



**Cigna  
Healthguard**  
Sales Brochure



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## About your Healthguard plan

Membership of the Healthguard plan means that *you* and *your* eligible family members can be sure of receiving comprehensive advice, and *treatment* in case of *illness* or accident.

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 holding a resident visa and residing in the Emirate of Dubai or the Northern Emirates.
- Quick and easy access to health care 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.

A Cigna Healthcare-Neuron digital ID card is provided for *you* and *your* eligible family members. *You* will receive the digital ID card on *your* registered email ID.

Please ensure *you* have *your* digital ID cards with *you* whenever *you* visit a *healthcare provider* as they are important to access care within *our* networks. Within the UAE, members can access care simply by showing their registered Emirates ID and stating that they are insured with Cigna Healthcare-Neuron.



## Important contact information



Customer service can be contacted 24 hours a day, 7 days a week.

### **Our 24-hour helpline numbers:**

**If you are inside the UAE, call toll-free on: 800 55 33**

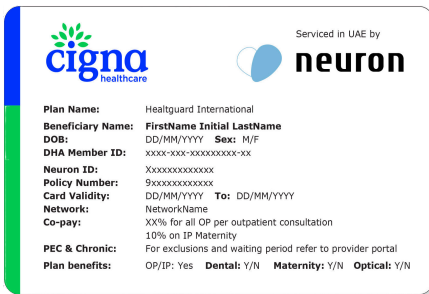
**If you are outside the UAE call: +971 4 317 849**

### **For the Emirate of Dubai:**

The health insurance law for Dubai exists to ensure that residents in the emirate of Dubai enjoy a minimum level of health cover to protect them in the case of *illness* or medical emergency.

All our plans are compliant with the regulations of the Dubai Health Authority.

# About your digital ID cards



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

1. A **Cigna Healthcare-Neuron** digital ID card is provided for *you* and *your* eligible family members. *You* will receive the digital ID card on *your* registered email ID. Within the *UAE*, members can access care simply by showing their registered Emirates ID and stating that they are insured with *Cigna Healthcare-Neuron*.



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

2. A **Cigna Healthcare global** digital ID card is provided for *you* and *your* eligible family members. *You* can access care outside the *UAE* using *your Cigna Healthcare global* digital ID cards. *You* will receive the digital ID card on *your* registered email ID.

## 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* contact 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 authorisation*, 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.

## Emergency out-of-area 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*.



An emergency is defined as the sudden onset of an illness, *injury* or medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) requiring immediate and unscheduled medical care, and if left untreated could result in placing the person's life and/or health in serious jeopardy; serious impairment to bodily functions; serious dysfunction of a bodily organ or part; serious disfigurement; or in the case of a pregnant woman, serious jeopardy to the health of the foetus.

It is the emergency medical condition of the patient, not the diagnosis, which drives the necessity for immediate treatment. Symptoms must be sufficiently severe to cause the patient to seek immediate medical aid.



## If it's an emergency

Get the *emergency treatment* you need and call us if you need any advice or support

### Inside the UAE:

*Your healthcare provider* should call us on **800 5533**, within 48 hours of the emergency, to inform us of the hospitalisation.

### Outside the UAE:

Either *you*, one of *your dependants* or a colleague needs to call us on **00971 4 317 8499**



## Important information about your plan



### Plan eligibility

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

### Adding eligible dependants to your plan

You may add certain persons (e.g., family members) as *beneficiaries* to your *policy*. 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.

Your *beneficiaries* must be added to the same plan you have.

## Leaving your plan

*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.

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* 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.

## Renewing your plan

*Your policy* is not automatically renewed. 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*.

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 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 your *policy* is not renewed on time and medical *treatment* is required, you will need to cover the costs upfront and upon renewal, you may claim reimbursement of up to 80% of the *treatment* cost.

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

You and your eligible family members will receive two digital *membership ID cards*.

# How to use your plan

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

To keep the experience simple and cost effective we always advise members to select an in-network provider and avail *direct billing* services.

## Inside the UAE

Your Healthguard plan gives you access to an unparalleled regional network of medical providers. This means you can choose any in-network provider and *benefit* from the *direct billing* facilities without the hassle of paying and claiming.

You will only need to present your Emirates ID or your digital ID at any in-network provider in order to avail *in-patient* and/or *out-patient treatment* on a *direct billing* basis.

This will remove the worry or inconvenience of needing to pay for *treatment* up front. Only the respective network or *benefit* level *co-pay* will need to be paid by you.

If you opt to pay out of your own pocket for *treatment* either at an in-network or out-of-network provider, then you will need to pay and claim. This will be reimbursed as a percentage on actual cost, with the percentage depending on the plan selected. Please note that the reimbursement is also subject to any *benefit* level *co-pay* in addition and where applicable.

## Advantages of visiting in-network medical providers:



### Direct payment facility.

Only pay your *co-pay* (if applicable) and we will cover the rest.



### No claim forms to fill.

No documents to send.

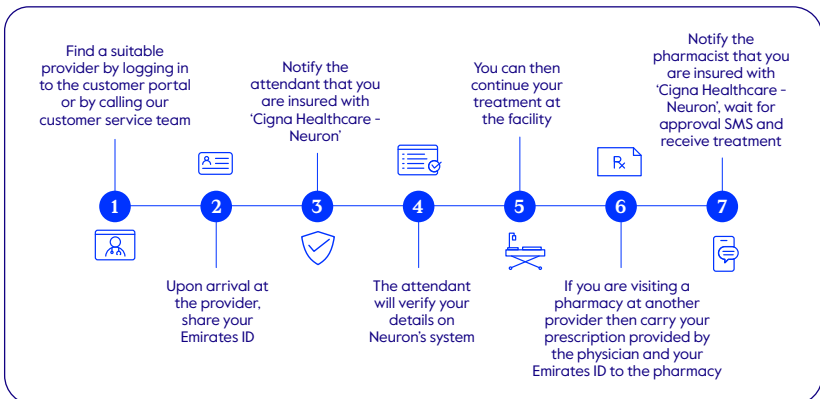


### Get your medication on the spot.

All you need to pay is your *co-pay* (if applicable).



### Pre-approvals are arranged by the network medical provider.





## Outside the UAE

You may receive services from any *hospital, clinic, or doctor* outside the UAE, within your area of coverage, using your *Cigna Healthcare* global ID card. We recognise that you may be unfamiliar with local medical providers. To assist you in this process, we have created a provider directory of pre-screened primary care physicians, *dentists* and full-service *hospitals* for over 450 cities.

To view the provider directories, visit your customer area.

We recommend that you call our customer service team on +971 4 317 849 so that we can assist you to source a suitable in-network provider when you are outside the UAE.

Providers may also call the 24-hour global helpline on +44 1475 78 8610 to verify coverage.


**Please note: Direct billing on the Healthguard plans is only available in the UAE.**

## Inside the USA

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

You may receive services from any in-network *hospital, clinic, or doctor* inside the USA, within your area of coverage, using your *Cigna Healthcare* global ID card.

*Prior authorisation* must be obtained ahead of any *treatment* within the USA, if you choose to receive *treatment* at a *healthcare provider* that is not a part of our international network in the USA, you will be responsible to pay 20% of the *treatment* costs.



## How is co-pay calculated



If your plan has a *co-pay*, it means you have to pay a certain percentage of the *treatment* cost. This amount will depend on:

- The percentage of *out-patient co-pay* set out in your *table of benefits*.
- Whether you visited an in-network provider on a *direct billing* basis or *pay-and-claim* basis or, an out-of-network provider on a *pay-and-claim* basis.
- Your *co-pay* caps; where multiple *co-pays* are applicable, the sequencing of how they are applied always starts with any *benefit level co-pay*.

Please refer to your *table of benefits* for more details.

The examples on the next three pages show how the different *co-pay* will be calculated based on different scenarios. The actual *co-pay* applied will be based on the plan you selected.

If you have any further questions do not hesitate to contact the customer service team on **800 55 33** inside the UAE.

If you are outside the UAE you can call **00971 4 317 8499**.



### 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 *table of benefits*). *Benefits* that are 'Covered' are subject to the overall annual *benefit* maximum, where applicable. Please read the additional accompanying notes applicable to each *benefit* in the *table 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.

<b>Example 1: Healthguard Regional Plan - out-patient visit</b>	<b>You pay AED 100</b>	<b>We pay AED 1,580</b>
<p><b>Co-pay selected:</b> 20% up to a maximum of AED 100 per consultation.</p> <p>Visit to a provider for the following <i>out-patient benefits</i> on the same day:</p> <ul style="list-style-type: none"> <li>• Consultation with <i>medical practitioner</i> (AED 500)</li> <li>• Multiple <i>diagnostic tests</i> (AED 1,180)</li> </ul> <p><b>Total visit value: AED 1,680</b></p>	<p><b>What this means for you...</b> Your selected <i>co-pay</i> is 20% up to a maximum of AED 100 per consultation which means the amount you pay for each <i>out-patient</i> consultation is capped at AED 100, so that your contribution is limited to AED 100.</p>	
<b>Example 2: Healthguard International Plan - out-patient visit</b>	<b>You pay AED 100</b>	<b>We pay AED 1,330</b>
<p><b>Co-pay selected:</b> 20% up to a maximum of AED 100 per consultation.</p> <p>Visit to a provider for the following <i>out-patient benefits</i> on the same day:</p> <ul style="list-style-type: none"> <li>• Consultation with <i>medical practitioner</i> (AED 500)</li> <li>• Multiple <i>diagnostic tests</i> (AED 300)</li> </ul> <p>Next visit to the same provider for further <i>out-patient benefits</i> on a different day:</p> <ul style="list-style-type: none"> <li>• Multiple <i>diagnostic tests</i> (AED 880)</li> </ul> <p><b>Total visit value: AED 1,680</b></p>	<p><b>What this means for you...</b> Your selected <i>co-pay</i> is 20% up to a maximum of AED 100 per consultation which means the amount you pay for each <i>out-patient</i> consultation is capped at AED 100, so that your contribution is limited to AED 100.</p>	
<b>Example 3: Healthguard International Plus Plan - out-patient visit</b>	<b>You pay AED 500</b>	<b>We pay AED 6,000</b>
<p><b>Co-pay selected:</b> 10% up to a maximum of AED 50 per consultation.</p> <p>Visit to a provider for the following <i>out-patient benefits</i> on the same day:</p> <ul style="list-style-type: none"> <li>• Consultation with <i>medical practitioner</i> (AED 500)</li> <li>• Multiple <i>diagnostic tests</i> (AED 600)</li> </ul> <p>9 visits to the same provider for further <i>out-patient benefits</i> on a different day:</p> <ul style="list-style-type: none"> <li>• 9 consultations (AED 5,400)</li> </ul> <p><b>Total visit value: AED 6,500</b></p>	<p><b>What this means for you...</b> Your selected <i>co-pay</i> is 10% up to a maximum of AED 50 per consultation which means the amount you pay for each <i>out-patient</i> consultation is capped at AED 50. The amount you pay for each <i>out-patient</i> consultation is capped at AED 50, so that your contribution is limited to AED 500 (10 x AED 50).</p>	

## 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 *in-patient* and *day patient* basis are not subject to the associated limit of AED 50 applicable for the optional *co-pay* in relation to *out-patient 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*.

## Pre-existing conditions

It is very important that you have told us about any *pre-existing conditions* or *chronic conditions* as part of your *application*. We require you to disclose every aspect of the medical history for all applicants. This includes telling us about any changes to any medical conditions, *treatment*, or medication and any outstanding, ongoing, or repeat medical tests that have been suggested. 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 proposal. If there is any change in your health status from completing the *application* to the *start date* of the *policy* it is your responsibility to update us. Failing to do this can result in denial of your claims.

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 *table 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*.

### Example #5: Prescribed drugs for a pre-existing condition

Prescription drugs limit: AED 9,000

*Pre-existing conditions* limit: AED 150,000

Service	Net amount	Drugs limit	We pay	You pay
Prescribed Drugs and Dressing	AED 10,000	AED 9,000	AED 9,000	AED 1,000

Remaining *pre-existing conditions* limit: AED 141,000

Remaining prescribed drugs limit: AED 0

### Example #6: Non-emergency mental health for a pre-existing condition

Non-emergency mental health care: AED 10,000

*Pre-existing conditions* limit: AED 150,000

Service	Net amount	OP Mental Health limit	We pay	You pay
Non-emergency mental health care	AED 10,000	AED 10,000	AED 10,000	AED 0

Remaining *pre-existing conditions* limit: AED 140,000

Remaining non-emergency mental health care limit: AED 0



# Access your online Customer Area



To access your secure online Customer Area, please log on to [www.cignaglobal.com](http://www.cignaglobal.com) then;

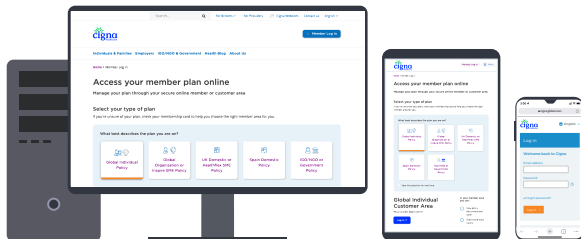
Click on the 'Customer Area Login' button at the top right of the page



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.

As a Cigna Healthcare 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.
- Check your coverage for you and your family.
- Submit claims online.
- Search for health care facilities and professionals near your location.
- Access the health and wellbeing site.

Download the Cigna Wellbeing app



Download the Safe Travel by Cigna app  
(International and International Plus plan customers only)



# 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 health care;
- Detailed coverage information;
- Personalised support and case management and;
- Global Care On Demand.

# Claim submission

Where *treatment* takes place at an in-network provider, we will settle *your* invoices directly with the provider. Please ensure *you* present *your* ID card, or *your* Emirates ID (in the UAE), at the time of receiving *treatment*. *You* only need to pay any applicable *benefit* level *co-pay* to the provider at the time of receiving *treatment*. When applicable to your plan, for *treatment* received at an out-of-network provider *you* will need to pay the provider and then submit *your* invoice and claim form.

## When to submit?

For reimbursement, claims should be submitted within a maximum of 180 days of receiving *treatment*. Any claims submitted after 180 days will not be considered. As per the reimbursement rule, the following needs to be submitted – all claim forms duly completed, together with all certificates, invoices, reports, test results etc., and more particularly a clear diagnosis by a *medical practitioner*. We reserve the right to request original copies of all documentation at any time.

## What to submit?

*You* will have to submit, at all times a duly filled claim form attaching the following:

- Copy of radiology/imaging reports, blood test results, other reports for special/diagnostic procedures etc. (where *you* have paid and are claiming for radiology/x-rays, imaging procedures e.g. Ultrasound, CT and/or MRI scans, blood tests, etc.).
- Copy of the prescription/s (where *you* have paid and are claiming for medications). Discharge summary and medical report (in case *you* are claiming in-*hospital* patient admissions).
- In case of surgical procedure, please attach operative notes, anesthesia sheets, and all histopathology reports.
- All invoices (with proper and detailed breakdown of amounts) and receipts (clearly showing that cash/credit card payment has been made by *you*).

## Tips to ensure a speedy claims settlement:

- Provide a *diagnosis* or *explanation of treatment* on the claim form.
- State *how* and *where* you want the reimbursement issued.
- Where the payment method selected is '*electronic bank transfer*', full details must be provided, including bank name and address, account name, account number and your bank's SWIFT code.
- Email scanned copies of *your* claim for reimbursement.

## For out-patient treatment:

- Official receipt showing the attending physician's detailed charges.

## Where to submit claims?

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

Email: [Claims.Healthguard@Cignahealthcare.com](mailto:Claims.Healthguard@Cignahealthcare.com)

## Non-reimbursable providers

We reserve the right to deny payment of reimbursement claims at specified out-of-network *healthcare providers* at our sole discretion. The list of non-reimbursable providers is available on our website, and it will be updated from time to time. Any claims for reimbursement of *treatment* incurred at any of these non-reimbursable provider, are not eligible for reimbursement. If you are unsure if a provider is on the non-reimbursable provider list please check the link on the website or call *your* customer service representative for assistance.

Please click [here](#) to access the list of non-reimbursable providers.

## Complaints procedures

We are committed to providing the highest standards of service to *our* customers. However, should there ever be an occasion when *you* feel that we have failed to honor *our* promise and that *you* would like to share your valuable feedback, we will do everything possible to ensure that your complaint is dealt with fairly, effectively and promptly.

### **The information provided here will show you how to:**

- Submit a complaint.
- Contact the right person quickly.
- Take further action if *you* are unhappy with the outcome.

### **The following standards apply to all complaints handling:**

- We will conduct complaints handling in a fair, transparent and timely manner;
- We will only ask and take into account relevant information when deciding on *your* complaint;
- At all times during the complaint process:
  - *You* will be treated with courtesy;
  - *Your* information will be treated with confidentiality;
  - *You* have the right to enquire about the progress of *your* complaint.

## Submission of complaints

You have a number of options to submit *your* complaint:

**a) Send an email** (along with any supporting material) to:

[Complaints.Healthguard@Cignahealthcare.com](mailto:Complaints.Healthguard@Cignahealthcare.com)

**b) Or call us:**

- Inside the UAE: **800 5533**
- Outside the UAE: **00971 4 317 8499**

### **Please ensure that your complaint is properly addressed to the Complaints Officer.**

In compliance with the applicable regulations, a Complaints Officer will be responsible for ensuring that *your* complaint is acknowledged, properly investigated, and that the company's response is promptly communicated to *you*.

### **What happens after your complaint is logged?**

- Once *you* have lodged *your* complaint, we will acknowledge within 2 working days of receipt of complaint.
- The Complaints Officer will refer *your* complaint to the concerned person/ department which will investigate it thoroughly and a written response detailing the outcome of *our* investigation and *our* decision shall be provided to *you* within 15 calendar days.
- In the unlikely event that *your* complaint has not been answered within the time frame mentioned above, we will write and let *you* know the reasons why and the further action that we will take including when we anticipate to have concluded *our* investigation.
- In the unlikely event that *you* are not satisfied with the solution provided by *us*, *you* have the right to escalate your complaint to Cigna Healthcare Senior Manager at [ceo.healthguard@cignahealthcare.com](mailto:ceo.healthguard@cignahealthcare.com). *Your* escalation will be acknowledged within two (2) business days, and a resolution sent within five (5) business days.
- After receiving the Senior Manager's written decision, and if *you* are still not satisfied, *you* can write directly to the following Regulatory Authority:

#### **- UAE:**

##### **UAE Central Bank – Sanadak Unit**

Ombudsman Unit for the  
United Arab Emirates

Emirates Institute of Finance Building,  
Ground Floor, Sultan Bin Zayed the  
First Street, Abu Dhabi.

Tel: 800 SANADAK (800 7 26 23 25)

Email: [info@sanadak.gov.ae](mailto:info@sanadak.gov.ae)

Link: <https://sanadak.gov.ae/>

#### **- Dubai:**

##### **Dubai Health Authority**

Feedback, complaints and  
suggestions can be logged on  
the health insurance partner  
relations opinion management  
e-system (iPROMes).

Link: <http://www.isahd.ae/Home/Ipromes>

# Frequently asked questions

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- 1. Who is Neuron?**

Neuron is a strategic partner of *Cigna Healthcare*. *Your* health insurance plan is serviced by Neuron.

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- 2. How do I know which providers are in the network?**

If *you* have any questions about *your* network, please contact our Customer Care Team.

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

**Email:** [service.healthguard@cignahealthcare.com](mailto:service.healthguard@cignahealthcare.com)

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- 3. Who should I contact if I have any questions about the policy?**

If *you* have any questions about *your* policy, please contact our Customer Care Team.

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

**Email:** [service.healthguard@cignahealthcare.com](mailto:service.healthguard@cignahealthcare.com)

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- 4. What happens if I claim outside my direct-billing network?**

If *you* have decided to be treated at a provider which is not listed in the *direct billing* network covered by *your* plan a different process applies and it would be subject to an out of network penalty and any *benefit* level *co-pay* applicable to *your* plan.

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- 5. When would I be required to pay an out-of-network (OON) co-pay?**

We have created a network of *healthcare providers*, with whom we have negotiated prices for certain services. In order to benefit from our negotiated prices, we encourage *you* to visit in-network providers.

If *you* choose to visit an OON provider (within *your* area of coverage) then *you* may need to pay OON *co-pay* based on the plan that *you* have chosen. The *co-pay* amount that *you* will need to pay is detailed within the *Table of Benefits*

It is also a requirement to show *your* ID card. If *you* do not show *your* ID card, even at an in-network provider, *your* claim will be incurred on an OON basis.

*Our* health insurance plans can provide coverage for services received when *you* have not used *your* ID card however these claims would be considered 'out of network (OON)', and charges at an OON provider are generally higher than our negotiated prices.

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- 6. Are all benefits subject to out-of-network co-pay?**

OON *co-pay* will apply to all *in-patient* and *out-patient* medical treatment received at an OON facility or at an in-network facility where *your* card was not shown to the provider.

OON *co-pay* does not apply to *emergency treatment* up to the

point of stabilisation or in the case that the *treatment* is not available within the network.

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## 7. When is prior authorisation required?

Prior authorisation is required for the following:

- All *in-patient* and *day-patient 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;
- *Dental* and optical *treatment*.
- Maternity antenatal
- Physiotherapy
- *Out-patient pathology*, radiology, and *diagnostic tests*

For prior approvals for *treatment*, please email us at: [Service.healthguard@signahealthcare.com](mailto:Service.healthguard@signahealthcare.com).

If you do not get *prior authorisation* 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 authorisation* when it was required for *treatment* inside the USA
- 20% if you did not obtain *prior authorisation* 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 *out-patient 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.

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## 8. How do I renew my Policy?

Your *policy* is not automatically renewed. 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 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*.

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**9. How do I add or remove a beneficiary?**

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.

Removal of a *beneficiary* is subject to the cancellation process.

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**10. Can I make changes to my 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, prior to confirmation of the renewal. No changes can be made once the renewal has been confirmed. Please contact your Sales representative if this is a New *Policy* during your first 30 days or your dedicated renewal team at least thirty (30) days prior to your *annual renewal date* and confirmation of your renewal, they will be happy to help and discuss the various options and any additional premiums payable.

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**II. How do I cancel my 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. 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).

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# Plan definitions

<b>Active treatment</b>	<i>Treatment</i> , which is intended to shrink a <i>cancer</i> , stabilise it or slow down the spread of the disease. This excludes <i>treatment</i> given solely to relieve symptoms.
<b>Acute</b>	A disease, <i>illness</i> or <i>injury</i> that occurs suddenly without any existing symptoms but improves over a short period of time and likely to respond quickly to <i>treatment</i> which aims to return the <i>beneficiary</i> to the state of health he or she was in immediately before suffering the disease, <i>illness</i> or <i>injury</i> , or which leads to his or her full recovery.
<b>Annual renewal date</b>	The anniversary of the <i>start date</i> each year.
<b>Application</b>	The <i>policyholder's application</i> (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 <i>they</i> made during their enrolment for <i>them</i> and any beneficiaries included in the <i>application</i> .
<b>Appropriate age intervals</b>	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>Area of cover - Regional</b>	Gulf Cooperation Council (GCC) countries, Armenia, Azerbaijan, Bangladesh, Bhutan, Brunei Darussalam, Cyprus/Northern Cyprus, Cambodia, Egypt, Georgia, India, Indonesia, Jordan, Kazakhstan, Kyrgystan, Lao Peoples Democratic Republic, Lebanon, Macao, Malaysia, Maldives, Mongolia, Myanmar, Nepal, Pakistan, Palestine / Isreal, Philippines, South Korea, Sri Lanka, Taiwan, Tajikistan, Thailand, Timor-Leste, Turkey, Turkmenistan, Yemen, Uzbekistan and Vietnam except where coverage and services (including payments) are illegal pursuant to and in compliance with applicable sanction laws
<b>Area of cover - Worldwide excluding USA</b>	All countries worldwide with the exception of The United States of America (USA).
<b>Area of cover - Worldwide including the USA</b>	Every country throughout the world and at sea, excluding any country or jurisdiction where, at the date of commencement of treatment, sanctions are applicable in accordance with the preamble of this policy and/or coverage and services (including payments) are illegal pursuant to applicable laws.
<b>Beneficiaries/ beneficiary</b>	Anybody named on <i>your Certificate of Insurance</i> as being covered under this <i>policy</i> , including newborn children.
<b>Benefit(s)</b>	Any <i>benefit( s)</i> shown in the <i>table of benefits</i> .

<b>Cancer</b>	A malignant tumour, tissues or cells, characterised by the uncontrolled growth and spread of malignant cells and invasion of tissue.
<b>Certificate of Insurance</b>	The certificate issued to the <i>policyholder</i> . This shows the <i>policy</i> number, <i>start date</i> , period of insurance, area of cover, network, plan <i>benefits</i> , optional modules and <i>out-patient co-pay</i> (if applicable), details of who is covered and any <i>conditions</i> that are covered at an additional premium.
<b>'Cigna Healthcare' 'we', 'us', 'our' 'the insurer'</b>	The insurer providing your policy; 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
<b>Chronic</b>	<i>Chronic</i> is defined as a disease, <i>illness</i> , or <i>injury</i> that has one or more of the following characteristics: <ul style="list-style-type: none"> <li>• It needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests.</li> <li>• It needs ongoing or long-term control or relief of symptoms.</li> <li>• It may require <i>rehabilitation</i> or the patient to be trained to cope with it.</li> <li>• It continues indefinitely.</li> <li>• It comes back or is likely to come back.</li> </ul>
<b>Clinic(s)</b>	A health care facility which is registered or licensed in the country in which it is located, primarily to provide care for <i>out-patients</i> and where care or supervision is by a <i>medical practitioner</i> .
<b>Complaints procedure</b>	Our policy and procedure for a <i>beneficiary</i> to make a complaint in relation to their <i>policy</i> contained in this <i>customer handbook</i> .
<b>Complementary therapist</b>	An acupuncturist, homeopath or practitioner of Chinese medicine who is appropriately qualified and entitled to practise in the country where <i>treatment</i> is given.
<b>Condition</b>	Any abnormality, deformity, disease, <i>illness</i> or <i>injury</i> ;
<b>Congenital condition</b>	Any <i>condition</i> present at birth, whether diagnosed or not.
<b>Co-pay/co-pay(s)</b>	Is the percentage of each claim which a <i>beneficiary</i> must pay themselves. The optional <i>out-patient co-pay</i> will be shown in the <i>Certificate of Insurance</i> , if applicable.
<b>Cosmetic</b>	Services procedures or items that are supplied only for aesthetic purposes and which are not needed in order to maintain an acceptable standard of health.
<b>Country of nationality</b>	Any country of which a <i>beneficiary</i> is a citizen, national or subject, as stated on your <i>application</i> .

<b>Customer Handbook</b>	This document which contains claiming information, the terms and conditions governing the <i>policy</i> . General Exclusions and Definitions which forms part of the <i>policy</i> .
<b>Day-patient treatment</b>	Care involving admission to <i>hospital</i> and using a bed but not staying overnight. In respect of <i>USA</i> based admissions, this also includes surgical procedures carried out in the <i>doctor's surgery</i> .
<b>Day-patient</b>	A patient who is admitted to a <i>hospital</i> or <i>day-patient</i> unit or other medical facility for <i>treatment</i> or because they need a period of medically supervised recovery, but who does not occupy a bed overnight.
<b>Dental emergency</b>	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 <i>beneficiary's</i> usual <i>dentist</i> or the <i>beneficiary</i> is staying at a place which is away from the dental practice he or she usually visits. The <i>treatment</i> covered in such an instance is to purely stabilise the problem and relieve severe pain.
<b>Dental injury</b>	<i>Injury</i> to a <i>sound natural</i> tooth caused by extra-oral impact. <i>Treatment</i> 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 <i>policy</i> .
<b>Dental treatment</b>	Any dental procedure or service which: <ul style="list-style-type: none"> <li>• Is needed for continued <i>oral health</i>; and</li> <li>• Is carried out or personally controlled by a <i>dentist</i>, including procedures provided by a hygienist; and</li> <li>• Is included in the <i>table of benefits</i>, or, though not included in the <i>table of benefits</i>, is accepted by <i>us</i> 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.</li> </ul>
<b>Dentist</b>	A <i>dentist</i> , 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 <i>treatment</i> is provided.
<b>Diagnostic tests</b>	Investigations such as x-rays or blood tests to find or to help to find the cause of the <i>beneficiary's</i> symptoms.
<b>Doctor</b>	A medical professional who holds an appropriate doctoral degree, is registered and licensed under the laws of the country, state or regulated area to practice medicine in the country in which the <i>treatment</i> is provided.
<b>Direct Billing</b>	<i>The Insurer</i> has arrangements with the Designated <i>Health care Providers</i> in the region allowing the Member to avail medical <i>Treatment</i> on a <i>direct billing</i> basis meaning that the <i>Insurer</i> will pay for the <i>treatment</i> direct to the Designated <i>Healthcare Provider</i> and the member does not have to submit a claim for reimbursement to <i>the Insurer</i> .
<b>Eligible female</b>	A married female on the <i>policy</i> , being either the <i>policyholder</i> or the <i>spouse</i> of the <i>policyholder</i> .

<b>Emergency treatment</b>	<i>Treatment</i> 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 <i>emergency conditions</i> include but are not limited to, heart attack, poisoning, severe allergic reaction, convulsions, unconsciousness, and uncontrolled bleeding. Services received in a <i>doctor's</i> office or urgent care facility are not considered emergencies.
<b>End date</b>	The date on which cover under this <i>policy</i> ends, as shown in the <i>Certificate of Insurance</i> and your <i>UAE Medical ID card</i> .
<b>Evidence-based treatment</b>	<i>Treatment</i> which has been researched, reviewed and recognised by: <ul style="list-style-type: none"> <li>• The National Institute for Health and Clinical Excellence; or</li> <li>• The <i>Cigna Healthcare</i> Medical Team; or</li> <li>• Another source recognised by the <i>Cigna Healthcare</i> Medical Team.</li> </ul>
<b>Excluded treatments</b>	<i>Treatment</i> which is excluded under the terms of your <i>policy</i> including the <i>treatments</i> outlined under the <i>general exclusions</i> .
<b>GCC</b>	Gulf Cooperation Council countries from time to time (which at the date of publication include; Saudi Arabia, <i>UAE</i> , Kuwait, Oman, Bahrain and Qatar).
<b>General exclusions</b>	Those matters, circumstances and <i>treatments</i> detailed in this <i>Customer Handbook</i> which are generally excluded and therefore not covered by your <i>policy</i> .
<b>Guarantee of payment</b>	A guarantee to pay agreed costs associated with particular <i>treatment</i> which we may give to a <i>beneficiary</i> or a <i>healthcare provider</i> .
<b>Group Companies</b>	The <i>Cigna Group</i> and any of its branches, subsidiaries or affiliates.
<b>Gene Therapy or Genetic Therapy</b>	<p><i>Treatment</i> 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. <i>Gene Therapy</i> is a technique that modifies a person's genes to treat or cure disease. <i>Gene Therapies</i> can work by several mechanisms:</p> <ul style="list-style-type: none"> <li>• Replacing a disease-causing gene with a healthy copy of the gene,</li> <li>• Inactivating a disease-causing gene that is not functioning properly or</li> <li>• Introducing a new or modified gene into the body to help treat a disease.</li> </ul> <p>Each <i>Gene Therapy</i> product is specific to a particular disease and is administered in a specialised manner. <i>Cigna Healthcare</i> determines which products are in the category of <i>Gene Therapy</i>, based on the <i>Cigna Healthcare</i> Clinical Guidelines and in part on:</p> <ul style="list-style-type: none"> <li>• The nature of the <i>treatment</i>, how it is distributed and administered, and</li> <li>• The <i>treatment</i> being considered <i>orthodox</i> including having received the necessary regulatory approvals.</li> </ul>

<b>Healthcare provider</b>	Any organisation which is registered or licensed as a medical or surgical <i>hospital, clinic</i> , laboratory, pharmacies, physiotherapy centres and other paramedical institutions or individual licensed (including <i>medical practitioners</i> ) to provide health care services in the country in which the <i>beneficiary</i> is located and where the patient is under the daily care or supervision of a <i>medical practitioner</i> or <i>qualified nurse</i> .
<b>Home nursing</b>	Visits from a <i>qualified nurse</i> to the <i>beneficiary's</i> home to give expert nursing services for up to thirty (30) days: <ul style="list-style-type: none"> <li>• Immediately after <i>hospital treatment</i> as required by <i>medical necessity</i>; and</li> <li>• Visits for <i>treatment</i> which would normally be provided in a <i>hospital</i>.</li> </ul> <i>Home nursing</i> is only covered when the <i>specialist</i> who treated the <i>beneficiary</i> has recommended such services.
<b>Hospital</b>	Any organisation or institution which is registered or licensed as a medical or surgical <i>hospital</i> in the country in which it is located and where the <i>beneficiary</i> is under the daily care or supervision of a <i>medical practitioner</i> or <i>qualified nurse</i> .
<b>Initial start date</b>	The first day the <i>beneficiary's</i> cover commenced.
<b>Injury</b>	A <i>physical injury</i> .
<b>In-patient</b>	A patient who is admitted for <i>treatment</i> to <i>hospital</i> and who occupies a bed overnight or longer or who has received more than eight (8) hours continuous <i>treatment</i> or care in a <i>hospital</i> (where such patient has been registered as an admission), for medical reasons.
<b>Insurance</b>	The coverage which is provided by <i>us</i> to the <i>beneficiaries</i> subject to the terms, conditions, limits and exclusions set out in this <i>Customer Handbook</i> , your <i>Certificate of Insurance</i> and <i>medical ID Card(s)</i> .
<b>Intensive care</b>	A specialised department in a <i>hospital</i> that provides <i>intensive care treatment</i> , for example an <i>intensive care unit</i> , critical care unit, intensive therapy unit, or <i>intensive treatment unit</i> .
<b>International Emergency Services</b>	<i>International Emergency Services</i> means services arranged by the <i>Medical Assistance Service</i> for the <i>Policy</i> that may cover emergency medical evacuation, medical repatriation, and repatriation of mortal remains.

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## 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*.

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## Medically appropriate

Medical *Treatment* appropriate with reference to locally and internationally recognised clinical guidelines of medical practice relative to a specific *condition*.

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## 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.

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## 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 health care 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.

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<b>Medical practitioner</b>	A <i>doctor</i> or <i>specialist</i> who is registered or licensed to practice medicine under the laws of the country, state or other regulated area in which the <i>treatment</i> is provided, and who is not a <i>beneficiary</i> under this <i>policy</i> , or a family member of a <i>beneficiary</i> under this <i>policy</i> .
<b>Medical ID cards</b>	The identity cards issued to <i>beneficiaries</i> to access <i>treatment</i> . Each <i>beneficiary</i> will receive two ID cards. One for receiving <i>treatment</i> in the UAE region and the other one for <i>treatment</i> in all other countries, subject to the terms of <i>your policy</i> .
<b>Oral health</b>	For a patient, a reasonable standard of <i>oral health</i> of the teeth, their supporting structures and other tissues of the mouth, and of dental efficiency, according to a standard acceptable to a <i>dentist</i> of ordinary competence and skill in the Emirate of Dubai and the Northern Emirates which will safeguard his or her general health.
<b>Orthodox</b>	When used in relation to a procedure or <i>treatment</i> that is medically accepted in the jurisdiction in which it was performed and which meets minimally accepted international medical standards at the time of the commencement of the procedure or <i>treatment</i> , in that it accords with that upheld by a respectable, responsible and substantial body of medical opinion, experienced in the particular field of medicine.
<b>Out-patient</b>	A <i>beneficiary</i> who does not need to stay overnight in a <i>Healthcare Provider</i> for either consultation with a <i>Specialist</i> or for <i>Treatment</i> .
<b>Out-patient visit</b>	A visit on an <i>out-patient</i> basis to receive an <i>out-patient benefit</i> or multiple <i>out-patient benefits</i> , as included in the <i>table of benefits</i> , on the same day and with the same <i>healthcare provider</i> . An <i>out-patient visit</i> also includes the collection or delivery of prescription drugs and dressings prescribed on an <i>out-patient</i> basis. Any visit to a different <i>healthcare provider</i> on the same day will be treated as a separate <i>out-patient visit</i> . Any <i>out-patient benefit(s)</i> received on a different day will also be treated as a separate <i>out-patient visit</i> .
<b>Palliative care</b>	<i>Treatment</i> that does not cure or substantially improve a <i>condition</i> but is given in order to alleviate symptoms.
<b>Period of cover</b>	The twelve (12) month continuous period during which the <i>beneficiaries</i> are covered under this <i>policy</i> , being the period from the <i>start date</i> to the <i>end date</i> as noted on the <i>Certificate of Insurance</i> or earlier if terminated in accordance with Clause 19 of the <i>Customer Handbook</i> .
<b>Persistent vegetative state</b>	A <i>beneficiary</i> who is in a vegetative state for at least ninety (90) consecutive days. A <i>persistent vegetative state</i> means a <i>condition</i> caused by <i>injury</i> , disease or illness in which the <i>beneficiary</i> 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.

<b>Policy</b>	The <i>policy</i> comprising this <i>Customer Handbook</i> (which includes the <i>complaints procedure</i> ) and your <i>Certificate of Insurance</i> .
<b>Policy documents</b>	The documentation relating to the <i>policy</i> , comprising of this <i>Customer Handbook</i> , your <i>application</i> , your <i>Certificate of Insurance</i> , your <i>Table of Benefits</i> and your <i>Medical ID Card (s)</i> .
<b>Policyholder</b>	A person who has made an <i>application</i> to us which has been accepted in writing by us, and who pays the premium under the <i>policy</i> .
<b>Prior authorisation</b>	A process through which a <i>beneficiary</i> or designated <i>healthcare provider</i> seeks approval from us prior to undergoing <i>treatment</i> to ensure that the proposed <i>treatment</i> falls within the scope of cover, subject to the terms of the <i>policy</i> and shall fall within the <i>healthcare providers</i> agreed rates.
<b>Pre-existing condition</b>	Any known/unknown <i>medical condition</i> or related <i>medical condition</i> ( <i>Injury</i> , illness, <i>Sickness</i> , disease or other physical, medical, mental or nervous <i>condition</i> , disorder or ailment) that with reasonable medical certainty existed prior to joining the <i>policy</i> , whether or not previously manifested or symptomatic, diagnosed, treated or disclosed, including any subsequent, <i>chronic</i> or recurring complications related to it.
<b>Qualified nurse</b>	A nurse who is registered or licensed as such under the laws of the country, state or other regulated area in which the <i>treatment</i> is provided.
<b>Qualifying life event</b>	<ul style="list-style-type: none"> <li>• Marriage;</li> <li>• Divorce or separation;</li> <li>• Birth of a child;</li> <li>• Legal adoption of a child; or</li> <li>• Death of a <i>spouse</i>, partner or child.</li> </ul> <p>We may require evidence of the above event.</p>
<b>Reasonable and customary costs</b>	<p>Those charges which we or our medical team consider as being <i>reasonable and customary</i> in the relevant territory for <i>treatment</i> provided by <i>medical practitioners</i> or <i>healthcare providers</i> outside of our network to the extent that they do not exceed the general level of charges being made by <i>healthcare providers</i> or <i>medical practitioners</i> of similar standing in the locality where the charges are incurred when providing comparable <i>treatment</i>, services or supplies to individuals of the same sex and of comparable age for a <i>condition</i>.</p> <p>The charges will be limited to the level of charges that would have been incurred by us should the <i>beneficiary</i> have received <i>treatment</i> at any <i>healthcare provider</i> in our applicable network;</p>
<b>Rehabilitation</b>	Physical, speech and occupational therapy for the purpose of <i>treatment</i> aimed at restoring the <i>beneficiary</i> to their previous state of health after an <i>acute</i> event.

<b>Schedule of surgical procedures</b>	The current <i>schedule of surgical procedures</i> approved by our chief medical officer.
<b>Selected area of coverage</b>	Either: <ul style="list-style-type: none"> <li>• GCC, Middle East, Asia (excluding Singapore, Japan, Hong Kong and China)</li> <li>• Worldwide, including the <i>USA</i>; or</li> <li>• Worldwide, excluding the <i>USA</i>.</li> </ul>
<b>Short-term</b>	A period of time consistent with the recuperation time required for the <i>treatment</i> and as prescribed by the treating <i>medical practitioner</i> with the approval of our medical director.
<b>Sickness</b>	A physical or mental illness, including illness resulting from or relating to pregnancy.
<b>Sound natural tooth/teeth</b>	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: <ul style="list-style-type: none"> <li>• Decay or filling;</li> <li>• Gum disease associated with bone loss;</li> <li>• Root canal <i>treatment</i>.</li> </ul>
<b>Specialist</b>	A <i>doctor</i> who is recognised, registered or licensed as such under the laws of the country, state or other regulated area in which the <i>treatment</i> is provided and only for the <i>treatment</i> which is being recommended.
<b>Spouse</b>	A <i>beneficiary's</i> legal husband or wife, who we have accepted for cover under this <i>policy</i> .
<b>Start date</b>	The date on which coverage under this <i>policy</i> starts, as shown in the <i>Certificate of Insurance</i> and your <i>UAE Medical ID card</i> .
<b>Surgery</b>	The branch of medicine that treats diseases, <i>injuries</i> , and deformities by operative methods which involves an incision into the body.
<b>Surgical appliance(s), Medical appliance(s)</b>	Either: <ul style="list-style-type: none"> <li>• An artificial limb, prosthesis or device which is required for the purpose of or in connection with <i>surgery</i>; or</li> <li>• An artificial device or prosthesis which is a necessary part of the <i>treatment</i> immediately following <i>surgery</i> for as long as required by <i>medical necessity</i>; or</li> <li>• A prosthesis or appliance which is <i>medically necessary</i> and is part of the recuperation process on a <i>short-term</i> basis.</li> </ul>
<b>Table of Benefits</b>	The list of <i>benefits</i> and exclusions agreed between <i>Us</i> and <i>You</i>
<b>Therapist</b>	A speech <i>therapist</i> , dietician or orthoptist who is suitably qualified and holds the appropriate license to practice in the country where <i>treatment</i> is received.

<b>Treatment</b>	Any surgical or medical <i>treatment</i> controlled by a <i>medical practitioner</i> that is <i>medically necessary</i> to diagnose, cure or substantially relieve disease, illness or <i>injury</i> .
<b>UAE</b>	The United Arab Emirates.
<b>Unauthorised Claim</b>	A claim in relation to <i>treatment</i> (or any related costs or services) which does not or is subsequently determined by <i>us</i> as not qualifying for payment under this <i>policy</i> .
<b>Underwriting Proposal form</b>	A summary statement of our decision provided during the <i>application</i> process following our review of <i>your</i> medical questionnaire completed for <i>you</i> and any <i>beneficiary</i> .
<b>USD</b>	United States Dollars, the lawful currency of the United States of America.
<b>You, your</b>	The <i>policyholder</i> .

# Terms and Conditions

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## 1. Scope of cover

Subject to the terms, conditions, limits and exclusions set out in this *policy*, Cigna Healthcare 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*, *your Table of Benefits* 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?

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 proposal 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 *table 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 proposal form*.

Any *pre-existing conditions* and/or any *preexisting 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.

## 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 Healthcare not to renew shall not be based on your claim's 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*. 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 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.

## 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 *table 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).

## II. Return Home Cash Benefit

- 10.1 If a *beneficiary* requests to travel back to their *country of nationality* for *medically necessary in-patient* or *day-patient* 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 *in-patient* and *day-patient 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;
- *Dental* and optical *treatment*.
- Maternity antenatal;

- Physiotherapy;
- *Out-patient* pathology, radiology and *diagnostic tests*

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

There are a number of *out-patient treatments* and consultations that do not require *prior authorisation*. Where *prior authorisation* is not required for *out-patient 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. Prior authorisation for treatment

- 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 your *table of benefits*.
- 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 will be set out in your *table of benefits*.

#### 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

#### 14.1 Standard Maternity Care

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 *table 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 conditions* covered under the *benefit 'Complications arising from Maternity and childbirth (Treatment for life threatening maternity conditions) and medically necessary termination'*.

#### **14.2 Optional Mother and Baby Care Module for enhanced Maternity Care**

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*.

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 in 'Area of cover - Regional' on page 20 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. Healthguard plans coverage

*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 *table of benefits* and any *out-patient 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 health care 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. Healthguard plans coverage

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 AED 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* 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*'.

A list of *Cigna Healthcare* 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 annually or quarterly by credit card or bank transfer.

## 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 *table of benefits*.
- If you select the optional Healthy Connect extra coverage, a mandatory *co-pay* applies to certain *dental treatments* as detailed in the *table of benefits*.
- 18.2 You can select an optional *co-pay* in relation to *out-patient treatment*.
- If you have selected the 10% up to a maximum of AED 50 *co-pay*, the maximum amount you will pay for every *out-patient* consultation is AED 50.
  - If you have selected the 20% up to a maximum of AED 100 *co-pay*, the maximum amount you will pay for every *out-patient* consultation is AED 100.
  - If you have selected the 10% on all *out-patient co-pay*, you will pay 10% of the total cost of the invoice.
  - This means the amount we pay towards the *out-patient visits* is reduced by the *co-pay* percentage. The *co-pay* percentage results in a proportion of the *out-patient* costs not being covered by us;.
  - 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 *out-patient 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 *out-patient* 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*). 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 19.14 or Clause 19.15, 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 group from *The 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 email address you have given us.

## 25. Contacting us

If you need to contact us, you should email us at:  
[service.healthguard@cignahealthcare.com](mailto:service.healthguard@cignahealthcare.com)

or 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.

**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. Contacting us

- 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 health care 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 Healthcare 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 in this *Customer Handbook* and forming part of the *policy*.

#### Applicable law and jurisdiction

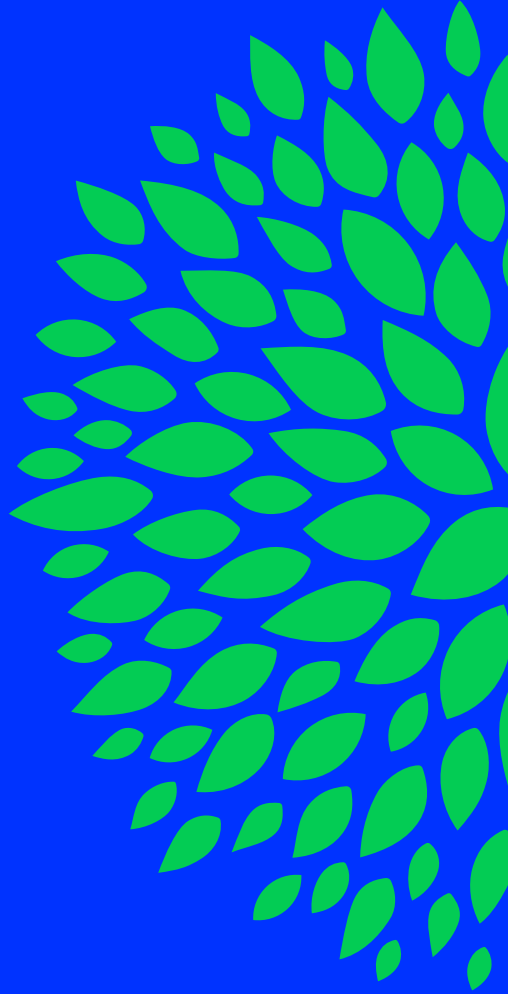
34.1 This *policy* is governed by, and will be interpreted in accordance with the law of the UAE.

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

## 5 Assignment and Transfers

You hereby irrevocably agree that we may assign, sell, transfer or novate, as the case may be, any of *our* rights and obligations under the whole or any part of this *Policy* to any of *our Group Companies* (Transferee), including the transfer of any personal information of a member or other individual covered under this *Policy* (Transfer). For the avoidance of doubt, You will not be required to provide any further prior consent to a Transfer, whether in writing or otherwise, provided that we shall give written notice to You following the Transfer.

Following the date of the Transfer, this *Policy* shall be binding on the Transferee, who, for the avoidance of doubt, shall be liable for all claims under this *Policy* by a member or other individual covered under this *Policy*. You hereby waive any claims under this *Policy* against us following the date of the Transfer. Except as expressly permitted by this clause 35, neither Party may assign, grant any security interest over, hold on trust or otherwise transfer the benefit of the whole or any part of this *Policy*.



Cigna Insurance Middle East S.A.L. (Dubai Branch), The Offices 3 at One Central, Dubai World Trade Centre, Office No. 111, Level 1, PO Box 3664, Dubai, UAE. Cigna Insurance Middle East S.A.L. (Dubai Branch), is the local insurer in UAE. Registered and authorised by the UAE Insurance Authority as a branch of a foreign insurance company under registration No. 48 on 31 December 1984.