Delivering what people need to be their healthiest

Hollard. zambia

In partnership with Hollard. health

BETTER HEALTH FOR BETTER FUTURES

We are passionate about Africa and we believe that the most powerful way to create a better future for the continent, is to improve the health of her people.

We believe in working together with you, giving you access to the most advanced tools and the best guidance available, to live fully in good health.

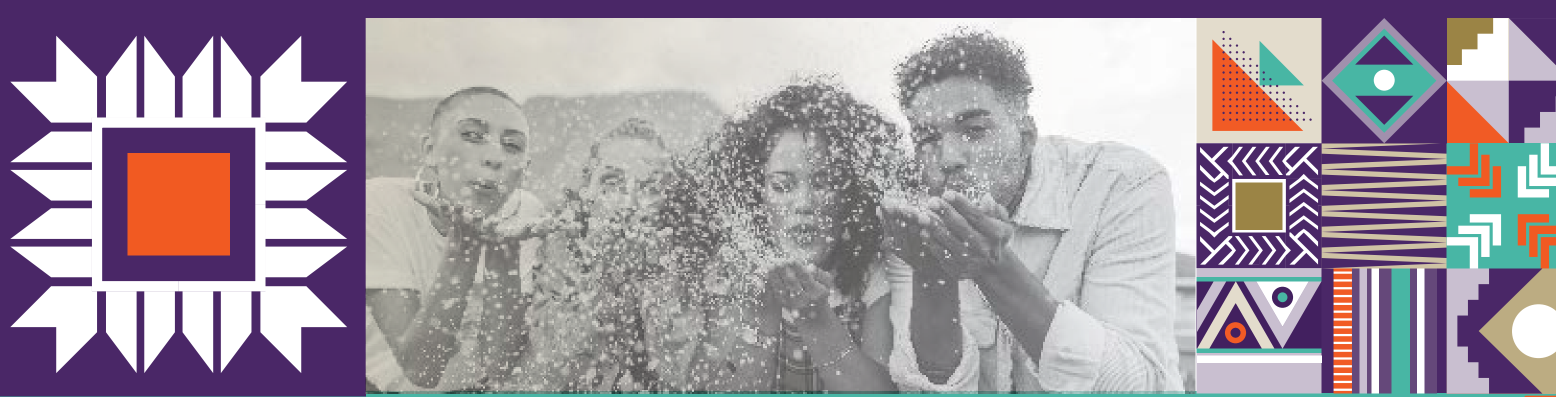
And when things go wrong, we're right there with you, giving you access to the best medical care.

We do health with heart

We treat every person with care and dignity and are there when you need us most. We push boundaries, we reimagine and we always find a better way. We put your fears and desires at the heart of our solutions.

International health insurance – by Africa, in Africa, for Africa

We are of Africa and deeply understand Africa's unique demands. We know how important it is to have access to care beyond your borders – our offering is deliberately international, our partners global and our business agile enough to adapt to the ever-changing environment.



A FRESH APPROACH TO YOUR HEALTH

Combining world-leading tech with the human touch to optimize your health journey

1. Know where you are to know where you're going

Making better health choices starts with knowing where you are right now – we give you really easy-to-use health assessments, that you can access on your phone. Our at-home essential screenings use personalised data for you to know where your health presently stands so you can keep doing what's working and make shifts where it isn't.

2. Enjoy the journey

Proactive health management can now be sociable, fun and easy. Whether it's through group or individual challenges, engagement through social platforms, incentives and rewards, we make it easier for you to enjoy getting healthier in ways that support you on your unique health journey.

3. Get the right care at the right time

When things do go wrong, we focus on how we can help to make things go right. We have the experience and capabilities to give you access to the right information, quality providers and expert care when it matters the most. We take care of the details so that you can focus on recovery.

OUR VALUES

Positive change one person at a time

We empower people to take charge of their health with easy-to-understand information and smart tools, supporting them to make the best choices for their health and wellbeing, now and into the future.

Collaboration is key

We listen first, then give insights and a methodology to create real shifts. This goes beyond employee productivity; to truly understanding and delivering what individuals need to be their healthiest and happiest.

Using tech for the greater good

We leverage technology but never forget our humanity. Our highly efficient platform manages processes and handles day-to-day claims, but when the big stuff happens, real people with real expertise and experience are there to guide individuals every step of the way.

Our cutting-edge tools efficiently mitigate fraud, waste and abuse while richer and richer data gives us the insights to continually refine our pricing methodologies to deliver optimum pricing levels.

Creating the win-win-win

We are committed to ensuring that everyone concerned is aligned and benefitting from keeping and making employees healthier.

- For employers: healthier employees mean lower claims, breaking the cycle of medical inflation increases.
- For local Insurers and industry: by working with and supporting the local insurance industry, we add to economies and make insurers sustainable.
- For dedicated healthcare providers: swift payment ensures they can continuously deliver their vital healthcare services, knowing their cashflow is sorted.

HEALTHMOV

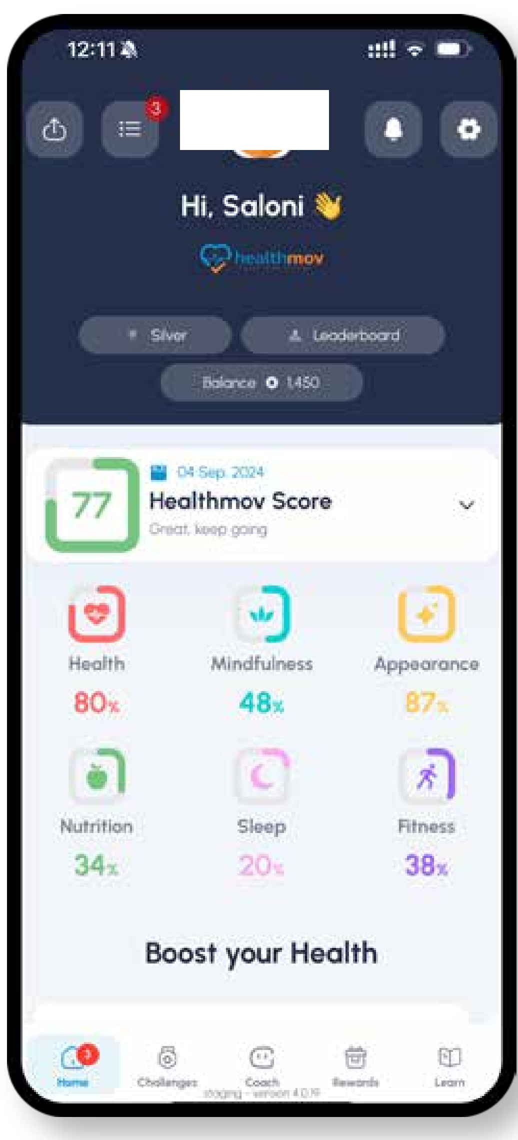
Bringing you a wellness proposition that can work for everyone.

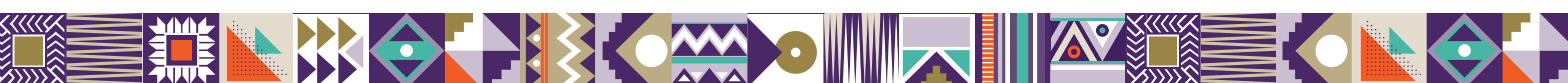
The wellness game changer that starts with a selfie

The good news:	a healthier workforce is a more productive and happier workforce.
The great news:	a healthier, happier, more productive workforce means lower premiums for you.
The BEST news:	it doesn't have to be hard – great employee wellness could start with the simple act of taking a selfie.

Powered by the Hollard HealthMov App that uses smart tech to track, monitor and provide real-time feedback to employees so that they can make small changes each day that will make a HUGE impact to their long-term health. It is so intuitive, it can scan facial features and movement to measure heartrate, breathe rate, stress level and BMI. This information is then collated to give feedback, suggestions and rewards. Your employees will have a virtual personal trainer, health coach and mentor in their pockets.

The information is collated into an anonimised dashboard giving a view of the wellbeing of the employees and their families. From there we can customise relevant health interventions, driven through the App.





TELEHEALTH

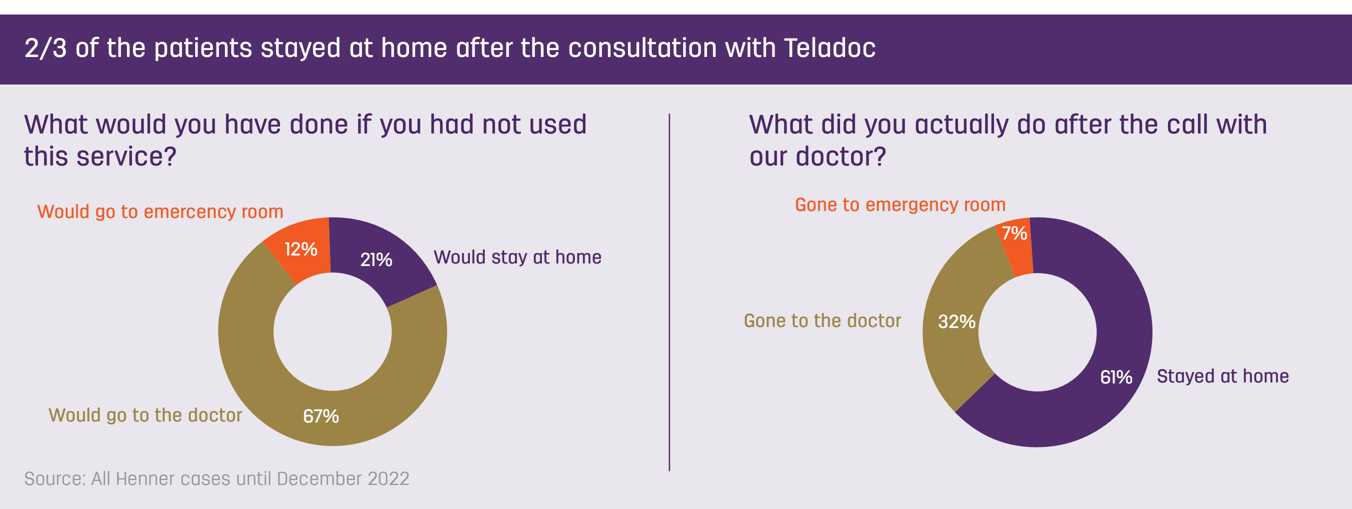
With Hollard everyone has access to telehealth, no matter what plan they are on.

The advantages of Teladoc service for Hollard members?

- Unlimited access to a team of qualified doctors available 24/7
- Video consultation in an entirely secure and confidential environment thanks to the Hollard-Teladoc platform available via the Hollard member portal
- Appointment scheduling service or call-back for emergencies
- Avoid waiting time and travel to a doctor's office

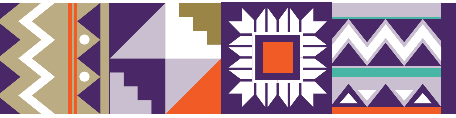
GP Consultation

- Access to medical advice and guidance by a qualified doctor in English, Portuguese, French and more
- Get a medical prescription (except if the local legislation does not allow it in the considered country)



Second Medical Opinion

- Analysis of medical records, images and test results
- Confirm diagnoses accuracy and treatment plans
- To provide a medical protocol for the patient and their physician/medical team
- To obtain reassurance and support when seeking treatment



Our product

Step 1 – Basic	Option 1	Option 2	Option 3	Option 4	Option 5
Inpatient **Condition management** **Wellness & preventative care** **Evacuation & out of country care**	$75,000	$200,000	$750,000	$3,000,000	$10,000,000

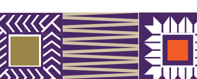
Step 2 – Enhanced	Option 1	Option 2	Option 3	Option 4	Option 5
Outpatient	$1,500	$2,500	$4,000	$6,000	Paid in full

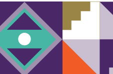
Step 3 – Complete	Option 1	Option 2	Option 3	Option 4	Option 5
Dental Treatment	$500	$750	$1,500	$3,000	$4,500
Vision Care	$100	$150	$300	$450	$600

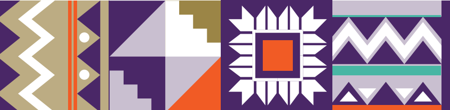
You can **choose** if you want only Step 1 which will give you our Basic Plan. Thereafter you can decide if you would like to add Step 2 and have the Enhanced Plan and finally you could add all 3 steps and so have our Complete Plan. Within each step you can choose the option that you require. In case it was not clear, you cannot skip a step but you can **mix and match** your options.

All the values reflected above are the annual maximum benefit that applies for each of the steps. However, the option you select in Step 1, also determines the policy's annual maximum benefit, which is the total that we will pay in a year when you sum the amounts we have paid for all the treatment a single insured person had in a year.

This is a very high-level summary of the benefits we offer, for the full details of all that we cover, the limit, sub-limits and any other limitations, please refer to the complete benefit overview.

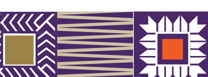


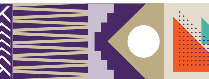




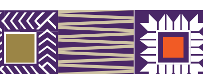
All the limits reflected are the amount up to which payment will be made. The amounts apply per insured person, per insurance year (unless specifically stated as otherwise).

Step 1 – Basic	Option 1	Option 2	Option 3	Option 4	Option 5
Annual maximum benefit	$75,000	$200,000	$750,000	$3,000,000	$10,000,000
Inpatient					
Hospital room and board	Standard private room				
Intensive care unit	Paid in full	Paid in full	Paid in full	Paid in full	Paid in full
Doctor's fees › Surgeons › Anaesthetists › Any other specialist doctors					
Surgery Including day surgery					
Routine childbirth *					
Maternity complications * › During pregnancy › Non-elective caesarean section › Surgery following a complicated birth					
Sterilisation					
Organ transplant					
Operating theatre					
Hospital supplies and service › Nursing › Prescribed drugs › Dressings, splints and plaster casts					
Diagnostic tests Includes pathology tests, laboratory tests, radiology, MRI scan, CT scan, PET scan and the like					

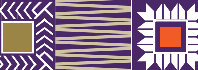


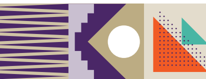
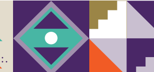


Step 1 – Basic	Option 1	Option 2	Option 3	Option 4	Option 5
Inpatient (cont.)					
Physiotherapy, speech and occupational therapy	Paid in full	Paid in full	Paid in full	Paid in full	Paid in full
Ambulance to nearest hospital Domestic road ambulance services to and/or from the hospital					
Surgical and medical appliances › an artificial limb, prosthesis, appliance or device	$3,750	$7,500	$10,000	Paid in full	
Elective caesarean *	$2,000	$3,000	$4,000	$8,000	
Convalescence and rehabilitation	Paid in full for up to 14 days	Paid in full for up to 21 days	Paid in full for up to 28 days	Paid in full for up to 42 days	
Home nursing	$300 per day for up to 14 days	$300 per day for up to 21 days	$300 per day for up to 28 days	$300 per day for up to 42 days	
Psychiatric care	Paid in full for up to 7 days	Paid in full for up to 14 days	Paid in full for up to 21 days	Paid in full for up to 28 days	Paid in full for up to 42 days
Hospital cash benefit Daily allowance when room, board and treatment are received free of charge	$100 per day for up to 7 nights	$100 per day for up to 14 nights	$100 per day for up to 21 nights	$100 per day for up to 28 nights	$100 per day for up to 42 nights
Parental accommodation	Paid in full for up to 30 days	Paid in full for up to 30 days	Paid in full for up to 30 days	Paid in full for up to 30 days	Paid in full for up to 30 days
Condition management					
Cancer Includes prescription drugs, radiotherapy, chemotherapy and the like	Paid in full	Paid in full	Paid in full	Paid in full	Paid in full
Kidney failure Dialysis and prescription drugs					
Chronic conditions Includes specialist doctors fees, prescription drugs and hospitalisation					



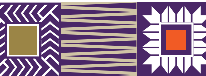
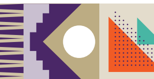
Step 1 – Basic	Option 1	Option 2	Option 3	Option 4	Option 5
Condition management (cont.)					
HIV and Aids * Includes specialist doctors fees, prescription drugs and hospitalisation	Paid in full	Paid in full	Paid in full	Paid in full	Paid in full
Palliative treatment For patients with a life expectancy of less than 6 months	$5,000	$10,000	$25,000	$100,000	
Wellness and preventative care					
1 x Routine adult physical examination	Paid in full	Paid in full	Paid in full	Paid in full	Paid in full
1 x Pap smear every 3 years					
Mammograms › one baseline for women aged 35-39 › one every two years for women aged 40-49 › one every year for women aged 50 and over					
Prostate screening One every year for men from age 50					
Hearing test › One for babies aged 0 to 6 months › One for children aged 7 months to 3 years old › One for children aged 3 to 6 years old › One every 5 years for children and adults aged 7 and older					
Well child developmental tests					
Emergency transport, evacuation & out of country care					
Transport › the cost of a road ambulance and/or air ambulance and/or commercial flight for the insured person and a close family member, to and from the closest hospital that is most suitable to provide the care required by the insured person	Paid in full	Paid in full	Paid in full	Paid in full	Paid in full



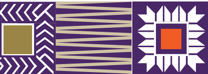



Step 1 – Basic	Option 1	Option 2	Option 3	Option 4	Option 5
Emergency transport, evacuation & out of country care (cont.)					
› reimbursement of accommodation costs of the insured person and accompanying close family member until the insured person is repatriated	Up to $200 per person per day for a maximum of 7 days	Up to $200 per person per day for a maximum of 14 days	Up to $200 per person per day for a maximum of 21 days	Up to $200 per person per day for a maximum of 28 days	Up to $200 per person per day for a maximum of 35 days
The costs of transport and accommodation will be included for a close family member when the insured person receiving treatment: › will be hospitalised for more than 5 days, or › is a minor, or › is disabled					
Early return assistance Organising and paying the cost of transport in the event of life-threatening Illness or death of a family member in the insured person's home country	Paid in full	Paid in full	Paid in full	Paid in full	Paid in full
Death assistance › Repatriation of mortal remains › additional costs for the transportation of the deceased's insured family					
Emergency out of area cover	Covered for a maximum of 14 days per trip and for a total of 60 days per insurance year for up to $35,000	Covered for a maximum of 21 days per trip and for a total of 60 days per insurance year for up to $50,000	Covered for a maximum of 28 days per trip and for a total of 60 days per insurance year for up to $100,000	Covered for a maximum of 35 days per trip and for a total of 90 days per insurance year	Covered for a maximum of 35 days per trip and for a total of 90 days per insurance year

* Waiting periods may be applied to these benefits when full medical underwriting is required.

Step 2 – Enhanced	Option 1	Option 2	Option 3	Option 4	Option 5
Annual maximum benefit	$1,500	$2,500	$4,000	$6,000	Paid in full
Outpatient					
Doctor's fees › General practitioners › Specialist doctors	Paid in full	Paid in full	Paid in full	Paid in full	Paid in full
Diagnostic tests Includes pathology tests, laboratory tests, radiology, MRI scan, CT Scan, PET scan and the like					
Vaccinations for children Routine Immunisations for children and adolescents					
Vaccinations for adults Preventative vaccinations and when traveling to gain access to the country					
Prenatal Care Routine check-ups and screening					
Alternative Medicine › Practitioner › Chiropractor › Osteopath › Acupuncturist › Homeopath	Not covered	Not covered	Not covered		
Surgical and/or medical appliances › Orthopedic devices › Hearing aids › Wheelchairs › Hospital bed › Standing frame › Rollator › Special bra following breast amputation › Wig › CPAP Machine	$500	$1,000	$1,500		
Physiotherapy	10 sessions	10 sessions	10 sessions		
Prescription drugs	$500	$1,000	$1,500		
Dental treatment following injury	$500	$1,000	$1,500	$2,000	$2,500



Step 2 – Enhanced	Option 1	Option 2	Option 3	Option 4	Option 5
Outpatient (cont.)					
Psychiatric care	$500	$500	$1,000	$1,500	$1,500
Additional Therapies › Ergotherapy › Occupational therapy › Logopaedics › Speech therapy	Not covered	Not covered	Not covered	50% reimbursed up to $1,500	50% reimbursed up to $1,500
Infertility treatment * Diagnosis and treatment	Not covered	Not covered	Not covered	Not covered	50% reimbursed up to $15,000 for each insurance year and $7,500 per fertilisation attempt

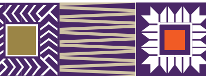
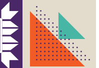
* Waiting periods may be applied to these benefits when full medical underwriting is required.

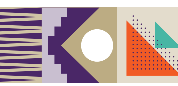
Step 3 – Complete	Option 1	Option 2	Option 3	Option 4	Option 5
Dental Treatment					
Annual maximum benefit	$500	$750	$1,500	$3,000	$4,500
Investigative and preventative dental treatment	Paid in full				
Basic restorative treatment and minor periodontal treatment	Paid in full				
Major restorative treatment and major periodontal treatment *	50% reimbursement				
Vision Care					
One eye examination per insurance year	Paid in full				
Ophthalmological care › Lenses to correct vision › Eyeglass frames › Prescription sunglasses	$100	$150	$300	$450	$600

* Waiting periods may be applied to these benefits when full medical underwriting is required.

Hollard Insurance Zambia Limited, with its registered office at: Stand No 2374, Pangea Office Park, Off Great East Road, Private Bag 891, Lusaka, Zambia (Registration Number 91794).

Hollard Health International, is a protected cell in Manzillo Insurance (PCC) Limited, with its registered offices at: Second Floor, Block A, Lefebvre Court, Lefebvre Street, St Peter Port, Guernsey, GY1 2JP and is regulated by the Guernsey Financial Services Commission (Registration No. 35007).



Area of cover map

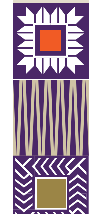
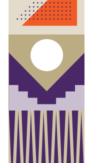
Area 1
Africa & India

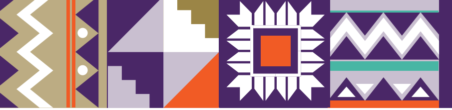
Area 2
Africa, India and Europe

Area 3
Worldwide
(excl. the USA)

Area 4
Worldwide

In partnership with



When you review the benefit overview, the following definitions or explanations on a benefit may provide you with some clarity on certain points. If you want a full understanding of all the benefits the very best thing to do is to read our policy wording.

Paid in Full

The amount of the claim that will be fully paid by the *insurer*, subject to the annual maximum benefit.

Annual Maximum Benefit

We will not pay more than the annual maximum benefit stated in the benefits overview for any *treatment*, claim or expense. The annual maximum benefit is the total payable for the sum of all benefit claims for a single insured person over an insurance year, subject to the limits and limitations set out in the benefits overview.

Chronic condition

a) A chronic condition is defined as an illness which has 2 (two) or more of the following characteristics:

- i) is recurrent in nature
- ii) is without a known and generally recognised cure
- iii) is not generally deemed to respond well to treatment
- iv) requires palliative treatment
- v) requires prolonged supervision or monitoring
- vi) leads to you becoming a permanent invalid.

b) If you are diagnosed with a chronic condition, we will reimburse charges incurred for the treatment of this condition performed by:

- i) a hospital, or
- ii) a recognised and legally registered treatment centre, and/or
- iii) a specialist doctor in the chronic condition.

c) Charges for the treatment includes any prescription drugs.

Emergency transport, evacuation and out of country care

Should you have a medical emergency, or should medical care not be locally available, we will pay to transport you to the closest, most suitable hospital that can provide you with the required care. The type of transport is limited to either a road ambulance, air-ambulance or commercial flight. We will also pay the costs of a commercial flight (or the air-ambulance if it can accommodate them) for 1 (one) close family member.

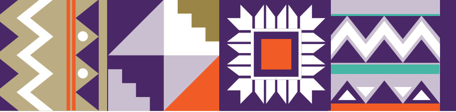
a) Decisions relating to locally available medical care will be made by us according to the following criteria:

- i) Adequate treatment must not be available in the host country for an expatriate and home country for local employee. We will consider both the availability and quality of treatment.
- ii) A referral letter from the local treating physician must be provided.
- iii) Where you are an expatriate, the care cannot be postponed till you are scheduled to return to your home country for a holiday, rest or family visit.

b) Approval of an air-ambulance will be subject to the following criteria:

- i) A domestic road ambulance must not be reasonably able to transport you to the closest, most suitable hospital that can provide you with the required care.
- ii) The use of an air-ambulance must be faster than a domestic road ambulance.
- iii) The urgency with which the treatment is required must make it medically necessary to transport you as quickly as possible.
- iv) The air-ambulance must be able to safely access and land at your location.

c) If you are transported to a hospital that is not in your home country or host country and you are unaccompanied by a close family member, we will pay the costs of transport for a close family member to join you.



Frequently asked questions

Caring for employees and their families

1. **How can employees access their benefits and use your services?**

   We have a combination of a web-portal and an app which provides our members full visibility on their personal information, the policy benefits and our Network. They can submit and track their claims on these platforms. If they need a personal touch, they can contact us 24/7/365 on our call centre. In several countries we have toll-free and local phone numbers, as well as a call-back service if they just let the phone ring twice, but we are finding that, more and more, people prefer our digital chat functionality.

2. **Which languages will you provide services in?**

   We will always have team members available who speak English, Portuguese and French. For other languages we can tap into our diverse team as well as a professional translation service. We want to be sure that your people can be assisted in the language they feel most comfortable speaking, knowing that some of the conversations that take place can be stressful.

3. **What is your promise on claims payments?**

   We know that when you have paid for treatment out of your own pocket, it is important to get back what is due to you as quickly as possible. Once all the information is submitted to us, we strive to pay 90% of our members in less than five working days.

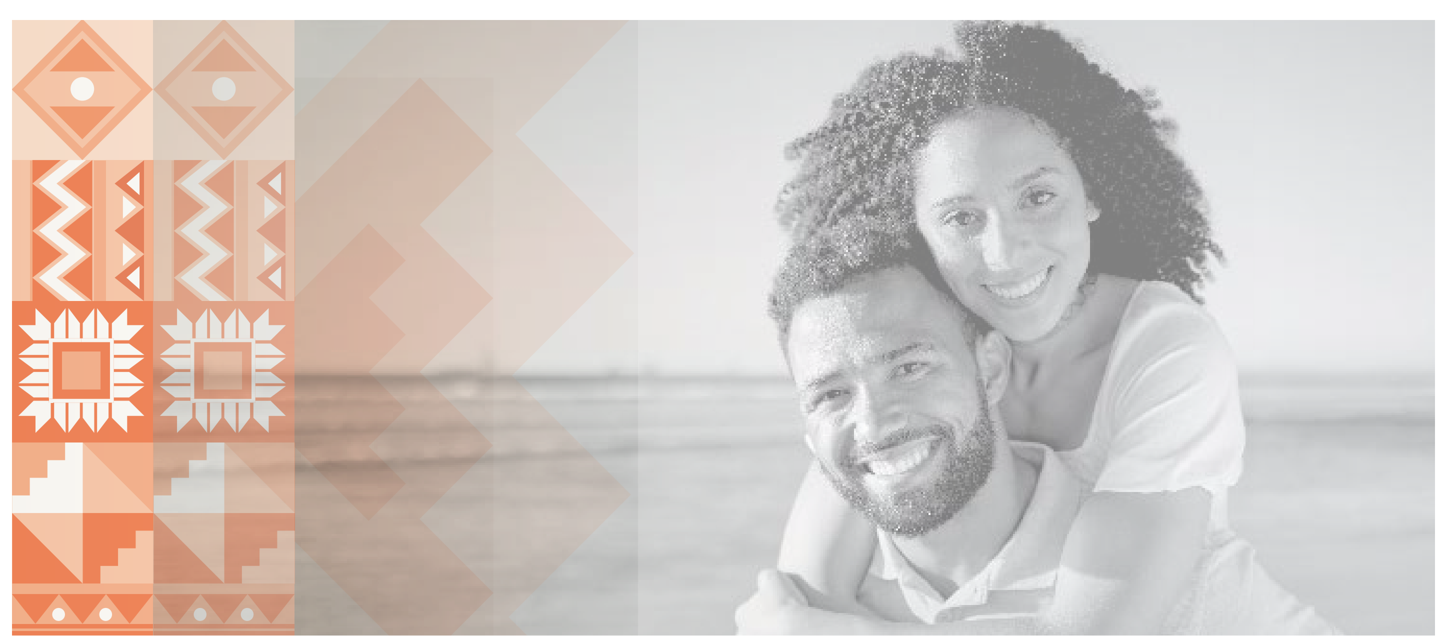
4. **Do you give out physical membership cards?**

   Everyone has a digital card within their app but we can also provide a physical card – you will be able to specify if you require both.

5. **What happens if someone needs to be hospitalised?**

   For non-emergency treatment, pre-approval must be obtained from us. Our goal is to provide 80% of the necessary approvals to the member and/or the provider within three working days and the balance within five working days. For emergency hospital admissions, we must be informed within 48 (forty-eight) hours unless there are extenuating circumstances. When there is a medical emergency our network providers know, first and foremost, to focus on providing you with the emergency care you need, and we work together in the background to provide the necessary approvals within two hours.

   If a member does not comply with these requirements, we will apply a penalty of 25% (twenty-five percent). This means that a reimbursement of only 75% (seventy-five percent) of the amount due will be paid.



Adding groups and employees

1. **When can medical underwriting be waived?**

   If a group of 10 or more employees is enrolled, we may waive the requirement for medical underwriting. Our decision will be based on our assessment of the risk profile of the group. If we waive the requirement for health declarations, it means that there will be immediate and full acceptance of the employees and dependents you want enrolled.

2. **If medical underwriting results in a decision to load the premiums are there any other options?**

   In most cases we will give the option for an exclusion of the medical condition, that led to the loading to be applied. But there are some conditions that have a wide-spread affect on many systems in the body, in which case we will not approve the option for an exclusion. That said, we will always recommend accepting the loading, to ensure that the individual has the cover they need to take good care of their health.

3. **If we switch to you while an employee is undergoing treatment, what will happen?**

   If there are more than 10 employees, there should be no impact at all, we will follow through on any treatment that has already been approved by the current insurer, so long at this is in line with our policy limits, conditions and exclusions. If there are less than 10 employees, we may apply a loading or exclusion in the medical underwriting process.

4. **Who sets the rules for who may be included on the policy?**

   The employer sets the rules for who may be included on the policy and may choose from one the following rule sets:

   a) Compulsory for all employees only
   b) Compulsory for all employees and their dependents
   c) Compulsory for a specific category of employees
   d) Compulsory for a specific category of employees and their dependents

   The category of employees will be declared in the application form. The purpose of categorisation is to ensure that a clear group of individuals can be defined and that all employees who fit into this description will be included.

5. **When do you view someone as a dependent?**

   The following people, who are financially dependent on the main insured person:

   a) Legal spouse or spouses (or legal partner or legal partners)
   b) Unmarried children until the end of the insurance year in which the insured child turns 26 years of age

6. **Is there anything important we need to remember when adding new-born babies?**

   You can cover not only new-born babies but also adopted children, or wards, just remember that the application must be made within two months of the birth, adoption or guardianship, to avoid medical underwriting being required. As soon as they are added, the child will have full cover from the date of birth, adoption or guardianship.

7. **What is the maximum age for a new member?**

   You can only enrol employees and spouses who are younger than 65 years of age. If they have not been enrolled before their 65th birthday, they are not eligible for cover.

8. **Can the employer decide mid-way through the year to change the plan selection or area of cover?**

   Ordinarily this type of change can only be made at renewal. However, if a member is relocating to a country that is not within the area of cover originally chosen by the employer, then we will need to amend it. You will need to get our approval for the country the member is moving to and remember that an entire family must have the same area of cover. If the member is moving to the US, and the plans selected are for Options 1 or 2 in any of our steps, then the member and all the dependents will have to move to a higher plan.

More about certain benefits and conditions

1. Is there cover if there is an epidemic or pandemic?

Most definitely, we do not have any exclusion for treatment in the event of an epidemic or pandemic. But, as we have all seen of late, as much as an evacuation may be desirable in some cases it will be impossible if the preferred destination country is not open to people with the illness.

2. Worried about employees and dependents with chronic conditions?

For people who suffer with chronic conditions, we all know that the medication they may have to take just to manage the condition, as well as the monitoring required by a specialist doctor, could quickly deplete their outpatient benefits. We believe that the outpatient benefits should be there for the day-to-day treatment needs, prenatal monitoring and first diagnosis. To make sure that people with chronic conditions don't find their benefits depleted before most other people and so struggle to remain on top of their treatment protocol, we have included Chronic Conditions in our Condition Management section, which will cover treatment in a hospital or recognised treatment centre, as well as the cost of their specialist doctors and prescription drugs.

3. What do you consider to be a chronic condition?

The below is a list of conditions, but these are not intended to be the only conditions that we will cover as there are many more, these are just the most common. If someone's condition is not listed on the table, they can submit the details to us for evaluation on if it is of comparable seriousness, considering that our definition of a chronic condition is that it is an illness which has two or more of the following characteristics:

a) is recurrent in nature
b) is without a known and generally recognised cure
c) is not generally deemed to respond well to treatment
d) requires palliative treatment
e) requires prolonged supervision or monitoring
f) leads to you becoming a permanent invalid.

Addison's disease	Coronary artery disease	Glaucoma
Asthma	Crohn's disease	Haemophilia
Bronchiectasis	Diabetes insipidus	Ulcerative colitis
Cardiac failure	Diabetes mellitus types 1 & 2	Systemic lupus erythematosus
Cardiomyopathy	Dysrhythmias	Rheumatoid arthritis
Chronic obstructive pulmonary disorder	Epilepsy	Parkinson's disease
Chronic psychiatric afflictions	Hypothyroidism	Hyperlipidaemia
Chronic renal disease	Hypertension	Multiple sclerosis

One other point that links to chronic conditions is that we do not exclude congenital or hereditary defects.

4. Are people covered in the event of a war?

If a person is an active participant in a war or act of terrorism, they will not enjoy cover under the policy. But should a person be a victim of an act of war or terrorism they will be covered. If war (or a war-like situation) breaks out whilst a person is a visitor to a country (for business or leisure purposes), they will need to leave the country in 14 days to avoid their cover ceasing.

Common concerns for members

We have seen from some questions we get from members, asking us to include or change certain benefits, that we need to ensure that we highlight to you certain key points on questions asked.

1. **Why can I or my spouse only have a mammogram, prostate screening or pap smear at certain time intervals or ages?**

   The time intervals and ages we provide are in line with the World Health Organisation's guideline for preventative care. But these only apply if the insured person is asymptomatic. They will also not apply if your doctor deems it is medically necessary to test sooner or more frequently. In other words, if you have a concerning symptom that your doctor prescribes one of these screenings to support a diagnosis you can have it. Furthermore, if you have a personal or family history that puts you into a higher risk category for any of the conditions that the preventative screenings test for, you can submit your doctor's recommendations for the screenings.

2. **What happens if my baby needs treatment immediately or very soon after it is born?**

   If your baby needs treatment immediately or very soon after birth, we will issue a guarantee of payment for this care under the mother´s plan. This care is subject to the benefit limits that are in place on the mother's plan. Also, this can only be activated if the membership rules allow for the addition of dependents. As soon as practical, you need to advise your employer to add the baby to the policy (remember this must be done by no later than two months from the date of birth).

3. **Are congenital and hereditary illnesses or defects covered?**

   We do not exclude congenital or hereditary illness or defects, so this means that all of the benefits and treatments available can be utilised for such conditions. Remember that some may even fall under the chronic condition benefit.

4. **Is orthodontics covered and are there any limitations we need to be aware of?**

   Orthodontics is covered as a Major restorative treatment under the Dental treatment benefit. This is only covered for children under the age of 18.

5. **Should a member require an organ transplant, who pays the living donor's costs?**

   Charges incurred for the living donor, including the donor's preliminary tests, surgery and post-operative recovery are covered under the insured person's plan, remembering that the sum of both parties' treatment will be subject the benefit limits and the annual maximum benefit.

   The following expenses are excluded:

   a) Costs related to the search for a donor.
   b) Costs for acquisition of the organ (in case a price is charged for the organ).
   c) Costs incurred for the transport of the living donor or the donor organ and/or any other financial compensation to the donor.

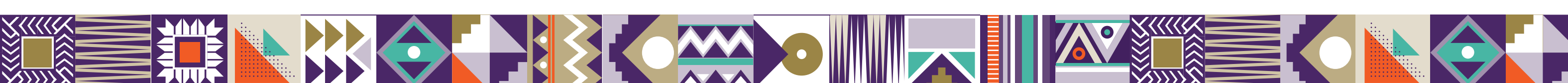
6. **Many insurers seem to exclude treatment required because of drugs, alcohol or suicide; how do you respond?**

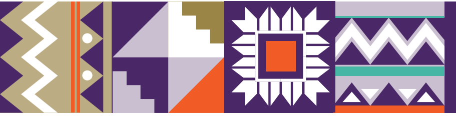
   We understand that addiction and depression are clinical conditions, and so we make provision for an insured person to receive treatment for up to $150,000 per lifetime for treatment that arises from or is in any way connected with attempted suicide, drug and/or alcohol addiction, including the costs of registered rehabilitation treatment centres. The treatment required will be covered in terms of the benefit that applies and any limit or sub-limit at the time of claiming.

7. **Are Autism and Attention Deficit Disorders covered?**

   We do not exclude these conditions, this means that so long as the medically necessary treatment (in line with best practice) as prescribed by a doctor is listed and included under the benefits, it will be covered.

We have tried to highlight in these frequently asked questions some key items that most people want to know. However the best way to understand the rules, exclusions and benefits is to read the policy wording. We have tried to write it in a way that is easy to understand and would appreciate your feedback if you find any points to not be clear and concise.





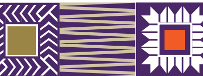
We are committed to providing world-class service and hold ourselves to the below targets and are proud of how often we do even better than expected.

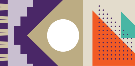
ACTIVITY	KPI	TARGET
OPERATIONS MANAGEMENT		
Claims paid to members	Average TAT between date of receipt of claim and date of claim validation	5 days
Guarantee of Payment	Average TAT from request to issuance of the GOP	5 days
E-mails	Average TAT from reception to answering of the email	2 days
Calls	Call abandonment rate % of calls answered within 15 seconds	<=3% 80%
Complaints	Average TAT from when we receive the complaint to the closing of it	90% <5 days
Movements	Average TAT from request to processing of the movement	5 days

Toll-free or Local numbers

We are also proud of our ever-growing list of local phone numbers available for members. This means our members can reach out to us from the country they live in or may be visiting, in the most reliable and cost-effective way possible.

We already have 17 local numbers, soon 20 and more.





EVERYONE HAS A ROLE TO PLAY

By pulling together the best that everyone has to offer, we bring you world-class service, legal compliance and local know-how, all put together with our customers at the center of all we do.

Local Insurer
Insurer of reference
Sort regulatory compliance
Pay local taxes
Physical presence and knowledge
Local sales and account management

Hollard Health International (a protected cell within Manzillo Insurance (PCC) Ltd)
Reinsurer to Local Insurers
On some expat programs the insurer of reference

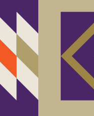
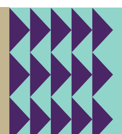
Hollard Health (Pty) Ltd
Pan African Sales
Product design
Pricing and technical underwriting
Account Management
Membership additions and removals
Billing and credit control
Broker commission calcs and recons

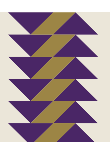
AXA PPP Healthcare Limited
Reinsurer to HHI
Develop commercial opportunities in Eastern & Southern Africa
Support to pricing and technical underwriting

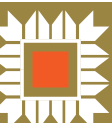
Henner SAS
Manage the 24/7/365 member engagements
- Web portal and App
- Telehealth and 2nd opinion

Administer claims
Manage network
Manage the evacuation provider

Health Mov
Creator of the HealthMov App
Manager of the rewards provider
Manager of the health dashboards





THE VALUE OF HOLLARD

We started here

Hollard was born in Africa and our ways are inspired by each region we serve. We are financially sound and remain fully invested in Africa.

Established in 1980, we provide short-term and life insurance as well as investment products to a diverse customer base, including individual consumers, commercial entities and corporate clients.

We are purpose-driven and measure our social dividends alongside our shareholder contributions. Since inception, 'partnership' has been at the heart of our business model, with the group today boasting over 100 ventures across the insurance value chain. Each one supports our purpose of enabling more people to create and secure a better future.

Our group touches more than 4 million policyholders, we employ more than 3 000 people across the globe and have posted over $2,5bn in premium income in the year to June 2021.

As a Hollard customer you can expect to be treated with respect, dignity and above all, a sense of common humanity. We expect to be held to the highest standards and whilst we can't claim to always get it right, we never stop enhancing and innovating, enabling more people to create and secure better futures.

ACTING FOR HUMAN PROGRESS BY PROTECTING WHAT MATTERS

AXA PPP Healthcare Limited trading as AXA Health is part of the AXA Group, one of the world's leading insurance brands.

Present in 51 countries, AXA's 145,000 employees and distributors are committed to serving our 93 million clients. Our areas of expertise are applied to a range of products and services that are adapted to the needs of each and every client across three major business lines: property-casualty insurance, life & savings, and asset management.

AXA's deep-rooted DNA to bring positive impacts to society and the environment is driven by its employees. Skilled, motivated and purpose-driven people enable the Group to act for human progress by protecting what matters to our customers.

The Group achieves this through a culture built on AXA's values and a working environment that embraces the individual contributions of all, nurtures personal learning and development, and supports employee well-being in current smart ways of working.

If you would like to find out more about AXA, please visit axa.com.

HOLLARD ZAMBIA - WHO WE ARE

Hollard Insurance Zambia Limited was founded in 2010 as a general insurance company and Hollard Life Assurance Zambia Limited was launched in 2011. We have seen consistent revenue growth ever since, with over 10,000 Short-Term policy holders and over 12,000 Life policy holders. We have branches in Lusaka, Kitwe, Solwezi, Mansa and Kasama.

Hollard Insurance is an authorised general insurance provider and Hollard Life Assurance is an authorised life assurance provider. We offer a wide variety of insurance products and risk management services for our customers' personal and business insurance needs.

We strive to be an intelligent, passionate team of insurance partners, offering quality general and life insurance solutions with utmost integrity. Our team works with a wide portfolio of clients ranging from individuals to retailers, banks, mining houses, government institutions and multinational organisations.

Through our innovative business insurance partners and products, we offer solutions tailored to address the very specific needs and objectives of our customers. These solutions are cost-effective and flexible, from Credit Life to Group Funeral cover and more.

HENNER - HERE TO CARE

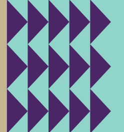
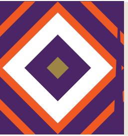
Henner, an international and independent group created in 1947 in France, is a leading expert in consulting, designing, and managing innovative international healthcare solutions. With a strong international presence in 4 continents, our company has 1 550 employees in Europe, Asia, Africa and North America.

Active in all segments of health and life insurance – medical, death and disability, retirement – over 15,000 companies and organizations of all sizes trust Henner to manage insurance plans for over 2 million members.

As an independent Third-Party Administrator, Henner has always placed its clients at the center of its business model. Thanks to this approach and to our 75 years of experience in the field of Medical Insurance, our Client relationships last for an average of 26 years.

Henner has clients from a vast range of sectors, which gives us a unique perspective to understand and anticipate market trends and deliver solutions tailored to their own specific needs. To ensure that members have access to care wherever they are, the Group has built up one of the strongest proprietary global network of healthcare partners in the industry.

We strive to deliver a unique member experience and state-of-the-art services to our members. Our holistic approach towards health management, innovative approach towards cost-containment and continuous investment in our medical and wellbeing services supports our clients in creating healthier populations and sustainable health plans.

OUR FOOTPRINT

Our in-country insurers provide us our valued admitted status. We will continue to grow our footprint to ensure we can assist you with more and more of the local national residents across Africa.

Admitted

Expats only

Cannot assist

Ghana – PREMIER HEALTH INSURANCE, Your bridge to premier healthcare

Nigeria – NSIA INSURANCE

Democratic Republic of Congo – SFA Société Financière d'Assurance

Angola – unisaúde seguros

Zambia – Hollard.

Namibia – Hollard.

Botswana – Hollard.

Kenya – APA INSURANCE, GENERAL • LIFE • HEALTH

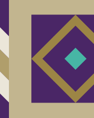
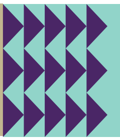
Tanzania – RESOLUTION INSURANCE

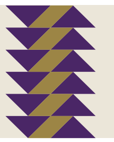
Mozambique – Hollard.

Zimbabwe – CELLMED HEALTH MEDICAL FUND

Hollard. Lesotho

Mauritius



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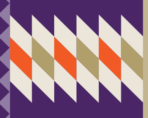
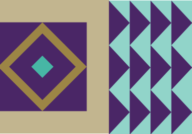
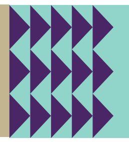
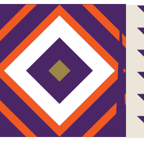
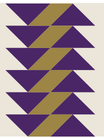
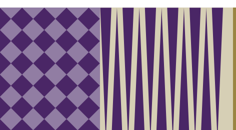
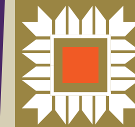

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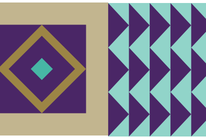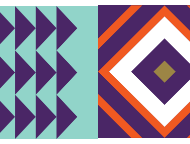 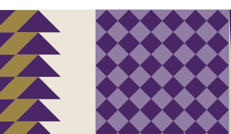 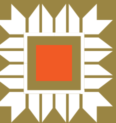

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