to *treatment* (or any related costs or services) which does not or is subsequently determined by *us* as not qualifying for payment under this *policy*.

'Underwriting summary form' – a summary statement of *our* decision provided during the *application* process following *our* review of *your* medical questionnaire completed for *you* and any *beneficiary*.

'USA' - the United States of America.

W

'Worldwide including the USA' – every country throughout the world and at sea, excluding any country or jurisdiction where, at the date of commencement of *treatmen*t, sanctions are applicable in accordance to the preamble of this *policy* and/or coverage and services (including payments) are illegal pursuant to applicable laws.

'Worldwide excluding the USA' - worldwide, with the exception of the *USA*.

Y

'You, your' - the *policyholder*.

AREA OF COVERAGE GUIDE FOR REGIONAL PLAN

The Regional plan includes the following countries:

Gulf Cooperation Council (GCC) countries*:
Kingdom of Bahrain
State of Kuwait
Sultanate of Oman
State of Qatar
Kingdom of Saudi Arabia
United Arab Emirates (*UAE*)

Other Middle East and Asia countries:	
Armenia	Malaysia
Azerbaijan	Maldives
Bangladesh	Mongolia
Bhutan	Myanmar
Brunei Darussalam	Nepal
Cyprus/Northern Cyprus	Pakistan
Cambodia	Palestine/Israel
Egypt	Philippines
Georgia	South Korea
India	Sri Lanka
Indonesia	Taiwan
Jordan	Tajikistan
Kazakhstan	Thailand
Kuwait	Timor-Leste
Kyrgyzstan	Turkey
Lao People's Democratic	Turkmenistan
Republic	Yemen
Lebanon	Uzbekistan
Macao	Vietnam

*Which at the date of publication include the following countries.

The following countries in Asia are not included in the **Healthguard Regional plan**:

Not included in the Healthguard Regional plan
Singapore
Hong Kong
China

Important note

Notwithstanding the foregoing areas of cover, *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.

COMPLAINTS HANDLING PROCEDURE

Cigna aims to resolve all complaints fairly, consistently and promptly.

If any *beneficiary* or *policyholder* has cause to complain, *we* will deal with concerns raised as effectively and quickly as possible whilst undertaking *our* investigations competently and impartially.

These are the steps to be followed in the event of a reason for dissatisfaction arising:

Submission of Complaints

Our mission is to help improve *your* health, wellbeing and sense of security - everything *we* do is designed to achieve this. Providing *you* with clear and accurate information, whether in writing or by telephone, is an important part of *our* service. *Our* Customer Care Team is always there to offer advice about *your* Healthguard *plan*, and the eventualities that it covers.

In the unlikely event, that *you* are dissatisfied with any services that *you* have received from *us* or *our* partners, *you* can submit a complaint via email (including all supportive documents), telephone or post as set out below:

Email: **complaints.healthguard@cigna.com**

Call: Inside the *UAE*: 800 5533
Outside of the *UAE*: 00971 4 317 8499

You can also call *our* Customer Care Team to submit a complaint. The details of *your* case will be immediately escalated to the Complaints Handling Team.

Post: Complaints Handling Team
Cigna Insurance Middle East S.A.L
The Offices 3 at One Central
Dubai World Trade Centre
Office No. 111, Level 1
Po Box 3664
Dubai
United Arab Emirates

Complaint Acknowledgement

We endeavor to acknowledge complaints by return, and within no more than five (5) business days from a complaint being received. *We* may request clarifications and additional information at this point.

Complaints Investigation

All complaints made will be assessed by *our* trained and competent Complaints Handling Team. During the course of *our* investigations, *we* may contact *you* requesting additional information or clarifications. Please be aware that, when assessing the circumstances of *your* complaint, *we* may on occasions need to share *your* details with *our* concerned departments and partner organisations.

In the unlikely event that a complaint has not been resolved or that *you* are unsatisfied with the decision offered by *Cigna*, *you* then have the right to escalate the case to *our* Senior Manager using the following methods of contact:

Post: Senior Manager
(Healthguard complaints)
Cigna Insurance Middle East S.A.L
The Offices 3 at One Central
Dubai World Trade Centre
Office No. 111, Level 1
Po Box 3664
Dubai
United Arab Emirates

Email: **ceo.healthguard@cigna.com**

Escalations will be acknowledged within two (2) business days, and a resolution sent within five (5) business days.

Complaints Resolution

Our Complaint Handling Team will gather information, and review the facts of the case in order to reach a conclusion. *We* will seek to do this with as little delay as possible, and in any event within fifteen (15) calendar days of receiving the full information which *we* require. If the investigation is likely to take longer to complete *we* will inform *you* promptly of the status of *your* complaint and *our* estimate of the time to resolve.

Informing *you* of progress and *our* conclusions

We will keep *you* updated of the progress of *your* complaint. Once the investigation is completed, *our* Complaints Handling Team will write to *you* with a full account of their investigation and decision. Whether *our* decision is to agree that *your* complaint is justified, or to state that *we* feel *your* concerns are unfounded, *we* will set out *our* conclusions so that *you* will be able to see that the decision is fair and reasoned based on the information gathered.

Independent Complaints Bodies

Cigna's complaint handling procedures conform to the guidance and rules set out by *our* regulators. In addressing concerns raised, *we* would hope to reach an amicable conclusion. However, if there remain causes for dissatisfaction, *you* may be eligible to refer the matter to the regulator or ombudsman in *your* jurisdiction:

> **Dubai Health Authority**

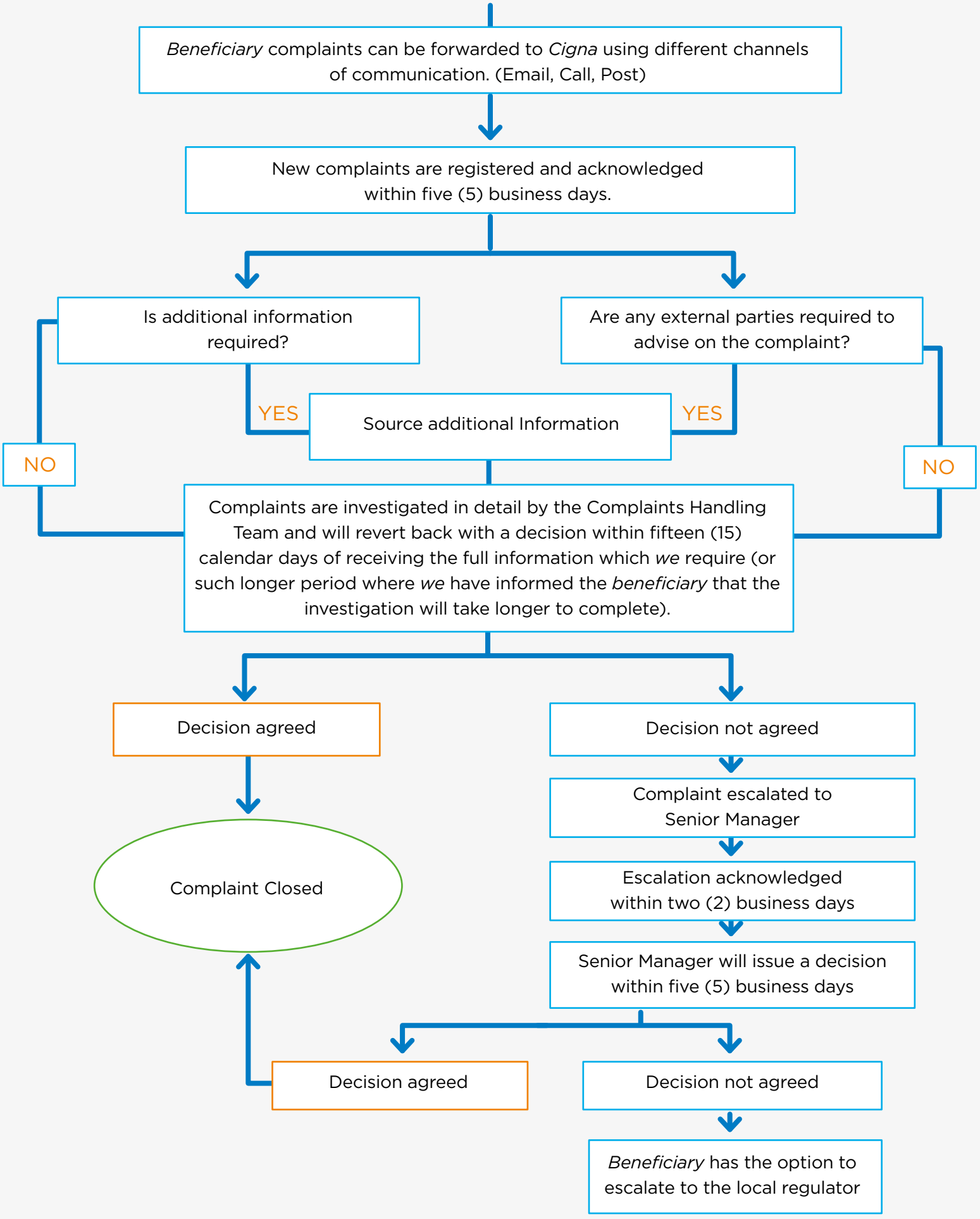
Feedback, complaints and suggestions can be logged on the health insurance Partner Relations Opinion Management e-system (iPROMes).
http://www.isahd.ae/Home/Ipromes

> **Federal Insurance Authority (IA)**

Address: Aldar HQ Building, 16th Floor, Al Raha beach
Telephone: 024990111
Fax: 025572111

Online: through the Dispute Resolution System
https://smartservices.ia.gov.ae/ecomplaint/ecomplaint/complaint?lang=en

BENEFICIARY COMPLAINTS HANDLING PROCEDURE



NOTES

Together, all the way.[SM]

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