Cigna VHIS Series

Standard Plan

The Standard Plan is Cigna Healthcare's simple, no-frills VHIS plan that covers all the essentials. It gives you valuable financial support for private hospitalization and a range of common surgical treatments.

Plan at a glance

Certified Plan	Cigna VHIS Series - Standard Plan
Plan type	This product is a standalone individual policy which aims to provide hospitalization benefits. It is an indemnity insurance policy without cash value.
Policy term and Premium structure	1 year and annually renewable The plan provides a protection period of 1 year and guaranteed renewable up to Age 100 of Insured Person, with payment period until the end of protection period. Premium rate will increase with Age, and yearly adjustable
Entry Age (at last birthday)	15 days to Age 80
Enrolment	No medical examination required before enrolment
Premium payment frequency	Annual/ Monthly
Policy currency	HKD
VHIS Certification Numbers	S0003I-0I-000-02
Area of coverage	Worldwide[1]
Choice of healthcare services providers	No restriction
Choice of ward class	No restriction
Annual Benefit Limit (Applies across benefit items)	HK$420,000 per Policy Year
Lifetime Benefit Limit	Nil

Remarks:

I. Psychiatric treatments benefit is limited to Hong Kong only.

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Thank you for considering Sun Flower to be one of your selected intermediaries.

We are pleased to get in touch should you have any enquiry regarding the captioned insurance.

Benefit schedule

Benefits are reimbursed on Medically Necessary and Reasonable and Customary basis. For more information, please refer to "Important Information" of this brochure or Policy Provision.

Benefit items[1]	Benefit limit (in HKD)
a. Room and board	$750 per day Maximum 180 days per Policy Year
b. Miscellaneous charges	$14,000 per Policy Year
c. Attending doctor's visit fee	$750 per day Maximum 180 days per Policy Year
d. Specialist's fee[2]	$4,300 per Policy Year
e. Intensive care	$3,500 per day Maximum 25 days per Policy Year
f. Surgeon's fee	Per surgery, subject to surgical category for the surgery/procedure in the Schedule of Surgical Procedures – • Complex $50,000 • Major $25,000 • Intermediate $12,500 • Minor $5,000
g. Anaesthetist's fee	35% of Surgeon's fee payable[5]
h. Operating theatre charges	35% of Surgeon's fee payable[5]
i. Prescribed Diagnostic Imaging Tests[2,3]	$20,000 per Policy Year Subject to 30% Coinsurance
j. Prescribed Non-surgical Cancer Treatments[4]	$80,000 per Policy Year
k. Pre- and post-Confinement/Day Case Procedure outpatient care[2]	$580 per visit, up to $3,000 per Policy Year • 1 prior outpatient visit or Emergency consultation per Confinement/ Day Case Procedure • 3 follow-up outpatient visits per Confinement/Day Case Procedure (within 90 days after discharge from Hospital or completion of Day Case Procedure)
l. Psychiatric treatments	$30,000 per Policy Year

Remarks:

1. Eligible Expenses incurred in respect of the same item shall not be recoverable under more than one benefit item in the table above.
2. The Company shall have the right to ask for proof of recommendation e.g. written referral or testifying statement on the claim form by the attending doctor or Registered Medical Practitioner.
3. Tests covered here only include computed tomography ("CT" scan), magnetic resonance imaging ("MRI" scan), positron emission tomography ("PET" scan), PET-CT combined and PET-MRI combined.
4. Covers a number of non-surgical cancer treatments including chemotherapy, radiotherapy, targeted therapy, immunotherapy and hormonal therapy etc. Proton therapy, gamma knife and cyber knife are radiation treatments that are also covered as radiotherapy.
5. The percentage here applies to the Surgeon's fee actually payable or the benefit limit for the Surgeon's fee according to the surgical categorisation, whichever is the lower.

Important information

The product information included in the brochure does not contain the full terms of the Policy and the full terms can be found in the Policy document.

Cooling-off right and Policy Cancellation

You may cancel your policy and obtain a refund of any premium(s) and levy paid by you within the cooling-off period. The cooling-off period is the period of 30 calendar days immediately following either the day of delivery of the policy or the cooling-off notice to you or your nominated representative (whichever is the earlier). The cooling-off notice is a notice that will be sent to you or your nominated representative by Cigna Worldwide General Insurance Company Limited to notify you of the cooling-off period around the time the policy is delivered. To exercise this right, a written notice of cancellation must be signed by you and received directly by Cigna Worldwide General Insurance Company Limited at 16/F, 348 Kwun Tong Road, Kwun Tong, Kowloon, Hong Kong within the cooling-off period. No refund can be made if a claim has been made.
After the cooling-off period, the Policy Holder can request cancellation of the policy by giving thirty (30) days prior written notice to the Company, provided that there has been no benefit payment under the policy during the relevant Policy Year.

Claims Procedure

To make a claim, please login to our customer portal or register at www.mycigna.com.hk or download our MyCigna app. For details of procedures by claims type, please visit the Company website www.cigna.com.hk/en/customer-service/insurance-claim-procedure.

Reasonable and Customary

Reasonable and Customary shall mean, in relation to a charge for Medical Service, such level which does not exceed the general range of charges being charged by the relevant service providers in the locality where the charge is incurred for similar treatment, services or supplies to individuals with similar conditions, e.g. of the same sex and similar Age, for a similar Disability, as reasonably determined by the Company in utmost good faith. The Reasonable and Customary charges shall not in any event exceed the actual charges incurred.
In determining whether a charge is Reasonable and Customary, the Company shall make reference to the followings (if applicable)-

a. treatment or service fee statistics and surveys in the insurance or medical industry;
b. internal or industry claim statistics;
c. gazette published by the Government; and/or
d. other pertinent source of reference in the locality where the treatments, services or supplies are provided.

Medically Necessary

Medically Necessary shall mean the need to have medical service for the purpose of investigating or treating the relevant Disability in accordance with the generally accepted standards of medical practice and such medical service must –

a. require the expertise of, or be referred by, a Registered Medical Practitioner;
b. be consistent with the diagnosis and necessary for the investigation and treatment of the Disability;
c. be rendered in accordance with standards of good and prudent medical practice, and not be rendered primarily for the convenience or the comfort of the Insured Person, his family, caretaker or the attending Registered Medical Practitioner;
d. be rendered in the setting that is most appropriate in the circumstances and in accordance with the generally accepted standards of medical practice for the medical services; and
e. be furnished at the most appropriate level which, in the prudent professional judgment of the attending Registered Medical Practitioner, can be safely and effectively provided to the Insured Person.

Pre-existing condition

Pre-existing Condition means any Sickness, Disease, Injury, physical, mental or medical condition or physiological degradation, including congenital condition, that has existed prior to the Policy Issuance Date or the Policy Effective Date, whichever is the earlier. You are considered to be aware of a Pre-existing Condition where –

a. it has been diagnosed;
b. it has manifested clear and distinct signs or symptoms; or
c. medical advice or treatment has been sought, recommended or received.

Eligible Expenses arising from unknown Pre-existing Condition(s) that you would not reasonably have been aware of are payable according to the following waiting period and reimbursement arrangement.

- Ist Policy Year: no coverage
- 2nd Policy Year: 25% reimbursement
- 3rd Policy Year: 50% reimbursement
- 4th Policy Year onwards: full coverage

However, if you are requested but fail to disclose to us upon submission of the insurance application, including any updates of and changes to the required information, that the Insured Person is suffering from a Pre-existing Condition of which the Policy Holder or the Insured Person is aware or should have reasonably been aware of at the time of submission of Application, the Company has the right to declare the relevant insurance policy void, demand repayment of any benefits paid and/or refuse to provide coverage under its terms and benefits. In such event, the Company shall refund the premium.

Premium

1. **Premium Level**
   The premium corresponding to the plan you select is determined based on the Age and smoking habit of the Insured Person at the Policy Effective Date.

2. **Non-payment of Premium**
   If you fail to pay the initial premium, your Policy will not take effect from the commencement date of your Policy. Except for the initial premium payment, there will be a grace period of 30 days after any premium due date. Your Policy will remain effective during this grace period. If any premium is not paid at the end of the grace period, your Policy will lapse on the premium due date and you will lose the insurance cover.
   We will not make any claim payment or any other payment payable under the Policy, until we receive payment

of all outstanding premium up to the date of the claim payment or when the Policy terminates.

3. **Mis-statement of Age or Smoking Habit**
   If Age or smoking habit is mis-stated by you or any Insured Person (and the relevant Insured Person would still be eligible for coverage), we have the right to adjust the premiums payable based on the correct information.

4. **Premium adjustment**
   The Company reserves the right to revise the Standard Premium of the Policy on the anniversary date or upon renewal. Factors leading to premium adjustment may include but are not limited to our overall experience in claims and expenses incurred by and/or in relation to this product.

Duplicated policy

Each person can only be covered under one single "Cigna VHIS Series" policy. The series includes "Cigna VHIS Series – Standard Plan", "Cigna VHIS Series – Flexi Plan(SMM)", "Cigna VHIS Series – Flexi Plan (Superior)" and any other insurance policies that fall under the "Cigna VHIS Series" as defined and issued by the Company from time to time.
Existing holders of "Cigna HealthFirst Medical Plan Series" policies should contact the Company to discuss their options with regard to policy migration.

Conversion of policy

If you have an existing medical insurance policy and intend to switch the coverage to this plan, please be aware of the potential implications in terms of insurability, claims eligibility and financial values regarding the change to the insurance arrangement.

Some benefits under the existing policy may be changed or not be covered under this plan due to changes in policy features, Age, health conditions, occupation, lifestyle, habit or recreational activities. Also, riders or supplementary benefits under your existing insurance policy may not be available under this plan.

Benefits under the existing insurance policy will no longer be payable to you if you surrender the policy or allow it to lapse. Besides, you may need to start a new waiting period (if any) in respect of certain benefits under the terms and conditions of the new policy.

Renewal

This Policy shall be effective for an initial period of twelve (12) months and is thereafter guaranteed to be automatically renewable for successive periods of twelve (12) months up to the Age of one hundred (100) years of the Insured Person. The Company shall have the right to revise the Terms and Benefits of the Policy and/or the Premium upon each renewal.

Termination

1. The Policy will be automatically terminated when one of the following happens:
   - The Insured Person passes away;
   - Any premium is not paid at the end of the grace period;
   - The Policy is terminated or not renewed by the Policy Holder; or
   - The Company has ceased to have the requisite authorisation under the Insurance Ordinance to write or continue to write this Policy.

2. If there is any fraud, mis-statement or concealment in the application or declaration, or if you or your beneficiary makes a dishonest claim, we have the right to cancel the policy immediately. In such case, all the premium paid will not be returned and you shall immediately return all payment including claims paid by us under the Policy.

Inflation risk

Your current planned benefit may not be sufficient to meet your future needs since the future cost of living may become higher than it is today due to inflation. Where the actual rate of inflation is higher than expected, you may receive less in real terms even if we meet all of our contractual obligations.

Key Exclusions

The following list is for reference only and it is not a full list of exclusions. Please refer to the Terms and Conditions for the complete list and details of exclusions.

Cigna Healthcare shall not pay any benefits in relation to or arising from the following:

1. Medical Services that are not Medically Necessary.
2. Confinement solely for the purpose of diagnostic procedures or allied health services, including but not limited to physiotherapy, occupational therapy and speech therapy.
3. Human Immunodeficiency Virus ("HIV") and its related Disability.
4. Dependence, overdose or influence of drugs, alcohol, narcotics or similar drugs or agents, self-inflicted injuries or attempted suicide, illegal activity, or venereal and sexually transmitted disease or its sequelae.
5. Services for beautification or cosmetic purposes, or correcting visual acuity or refractive errors that can be corrected by fitting of spectacles or contact lens.
6. Prophylactic treatment or preventive care, including but not limited to general check-ups, routine tests, screening procedures for asymptomatic conditions, immunisation or health supplements.
7. Dental treatment and oral and maxillofacial procedures performed by a dentist.
8. Maternity conditions and its complications.
9. Purchase of durable medical equipment or appliances.
10. Traditional Chinese Medicine treatment.
11. Experimental or unproven medical technology or procedure in accordance with the common standard, or not approved by the recognised authority, in the locality where the treatment, procedure, test or service is received.
12. Congenital Condition(s) which have manifested or been diagnosed before the Insured Person attained the Age of eight (8) years.
13. Eligible Expenses which have been reimbursed under any law, or other medical program or insurance policy.
14. War, civil war, invasion, acts of foreign enemies, hostilities, rebellion, revolution, insurrection, or military or usurped power.

Notes:
"Cigna Healthcare", "the Company", "We", "our" or "us" herein refers to Cigna Worldwide General Insurance Company Limited.
This product brochure is also available in Chinese. You may request for the Chinese version from us.
此產品小冊子同時備有中文版本，閣下可向本公司索取中文版本。

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