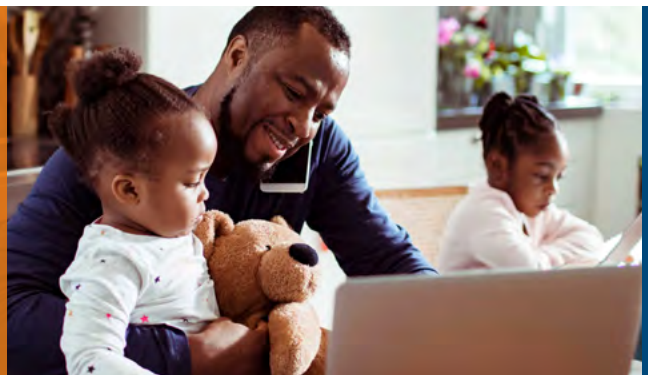
CIGNA AFRICA:
GENERAL TERMS & CONDITIONS

Together, all the way.®

Cigna®

Assemble INSURANCE

CONTENTS



IMPORTANT INFORMATION

The General Policy Provisions as set out in Section I, are only valid insofar as they are not contradicted by or in conflict with the specific provisions of the different types of cover as set out in Section II. In case of contradiction or conflict, the latter take precedence over the former. Moreover, the Special Terms and Conditions will always take precedence over the General Terms and Conditions.

1. Translated Wordings

If the Policyholder has been provided with a translation of the English version of the present General Terms and Conditions, it is understood and agreed that the translation is provided for convenience only and that the English version of the present General Terms and Conditions governs the relationship between the Policyholder and the Insurer.

In the event of a discrepancy between the English version of the General Terms and Conditions and the translation, the English version shall prevail.

2. Right of withdrawal

If the Policyholder is not satisfied with this Policy for whatever reason, it may be returned to the Administrator within a period of fourteen (14) calendar days. The period for withdrawal shall begin from the Commencement Date or the day on which the Policyholder receives these General Terms and Conditions (if that is later). The Administrator will cancel the Policy and refund all premiums paid, on the condition that no claims have been incurred or submitted yet.

3. Change of address

The Policyholder and/or Insured Persons should notify the Administrator immediately of any change of address (including e-mail address) so that the Administrator can keep them informed of important information or to facilitate the payment of claims.

4. General information

The Administrator

Cigna International Health Services Kenya Limited,
One Africa Place, 12th Floor,
PO BOX 331-00606, Nairobi, Kenya.

The Insurer

The Insurer set out in the
Special Terms and Conditions
attached hereto.

5. Contacts

If the Policyholder (Employer) has any queries on this Policy, they can contact their dedicated Client Executive or Client Manager, or write to: [TBC – client email address]

If the Insured Person (Employee) has any queries they can contact:

Telephone:	[TBC – phone number]or;
Email:	[TBC – member email address] or;
Logon to:	[Envoy address] – using the plan member info provided or;
Post:	[TBC – Cigna Address for CS]

The above contact information will enable the Insured Person to manage the following category of queries:

1. Benefits available and used within the plan;
2. Requests for guarantees of payment;
3. Claim payment received or outstanding;
4. Emergency evacuations.

6. Complaints

If the Policyholder and/or an Insured Person have exhausted the avenues offered above and either remain dissatisfied with a claims decision or the standard of service received under this Policy, they should:

Email:	[TBC- Complaints email]
Post:	[TBC – Complaints address]

SECTION I: GENERAL POLICY PROVISIONS

1. Order of precedence, purpose and compliance

1.1. Contract documents and order of precedence

This Policy constitutes the entire agreement between the Insurer and the Policyholder and includes the present Cigna Africa General Terms and Conditions and the Special Terms and Conditions which are attached to this Policy.

The General Policy provisions as set out in Section I are only valid insofar as they are not contradicted by or in conflict with the specific provisions of the different types of cover as set out in Section II. In case of contradiction or conflict, the latter shall prevail over the former.

The Special Terms and Conditions will always take precedence over the General Terms and Conditions.

1.2. Purpose of the insurance

The Cigna Africa Base Plan provides the following insurance cover for employers for the benefit of their eligible Employees and can include Dependents.

Base Plan

1. Cigna Africa

The Cigna Africa Base Plan reimburses – Reasonable and Customary expenses for Outpatient Treatment as well as for Inpatient Treatment, provided these expenses have been incurred because of Illness, Injury or Maternity. The full benefits are set out in Section II, up to the limits defined in this Policy and according to its terms and conditions.

The Policyholder can choose between the following different plans, each providing different levels of cover (listed in increasing order of the level of cover afforded):

1.1. Core Care
1.2. Standard Care
1.3. Select Care
1.4. Essential Care
1.5. Executive Care
1.6. Elite Care

The plan chosen by the Policyholder is specified in the Special Terms and Conditions of the Policy.

Additional Insurances

2. Dental and Vision Care

This insurance can be taken out as additional insurance to the Cigna Africa Base Plan.

1.3. Compliance

1.3.1. The Insurer's products and services (including those services provided by the Administrator) may not be available in all jurisdictions and are expressly excluded from this Policy where prohibited by the applicable law.

1.3.2. This Policy has been issued on the understanding that, neither the Policyholder nor Insured Persons are on any economic sanctions list as for example, but not limited to, Specially Designated Nationals and Blocked Persons. It is further expected that neither the Policyholder nor Insured Persons are engaged directly or indirectly in the activities that these sanctions specifically condemn. Should it emerge at any point that this is not the case the Insurers may cancel the Policy and all coverage will be null and void.

1.3.3. The Insurer, Policyholder and any Insured Person must comply with economic sanctions rules related to individuals, entities, including but not limited to those imposed by the United Nations, the European Commission, the United States, and Canada. Cover will not be provided nor benefits payable if doing so would violate these sanctions rules.

1.3.4. In the event it becomes apparent that a sanctioned individual or entity is enrolled under the Policy, all appropriate action will be taken, which could include blocking, reporting, and terminating coverage. There is no obligation to provide notice in advance of taking these actions, or to obtain licenses from any government to enable the extension of coverage in compliance with sanctions laws.

1.3.5. Restrictions will apply to claims incurred in sanctioned countries where there is no relevant, approved license from the U.S. Office of Foreign Assets Control. Among the restrictions, the following will not be covered: (1) elective or pre-scheduled treatment in sanctioned countries; or (2) Insured Person(s) considered "ordinarily resident" in a sanctioned country. Insured Person(s) are considered ordinarily resident if they visit a sanctioned country for a period of longer than six (6) weeks over the course of any twelve (12) month period.

1.3.6. The Insurer, Policyholder and Insured Person must comply with the United States of America Foreign Corrupt Practices Act of 1977 (as amended), and any comparable laws in any country in which they operate or reside. The Insurer and Policyholder agree that, except as explicitly stated in the Policy, nothing of value has been offered or provided by either of them or anyone acting on their behalf, in relation to this Policy. Should it emerge at any point that any anti-corruption laws have been breached, the Policy may be cancelled, and all coverage will be null and void.

1.3.7. This Policy does not replace any state health insurance scheme or adhere to the local insurance or other legislative requirements of every country. The Policyholder and/or Insured Person should not stop contributing to any state health insurance scheme unless they have received advice on and are happy to carry the risks of doing so.

1.3.8. The Insurer may terminate or change any benefits, terms and conditions under the Policy due to changes in the law or regulations governing the Policy by providing to the Policyholder thirty (30) days' notice in writing.

2. Definitions, in Alphabetical order

'Accident'	A sudden and unexpected event, the cause of which occurs outside the victim's body and which results in bodily Injury. The following events are also considered to be Accidents: 1. a rescue attempt of persons or goods in peril; 2. gas or vapour inhalation and the absorption of poisonous or corrosive substances; 3. dislocations, distortions, ruptures and muscular lacerations provoked by a sudden effort; 4. freezing; 5. drowning.
'Africa'	Algeria, Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cape Verde, Central African Republic, Chad, Comoros, Congo, Ivory Coast, Democratic Republic of Congo, Djibouti, Egypt, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Liberia, Libya, Madagascar, Malawi, Mali, Mauritania, Mauritius, Morocco, Mozambique, Namibia, Niger, Nigeria, Reunion, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, Somalia, South Africa, South Sudan, Sudan, Swaziland, Tanzania, Togo, Tunisia, Uganda, Western Sahara, Zambia and Zimbabwe.
'Alternative Medicine Practitioner'	An acupuncturist, chiropractor, homeopath, osteopath or Chinese medicine practitioner who is legally qualified and allowed to practice alternative medicine by the authorities in the country in which the Treatment is received.
'Ambulance'	A purpose-built vehicle operated by a recognised Ambulance service.
'Assistance Provider' (AP)	The provider(s) appointed by the Administrator for the Medical Emergency Evacuation and/or Planned Out of Country Care benefits.
'Close Family Member'	A member of the Insured Person's family who is either his/her spouse or common-law partner, an ascendant (parent or grandparent), in-laws (parents of the spouse or common-law partner), descendant (brother or sister), his/her legal guardian, a person for whom he/she is the guardian.

'Commencement Date'	The date upon which this Policy comes into effect as specified in the Special Terms and Conditions.
'Dental Treatment Annual Maximum Benefit'	The total payable under this Policy for the sum of all Dental Treatment claims for a single Insured Person over an Insurance Year, subject to the limits and limitations set out in the Benefits Overview. If the maximum benefit has been exhausted, no further Dental Treatment claim payments shall be made for the remaining period of the Insurance Year.
'Dentist' (or Dental Surgeon)	A person officially qualified and licensed to practise dentistry in the country where the dental Treatment is received.
'Dependent'	The legal spouse (or legal partner) and/or unmarried children who are either in full-time education or financially dependent on the Main Insured Person, until they turned Twenty-Five (25) by the Policy Renewal Date.
'Doctor'	A person who graduated from a recognised medical school as listed in the World Health Organisation directory of medical schools and who is licensed to practise medicine in the country where the Treatment is received.
'Eligible Medical Expenses'	Medically Necessary expenses incurred due to a covered Illness, Injury or Maternity but not exceeding the limits in the Benefits Overview of the Policy.
'Employee'	Any member of staff who works a minimum of thirty (30) hours per week, performing non-manual work only, who is nominated and sponsored by the Policyholder.
'Europe'	Albania, Andorra, Austria, Belarus, Belgium, Bosnia, Bulgaria, Croatia, Cyprus, Czech Republic, Denmark, Estonia, Faroe Islands, Finland, France, Germany, Greece, Greenland, Guernsey, Herzegovina, Hungary, Iceland, Ireland, Isle of Man, Italy, Jersey, Kosovo, Latvia, Liechtenstein, Lithuania, Luxembourg, Macedonia, Malta, Moldova, Monaco, Montenegro, Netherlands, Norway, Poland, Portugal, Romania, San Marino, Serbia, Slovakia, Slovenia, Spain, Sweden, Switzerland, Ukraine, United Kingdom and Vatican City.
'Expatriate'	A person living and working abroad (outside his/her Home Country).
'General Practitioner'	A Doctor providing Medical Treatment not requiring a Specialist Doctor's training.
'Health Declaration Form'	A document completed by the Insured Person/Policyholder to declare Pre-existing conditions.
'Home Country'	The country where the Insured Person normally resides or used to reside and out of which he/she is expatriated to another country (as declared by the Policyholder). If the Home Country cannot be named according to this definition, it is the country of which the Insured Person has nationality and holds a passport from.
'Hospice'	A facility that provides Palliative Treatment.
'Hospital'	Any organisation which is registered or licensed as a medical or surgical Hospital in the country in which it is located and where the patient is under the daily care or supervision of a Doctor or Nurse.
'Host Country'	The country where the Insured Person is expatriated to and will spend the majority of their time when not in their Home Country, as declared by the Policyholder.

'Illness'	A condition marked by a pathological deviation from the normal healthy state, as confirmed by a Doctor.
'Infertility Treatment'	The Treatment of infertility and all investigative procedures necessary to establish the cause(s) of infertility (e.g., hysterosalpingography, laparoscopy and hysteroscopy).
'Injury'	Bodily Injury caused solely by Accident.
'Inpatient and Outpatient Treatment Methods Annual Maximum Benefit'	The total payable under this Policy for the sum of all Inpatient Treatment and Outpatient Treatment claims, related to the Treatment of Cancer, Kidney Failure, Serious Illnesses, HIV and Aids as well as Palliative Treatment, for a single Insured Person over an Insurance Year, subject to the limits and limitations set out in the Benefits Overview. If the maximum benefit has been exhausted, no further claim payments shall be made for the remaining period of the Insurance Year.
'Inpatient Treatment'	Treatment for which, for medical reasons, the patient must stay overnight in a Hospital.
'Inpatient Treatment Annual Maximum Benefit'	The total payable under this Policy for the sum of all Inpatient Treatment claims for a single Insured Person over an Insurance Year, subject to the limits and limitations set out in the Benefits Overview. If the maximum benefit has been exhausted, no further claim payments shall be made for the remaining period of the Insurance Year.
'Insurance Year'	A twelve (12)-month period, starting on the Commencement Date of coverage of the Policy.
'Insured Person'	The Main Insured Person(s) and their Dependents, as declared by the Policyholder, who are covered under this Policy.
'Insurer'	The insurance company underwriting the risks covered by the Policy.
'Intensive Care Unit'	A section within a Hospital that is designated as an Intensive Care Unit, and which is maintained on a twenty-four (24) hour basis solely for the Treatment of patients in a critical condition and which is equipped to provide special nursing and Medical Treatment not available elsewhere in the Hospital.
'Main Insured Person'	The Employee who becomes a member of the Cigna Africa Base Plan.
'Maternity'	Shall mean all Medical Treatment relating to pregnancy or childbirth; Maternity will be treated similarly to an Illness for the purposes of this Policy.
'Maternity Annual Maximum Benefit'	The total payable under this Policy for the sum of all Maternity claims for a single Insured Person over an Insurance Year, subject to the limits and limitations set out in the Benefits Overview. If the maximum benefit has been exhausted, no further Maternity claim payments shall be made for the remaining period of the Insurance Year.
'Medical Emergency'	An Injury or a sudden and unexpected onset of a change in a person's physical or mental condition which, if the Treatment was not performed immediately could reasonably be expected to result in loss of life or limb or significant impairment to bodily function or permanent dysfunction of a body part, as determined by the Doctor in attendance.

'Medical Evacuation and Out of Country Assistance Annual Maximum Benefit'	The total payable under this Policy for the sum of all Medical Emergency Evacuation and Out of Country Assistance claims for a single Insured Person over an Insurance Year, subject to the limits and limitations set out in the Benefits Overview. If the maximum benefit has been exhausted, no further Medical Evacuation and Out of Country Assistance claim payments shall be made for the remaining period of the Insurance Year.
'Medically Necessary'	A Medical Treatment which is: 1. consistent with the diagnosis and customary Medical Treatment for a covered Illness or Injury; 2. in accordance with standards of good medical practice, consistent with current standard of professional medical care, and of proven medical benefit; 3. not for the convenience of the Insured Person or the Doctor, and unable to be reasonably rendered out of Hospital (if admitted as an inpatient); 4. not of an experimental, investigational or research nature.
'New Employee'	An eligible Employee who commences new employment with the Policyholder during the Insurance Year.
'Nurse'	Shall mean a licensed graduate and registered Nurse under the laws of the country, state or other regulated area in which the Treatment is provided and who is not: 1. employed by the Policyholder and/or Insured Person, 2. living in the Insured Person's household, or 3. a parent, sibling, spouse or child of the Insured Person.
'Outpatient Treatment'	Medical Treatment for which the patient does not have to stay overnight in a Hospital.
'Outpatient Treatment Annual Maximum Benefit'	The total payable under this Policy for the sum of all Outpatient Treatment claims for a single Insured Person over an Insurance Year, subject to the limits and limitations set out in the Benefits Overview. If the maximum benefit has been exhausted, no further Outpatient claim payments shall be made for the remaining period of the Insurance Year.
'Paid in Full'	Subject to the terms and conditions of this Policy, the amount of the claim submitted will be fully paid by the Insurer, but subject to the Policy Annual Maximum Benefit, as well as the Inpatient, Outpatient, Maternity, Preventative Care and Wellness and the Medical Evacuation and Out of Country Assistance Annual Maximum Benefits.
'Palliative Treatment'	Treatment offered for end-stage of a terminal Illness with a life expectancy of less than six (6) months that no longer attempts to alter the condition's growth or progression but is given to alleviate symptoms.
'Planned Out of Country Care'	Travel for non-emergency but Medically Necessary Treatment where such travel has been approved by the Administrator and where the following has been established by the Administrators medical consultants: 1. That adequate Treatment is not available in the Host Country in the case of an Expatriate and Home Country in the case of local employees. In establishing this the medical consultant will consider both whether the Treatment is available and/or of the right quality in accordance with generally accepted medical standards; 2. A referral letter from the local treating physician is provided; 3. Where the Insured Person is an Expatriate that the care cannot be postponed till the Insured Person is scheduled to return to their Home Country for a holiday, rest and/or family visit.

'Policy'	This insurance agreement entered into by and between the Insurer and the Policyholder which includes these General Terms and Conditions and the Special Terms and Conditions attached hereto and as amended from time to time.
'Policy Annual Maximum Benefit'	The total payable under this Policy for the sum of all claims for a single Insured Person over an Insurance Year, subject to the limits and limitations set out in the Benefits Overview. If the maximum benefit has been exhausted, no further payments shall be made for the remaining period of the Insurance Year.
'Policyholder'	The employer taking out the insurance for the benefit of the Insured Person/s, having to pay the appropriate premium to the Insurer on behalf of the Insured Person/s. The name of the Policyholder is mentioned in the Special Terms and Conditions.
'Policy Renewal Date'	The anniversary of the Commencement Date of the Policy each year or any other date which the Parties may agree to in writing and as specified in the Special Terms and Conditions.
'Pre-existing Conditions'	Medical conditions which the Insured Person, his/her Dependents or Doctors knew, or can reasonably have been assumed to have known, existed at any time during the five (5) years before commencement of cover under this Policy. Where symptoms of a medical condition existed during that time, the medical condition shall be presumed to have been known unless such symptoms were not noticed, where reasonably believed: 1. to not to relate to a medical condition or 2. to relate to a different medical condition. Any condition relating to or resulting from a Pre-existing Condition shall also be deemed to be a Pre-existing Condition.
'Prescription Drugs'	Drugs or medicines that are Medically Necessary to treat a confirmed medical diagnosis or medical condition, and which are not available without a prescription from a Doctor (excluding over the counter (OTC) drugs).
'Preventative Care and Wellness Annual Maximum Benefit'	The total payable under this Policy for the sum of all Preventative Care and Wellness Treatment claims for a single Insured Person over an Insurance Year, subject to the limits and limitations set out in the Benefits Overview. If the maximum benefit has been exhausted, no further Preventative Care and Wellness claim payments shall be made for the remaining period of the Insurance Year.
'Private Room'	A Hospital room with one bed and a private en-suite bathroom, including a toilet, basin and bath or shower.
'Reasonable and Customary'	Medical expenses will be considered Reasonable and Customary if they correspond to the charge usually made for a similar Medical Treatment and do not exceed the normal charge made under the best prevailing conditions for such a Medical Treatment in the locality where the Medical Treatment is received. If usual and prevailing charges cannot be determined because of the unusual nature of the Medical Treatment, the Administrator will determine on behalf of the Insurer to what extent the charge is reasonable, considering: 1. the complexity involved; 2. the degree of professional skill required; 3. the specialist equipment and materials required; 4. all other pertinent factors.

'Relevant Jurisdiction'	The country in which the personal data of the Insured Person is processed
'Specialist Doctor'	A Doctor having a specialised qualification in the field of, or expertise in, the Treatment of the Illness or Injury.
'Special Terms and Conditions'	A document issued with each Policy, stating: 1. the identity of the Policyholder; 2. the plan opted for and Area of Cover; 3. the Insurer; 4. any specific additional terms and condition or any deviations from the General Terms and Conditions.
'Spouse'	The Employee's legal husband or wife, or unmarried or civil partner accepted for cover under the Policy.
'Standard Private Room'	Is the lowest rate Private Room in a Hospital.
'Surgery'	Any of the following medical procedures: 1. incision, excision or electrocauterisation of any organ or body part, except for dental services; 2. repair, revision, or reconstruction of any organ or body part, both invasive and non-invasive; 3. reduction of a fracture or dislocation by manipulation; 4. use of endoscopy to remove a stone or object from the larynx, bronchus, trachea, oesophagus, stomach, intestine, urinary bladder, or urethra.
'Treatment or Medical Treatment'	Medical examinations and/or medical procedures needed to restore health, performed or prescribed by a Doctor.
'Waiting Period'	Is the period of time specified which must pass before cover, under the benefit to which it applies, will commence.

3. Eligibility and acceptance into insurance

3.1. Eligibility

The insurance under this Policy is available for employers to cover their Expatriated Employees sent on assignment abroad and local management staff (and their Dependents) and any other eligible Employees that the employer may agree with the Insurer.

3.2. Acceptance into insurance

In case of compulsory enrolment by an employer of a group of ten (10) or more Employees the Insurer, at its sole discretion, can request that Health Declaration Form(s) are provided for each Employee and each Dependent for submission to the medical consultant of the Administrator. The medical consultant is entitled to accept, refuse cover, or propose an additional premium based on the information provided in the Health Declaration Form(s).

If the number of enrolled Employees is less than ten (10), a Health Declaration Form must be completed for each Employee and each Dependent and must be submitted by the Insured Person to the medical consultant of the Administrator. The medical consultant can accept, refuse cover, or propose an additional premium and waiting periods based on the information provided in the Health Declaration Form(s).

Should the number of enrolled Employees, fall below ten (10), the Insurer may, at its sole discretion, request that Health Declaration Form(s) be completed for each Employee and each Dependent and must be submitted by the Insured Person to the medical consultant of the Administrator. The medical consultant is entitled to accept, refuse cover, or propose an additional premium and waiting periods based on the information provided in the Health Declaration Form(s).

In such circumstances, the Insurer will give the Policyholder at least twenty-eight (28) days' notice of the new premium rates together with an explanation for their introduction before they will be applied. If the new premium rates are not acceptable to the Policyholder, and provided the Policyholder responds within twenty-one (21) days of receiving the notification, the Policyholder may elect to terminate the plan. In this instance, cover will continue under the plan at the current Premium Rates for the period of fifty-six (56) days following the communication of

the intention to terminate from the Policyholder to the Insurer or until such date as may be agreed between the parties.

Should the number of enrolled Employees, rise to (10) or above, the Insurer may, at its sole discretion, request that Health Declaration Form(s) are provided for New Employees and their Dependents for submission to the medical consultant of the Administrator. The medical consultant is entitled to accept, refuse cover, or propose an additional premium based on the information provided in the Health Declaration Form(s).

3.3. Addition of new Dependent(s) into the Insurance

A new-born or adopted child can be added, provided that the application is made within 30 Days following the date of birth or adoption (of a minor child). In such case the new-born or adopted child will be covered from the date of birth or adoption. The premium due will be calculated from the date of birth or adoption.

A Spouse can be added, provided that the application is made within 30 Days following the date of marriage or from when the parties are deemed legal partners. In such cases the Spouse will be covered from the date of marriage or legal partnership. The premium due will be calculated from the date of marriage or legal partnership.

If the Administrator is not advised of a new-born child, adopted child, marriage or legal partnership within 30 Days, a Health Declaration Form must be completed by the Insured and sent to the medical consultant of the Administrator. The medical consultant is entitled to accept, refuse cover, or propose an additional premium and waiting periods based on the information provided in the Health Declaration Form(s). Cover will incept from the date of acceptance by the Insurer and the premiums due will be calculated from the date of acceptance.

3.4. Addition of New Employee(s) into the Insurance

Subject to agreement by the Insurer, the Policyholder may add a New Employee during the Insurance Year, provided that the application is made within 30 days from the date the employment started. Cover for the New Employee will begin from the date of employment provided by the Policyholder. If the Policyholder fails to inform the Insurer of a New Employee within 30 days from the start of employment, a Health Declaration Form must be completed by the New Employee along with a justification for the delay and sent to the Administrator. Acceptance is not guaranteed and may be refused. If a New Employee is accepted for cover additional terms, conditions and /or premiums may apply. Cover will incept from the date of acceptance by the Insurer and the premiums due will be calculated from the date of acceptance.

3.5. Age Limits for enrolment

For Employees, enrolled on a compulsory basis by their employer, there is an age limit of sixty-five (65) for enrolment into the Cigna Africa Base Plan area of cover selected defines the area in which this Policy covers Treatments provided.

3.6. Area of Cover

The Policyholder can choose between five (5) geographic Areas of cover for the Cigna Africa Base Plan. The area of cover selected defines the area in which this Policy covers Treatments provided:

Area 1 – Africa

Area 2 – Africa Plus (Africa and including India, Pakistan, Sri Lanka, Lebanon and Bangladesh)

Area 3 – Europe (including Africa, India, Pakistan, Sri Lanka, Lebanon and Bangladesh)

Area 4 – Worldwide excluding the United States of America

Area 5 – Worldwide

Area 5 is not available for Core Care and Standard Care.

Where the Insured Person resides in the United States of America (i.e. his/her Host Country is the United States of America), subscription to Area 5 the Worldwide area of cover is compulsory.

Emergency Out of Area Cover

During business trips or holidays, not exceeding thirty (30) days per trip and ninety (90) days in total per Insurance Year, medical expenses incurred in another geographic area than the area of the Policy and which have been incurred as a direct consequence of a Medical Emergency are covered up to the limits set out in the Benefits Overview. However, if the medical condition concerned already existed prior to the travel to the other geographic area or if obtaining care in another geographic area was the objective of the travel, the medical expenses are not covered. Expenses related to pregnancy (and complications thereof) and/or childbirth will not be deemed an Injury or Medical Emergency and will therefore not be covered.

3.7. Change of Area of Cover

There can only be a change to the Area of cover, in the event of a change to the Insured Person's Host Country. The area of cover cannot be changed where the objective is to seek or receive Treatment outside the current area of cover.

A change to the area of cover must be requested at least one (1) month before the change of Host Country.

3.8. Change of Level of Cover

Downgrading and and upgrading of the level of cover level can only be done at the Policy Renewal Date. This change can only be made at group or sub group level.

In such an event, the Premium rates may go up or down depending on the new Level of Cover selected. The change of level of cover must be requested at least one (1) month before the Policy Renewal Date.

As the Core Care and Standard Care plan are not available for Area 5 Worldwide if an Employee on the Core Care or Standard Care Plan is being sent on their next assignment to the United States of America, the Policyholder must request to upgrade the Employee and their Dependents onto either Select Care, Essential Care, Executive Care or Elite Care, and then upgrade their Area of cover – such circumstances are the only time a Policyholder or Insured Person may request a change in the level of cover prior to the Policy Renewal Date.

The level of cover cannot be changed where the objective is to receive Treatment that is not available or more expensive than the current level of cover provides for.

4. Effective date of Coverage

The insurance cover takes effect on the day immediately following:

4.1. The acceptance by the Administrator of a completed application form; and

4.2. The acceptance into the insurance of the Insured Person by the medical consultant, whenever such medical acceptance is required in accordance with the specific eligibility and acceptance rules of each insurance cover, as described in the different Sections of these General Terms and Conditions.

With regards to the declaration of new Dependents, reference is made to Section I Clause 3.3.

5. Duration and cancellation of the Policy

5.1. Period of cover and renewal

Unless otherwise agreed upon by both parties (Policyholder and Insurer), the duration of the Policy is fixed at twelve (12) months, starting from the Commencement Date of coverage. At the end of the twelve (12) month period, the Policy will be automatically renewed by tacit agreement for successive periods of twelve (12) months each.

5.2. Cancellation of the Policy

The Policy can be terminated by the Insurer and the Policyholder through written notification by registered letter, delivered to the other party at least one (1) month before the Policy Renewal Date.

Termination of the Additional Insurance cover (Dental and Vision benefits) will not automatically lead to termination of the Base Plan, unless otherwise agreed upon by both parties (Policyholder and Insurer).

5.3. Aggravation of the risk

Except for changes in the state of health of the Insured Person(s) occurring after acceptance into the insurance, the Policyholder is obliged to inform the Administrator of any change in circumstances or conditions that may increase the risk of Illness or Injury (e.g. dangerous professional activities). The Insurer may then propose new insurance conditions, and/or amended premiums (within a period of one (1) month after having received notification of the aggravation of the risk) or cancel the insurance cover, within one (1) month, retro-actively as from the moment of the start of the aggravation of the risk.

6. Termination of cover

6.1. For the Insured Person, the cover under this Policy shall automatically terminate:

6.1.1. If any premium on this policy is not paid on the due date set out on the premium invoice;

6.1.2. If the insured person is a dependent child, they will no longer be considered to be a dependent child under the policy, and therefore not eligible for cover, if the dependent child has turned twenty-five (25) years old by the policy renewal date or the dependent child got married during the insurance year. The policyholder is required to inform the insurer when the marital status of a dependent child changes. Failure to do so may result in denial of claims and/ or immediate termination of cover. The policyholder will be responsible to refund to the insurer any amount paid by the insurer in respect of claims submitted by or on behalf of that dependent child after the dependent child's marital status has changed.

6.1.3. If the dependent is the spouse or legal partner, upon the date of divorce or legal separation from the main insured person, or as from the end of the legal partnership;

6.1.4. If it becomes unlawful for the insurer to provide any of the cover available under this policy;

6.1.5. If the insurer and/or the administrator have been provided with misleading information or if information has been withheld that should have been provided and could have affected the assessment of the risks to be insured under this policy;

6.1.6. Upon the death of the insured person. In such case, the policyholder may agree to continue cover for their dependent(s) up to the next annual renewal date when their cover will end.

6.2. Suspension of cover and cancellation of the insurance because of non-payment of premium

In the event of the Policyholder failing to pay the premium on the due date (set out on the premium invoice), the Insurer has the right to suspend and subsequently cancel the Policy.

To exercise this right, the Insurer will first notify the Policyholder in writing, reminding the Policyholder of the amount of the premium that is overdue, and providing information on the consequences of non-payment.

If the premium is then not paid within fifteen (15) days following the written notice, the insurance cover will automatically be suspended. The consequence of the Policy being suspended is that all claims submitted will be put on hold for payment or pre-certification. Payment by the Policyholder of the premiums due will terminate the suspension.

The Insurer may cancel the Policy after the period of suspension. In this case, cancellation shall take effect on the expiry of a period of fifteen (15) days, starting from the first day of suspension. Cancellation of the policy will result in all claims incurred from the first day of any period for which premiums due remained unpaid, not being covered and the Insurer may recover from the Policyholder any claim amounts remitted.

6.3. Fraud, Abuse and Misrepresentation

Coverage of an Insured Person under the Policy may also be suspended or terminated by the Insurer in the event of reasonably demonstrated fraud (including abuse and/or misrepresentation) committed by or on behalf of the Insured Person (such as the submission of false claims, falsified written evidence supporting the claim and the like). In the event of such reasonably demonstrated fraud (including abuse and/or misrepresentation) the Insurer and/or the Administrator shall be authorised to take any and all (both extra-judicial and judicial) steps to act against such fraud, including, steps in view of recovering the moneys paid out on the basis of such fraudulent acts, including the right for the Insurer to offset any amounts paid on the basis of fraudulent claims with any outstanding amounts under pending claims submitted by the Insured Person concerned.

7. Premium and Premium increase

7.1. Premium Calculation and Validity

7.1.1. Premium Calculation and Validity

Premiums may vary according to age bands. When entering a new age band, the higher premium, related to the new age band, will be applied as from the next Policy Renewal Date.

Premiums are valid per Insurance Year and may change on the Policy Renewal Date.

The Insurer however reserves the right to recalculate the rates under any of the following circumstances that occur during the covered period that have not been agreed prior to inception or renewal:

7.1.1.1. Any changes in the selected Area of Cover that relates to a change in the Host Country for existing Insured Persons;

7.1.1.2. Any additional Employees and/or their Dependents to the plan where they are transferring onto the plan from a separate Policy;

7.1.1.3. Any significant changes in the number of Insured Persons (defined as more than or equal to 10% of total membership).

In such circumstances, the Insurer will give the Policyholder at least twenty-eight (28) days' notice of the new premium rates together with justification for their introduction before the rates will be applied. If the justification for the new rates does not prove satisfactory to the Policyholder and provided the Policyholder responds within twenty-one (21) days of receiving notification of the amended rates, the Policyholder may elect to terminate the plan. In this instance, cover will continue under the plan at the current premium rates for the period of fifty-six (56) days following the communication of the intention to terminate from the Policyholder to the Insurer or until such date as may be agreed between the parties.

7.1.2. Premium Payment and Taxes

The premium is payable by the Policyholder to the Insurer on a yearly basis, in advance, unless otherwise agreed upon between both the Policyholder and the Insurer.

Taxes and charges as established by the applicable laws will be added by the Insurer to the premium and will be settled by the Insurer with the local authorities.

In respect of cover and billing for Employees or Dependents (where applicable) who are joining or leaving the Policy, the Administrator will apply the following rules:

7.1.2.1. In respect of additional insured Persons:

Any Employee or Dependent (where applicable) who joins the Policy during the first fifteen (15) days of the month, will be covered from the date of joining and will be billed for the entire month.

Any Employee or Dependent (where applicable) who joins the Policy after the first fifteen (15) days of the month, will be covered from the date of joining but will not be billed for that month whereupon billing will commence at the beginning of the following month.

7.1.2.2. In respect of terminated Insured Persons:

Any Employee or Dependent (where applicable) who leaves the Policy during the first fifteen (15) days of the month, will be covered up to the date of leaving but will not be billed for that month.

Any Employee or Dependent (where applicable) who leaves the Policy after the first fifteen (15) days of the month, will be covered up to the date of leaving and will be billed for that month.

7.1.3. Premium Increase

In the event of the Insurer increasing the premium rate, the Policyholder will be notified in writing, of said increase and of the date as from which the new premium will become effective.

This notification will be sent to the Policyholder, in writing, at the latest two (2) months prior to the Policy Renewal Date, unless otherwise agreed upon between the Policyholder and the Insurer.

The new premium rates will become effective as from the next Policy Renewal Date.

If the Policyholder does not agree with the new premium conditions, he can terminate the Policy through notification of cancellation to the Insurer as set out in Section I Clause 5.2.

There will be no notification in the event of a premium increase due to a change of age band. The new premium rates will become effective as from the next Policy Renewal Date.

In absence of termination by the Policyholder, the Policyholder will be deemed to have accepted the premium increase and the Policy will be automatically renewed against the new premium rates.

8. Currency

The Cigna Africa Base Plan and Additional Insurances can be taken out in USD. Premiums and claims shall be payable in USD, unless otherwise agreed between the Insurer and the Policyholder.

With respect to medical expenses incurred in another currency than the currency of the Policy, the conversion will be based on the OANDA daily rate of exchange in effect on the date of the Treatment.

The Administrator may settle medical bills in another currency (than the currency of the Policy), viz. in the original currency, especially in case of direct payment to Hospitals insofar as allowed under the local legislation of the country concerned.

9. General Exclusions

The cover described in this Policy does not extend to the:

9.1. Consequences of a voluntary or intentional act committed by the insured person, which could be but is not limited to:

9.1.1. Participation in brawls or fights and all kinds of disturbances and measures taken to combat them, except in the case of self-defense;

9.1.2. The preparation of or participation in crimes or misdemeanors;

9.1.3. Events related to bets or challenges.

9.2. Consequences of participation in any sport as a professional or under contract providing remuneration, as well as any preparatory training;

9.3. Expenses resulting from any kind of competition with motor vehicles;

9.4. Solo scuba-diving or scuba diving at depths greater than 30 meters unless the diver is padi qualified (or equivalent) for that depth;

9.5. Consequences of insurrections or riots if by taking part the insured person has broken the applicable laws;

9.6. Direct or indirect consequences of any action relating to what is commonly designated as 'nuclear risk' This exclusion is not applicable to medical radiations required by covered medical treatment;

9.7. Consequences of war or acts of war and terrorism, to the extent mentioned in Section I clause 10 hereafter.

Important remark:

For the additional specific exclusions relating to each separate cover of the current Cigna Africa Base Plan and Additional Insurances , reference is explicitly made to the provisions under the different types of cover (see Section II).

10. War and Terrorism

10.1. Definitions

'War'	1. armed conflict, declared or undeclared, between one State and another, an invasion or a state of siege; 2. also considered as acts of War are: all similar actions, the use of military force by a sovereign nation to achieve certain economic, geographic, nationalistic, political, racial, religious or other ends; 3. civil War: armed conflict between two (2) or several parties belonging to one (1) and the same state, the members of which are of different ethnic origin, religion or ideology; 4. also considered as acts of civil War are: an armed rebellion, revolution, a sedition, an insurrection, a coup d'état, the consequences of martial law and border closings ordered by government or by local authorities.
'Terrorism'	1. any actual or threatened use of force or violence directed at or causing damage, Injury, harm or disruption; 2. commission of an act dangerous to human life or property, against any individual, property or government, with the stated or unstated objective of pursuing economic, ethnic, nationalistic, political, racial or religious interests, whether such interests are declared or not; 3. robberies or other criminal acts, primarily committed for personal gain and acts arising primarily from prior personal relationships between perpetrator(s) and victim(s) shall not be considered terrorists acts. Terrorism shall include any act that is verified or recognised by the (relevant) government as an act of Terrorism.

10.2. Description of Benefits

With respect to the risks and consequences of War and Terrorism, all consequences of active participation by the Insured Person in operations of War and Terrorism are explicitly excluded from all cover.

Where the Insured Person is a victim of acts of War and Terrorism without any active involvement on behalf of the Insured Person in these acts, the Insured Person is covered within the limits and the ceilings of the cover.

In the event the Insured Person, whilst abroad, is faced with the sudden, unanticipated occurrence of a new (outbreak of) War or warlike situations and acts, the insurance cover remains valid for fourteen (14) days starting from the beginning of the hostilities.

11. Data Protection

11.1. This policy is subject to compliance with all applicable data protection and privacy laws and regulations in the Relevant Jurisdiction relating to the processing of personal data in connection with this Policy.

11.2. The Insurer and Administrator will provide sufficient guarantees in respect of the technical and organisational measures governing the data processing to be carried out and will therefore operate technical and organisational measures to protect against unauthorised or unlawful processing of such data and against accidental loss or destruction of or damage to such data. They shall comply with the following obligations:

11.2.1. Process the personal data solely for the execution of the present Policy and for the purposes for which they have been transferred to the Insurer or the Administrator;

11.2.2. Take care that the access to the data and possibilities of processing for the persons who are acting under their authority, are limited to what is necessary for the fulfilment of their duties and for the requirements of the service that is the subject of the present Policy;

11.2.3. Only disclose personal data to third parties to the extent that such disclosure is necessary for the purposes of providing the services covered by the Policy.

12. Subrogation

The Insurer has full rights of subrogation for any benefits paid within the framework of this Policy. This means that the Insurer becomes the beneficiary of the Insured Person's rights and actions against any person or legal entity that is responsible for the Injury or Illness which was the cause of the amount of compensation the Insurer paid and the services it provided.

When the compensation paid, or services provided in performance of this contract are either wholly or partly covered by a National Social Security Fund or covered by any other institution, the Insurer shall have the right to subrogate against the said scheme or institution.

Therefore, when asked to confirm this right to the Insurer in order to assist the Insurer in recovering from a third (3rd) party any amount paid, or which will be paid by the Insurer to the Insured Person or expenses incurred on behalf of the Insured Person, the Insured Person shall be obliged to provide this confirmation in writing to the Insurer.

13. Defence

Any defence inherent in the insurance contract which the Insurer may raise against the Policyholder may also be raised against the Insured Person, whoever he/she may be.

14. Dispute Resolution including Arbitration

14.1. Dispute Resolution

If any dispute of whatever nature arises or is otherwise created between the Insurer and the Policyholder or Insured Person ("the Parties") arising out of, or relating to this Policy ("Dispute") then the representatives of the Parties under this Policy if concerned or involved in such Dispute, shall within thirty (30) days of service of written notice from one Party to the other hold a dispute meeting in an effort to resolve the Dispute. If another venue is not agreed upon, then the dispute meeting will be held at the principal place of business of the Insurer and at its cost.

14.2. Arbitration

If the Parties fail or are not able despite discussions and exchanges of documents in good faith, to resolve the Dispute, then either Party will be entitled upon written notice to the other Party to have the Dispute referred to and determined by arbitration in accordance with the following provisions:

14.2.1. Governing Law:

The procedural and related rules that will govern the determination of the Dispute will be the Rules identified in the Special Terms and Conditions – that are in force at the time of such referral and which Rules are deemed to be incorporated by reference into this clause 14.2 and this Policy and that include an appeal under such Rules. The Parties may by specific written agreement agree to vary one or other Rule to suit the specific circumstances and/or requirements to assist in the determination of the Dispute.

14.2.2. Arbitration Rules:

The procedural and related rules that will govern the determination of the Dispute will be the Rules identified in the Special Terms and Conditions – that are in force at the time of such referral and which Rules are deemed to be incorporated by reference into this clause 14.2 and this Policy and that include an appeal under such Rules. The Parties may by specific written agreement agree to vary one or other Rule to suit the specific circumstances and/or requirements to assist in the determination of the Dispute.

14.2.3. Place of Arbitration:

The seat of, or the place at which the arbitration proceedings will be held is identified in the Special Terms and Conditions and shall be at the principal place of business of the Insurer unless the Parties agree to another venue.

14.2.4. Arbitral Tribunal:

The Arbitral Tribunal will be appointed in accordance with the terms set out in the Special Terms and Conditions.

14.2.5. Language:

The language to be used in the arbitration proceedings will be the language stated in the Special Terms and Conditions.

14.2.6. Costs:

Unless the Parties should agree otherwise in writing and save for (excluding) the direct costs of holding the arbitration at the main office of the Insurer, each Party will initially be liable and responsible for one half of the arbitration costs specifically, the fees and charges of the Arbitral Tribunal pending the issue of the award of the Arbitral Tribunal.

14.3. Awards and Findings

The final award of the Arbitral Tribunal shall be binding on the Parties and each Party will forthwith implement such findings and/or awards.

SECTION II: BENEFITS AND PROVISIONS TO THE DIFFERENT TYPES OF COVER

Base Plan

1. Cigna Africa – Benefits Overview

All benefits are valid per Insured Person, per Insurance Year (unless specifically stated as otherwise)

	Core Care	Standard Care	Select Care	Essential Care	Executive Care	Elite Care
Area(s) of cover	1. **Africa** 2. **Africa +** (including India, Pakistan, Sri Lanka, Lebanon and Bangladesh) 3. **Europe** (including Africa, India, Pakistan, Sri Lanka, Lebanon and Bangladesh) 4. **Worldwide** (excluding US)		1. **Africa** 2. **Africa +** (including India, Pakistan, Sri Lanka, Lebanon and Bangladesh) 3. **Europe** (including Africa, India, Pakistan, Sri Lanka, Lebanon and Bangladesh) 4. **Worldwide** (excluding US) 5. **Worldwide**			
Policy Annual Maximum Benefit	Up to $ 50,000	Up to $ 100,000	Up to $ 500,000	Up to $ 2,000,000	Up to $ 4,000,000	Up to $ 6,000,000
Emergency Out of Area Cover	Covered for a maximum of 30 days per trip and for a total of 90 days per Insurance Year for up to $ 30,000	Covered for a maximum of 30 days per trip and for a total of 90 days per Insurance Year for up to $ 30,000	Covered for a maximum of 30 days per trip and for a total of 90 days per Insurance Year for up to $ 75,000	Covered for a maximum of 30 days per trip and for a total of 90 days per Insurance Year	Covered for a maximum of 30 days per trip and for a total of 90 days per Insurance Year	Covered for a maximum of 30 days per trip and for a total of 90 days per Insurance Year
1. Inpatient Treatment						
Inpatient Treatment Annual Maximum Benefit	Up to $ 50,000	Up to $ 100,000	Up to $ 500,000	Up to $ 2,000,000	Up to $ 4,000,000	Up to $ 6,000,000
Hospital Room type	Standard private room	Standard private room	Standard private room	Standard private room	Standard private room	Standard private room
Intensive Care Unit	Paid in Full	Paid in Full	Paid in Full	Paid in Full	Paid in Full	Paid in Full
Doctors Fees > Surgeons > Anaesthetists > Other Specialist Doctors	Paid in Full	Paid in Full	Paid in Full	Paid in Full	Paid in Full	Paid in Full
Surgery Including Day Surgery	Paid in Full	Paid in Full	Paid in Full	Paid in Full	Paid in Full	Paid in Full

	Core Care	Standard Care	Select Care	Essential Care	Executive Care	Elite Care
1. Inpatient Treatment (cont.)						
Maternity complications > During pregnancy > Non-Elective Caesarean Section > Surgery following a complicated birth	Paid in Full	Paid in Full	Paid in Full	Paid in Full	Paid in Full	Paid in Full
Organ transplant	Paid in Full	Paid in Full	Paid in Full	Paid in Full	Paid in Full	Paid in Full
Operating Theatre Including recovery room charges	Paid in Full	Paid in Full	Paid in Full	Paid in Full	Paid in Full	Paid in Full
Hospital supplies and service > Nursing > Prescribed drugs > Dressings, splints and plaster casts	Paid in Full	Paid in Full	Paid in Full	Paid in Full	Paid in Full	Paid in Full
Surgical Appliances and Medical Appliances > An artificial limb, prosthesis, appliance or device	Up to $ 2,500	Up to $ 5,500	Up to $ 7,500	Paid in Full	Paid in Full	Paid in Full
Diagnostic tests Includes pathology tests, laboratory tests, radiology, MRI scan, CT Scan, PET scan and the like	Paid in Full	Paid in Full	Paid in Full	Paid in Full	Paid in Full	Paid in Full
Physiotherapy, Speech and Occupational Therapy	Paid in Full	Paid in Full	Paid in Full	Paid in Full	Paid in Full	Paid in Full
Psychiatric Care	Paid in Full up to 10 days	Paid in Full up to 10 days	Paid in Full up to 10 days	Paid in Full up to 20 days	Paid in Full up to 30 days	Paid in Full up to 45 days
Ambulance to nearest hospital Domestic Road Ambulance Services to and/or from the Hospital	Up to $ 1,125	Up to $ 1,400	Up to $ 2,000	Paid in Full	Paid in Full	Paid in Full
Parental accommodation To accompany an insured dependent child under 18 years of age	Paid in Full up to 30 days	Paid in Full up to 30 days	Paid in Full up to 30 days	Paid in Full up to 30 days	Paid in Full up to 30 days	Paid in Full up to 30 days
Home Nursing	$ 200 per day for up to 28 days	$ 200 per day for up to 28 days	$ 200 per day for up to 28 days	Paid in Full for up to 45 days	Paid in Full	Paid in Full
Convalescence and rehabilitation	Paid in Full for up to 30 days	Paid in Full for up to 30 days	Paid in Full for up to 30 days	Paid in Full for up to 45 days	Paid in Full	Paid in Full
Hospital Cash Benefit For each overnight stay in a free of charge Hospital	Not covered	Not covered	$ 75 per night for up to 5 nights	$ 150 per night for up to 10 nights	$ 150 per night for up to 20 nights	$ 150 per night for up to 30 nights
2. Inpatient and Outpatient Treatment Methods						
Inpatient and Outpatient Treatment Methods Annual Maximum Benefit	Up to $ 50,000	Up to $ 100,000	Up to $ 500,000	Up to $ 2,000,000	Up to $ 4,000,000	Up to $ 6,000,000

	Core Care	Standard Care	Select Care	Essential Care	Executive Care	Elite Care
2. In-patient and Outpatient Treatment Methods (cont.)						
Cancer Includes Doctor Fees, Surgery, Prescribed Drugs, Diagnostic Tests, Oncology, Radiotherapy, Chemotherapy and the like.	Paid in Full	Paid in Full	Paid in Full	Paid in Full	Paid in Full	Paid in Full
Kidney Failure Dialysis and Prescribed Drugs	Paid in Full	Paid in Full	Paid in Full	Paid in Full	Paid in Full	Paid in Full
Serious Illnesses Includes Specialist Doctors Fees, Prescribed Drugs and Hospitalisation	Paid in Full	Paid in Full	Paid in Full	Paid in Full	Paid in Full	Paid in Full
HIV and Aids Includes Specialist Doctors Fees, Prescribed Drugs and Hopitalisation. *Waiting Period 12 months (unless waived)*	Paid in Full	Paid in Full	Paid in Full	Paid in Full	Paid in Full	Paid in Full
Palliative Treatment For Patients with a life expectancy of less than 6 months.	Not covered	Not covered	Not covered	Up to $ 60,000	Up to $ 60,000	Up to $ 60,000
3. Out-patient Treatment						
Outpatient Treatment Annual Maximum Benefit	Up to $ 1,500	Up to $ 2,500	Up to $ 3,000	Up to $ 4,000	Up to $ 4,000,000	Up to $ 6,000,000
Doctors Fees > General Practitioners > Specialists	Paid in Full	Paid in Full	Paid in Full	Paid in Full	Paid in Full	Paid in Full
Diagnostic tests Includes pathology tests, laboratory tests, radiology, MRI scan, CT Scan, PET scan and the like	Paid in Full	Paid in Full	Paid in Full	Paid in Full	Paid in Full	Paid in Full
Prescription Drugs	Up to $ 500	Up to $ 1,000	Up to $ 1,500	Paid in Full	Paid in Full	Paid in Full
Alternative Medicine Practitioner > Chiropractor > Osteopath > Acupuncturist > Homeopath > Chinese Medicine Practitioner	Not covered	Not covered	Not covered	Paid in Full	Paid in Full	Paid in Full
Physiotherapy	5 sessions	10 sessions	10 sessions	Paid in Full	Paid in Full	Paid in Full
Dental Treatment following Injury	Up to $ 500	Up to $ 500	Up to $ 1,000	Up to $ 1,500	Up to $ 1,500	Up to $ 1,500
Vaccinations for children Routine Immunizations for children and adolescents	Paid in Full	Paid in Full	Paid in Full	Paid in Full	Paid in Full	Paid in Full
Vaccinations for adults Preventative Vaccinations and when traveling to gain access to the country	Paid in Full	Paid in Full	Paid in Full	Paid in Full	Paid in Full	Paid in Full

	Core Care	Standard Care	Select Care	Essential Care	Executive Care	Elite Care
3. Outpatient Treatment (cont.)						
Psychiatric care	Up to $ 500	Up to $ 500	Up to $ 500	Up to $ 1,500	Up to $ 1,500	Up to $ 1,500
Additional Therapies > Ergotherapy > Occupational Therapy > Logopaedics > Speech Therapy	Not covered	Not covered	Not covered	50% reimbursement up to $ 1,500	50% reimbursement up to $ 1,500	50% reimbursement up to $ 1,500
Surgical and Medical Appliances > Orthopedic devices > Hearing Aids > Wheelchairs > Hospital bed > Standing frame > Rollator > Special bra following breast amputation > Wig > CPAP Machine	Up to $ 500	Up to $ 1,000	Up to $ 1,500	Paid in Full	Paid in Full	Paid in Full
4. Maternity (Waiting Period 10 Months, unless waived)						
Maternity Annual Maximum Benefit	Up to $ 2,500	Up to $ 3,500	Up to $ 5,000	Up to $ 8,000	Up to $ 4,000,000	Up to $ 6,000,000
Prenatal Care Routine check-ups and screening	Paid in Full	Paid in Full	Paid in Full	Paid in Full	Paid in Full	Paid in Full
Complications related to Pregnancy	Paid in Full	Paid in Full	Paid in Full	Paid in Full	Paid in Full	Paid in Full
Routine Childbirth and Elective Caesarean Surgery	Paid in Full	Paid in Full	Paid in Full	Paid in Full	Paid in Full	Paid in Full
Infertility Treatment > Infertility Diagnosis > Infertility Treatment	Not covered	Not covered	Not covered	Not covered	Not covered	50% reimbursement Up to $10,000*
Sterilisation	Paid in Full	Paid in Full	Paid in Full	Paid in Full	Paid in Full	Paid in Full
5. Preventative Care and Wellness						
Preventative Care and Wellness Annual Maximum Benefit	Up to $ 200	Up to $ 300	Up to $ 500	Up to $ 500	Up to $ 1,000	Up to $ 2,000
1 x Routine adult physical exams	Paid in Full	Paid in Full	Paid in Full	Paid in Full	Paid in Full	Paid in Full
1 x Pap smear	Paid in Full	Paid in Full	Paid in Full	Paid in Full	Paid in Full	Paid in Full
Mammograms > One baseline for women aged 35-39; > One every two years for women aged 40-49; > One every year for women aged 50 and over.	Paid in Full	Paid in Full	Paid in Full	Paid in Full	Paid in Full	Paid in Full

***Reimbursement up to $ 10,000 for each Insurance Year and $ 5,250 per fertilization attempt.**
Note: Refer to the Inpatient Section for hospitalisation following maternity complications.

	Core Care	Standard Care	Select Care	Essential Care	Executive Care	Elite Care
5. Preventative Care and Wellness (cont.)						
Prostate Cancer Screening One every year for men from age 50	Paid in Full	Paid in Full	Paid in Full	Paid in Full	Paid in Full	Paid in Full
Routine Hearing Test > One for babies aged 0 to 6 months; > One for children aged 7 months to 3 years old; > One for children aged 3 to 6 years old > One every 5 years for children aged 7 and older and adults	Paid in Full	Paid in Full	Paid in Full	Paid in Full	Paid in Full	Paid in Full
Well Child Developmental Tests	Paid in Full	Paid in Full	Paid in Full	Paid in Full	Paid in Full	Paid in Full
6. Medical Evacuation and Out of Country Assistance						
Medical Evacuation and Out of Country Assistance Annual Maximum Benefit	Up to $ 50,000	Up to $ 50,000	Up to $ 50,000	Up to $ 2,000,000	Up to $ 4,000,000	Up to $ 6,000,000
Evacuation Assistance > Organising and paying the cost of transportation to a hospital	Paid in Full	Paid in Full	Paid in Full	Paid in Full	Paid in Full	Paid in Full
> Organising and paying the cost of the trip of an accompanying close family member	Paid in Full	Paid in Full	Paid in Full	Paid in Full	Paid in Full	Paid in Full
> Reimbursement of accommodation costs of the insured person and accompanying close family member	Up to $ 150 per day for a maximum of 10 days	Up to $ 150 per day for a maximum of 10 days	Up to $ 150 per day for a maximum of 10 days	Up to $ 150 per day for a maximum of 10 days	Up to $ 150 per day for a maximum of 10 days	Up to $ 150 per day for a maximum of 10 days
> Organising and paying the costs of a return trip for the insured person and accompanying close family member	Paid in Full	Paid in Full	Paid in Full	Paid in Full	Paid in Full	Paid in Full
Planned Out-of-Country Care When adequate Treatment is not locally available > outward/return journey	Paid in Full	Paid in Full	Paid in Full	Paid in Full	Paid in Full	Paid in Full
> Cost of accommodation locally until the Insured Person is repatriated	Up to $ 150 per day for a maximum of 10 days	Up to $ 150 per day for a maximum of 10 days	Up to $ 150 per day for a maximum of 10 days	Up to $ 150 per day for a maximum of 10 days	Up to $ 150 per day for a maximum of 10 days	Up to $ 150 per day for a maximum of 10 days
> When the Insured Person will be hospitalised for more than 5 days (or 48 hours if a child) the above benefits include an accompanying Close Family Member						
Early Return Assistance Organizing and paying the cost of transport in the event of life-threatening Illness or death of a family member in the Insured Person's Home Country	Paid in Full	Paid in Full	Paid in Full	Paid in Full	Paid in Full	Paid in Full

	Core Care	Standard Care	Select Care	Essential Care	Executive Care	Elite Care
6. Medical Evacuation and Out of Country Assistance (cont.)						
Assistance in the event of the assignment of the Insured Person being curtailed due to a covered Illness or Injury Paying the travel costs of the replacement employee	Paid in Full	Paid in Full	Paid in Full	Paid in Full	Paid in Full	Paid in Full
Dispatch of Prescription Drugs	Paid in Full	Paid in Full	Paid in Full	Paid in Full	Paid in Full	Paid in Full
Death Assistance > Repatriation of mortal remains > Additional costs for the transportation of the deceased's Insured family	Paid in Full	Paid in Full	Paid in Full	Paid in Full	Paid in Full	Paid in Full
7. Value Add Services						
Medical Advice and Support Services > Clinical Case Management > Chronic Condition Management > Decision Support	Included	Included	Included	Included	Included	Included
Employee Assistance Programme Telephone counseling access 24/7	Not Included	Not Included	Not Included	Included	Included	Included
Health Risk Assessment and Targeted Risk Assessment Access to online health risk assessments	Not Included	Not Included	Not Included	Included	Included	Included
Telehealth Video and telephonic consultations with doctors, nurses and healthcare specialists	Included	Included	Included	Included	Included	Included

2. Description of Benefits

This Policy will reimburse Reasonable and Customary expenses incurred for Medically Necessary Treatment. This Section should be read in conjunction with the Benefits Overview as reimbursement is subject to the limits and sub-limits listed in the Benefits Overview as well as the Policy Conditions and Exclusions.

3. Pre-certification requirement

All Day Surgery and Inpatient Treatments (except for emergency Hospital admissions), are subject to pre-certification. This means that in the event of a non-emergency hospitalisation and Day Surgery, for which the diagnosis of the medical condition has been established more than five (5) days before actual admission into Hospital (or before the start of the Day Surgery), the Administrator has to be informed in writing at the latest five (5) days before the Treatment will be performed (in case of childbirth, five (5) days before the delivery is expected to take place). The following information is required:

3.1. Diagnosis;

3.2. Description of the required medical treatment;

3.3. Name and address of the hospital where the treatment will be given;

3.4. Expected length of stay in the hospital;

3.5. Estimated cost of the treatment.

In the event of an emergency hospitalisation, the Administrator must be informed as soon as possible (normally within forty-eight (48) hours) and at the latest before discharge from the Hospital. In event of failure to comply with the pre-certification requirement, a penalty of twenty-five percent (25%) will be applied by the Insurer, meaning that the reimbursement of the Reasonable and Customary expenses will be reduced to seventy-five percent (75%) of the amount the Insured Person would normally be entitled to if he/she had duly fulfilled the said requirements subject to the Policy Annual Maximum Benefit.

4. Restrictions and exclusions

In addition to the exclusions mentioned in Section I of Clause 9, the following items or services are excluded from cover:

4.1 Treatment that is considered experimental/investigative according to accepted professional medical standards and Treatment that is not medically indicated;

4.2 Treatment that arises from or is in any way connected with attempted suicide or any Injury or Illness that the Employee or Dependent inflicts upon himself which exceeds an upper lifetime limit of $ 150,000 per patient;

4.3 Treatment that arises from or is in any way connected with drug and/or alcohol addiction, including the costs of registered rehabilitation Treatment centers, which exceeds an upper lifetime limit of $ 150,000 per patient;

4.4 Charges for residential stays in a Hospital which are arranged wholly or partly for domestic reasons or where Treatment is not required or where the Hospital has effectively become the place of domicile or permanent abode;

4.5 Only Treatment costs for kidney dialysis will be covered; travel and accommodation expenses in connection with such Treatment will not be covered;

4.6 Non-prescribed Medical Treatments;

4.7 Charges from an Alternative Medicine Practitioner other than those explicitly mentioned in the Policy;

4.8 Rejuvenation and spa cures, cosmetic Treatments and convalescent rest;

4.9 Facilities for the aged and disabled, primarily giving custodial care (such as such as help with activities of daily living like bathing, dressing, eating, getting in or out of bed, moving around, and using the bathroom) including recreational and educational;

4.10 Cosmetic/aesthetic Treatment except restorative Treatment following Injury or Illness;

4.11 Surgical procedure costs aimed at correcting the refraction of the lens (Keratectomy and Keratotomy, including LASIK and LASEK procedures), except in the event of refractive Illness of the cornea in which case they are covered as any other surgical expenses;

4.12 Remedial teaching;

4.13 Sex change operations or any Treatment needed to prepare for or recover from these operations (for example, psychological counselling) including complications arising out of such treatment.;

4.14 Sunglasses and Orthoptic Treatment;

4.15 Costs for Treatment that has not yet taken place, even if advanced authorisation has been given or a guarantee of payment has been put in place.

5. Claims Procedure/Coordination of Benefits – Other insurance/Claims payment

5.1 **Claims Procedure**

Each claim must be submitted to the Administrator, in writing – using the special claim forms made available by the Administrator or the Cigna Envoy portal – as soon as possible after the event giving rise to the claim has occurred. The claim must be accompanied by the original supporting documentation including all relevant invoices, and proof of payment whenever requested by the Administrator. Moreover, in case of Accident, the Insured Person must provide the following additional information:

5.1.1 Date and detailed description of circumstances and place of the accident;

5.1.2 Identity of persons involved, as well as of witnesses and persons possibly liable;

5.1.3 Official report from local authorities (police or other).

5.2 Coordination of benefits – other insurance

If the Insured Person is entitled to a reimbursement by another insurer or social security system, cover, in accordance with the provisions of Section II Clause 5.1, will be applied on the difference between the Eligible Medical Expenses and the reimbursement made by the other insurer. The Insured Person must attach (to his/her claim) copies of the pertaining medical bills and the original settlement notes (with details of the amount reimbursed) provided by the other insurer or the social security system concerned. Total reimbursement for any given claim will never exceed the total amount of expenses actually incurred by the Insured Person.

5.3 Claims Payment

The Administrator reimburse the covered Reasonable and Customary medical expenses (up to the Policy Annual Maximum Benefit) following the receipt of the claim form and the relevant and complete written evidence of the medical expenses (original invoices of medical service providers, etc.).

Reimbursements shall be made to the Insured Person, but if the Insured Person has deceased, payment shall be made at the sole discretion of the Insurer, or to any person submitting satisfactory evidence that he/she is entitled to such payment.

Benefits may be directly assigned to Hospitals.

5.4 Medical information and/ or supporting documentation

Whenever required for the smooth settlement of any claim which is covered under the Policy, the Insurer may request the Insured Person provide to the Administrator (either directly or through his/her Doctor) all the necessary medical information and / or supporting documentation considered relevant to the claim. Failure of the Insured Person to provide all necessary medical information and /or supporting documentation when requested by the Insurer may result in a delay or refusal of the Insurer to pay the claim.

5.5 Medical Second Opinion

An Insured Person has access to a second opinion service where they can speak to a Doctor or nurse. This can offer a second opinion on Treatment or a simple reassurance to an Insured Person at what can be a difficult time. Where Treatment is more complex, the medical consultants of the Administrator can take over the case providing clinical guidance and reassurance. In addition, that medical consultant can become the dedicated point of contact for the Insurer Person throughout the Treatment process.

5.6 Time Limitation

Claims should be submitted to the Administrator as soon as possible after their occurrence but no later than twelve (12) months after the Treatment Date. Failure to submit the claim within this time period will disqualify the Insured Person from reimbursement.

6. Inpatient Treatment

For all In-Patient Treatment, pre-certification is always required, except in the event of a Medical Emergency. Failure to comply with the pre-certification requirement will result in a reduction of the reimbursement amount by twenty-five percent (25%).

The following benefits fall within the cover provided for Inpatient Treatment subject to the limits and sub-limits set out herein as well as those listed in the Benefits Overview:

6.1 Hospital Room and Board

Reimbursement of the charges for room accommodation and meals incurred during the Insured Person's stay as an Inpatient in Hospital shall be equal to the actual charges made by the Hospital during the Insured Person's or, for any one (1) day, the rate of a Standard Private Room., whichever is less.

6.2 Intensive Care Unit

Reimbursement of the charges for actual room and board incurred during the Insured Person's stay as an Inpatient in the Intensive Care Unit of the Hospital. No Hospital room and board benefits shall be paid for the same hospitalisation period where the daily Intensive Care Unit benefit is payable.

6.3 Doctor's Fees

Doctors Fees are deemed to also include the fees of Surgeons, Anaesthetists and any other Specialist Doctors.

6.4 Surgery

Reimbursement of the costs of Surgery including Day Surgery. Day Surgery is defined as Surgery requiring the use of a conventional operating theatre and performed on an Outpatient basis without an overnight stay.

6.5 Maternity Complications

In the event of complications during pregnancy that require hospitalisation, all charges incurred for the Treatment of a condition that may threaten the normal evolution of a pregnancy and well- being of the Insured Person, will be reimbursed subject to the limits and sub-limits set out herein as well as those listed in the Benefits Overview.

Reimbursement of the costs of a Caesarean Section that was Medically Necessary, which will be determined by the Administrator's medical consultants. In the event of there being complications during the birth (routine or Caesarean) that lead to the Insured Person requiring further Surgery, the costs thereof will be covered hereunder.

6.6 Organ transplant

Reimbursement of:

6.6.1 The charges incurred for transplantation Surgery and registration fees for the Insured person being the recipient of the transplant of an organ and;

6.6.2 The charges incurred for the living donor including the donor's preliminary tests, surgery and post-operative recovery;

6.6.3 The following expenses are excluded from cover:

6.6.3.1 Costs related to the search for a donor;

6.6.3.2 Costs for acquisition of the organ (in case a price is charged for the organ);

6.6.3.3 Costs incurred for the transport of the living donor or the donor organ or any other financial compensation the donor might have.

Prior approval of the medical consultant of the Administrator is always required.

6.7 Operating theatre

Reimbursement of the operating and recovery room charges incidental to the Surgery.

6.8 Hospital Supplies and services

Reimbursement of the charges incurred for general nursing, prescribed medicines, drugs and dressings for Day-Surgery and In-patient Treatment only.

6.9 Surgical Appliances and Medical Appliances

Reimbursement of the charges incurred for Surgical Appliances and Medical Appliances which includes any of the following devices:

6.9.1 An artificial limb, prosthesis or device which is required for or in connection with surgery;

6.9.2 An artificial device or prosthesis which is a necessary part of the treatment immediately following surgery for as long as medically necessary;

6.9.3 A prosthesis or appliance which is medically necessary and is part of the recuperation process on a short-term basis.

6.10 Diagnostic tests

Reimbursement of the charges incurred whilst admitted as an Inpatient to a Hospital for all tests performed to diagnose an Illness, evaluate an Injury and monitor a condition under Treatment. This would include but not be limited to pathology tests, laboratory tests, radiology, magnetic resonance imaging (MRI), computed tomography (CT Scan), positron emission tomography (PET Scan) and the like.

6.11 Physiotherapy, speech and occupational therapy

Reimbursement of the charges incurred whilst admitted as an Inpatient to a Hospital for physiotherapy, speech therapy and occupational therapy prescribed by a Doctor

6.12 Psychiatric Care

Reimbursement of the charges incurred whilst receiving psychiatric care that could not otherwise have been provided on an Outpatient basis. Prior approval of the medical consultant of the Administrator is always required.

6.13 Ambulance to the nearest hospital

Reimbursement of the charges incurred for domestic road Ambulance services (including attendant) to the Hospital in the event of a Medical Emergency. No reimbursement will be made if the Insured Person is not subsequently hospitalised. This benefit includes the charges of an Ambulance where it is Medically Necessary to transfer the Insured Person from one Hospital to another by Ambulance.

6.14 Parental accommodation

Reimburses the expenses for meals and lodging for one (1) parent accompanying an insured dependent child, aged below eighteen (18) years, in Hospital.

6.15 Home Nursing

Reimbursement of the charges incurred for visits from a Nurse to the patient's home to provide expert nursing services:

6.15.1 Immediately after hospital treatment for as long as is medically necessary;

6.15.2 Visits for as long as is medically necessary for treatment which should normally be provided in a hospital.

In either case, the Doctor treating the patient must have prescribed these services.

6.16 Convalescence and rehabilitation

Convalescence and rehabilitation care (in a recognised centre and when the admission is medically motivated) is covered when the admission immediately follows (within five (5) days) a hospitalisation for Illness or Surgery.

6.17 Hospital Cash Benefit

Hospital cash benefit refers to a daily allowance, which is granted only when room and board and Treatment are received free of charge. This benefit requires submission of all the relevant medical documentation and certification of the Hospital stay from the Hospital. Payment of this benefit is subject to the approval of the Administrators medical consultant.

7. Inpatient and Outpatient Treatment

7.1 The following Illnesses are most frequently treated with a combination of Inpatient and Outpatient Treatment methods. Regardless of whether the Treatment is provided on an Inpatient or Outpatient basis, cover for these Illnesses will be subject to the limits and any other sub-limits or conditions as set out below and in the Benefits Overview:

7.1.1 Cancer

Cancer is defined as uncontrollable growth and spread of malignant cells and the invasion and destruction of normal tissue for which major interventionist Treatment or Surgery (excluding endoscopic procedures alone) is considered necessary. The Cancer must be confirmed by histological evidence of malignancy. If an Insured Person is diagnosed with Cancer the Insurer will reimburse the charges incurred for the Treatment of Cancer performed at a legally registered Cancer Treatment centre or a Hospital. The Treatment must immediately follow diagnosis, or discharge from a Hospital. The Treatment includes radiotherapy

or chemotherapy and the like, but specifically excludes any experimental Treatment. Charges for the Treatment includes any Prescription Drugs.

7.1.2 Kidney Failure

Kidney Failure is defined as end stage chronic renal failure which indicates the irreversible loss of the ability of both kidneys to function as a result of which renal dialysis is initiated. If an Insured Person is diagnosed with Kidney Failure the Insurer will reimburse the charges incurred for kidney dialysis Treatment performed at a Hospital or at a legally registered dialysis centre. The benefit specifically excludes any experimental Treatment. Charges for the Treatment includes any Prescription Drugs.

7.1.3 Serious Illness

A Serious Illness is defined as an Illness which has two (2) or more of the following characteristics:

7.1.3.1 Is recurrent in nature;

7.1.3.2 Is without a known and generally recognised cure;

7.1.3.3 Is not generally deemed to respond well to treatment;

7.1.3.4 Requires palliative treatment;

7.1.3.5 Requires prolonged supervision or monitoring;

7.1.3.6 Leads to the insured person becoming a permanent invalid.

If an Insured Person is diagnosed with a Serious Illness the Insurer will reimburse the charges incurred for the Treatment of this condition performed by a Hospital or a recognised and legally registered Treatment centre and/or Specialist Doctor in the Serious Illness. This benefit specifically excludes any experimental Treatment. Charges for the Treatment includes any Prescription Drugs.

The following Illnesses are considered Serious Illnesses: medullary aplasia and other chronic cytopenias, chronic arteriopathy with ischemic manifestations, serious heart insufficiency, serious valvular cardiopathy, serious heart rhythm disorders, serious congenital cardiopathy, myocardial infection, coronary diseases, chronic active affections of the liver, cirrhosis of the liver, primary immunodeficiencies, Diabetes type 1, Diabetes type 2, serious forms of neurological and muscular affections (amongst others: myopathy), epilepsy, haemoglobinopathies, chronic constitutional and acquired haemolytic affections, haemophilia and serious constitutional coagulation disorders, serious chronic respiratory insufficiency, Chronic obstructive pulmonary disease (COPD), Alzheimer and other forms of dementia, Parkinson, congenital metabolic disorders requiring prolonged specialised treatment, mucoviscidosis, serious chronic nephropathy, nephrotic syndrome, paraplegia, polyarteritis Nodosa, systemic Lupus erythematosus, progressive generalised Scleroderma, progressive form of Rheumatoid arthritis, neurodevelopmental disorders, rectocolitis ulcerosa, Crohn disease, Multiple Sclerosis (encephalomyelitis disseminate), progressive form of scoliosis (with a cobb's angle > 25°), ankylosing spondylitis, consequences of organ transplant, active tuberculosis and leprosy. Chronic psychiatric afflictions (anorexia nervosa, psychosis, bipolar disorder, obsessive compulsive disorder, severe depression with suicidal risk, severe personality disorder such as paranoia or schizophrenia, neuropsychiatric disorders) are covered under this section. Any other psychiatric or psychological conditions are subject to the Inpatient and Outpatient Psychiatric Care benefits and limitations.

This list of serious Illnesses is not exhaustive and may be further updated as deemed necessary. It is meant to give a good representation of illnesses that can be considered serious illnesses. The list can be extended to any illness of comparable seriousness. The medical consultant will take a case-by-case decision on whether or not the Insured's illness can be recognised as a serious Illness.

7.1.4 HIV and AIDS

Is defined as Acquired Immunodeficiency Syndrome (AIDS) and is a chronic, potentially life-threatening condition caused by the human immunodeficiency virus (HIV). If an Insured Person is diagnosed with HIV, whether at the stage of AIDS or not, the Insurer will reimburse the charges incurred for the Treatment of this condition performed by a Hospital or a recognised and legally registered HIV and AIDS Treatment centre. The benefit specifically excludes any experimental Treatment. Charges for the Treatment includes any Prescription Drugs.

Cover under this benefit is subject to a 12 month Waiting Period unless waived at the sole discretion of the Insurer. Such waiver is only valid if explicitly stated in the Special Terms and Conditions of the Policy.

7.2 Palliative Treatment

Palliative Treatment may be as an Inpatient or Outpatient at home. If an Insured Person has an Illness that cannot be cured and a life expectancy of less than six (6) months the Insurer will reimburse the charges incurred for Palliative Treatment. This Treatment must be administered by a Hospice or a recognised organisation providing Palliative Treatment services for patients or at a registered centre for controlling pain and other symptoms. Palliative Treatment includes psychological and social support (medical and paramedical) for the patient during the last stages of life. Palliative Treatment is offered as an alternative to Hospital Treatment or Home Nursing. Prior approval of the medical consultant of the Administrator is always required.

8. Outpatient Treatment

The following benefits fall within the cover provided for Outpatient Treatment subject to the limits and sub-limits set out herein as well as those listed in the Benefits Overview.

8.1 Doctor's fees

Consultation fees with legally registered General Practitioners and Specialist Doctors because of Illness or Injury when Treatment in a Hospital is not required.

8.2 Diagnostic tests

Reimbursement of the charges incurred for all tests recommended by a Doctor and performed to diagnose an Illness, evaluate an Injury and monitor a condition under Treatment. This would include but not be limited to pathology tests, laboratory tests, radiology, magnetic resonance imaging (MRI), computed tomography (CT Scan), positron emission tomography (PET Scan) and the like.

8.3 Prescription Drugs

Only drugs that are prescribed by a Doctor can be reimbursed, such drugs must contain active pharmaceutical ingredients recognised for their curative effects. Lifestyle products, dietary products, vitamins, food supplements not qualify for reimbursement.

8.4 Treatment performed by Alternative Medicine Practitioners

Reimbursement of the charges incurred for Treatment by the following Alternative Medicine Practitioners. These Treatments must be prescribed by a Doctor:

8.4.1 Chiropractor;

8.4.2 Osteopath;

8.4.3 Acupuncturist;

8.4.4 Homeopath;

8.4.5 Chinese medicine practitioner.

8.5 Physiotherapy

Reimbursement of the charges incurred for physiotherapy prescribed by a Doctor and performed by a certified physiotherapist.

8.6 Dental Treatment following Injury

Reimbursement of the charges incurred for Dental Surgery only if required to restore damage to natural teeth because of an Accident.

8.7 Vaccinations for children

For Insured Persons who are Dependent children cover is provided for vaccinations in line with the World Health Organisations Recommended Routine Immunizations for children and adolescents.

8.8 Vaccinations for adults

Reimbursement of the charges incurred for preventative vaccinations in line with the World Health Organisations Recommended Routine Immunizations for adults. Cover also includes vaccinations required when travelling to a country to gain entry to that country or when recommended by a Doctor if the Insured Person is seen to fall into a high-risk category for diseases that can occur in that country.

8.9 Psychiatric care

Reimbursement of charges incurred for Outpatient psychiatric care only when prescribed by a Doctor and performed by a registered Psychologist and/or Psychiatrist. The covered amount includes the Psychiatrists Fees for the Treatment but does not include any drugs. Drugs are covered according to the provisions for Prescription Drugs.

8.10 Additional Therapies

Reimbursement of the charges incurred for ergo therapy, occupational therapy, logopaedics and/ or speech therapy when prescribed a Doctor.

8.11 Surgical and/or medical appliances

Reimbursement of charges incurred for surgical and/or medical appliances such as orthopaedic devices, repair of orthopaedic devices, hearing aids, wheel chairs, adapted buggies, hospital bed, standing frame, rollator, special bra after breast amputation, wig and Continuous positive airway pressure (CPAP) machine.

9. Maternity

The following benefits fall within the cover provided for Maternity Treatment subject to the limits and sub-limits set out herein as well as those listed in the Benefits Overview:

9.1 Prenatal Care

Reimbursement of all charges incurred for the recommended routine check-ups and screening during the Insured Person's pregnancy.

9.2 Complications related to Pregnancy

Reimbursement of all charges incurred for conditions that may threaten the normal evolution of a pregnancy and well-being of the Insured Person.

Complications during pregnancy, that require hospitalisation, are covered as Inpatient Treatment.

9.3 Routine Childbirth and Elective Caesarean Surgery

Reimbursement of the expenses incurred for a routine childbirth and elective Caesarean Surgery including Doctor's Fees, Hospital Room and Board and other related Hospital Services incurred during the Hospital stay.

Caesarean Surgery that is Medically Necessary and or complicated childbirth, is covered as Inpatient Treatment. The assessment as to whether a Caesarean is Medically Necessary or not, will be made by the Administrators medical consultant.

9.4 Infertility Treatment

9.4.1 Infertility diagnosis

Investigative procedures necessary to establish the cause of infertility.

9.4.2 Infertility Treatment

The expenses related to Infertility Treatment are only covered under the Elite Care plan, as Outpatient or Inpatient expenses, subject to the following conditions:

9.4.2.1 It must concern a primary infertility;

9.4.2.2 Maximum four (4) attempts per insured person and per lifetime are covered;

9.4.2.3 Maximum age of the female insured person of forty (40) years;

9.4.2.4 The expenses related to the sperm/egg donation are not covered;

9.4.2.5 The expenses related to a surrogate mother are not covered;

9.4.2.6 Prior approval of the administrators' medical consultant is always required.

Primary infertility is defined as the inability of either partner in a long-term relationship to conceive within two (2) years while sexually active and not using modern contraception. In primary infertility, pregnancy has never occurred.

Secondary infertility (which is not covered) is defined as the inability of a couple who has previously conceived to conceive again after a full year of trying.

9.5 Sterilisation

Reimbursement of expenses incurred for one (1) sterilisation per Insured Person and per lifetime.

9.6 Waiting Period

There is a ten-month (10-month) Waiting Period for all medical expenses related to Pregnancy, Childbirth and Infertility Treatment. This Waiting Period may be waived for groups at the sole discretion of the Insurer. Such waiver is only valid if explicitly mentioned in the Special Terms and Conditions of the group contract in question.

9.7 Treatment directly related to surrogacy exclusion

The Insurer will not pay maternity benefits to:

9.7.1 An insured person who acts as a surrogate; or

9.7.2 Anyone else acting as a surrogate for an insured person.

10. Preventative Care and Wellness Benefits

The following benefits fall within the cover provided for Preventative Care and Wellness Benefits subject to the limits and sub-limits set out herein as well as those listed in the Benefits Overview: For the tests described in items 10.2 to 10.5 below, the frequency of the testing and/or age limits only apply where the Insured Person is asymptomatic. Furthermore, the age limits and frequency of testing will not apply where it is deemed Medically Necessary to test sooner or more frequently, for example where there is a strong family history of the cancers being screened for.

10.1 One (1) routine adult physical examination per Insurance Year for Insured Persons over the age of eighteen (18) years old, this benefit is limited to the charges for the Doctors fees, glucose, cholesterol and HIV screening;

10.2 One (1) Papanicolaou Screening (Pap smear) per Insurance Year for female Insured Persons over the age of twenty-one (21) years old;

10.3 Mammograms for breast cancer screening or diagnostic purposes for female Insured Persons are included on the following basis:

10.3.1 One (1) baseline mammogram for asymptomatic women when they are aged between thirty-five (35) to thirty-nine (39) years old;

10.3.2 One (1) mammogram for asymptomatic women aged forty (40) to forty-nine (49) years old every two years;

10.3.3 One (1) mammogram every year for women aged fifty (50) years old and over.

10.4 One (1) Prostate Screening Test per Insurance Year for male Insured Persons from the age fifty (50) years old;

10.5 A routine hearing test at the appropriate age intervals involving a comprehensive examination performed by a licensed audiologist that includes counseling to understand and interpret the test results.

The appropriate age intervals are:

10.5.1 One for babies aged 0 to 6 months

10.5.2 One for children aged 7 months to 3 years old

10.5.3 One for children aged 3 to 6 years old

10.5.4 One every 5 years for children aged 7 and older and adults

10.6 Well child developmental tests

Reimbursement for the charges incurred for tests performed at any of the appropriate age intervals (further defined below) for an Insured Person who is a child who is six (6) years old or less. Such tests performed must be for child preventive care, consisting of the following services delivered or supervised by a Doctor, which services amount to orthodox Treatment:

10.6.1 Medical history of the child;

10.6.2 Physical examination;

10.6.3 Development assessment;

10.6.4 Anticipatory guidance.

Appropriate age intervals are – birth, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 2 years, 3 years, 4 years, 5 years and 6 years.

Cover hereunder is limited to one (1) visit to a Doctor for child preventive care services at each of the appropriate age intervals.

11. Medical Evacuation and Out of Country Assistance Benefits

11.1 General provisions of the Medical Evacuation and Out of Country Assistance cover

11.1.1 Exclusions

In respect of all the benefits provided under the Medical Evacuation and Out of Country Assistance covers, and in addition to the General Exclusions under Section I Clause 9, the following are excluded:

11.1.1.1 Events for which liability may fall either on the travel organiser by application of the local legislation stipulating the conditions for pursuing the business of organising and selling travel arrangement or on the carrier, principally for reasons of air safety and/or overbooking;

11.1.1.2 Refusal of the insured person to board the flight originally planned and approved by the administrator.

11.1.2 For transport costs

When the Administrator organises transport, in terms of the cover provided hereunder, this will be first (1st) class train travel and/or economy class flights or by taxi, depending on the decision taken by the Administrator. When Medically Necessary the Administrator may organise an air-ambulance.

11.1.3 Scope of the Administrator and AP assistance services

The Administrator and any AP they may appoint acts in compliance with national and international laws and regulations and the services are subject to obtaining the necessary approval from the competent administrative authorities.

Moreover, the Administrator and AP cannot be held liable for delays or any hindrance to the performance of the agreed services because of a case of force majeure or events such as strikes, riots, popular movements, restrictions on free circulation, sabotage, terrorism, civil or foreign wars, the consequential effects of a radioactive source or any other exceptional circumstances.

11.2 Evacuation Assistance

11.2.1 In the event of a Medical Emergency the Insurer will pay the costs of an air-ambulance or commercial flight to transport the Insured Person and one (1) Close Family Member (if they can be accommodated in the air-ambulance) to the Hospital which is closest and/ or is most suitable to provide the care required

by the Insured's Person's state of health. This benefit requires the prior approval of the Administrators medical consultants and/ or AP which approval will be subject to the following:

11.2.1.1 A Domestic Road Ambulance not being reasonably able to transport the Insured Person to the Hospital which is closest and/or is the most suitable to provide the care, as determined by the Administrator required by the Insured Person's state of health;

11.2.1.2 It being their assessment that the use of an air-ambulance is faster than a Domestic Road Ambulance and that the urgency with which the Treatment is required makes it Medically Necessary to transport the Insured Person as quickly as possible;

11.2.1.3 The air-ambulance being able to safely access and land where the Insured Person is located.

11.2.2 Organising and paying the costs of a Close Family Member

Should the Insured Person be transported to a Hospital that is not in their Home or Host Country and be unaccompanied by a Close Family Member, the Insurer pays the costs of transport for a Close Family Member to join the Insured Person.

11.2.3 Accommodation Costs

On presentation of receipts and subject to the limits and limitations set-out in the Benefit Overview, the Administrator reimburses to the Insured Person his/her additional accommodation costs and those incurred by the Close Family Member travelling with him/her, from the day of the evacuation up to the day of return to his/her Host Country or Home Country. The limit set out in the Benefit Overview is for the combined expenses of both the Insured Person and accompanying Close Family Member.

11.2.4 Return to Host Country

Where the Insured Person and Close Family Member have been transported out of their Home or Host Country as a result of a Medical Evacuation the Insurer will organise and pay for the return trip to the Host Country.

Cover hereunder is limited to two (2) evacuations arising from the same Illness per Insured Person per lifetime.

Important Remark:

Decisions are only taken in consideration of the Insured Person's medical interests.

The Administrator's Doctors contact the local medical teams and, if required, the Insured Person's usual Doctor, to gather the information that will enable the most appropriate decisions in respect of his/her state of health to be taken.

Evacuation is decided on and managed by medical staff who hold qualifications that are legally recognised in the country in which they usually practice their professional activity.

If the Insured Person refuses to comply with the decisions taken by the Administrators medical consultants, he/she discharges the Insurer of any liability in relation to the consequences of such an initiative and loses all rights to services and compensation from it.

11.3 Planned Out of Country Assistance

In the event of Planned Out of Country Care where the Insured Person has agreed to Treatment at the closest Hospital which is most suitable to provide the care required by the Insured Person's state of health, as determined by the medical consultants of the Insurer's Administrator, the Insurers will organise and pay for:

11.3.1 The cost of transport from and back to the Host country as well as accommodation of the Insured Person requiring the Treatment;

11.3.2 The cost of transport from and back to the Host country as well as accommodation of a Close Family Member of the Insured Person requiring the Treatment, if they are to be hospitalised for more than five (5) days (or more than forty-eight (48) hours if he/she is a minor or disabled).

The limit set out in the Benefit Overview for the cost of accommodation is for the combined expenses of both the Insured Person and accompanying Close Family Member.

If the Insured Person or his/her companion arranges one of the services stated in this section of the Policy, this will only give rise to a refund if the Administrator has been previously notified and has given its express and written agreement, on the planned itinerary, which would include details on such items as the mode of transport, date, times, destination and accommodation. In this case, the costs incurred will be refunded on presentation of the original receipts up to the limit of those to which the Administrator would have committed in arranging the service.

This service is not additional to the service detailed under Section II Clause 11.2.2.

11.4 Early Return Assistance

The Administrator will organise, and the Insurer will pay, the costs for a round trip to the Home Country for the Insured Persons under this Policy.

The Insured Person can receive this service under the following circumstances:

11.4.1 In the case of an Illness or Injury, resulting in emergency hospitalisation and which, in the opinion of the Administrators medical consultants is of a life-threatening nature, of his/her spouse or common-law partner or of a minor or disabled dependent, who is not residing in the Host Country and is living in the Insured Person's Home Country;

11.4.2 To attend the funeral after the death of a Close Family Member, who lives in the Insured Person's Home Country and is under the age of eighty-five (85).

11.5 Assistance in the event of a business assignment being curtailed

In the event of a business assignment of the Insured Person being curtailed because of a covered event, the Insurer pays the travel costs incurred by the Insured Person's company to send out a replacement colleague to continue the disrupted assignment.

11.6 Dispatch of Prescription Drugs

When an Insured Person requires Prescription Drugs that are not available locally:

11.6.1 The Administrator will use all reasonable endeavours to dispatch Prescription Drugs that are not available locally, subject to the agreement of the Insured Person's attending prescribing Doctor, and only if they are essential to a Treatment in progress, provided that no equivalent for the Prescription Drugs can be prescribed locally, and that national and international customs regulations or health regulations do not prevent the medicines from being dispatched;

11.6.2 The Administrator and Insurer shall not be held liable for any delay in the dispatch of Prescription Drugs, howsoever caused, or for the potential unavailability of Prescription Drugs. Payment by the Insurer for the costs of the Prescription Drugs is subject to the Terms and Conditions and benefit limits of your policy.

11.7 'Unforeseen event' Assistance

Communication with the Insured's family or company

If the Insured Person is unable to contact his/her family or employer, but can manage to contact the Administrator, the Administrator will transmit the Insured Person's urgent messages.

11.8 Death Assistance

In the event of the death of an Insured Person, the Administrator will organise, and the Insurer will pay the cost of:

11.8.1 Transportation of the body from the location where it is placed in the coffin to the burial place in the Home Country or burial at the location,

11.8.2 Additional expenses for the transportation of the Insured Persons who are members of the deceased person's family or an Insured Person's family, travelling with the deceased person, insofar as their originally planned means of returning can no longer be used because of this death.

11.9 Cover exclusions

In addition to the exclusions that are common to all cover, the following are also excluded in respect of 'Evacuation Assistance', "Planned Out Of Country Assistance", 'Unforeseen events Assistance', and 'Death Assistance':

11.9.1 Expenses incurred without the prior approval of the Administrator;

11.9.2 Expenses incurred where the Insured Person has travelled out of their Home or Host Country when a Doctor has pronounced them not fit to travel;

11.9.3 The consequences of Illnesses or Injuries that can be treated at the location;

11.9.4 Psychiatric Treatment;

11.9.5 The consequences:

11.9.5.1 Of infectious risk situations in an epidemic scenario;

11.9.5.2 Of exposure to infectious biological agents;

11.9.5.3 Of exposure to chemical agents of a combat gas type;

11.9.5.4 Of exposure to incapacitating agents;

11.9.5.5 Of exposure to neurotoxic agents or agents with residual neurotoxic effects, which require a quarantine period or specific preventive or monitoring measures by the local and/or national health authorities of the country in which the insured is staying, unless there is a sudden outbreak in the place of contamination after his/her arrival;

11.9.5.6 Of the insured's participation in any sport practised as a professional or under a paid contract, in addition to preparatory training;

11.9.5.7 Of the insured's failure to comply with official prohibitions and his/her non- compliance with official security rules, related to the practice of a sports activity;

11.9.5.8 Of insured persons working on off-shore rigs and vessels and cover hereunder specifically excludes rig/ship-to-shore evacuations.

11.9.6 The consequences of an Accident that occurs when the Insured Person is taking part in an air sport (including hang-gliding, paragliding, gliding) or one of the following sports: skeleton, bobsleigh, ski jumping, alpinism, rock climbing, scuba diving, pot-holing, bungee jumping, parachute jumping;

11.9.7 Expenses not expressly mentioned as giving rise to a refund (such as the cost of meals) and any expenses for which the Insured Person is unable to produce a receipt.

11.9.8 Any expenses related to securing the necessary travel documents in order for the Insured Person to leave or enter a country, such as passports, visas and the like.

11.10 What the Insured must do when making a Claim

11.10.1 To Request Assistance

The Insured Person must contact the Administrator or get a third (3rd) party to contact the Administrator as soon as his/her situation is expected to involve early return or expenses that fall within the scope of the Policy's cover.

The Administrators services are available 24/7: [TBC – AP number]

11.10.2 For a Refund Claim

In order to receive a refund of expenses advanced by the Insured Person with the Administrator's approval, the Insured Person must provide the receipts that will enable the Administrator to determine the validity of the Claim.

Services which have not been requested in advance and which have not been organised by the AP do not entitle the Insured Person to a refund or a compensation payment.

SECTION III: ADDITIONAL INSURANCES

1. Dental Treatment and Vision Care

This Section should be read in conjunction with the below Benefits Overview as reimbursement is subject to the limits and sub-limits listed in the Benefits Overview as well as the Policy Conditions and Exclusions.

ADDITIONAL BENEFITS			
	Standard	**Extra**	**Booster**
Dental Treatment			
Dental Treatment Annual Maximum Benefit	Up to $ 500	Up to $ 1,000	Up to $ 2,000
Investigative and Preventative Dental Treatment	Paid in Full	Paid in Full	Paid in Full
Basic Restorative Treatment and Minor Periodontal Treatment	80% reimbursement Up to $ 500	80% reimbursement Up to $ 1,000	80% reimbursement Up to $ 2,000
Major Restorative Treatment and Major Periodontal Treatment *Waiting Period 12 months (unless waived)*	50% reimbursement Up to $ 500	50% reimbursement Up to $ 1,000	50% reimbursement Up to $ 2,000
Vision Care			
One eye examination per insurance year	Paid in Full	Paid in Full	Paid in Full
Vision Expenses for: > Lenses to correct vision > Eyeglass frames > Prescription sunglasses	Up to $ 100 per insurance year	Up to $ 200 per insurance year	Up to $ 400 per insurance year

1.1. Eligibility

The choice for taking out the Dental and Vision Care insurance (as an additional cover to the Cigna Africa Base Plan) and the level of cover (Standard, Extra or Booster) must be made (by the Policyholder) at a group level (i.e. for all Insured Persons covered by the Cigna Africa Base Plan or none). Once the Dental and Vision Care cover has been taken out, it has to be maintained for at least one (1) year.

1.2. Area of cover

The area of cover for the Dental and Vision Benefits is the same as that selected for the Base Plan in the Policy.

1.3. Benefits

This Policy will reimburse Reasonable and Customary expenses incurred for Medically Necessary dental and vision Treatment. This Section should be read in conjunction with Benefits Overview as reimbursement is subject to the limits and sub-limits listed in the Benefits Overview as well as the Policy Exclusions and Conditions.

1.3.1. Investigative and Preventative Dental Treatment

Preventative Dental Treatment is dental care designed to avoid or lessen the effects of cavities, gingivitis, enamel loss and periodontitis (gum disease). This benefit is limited to two (2) visits per insurance year, which visits may include a visual examination, scaling and polishing as well as a fluoride application. One of the two (2) visits may include x-rays, such x-rays will be limited to two (2) bite-wing x-rays on each side of the mouth and two (2) films for intraoral occlusal x-rays. The benefit also includes an orthopantomogram (OPG) once every three (3) years.

1.3.2. Basic Restorative Treatment and Minor Periodontal Treatment

Basic Restorative Dental Treatment covers the costs of fillings, simple extractions and Dental Emergency Services. Minor Periodontal Treatment covers root planing with a maximum of one (1) Treatment per quadrant per annum. Where it is Medically Necessary for any of the Treatments under this benefit the costs of anaesthetic will also be covered.

For this benefit Dental Emergency Services are defined as dental service that are required immediately to either alleviate pain or to treat the sudden onset of an acute dental condition. These are usually minor procedures performed in response to serious symptoms, which temporarily relieve significant pain, but do not effect a definitive cure, and which, if not rendered, will likely result in a more serious dental or medical complication.

1.3.3. Major Restorative Treatment and Major Periodontal Treatment

This benefit covers the costs of:

1.3.3.1. Dental bridges;

1.3.3.2. Crowns, in-plants, in-lays or on-lays;

1.3.3.3. Dentures including relines, rebases, adjustments and repairs to dentures;

1.3.3.4. Mouth guards and occlusal splints;

1.3.3.5. Root canal treatment and endodontics;

1.3.3.6. Major periodontics;

1.3.3.7. Oral surgery and surgical extraction of impacted teeth;

1.3.3.8. Orthodontics for insured persons under the age of eighteen (18)

1.3.3.9. The costs of anaesthetic when medically necessary.

An OPG may be requested by the Administrator both before and after extensive Treatment. For Major Restorative Treatment it is advisable to submit the Treatment details to the Administrator for prior approval and confirmation of benefits by the Administrator.

A Waiting Period of twelve (12) months applies for all major dentistry. This Waiting Period may be waived for groups at the sole discretion of the Insurer. Such waiver is only valid if explicitly mentioned in the Special Terms and Conditions.

1.3.4. Eye examination

One (1) eye examination per year of insurance by an Optometrist or an Opthalmologist.

1.3.5. Ophthalmologic care

This benefit includes expenses for lenses to correct vision, eyeglass frames and prescription sunglasses.

Contact our sales team with all your questions on: [TBC email@cigna-africa.com]

Policy Services are provided by Cigna International Health Services Kenya Limited (Company Registration Number CPR/2015/178985) directly or through a member of its group (in relation to Cigna International Health Services Kenya Limited means Cigna International Health Services Kenya Limited, any subsidiary, any affiliated company or holding company from time to time of Cigna International Health Services Kenya Limited and any subsidiary from time to time of a holding company of Cigna International Health Services Kenya Limited). Information contained herein is subject to the Terms and Conditions of your policy. To discuss the cover under your policy, please contact Cigna International Health Services Kenya Limited using the number of the back of your ID Card. Cigna International Health Services Kenya Limited (Company Registration Number CPR/2015/178985) or a member of its group (as relevant in your jurisdiction) is the administrator of your health policy.

Cigna® | Assemble INSURANCE

Contents >>