COVERN'GO GLOBAL PLAN

Frequently Asked Questions

ENROLMENT, ELIGIBILITY AND COVER

1. In which regions can plan members be covered?

We offer 5 regions of cover:

- Region 1. – Africa
- Region 2. – Worldwide excluding USA, Russia, Switzerland, UK, China, Japan, Singapore & Hong Kong
- Region 3. – Worldwide excluding USA & Hong Kong
- Region 4. – Worldwide excluding USA
- Region 5. – Worldwide

Usually, we match the region of cover with the member's location and nationality.

2. Are members covered if they travel to countries excluded from their region of cover?

Members are covered outside their region of cover for accidents and emergencies (90 days per member and per insurance year).

3. Is war risk covered?

If a member is victim of acts of war and terrorism without any active involvement, he/she is covered within the limits of the medical cover. All consequences of active participation in operations of war and terrorism are explicitly excluded from all cover. The additional non-medical covers are not valid when the member is travelling to or from, or is residing in a country publicly known to be in state of war or civil war.

4. What are the differences in cover between the 3 core plans?

	PHOENIX	ORION	PEGASUS
Maximum reimbursement per insured and per insurance year	€ 1,000,000 £ 650,000 $ 1,250,000 CHF 1,500,000	€ 1,500,000 £ 1,000,000 $ 1,875,000 CHF 2,250,000	€ 3,000,000 £ 2,000,000 $ 3,750,000 CHF 4,500,000
Inpatient treatment	100%	100%	100%
Outpatient treatment	80%	90%	100%
Other benefits (AIDS/HIV treatment, cancer treatment, organ transplant, local ambulance (to nearest hospital), vaccinations /preventive medication (e.g. against malaria))	100%	100%	100%
Medical evacuation and assistance services	100%	100%	100%

Please refer to the table of benefits for a detailed benefits overview. Reimbursements ceilings apply.

5. Is a medical questionnaire needed?

It depends on the number of employees in your organisation. For small groups of less than 10 employees, a medical questionnaire has to be completed by each employee and each dependant. We offer the flexibility of an additional premium to waive exclusions, or alternatively, we can offer partial or total exclusion of a particular condition. For larger groups of 10 or more employees, a medical questionnaire is not required, meaning that pre-existing and chronic conditions are covered, there are no waiting periods and all members are fully covered from day one.

6. As from when are my employees covered?

For groups of less than 10 employees, cover starts as from the date on which our Medical Consultant approves their application.
For groups of 10 or more employees where no medical application is required, cover starts from date of enrolment.

7. Is there an age limit for enrolment?

There is no specific age limit for enrolment in the medical core plan. For any additional cover, the maximum age is set at the age of retirement:

- Life Cover: age 60
- Accidental death and invalidity: no age limit
- Temporary Incapacity: age 65
- Permanent Disability: age 65

8. What happens when an employee returns to his or her home country?

Please inform us in writing of the exact date of relocation to the home country when an employee returns to his or her home country. The cover can be extended by a maximum of 3 months to allow the employee time to enrol in a local social security scheme or find another private insurance.

9. Can my employees' family members also be covered?

Yes. The spouse (partner) and children of your employees can be enrolled at any time. Their dependent children can be covered as of birth up to the age of 28.

10. Is evacuation and repatriation covered?

Yes, evacuation and repatriation are fully covered and integrated into the cover, subject to exclusions and limitations as described in the policy terms and conditions.

11. Are malaria tablets and vaccinations covered?

Yes, including yearly check-ups; please refer to the table of benefits under the outpatient section.

HEALTH CARE PROVIDERS

1. Can my employees receive treatment in any hospital?

Yes. Your employees and their dependants have complete freedom of choice when it comes to choosing hospitals, doctors and specialists. They may consult the health care provider of their choice, in their region of cover.
They can also rely on our own network of 10,500 hospitals, doctors and specialists and benefit from the direct payment agreements and discounts we have negotiated.

2. How can my employees avoid advancing the costs of treatment?

- If an admission is planned, they should contact us well in advance so we can arrange for direct payment of their expenses. Please note that direct payment is not possible in sanctioned countries.
- Direct payment is also possible in case of an emergency or accident. Patients simply need to show their membership card to the health care provider upon admission and have someone contact us by phone as soon as possible. Members can contact us using the contact details on the front of their membership card. Contact details for providers can be found on the back of the membership card.

If a member loses their membership card or doesn't have it with them, they can download or email an electronic version of their card for themselves of one of their eligible dependants whenever they need it. They can access this service on their personal webpages or on the Cigna Health Benefits mobile app, which they can download from the Apple App Store℠ and Google Play™ for Android phones.

3. What should members do if they need an insurance certificate?

They can download their personal certificate from their personal webpages.

CLAIMS AND COMMUNICATION SERVICES

1. What should a member do if emergency treatment is needed?

They should call the number (available 24/7) indicated on the front of their membership card. There is only one number for CoverN'GO (+32 3 217 6896). This number is a one-stop shop for all types of questions and the call can be transferred to Healix if an emergency medical evacuation is needed.

2. When are claims reimbursed?

We aim at a rapid and hassle-free settlement of all claims and process 99% of the claims within 5 days of receiving all required documents.

3. How can a member be sure that he/she is covered before receiving treatment?

For planned hospital admissions, we advise plan members to consult the benefits on their personal webpages or to call our 24/7 Contact Centre to check whether the treatment is covered under their plan.

4. Can members receive assistance over the phone?

Yes. Our Contact Centre agents are available 24/7, 365 days a year.

5. What information and services are available online?

Plan members can find all information regarding their plan and access our services anytime, anywhere on their personal webpages. They can search our worldwide network of health care providers, find instructions on how to claim, download personalised forms, check their reimbursements, claim online and download an electronic version of their membership card.

6. What if members require advice or assistance?

If they require any advice or assistance, a multilingual 24 hour helpline is available. The contact details are available on the front of the membership card and are as follows:
24/7 helpline: + 32 3217 6896
24/7 fax: + 32 32 35 8351
24/7 email address: claims@coverngo.com

7. How does the co-payment work?

With Phoenix as cover level, Cigna will pay 80% of all invoices for doctors' visits and prescribed drugs. For other benefits with a limit, for example alternative medicine, the annual limit per person is € 1,000 and Cigna pays 80% until the € 1,000 limit is reached.

8. What happens if members have started or are halfway through a course of treatment on the date of enrolment?

For groups of more than 10 employees, that does not impact on their treatment. All hospitalisations and series of treatment approved by their current insurer will be respected by CoverN'GO.

9. Are members covered if they have an accident?

Yes, the plan does not distinguish between illness or accidents, and covers members 365 days of the year for medical treatment resulting from an accident.

10. How will members receive the reimbursement?

The money can be transferred to their bank account (recommended) or they can receive a cheque.

DEFINITIONS

1. What is a deductible?

A deductible is the amount your employees have to pay from their own pocket for medical expenses before the insurance company starts covering the expenses

2. What are a standard private and a semi-private room?

A standard private room is a room with one bed – the lowest rate (regular) private room in a hospital. A semi-private room is a room with 2 beds.

3. What are prescription drugs?

Prescription drugs are medicines that are necessary to treat a medical condition and are not available without a doctor's prescription (excluding over the counter drugs).

4. What is a host country?

The host country is the country in which the plan member will be living and working (as declared in the Application form).

5. What is a home country?

The home country is the country where the insured normally resides or used to reside and out of which he/she is expatriated to another country (as declared in the Application form). If the home country cannot be named according to this definition, it is the country of which the insured has the nationality and is holding a passport from..

6. What are reasonable and customary expenses?

Medical expenses will be considered Reasonable and Customary if they correspond to the charge usually made for a similar service or supply and do not exceed the normal charge made under the best prevailing conditions for such a service or supply in the locality where the service or supply is received. If usual and prevailing charges cannot be determined because of the unusual nature of the service or supply, the Administrator will determine on behalf of the Insurer to what extent the charge is reasonable, taking into account:

- the complexity involved;
- the degree of professional skill required;
- all other pertinent factors.