CIGNA EXPATPLUS GENERAL CONDITIONS

2020

IMPORTANT INFORMATION

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

In case we have provided the Policyholder with a translation of the English version of the General Conditions, the Policyholder agrees that the translation is provided for his/her convenience only and that the English version of the General Conditions will govern his/her relationship with Cigna.

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

1. Right of withdrawal

If the Policyholder is not satisfied with this agreement for whatever reason, he/she may return it to the Administrator within a period of fourteen (14) calendar days. The period for withdrawal shall begin from the day of the conclusion of the distance contract or the day on which the Policyholder receives the contractual conditions (if that is later). The Insurer will cancel the policy and refund to the Policyholder all premiums paid, on the condition that no claims have been submitted yet.

2. Change of address

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

3. General information

The Insurer

Cigna Life Insurance Company of Europe SA/NV (hereinafter 'Cigna')
52, Avenue de Cortenbergh 1000 Brussels
Belgium
RPR 0421.437.284
FSMA licence for accident, sickness and life

Cigna Europe Insurance Company SA/NV
52, Avenue de Cortenbergh 1000 Brussels
Belgium
RPR 0474.624.562
FSMA licence for miscellaneous financial loss

The Assistance Provider (hereinafter 'the AP')

Healix Group of Companies
Healix House
Esher Green
Esher
Surrey
KT10 8AB United Kingdom

The Administrator

Cigna International Health Services BV
Plantin en Moretuslei 299 or P.O. Box 69 2140 Antwerpen
Belgium
RPR 0414.783.183
FSMA 13799 A-R

The Supervisory Authority
FSMA (Financial Services and Markets Authority)
12-14, Rue du Congrès
1000 Brussels, Belgium
www.fsma.be

4. Contact
If the Policyholder has any queries on his/her policy, he/she can contact the Administrator at:

Cigna expatplus
P.O. Box 69
2140 Antwerp, Belgium
Tel. + 32 3 217 65 29
Fax + 32 3 663 73 14
info@expatplus.com
www.expatplus.com

For any enquiries or complaints pertaining to any International Medical Insurance related matter on this policy the Policyholder may refer to our Contact Centre (24/7) at the following address:

Cigna expatplus
P.O. Box 69
2140 Antwerp, Belgium
Tel. + 32 3 217 69 72
Fax + 32 3 235 83 51
claims@expatplus.com

5. Ombudsman – out of court procedure
In case of disagreement with the Insurer or Insurance intermediary, the Ombudsman will try to arrange a friendly settlement.

Ombudsman van de verzekeringen de Meeûssquare 35
1000 Brussels, Belgium
Fax + 32 2 547 59 75
info@ombudsman.as

Chapter I: General policy provisions

1. Order of precedence of the conditions, compliance and purpose of the insurance

1.1. Order of precedence of the conditions

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

With respect to Medical Evacuation and Assistance Services, the provisions of Chapter II take precedence over the General policy provisions of Chapter I.

Moreover, the Special Conditions will always take precedence over the Cigna expatplus General Conditions.

1.2. Compliance

The Insurer's products and services may not be available in all jurisdictions and are expressly excluded from this policy where prohibited by applicable law, including but not limited to, anti-corruption laws and economic sanctions programs. Any such coverage will be null and void. The Cigna expatplus policy does not replace participation to a state-run or local health insurance scheme or compliance to any other legislative requirements of any country whatsoever. Cigna expatplus Insured should not stop contributing to a state-run health insurance scheme unless they have been given advice about the risks of doing so.

The Insurer and Policyholder agree that, except as explicitly stated in the present General Conditions and/or Special Conditions of the Insurance Policy, nothing of value has been offered or provided by either of them or anyone acting on their behalf, in relation with this Insurance Policy.

1.3. Purpose of the insurance

The Cigna expatplus insurance programme consists of several insurance benefits, intended to offer social protection to expatriated persons.

CORE PLAN

1. International Medical Insurance

The International Medical Insurance cover reimburses - up to the limits defined in this policy - Reasonable and Customary expenses for outpatient as well as for inpatient medical services, provided these expenses have been incurred because of Illness, Accident or maternity.

2. Medical Evacuation and Assistance Services

Emergency Medical Evacuation and Assistance Services are included within the Core Plan.

ADDITIONAL INSURANCES

Persons insured under the Core Plan can also apply for the following Additional Insurances:

3. Dental Care

This insurance can be taken out by Insured who are accepted into the Core Plan.

4. Life Cover

This insurance can be taken out as an Additional Insurance to the Core Plan and guarantees the payment of a lump sum in case of death due to any cause.

5. Accidental Death and Disability

This insurance can be taken out as an Additional Insurance to the Core Plan and guarantees the payment of a lump sum in case of accidental death or in case of permanent Disability caused by an Accident.

6. Temporary Incapacity

This insurance can be taken out as an Additional Insurance on top of the Core Plan and guarantees payment of a monthly allowance in case the Insured is totally unable to perform his/ her professional activities because of Illness or Accident.

7. Permanent Disability

This insurance can only be taken out as a supplement to the Temporary Incapacity insurance and guarantees the payment of a monthly allowance to the Insured who is affected by a permanent disability caused by an Illness or Accident, prohibiting him/her from fully or partially continuing his/her professional occupation, therefore leading to a total or partial loss of income.

2. Definitions, in alphabetical order

'Accident'

A sudden, unexpected event, the cause of which is situated outside the victim's body, which results in bodily Injury. Following events are also considered to be Accidents:

- a rescue attempt of persons or goods in peril;
- gas or vapour inhalation and the absorption of poisonous or corrosive substances;
- dislocations, distortions, ruptures and muscular lacerations provoked by a sudden effort;
- freezing;
- drowning.

'Administrator'

The claims handler and plan Administrator.

Cigna International Health Services BV, Plantin en Moretuslei 299, 2140 Antwerp, Belgium or P.O. Box 69, 2140 Antwerp, Belgium, hereafter called the Administrator.

'Annual Renewal Date'

For individual policies: 1st January. For group policies: see Special Conditions.

'Assistance Provider' (AP)

The provider for emergency medical evacuation and assistance services.

'Chronic Conditions'

Illness or Injury which has one or more of the following characteristics:

- is recurrent in nature;
- is without a known, generally recognised cure;
- is not generally deemed to respond well to Treatment;
- requires palliative Treatment;
- requires prolonged supervision or monitoring;
- leads to permanent Disability.

'Complementary Medicine Practitioner'
An acupuncturist, chiropractor, homeopath or osteopath who is legally qualified and allowed to practise complementary medicine by the authorities in the country in which the Treatment is received.

'Day Care'
Treatment in a hospital or medical day-care centre, for which the patient does not have to stay overnight.

'Day Surgery'
Surgery requiring the use of a conventional operating theatre and performed on an in-and-out same-day basis without an overnight stay.

'Deductible'
The (first) part of the (eligible) medical expenses, not reimbursed by the Insurer and deducted from the amount (of Eligible Medical Expenses) on which the reimbursement is calculated.

'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, until the thirty-first (31st) of December of the year of the twenty-eighth (28th) birthday of the insured child, who are financially dependent on the Expat.

'Disability'
Incapacity of permanent nature, caused by a chronic Illness or Injury.

'Doctor'
A person who graduated from a recognised medical school as listed in the WHO World 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, Accident or maternity but not exceeding the limits in the Benefits Overview.

'Expat (or Expatriated person)'
A person living and working abroad (outside his/her Home Country).

'Family Doctor or GP (General Practitioner)'
A Doctor providing Medical Treatment not requiring a specialist Doctor's training.

'GP (General Practitioner)'
See definition of 'Family Doctor'.

'Home Country'
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) and to which he/she intends to return to after the expatriation period. 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.

'Host Country'
The country where the Insured is expatriated to, as declared in the Application form.

'Illness'
A condition marked by a pathological deviation from the normal healthy state 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, hysteroscopy).

'Injury'
Bodily Injury caused solely by an Accident.

'Inpatient Treatment'
Treatment for which, for medical reasons, the patient has to stay overnight in a hospital.

'Insurance Year'
A twelve (12)-month period, starting on the effective date of coverage of the Insured.

'Insured'
The person(s) covered by the Cigna expatplus insurance and whose name(s) is(are) mentioned in the Special Conditions.

'Insurer'
The insurance company underwriting the risks covered by the insurance plan.

'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 critical condition and which is equipped to provide special nursing and medical services not available elsewhere in the hospital.

'Maximum Annual Reimbursement'
Benefits payable in respect of expenses incurred for Treatment provided to the Insured during the period of insurance shall be limited to overall annual limits as stated in the Benefits Overview. In the event the overall annual limit has been exhausted, no further payments shall be made for the remaining period of the Insurance Year.

'Medical Emergency'
An accidental Injury or a sudden and unexpected onset of a change in a person's physical or mental condition which, if the procedure or 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 Emergency Evacuation'
Evacuation in case of an accidental Injury or a sudden and unexpected onset of a change in a person's physical condition which, if the procedure or 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 AP.

'Medically Necessary'
A medical service which is:

- consistent with the diagnosis and customary Medical Treatment for a covered Illness or Injury;
- in accordance with standards of good medical practice, consistent with current standard of professional medical care, and of proven medical benefits;
- not for the convenience of the Insured or the Physician, and unable to be reasonably rendered out of hospital (if admitted as an inpatient);
- not of an experimental, investigational or research nature, preventive or screening nature;

- for which the charges are fair and reasonable for the Treatment.

'Outpatient Treatment'
Medical Treatment for which the patient does not have to stay overnight in a hospital.

'Physician'
See definition of 'Doctor'.

'Policyholder'
The employer or the individual Expat taking out the insurance for the benefit of the Insured, having to pay the appropriate premium to the Insurer on behalf of the Insured. The name of the Policyholder is mentioned in the Special Conditions.

'Policy Renewal Date'
For individual policies: depending on the chosen policy duration. For quarterly policies: 1st January, 1st April, 1st July and 1st October. For half-yearly policies: 1st January and 1st July. For yearly policies: 1st January.

For group policies: 1st January or the Annual Renewal Date (see Special Conditions).

'Pre-existing Conditions'
Medical conditions or any related conditions, for which symptom(s) has/have been shown prior to commencement of cover, irrespective of whether any Medical Treatment or advice was sought. Any such condition or related condition, about which the Insured or his/her Dependents know, knew or could reasonably have been assumed to have known, will be deemed to be pre-existing.

'Prescription Drugs'
Drugs/medicines that are necessary to treat a confirmed medical diagnosis or medical condition, and which are not available without prescription by a Doctor (excluding OTC ('over-the-counter') drugs).

'Reasonable and Customary'
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 relevant factors.

'Salary'
The gross Salary being paid to the Insured at the commencement of his/her insurance, before deduction of any income tax. Gross Salary does not include any benefits in kind such as car, living accommodation, bonuses or overtime. In the event of a claim, satisfactory proof of income will be required.

The Salary for a self-employed Insured shall mean the gross average Salary during each of the three (3) years leading up to the date of the event entitling to benefits.

'Special Conditions'
A document issued with each insurance policy, stating:

- the identity of the Policyholder and of the Insured;
- the cover opted for, and the term of the policy;
- the amount of the insurance premiums;
- any particular agreement or any deviations from the General Conditions.

'Specialist Doctor'
A Doctor having a specialised qualification in the field of, or expertise in, the Treatment of the Illness or Injury.

'Standard Private Room'
A room with one bed. A Standard private room is the lowest rate (regular) private room in a hospital.

'Surgery'
Any of the following medical procedures:

- incision, excision or electrocauterisation of any organ or body part, except for dental services;
- repair, revision, or reconstruction of any organ or body part, both invasive and non-invasive;
- reduction of a fracture or dislocation by manipulation;
- 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.

3. Eligibility and acceptance into the insurance

3.1. Eligibility

The Cigna expatplus insurance is available for individual Expats (private persons and their Dependents[1]) and for employers to cover their expatriated employees (and their Dependents[1]) sent on assignment abroad (group policy).

The policy must be domiciled in the European Economic Area (reference is made to the policy address).

Partners and dependents living at the same address must take out the same type of cover (including the deductible amount) and will only be able to subscribe to one single policy.

For group policies, if the number of enrolled staff decreases to 1 (one) employee, the insurer has the right to terminate the policy.

3.2. Acceptance into the insurance

3.2.1. Individual Expats ('individual policy')

A Medical questionnaire has to be completed for each Insured (including each Dependent) and has to be sent at the time of application by the candidate-Insured to the medical consultant of the Administrator. The medical consultant can define partial exclusions, total exclusion from cover (refusal of cover), or, at his discretion, propose an additional premium to waive exclusions.

The information provided on the Medical questionnaire is valid for 4 months. If the policy enters into effect later than 4 months after the date of signature of the questionnaire, a new Medical questionnaire needs to be completed and signed.

3.2.2. Expatriated employees ('group policy')

In case of compulsory enrolment by the employer of a group of ten (10) or more employees and after an assessment of the risk profile of the group, the health declaration(s) for the International Medical Insurance plan may be waived at the

[1] For the definition of 'Dependents' see Art. I-2.; the Core Plan (including Medical Evacuation and Assistance Services) as well as the Additional Insurances Dental Care are open to the Insured's Dependents. The Additional Insurances Temporary Incapacity and Permanent Disability are not open to the Dependents. The Additional Insurances Accidental Death and Invalidity and Life Cover, however, can be taken out for the spouse (or legal partner) and dependent adult children (i.e. as from age 18) of the employee or the individual Expat, insofar as these persons are also covered by the Core Plan.

discretion of the Insurer, meaning that there will be immediate and full acceptance into the International Medical Insurance (including the Emergency medical evacuation and Assistance services cover as well as the Dental Care plan) of both employees and Dependents. However, for the Temporary Incapacity cover/ Permanent Disability cover and Life Cover, the Insurer can still define partial or total exclusion from cover, or, at his discretion, propose an additional premium to waive exclusions.

If the number of enrolled staff comes down to less than ten (10) employees, a Medical questionnaire has to be completed for each employee and each Dependent and has to be submitted by the candidate-Insured to the medical consultant of the Administrator. The medical consultant can define partial exclusions, total exclusion from cover (refusal of cover) or, at his discretion, propose an additional premium to waive exclusions.

3.3. Addition of new Dependents into the insurance

Addition of a new-born or adopted child is possible, provided that the application is made within two (2) months following the date of birth or adoption (of a minor child).

In case the declaration of a new-born has not been made within two (2) months, a Medical questionnaire has to be completed and has to be sent to the medical consultant of the Administrator. The medical consultant can propose an additional premium to waive exclusions.

Premiums for the new-born baby are due as from the first (1st) day of enrolment.

3.4. Adding/removing employees to/from the group insurance

The minimum insurance period for new employees who join a group insurance is 3 months.

Requests to add or remove employees can be processed retroactively up to a maximum of 60 days after receipt of the notification to the Insurer.

3.5. Age limits for enrolment

- For individual Expats, the minimum and maximum ages for enrolment are eighteen (18) years and sixty (60) years.
- For expatriated employees enrolled on a compulsory basis by their employer, there is no specific age limit set for enrolment into the Core Plan.
- For the Additional Insurances, reference is made to the conditions applying to each of these insurance plans.

3.6. Change of geographical scope, level of cover or deductible

3.6.1. For individual policies

In case the Insured is residing in the USA, Canada, China, Hong Kong or Singapore (i.e. his/her Host Country is the USA, Canada, China, Hong Kong or Singapore), the subscription to the Worldwide area of cover is compulsory.

The possibility to switch to another area of cover (territoriality) depends on the Host Country. However, it is not possible to switch to the Worldwide area of cover with the objective of receiving treatment in the USA, Canada, China, Hong Kong or Singapore.

If the expat's host address changes to the USA, Canada, China, Hong Kong or Singapore, the Insurer has the right to adjust the geographical scope of the policy from 'Worldwide excluding USA, Canada, China, Hong Kong and Singapore' to 'Worldwide'.

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

If the Home Country is the USA, Canada, China, Hong Kong or Singapore, the Insured is free to choose between two areas of cover: Worldwide or Worldwide excluding USA, Canada, China, Hong Kong and Singapore, upon initial subscription to the Cigna expatplus insurance. This initial choice is final and cannot be altered for as long as the Insured is covered by the Cigna expatplus insurance.

Downgrading and upgrading of cover levels is possible, but only on the Policy Renewal Date.

In case of an upgrade, the Insurer has the right to adjust the geographical scope of the policy based on the expat's host address, from 'Worldwide excluding USA and Canada' and 'Worldwide excluding USA, Canada, China, Hong Kong and Singapore' to 'Worldwide'.

In case of upgrade, a new Medical questionnaire has to be completed and signed (if applicable on the initial date of acceptance).

Waiting periods will apply to the new cover level as from the effective start date of the new cover level.

In case of change of deductible, the new deductible amount will be valid for costs incurred as from the effective start date of the new deductible, regardless of the deductible amount already paid so far. This means the new deductible amount is entirely due as from its effective start date.

The change of cover level or deductible amount has to be requested at least one (1) month before the Policy Renewal Date.

For compliance with these deadlines it is sufficient for the Policyholder to send his/her notice by post, e-mail or fax to the Administrator.

3.6.2. For group policies

In case the Insured is residing in the USA or Canada (i.e. his/her Host Country is the USA or Canada) or in case the Insured is a US or Canadian national (i.e. his/her Home country is the USA or Canada), the subscription to the Worldwide area of cover is compulsory, unless otherwise requested and approved by the Insurer.

The possibility to switch to another area of cover (territoriality) depends on the Home and Host Country. However, it is not possible to switch to the Worldwide area of cover with the objective of receiving treatment in the USA or Canada.

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

Downgrading and upgrading of cover levels is possible, but only on the Policy Renewal Date.

In case of upgrade, a new Medical questionnaire has to be completed and signed (if applicable on the initial date of acceptance).

Waiting periods will apply to the new cover level as from the effective start date of the new cover level.

In case of change of deductible, the new deductible amount will be valid for costs incurred as from the effective start date of the new deductible, regardless of the deductible amount already paid so far. This means the new deductible amount is entirely due as from its effective start date.

The change of cover level or deductible amount has to be requested at least one (1) month before the Policy Renewal Date.

For compliance with these deadlines it is sufficient for the Policyholder to send his/her notice by post, e-mail or fax to the Administrator.

3.7. Individual continuation

Expatriated employees who have been insured for at least six (6) months under a Cigna expatplus group cover and whose cover will expire, can (on the condition that they continue their expat status), submit their request before the actual date of expiration of their group cover and apply for an international medical insurance cover on an individual basis, which terms and conditions (including benefits and premiums) may however differ from the Cigna expatplus group cover they have benefited from. No Medical questionnaire has to be completed and no waiting periods are applicable. However, Art. I-3.4. and I-3.5. above are still applicable. For the exact Terms and conditions including eligibility criteria, expatriated employees are requested to contact the Insurer or the Administrator.

4. Effective date of coverage

The insurance cover takes effect on the day immediately following:

- the acceptance by the Administrator of the completed Application form; and
- the acceptance into the insurance of the candidate-Insured 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 chapters of these General Conditions.

With regard to the declaration of new Dependents, reference is made to Art. I-3.3.

However, the insurance cover cannot take effect before the initial premium has been duly received by the Administrator (on behalf of the Insurer).

5. Right of withdrawal

The Policyholder shall have a period of fourteen (14) calendar days to withdraw from the contract without penalty and without giving any reason. The period of withdrawal shall begin either from the day of the conclusion of the distance contract or from the day on which the consumer receives the contractual terms and conditions if that is later. The insured will be entitled to the return of the full premium paid, on the condition that not one claim has been submitted yet.

For compliance with this deadline it is sufficient for the Policyholder to send his/her notice of withdrawal by post, e-mail or fax to the Administrator.

6. Duration and cancellation of policy

6.1. Period of individual cover and renewal

Unless otherwise agreed upon by both parties (Policyholder and Insurer), the duration of the insurance policy is fixed at three (3) months, starting from the effective date of coverage as stipulated in Art. I-4. above. At the end of the three (3)-month period, the policy will be automatically renewed by tacit agreement for successive periods of three (3) months each.

If the effective date of coverage is other than the first (1st) day of a calendar quarter, the policy will be renewed on the first (1st) day of the next calendar quarter.

6.2. Period of group cover and renewal

Unless otherwise agreed upon by both parties (Policyholder and Insurer), the duration of the insurance policy is fixed at 12 months. On the policy renewal date, policies can be renewed after receipt by the Insurer of the signed Special Conditions, and on the condition that the premium for the new insurance period is paid.

6.3. Cancellation of the policy

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

Termination of one or more of the Additional Insurance covers (Accidental Death and Disability cover, Temporary Incapacity cover and Permanent Disability cover, Dental Care cover and/or Life cover), will not automatically lead to termination of the Core Plan, unless otherwise agreed upon by both parties (Policyholder and Insurer).

6.4. Aggravation of the risk

Except for changes in the state of health of the Insured incurred after acceptance into the insurance, the Insured is obliged to inform the Administrator of any change in circumstances or conditions that may increase the risk of Illness or Accident (e.g. dangerous professional activity). The Insurer may then propose new insurance conditions (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, retroactively as from the moment of the start of the aggravation of the risk.

7. Termination of cover

7.1. For the Insured, the insurance under this policy shall automatically terminate:

- if any premium on this policy is not paid on the due date or within the grace period;
- if the Insured is a dependent child, on the thirty-first (31st) of December of the year during which the dependent child becomes twenty-eight (28) years old or when he/she is no longer considered to be a dependent child or upon the date of marriage;
- if the dependent is the spouse or legal partner, upon the date of divorce or legal separation from the Insured, or as from the end of the legal partnership;
- if it becomes unlawful for the Insurer to provide any of the covers available under this policy;
- if the Insurer has been provided with misleading information or if information has been withheld that should have been provided and could have affected the Insurer's assessment of the risks to be insured under this policy;
- upon the death of the Insured.

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

In case of failure by the Policyholder to pay the premium on the due date, the Insurer has the right to suspend or cancel the insurance policy.

The Insurer will first notify the Policyholder by means of a registered letter, reminding the Policyholder of the amount of the premium that has to be paid, and informing him/her of the consequences of non-payment. If the premium has not been paid within fifteen (15) days following service or posting of the registered letter, the insurance cover will be suspended automatically. Payment by the Policyholder of the premiums due shall terminate suspension.

The Insurer may cancel the policy during the period of suspension. In this case, cancellation shall take effect on the expiration of the period of fifteen (15) days, starting from the first day of suspension.

Claims incurred during the period of suspension are not covered.

8. Premium and premium increase

8.1. Amount and payment of the premium

The amount of the insurance premium is mentioned in the Special Conditions.

The premium is payable by the Policyholder to the Insurer (through the Administrator) on a quarterly, half-yearly or 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 to the amount of the premium, and have to be paid in full by the Policyholder.

The premium payment frequency can be altered:

- from quarterly to half-yearly or to yearly (frequency decrease), if requested at least one (1) month before the Policy Renewal Date;
- from yearly to half-yearly or to quarterly (frequency increase), if requested at least one (1) month before the Annual Renewal Date.

8.2. Premium increase

In case the Insurer increases the premium rate, he will notify the Policyholder, 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 on:

- for individual policies, the fifteenth (15th) of November of the expiring calendar year;
- for group policies, two (2) months prior to the Annual Renewal Date, unless otherwise agreed upon between the Policyholder and the Insurer.

The new premium rates will become effective as from:

- for individual policies, first (1st) of January of the next calendar year;
- for group policies, the next Annual Renewal Date (on or after first (1st) of January of the next calendar year).

If the Policyholder does not agree with the new premium conditions, he/she can terminate the policy through notification of cancellation to the Insurer by registered letter, e-mail or fax delivered to the Insurer or the Administrator:

- for individual policies before fifteenth (15th) of December;
- for group policies at least one (1) month before the Annual Renewal Date of the policy.

Alternatively and exceptionally for individual contracts, the Insurer accepts an upgrade or a downgrade of cover level on 1st January. This exceptional change has to be requested the thirtieth (30th) of November at the latest through notification to the Insurer by registered letter, e-mail or fax delivered to the Insurer or the Administrator.

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. There is no possibility to terminate the contract due to an age band-related premium increase.

9. Return to the Home Country

When the Insured returns to live and/or to work in his/her Home Country, thereby ending the period of expatriation abroad, the Insured or the Policyholder have to notify the Insurer (through the Administrator) in writing of the exact date of relocation to the Home Country, at least one (1) month prior to the Policy Renewal Date. The insurance will remain in force until the exact date of return to the Home Country, at which date it will be automatically terminated.

The Policyholder can nevertheless request - in writing and at least one (1) month before the Policy Renewal Date - cover for one additional three (3)-month period (without interruption of cover), at the conditions prevailing on the first day of this additional three (3)-month period. During this period the Insured (or the Policyholder) can apply for affiliation to a local social security scheme or look for another private insurance.

Failure to notify the Insurer of the relocation to the Home Country, shall result in the Insurer not providing cover for the duration of the Insured's return to the Home Country.

10. Currency

The Cigna expatplus plan can be taken out in EUR, GBP, USD or CHF.

The choice of currency has to be made (by the Policyholder) before the cover takes effect, and can only be changed on the Annual Renewal Date. The change of currency has to be requested at least one (1) month before the Policy Renewal Date. A change of currency implies that the deductible amount due by the Policyholder is automatically reset to 0.

Premiums and claims shall be payable in EUR, GBP, USD or CHF, according to the currency in which the policy has been concluded. With respect to medical expenses incurred in another currency than the currency of the policy, the conversion will be based on the European Central Bank daily rate of exchange in effect on the date the medical service has been billed.

The Administrator may settle medical bills in another currency (than the currency of the insurance 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.

11. General exclusions

The cover described in this policy does not extend to:

- consequences of a voluntary or intentional act committed by the Insured or his/her beneficiary;
- consequences of any sport for professional purposes, even as a secondary profession;
- consequences of insurrections or riots if by taking part the Insured or his/her beneficiary has broken the applicable laws;
- consequences of brawls, fights and all kinds of disturbances and measures taken to combat them, except in case of self-defence;
- consequences of the preparation of or participation in crimes or misdemeanours;
- consequences of drug addiction and alcoholism;
- 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;
- events related to bets or challenges;
- expenses resulting from any kind of competition with motor vehicles;
- flight risk: the insurance covers the use, as a passenger, of all planes, hydroplanes or helicopters duly authorised to transport persons, as long as the Insured is not a member of the crew and does not exercise in the course of the flight a professional or other activity, in relation with the plane or the flight. However, this exclusion is not applicable to the International Medical Insurance plan and Dental Care;
- consequences of War or acts of War and Terrorism, to the extent mentioned in Art. I-12. hereafter.

Important remark

For the additional specific exclusions relating to each separate cover of the Cigna expatplus insurance, reference is explicitly made to the provisions proper to the different types of cover (see Chapter II).

12. War and Terrorism

12.1. Definitions

'War'

- armed conflict, declared or undeclared, between one State and another, an invasion or a state of siege.
- 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.
- civil War: armed conflict between two (2) or several parties belonging to one and the same state, the members of which are of different ethnic origin, religion or ideology.
- also considered as acts of civil War are: an armed rebellion, revolution, sedition, an insurrection, a coup d'état, the consequences of martial law and border closings ordered by government or by local authorities.

'Terrorism'

- any actual or threatened use of force or violence directed at or causing damage, injury, harm or disruption;
- 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;
- 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.

12.2. Description of benefits

With respect to the risks and consequences of War and Terrorism, all consequences of active participation of the Insured (and/or his/her covered Dependents) in operations of War and Terrorism are explicitly excluded from all covers.

In case the Insured is victim of acts of War and Terrorism without any active involvement on behalf of the Insured or his/her beneficiaries in these acts, the Insured is covered within the limits and the ceilings of the cover.

The optional insurance covers (Life, Accidental Death and Disability, Temporary Incapacity and Permanent Disability) are not valid when the Insured (or covered Dependent) is travelling to or from or is residing in a country or a part of a country publicly known to be in state of War or civil War at the time damages (bodily Injury, or death) to the Insured or his/her covered Dependents happen. In case of a dispute about whether a given country is known to be in state of War or civil War, the list of countries for which the UK Foreign and Commonwealth Office (FCO) advises not to travel to ('We advise against all travel to these countries/parts of these countries'), as published on its official website www.fco.gov.uk, will be decisive.

In the event the Insured, 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.

13. Data protection

The insurance policy is subject to compliance with the Belgian Data Protection Act of 1992. This Act applies in relation to any personal data processed in connection with this insurance policy. 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:

- process the personal data solely for the execution of the present insurance policy and for the purposes for which they have been transferred to the Insurer or the Administrator;
- ensure 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 insurance policy;
- 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 insurance policy.

14. Subrogation

The Insurer has full rights of subrogation for any benefits paid within the framework of this insurance policy.

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

15. Defence

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

16. Complaints procedure

If an Insured has any complaint regarding the standard of service received under this insurance policy, the following procedure is available to restore the situation:

- in first instance, the Insured should write to the:
  Head of the Cigna expatplus Claims Unit, Cigna expatplus, P.O. Box 69, 2140 Antwerp, Belgium.

- if still not satisfied, the Insured can write to the:
  Chief Executive Officer, Cigna expatplus, P.O. Box 69, 2140 Antwerp, Belgium.

In case of disagreement with the Insurer or insurance intermediary, the Ombudsman will try to arrange a friendly settlement.

Ombudsman van de verzekeringen de Meeûssquare 35
1000 Brussels
Fax + 32 2 547 59 75
info@ombudsman.as

17. Governing Law

This insurance policy is issued under and governed by Belgian law.

Chapter II: Benefits and provisions proper to the different types of cover

CORE PLAN

1. International Medical Insurance

All benefits are valid per insured person, per Insurance Year (unless specifically stated).

	GLOBE	ORBIT	UNIVERSE
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
Area of cover	**For individual policies:** - Worldwide - Worldwide excluding USA, Canada, China, Hong Kong and Singapore[2] **For group policies:** - Worldwide - Worldwide excluding USA and Canada[2]		
Deductible for Outpatient Treatment per Insured and per Insurance Year	€ 0 - £ 0 - $ 0 - CHF 0 € 100 - £ 65 - $ 125 - CHF 150 € 300 - £ 200 - $ 375 - CHF 450 € 1,000 - £ 650 - $ 1,250 - CHF 1,500	€ 0 - £ 0 - $ 0 - CHF 0 € 100 - £ 65 - $ 125 - CHF 150 € 300 - £ 200 - $ 375 - CHF 450 € 1,000 - £ 650 - $ 1,250 - CHF 1,500	€ 0 - £ 0 - $ 0 - CHF 0 € 300 - £ 200 - $ 375 - CHF 450 € 500 - £ 325 - $ 625 - CHF 750 € 1,000 - £ 650 – $ 1,250 - CHF 1,500
1. Inpatient Treatment (Treatment with overnight stay in hospital and Day Surgery)			
Hospital room & board (pre-certification required)	100% of semi-private or 80% of Standard Private Room	100% of Standard Private Room	100% of Standard Private Room
Doctor's fees (surgeon, anaesthetist)	100%	100%	100%
Other medical expenses (medical imaging, drugs and dressings and use of operating room)	100%	100%	100%

[2] In case of Accident and emergency Treatment in the USA, Canada, China, Hong Kong and Singapore, the Insured is covered up to 90 days during each Insurance Year.

	GLOBE	ORBIT	UNIVERSE
Hospital accommodation in intensive care unit (ICU)	100%	100%	100%
Rehabilitation and convalescence rest/care (when the admission immediately follows hospitalisation)	Not covered	Not covered	100% (max. 28 days)
Parent accommodation of one parent for child < 16	100% up to € 1,500 100% up to £ 1,000 100% up to $ 1,875 100% up to CHF 2,250	100% up to € 1,500 100% up to £ 1,000 100% up to $ 1,875 100% up to CHF 2,250	100% up to € 1,500 100% up to £ 1,000 100% up to $ 1,875 100% up to CHF 2,250
2. Outpatient Treatment			
Doctor's fees (generalist, specialist)	80%	90%	100%
Diagnostic tests, lab tests, medical imaging (x-ray, MRI- and CT-scans)	80%	90%	100%
Prescribed Drugs	80%	90%	100%
Physiotherapy	80% up to € 1,000 80% up to £ 650 80% up to $ 1,250 80% up to CHF 1,500	90% up to € 2,000 90% up to £ 1,300 90% up to $ 2,500 90% up to CHF 3,000	100% up to € 3,000 100% up to £ 2,000 100% up to $ 3,750 100% up to CHF 4,500
Preventive care • Yearly check-up • Eye test • Mammogram • Pap-smear test • PSA-test	100% up to € 600 100% up to £ 400 100% up to $ 750 100% up to CHF 900	100% up to € 800 100% up to £ 535 100% up to $ 1,000 100% up to CHF 1,200	100% up to € 1,000 100% up to £ 650 100% up to $ 1,250 100% up to CHF 1,500
Vaccinations	100% up to € 200 100% up to £ 130 100% up to $ 250 100% up to CHF 300	100% up to € 400 100% up to £ 270 100% up to $ 500 100% up to CHF 600	100% up to € 600 100% up to £ 400 100% up to $ 750 100% up to CHF 900
Alternative medicines such as homeopathy, acupuncture, chiropraxis and osteopathy	80% up to € 1,000 80% up to £ 650 80% up to $ 1,250 80% up to CHF 1,500	90% up to € 2,000 90% up to £ 1,300 90% up to $ 2,500 90% up to CHF 3,000	100% up to € 3,000 100% up to £ 2,000 100% up to $ 3,750 100% up to CHF 4,500
Therapies • Ergotherapy • Logopaedics and speech therapy • Psychiatric outpatient care	Not covered	50% up to € 1,000 50% up to £ 650 50% up to $ 1,250 50% up to CHF 1,500	50% up to € 2,000 50% up to £ 1,300 50% up to $ 2,500 50% up to CHF 3,000

	GLOBE	ORBIT	UNIVERSE
3. Other Medical Treatment			
Pregnancy and childbirth (a waiting period of 10 months may apply)[3]			
• Pregnancy	Reimbursement according to type of Outpatient Treatment	Reimbursement according to type of Outpatient Treatment	Reimbursement according to type of Outpatient Treatment
• Infertility Treatment (a waiting period of 10 months applies) and sterilisation (IVF, ICSI, AI and all similar Treatments) (limit per lifetime)21	Not covered	Not covered	100% up to € 16,800 (4x € 4,200) 100% up to £ 11,200 (4x £ 2,800) 100% up to $ 21,000 (4x $ 5,250) 100% up to CHF 25,200 (4x CHF 6,300)
• Childbirth (without complications)	80% up to € 5,000 80% up to £ 3,250 80% up to $ 6,250 80% up to CHF 7,500	100% up to € 7,500 100% up to £ 5,000 100% up to $ 9,375 100% up to CHF 11,250	100% up to € 10,000 100% up to £ 6,500 100% up to $ 12,500 100% up to CHF 15,000
• Childbirth (with complications)	see 1. Inpatient Treatment	see 1. Inpatient Treatment	see 1. Inpatient Treatment
Cancer Treatment (excluding experimental Treatments) • Hospitalisation and chemo- or radiotherapy • Other costs	100% see 2. Outpatient Treatment	100% see 2. Outpatient Treatment	100% see 2. Outpatient Treatment
Chronic and Pre-existing Conditions[4]	Covered	Covered	Covered
AIDS / HIV Treatment • Inpatient Treatment • Outpatient Treatment	100% 80%	100% 90%	100% 100%
Nursing at home	80% up to € 160/ day 80% up to £ 110/ day 80% up to $ 200/ day	90% up to € 180/ day 90% up to £ 120/ day 90% up to $ 225/ day	100% up to € 200/ day 100% up to £ 135/ day 100% up to $ 250/ day

[3] For individuals and companies without MHD (Medical History Disregarded). For companies with more than 10 insured employees the waiting period can be waived subject to the Insurer's approval.

[4]Acceptance into the insurance can be subject to a Medical questionnaire and approval by the medical consultant. For companies with more than 10 insured employees, medical history may be disregarded. Pre-existing and Chronic Conditions are covered within the limits of the plan if accepted by the medical consultant at the time of enrolment.

	GLOBE	ORBIT	UNIVERSE
	80% up to CHF 240/ day (max. 60 days)	90% up to CHF 270/ day (max. 60 days)	100% up to CHF 300/ day (max. 100 days)
Organ transplant (excluding costs for donor – prior approval required)	100% up to € 100,000 100% up to £ 65,000 100% up to $ 125,000 100% up to CHF 150,000	100% up to € 125,000 100% up to £ 83,500 100% up to $ 156,250 100% up to CHF 187,500	100% up to € 150,000 100% up to £ 100,000 100% up to $ 187,500 100% up to CHF 225,000
Kidney dialysis (excluding experimental Treatments)	100%	100%	100%
Local ambulance (to nearest hospital)	100% up to € 1,500 100% up to £ 975 100% up to $ 1,875 100% up to CHF 2,250	100% up to € 3,000 100% up to £ 1,950 100% up to $ 3,750 100% up to CHF 4,500	100% up to € 4,500 100% up to £ 3,000 100% up to $ 5,625 100% up to CHF 6,750
Accident related dental Treatment			
Emergency dental Treatment	100% up to € 750 100% up to £ 500 100% up to $ 950 100% up to CHF 1,125	100% up to € 1,000 100% up to £ 650 100% up to $ 1,250 100% up to CHF 1,500	100% up to € 1,250 100% up to £ 850 100% up to $ 1,575 100% up to CHF 1,875
Dental Surgery	100% up to € 2,000 100% up to £ 1,300 100% up to $ 2,500 100% up to CHF 3,000	100% up to € 2,500 100% up to £ 1,625 100% up to $ 3,125 100% up to CHF 3,750	100% up to € 3,000 100% up to £ 2,000 100% up to $ 3,750 100% up to CHF 4,500
Psychiatric care			
Inpatient Treatment	Not covered	90% up to € 10,000 90% up to £ 6,500 90% up to $ 12,500 90% up to CHF 15,000	100% up to € 20,000 100% up to £ 13,500 100% up to $ 25,000 100% up to CHF 30,000
Outpatient Treatment	see 2. Outpatient Treatment: Therapies	see 2. Outpatient Treatment: Therapies	see 2. Outpatient Treatment: Therapies
Vision care (glasses, frames, contact lenses)	80% up to € 100 80% up to £ 65 80% up to $ 125 80% up to CHF 150	90% up to € 200 90% up to £ 135 90% up to $ 250 90% up to CHF 300	100% up to € 300 100% up to £ 200 100% up to $ 375 100% up to CHF 450
Medical aids (hearing aids and orthopaedic appliances)	80% up to € 1,500 80% up to £ 1,000 80% up to $ 1,875 80% up to CHF 2,250	90% up to € 2,500 90% up to £ 1,650 90% up to $ 3,125 90% up to CHF 3,750	100% up to € 3,000 100% up to £ 2,000 100% up to $ 3,750 100% up to CHF 4,500
Palliative care	80% up to € 40,000 80% up to £ 26,600 80% up to $ 50,000 80% up to CHF 60,000	90% up to € 45,000 90% up to £ 30,000 90% up to $ 56,000 90% up to CHF 67,000	100% up to € 50,000 100% up to £ 33,300 100% up to $ 62,500 100% up to CHF 75,000

1.1. Purpose

The International Medical Insurance reimburses - up to the limits defined in the present General Conditions - Reasonable and Customary expenses for outpatient as well as for inpatient medical services, provided these expenses have been incurred because of Illness, Accident or maternity.

1.2. Eligibility and acceptance

With respect to eligibility and acceptance into the insurance, reference is made to conditions as set out in Art. I-3.

1.3. Types of International Medical Insurance plans

There are three (3) different plans:

- Globe;
- Orbit;
- Universe.

The plan chosen by the Policyholder is mentioned in the Special Conditions of the insurance policy. Each plan corresponds to a different level of benefits, details of which are mentioned in the Benefits Overview above. With regard to the change of level of cover, reference is made to Art. I-3.5.

1.4. Territorial scope of the insurance

The Policyholder can choose between two (2) geographic areas of cover:

For individual policies:

- worldwide cover;
- worldwide cover with the exception of medical expenses incurred in the United States of America (USA), Canada, China, Hong Kong and Singapore.

For group policies:

- worldwide cover;
- worldwide cover with the exception of medical expenses incurred in the United States of America (USA) and Canada.

However, during business trips or holidays not exceeding ninety (90) days (in total) per Insurance Year, medical expenses incurred in the excluded countries as a direct consequence of an Accident or a Medical Emergency are covered up to the limits of the policy. If the medical condition concerned already existed prior to the travel to an excluded country or 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 considered to be Accident or emergency expenses, and will therefore not be covered.

1.5. Benefits

1.5.1. Definitions

Reference is made to Art. I-2.

1.5.2. Description of benefits

Eligible Medical Expenses, subject to the exclusions, limits and ceilings mentioned in this policy, are listed in the Benefits Overview above.

To qualify for reimbursement, all Treatments and procedures have to be Medically Necessary and appropriate (consistent with the diagnosis as established by a Doctor). They have to be prescribed by a Doctor, and performed by a Doctor or by a legally qualified and duly licensed medical practitioner. The reimbursement ceilings (i.e. the maximum amount of reimbursement) for certain types of medical services are - unless indicated otherwise in the Benefits Overview – always applicable per Insured and per Insurance Year. This means that each ceiling is applicable for a twelve-month (12-month) period of uninterrupted cover, starting on the effective date of coverage of the Insured.

1.5.2.1. Inpatient Treatment

Pre-certification as stated in Art. II-1.6. below is always required except in case of emergency. Failure to comply with this pre-certification requirement will lead to a reduction of the reimbursement with twenty-five (25)%.

- Hospital room and board
  Reimbursement of the Reasonable and Customary charges for room accommodation and meals. The amount of the benefit shall be equal to the actual charges made by the hospital during the Insured's stay but in no event shall the benefit exceed, for any one (1) day, the rate of a Standard Private Room.
- Intensive Care Unit
  Reimbursement of the Reasonable and Customary charges for actual room and board incurred during the Insured's stay as an inpatient in the Intensive Care Unit of the hospital.

  This benefit shall be payable equal to the Reasonable and Customary actual charges made by 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.
- Doctor's fees
  - Surgical fees
    Reimbursement of the Reasonable and Customary charges for Surgery by a Specialist within the maximum indicated in the Benefits Overview.
  - Anaesthetist's fee
    Reimbursement of the Reasonable and Customary charges by the anaesthetist for the administration of anaesthesia not exceeding the limits as set forth in the Benefits Overview.
- Other medical expenses
  - Operating theatre
    Reimbursement of the Reasonable and Customary operating and recovery room charges incidental to the surgical procedure.
  - Hospital supplies and services
    Reimbursement of the Reasonable and Customary charges actually incurred for general nursing, prescribed and consumed drugs and medicines, dressings, splints, plaster casts, medical imaging (x-ray, CT, MRI, etc.), medical aids, laboratory examinations, electrocardiograms, physiotherapy, logopaedic Treatment, speech therapy, occupational therapy and ergotherapy.
- Parent accommodation
  Reimburses up to the limits stated in the Benefits Overview the expenses for meals and lodging for accompanying an insured dependent child, aged below sixteen (16) years, in hospital.
- Hospital cash benefit
  Hospital cash benefit is the daily allowance, only when room and board and Treatment are received free of charge. It amounts to 75 EUR/50 GBP/93.75 USD/112.50 CHF per night (Globe) or 100 EUR/65 GBP/125 USD/150 CHF per night (Orbit and Universe) with a maximum of sixty (60) nights.
- Convalescence and rehabilitation
  Convalescence and rehabilitation rest/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 and with a maximum of twenty-eight (28) days.

1.5.2.2. Outpatient Treatment

This benefit provides for the reimbursement of actual expenses incurred for Outpatient Treatment subject to the stated sub-limits set forth in the Benefits Overview (if applicable).

- Doctor's fees
  Consultation with a legally registered General Practitioner, Family Doctor, Specialist Doctor as a result of Illness and bodily Injuries, when hospitalisation is not required.

- Diagnostic tests
  Reimbursement of the Reasonable and Customary charges for tests (ECG, x-ray, laboratory tests, etc.) which are performed for diagnostic purposes on account of an Injury or Illness, within the amount as set forth in the Benefits Overview and which are recommended by a qualified medical practitioner.

- Prescription Drugs/Medicines
  Only drugs that are prescribed by a Doctor and that are not available without prescription can be reimbursed. OTC ('over-the-counter') medicines do not qualify for reimbursement, nor do lifestyle products, dietary products, vitamins, food supplements etc. For vaccines, the special provisions of the Vaccination benefit apply.

- Preventive care and wellness benefits
  - one (1) adult physical examination per Insurance Year;
  - one (1) routine eye test per Insurance Year;
  - one (1) (bilateral) mammogram per Insurance Year for insured females as of age thirty-five (35);
  - one (1) Pap smear test per Insurance Year for insured females as of age thirty-five (35);
  - one (1) PSA test per Insurance Year for insured males as of age fifty (50);
  - well-baby care.

- Vaccinations (adults and children)
  - travel vaccinations
  - preventive vaccinations and immunisations for young children.

- Physiotherapy
  Physiotherapy prescribed by a Doctor, including Mensendieck physiotherapy, is covered on condition that the medical prescription clearly mentions the need for this specific form of physiotherapy and on condition that the care provider is a certified physiotherapist.

- Treatments performed by complementary medical practitioners
  - chiropractor;
  - osteopath;
  - acupuncturist;
  - homeopath.

  These Treatments have to be prescribed by a Doctor.

1.5.2.3. Other Medical Treatment

These benefits provide for the reimbursement of actual expenses incurred subject to the overall annual limit per Insured per Insurance Year for:

- Pregnancy
  Costs are reimbursed according to the type of Outpatient Treatment.

- Childbirth
  The covered amount includes reimbursement for Doctor's fees, hospital accommodation and other related medical expenses incurred during the hospital stay. Elective caesarean Surgery is excluded from cover. However, if caesarean Surgery is Medically Necessary, it is covered as Inpatient Treatment. All other deliveries with complications are also covered as Inpatient Treatment. The assessment as to whether a caesarean is medically necessary or not will be made by the Insurer's medical consultant.

- Infertility Treatment
  - Infertility diagnosis
    Investigative procedures necessary to establish the cause of infertility.
  - Infertility Treatment
    The expenses related to Infertility Treatment are covered as outpatient or inpatient expenses, subject to the following conditions:
    - it has to concern a primary infertility;
    - maximum four (4) attempts per Insured and per lifetime are covered;
    - maximum 4,200 EUR/2,800 GBP/5,250 USD/6,300 CHF per attempt;
    - maximum age of the female Insured of forty (40) years;
    - the expenses related to the sperm/egg donation are not covered;
    - the expenses related to a surrogate mother are not covered;
    - prior approval of the Insurer's medical consultant is always required.

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

    Secondary infertility is defined as the inability of a couple who has previously conceived to conceive again after a full year of trying.

    Once the female of the couple has reached the age of 41, expenses for infertility treatment will no longer be reimbursed, for either insured partner.
  - Expenses related to sterilisation
    One (1) sterilisation per Insured and per lifetime.

  - Ceiling
    For the expenses related to artificial insemination (AI) and other similar Treatments, there is no maximum number of attempts.
  - Waiting period
    There is a ten-month (10-month) waiting period for all medical expenses related to Pregnancy, Childbirth and Infertility Treatment meaning that only expenses incurred as from the eleventh (11^{th}) month after acceptance into the insurance can be eligible for reimbursement. This waiting period can be waived for groups. Such waiver is only valid if explicitly mentioned in the Special Conditions of the group policy in question.

- Cancer Treatment
  If an Insured is diagnosed with cancer as defined below, the Insurer will reimburse the Reasonable and Customary charges incurred for the Treatment of cancer performed at a legally registered cancer Treatment centre subject to the limit specified in the Benefits Overview. Such Treatment (e.g. radiotherapy or chemotherapy excluding experimental Treatment, consultation, examination tests) must be received on an inpatient or outpatient basis at a hospital or a registered cancer Treatment centre immediately following diagnosis, or discharge from hospital stay or Surgery. 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.

- Organ transplant
  Reimbursement of Reasonable and Customary charges incurred for transplantation Surgery for the Insured being the recipient of the organ transplant. Payment for this benefit is applicable whilst the policy is in force and shall be subject to the limit as set forth in the Benefits Overview. The covered amount includes Doctor's fees, hospital accommodation (Standard Private Room) and other related medical expenses during the hospital stay. Prior approval of the medical consultant of the Administrator is always required.

  Following expenses are excluded from cover:
  - costs related to the search for a donor;

- costs for acquisition of the organ (in case a price is charged for the organ);
- costs incurred for removal of organ from the donor.

- Kidney dialysis
  If an Insured is diagnosed with kidney failure as defined below, the Insurer will reimburse the Reasonable and Customary charges incurred for the Treatment of kidney dialysis performed at a Hospital or at a legally registered dialysis centre subject to the limits as specified in the Benefits Overview. Such Treatment (dialysis excluding consultation, examination tests) must be received on an inpatient or outpatient basis. Kidney failure means 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. These benefits exclude all experimental Treatments.

- Medical aids
  Reimbursement of expenses for hearing aids, orthopaedic appliances and stockings, artificial limbs, wheelchairs, etc.

- Local ambulance to the nearest hospital
  Reimbursement of the Reasonable and Customary charges incurred for necessary domestic ambulance services (including attendant) to and/or from the hospital. Reimbursement is subject to the maximum limit set forth in the Benefits Overview. Payment will not be made if the Insured is not hospitalised.

- Psychiatric care
  Outpatient psychiatric care only reimburses care prescribed by and performed by a Doctor. The covered amount includes fees of the Doctor and/or (Treatment fees of) the medical practitioner, but does not include drugs. Drugs are covered according to the provisions for Prescription Drugs. The following expenses will also fall under the same ceiling as outpatient psychiatric care: ergotherapy, logopaedics and/or speech therapy, occupational therapy.

- Dental Treatment following Accident
  Dental Surgery is only covered if required to restore damage to natural teeth as a result of an Accident.

- Palliative care
  Palliative care may be as an inpatient or outpatient at home, or at a centre for controlling pain and other symptoms, and provides psychological and social support (medical and paramedical) for the patient and patient's family during the last stages of life. Palliative care is offered as an alternative to eligible hospital Treatment or nursing at home. Palliative care has to be given by an organisation providing services for patients whose Illness cannot be cured with a life expectancy of less than six (6) months.

1.6. Pre-certification requirement

All inpatient Medical Treatments (except emergency hospital admissions), as well as Day Surgery and Day Care are subject to pre-certification. This means that in case of non-emergency hospitalisation, Day Surgery or Day Care, 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 Care or 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 will take place). The following information is required:

- diagnosis;
- description of the required Medical Treatment;
- name and address of the hospital where the Treatment will be given;
- expected length of stay in the hospital;
- estimated cost of the Treatment.

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

1.7. Restrictions and exclusions

In addition to the exclusions mentioned in Art. I-11., the following items or services are excluded from cover:

- Treatment that is considered experimental/investigative according to accepted professional medical standards and Treatment that is not medically indicated;
- non-prescribed Medical Treatments;
- complementary (and or alternative) Medical Treatments other than those explicitly mentioned in the Benefits Overview;
- rejuvenation and spa cures, cosmetic Treatments and convalescent rest;
- facilities for the aged, primarily giving custodial, educational and rehabilitory care;
- expenses resulting from maternity and childbirth during the first ten (10) months after the individual inception date of cover unless explicitly waived in the Special Conditions;
- non-Prescription Drugs;
- OTC ('over-the-counter') medicines; lifestyle products, dietary products, vitamins, food supplements and food products, baby food, mineral waters, tonics, cosmetic products etc.;
- contraceptive and birth control drugs, even if prescribed by a Physician;
- costs related to abortion except in case of absolute medical necessity;
- cosmetic/aesthetic Treatment except restorative Treatment following Accident;
- surgical procedures costs related to corrective eye Surgery (keratectomy and keratotomy, including LASIK and LASEK procedures), except in case of refractive Illness of the cornea in which case they are covered as any other surgical expenses;
- remedial teaching;
- elective caesarean delivery expenses;
- sex change operations and related Treatment expenses;
- sunglasses and orthoptic Treatment;
- participation in any sport as a professional or under contract providing remuneration, as well as any preparatory training.

1.8. Claims procedure/Coordination of benefits - other insurance/Claims payment

1.8.1. Claims procedure

Each claim has to be submitted to the Administrator, in writing - using the special claim forms made available by the Administrator - as soon as possible after the event giving rise to the claim has occurred. The claim has to 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 has to provide following additional information:

- date and detailed description of circumstances and place of the Accident;
- identity of persons involved, as well as of witnesses and persons possibly liable;
- official report from local authorities (police or other).

1.8.2. Coordination of benefits - other insurance

If the Insured is entitled to a reimbursement by another Insurer or social security system, the cover - in accordance with the provisions of Art. II-1.5. - will be applied on the difference between the Eligible Medical Expenses and the reimbursement made by the other Insurer. However, in case Cigna expatplus is offered as a supplementary Insurance (and this is reflected in the premium rates of Cigna expatplus), the amount reimbursed by the other insurance will be deducted from the amount of reimbursement as determined in accordance with the provisions of Art. II-1.5. In any case, the Insured has to 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.

1.8.3. Claims payment

The Administrator shall effect reimbursement of the covered Reasonable and Customary medical expenses (up to the limits defined in these General Conditions) 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, but if the Insured 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.

1.9. Medical information and examination

Whenever required for the smooth settlement of claims related to the insurance cover provided by the insurance policy, and in accordance with Belgian legislation concerning the protection of personal data, the Insured is obliged to provide (directly or through his/her Doctor) all the necessary medical information requested by the Insurer through the Administrator. Confidential information may be forwarded under sealed envelope to the Administrator's medical consultant. Whenever deemed necessary for the assessment of a claim, the Administrator is allowed to request a medical examination of the Insured, performed by a Doctor appointed by the Insurer, at the Insurer's expense. The Insured can ask for his/her own Doctor to be present at this examination, the costs for the own Doctor to be borne by the Insured himself/herself. In case the Insured and/or the Insured's Dependents do not comply with above obligations to provide the requested medical information or examination, the Insurer can refuse payment of benefits.

1.10. Time limitation

Claims should be reported to the Administrator as soon as possible after their occurrence. For some Treatments, precertification is required (Art. II-1.6.). In any case, claims have to be received by the Administrator no later than three (3) years after the date on which the specific treatment took place. Beyond this maximum term of three (3) years, no claim will qualify for payment or reimbursement by the Insurer.

2. Medical Evacuation and Assistance Services

	GLOBE	ORBIT	UNIVERSE
Evacuation Assistance			
• Organising and paying the cost of transportation to a hospital	100 %		
• Organising and paying the cost of a trip of an insured partner and/or minor children	100%		
• Reimbursement of the accommodation costs incurred by the insured patient or the insured person(s) travelling with him/her	up to € 100 / £ 65 / $ 125 / CHF 150 / day for a maximum of 10 days		
Hospitalisation in situ			
• Organising and paying the costs of the outward/return journey to enable a member of the family to get to the Insured in the hospital	100%		
• Cost of accommodation locally	up to € 100 / £ 65 / $ 125 / CHF 150 / day for a maximum of 10 days		
Search and/or Rescue costs	€ 1,500 / £ 1,000 / $ 1,875 / CHF 2,250		
Early return assistance Organising and paying transportation costs (round trip)	100%		
Assistance in the event of the Insured's business assignment being curtailed: paying for the travel costs of a replacement colleague (one way)	100%		
Dispatch of medicines unavailable locally	100%		
Unforeseen events assistance • Communication with the Insured's family or company • Theft of the Insured's identity documents, credit cards, travel tickets or business documents: advance of funds abroad	100% up to € 400 / £ 260 / $ 500 / CHF 600		
Psychological support in the event of severe trauma as a result of a covered Illness or Accident	two telephone calls per insured person and per insurance year		
Assistance in the event of an insured person's death			
• Transporting the body OR • Burial at the location	100%		
• Funeral costs necessary for transportation	€ 3,000 / £ 2,000 / $ 3,750 / CHF 5,500		
• Additional costs for the transportation of the insured members of the deceased's family or an insured person	100%		

2.1. General provisions

2.1.1. Definition of beneficiaries

All persons who will subscribe a contract with Cigna and whose work contract grants them the status of expatriates, as well as their legal spouse (or legal partner) and children who are financially dependent on them.

This cover is only available for:

- individual expatriates younger than seventy-five (75) years old;
- corporations: employees younger than seventy-five (75) years old (and their beneficiaries, if applicable).

The medical evacuation and assistance services under this policy shall automatically terminate as soon as the Insured and his/her beneficiaries become seventy-five (75) years old.

2.1.2. Territorial scope

Worldwide

2.1.3. Exclusions

In addition to the specific exclusions stated for each type of cover, Cigna never insures the consequences of the following circumstances and events:

- civil or foreign Wars, riots, popular movements, strikes, hostage taking, handling of weapons;
- the Insured's voluntary participation in bets, crimes or fights, except in a case of legitimate defence;
- any effects of a nuclear origin or caused by any source of ionizing radiation;
- intentional acts and fraudulent faults by the Insured's, including suicide and attempted suicide;
- consumption by the Insured of alcohol, drugs or any stupefying substance, not medically prescribed;
- 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 holidays or on the carrier, principally for reasons of air safety and/or overbooking;
- refusal of the Insured to board the flight originally planned by the approved organisation.

2.1.4. Financial commitment of the AP

If the beneficiary or his/her companions arrange one of the assistance services stated in this agreement, this will only give rise to a refund if the AP has been previously notified and has given its express agreement, in particular on the methods to be used, and has communicated a case number by fax, e-mail, telegram or telex. In this case, the costs incurred will be refunded on presentation of the original receipts up to the limit of those to which the AP would have committed in arranging the service.

2.1.5. Subrogation

Cigna becomes the beneficiary of the Beneficiary's rights and actions against any person who is responsible for the acts which were the cause of its intervention up to the amount of compensation it paid and the services it provided.

When the 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, Cigna shall have subrogated rights and actions against the said scheme or institution.

2.1.6. Time limitation

Any action arising from the 'Cigna expatplus Assistance' cover has a time limitation period of 2 (two) years commencing from the date of the event which gave rise to it.

2.2. Evacuation Assistance

In case of a medical emergency evacuation (as defined in paragraph I-2. Definitions), the AP will assist as follows:

- By organising and paying the cost of transportation to a hospital
  The AP organises and pays the cost of transport to the hospital which is closest and/or is the most suitable to provide the care required by his/her state of health.

  The AP can then organise the return to the Host Country address as soon as his/ her state of health permits.

- By organising and paying the costs of the trip of an insured partner and/or minor children
  The AP also organises, and pays the costs, once its medical department has agreed to this, for a trip for an insured partner to enable that person to accompany the insured patient and/or to enable the minor children to return to the Home Country if no adult member of the Insured's family is present with them.

- Reimbursement of the accommodation costs incurred by the insured patient or the insured person(s) travelling with him/her
  On presentation of receipts, the Administrator reimburses to the Insured patient, up to the limits stated in the cover amounts table, his/her additional hotel accommodation costs (excluding additional costs such as meals, laundry, internet etc.) and those incurred by the insured person(s) travelling with him/her, from the day he/she is immobilised up to the day of repatriation to his/her Host Country.

All medical expenses (hospital expenses, medical visits, insurance cover payments and refunds) will be administered and paid by the Administrator.

The AP will be responsible for activating services in relation to medical emergencies, such as hospitalisation or repatriation.

Emergency hospitalisation must be notified to the Administrator who will provide the payments and will be responsible for correct administration of the claim file. Non-emergency hospitalisation or emergency hospitalisation that does not require the patient to be evacuated will be directly administered by the Administrator. In the event that the AP is contacted in relation to one of the above types of case, the insured person or caller must be automatically redirected to the Administrator.

Important remark:
Decisions are only taken in consideration of the Insured's medical interests.

The AP's Doctors contact the local medical teams and, if required, the Insured's usual medical practitioner, in order 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 refuses to comply with the decisions taken by the AP's Medical Department, he/she discharges the AP of any liability in relation to the consequences of such an initiative and loses all rights to services and compensation from it.

Moreover, under no circumstances can the AP carry out the role of local emergency services organisations, nor can it pay the cost of expenses thus incurred.

2.3. Hospitalisation in situ

Paying the cost to enable a member of the Insured's family to get to his/her hospital bedside.

If the Insured is hospitalised locally for more than five (5) days (or more than forty-eight (48) hours if he/she is a minor or disabled and was not accompanied by another adult member of his/her family during the trip):

- the AP pays the cost of a round trip for a member of his/her family to enable them to get to his/her hospital bedside;

- on presentation of receipts, the Administrator refunds the Insured, up to the limit amount stated in the cover amounts table, for the cost of hotel accommodation (excluding additional costs such as meals, laundry, internet etc.) incurred by that person.

This service is not additional to the service detailed under the paragraph 'By organising and paying the cost of a trip of an insured partner and/or minor children'.

2.4. Search and/or rescue costs

On presentation of an official invoice, the Administrator reimburses the Insured for search costs at sea or in the mountains and/or the rescue costs incurred up to the ceiling limit stated in the cover amounts table.

2.5. Early return Assistance

The AP organises and pays the costs for a round trip to the Home Country for the persons insured under this policy.

The Insured can receive this service in the following cases:

- in the case of an illness or accident, resulting in emergency hospitalisation and which, in the opinion of the AP's Medical Department is of a life-threatening nature, of his/her spouse or common-law partner or of a minor or disabled descendant, who is not residing in the Host Country and is living in the insured person's Home Country;
- in order to attend the funeral after the death of his/her spouse or common-law partner, parents ,in-laws (parents of the spouse or common-law partner), descendant, brother, sister, his/her legal guardian, a person for whom he/she is the guardian, who lives in the insured person's Home Country and is under the age of eighty-five (85).

2.6. Assistance in the event of a business assignment being curtailed

In the event of a business assignment of the Insured being curtailed as a result of a covered event, the AP pays the travel costs incurred by his/her company to send out a replacement colleague to continue the disrupted assignment.

2.7. Dispatch of medicines

When the Insured is abroad, if he/she needs medicines that cannot be found locally:

- subject to the agreement of his/her attending prescribing Doctor, the AP undertakes to dispatch the medicines that cannot be found locally, if they are essential to a curative Treatment in progress, provided that no equivalent medication can be prescribed for him/her locally and that national and international customs regulations or health regulations do not prevent the medicines from being despatched;
- the AP will get these products to the Insured as soon as possible. The AP cannot, however, be held liable for delays attributable to the carrier companies used or for the potential unavailability of the medicines. The Insured undertakes to refund the AP the cost of these medicines within three (3) months of receiving them. After this time, the AP will be entitled to claim expenses and legal interest at the statutory rate in addition.

2.8. 'Unforeseen event' Assistance

2.8.1. Communication with the Insured's family or company

If the Insured is unable to contact his/her family or his/ her company, if he/she can manage to contact the AP, the AP will transmit his/her urgent messages to them.

2.8.2. Theft of identity papers credit cards, travel ticket or business documents

If the Insured's identity documents, credit cards and/or travel tickets are stolen, the Insured must report the theft within forty-eight (48) hours to the embassy of his/her Home Country nearest to the location of the theft and provide the AP with an 'Embassy report' or with a police report in case no identity documents have been stolen.

In such a situation:

- the AP can advise on the steps to take;

- the AP can assist by making the necessary stop requests if the Insured sends the AP a fax authorising the AP to do so;
- if the Insured no longer has any means of payment, the AP will grant him/her a funds advance for an amount not exceeding the ceiling stated in the cover amounts table.

2.9. Psychological support

The AP provides the Insured with its counselling and telephone support service, up to the limits stated in the cover amounts table, in the event of major trauma resulting from a covered 'Illness or Accident'.

2.10. Death assistance

In the event of the death of an insured person, the AP organises and pays the cost of:

- transportation of the body from the location where it is placed in the coffin to the burial place in the country of origin or burial at the location,
- funeral costs of transportation, up to the ceiling limit stated in the cover amounts table,
- additional expenses for the transportation of the insured 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 on account of this death.

2.11. TRAVEL ORACLE - Supplementary assistance

The AP provides the Insured with a dedicated website containing health and geopolitical information about the geographical area of the country in which he/she is expatriated. This includes practical information (country facts, alerts, health, country risk, media, risk rating watch, travel tips, vaccination manager, meeting planner tool, weather and local time and currency converter).

2.12. Cover exclusions

In addition to the exclusions that are common to all covers, the following are also excluded in respect of 'Medical Evacuation and Assistance Services':

- expenses incurred without the prior approval of the AP's Assistance Department;
- the consequences:
- of an ongoing treatment for which the Insured is being treated and for which he/she is making a convalescence trip,
- disorders that occur during a trip taken for the purpose of diagnosis;
- disorders that occur during a trip taken for the purpose of treatment;
- the eventual results (check-up, additional Treatment, recurrence) from an ailment which previously gave rise to two (2) previous repatriations (per lifetime);
- the consequences of ailments or minor Injuries that can be treated at the location;
- psychiatry;
- the consequences:
- of infectious risk situations in an epidemic scenario,
- of exposure to infectious biological agents,
- of exposure to chemical agents of a combat gas type,
- of exposure to incapacitating agents,
- 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;
- the Insured's participation in any sport practised as a professional or under a paid contract, in addition to preparatory training;
- 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;

- the consequences of an accident that occurs when he/she 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;
- expenses not expressly mentioned as giving rise to a refund, in addition to the cost of meals and any expenses for which the Insured is unable to produce a receipt.

2.13. What the Insured must do when making a claim

2.13.1. To request assistance

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

The AP's services are available 24/7:

+32 3 217 69 78

The Insured will be immediately assigned a case number and will agree to:

- give his/her policy number (255/xxxxx), as mentioned on the insurance card;
- give an address and telephone number where the AP can contact him/her and the details of the people who are assisting him/her,
- allow the AP's Doctors to access all his/her medical information or the medical information for the person needing assistance.

2.13.2. For a refund claim

In order to receive a refund of expenses advanced by the Insured with the AP's approval, he/she must provide the receipts that will enable the AP and the Administrator to determine the validity of his/her claim.

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

2.13.3. For transport costs cover

When the AP organises and pays the cost of transport as part of its cover, this will be 1st class train travel and/or tourist class flights or by taxi, depending on the decision taken by its Assistance Department. In this case, the AP takes ownership of the original tickets and the Insured undertakes to return them to the AP or to refund the AP with the amount he/she has managed to obtain as a refund from the organisation that issued these tickets.

2.14. Scope of the AP's assistance services

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

Moreover, the AP cannot be held liable for delays or hindrance to the performance of the agreed services as a result 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.

ADDITIONAL INSURANCES

3. Dental Care

	Basic	Comprehensive
Maximum Annual Reimbursement per Insured	€ 3,000 £ 2,000 $ 3,750 CHF 4,500	€ 5,000 £ 3,250 $ 6,250 CHF 7,500
Basic Dental Care (check-ups, basic Treatments)	80% up to € 1,500 80% up to £ 1,000 80% up to $ 1,875 80% up to CHF 2,250	100% up to € 2,500 100% up to £ 1,625 100% up to $ 3,125 100% up to CHF 3,750
Major dentistry (orthodontic, prostheses, bridges, implants) Orthodontic Treatment is only covered if started before age 15. A waiting period of 12 months applies to all major dentistry for individuals and companies without Medical History Disregarded.	60% up to € 1,500 60% up to £ 1,000 60% up to $ 1,875 60% up to CHF 2,250	80% up to € 2,500 80% up to £ 1,625 80% up to $ 3,125 80% up to CHF 3,750

3.1. Eligibility

Dental Care is only open to Insured who are accepted into the International Medical Insurance plan. The choice for taking out the Dental Care insurance has to be made:

- on a family level;
- on a group level for staff enrolled on a compulsory basis by their employer.

This means the Insured and his/her insured Dependents who are accepted into the International Medical Insurance plan, have to:

- take out Dental Care or not (i.e. all family members/expatriated employees or none);
- opt for the same Dental Care cover (Basic or Comprehensive).

If the Dental Care cover has been subscribed, it has to be maintained for at least one (1) year (unless the contract is terminated).

Children of less than two (2) years old do not pay premium and are not covered for Dental Care.

Once the Dental Care option is cancelled, it cannot be renewed afterwards.

3.2. Territorial scope of the insurance

With respect to the Core Plan and the additional Dental care insurance, the Policyholder can choose between two (2) geographic areas of cover:

For individual policies:

- worldwide cover;
- worldwide cover with the exception of medical expenses incurred in the United States of America (USA), Canada, China, Hong Kong and Singapore.

For group policies:

- worldwide cover;
- worldwide cover with the exception of medical expenses incurred in the United States of America (USA) and Canada

However, during business trips or holidays, not exceeding in total ninety (90) days per Insurance Year, medical expenses incurred in the excluded countries as a direct consequence of an Accident or a Medical Emergency are covered up to the limits of the policy and up to ninety (90) days per Insurance Year.

If the medical condition concerned already existed prior to the travel to an excluded country and was the objective of the travel, the medical expenses are not covered.

3.3. Benefits

Only expenses that are Reasonable and Customary can qualify for reimbursement, subject to the limits and ceilings as mentioned in the Benefits Overview above.

3.3.1. Basic Dental Care

Basic Dental Care includes up to two (2) periodic check-ups per year, prophylactic Treatments, fillings, root canal Treatment, extraction, paradental Treatment, Treatment of parodontosis, Treatment of gums, etc.

3.3.2. Major dentistry

Major dentistry covers bridges, implants, orthodontic Treatment and dental prostheses (dentures, crowns, inlays). The amount covered includes the fees of the Dentist (or dental surgeon). Dental Surgery is included under major dentistry.

3.4. Waiting period and age limit

A waiting period of twelve (12) months applies for all major dentistry. The waiting period can be waived for groups. Such waiver is only valid if explicitly mentioned in the Special Conditions.

Orthodontic Treatment is only covered if started before age fifteen (15) and provided it has been given since then without interruption.

3.5. Other provisions

Apart from the general policy provisions as set out in Chapter I of the General Conditions, the provisions of Art. II-1.8. up to and including II-1.10. also apply to the Dental Care cover.

4. Life Cover

4.1. Purpose and eligibility

The purpose of the Life Cover is to guarantee payment of a lump sum in case of death due to any cause.

The Life Cover can be taken out by the expatriated person as well as by his/her adult spouse insofar as this person is also accepted in and covered by the International Medical Insurance and maximum up to sixty (60) years of age.

4.2. Period of reflection

If the Policyholder is not satisfied with the agreement of the Life Cover for whatever reason, he/she may return it to the Administrator within thirty (30) days from the date of delivery. The Insurer will cancel the insurance and refund to the Policyholder all premiums paid, on the condition that no claims were reimbursed yet.

4.3. Benefits payment

A lump sum payment will be effected to the designated beneficiaries of the deceased Insured as indicated on the Nomination of beneficiaries form.

Benefits will be paid insofar as the Insured's decease occurs before the day of his/her sixty-fifth (65th) birthday. If the policy ends before the decease of the Insured, no payments will be effected.

4.4. Amount of the sum insured

The amount of the sum insured is specified in the Special Conditions. However, the minimum sum insured shall be 50,000 EUR/32,000 GBP/62,500 USD/75,000 CHF and can be increased up to a maximum sum insured of 500,000 EUR/325,000 GBP/625,000 USD/750,000 CHF. Premiums and benefits (lump sum) are calculated on the basis of the sum insured.

4.5. Additional exclusions

In addition to the general exclusions mentioned under Art. I-11. and I.12., following exclusions shall apply to the Life Cover:

- the consequences of suicide or of suicide attempts;
- death caused by a state of drunkenness or under the influence of non-prescribed drugs;
- death caused by ionising radiations other than the medical radiations required by covered Medical Treatment;

4.6. Obligation of the Insured

At the inception of the policy, the Policyholder has to provide the Claims Handler with the Nomination of beneficiaries form, duly filled out and signed by the Insured.

In case of death the Insurer will pay the lump sum insured to the Insured's designated beneficiaries or the lawful heir(s) in case no beneficiaries have been declared on the said form, within a month of receiving:

- copy of the birth certificate of the deceased or a certificate of civil status, and
- an original death certificate;
- a medical certificate, established by a Doctor, stating the cause of death;
- the Special Conditions of the Insured's policy.

The burden of proof lies with the beneficiaries.

5. Accidental Death and Disability

5.1. Purpose and eligibility

The Accidental Death and Disability cover guarantees:

- the payment of a lump sum in case of accidental death; or
- the payment of a lump sum in case of permanent Disability of at least 20%, caused by an Accident.

The Accidental Death and Disability cover can be taken out for or by the Expat, as well as for or by his/her adult Dependents as defined in Chapter I.

5.2. Time limits for the declaration of the Accident, claim assessment and benefits payment

5.2.1. Time limit for the declaration of the Accident

Any Accident resulting in - or which may result in – permanent Disability or death of the Insured, has to be declared in writing to the Insurer or the Administrator within a fortnight after the Accident occurred.

The declaration of the Accident should contain detailed information relating to the cause of the Accident and the nature of the Injuries.

5.2.2. Time limit for claim assessment and benefits payment

In case of accidental death, which has to occur within twelve (12) months after the date of the Accident causing the decease, a lump sum payment will be effected to the designated beneficiaries of the deceased Insured as indicated on the Nomination of beneficiaries form.

In case of permanent Disability, the Disability must be medically recognised at the latest one (1) year after the date of the Accident. However, if the Insured's condition has not entirely stabilised within two (2) years after the date of the Accident, the degree of permanent Disability will be assessed on the basis of the Insured's state of health at the end of that two (2)-year period.

5.3. Amount of the sum insured

The amount of the sum insured is specified in the Special Conditions. However, the minimum sum insured shall be 50,000 EUR/32,500 GBP/62,500 USD/75.000 CHF and can be increased up to a maximum sum insured of 500,000 EUR/325,000 GBP/625,000 USD/750,000 CHF. Premiums and benefits (lump sum) are calculated on the basis of the sum insured.

5.4. Insured benefits

5.4.1. Accidental death

In case of death of the Insured, caused by an Accident, the lump sum payable by the Insurer (to the beneficiaries of the Insured) will be equal to hundred (100)% of the sum insured, the amount of which is mentioned in the Special Conditions. In case the Insurer paid a benefit for Accidental permanent Disability, the benefit payable in case of ensuing death (within the time frame as mentioned in Art. II-5.2. caused by the same Accident which led to the Disability will be reduced by the amount already paid for the Disability.

5.4.2. Accidental Disability

In case of permanent Disability of the Insured caused by an Accident, the lump sum payable by the Insurer (to the Insured) will be equal to the amount of the sum insured (as mentioned in the Special Conditions) multiplied by the degree of Disability (percentage), the latter being determined in accordance with the Table of Disability hereafter. Permanent Disability of a degree of less than twenty (20)% will not qualify for payment of any benefit. If the permanent Disability caused by the Accident amounts to twenty (20)% or more than 20% according to the Table of Disability hereafter, the benefit amounts to the corresponding percentage of the sum insured.

5.5. Assessment of the degree of permanent Disability and use of the Table of Disability

5.5.1. Table of Disability

The following Table of Disability will be used to determine the degree of Disability:

Total paralysis	100%
Total blindness	100%
Incurable and total mental Disability	100%
Amputation or the permanent loss of the use of: a) both arms or both hands b) both legs or both feet c) one arm or hand and one leg or foot	100%
Total loss of sight of one eye with removal of the eye	50%
Total loss of sight of one eye	45%

Loss of bone of the skull forming a hole in the skull over: a) an area of at least 6 cm^2 b) an area of 3 to 6 cm^2 c) an area of less than 3 cm^2	 40% 20% 10%
Incurable total loss of hearing in both ears	100%
Incurable total loss of hearing in one ear	50%
Amputation of the lower jaw: a) total b) partial (upright branch plus the whole or half of the up toillary bone)	 70% 40%

Loss of top and bottom teeth and their sockets: a) impossibility of fitting dental prosthesis b) In the case of possible prosthesis with established functional improvement	 10 to 30% 1 to 10%	
	Right	**Left**
Loss of arm or hand	75%	60%
Total paralysis of an upper limb	65%	55%
Total paralysis of the circumflex nerve	20%	15%
Total paralysis of the median nerve	45%	35%
Total paralysis of the cubital nerve at the elbow	30%	25%
Total paralysis of the nerve of the hand	20%	15%
Total paralysis of the radial nerve above the triceps	40%	30%
Complete ankylosis of the shoulder: a) with immobilisation of the shoulder blade b) with mobility of the shoulder blade	 65% 35%	 55% 25%
Non-consolidated fracture of the upper arm (constitution of pseudo-arthrosis)	30%	25%
Total loss of movement of the elbow: a) in an unfavourable position b) in a favourable position	 40% 25%	 35% 20%
Non-consolidated fracture of the forearm (constitution of pseudo-arthrosis): a) both bones b) a single bone	 25% 10%	 20% 8%
Total loss of movement of the wrist: a) in an unfavourable position (flexion, forced extensions or supination) b) in a favourable position (straight or prone)	 40% 20%	 30% 15%
Amputation of a thumb: a) total b) partial (ungual phalanx)	 20% 10%	 18% 8%
Ankylosis of a thumb: a) total b) partial (ungual phalanx)	 15% 10%	 12% 8%

Amputation of index finger: a) total b) two phalanxes c) one phalanx	 16% 12% 6%	 14% 10% 5%
Amputation of second finger	12%	10%
Amputation of third finger	10%	8%
Amputation of fourth finger	8%	6%
Total paralysis of a lower limb	60%	
Complete paralysis of the internal popliteal sciatic nerve	30%	
Complete paralysis of the external popliteal sciatic nerve	30%	
Complete paralysis of both popliteal sciatic nerves	40%	
Shortening of a lower limb: a) at least 5 cm b) from 3 to 5 cm c) from 1 to 3 cm	 30% 20% 10%	
Complete ankylosis of the hip: a) in a bad position (flexion, adduction or abduction) b) in a straight position	 60% 40%	
Amputation of the thigh: a) upper half and leg b) lower half and leg	 60% 50%	
Non-consolidated fracture of the thigh or both bones of the leg (constitution of pseudo-arthrosis)	50%	
Complete ankylosis of the knee: a) in flexion (from 130 degrees) b) straight or almost straight	 50% 25%	
Chronic gonarthrosis according to the degree of muscular atrophy	3 to 20%	
Non-consolidated fracture of the knee cap with wide separation of the fragments and considerable difficulty in extension of the leg from the thigh	40%	
Amputation of a leg	50%	
Tibio-tarsian ankylosis	15%	
Amputation of a foot: a) total (tibio-tarsian disarticulation) b) sub-astragalian c) media-tarian d) tarso-metatarsian	 50% 40% 35% 30%	
Amputation of all toes	20%	
Amputation of big toe	10%	
Amputation of a toe other than big toe	3%	
Ankylosis of the big toe	3.5%	

5.5.2. Permanent nature of the Disability

In order to qualify for payment of the insured benefit, the Disability has to be of a permanent nature, meaning that it has been medically determined that continuation of the Medical Treatment will not lead to any significant improvement of the person's state of health, and that the Disability will therefore be definitive and irreversible.

5.5.3. Pre-existing state of infirmity

A pre-existing state of infirmity of limbs or organs cannot be taken into account for the assessment of the Injuries that are caused by the Accident.

5.5.4. Maximum degree of Disability

The degree of permanent Disability can never exceed 100%. Under no circumstances the sum payable by the Insurer will exceed 100% of the sum insured.

5.5.5. Several Injuries affecting the same limb

In case of several Injuries or infirmities resulting from the same Accident or from successive Accidents, each Injury or infirmity will be assessed separately, but the sum of Injuries or infirmities affecting a limb may not lead to a degree of Disability exceeding the degree of Disability corresponding to the full loss of the limb concerned.

5.5.6. Events or infirmities not listed in the Table of Disability

For events or infirmities not listed in the Table of Disability, the degree of Disability shall be determined by reference to the listed events or infirmities: the Table of Disability will be used as a guide to assess the degree of Disability by analogy with listed items. The sum payable will in no case be less than the amount payable for any reasonably analogous event or infirmity, listed in the Table of Disability.

5.5.7. Total loss of use of a limb

Total loss of use of a limb will be considered being equal to the loss of the limb itself.

5.5.8. Left-handed persons

Left-handed persons shall receive scaled benefits related to the upper right limb instead of upper left limb, and vice versa.

5.5.9. Aggravating facts

In the case of aggravation of the consequences of an Accident as a result of infirmities, Illness or circumstances independent of the accidental cause, the degree of Disability cannot be superior to the one that would have been determined if the Accident had struck a healthy organism.

5.6. Additional exclusions

In addition to the general exclusions mentioned under Art. I-11. and I-12., following exclusions shall apply to the Accidental Death and Disability cover:

- Accidents resulting from obviously foolhardy and/or reckless acts by the Insured, or Accidents he/she has intentionally caused or provoked;
- the consequences of suicide or of suicide attempts;
- Accidents occurring in a state of drunkenness or under the influence of non-Prescription Drugs except if it is established by the Insured or his/her beneficiaries that such state was not the cause of the Accident;
- Accidents provoked by ionising radiations other than the medical radiations required by covered Medical Treatment;
- Disability and/or death resulting from an Illness.

5.7. Obligations to be fulfilled by the Insured

5.7.1. Declaration of Accident

Any Accident that leads or that could lead to Disability or death must be declared in writing to the Insurer (through the Administrator) within a fortnight after the Accident occurred. The declaration must contain all information relating to the Accident, including:

- place, date and detailed circumstances of the Accident;
- names and addresses of persons involved;
- names and addresses of witnesses and of persons possibly liable;
- the official report from the local authorities (e.g. police report or other relevant documents).

A medical certificate must be attached to this declaration, indicating the nature and extent of the Injuries of the Insured and the probable duration of the Disability.

5.7.2. Changes to the extent of the Disability

Any changes to the extent of the Disability must be communicated by the Insured to the Insurer (through the Administrator) within one (1) month. In the absence of such communication, any amount unduly paid to the Insured will have to be refunded by him/her to the Insurer.

5.7.3. Medical information

The Insured shall authorise his/her attending Physician to communicate all relevant information concerning the Insured's state of health to the Insurer's medical consultant.

5.7.4. Force majeure

There shall be no loss of cover if the Insured can prove that the obligations, as stipulated by this article, have not been fulfilled as a result of circumstances totally beyond his/her control ('force majeure'), or if the good faith of the Insured cannot be called into question.

5.8. Payment of the benefit

At the inception of the policy, the Policyholder has to provide the Administrator with the duly completed and signed Nomination of beneficiaries form. In case of death caused by an Accident, the Insurer will pay the lump sum insured to the Insured's designated beneficiaries (or the lawful heir(s) in case no beneficiaries have been declared on the said form) within one (1) month of receiving:

- the documents mentioned under Art. II-5.7.1.;
- copy of the birth certificate of the deceased or a certificate of civil status;
- an original death certificate;
- a detailed medical certificate, established by a Doctor, stating the cause of death.

Before the claim can be paid, the causal link between the Accident and death should have been established. The burden of proof lies with the beneficiaries. In case of permanent Disability caused by an Accident, the Insurer will pay the lump sum insured to the Insured. The following documents have to be provided to the Administrator:

- the documents mentioned under Art. II-5.7.1.;
- copy of the birth certificate of the Insured concerned or a certificate of civil status;
- a detailed medical certificate, established by the attending Physician, stating the cause of the Disability, accompanied by all relevant documents needed to accurately assess the Disability (Art. II-5.5.).

After all documents have been received by the Administrator and the condition of the Insured concerned has sufficiently stabilised to allow the Insurer's medical consultant to assess the degree of Disability (according to the provisions as set out in Art. II-5.5.), payment of the insured sum due will be made within one (1) month.

6. Temporary Incapacity

6.1. Purpose and eligibility

The purpose of the Temporary Incapacity cover is to guarantee to the Insured, after the waiting period as defined hereafter, the payment of a monthly allowance during a maximum period of two (2) years, in case the Insured is totally unable to perform his/her professional occupation. The Temporary Incapacity cover can only be taken out by the individual Policyholder or the expatriated employee and is not available to his/her Dependents (spouse or legal partner/children).

6.2. Medical acceptance into the insurance

Joining the Temporary Incapacity cover is subject to the acceptance of the candidate-Insured into the insurance by the Insurer's medical consultant. If one subscribes to the Temporary Incapacity cover on a later date than the International Medical Insurance cover, a new Medical questionnaire has to be completed and signed.

6.3. Temporary Incapacity benefit

The Temporary Incapacity cover provides for a monthly allowance in case the Insured - further to an Illness or an Accident - is totally unable to perform his/her own professional occupation (i.e. the usual professional occupation at the time the incapacity started).

6.4. Waiting period

The allowance is payable after a waiting period of ninety (90) days (for which no benefits are due) of uninterrupted total incapacity to perform the own professional occupation. The waiting period shall commence on the starting date of the incapacity, as determined by the treating Physician.

6.5. Assessment of the incapacity

The incapacity has to be supported by sufficient medical evidence, to be presented by the Insured or his/her Physician to the medical consultant of the Insurer. The Insurer's medical consultant has the right to ask for relevant additional information and/or have the Insured medically examined to assess the incapacity at the moment the incapacity starts and, on a regular basis, during the period of incapacity and for as long as the (partial) incapacity allowance is paid. The Insurer has the right to refer the Insured to an external medical officer appointed by the Insurer, in order to receive an additional medical report on the incapacity.

6.6. Amount and duration of the benefit

The amount of the monthly allowance in case of total incapacity of the Insured to perform his/her own professional occupation is mentioned in the Special Conditions. The minimum amount to be insured is 1,000 EUR/650 GBP/ 1,250 USD/1,500 CHF (monthly allowance). The amount insured cannot exceed 80% of the gross (monthly) Salary of the Insured, nor can it exceed an amount of 10,000 EUR/ 6,500 GBP/12,500 USD/15,000 CHF per month. The Policyholder shall submit to the Administrator a copy of the latest official Salary statement of the Insured. After the waiting period of ninety (90) days, the allowance will be paid as long as the Insured is totally unable to perform his/her occupation, limited however to a maximum period of two (2) years.

6.7. Partial resumption of work

Persons who (after the ninety (90)-day waiting period) are benefiting from the monthly allowance and whose condition is improving to such an extent that they are capable of partially resuming work, may continue (within the limits of the maximum period of two (2) years after the waiting period) to receive an allowance. The amount of this allowance will however be reduced, and will be calculated by multiplying the (total monthly) sum insured by the percentage of the (remaining) incapacity. In case the incapacity would become less than thirty (30)%, the allowance will be discontinued.

6.8. Relapse

In the event of a relapse, the payment of the allowance shall be resumed without application of a new waiting period. By 'relapse' is meant: the incapacity to work, which arises within three (3) months of the end of incapacity covered by this insurance policy, and which is caused by the same Illness or the same Accident. Any additional incapacity resulting from another cause shall be subject to a new waiting period of ninety (90) days.

6.9. Benefit payment

The incapacity allowance shall be payable to the Insured, at the end of each month, and for the first time at the end of the month following the expiration of the waiting period. If the incapacity to work comes to an end in the course of a month, the allowance shall be proportional to the number of days lapsed in that month. Payments shall cease at the event of one of the following occasions:

- when the degree of incapacity becomes less than 30%;
- on the death of the Insured;
- at the end of the period of two (2) years of payment of the allowances;
- on the renewal date after the sixty-fifth (65th) birthday of the Insured;
- when the Insured fully resumes work.

6.10. Additional exclusions

In addition to the general exclusions mentioned in Art. I-11. and I-12., the following exclusions apply to the Temporary Incapacity cover:

6.10.1. Maternity leave and childbirth

Maternity leave and incapacity to work because of childbirth are not covered. They will not be taken into account for the calculation of any waiting period and will not give rise to any benefits. In case the Insured would, however, be in receipt of benefits for Temporary Incapacity for other reasons (than childbirth or maternity leave) during which period the maternity leave would start, the payment of benefits will be suspended to resume only after the end of the maternity leave, and only in case if the Insured is then still unable to resume work. If on the expiry date of the normal maternity leave of a female Insured, a health condition exists which prevents the Insured from fully resuming her usual professional occupation (total inability to work), the waiting period will start as from that date.

6.10.2. Dangerous sports

Incapacity resulting from any sport practised for professional purposes, even as a secondary profession or any remunerated participation in sports competitions, or any unremunerated practice of sports reputed to be rash and hazardous, such as:

- rugby;
- winter sports competitions and races;
- aerial sports (except ballooning);
- hunting big game (including safari);
- speleology, cave diving and tech diving;
- alpinism, if not on official paths;
- motor vehicle racing on land and water (except non-competitive recreational jet-ski, recreational water skiing, or tourist rallies for which no time or speed imperatives have been imposed);
- rafting, canyoning, bungee jumping, kite surfing and similar sports.

6.11. Obligations to be fulfilled by the Insured and/or the Policyholder

6.11.1. Notification of incapacity

In case of incapacity to perform the usual professional occupation because of Illness or Accident, such incapacity has to be notified by the Policyholder to the Administrator in writing as soon as possible and at the latest on the ninety-first (91st) day of the incapacity. At the same time, a medical report, established by the treating Physician of the

incapacitated person, indicating the nature and extent of the incapacity of the Insured as well as the probable duration of the incapacity, has to be forwarded to the Administrator, for the attention of the Insurer's medical consultant. Furthermore, a proof of income has to be provided.

6.11.2. Changes to the extent of the incapacity

Any changes to the extent of the incapacity must be communicated by the Insured or his/her Doctor to the Insurer's medical consultant (through the Administrator) within a month. In the absence of such communication, any amount unduly paid to the Insured will have to be refunded by him/her to the Insurer.

During the period of total incapacity, the Insurer's medical consultant can, at his discretion, request a detailed medical report (a follow-up report) from a specialist doctor in order to assess the extent of the incapacity.

6.11.3. Medical information

The Insured shall authorise his/her attending Physician to communicate all relevant information concerning the Insured's state of health to the Insurer's medical consultant.

6.11.4. Force majeure/Good faith

There shall be no loss of cover if the Insured can prove that the obligations, as stipulated by this article, have not been fulfilled as a result of circumstances totally beyond his/her control ('force majeure'), or if the good faith of the Insured cannot be called into question.

7. Permanent Disability

7.1. Purpose and eligibility

The purpose of the Permanent Disability cover is to guarantee payment of a monthly Disability allowance, (maximum up to age of sixty-five (65)) to the Insured who is affected by a Permanent Disability caused by an Illness or Accident, prohibiting him/her from fully or partially continuing his/her professional occupation, therefore leading to a total or partial loss of income.

The insurance covers Permanent Disability caused by an Illness or Accident and amounting to a degree exceeding thirty-three point thirty-three (33.33)%. Moreover, in case the degree of Disability exceeds sixty-six point sixty-seven (66.67)%, and if the Insured needs the assistance of a third person to perform the basic activities of daily living, the insurance guarantees an additional lump sum benefit, in accordance with the provisions as set out below.

The Permanent Disability cover can only be taken out as an Additional Insurance (supplement) to the Temporary Incapacity cover. The Permanent Disability cover can only be taken out by the individual Policyholder or the expatriated employee and is not available to his/her Dependents (spouse or legal partner/children).

7.2. Medical acceptance into the insurance

Joining the Permanent Disability cover is subject to the acceptance of the candidate-Insured into the insurance by the Insurer's medical consultant. If the subscription date to the Permanent Disability cover is later than the subscription date to the International Medical Insurance cover and/or the Temporary Incapacity cover, a new Medical questionnaire needs to be completed and signed.

7.3. Definition of Permanent Disability (resulting from an Illness or Accident)

7.3.1. Disability

An Insured is considered to be disabled because of Illness or Accident, if:

- his/her ability to work, i.e. the ability to perform his/her normal professional occupation (occupation at the time the Disability started) or any other gainful occupation for which he/she is reasonably fitted by training, education or experience has been reduced;
  and
- his/her ability to function in general has been reduced because of the Illness or Accident concerned. In order to qualify for the insured benefits, it has to be medically determined that the Insured's Disability is of a permanent nature and that the degree of (the combination of both) occupational and functional Disability exceeds 33.33% according to the Table of Disability hereafter (Art. II-7.5.) start at the earliest after the allowances paid by the Insurer within the framework of the Temporary Incapacity cover have come to an end.

7.3.2. Permanent Disability

Permanent Disability means that the continuation of the Medical Treatment will not lead to any significant improvement of the person's state of health, and that the Disability will therefore be definitive and irreversible.

7.4. Waiting period

The Permanent Disability cover is a supplement to the Temporary Incapacity cover. Benefit payment will therefore start at the earliest after the allowances paid by the Insurer within the framework of the Temporary Incapacity cover have come to an end.

7.5. Assessment of Disability

The degree of Permanent Disability will be determined by means of a medical examination. To this end, the Insurer (or the Administrator on behalf of the Insurer) will appoint a Doctor to determine the degree of Disability in accordance with the Table of Disability hereafter.

	Degree of functional Disability								
Degree of occupational Disability	20%	30%	40%	50%	60%	70%	80%	90%	100%
10%						36.59	40.00	43.27	46.42
20%				36.94	41.60	46.10	50.40	54.51	58.48
30%			36.54	42.17	47.62	52.78	57.69	62.40	66.94
40%			40.00	46.20	52.42	58.09	63.50	68.68	73.68
50%		35.57	43.09	50.00	56.46	62.57	68.40	73.99	79.37
60%		37.80	45.79	53.13	60.00	66.49	72.69	78.62	84.34
70%		39.79	48.20	55.93	63.16	70.00	76.52	82.79	88.79
80%		41.60	50.40	58.48	66.04	73.19	80.00	86.54	92.83
90%		43.27	52.42	60.82	68.68	76.12	83.20	90.00	96.55
100%	34.20	44.81	54.29	63.00	71.14	78.84	86.18	93.22	100.00

7.6. Amount and duration of the benefit

7.6.1. Calculation of the amount of the monthly Disability allowance

Insured allowance

The amount of the insured allowance is mentioned in the Special Conditions. In no event, the amount of the insured allowance shall be higher than the monthly allowance of the Temporary Incapacity cover.

The minimum amount to be insured is 1,000 EUR/650 GBP/ 1,250 USD/1,500 CHF (monthly allowance). The amount insured cannot exceed 80% of the gross (monthly) Salary of the Insured, nor can it exceed an amount of 10,000 EUR/ 6,500 GBP/12,500 USD/15,000 CHF per month.

Degree of Permanent Disability of less than 33.33%

No benefits will be due for Disabilities of less than thirty-three point thirty-three (33.33)% (=1/3).

Degree of Permanent Disability between 33.33% (= 1/3) and 66.67% (=2/3)

If the degree of Disability, as determined in accordance with the stipulations of Art. II-7.3. and II-7.5. above, is situated between thirty-three point thirty-three (33.33)% and 6 sixty-six point sixty-seven (66.67)%, then the amount of the Disability allowance will be calculated as follows:

((3 x n) – 1) x insured allowance, 'n' being the degree of Disability (%).

Degree of Permanent Disability exceeding 66.67% (=2/3)

If the degree of Disability, as determined in accordance with the stipulations of Art. II-7.3. and II-7.5. above, exceeds sixty-six point sixty-seven (66.67)%, then the amount of the Disability allowance will be equal to the amount of the insured allowance (hundred (100)%).

7.6.2. Additional lump sum benefit in case of need of assistance of a third person

If from the start of the Disability (i.e. as from the start of the payment of the Disability allowance) the degree of Permanent Disability exceeds sixty-six point sixty-seven (66.67)%, and if the Insured, as from the start of the Disability, needs the assistance of a third person to be able to perform the following activities of daily living:

- feeding oneself (taking and eating prepared food);
- dressing oneself;
- washing oneself;
- using the toilet or bedside commode;
- moving around (transferring from a bed to a chair or vice versa, and ability to move on level surfaces); then the Insurer will pay a once-only additional benefit of 25,000 EUR/ 16,250 GBP/31,250 USD/37,500 CHF (single lump sum) to the Insured.

7.6.3. Yearly adjustment of Disability allowance (indexation)

The monthly Disability allowance shall be subject to an annual increase of two (2)%. This adjustment will be applied for the first time at the end of the first month of the first (1st) calendar year following the first (1st) benefit entitlement.

7.6.4. Duration of benefit

Benefits will be paid at the latest till the end of the month in which the Insured:

- reaches the age of sixty-five (65);
- deceases;
- resumes work;

whichever event occurs first.

7.7. Benefit payment

The Disability allowance shall be payable on a monthly basis, at the end of each month. Before any payment can be made, the Administrator should have received a copy of the Insured's birth certificate or a certificate of civil status.

7.8. Additional exclusions

In addition to the general exclusions mentioned in Art. I-11. and I-12., the following exclusion applies to the Permanent Disability cover:

Disability resulting from any sport practised for professional purposes, even as a secondary profession or any remunerated participation in sports competitions, or any unremunerated practice of sports reputed to be rash and hazardous, such as:

- rugby;

- winter sports competitions and races;
- aerial sports (except ballooning);
- hunting big game (including safari);
- speleology, cave diving and tech diving;
- alpinism, if not on official paths;
- motor vehicle racing on land and water (except non-competitive recreational jet-ski, recreational water skiing, or tourist rallies without time or speed imperatives);
- rafting, canyoning, bungee jumping, kite surfing and similar sports.

7.9. Obligations to be fulfilled by the Insured

7.9.1. Assessment of Disability – medical information

The Disability has to be supported by sufficient medical evidence, to be presented by the Insured or his/her Physician to the medical consultant of the Insurer.

The Insured shall authorise his/her attending Physician to communicate all relevant information concerning the Insured's state of health to the Insurer's medical consultant.

The Insurer's medical consultant has the right to ask for relevant additional information and/or have the Insured medically examined to assess the Disability at the moment the Disability starts and, on a regular basis, during the period of disability and for as long as the disability allowance is paid. Furthermore, a proof of income has to be provided.

7.9.2. Changes to the extent of the Disability

Any changes to the extent of the Disability must be communicated by the Insured to the Insurer (through the Administrator) within one (1) month. In the absence of such communication, any amount unduly paid to the Insured will have to be refunded by him/her to the Insurer.

GENERAL CONDITIONS

If you need any additional information, please contact us.

Cigna expatplus
P.O. Box 69
2140 Antwerpen
Belgium
Tel. + 32 3 217 65 29
Fax + 32 3 663 73 14
info@expatplus.com
www.expatplus.com