Allianz Care

Benefit Guide

International Healthcare Plans Flexible solutions in partnership with Talent Trust

Talent Trust

Welcome

You and your family can depend on Allianz Care, as your international health insurer, to give you access to the best care possible. This Allianz Care's insurance solution is offered in partnership with Talent Trust, an association created for the benefit of charitable vocational groups and their dependants; Talent Trust's mission is to provide services and access to services for its members.

Talent Trust is the policyholder in this insurance contract with Allianz Care. When you choose to subscribe for this Allianz Care product, you do so as members of Talent Trust's group policy. In this document and in the policy documentation in general, we refer to Talent Trust members as 'members' or 'insured persons'.

This guide has two parts: 'How to use your cover' is a summary of all important information you are likely to use on a regular basis. 'Terms and conditions of your cover' explains your cover in more detail.

To make the most of your international healthcare plan, please read this guide together with your Insurance Certificate and Table of Benefits.

How to use your cover

Terms and conditions of your cover

This is an international health insurance policy designed for members of vocational groups. This policy is written, concluded, issued and delivered from Ireland by AWP Health & Life SA, Irish Branch.

AWP Health & Life SA is regulated by the French Prudential Supervisory Authority located at 4 place de Budapest, CS 92459, 75 436 Paris Cedex 09.

AWP Health & Life SA, acting through its Irish Branch, is a limited company governed by the French Insurance Code. Registered in France: No. 401 154 679 RCS Bobigny.
Irish Branch registered in the Irish Companies Registration Office, registered No.: 907619, address: 15 Joyce Way, Park West Business Campus, Nangor Road, Dublin 12, Ireland.
Allianz Care and Allianz Partners are registered business names of AWP Health & Life SA.

How to use your cover

Support services

We believe in providing you with the top-quality service that you deserve. In the following pages we describe the full range of services we offer. Read on to discover what is available to you, from our MyHealth Digital Services to the Expat Assistance Programme.

Talk to us, we love to help!

Talent Trust's Helpline is available to handle any questions about your policy or if you need assistance in an emergency.

Helpline

Talent Trust's Helpline: **+60 (4) 899 8945 (Monday to Friday, 10am to 6pm +8GMT)**

Email: **info@talent-trust.com**

Did you know...

...that most of our members find that their queries are handled quicker when they call us?

MyHealth Digital Services

Through MyHealth, available as a mobile app and online portal, you have easy and convenient access to your cover, no matter where you are or what device you are using.

MyHealth app and online portal features

My claims
View your claims history.

My contacts
Access Allianz Care's 24/7 multilingual Helpline. Live chat is also available (in English and on the online portal only).

Symptom checker
Get a quick and easy assessment of your symptoms.

Provider finder
Locate medical providers nearby.

Pharmacy aid
Look up the local equivalent names of branded drugs.

Medical term translator
Translate names of common ailments into 17 languages.

Emergency contact
Access local emergency numbers worldwide.

NOTE: on MyHealth you can find a 'My Policy' feature where policy documents can be accessed; however, this will not be available to you as you avail of a special solutions with special policy documentation offered via Talent Trust. You will also find that the 'My Claims' feature allows claim submission via the app/portal; however, please note that this feature is switched off for you, as your reimbursement claims are processed by Talent Trust.

Getting started:

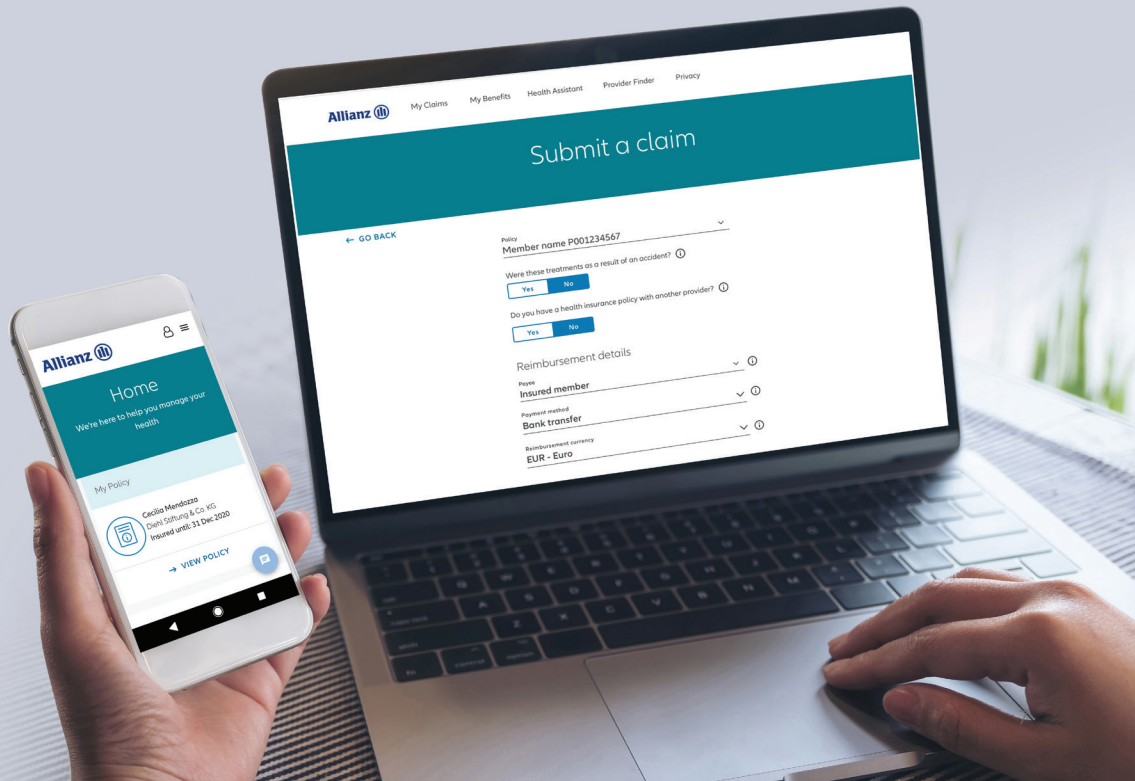
1. Login to MyHealth online portal to register. Go to **my.allianzcare.com/myhealth**, click on 'REGISTER HERE' near the bottom of the page and follow the on-screen instructions. Be ready to provide your policy number.

2. As an alternative, you can register via our MyHealth App. To download it, search for 'Allianz MyHealth' on the Apple App Store or Android's Google Play service.

   Download on the App Store GET IT ON Google Play

3. Once set up, you can use the email (username) and password you provided during registration to login to MyHealth online portal or app. The same login details are used for both and in the future, if you change login details for one, it will automatically apply to the other. You don't need to change them in both places. We also offer a biometric login option for the app, for example Touch ID or Face ID, where supported by your device.

For more information, please visit **www.allianzcare.com/en/myhealth.html**



Web-based services

On **www.allianzcare.com/members** you can:

- search for medical providers (you are not restricted to using the providers listed in our directory).
- download forms.
- access our Health Guides.

Second Medical Opinion**

As your health partner, we aim to provide you with peace of mind. Have you been diagnosed with a serious illness or had surgery recommended? Do you want expert help on the best treatment options available and where to get the most appropriate treatment? As part of your cover you have access to our Second Medical Opinion service.

When you access this service, we assign to you a dedicated case manager, i.e. a healthcare professional from our own Medical Team to guide and assist you. Your case manager will ask you to provide all the necessary information about your medical case: then he/she will help you find a hospital, doctor or specialist for the Second Medical Opinion and provide the opinion to you.

To access our service, simply contact us:

+1 (877) 499 4809

medical.smo@e.allianz.com

...and ask for the Second Medical Opinion service. You will need to state your policy number for identification.

Olive – Allianz Care's Health & Wellness support program

Your first steps towards a healthier life.

In today's increasingly busy and ever-changing world we recognise the importance of staying healthy and we firmly believe that prevention is better than cure. Olive**, our proactive care engine, is designed to motivate and guide you towards a healthier life. It includes the Health and Wellness hub and our HealthSteps app.

1. Health and Wellness hub

Our Health & Wellness Hub, accessible via our MyHealth Digital Services (mobile app and portal), offers you a range of services gathered in one convenient place to support you on your journey to a long, happy and healthy life.

On the Hub you will have access to:

- Tips and articles on topics such as sleep, fitness, nutrition and emotional wellbeing.
- Online health assessments**.
- Our BMI calculator.
- Our monthly live health and wellness webinars, with Q&A session, delivered by specialists.

2. HealthSteps app**

Did you know that by maintaining a healthy lifestyle, you may reduce the risk of developing medical conditions? The Allianz HealthSteps app was designed to give personalised guidance and help you reaching your health and fitness goals. By connecting to smart phones, wearables devices and other apps, HealthSteps monitors the number of steps taken, calories burned, sleep schedule and more.

HealthSteps features:

Plan
Choose a health goal and use the action plans to adopt and maintain good health habits:

- Lose weight
- Improve posture
- Sleep better
- Eat healthy
- Get moving and energised
- Stay healthy
- Reduce stress
- Lower blood pressure

Challenges
Join monthly challenges and get encouragement from other HealthSteps users by sharing your performance and competing against each other on group challenges. These challenges are based on steps, calories and distance.

Progress
Connect with popular health and activity trackers and monitor your progress against goals you set for yourself.

Library
Access articles and get tips and advice on how to live and maintain a healthy life.

Download the 'Allianz HealthSteps' app from App Store or Google Play.

Video consultation services via Telehealth Hub**

If your plan includes the 'video consultation' benefit , you have direct access to online doctor appointments where a provider is available in your geographical location.

With the Telehealth Hub, you can save time by seeing a doctor via video from the comfort of your own home or office. Offering a secure and confidential service, our telehealth network of doctors can provide medical advice, recommend treatments and offer prescriptions for non-emergency concerns.

The service is accessible via MyHealth portal or directly via our TeleHealth platform at:

www.allianzcare.com/telehealthhub

An appointment can be made to speak to a medical practitioner in English, subject to availability. Some third party providers may offer the service in additional languages.

Depending on your geographical location, local country regulations and insurance plan coverage, the teleconsultation service may also offer prescriptions.

In countries where a teleconsultation service is not yet available, you can always call our 24/7 medical advice helpline – this service is offered in English, German, French and Italian. The phone number is available on TeleHealth Hub.

Expat Assistance Programme (EAP)**

When challenging situations arise in life or at work, our Expat Assistance Programme provides you and your dependants with immediate and confidential support. EAP, where provided, is shown in your Table of Benefits.

This professional service is available 24/7 and offers multilingual support on a wide range of challenges, including:

- Work/Life balance
- Family/Parenting
- Relationships
- Stress, depression, anxiety
- Cross-cultural transition

Support services include:

Confidential professional counselling
Receive 24/7 support with a clinical counsellor through phone, video, email or face to face.

Critical incident support
Receive immediate critical incident support during times of trauma or crisis. Our wide-ranging approach provides stabilization and reduces stress associated with incidents of trauma or violence.

Legal and financial referral services
Whether it's help buying a home, handling a legal dispute or creating a comprehensive financial plan, we will refer you to a third-party advisor who can help answer your questions and reach your goals.

Access to the wellness website and app
Discover online support, tools and articles for help and advice on health and wellbeing.

Let us help:

+1 905 886 3605

This is not a free phone number. If you need a local number, please access the wellness website and you will find the full list of our 'International Numbers'.

Your calls are answered by an English-speaking agent, but you can ask to talk to someone in a different language. If an agent is not available for the language you need, we will organise interpreter services.

www.allianzcare.com/eap-login (available in English and French)

Download the TELUS Health One app in Google Play or Apple Store:

Login on the website or the app using the following details:

Username: AllianzCare
Password: Expatriate

Travel Security Services**

As the world continues to witness an increase in security threats, Travel Security Services offer 24/7 access to personal security information and advice for your travel safety queries – via phone, email or website. Your Table of Benefits shows whether your plan includes these services.

You can access:

Emergency security assistance hotline
Talk to a security specialist for any safety concerns associated with a travel destination.

Country intelligence and security advice
Security information and advice about many countries.

Daily security news updates and email travel safety alerts
Sign up and receive alerts about high-risk events in or near your current location, including terrorism, civil unrest and severe weather risks.

- To access the Crisis24 Horizon desktop website, go to **crisis24horizon.com/allianztravsec**, add your email address and select Create Account. Enter your details and add the Member ID of **ALLIANZTSS.**

- To access the Crisis24 Horizon mobile app, download either the Android or iOS version to your mobile device (you can also search for Crisis24 Horizon in either store), then **sign in** using the same email (username) and password you created above. You can also register directly on the mobile app using the Member ID.

crisis24horizon.com/allianztravsec

Download the Crisis24 Horizon app from App store or Google Play.

Download on the App Store

GET IT ON Google Play

All Travel Security Services are provided in English. We can arrange for you to use an interpreter where required.

*** Certain services that may be included in your plan are provided by third party providers outside the Allianz group, such as the Expatriate Assistance Programme, Travel Security services, HealthSteps app, Second Medical Opinion and tele-medicine services. If included in your plan, these services will show in your Table of Benefits. These services are made available to you subject to your acceptance of the terms and conditions of your policy and the terms and conditions of the third parties. These services may be subject to geographical restrictions. The HealthSteps app does not provide medical or health advice and the wellness resources contained within Olive are for informational purposes only. The HealthSteps app and the wellness resources contained within Olive shouldn't be regarded as a substitute for professional advice (medical, physical or psychological). They are also not a substitute for the diagnosis, treatment, assessment or care that you may need from your own doctor. You understand and agree that AWP Health & Life SA (Irish Branch) and AWP Health & Life Services Limited are not responsible or liable for any claim, loss or damage, directly or indirectly resulting from your use of any of these third party services.*

Understanding how your cover works

Who is eligible for cover?

You are eligible for this insurance offered in partnership with Talent Trust if you are:

1. a member of Talent Trust, and
2. an active member of a vocational group (see definition for 'Vocational group'), and
3. are travelling outside of your home country to fulfil your charitable work.

You can include in your cover any family member who is financially dependent on you (see definition for 'Dependant').

What is my geographical area of cover?

Your geographical area of cover is the area of the world where your cover is valid for eligible treatment. Please refer to your Table of Benefits to confirm which area of cover applies to your policy.

Note that cover in some countries is subject to local health insurance restrictions, particularly for residents of that country. It is your responsibility to ensure that your health cover is legally appropriate. If you are not sure, please get independent legal advice, as we may no longer be able to cover you. The cover we provide is not a substitute for local compulsory health insurance.

Also:

- Our policies are international health plans and are intended for international use. They are not intended as a replacement for domestic insurance products for citizens or residents of Malaysia.
- Regarding the USA: this cover doesn't meet the requirements of the comprehensive healthcare reform law of March 2010 (also referred to as ACA, PPACA, or 'Obamacare') and is not recognised as 'minimum essential cover'. If you are a US citizen residing inside or outside the USA and you are required to maintain minimum essential cover, you should seek cover under a US domestic health insurance plan. It is your responsibility to ensure that your healthcare cover is legally appropriate. We strongly recommend that you seek independent advice in this regard.

What am I covered for'?

You and your dependants are covered for medically necessary treatment and related costs, services and supplies arising from the occurrence or worsening of a medical condition, in accordance with your Table of Benefits. Within the scope of your policy, you are covered for medical treatment, costs, services or supplies that:

- we determine to be medically necessary, appropriate for the patient's condition, illness or injury.
- have a palliative, curative and/or diagnostic purpose.
- are performed by a licensed doctor, dentist or therapist.

Your cover is also subjected to:

- Policy definitions and exclusions (also available in this guide).
- Any special conditions shown on your Insurance Certificate (and on the Special Condition e-mail issued before the policy comes into effect, where relevant).
- **Costs being reasonable and customary** – these are costs that are usual within the country of treatment. We will only reimburse medical providers where their charges are in accordance with standard and generally accepted medical procedures. If we consider a claim to be inappropriate, we reserve the right to decline or reduce the amount we pay.

We do not cover pre-existing conditions (including pre-existing chronic conditions unless we say otherwise in your policy documents. If in doubt, please check your Table of Benefits to confirm if pre-existing conditions are covered.

If you are uncertain whether your planned medical treatment is covered under your plan, please contact us.

Call Allianz Care's Helpline: **+1 (877) 499 4809** (available 24 hours a day, 7 days of the week)

Or email Talent Trust: **info@talent-trust.com**

Where can I receive treatment?

You can receive treatment in any country within your area of cover, as shown in your Insurance Certificate. If the treatment you need is available locally but you choose to travel to another country in your area of cover, we will reimburse all eligible medical costs incurred within the terms of your policy; except for your travel expenses. If the eligible treatment is not available locally, and your cover includes 'Medical evacuation', we will also cover travel costs to the nearest suitable medical facility. To claim for medical and travel expenses incurred in these circumstances, you will need to complete and submit the Pre-authorisation Form before travelling. You are covered for eligible costs incurred in your home country, provided that your home country is in your area of cover

What are benefit limits?

The cover may be subject to a maximum plan limit. This is the maximum we will pay in total for all benefits included in the plan per member, per Insurance Year.

If your plan has a maximum plan limit, it will apply even where:

- the term 'Full refund' appears next to the benefit.
- a specific benefit limit applies - this is when the benefit is capped to a specific amount (e.g. US$ 10,000).

Benefit limits may be provided on a 'per Insurance Year' basis, on a 'per lifetime' basis or on a 'per event' basis (such as per trip, per visit or per pregnancy).

In some instances, in addition to the benefit limit, we will only pay a percentage of the costs for the specific benefit (e.g. 80%). This is called coinsurance or co-payment.

Benefit limits related to maternity

The benefits 'Routine maternity' and 'Complications of pregnancy and childbirth' are paid on either a 'per pregnancy' or 'per Insurance Year' basis. Your Table of Benefits will confirm this.

If your maternity benefits are payable on a 'per pregnancy' basis

When a pregnancy spans two Insurance Years and the benefit limit changes at policy renewal, the following rules apply:

- In year one – the benefit limits apply to all eligible expenses.
- In year two – the updated benefit limits apply to all eligible expenses incurred in the second year, less the total benefit amount already reimbursed in year one.
- If the benefit limit decreases in year two and we have already paid up to or over this new amount for eligible costs incurred in year one, we will pay no additional benefit in year two.

Limit for multiple-birth babies, all babies born by surrogacy, adopted and fostered children.

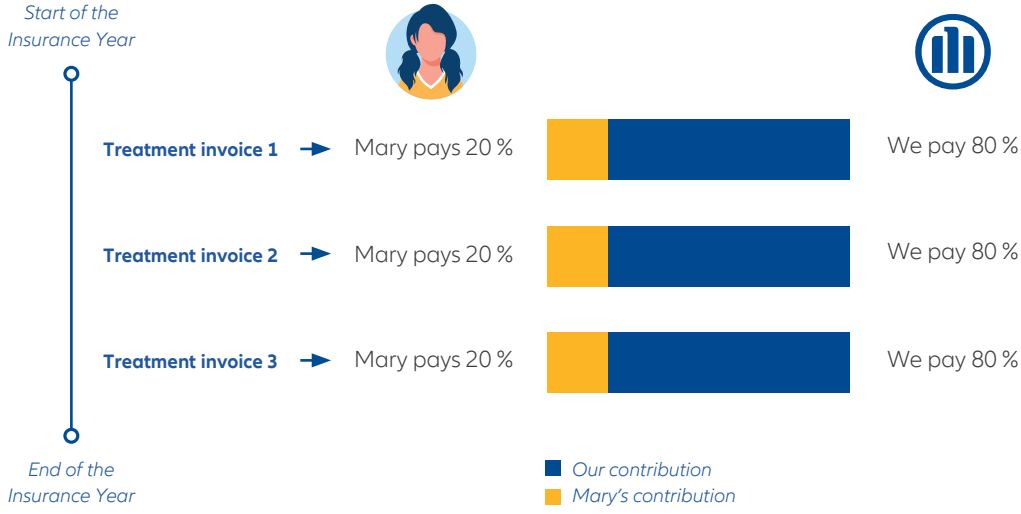
There is a limit for in-patient treatment that takes place in the first three months following birth if the baby:

- was born by surrogacy.
- is adopted.
- is fostered.
- is a multiple-birth baby born as a result of medically assisted reproduction.

This limit is US$ 40,500 per child. Out-patient treatment is paid under the terms of the Out-patient Plan.

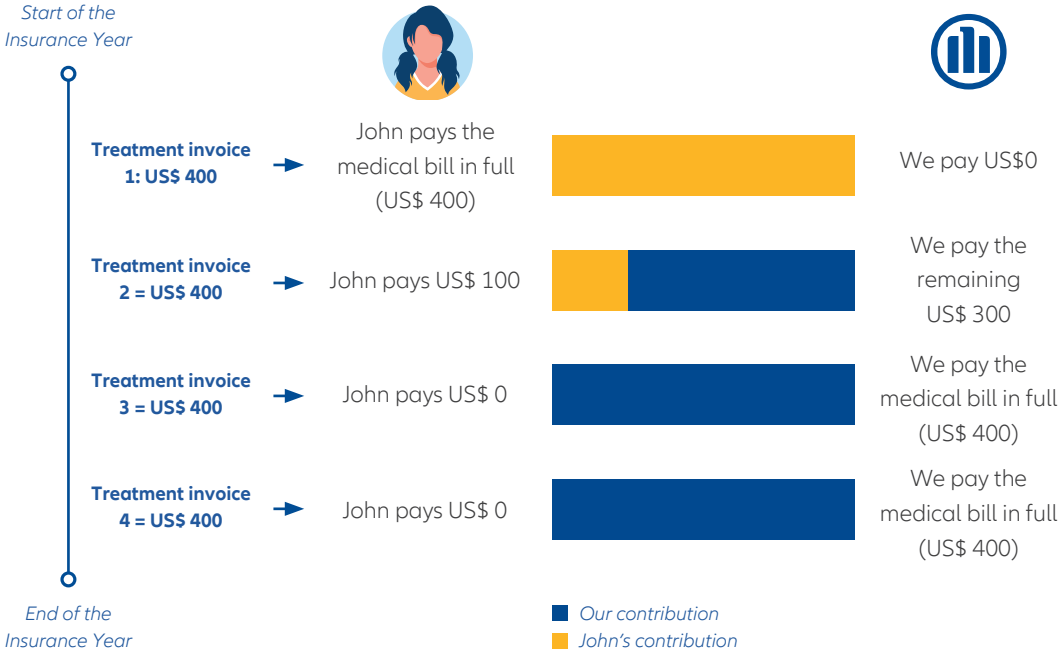
What are co-payments?

A **co-payment** is when you pay a percentage of the medical costs. Your Table of Benefits will show whether this applies to your plan and if it applies to treatment in a specific country. In the following example, Mary requires several dental treatments throughout the year. Her dental treatment benefit has a 20% co-payment, which means that we will pay 80% of the cost of each eligible treatment. The total amount payable by us may be subject to a maximum plan limit.



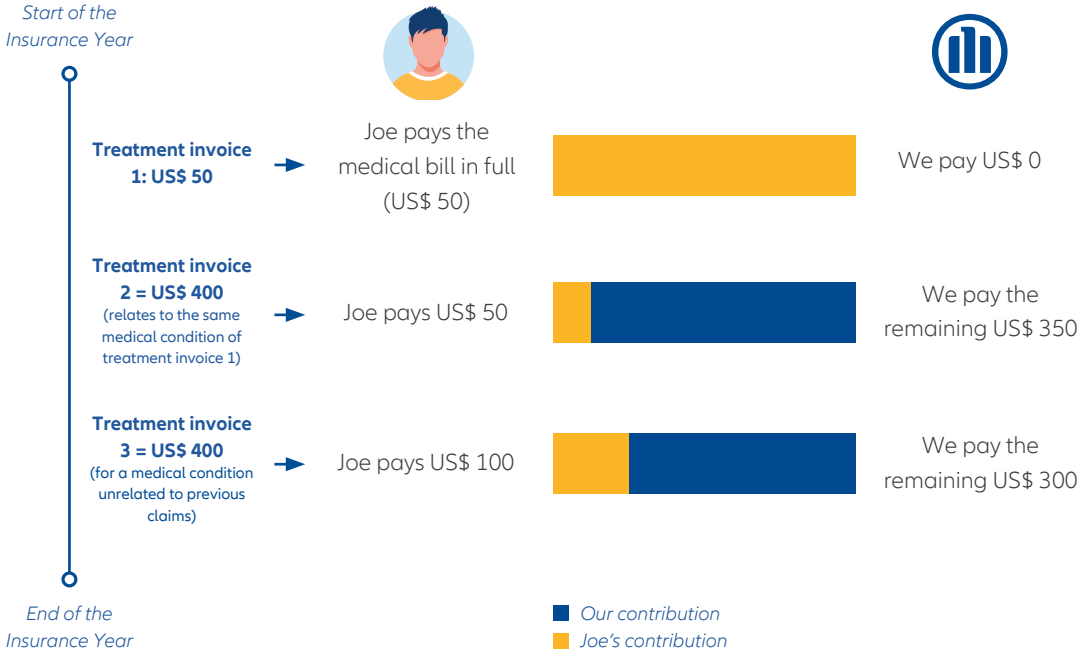
What are deductibles?

A **deductible** is a fixed amount you need to pay towards your medical bills per period of cover before we begin to contribute. Your Table of Benefits will show whether this applies to your plan. In the following example, John needs to receive medical treatment throughout the year. His plan includes a US$ 500 deductible.



What are excesses?

An **excess** is a fixed amount you need to pay towards your medical bills per condition and per person before we begin to contribute. The excess applies if your condition is unrelated to a previous claim.
Your Table of Benefits will show whether this applies to your plan. In the following example, Joe makes three separate claims throughout the year. His plan includes a US$ 100 excess.



Seeking treatment?

We understand that seeking treatment can be stressful. Follow the steps below so we can look after the details – while you focus on getting better.

Check your level of cover

First, check that your plan covers the treatment you are seeking. Your Table of Benefits will confirm what is covered. However, you can always call Talent Trust's Helpline if you have any queries.

Some treatments require our pre-authorisation

Your Table of Benefits will show which treatments require our pre-authorisation (via a Pre-authorisation form. These are mostly in-patient and high cost treatments. The pre-authorisation process helps us assess each case, organise everything with the hospital before your arrival and make direct payment of your hospital bill easier, where possible. We therefore highly recommend that you follow this process.

If you attend a direct settlement hospital, clinic or other medical facility in our medical provider network and we later determine that your claim is ineligible, we have the right to recover the full claim amount from you. If we pay a claim, it isn't an indication of our acceptance of liability for the claim or confirmation that we'll pay further costs for the same medical condition or related medical condition.

If we determine that a claim we've already approved is ineligible, we won't pay for the claim. If we've already paid any costs, you'll need to repay them to us within 14 days or we may withdraw any associated pre-authorisation, cancel your plan and keep the premium. If you'd like us to reassess a claim we've rejected, you'll have to prove that the claim is covered under the plan.

Getting in-patient treatment (pre-authorisation applies)

Please call Talent Trust's Helpline to obtain a copy of the Pre-authorisation form.

Complete the form and send it to us at least **five working days** before treatment.
You can send it by email, fax or post to the address shown on the form.

We contact the hospital to organise payment of your bill directly, where possible.

If it's an emergency:

Get the emergency treatment you need and call us if you need any advice or support.

If you are hospitalised, either you, your doctor, one of your dependants or a colleague needs to call the Allianz Care's Helpline (within 48 hours of the emergency) to inform us of the hospitalisation. We can take Pre-authorisation form details over the phone when you call us.

We can also take Pre-authorisation form details over the phone if treatment is taking place within 72 hours. Please note that we may decline your claim if pre-authorisation is not obtained, where required.

Claiming for your out-patient, dental and other expenses

If your treatment does not require our pre-authorisation, you can simply pay the bill and claim the expenses from us. In this case, follow these steps:

Receive your medical treatment and pay the medical provider.

Get an invoice and receipt from your medical provider. This should state your name, treatment date(s, the diagnosis/medical condition that you received treatment for, the date of onset of symptoms, the nature of the treatment and the fees charged.

Obtain a Claim Form by calling the Talent Trust's Helpline. Complete it, attach your invoice, receipt and supporting documentation and send it to us (you'll find the details on the Claim Form).

Quick claim processing

Once we have all the information required, we can process and pay a claim promptly. However, we can only do this if you have told us your diagnosis, so please make sure you include this with your claim. Otherwise, we will need to request the details from you or your doctor.

We will email or write to you to let you know when the claim has been processed.

Evacuations

At the first indication that you need medical evacuation, please call Allianz Care's 24 hour Helpline and we will take care of it. Given the urgency, we would advise you to phone if possible. However, you can also contact us by email. If emailing, please write 'Urgent – Evacuation' in the subject line.

Please contact us before talking to any providers, even if they approach you directly, to avoid excessive charges or unnecessary delays in the evacuation. In the event that evacuation services are not organised by us, we reserve the right to decline the costs.

+1 (877) 499 4809

TT.Medical@e.allianz.com

Seeking treatment in the USA

If you have 'Worldwide' cover, we offer you simple access to medical care in the USA, through our local third-party partner, supporting your access to medical providers in the country.

To access in patient/emergency treatment in the USA, simply show your membership card. Your medical provider will then contact our third-party partner to sort any paperwork related to your treatment. We will pay the cost of your eligible treatment directly to your medical provider, if applicable. If you are responsible for any part of the costs, your provider will let you know. For queries or requests for assistance related to treatment in the USA, please find all contact details on the back of your membership card.

If you do not have a membership card to access treatment in the USA, contact Allianz Care at the number below. We may require you to complete supporting documentation such as a Pre-Authorisation Form.

We will pay the cost of your eligible treatment directly to your medical provider, if applicable. If you are responsible for any part of the costs, your provider will let you know. It is recommended that you contact us at least 10 working days before seeking treatment, so that we can ensure there will be no delays at the time of admission.

+1 (877) 499 4809

TT.Medical@e.allianz.com

Additional information about claiming for your expenses

Medical claims

Before submitting a claim to us, please pay attention to the following points:

- **Claiming deadline:** You must submit all claims no later than six months after the end of the Insurance Year. If cover is cancelled during the Insurance Year, you should submit your claim no later than six months after the date that your cover ended. After this time, we are not obliged to settle the claim.

- **Claim submission:** You must submit a separate claim for each person claiming and for each medical condition being claimed for.

- **Supporting documents:** When you send us copies of supporting documents (e.g. medical receipts), please make sure you keep the originals. We have the right to request original supporting documents/ receipts for auditing purposes up to 12 months after settling your claim. We may also request proof of payment by you (e.g. a bank or credit card statement) for medical bills you have paid. We advise that you keep copies of all correspondence with us as we cannot be held responsible for correspondence that fails to reach us for any reason outside of our control.

- **Deductibles/excesses:** If the amount you are claiming is less than the deductible/excess figure in your plan, you can either:

  - collect all out-patient receipts until you reach an amount that exceeds this deductible/excess figure.
  - send us each claim every time you receive treatment. Once you reach the deductible/excess amount, we'll start reimbursing you.

  Attach all supporting receipts and/or invoices with your claim.

- **Currency:** Please specify the currency you wish to be paid in. On rare occasions, we may not be able to make a payment in that currency due to international banking regulations. If this happens, we will identify a suitable alternative currency. If we have to make a conversion from one currency to another, we will use the exchange rate that applied on the date the invoices were issued.

- **Reimbursement:** We will only reimburse (within the limits of your policy) eligible costs after considering any pre-authorisation requirements, deductibles/excess or co-payments outlined in the Table of Benefits.

- **Reasonable and customary cost:** We will only reimburse charges that are reasonable and customary in accordance with standard and generally accepted medical procedures. If we consider a claim to be inappropriate, we reserve the right to decline your claim or reduce the amount we pay.

- **Deposits:** If you have to pay a deposit in advance of any medical treatment, we will reimburse this cost only after treatment has taken place.

- **Providing information:** You and your dependants agree to help us get all the information we need to process a claim. We have the right to access all medical records and to have direct discussions with the medical provider or the treating doctor. We may, at our own expense, request a medical examination by our doctors if we think it's necessary. All information will be treated confidentially. We reserve the right to withhold benefits if you or your dependants do not support us in getting the information we need.

Treatment needed as a result of someone else's fault

If you are claiming for treatment that you need when somebody else is at fault, you must write and tell us as soon as possible. For example, if you need treatment following a road accident in which you are a victim. Please take any reasonable steps we ask of you to obtain the insurance details of the person at fault. We can then recover from the other insurer the cost of the treatment paid for by us. If you are able to recover directly the cost of any treatment which we have paid for, you will need to repay that amount (and any interest) to us.

Terms and conditions of your cover

Terms and conditions

This section describes the benefits and rules of your/your vocational group's health insurance policy. Please read it together with your Insurance Certificate and Table of Benefits.

Your health insurance policy is an annual contract between us and the insured person(s) or your vocational group named on the Insurance Certificate. The contract is made up of:

- The **Benefit Guide** (this document), which explains the standard benefits and rules of your/your vocational group's health insurance policy. It should be read together with your Insurance Certificate and Table of Benefits.

- The **Insurance Certificate**. This states the plan(s) chosen by you or your vocational group, the start date and renewal date of the policy (and effective dates of when dependants were added). If any other terms apply which are specific to your cover, these will be stated in the Insurance Certificate. They will also have been detailed on a Special Conditions e-mail which is sent to you before you're placed on cover (this applies only to policies with Full Medical Underwriting). TT will send you an updated Insurance Certificate(s) if you request a change which we accept, such as adding a dependant, or if we apply a change that we're entitled to make.

- The **Table of Benefits**. This shows the plan(s) selected, the benefits available to you, and states which benefits/treatments require submission of a Pre-authorisation form. It also confirms any benefits where specific benefit limits, waiting periods, deductibles/excesses and/or co-payments apply.

- Information provided to us by (or on behalf of) the insured person(s) in the signed Application Form, submitted Online Application Form, Confirmation of Health Status Form or others (we'll refer to all of these collectively as the 'relevant application form') or other supporting medical information.

Administration of your policy

When cover starts for you and your dependants

When you receive your Insurance Certificate, this is our confirmation that you've been accepted onto the policy. It will confirm the start date of your cover. Please note that no benefit will be payable under your policy until the initial premium has been paid, with subsequent premiums being paid when due.

Cover for dependants (if applicable) will start on the effective date shown on the most recent Insurance Certificate which lists them as your dependants. Their membership may continue for as long as you are a member of Talent Trust (and remain an active member of a vocational group) and, for children, as long as they remain under the defined age limit. Child dependants can be covered under your policy up until the day before their 18th birthday or up until the day before their 26th birthday if they are in full-time education. At that time, they may apply for cover in their own right.

Adding dependants

You/your vocational group may apply to include any member of your family as a dependant by completing the relevant application form. If you have a policy with moratorium, we'll cover the dependant from the date on which you contact us or from a later date that you may request – a new moratorium will apply for that dependant.

How do I add a newborn to my policy?

Please send an email to **info@talent-trust.com** within 60 days from birth and attach the birth certificate. With the exception of multiple birth babies, we will accept the baby without medical underwriting if the birth parent has been insured with us for a minimum of ten continuous months. Cover will start at birth.

However, if the baby is less than eight weeks old when you contact us, but we have not covered either of their parents for a continuous period of at least ten months then we'll (based on a completed application form for the dependant either cover the baby from the date on which you accept any terms we offer or decline to add the baby to your plan. If we decline to add the baby, we'll explain the reason for this in writing.

What happens if I don't notify you within 60 days?

The newborn child will be underwritten and if accepted, cover will start from the date of acceptance.

What if I am adding multiple birth babies, adopted and fostered children?

Multiple birth babies will be underwritten and if accepted, cover will start from the date of acceptance (for policies with full medical underwriting or subject to the moratorium terms (for policies with moratorium

Changes to the principal member on your policy

If a request is made at renewal to change the principal member on the policy, the proposed replacement will need to complete an application form and full medical underwriting may apply. Please refer to the section on 'Death of the principal member or a dependant' if the requested change is due to the death of the principal member.

Death of the principal member or a dependant

We hope you will never need to refer to this section; however, if the principal member or a dependant dies, please inform us in writing within 28 days.

If the principal member dies, the policy will be terminated and a pro rata repayment of the current year's premium will be made if no claims have been filed. We may request a death certificate before a refund is issued. Alternatively, if they wish to, the next named dependant on the Insurance Certificate can apply to become the principal member and keep the other dependants on their policy (subject to approval by Talent Trust and/or the vocational group). If the dependant applies to do this within 28 days, we will, at our discretion, not add any further special restrictions or exclusions that didn't already apply at the time of the principal member's death.

If a dependant dies, they will be taken off the policy and a pro rata repayment of the current year's premium for that person will be made, if no claims have been filed. We may request a death certificate before a refund is issued.

Changing your level of cover

If you/your vocational group want to change your level of cover, please get in touch with us before your policy renewal date to discuss your options. Changes to cover can only be made at policy renewal. If you want to increase your level of cover, we may ask you to complete a medical history questionnaire and/or to agree to certain exclusions or restrictions to any additional cover before we accept your application. If an increase in cover is accepted, an additional premium amount will be payable and waiting periods may apply.

Changing country of residence

It is important that you or your vocational group let us know when you change your country of residence. This may affect your cover or premium, even if you are moving to a country within your geographical area of cover, as your existing plan may not be valid there.

Contact us to check if your cover is valid in the country you are moving to:

Talent Trust's Helpline: **+60 (4) 899 8945** (Monday to Friday, 10am to 6pm +8GMT)

Talent Trust's email: **info@talent-trust.com**

Cover in some countries is subject to local health insurance restrictions, particularly for residents of that country. It is your responsibility to ensure that your health cover is legally appropriate. If you are not sure, please get independent legal advice, as we may no longer be able to cover you. The cover we provide is not a substitute for local compulsory health insurance. for example:

- Our policies are international health plans and are intended for international use. They are not intended as a replacement for domestic insurance products for citizens or residents of Malaysia.
- Regarding the USA: this cover doesn't meet the requirements of the comprehensive healthcare reform law of March 2010 (also referred to as ACA, PPACA, or 'Obamacare') and is not recognised as 'minimum essential cover'. If you are a US citizen residing inside or outside the USA and you are required to maintain minimum essential cover, you should seek cover under a US domestic health insurance plan. It is your responsibility to ensure that your healthcare cover is legally appropriate. We strongly recommend that you seek independent advice in this regard.

Changing your postal address or email address

We will send all correspondence to the address we have on record for you unless requested otherwise. You/your vocational group need to inform us in writing as soon as possible of any change in your home, business or email address.

Talent Trust's Helpline: **+60 (4) 899 8945** (Monday to Friday, 10am to 6pm +8GMT)

Talent Trust's email: **info@talent-trust.com**

Correspondence

When writing to us, please use email. We do not usually return original documents, but if you ask us to, we will.

Renewing cover

As part of our renewal process, 30 days before the renewal date, you/your vocational group will receive an invitation from Talent Trust to renew your policy. Please respond to our invitation by completing the provided fields in the email to update us with your/your members' latest information. We will send an updated Insurance Certificate to you/your vocational group once we have processed your policy renewal.

Ending your cover

You/your vocational group can end your cover or that of any of your dependants by notifying us in writing. We cannot backdate the cancellation of your cover. It will automatically end:

- at the end of the Insurance Year, if the agreement between you/your vocational group and us is terminated and/or your agreement with Talent Trust is terminated.
- if you decide or your vocational group decides to end or not to renew cover.
- if you do not or your vocational group does not pay premiums or any other payments which are due.
- if you are an individual payer and you do not pay premiums or any other payment due.
- when you leave vocational service or your vocational group.
- upon the death of the principal member on the policy.

Changes that we may apply at renewal

We have the right to apply revised policy terms and conditions, effective from the renewal date. The policy terms and conditions and the Table of Benefits that exist at renewal will apply for the duration of the Insurance Year. We may change the premium, benefits and rules of your membership on your renewal date, including how we calculate/determine premiums and/or the method or frequency of payment. These changes will only apply from your renewal date, regardless of when the change is made and we will not add any restrictions or exclusions which are personal to a member's cover in relation to medical conditions that started after their policy's inception, provided that they gave us the information we asked them for before incepting and they have not applied for an increase in their level of cover.

You/your vocational group will receive full information of any changes. If you don't, or your vocational group doesn't, accept any of the changes we make, you/your vocational group can end your membership and we will treat the changes as not having been made if you end your membership within 30 days of the date on which the changes take effect, or within 30 days of us telling you about the changes, whichever is later.

Your right to cancel

You can cancel the contract in relation to all insured persons, or only in relation to one or more dependants, within 30 days of receiving the full terms and conditions of your policy or from the start/ renewal date of your policy, whichever is later. Please note that you/your vocational group cannot backdate the cancellation of your membership or your dependants' membership.

If you wish to cancel, please contact Talent Trust by email to:

@ info@talent-trust.com

If you cancel your contract within this 30 day period, you will be entitled to a full refund of the cancelled member(s premiums paid for the new Insurance Year, provided that no claims have been made. If you choose not to cancel (or amend your policy within this 30 day period, the insurance contract will be binding on both parties and the full premium owing for the selected Insurance Year will be due for payment, according to the payment frequency that you selected.

Reasons your membership would end

Please remember that your membership (and that of all the other people listed on the Insurance Certificate) will end:

- if you/your vocational group cease(s) to be members of TT.
- if you don't/your vocational group doesn't pay any of the premiums on, or before, the date they are due. However, we may allow your/your vocational group's membership to continue without the need for completing a Confirmation of Health Status Form, if you/your vocational group pay the outstanding premiums within 30 days after the due date.
- if you don't/your vocational group doesn't pay the amount of any IPT, taxes, levies or charges that you/your vocational group have to pay under your agreement with us on or before the due date.
- upon the death of the principal member. Please see the section on 'Death of the principal member or a dependant' for further details.
- if there is reasonable evidence that the principal member or any dependants misled or attempted to mislead us. Examples are: giving false information, withholding pertinent information from us, working with another party to give us false information – either intentionally or carelessly – which may influence us when deciding:
  - whether we accept the application for cover.
  - the applicable premium to pay.
  - whether we have to pay a claim.

Please see the section on 'The following terms also apply to your cover' for further details.

- if you choose to cancel your cover, after giving us written notice within 30 days of receiving the full terms and conditions or from the start/renewal date of your policy, whichever is later. Please see section on 'Your right to cancel' for further details.

If your/your vocational group's membership ends for reasons other than for fraud/non-disclosure, we will refund any premiums you/your vocational group have/has paid which relate to a period after your/your vocational group's membership has ended, subject to the deduction of any money which you/your vocational group owe us.

Please note that if your/your vocational group's Talent Trust membership ceases, your dependants' cover will also end.

Policy expiry

Please note that upon the expiry of your/your vocational group's policy, your right to reimbursement ends. For up to six months after the expiry date, we will reimburse any eligible expenses incurred during the period of cover. However, we will no longer cover any on-going or further treatment that is required after the expiry date of your policy.

Paying premiums

Premiums for each Insurance Year are based on each member's age on the first day of the Insurance Year, their region of cover and other risk factors which may materially affect the insurance.

By accepting cover you/your vocational group have/has agreed to pay the premium amount shown on your quotation, by the payment method stated.

Changes in payment terms can be made at policy renewal, via written instructions, which must be received by us a minimum of 30 days prior to the renewal date. Failure to pay an initial premium or subsequent premium on time may result in loss of insurance cover.

If the initial premium is not paid in time, we are entitled to withdraw from the contract for as long as the payment remains outstanding. The insurance contract is deemed to be null and void unless we assert a claim to the premium in court within three months of the commencement date, the policy start date or the conclusion of the insurance contract. If a subsequent premium is not paid in time, we may, in writing and at your expense, set a time limit of not less than two weeks for you to pay the amount due. After that, we may terminate the contract in writing with immediate effect and will be exempt to pay benefits.

The effects of termination will cease if you/your vocational group make(s a payment within one month after the termination or, if the termination was combined with the setting of a time limit, within one month after the expiration of the time for payment, provided that no claims have been incurred in the intervening period. The above will apply unless you/your vocational group have an alternative arrangement in place with Talent Trust.

Paying other charges

If applicable, you/your vocational group may also need to pay the following taxes in addition to your premium:

- Insurance Premium Tax (IPT)
- VAT
- Other taxes, levies or charges relating to your/your vocational group's cover that we may have to pay or collect from you/your vocational group by law

These charges may already be in effect when you/your vocational group join but they could be introduced (or change) afterwards. Your/your vocational group's invoice will show these taxes. If they change or if new taxes are introduced, we will write to inform you/your vocational group.

In some countries you/your vocational group may also be required to apply withholding tax. If that is the case, it is your/your vocational group's responsibility to calculate and pay this amount to the relevant authorities in addition to payment of your full premium to us.

The following terms also apply to your cover

Applicable law: This policy is governed by the laws and courts of Ireland, unless otherwise required by law.

Sanctions suspension clause: Any benefits, cover and claims payments are suspended if any element of the cover, benefit, activity, business, or underlying business exposes the (re)insurer to:

- any applicable sanction, prohibition or restriction under the United Nations' resolutions, or
- the trade or economic sanctions, laws or regulations of the European Union, United Kingdom, or United States of America.

The above suspension will continue until such time as the (re)insurer will no longer be exposed to any such sanction, prohibition, or restriction.

The amounts we will pay: Our liability is limited to the amounts indicated in the Table of Benefits and any policy endorsements. The amount reimbursed, whether under this policy, public medical scheme or any other insurance will not exceed the figure stated on the invoice.

Who can make changes to your policy: No one, except an appointed representative is allowed to make changes to your/your vocational group's policy on your behalf. Changes are only valid when confirmed in writing by us.

When cover is provided by someone else: We may decline a claim if you or any of your dependants are eligible to claim benefits from:

- a public scheme.
- any other insurance policy.
- any other third-party.

If that is the case, you need to inform us and provide all necessary information. You and the third party cannot agree any final settlement or waive our right to recover expenses without our prior written agreement. Otherwise, we are entitled to get back from you any amount we have paid and to cancel your cover.

We have the right to claim back from a third party any amount we paid for a claim, if the costs were due from or also covered by them. We may take legal proceedings in your name, at our expense, to achieve this. This is called subrogation.

We will not make a contribution to any third-party insurer if the costs are fully or partly covered by that insurer. However, if our plan covers a higher amount than the other insurer, we'll pay the amount not covered by them.

Circumstances outside of our control (force majeure): We will always do our best for you, but we are not liable for delays or failures in our obligations to you caused by things which are outside of our reasonable control. Examples are extremely severe weather, floods, landslides, earthquakes, storms, lightning, fire, subsidence, epidemics, acts of terrorism, outbreaks of military hostilities (whether or not war is declared), riots, explosions, strikes or other labour unrest, civil disturbances, sabotage and expropriation by governmental authorities.

Fraud:

a) The information you and your dependants give us, e.g. on the Application Form or supporting documents, needs to be accurate and complete. If it isn't correct or if you don't tell us about things that may affect our underwriting decision, it may invalidate your policy from the start date. You also need to tell us about any medical conditions that arise between completing the Application Form and the start date of the policy. Medical conditions that you don't tell us about will most likely not be covered. If you're not sure whether certain information is relevant to underwriting, please call us and we'll be able to clarify that. For policies with moratorium, the moratorium cover will still apply even if you tell us about any pre-existing medical conditions you might have – we may apply new terms to the plan, void or cancel it and/or reduce or reject any related claims, based on your new material facts.

b) If the contract is rendered void due to incorrect disclosure or non-disclosure of any material facts, we will refund the premium amount(s) paid to date minus the cost of any medical claims already paid. If the cost of claims exceeds the balance of the premium, we will seek reimbursement of this amount from the principal member.

c) We will not pay any benefits for a claim if:
   - the claim is false, fraudulent or intentionally exaggerated.
   - you or your dependants or anyone acting on your or their behalf use fraudulent means to obtain benefit under this policy.

The amount of any claim we paid to you before the fraudulent act or omission was discovered will become immediately owing to us. If the contract is rendered void due to false, fraudulent, intentionally exaggerated claims or if fraudulent means/devices have been used, premium will not be refunded, in part or in whole, and any pending claims settlements will be forfeited. In the event of fraudulent claims, the contract will be cancelled from the date of our discovery of the fraudulent event.

Cancellation: We reserve the right to cancel the policy where you/your vocational group have/has not paid the full premium due and owing. We will notify you of this cancellation and the contract will be deemed cancelled from the date that the premium payment became due and payable.

Making contact with dependants: In order to administer your policy, we may need to request further information. If we need to ask about one of your dependants (e.g. when we need to collect an email address for an adult dependant), we may contact you as the person acting on behalf of the dependant or your vocational group, and ask you/your vocational group for the relevant information, provided it is not sensitive information. Similarly, for the purposes of administering claims, we may send you/your vocational group non-sensitive information that relates to a family member.

Use of Medi24: The Medi24 advice line and its health-related information and resources is extremely helpful, but it's not a substitute for professional medical advice or for the care that you receive from your doctor. It is not intended to be used for medical diagnosis or treatment and you should not rely on it for that purpose. Always seek the advice of your doctor before beginning any new treatment or if you have any questions about a medical condition. We are not responsible or liable for any claim, loss or damage directly or indirectly resulting from your use of Medi24 or the information or services provided by them. Calls to Medi24 will be recorded and may be monitored for training, quality and regulatory purposes.

Data protection

Allianz Care's Data Protection Notice explains how we protect your privacy and process your personal data. You must read it before sending us any personal data. To read Allianz Care's Data Protection Notice visit:

www.allianzcare.com/en/privacy.html

Alternatively, you can contact us on the phone to request a paper copy.

+1 (877) 499 4809 (available 24 hours a day, 7 days of the week)

If you have any queries about how we use your personal data, please email us at:

AP.EU1DataPrivacyOfficer@allianz.com

Complaints and dispute resolution procedure

If you have any comments or complaints, please contact us:

For Talent Trust's complaints/dispute resolution

Talent Trust's Helpline: **+60 (4) 899 8945** (Monday to Friday, 10am to 6pm +8GMT

info@talent-trust.com

For Allianz Care's complaints/dispute resolution

Allianz Care's Helpline: **+1 (877) 499 4809** (available 24 hours a day, 7 days of the week)

tt.medical@e.allianz.com

Customer Advocacy Team
Allianz Care
15 Joyce Way
Park West Business Campus
Nangor Road
Dublin 12, Ireland

We will handle your complaint according to our internal complaint management procedure.
For details see:

www.allianzcare.com/complaints-procedure

You can also contact Allianz Care's Helpline to obtain a copy of the complaints procedure.

Mediation

1. Any differences in respect of medical opinion in connection with the results of an accident or medical condition must be notified to us within nine weeks of the decision. Such differences will be settled between two medical experts appointed by you and us in writing.

2. If differences cannot be resolved in accordance with Clause 1 above, the parties will attempt to settle by mediation in accordance with the Centre for Effective Dispute Resolution (CEDR) Model Mediation Procedure any dispute, controversy or claim arising out of or relating to this Agreement or the breach, termination or invalidity thereof where the value is €500,000 or less and which cannot be settled amicably between the parties. The parties will endeavour to agree on the appointment of an agreed Mediator. If the parties fail to agree the appointment of an agreed Mediator within 14 days, either party, upon written notice to the other party, may apply to CEDR for the appointment of a Mediator.

   To initiate the mediation, a party must give notice in writing (Alternative Dispute Resolution (ADR) Notice) to the other Party to the dispute, requesting mediation. A copy of the request should be sent to CEDR. The mediation will start no later than 14 days after the date of the ADR notice. No Party may commence court proceedings/arbitration relating to any dispute pursuant to this Clause 2 until it has attempted to settle the dispute by mediation and either the mediation has terminated or the other Party has failed to participate in the mediation (provided that the right to issue proceedings is not prejudiced by a delay). The mediation will take place in the country of the Applicable Law. The Mediation Agreement referred to in the Model Procedure will be governed by, and construed and take effect in accordance with the laws of the country of the Applicable Law. The Courts of the country of the Applicable Law will have exclusive jurisdiction to settle any claim, dispute or matter of difference which may arise out of, or in connection with, the mediation.

3. Any dispute, controversy or claim which is:

   - arising out of or relating to this Agreement (or the breach, termination or invalidity thereof) with a value in excess of €500,000, or
   - referred to mediation pursuant to Clause 2 but not voluntarily settled by mediation within three months of the ADR Notice date

   will be determined exclusively by the Courts of the country of the Applicable Law and the parties will submit to the exclusive jurisdiction of those courts. Any proceedings brought pursuant to this Clause 3 will be issued within nine calendar months of the expiration date of the aforementioned three month period.

Legal action

You/your vocational group will not institute any legal proceedings to recover any amount under the policy until at least 60 days after the claim has been submitted to us and not more than two years from the date of this submission, unless otherwise required by mandatory legal regulations.

Definitions

The following definitions apply to our Healthcare Plans. The benefits you are covered for are listed in your Table of Benefits. If your plan includes any benefit not listed below, the definition will appear in the 'Notes' section at the end of your Table of Benefits. Wherever these words/phrases appear in your policy documents, they will always have the following meanings:

A

Accident
Sudden, unexpected event that causes injury and is due to a cause external to the insured person. The cause and symptoms of the injury must be medically and objectively definable, allow for a diagnosis and require therapy.

Accommodation costs for one parent staying in hospital with an insured child
Hospital accommodation costs of one parent for the duration of the insured child's admission to hospital for eligible treatment. If a suitable bed is not available in the hospital, we will contribute the equivalent of the daily room rate in a three-star hotel towards any hotel costs incurred. We do not cover sundry expenses such as meals, phone calls or newspapers. Please check your Table of Benefits to confirm whether an age limit applies with regard to your child.

Acute
Sudden onset of symptoms of a medical condition.

Acute medical condition
A medical condition that is brief, has a definite end point, and, in our reasonable opinion, based on advice or general advice can be cured by treatment.

Advice
Any consultation from a medical practitioner or specialist including the issue of any prescriptions or repeat prescriptions.

Assisted conception
A pregnancy that is conceived following fertility treatment, including pregnancies conceived through Intrauterine Insemination, In Vitro Fertilisation (IVF) or any other Assisted Reproductive Technology, and pregnancies conceived within one month of using fertility medication.

B

Burial expenses
Refers to the cost of burials or cremation that take place in the home country or principal country of residence. It doesn't include related ceremonial costs such as food and beverage, travel, accommodation, flowers and sympathy cards.

C

Cancer screening
Health checks, tests and examinations for the early detection of illness or disease, performed at appropriate age intervals, without any clinical symptoms being present. To be covered, you need to receive the cancer screening services at a licensed medical institution or a licensed health examination institution, or under the guidance of a doctor in an appropriate setting and in accordance with the international clinical practice guidelines.

Please refer to your Table of Benefits to confirm what tests and checks are covered under this benefit.

Chronic condition
Sickness, illness, disease or injury that lasts longer than six months or requires medical attention (such as check-up or treatment) at least once a year. It also 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
- Leads to permanent disability

Please refer to the 'Notes' section of your Table of Benefits to confirm whether chronic conditions are covered.

Complementary treatment
Therapeutic and diagnostic treatment that exists outside of traditional Western medicine. Please refer to your Table of Benefits to confirm whether any of the following complementary treatment methods are covered: chiropractic treatment, osteopathy, Chinese herbal medicine, homeopathy, acupuncture, podiatry and ayurvedic treatment as practised by approved therapists.

Complications of childbirth
It refers to complications that arise during childbirth, such as medically necessary caesarean section, post-partum haemorrhage and retained placental membrane.

Complications of pregnancy
It relates to the health of the mother. Only the following complications that arise during the pre-natal stages of pregnancy are covered: ectopic pregnancy, gestational diabetes, pre-eclampsia, miscarriage, threatened miscarriage, stillbirth and hydatidiform mole.

Congenital conditions
Any abnormality, deformity, disease, disorder, illness, malformation, defect, anomaly or injury that is hereditary or acquired before or during birth. A congenital condition can be diagnosed at birth or later in life.

Co-payment
The percentage of the costs which you must pay. E.g. if a benefit has a 80% refund, this means that a co-payment of 20% applies, therefore we will pay 80% of the costs of each eligible treatment per insured person, per Insurance Year. Video consultation services are not subject to co-payment when accessed via TeleHealth Hub.

D

Day-care treatment
Planned treatment received in a hospital or day-care facility during the day, including a hospital room and nursing, that does not medically require the patient to stay overnight and where a discharge note is issued.

Deductible
It is the part of the cost that is payable by you and that we deduct from the amount we will pay.

Where deductibles apply, they are payable per person per Insurance Year, unless your Table of Benefits states otherwise.

Dental practitioner
A person who:

- has attained primary degrees in dentistry and/or dental surgery by attending a dental and/or medical school recognised by a relevant accredited professional body, and
- is licensed by the relevant authority to practice dentistry and/or dental surgery in the country where the treatment is given.

Dental prostheses
Crowns, inlays, onlays, adhesive reconstructions/restorations, bridges, dentures and implants as well as all necessary and ancillary treatment required.

Dental prescription drugs
Drugs prescribed by a dentist for the treatment of dental inflammation or infection. The prescription drugs must be proven to be effective for the condition and recognised by the pharmaceutical regulator in a given country. They do not include mouthwashes, fluoride products, antiseptic gels and toothpastes.

Dental surgery
Surgical extraction of teeth, as well as other tooth-related surgical procedures such as apicoectomy and dental prescription drugs. All investigative procedures that establish the need for dental surgery such as laboratory tests, X-rays, CT scans and MRI(s) are included under this benefit. Dental surgery does not cover surgical treatment that relates to dental implants.Dental surgery does not cover surgical treatment that relates to dental implants.

Dental treatment
An annual check-up, simple fillings related to cavities or decay, root canal treatment, simple extractions and dental prescription drugs.

Dependant
Your spouse or partner and unmarried children that are named as dependants on your Insurance Certificate. Children are covered up to the day before their 18th birthday; or up to the day before their 26th birthday if they are in full-time education.

Diagnostic tests
Investigations such as x-rays or blood tests, carried out for diagnostic purposes. These tests are covered when you are already displaying symptoms or when needed following other medical test results. This benefit does not cover annual check-ups or routine screenings.

Digital health app
Contribution towards one digital health app of your choice per Insurance Year. The app should assist with the prevention, detection or management of a disease or condition such as back pain, diabetes or mental health issues. Cover is provided when the insured member is the subscriber to the app, covered under a valid policy at the time of purchase. When submitting a claim, please attach a dated receipt.

Direct family history
It exists where a parent, grandparent, sibling or child has been previously diagnosed with the medical condition in question.

Doctor
A person who is licensed to practise medicine under the law of the country in which treatment is given and where they are practising within the limits of their licence.

E

Effective date
The first day we cover you under the plan during the insurance Year, as shown on your Insurance Certificate.

Emergency
The onset of a sudden and unforeseen medical condition that requires urgent medical assistance. Only treatment commencing within 24 hours of the emergency event will be covered.

Emergency in-patient dental treatment
Acute emergency dental treatment for the relief of pain that is due to a serious accident and requires admission to hospital. The treatment must take place within 24 hours of the emergency event. Cover does not extend to follow-up dental treatment, dental surgery, dental prostheses, orthodontics or periodontics. If cover is provided for these benefits, it will be listed separately in the Table of Benefits.

Emergency out-patient dental treatment
Treatment received in a dental surgery or hospital emergency room for the immediate relief of dental pain caused by an accident or an injury to a sound natural tooth. Treatment may include pulpotomy or pulpectomy and the subsequent temporary fillings, limited to three fillings per Insurance Year. Treatment must take place within 24 hours of the emergency event. It does not include any form of dental prostheses, permanent restorations or the continuation of root canal treatment. However, if your policy also includes a Dental Plan, it will cover dental treatment in excess of the limit on 'Emergency out-patient dental treatment' benefit. In that case, the Dental Plan terms will apply.

Emergency out-patient treatment
Treatment received in a casualty ward or emergency room within 24 hours of an accident or sudden illness, where there is no medical necessity for you to occupy a hospital bed. If your policy includes out-patient benefits, it will cover you for out-patient treatment in excess of the limit on 'Emergency out-patient treatment' benefit.

Emergency treatment outside area of cover
Where applicable, it is listed as a benefit in your Table of Benefits. It covers treatment for medical emergencies which occur during business or holiday trips outside your area of cover. Cover is provided for up to 60 days per Insurance Year. It includes treatment required due to an accident or illness which presents an immediate threat to your health. Treatment by a doctor must start within 24 hours of the emergency event. Cover is not provided for curative or follow-up non-emergency treatment, even if you are deemed unable to travel to a country within your geographical area of cover. Nor does it extend to pre-existing conditions or charges relating to maternity, pregnancy, childbirth or any complications of pregnancy or childbirth. You must tell us if you are going to be outside your area of cover for more than six weeks.

Excess
The amount payable by you in respect of expenses incurred, before any benefits are paid under the policy, as specified in your Table of Benefits.

Expenses for one person accompanying an evacuated person
Travel costs for one person accompanying the evacuated person. If they can't travel in the same vehicle, we will pay for an alternative form of transport at economy rates. Following completion of treatment, we will also cover the cost of the companion's return trip, at economy rates, to the country where the evacuation started from. Cover is also provided for hotel accommodation for pre and post hospital admission periods, provided that the member is under the care of a specialist.

F

Family history
It exists where a parent, grandparent, sibling, child, aunt or uncle has been previously diagnosed with the medical condition in question.

Follow-me-home (optional upgrade on Outreach plan)
Cover upgrade that you can use in the event that it is medically necessary for you or your dependant to be evacuated to the country of domicile or country of residence (if this is the nearest country with appropriate medical facilities to the place of incident).

Full medical underwriting
The assessment of insurance risk based on information that you give us when applying for cover. Our underwriting team uses this information to decide the terms of our offer.

G

General advice
Any medical opinion or medical recommendation from a relevant accredited professional body in relation to a medical condition or treatment which confirms, in our reasonable opinion, an established medical practice or opinion.

H

Health and wellbeing checks including screening for the early detection of illness or disease
Health checks, tests and examinations, performed at appropriate age intervals, without any clinical symptoms being present. To be covered, you need to receive the health and wellbeing screening services at a licensed medical institution or a licensed health examination institution, or under the guidance of a doctor in an appropriate setting and in accordance with the international clinical practice guidelines.

HIV or AIDS treatment
A benefit that covers consultations, investigations, in-patient and out-patient treatment related to a diagnosis of Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS). If included in your plan as a specific benefit, cover is limited to the amount shown in your Table of Benefits.

Home country
A country for which you hold a current passport or which is your principal country of residence.

Hormone replacement therapy
The use of female hormones for the relief of symptoms resulting from cessation of ovarian function, either at the time of the natural menopause or following surgical removal of the ovaries. Cover is provided for medical practitioner fees, specialists fees as well as prescription drug expenses.

Hospital
Any establishment which is licensed as a medical or surgical hospital in the country where it operates and where the patient is permanently supervised by a doctor. The following are not considered hospitals: rest and nursing homes, spas, cure-centres and health resorts.

Hospital accommodation
Standard private or semi-private accommodation as shown in the Table of Benefits - deluxe, executive rooms and suites are not covered. The hospital accommodation benefit only applies when the hospitalisation is not related to any other in-patient benefit shown on the Table of Benefits. For example, if a member is hospitalised for cancer treatment, the hospital accommodation will be covered under the oncology benefit, and not under the hospital accommodation benefit. Examples of benefits that already include hospital accommodation (if included in your plan) are: Psychiatry and psychotherapy, Organ transplant, Oncology, Routine maternity and Palliative care.

I

Infertility treatment
All invasive investigative procedures necessary to establish the cause of infertility such as hysterosalpingogram, laparoscopy or hysteroscopy.

In-patient cash benefit
Amount that we pay to you if you receive in-patient treatment for a medical condition that would be covered by your plan, but in your country of treatment you access it free

of charge: this happens when the full cost of your hospital admission and in-patient treatment is government-funded. As you don't receive any invoice or pay any amount to your medical provider, you can't claim a reimbursement with us or any other insurer you may have, as there is no expenditure on your side. In this case you can claim the payment of the in-patient cash benefit, which is limited to the amount specified in the Table of Benefits and is payable after you are discharged from hospital.

In-patient treatment
Treatment received in a hospital where an overnight stay is medically necessary.

Insurance Certificate
A document we issue that outlines the details of your cover. It confirms that an insurance relationship exists between you and us.

Insured person
You and your dependants as stated on your Insurance Certificate.

Insurance Year
It applies from the effective date of your policy, as shown on the Insurance Certificate and ends at the expiry date of the Company Agreement. The following Insurance Year coincides with the year that is defined in the Company Agreement.

L

Local ambulance
Ambulance transport that is required for an emergency or out of medical necessity, to the nearest available and appropriate hospital or licensed medical facility.

M

Medical advice
Any medical opinion, medical recommendation or information given by a medical professional.

Medical condition
Any injury, illness or disease including psychiatric illness.

Medical evacuation (for emergencies only)
It applies in the following scenarios:

- If the necessary treatment you are covered for is not available locally
- If adequately screened blood is unavailable in an emergency

We will evacuate you to the nearest appropriate medical centre (which may or may not be in your home country) by ambulance, helicopter or aeroplane. The medical evacuation should be requested by your doctor, and will be carried out in the most economical way that is appropriate to your medical condition. Following completion of treatment, we will also cover the cost of your return trip at economy rates to your principal country of residence.

If you can't travel or be evacuated for medical reasons following discharge from an in-patient episode of care, we will cover the reasonable cost of hotel accommodation in a private en-suite room for up to seven days. We do not cover costs for hotel suites or four or five-star hotel accommodation.

If you are evacuated to the nearest appropriate medical centre for ongoing treatment, we will cover the reasonable cost of hotel accommodation in a private en-suite room. This cost must be more economical than the cost of a series of journeys between the nearest appropriate medical centre and your principal country of residence. Hotel accommodation for an accompanying person is not covered.

Where adequately screened blood is not available locally, we will, where appropriate, try to locate and transport screened blood and sterile transfusion equipment, if this is advised by the treating doctor and our own medical experts. We and our agents accept no liability if we are unsuccessful or if contaminated blood or equipment is used by the treating authority.

You must contact us at the first indication that you need an evacuation. From this point onwards, we will organise and coordinate the evacuation until you arrive safely at your destination of care. If evacuation services are not organised by us, we reserve the right to decline all costs incurred.

Medical necessity
Medical treatment, services or supplies that fulfil all of the following:

- Essential to identify or treat your condition, illness or injury
- Consistent with your symptoms, diagnosis or treatment of the underlying condition

- In accordance with generally accepted medical practice and professional standards of care in the medical community at the time (this does not apply to complementary treatment methods if they form part of your cover)
- Required for reasons other than the comfort or convenience of you or your doctor
- Proven and demonstrated to have medical value (this does not apply to complementary treatment methods if they form part of your cover)
- Considered to be the most appropriate type and level of service or supply
- Provided at an appropriate facility, in an appropriate setting and at an appropriate level of care for the treatment of your medical condition
- Provided only for an appropriate duration of time

In this definition, the term 'appropriate' means taking patient safety and cost effectiveness into consideration. In respect to in-patient treatment, 'medically necessary' also means that diagnosis can't be made or treatment can't be safely and effectively provided on an out-patient basis.

Medical practitioners
Doctors who are licensed to practise medicine under the law of the country in which treatment is given and where they are practising within the limits of their licence.

Medical practitioner fees
Fees charged for non-surgical treatment performed or administered by a medical practitioner.

Midwife fees
Fees charged by a midwife or birth assistant, who, according to the law of the country in which treatment is given, has completed the necessary training and passed the necessary state examinations.

Moratorium (MORI)
A waiting period of 24 months from either your start date or the date shown in the special terms section of your Insurance Certificate that must have passed before claims for any pre-existing medical conditions may become eligible under the plan. Once you've completed a continuous 24-month period after your start date, your pre-existing medical condition may be covered, provided that you've not had symptoms, needed or received treatment, medication, a special diet or advice, or had any other indications of the condition.

N

Near relative
Spouse, child, brother, sister, parent, parent in law, sister or brother in law, and fiancé.

Newborn care
The following essential examinations, diagnostic procedures and treatments as required following birth:
- Customary examinations required to assess the integrity and basic function of the child's organs and skeletal structures
- One hearing examination
- Screening tests for PKU, congenital hypothyroidism and G6PD
- Vitamin K, hepatitis B and BCG vaccinations

Cover doesn't include further preventive diagnostic procedures, such as routine swabs or blood typing. However, if for medical reasons the child needs any follow-up investigations and treatment, these are covered under the newborn's own policy (if they have been added as a dependant).

For multiple birth babies born as a result of medically assisted reproduction, and adopted and fostered children, in-patient treatment is limited to US$ 40,500 per child for the first three months following birth: this limit applies before any other benefit in your plan.

Outpatient treatment is paid within the terms of the Out-patient Plan.

Newborn treatment
In-patient treatment of a newborn baby's acute medical condition that manifests within 30 days following birth.

For multiple birth babies born as a result of medically assisted reproduction, and adopted and fostered children, in-patient treatment is limited to US$ 40,500 per child for the first three months following birth: this limit applies before any other benefit in your plan.

Non-emergency travel (optional upgrade)
It covers the cost of return economy-class travel to the country where the nearest appropriate medical facility is located, in the event that you require in-patient or day-care non-emergency treatment that is unavailable in the country you are. Cover is subject to our pre-authorisation and to your attending medical practitioner or specialist releasing certified instructions on the medical necessity of the travel, including confirmation that the required treatment is unavailable at the place of incident.

Non-underwritten policies
Policies where we don't request the insured persons to provide information about their health at the point of joining, as their medical history is not considered nor assessed. Pre-existing medical conditions are covered subject to the benefits, terms and conditions of the policy.

Nursing at home or in a convalescent home
Nursing received immediately after, or instead of, eligible in-patient or day-care treatment. We will pay the benefit listed in the Table of Benefits if the treating doctor decides that it is medically necessary for you to stay in a convalescent home or have a nurse in attendance at home. This benefit also needs to be approved by our Medical Director.
This benefit doesn't cover spas, cure centres, health resorts or palliative care.

Obesity
It is diagnosed when a person has a body mass index (BMI) of over 30 (you can find a BMI calculator at: **www.allianzcare.com/en/support/health-and-wellness/bmi-calculator.html**).

Occupational therapy
Treatment that helps you develop skills needed for daily living and interactions with other people and the environment. These refer to:

- Fine and gross motor skills (how you perform small, precise tasks and whole-body movement).
- Sensory integration (how the brain organises a response to your senses).
- Coordination, balance and other skills such as dressing, eating and grooming.

We will need to see a progress report after every 20 sessions.

Oncology
Specialist fees, diagnostic tests, radiotherapy, chemotherapy and hospital charges related to the treatment of cancer from the point of diagnosis.

Oral and maxillofacial surgical procedures
Surgical treatment on the mouth, jaws, face or neck performed in a hospital by an oral and maxillofacial surgeon for: oral pathology, temporomandibular joint disorders, facial bone fractures, congenital jaw deformities, salivary gland diseases and tumours.

Unless you hold a Dental Plan, we do not cover the following procedures even if they are performed by an oral and maxillofacial surgeon:

- Surgical removal of cysts
- Orthognathic surgeries for the correction of malocclusion

Organ transplant
The following organ or tissue transplants: heart, heart/valve, heart/lung, liver, pancreas, pancreas/kidney, kidney, bone marrow, parathyroid, muscular/skeletal and cornea. We do not reimburse the costs of acquiring organs.

Orthodontics
The use of devices to correct malocclusion (misalignment of your teeth and bite). We only cover orthodontic treatment that meets the medical necessity criteria described below. As the criteria is very technical, please contact us before starting treatment so we can verify if your treatment meets the criteria. Medical necessity criteria:

- Increased overjet > 6mm but <= 9 mm
- Reverse overjet > 3.5 mm with no masticatory or speech difficulties
- Anterior or posterior crossbites with > 2 mm discrepancy between the retruded contact position and intercuspal position
- Severe displacements of teeth > 4
- Extreme lateral or anterior open bites > 4 mm
- Increased and complete overbite with gingival or palatal trauma • Less extensive hypodontia requiring pre-restorative orthodontics or orthodontic space closure to obviate the need for a prosthesis
- Posterior lingual crossbite with no functional occlusal contact in one or more buccal segments
- Reverse overjet > 1 mm but < 3.5 mm with recorded masticatory and speech difficulties
- Partially erupted teeth, tipped and impacted against adjacent teeth
- Existing supernumerary teeth You will need to send us some supporting information to show that your treatment is medically necessary and therefore covered by your plan.

The information we ask for may include, but is not limited to:

- A medical report issued by the specialist, stating the diagnosis (type of malocclusion) and a description of your symptoms caused by the orthodontic problem.
- A treatment plan showing the estimated duration and cost of the treatment and the type/material of the appliance used.
- The payment arrangement agreed with the medical provider.
- Proof of payment for orthodontic treatment.

- Photographs of both jaws clearly showing dentition before the treatment.
- Clinical photographs of the jaws in central occlusion from frontal and lateral views.
- Orthopantomogram (panoramic x-ray).
- Profile x-ray (cephalometric x-ray).
- Any other document we may need to assess the claim.

We will only cover the cost of standard metallic braces and/or standard removable appliances. However, we'll cover cosmetic appliances such as lingual braces and invisible aligners up to the cost of metallic braces, subject to the 'Orthodontic treatment' benefit limit.

Orthomolecular treatment
Alternative treatment that aims to restore the individual biochemical balance through supplements. It uses natural substances such as vitamins, minerals, enzymes and hormones.

Out-patient surgery
Surgical procedure performed in a surgery, hospital, day-care facility or out-patient department that does not require you to stay overnight out of medical necessity.

Out-patient treatment
Treatment provided in the practice or surgery of a medical practitioner, therapist or specialist that does not require you to be admitted to hospital.

P

Palliative care
Ongoing treatment that aims to alleviate the physical/psychological suffering associated with progressive, incurable illness and to maintain quality of life. It includes in-patient, day-care and out-patient treatment following the diagnosis of a terminal condition. We will pay for physical care, psychological care, hospital or hospice accommodation (for the duration indicated in your Table of Benefits), nursing care and prescription drugs.

Partner
Your married spouse.

Periodontics
Dental treatment related to gum disease.

Podiatry
Medically necessary treatment carried out by a State Registered podiatrist.

Post-natal care
Routine post-partum medical care received by the mother for up to six weeks after delivery.

Pre-existing conditions
Medical conditions for which one or more symptoms presented at some point during your or your dependants' lifetime. This applies regardless of whether you or your dependants sought any medical advice or treatment. We would deem any such condition to be pre-existing if we could reasonably assume you or your dependants would have known about it.

We don't normally cover pre-existing conditions, unless we tell you otherwise in writing.

We will also treat as pre-existing any medical conditions that arise between the date you completed the application form and the later of the following:

- the date the Insurance Certificate is issued or
- the start date of your policy

Such pre-existing conditions will also be subject to full medical underwriting and if they are not disclosed, they will not be covered.

If your Insurance Certificate shows that your underwriting terms are **moratorium**, your claim will also not be paid if it's relating to a pre-existing medical condition, should one or more of the following have applied within the 24-month period before your start date (or the date shown in your Insurance Certificate):

- It could be reasonably foreseen that the medical condition would occur after your start date.
- The condition clearly showed itself.
- You had signs or symptoms of the condition.
- You asked for advice about the condition.
- You received treatment for the condition, or
- To the best of your knowledge, you were aware you had the condition.

Once you've completed a continuous 24-month period after your date of joining we may cover your pre-existing medical condition provided you've not had symptoms, needed or received treatment, medication, a special diet or advice, or had any other indications of the condition.

Pregnancy
The period of time when you are expecting a baby, from the date of the first diagnosis until delivery.

Pre-natal care
Common screening and follow-up tests required during pregnancy. For women aged 35 and over, this includes Triple/Bart's, Quadruple and Spina Bifida tests, amniocentesis and, if directly linked to an eligible amniocentesis, DNA-analysis.

Prescribed drugs and dressings
Drugs prescribed by a doctor to:

- treat a confirmed diagnosis or medical condition.
- compensate a lack of vital bodily substances.

Prescribed drugs must be clinically proven to be effective for the diagnosed condition. They must also be recognised by the pharmaceutical regulator in the country where you use the prescription. Even if you can legally buy a medication without a doctor's prescription in that country, you must get a prescription for these costs to be covered. You can claim for a supply of up to three months from the prescription date, subject to length of time remaining on the policy.

Prescribed medical aids
Any device that is prescribed and medically necessary to enable you to carry out everyday activities. Examples include:

- Biochemical aids such as insulin pumps, glucose meters and peritoneal dialysis machines.
- Motion aids such as crutches, wheelchairs, orthopaedic supports/braces, artificial limbs and prostheses.
- Medically graduated compression stockings.
- Long-term wound aids such as dressings and stoma supplies.

We do not cover hearing and visual/speaking aids such as electronic larynx. We also do not cover costs for medical aids that form part of palliative care.

Prescribed physiotherapy
Treatment provided by a registered physiotherapist following referral by a doctor. Physiotherapy is initially restricted to a set number of sessions per condition as stated in your Table of Benefits, after which treatment must be reviewed by the doctor who referred you. If you need further sessions, you must send us a new progress report after the set number of sessions stated in your Table of Benefits, indicating the medical necessity for more treatment. Physiotherapy does not include therapies such as Rolfing, massage, Pilates, Fango and Milta.

Prescription Drugs
Products which you can't buy without a prescription and are to treat a confirmed diagnosis or medical condition or to compensate a lack of vital bodily substance. Examples are antibiotics, sedatives etc. Prescription drugs must be clinically proven to be effective for the diagnosed condition. They must also be recognized by internationally accepted medical guidelines. You can claim for a supply of up to three months from the prescription date, subject to length of time remaining on the policy.

Principal country of residence
The country where you and your dependants (if applicable) live for more than six months of the year.

Principal member
A member of TT who is eligible for cover as complying to all of the following criteria:

- Is a member of TT, and
- Is an active member of a vocational group (see definition for 'Vocational group'), and
- Is travelling outside of their home country to fulfil their charitable work.

Professional sport
Means any sporting activity which is undertaken by the insured Person from which he/she derives salary or other economic compensation.

Psychiatry and psychotherapy
Treatment of mental, behavioral and personality disorders, including autism spectrum (Omega plus plan only) and eating disorder. Treatment must be carried out by a psychiatrist, clinical psychologist or licensed psychotherapist. The condition must be clinically significant and the treatment medically necessary. All day-care or in-patient admissions must include prescription medication related to the condition. Out-patient psychotherapy treatment (where covered) requires referral by a doctor and is limited to 10 sessions per condition initially. After every 10 sessions, a psychiatrist must review the treatment. If you need more sessions, you must send us a progress report that indicates the diagnosis and the medical necessity for further treatment. Counselling is available through our Expat Assistance Programme (EAP) and refers to short-term, solution-focused interventions, and typically deals with current issues that are easily resolved on the conscious level. This is not meant for longer-term situations or the treatment of clinical disorders. EAP can help you and your immediate family deal with challenging situations that may arise in life, such as stress, anxiety, bereavement, workplace challenges, relationship issues, cross-cultural transition, coping with isolation and loneliness. For more information see the 'Expat Assistance Programme (EAP)' section of this guide.

R

Reasonable and customary
Treatment costs that are usual within the country of treatment. We will only reimburse the cost of medical providers where their charges are reasonable and customary and in accordance with standard and generally accepted medical procedures.

Reasonable additional treatment and accommodation charges for up to 6 months
After the expiry of the Insurance Year, your cover ends. However, this benefit allows you to continue being covered for additional treatment required after a medical emergency (related to an eligible condition) incurred during the period your policy was active. The additional treatment is covered if you need it in your overseas location and/or inside your country of residence (please refer to your Table of Benefits).

Related medical conditions
refers to any injury, illness or disease that, based on medical advice or general advice, we determine is the result of any one or more other medical conditions.

Rehabilitation
Treatment that combines therapies such as physical, occupational and speech therapy. It aims to restore original form or function after an acute illness, injury or surgery. Treatment must take place in a licensed rehabilitation facility and start within 14 days of discharge from acute medical and/or surgical treatment. We cover in-patient or day-care accommodation costs only if admission to a rehabilitation facility was requested by your doctor and approved by us.

Repatriation of mortal remains
The transportation of the deceased insured person's remains to their home country. If the insured passes away in their home country, we will cover transportation to the location of burial or cremation in that country, or to another home country where more than one home country exists. We cover costs such as: embalming, a container legally appropriate for transportation, shipping and the necessary government authorisations.

We do not cover costs incurred by anyone accompanying the remains unless this is listed as a specific benefit in your Table of Benefits.

Routine management of chronic conditions
Check-ups associated with the chronic condition, drugs and dressing prescribed for the management of the condition, hospital accommodation, nursing, surgery, and palliative treatment.

Cover under this option further includes medical expenses which arise from or are in any way related to Human Immunodeficiency Virus (HIV) and/or related HIV illnesses, including Acquired Immune Deficiency Syndrome (AIDS) or Aids Related Complex (ARC) and/or any mutant derivative or variations. Expenses are limited to:

- Pre and post diagnosis consultations
- Routine check-ups for this condition
- Prescribed drugs and dressings (except experimental or investigational)
- Hospital accommodation and nursing fees

Routine delivery
Medically necessary costs incurred during childbirth. This includes hospital charges, specialist fees, midwife fees (during labour only) and newborn care (see the definition of 'Newborn care' for what we cover under this benefit and for in-patient treatment limits that apply to adopted and fostered children and multiple birth babies born as a result of medically assisted reproduction). We do not cover costs of complications of pregnancy and childbirth under the 'Routine delivery' benefit. Caesarean sections that are not medically necessary are covered up to the cost of a routine delivery in the same hospital, subject to any benefit limits. Medically-necessary caesarean sections are paid for under the 'Complications of childbirth' benefit. In case of home deliveries, we will pay a lump sum up to the amount specified in the Table of Benefits if your plan includes the 'Home delivery' benefit.

Routine maternity
Medically necessary costs incurred during pregnancy and childbirth. This includes hospital charges, specialist fees, the mother's pre-natal and post-natal care, midwife fees (during labour only) and newborn care (see the definition of 'Newborn care' for what we cover under this benefit and for in-patient treatment limits that apply to adopted and fostered children, and multiple birth babies born as a result of medically assisted reproduction).

Please note that 3D and 4D ultrasound scans are covered up to the cost of a 2D scan only.

Caesarean sections that are not medically necessary are covered up to the cost of a routine delivery in the same hospital, subject to any 'Routine Maternity' benefit limits. Medically-necessary caesarean sections are paid for under the 'Complications of childbirth' benefit.

In case of home deliveries, we will pay up to the amount specified in the Table of Benefits if your plan includes the 'Home delivery' benefit. The benefit also covers the costs of the elective circumcision surgical procedure undertaken on newborn males within 30 days from birth, as well as any follow-up consultation required.

S

Sleep apnoea
A sleep disorder characterised by pauses in breathing or periods of shallow breathing during sleep. If this benefit is indicated in your Table of Benefits, we will provide cover for the medically necessary treatment and diagnostic procedures related to a confirmed or suspected sleep apnoea diagnosis. The costs which are covered under this benefit include professional fees, a medically necessary sleep study, other necessary diagnostic tests, medical aids and drugs, up to the limits indicated on your Table of Benefits. Please note that proof of medical necessity is required.

Specialist
A licensed doctor possessing the additional qualifications and expertise necessary to practise as a recognised specialist in diagnostic techniques, treatment and prevention in a particular field of medicine.

Specialist fees
Non-surgical treatment performed or administered by a licensed doctor. This benefit does not include cover for psychiatrist, psychologist fees or any treatment that is already covered by another benefit under your Table of Benefits. We don't cover specialist treatment that is excluded under your policy.

'Stay alive' policy (optional upgrade)
It is a feature that enables you to pause your cover for a year or two years, until you need it again. The feature allows you to retain benefits and maintain continuous coverage, without purchasing a full annual policy; however, it is subject to payment of a reduced premium. You can avail of this if you obtain temporary, alternative cover from a government-sponsored source, or through employment, but intend to return to your TT policy at a later stage. During the period of cover pause, you will not be covered for any medical benefit. The conditions applicable to this feature are:

- Not having submitted any claims 12 months prior to switching to the 'Stay alive' policy.
- Having notified TT with 30-day notice before switching from the 'Stay alive' policy back to your previous policy.

Existing [WJ(P1] date of entry and 'No Claims' Bonus (if any) under your policy will be transferred to the 'Stay alive' policy. Any new medical conditions that start during the 'Stay alive' policy will be considered pre-existing once you resume your policy. These new medical conditions will be excluded from cover and a new medical declaration will need to be submitted. Maximum period of cover under the 'Stay alive' policy is two years.

The Stay Alive plan is subject to any change lin our licensing and sanctions policies.

Surgical appliances and materials
Those required for surgeries. They include artificial body parts or devices such as joint replacement materials, bone screws and plates, valve replacement appliances, endovascular stents, implantable defibrillators and pacemakers.

T

TT
TT is an association created for the benefit of charitable vocational groups, which are comprised of the members defined under this guide and their dependants. TT provides the members and their dependants with health insurance cover while they are in pursuit of their vocational duties. TT is the policyholder for this group policy.

Therapist
A chiropractor, osteopath, Chinese herbalist, homeopath, acupuncturist, physiotherapist, occupational therapist or , who is qualified and licensed under the laws of the country in which treatment takes place.

Travel costs of insured members to be with a close relative who is at peril of death or who has died
The reasonable transportation and accommodation costs of insured members to be with a close relative who is at peril of death or who has died (up to the amount specified in your Table of Benefits). Cover includes one round trip per insured member per Insurance Year. If the close relative has passed away, travel must commence within six weeks of their date of death.

A close relative is a spouse/partner, parent (including legally adoptive parent), stepparent, legal guardian, parent in law, brother or sister (including stepbrother/stepsister and brother/sister in law), child (including adopted child, fostered child or step-child), son or daughter in law, grandparent or grandchild.

Reasonable transportation costs are considered to be round trip transport costs at economy rates. When claiming, please include copies of the travel tickets/accommodation receipts and the death certificate or a doctor's certificate supporting the reason for travel.

Treatment
Medical, surgical or therapeutic interventions received to diagnose, prevent, cure or relieve illness and injury, or physical and mental disorder.

Treatment of autism spectrum disorder
A range of therapies to improve the skills of an insured person with autism. This includes specialist medical treatment and accredited behavioural programmes. Treatment is covered as part of the 'Psychiatry and psychotherapy' benefit of your Out-patient Plan, if you have one. Check your Table of Benefits for any limits that may apply. We don't cover admissions, stays or day care treatment at specialised educational facilities.

Treatment of eating disorders
A combination of psychotherapies, including cognitive behavioural therapy, medical monitoring, prescribed medication and nutritional counselling to treat anorexia nervosa, bulimia nervosa and binge-eating disorder. All day-care or in-patient admissions must include prescription medication related to the condition.

Out-patient therapy (where covered) requires referral by a doctor and is limited for 10 sessions per condition initially. After every 10 sessions, a psychiatrist must review the treatment. If you need more sessions, you must send us a progress report that indicates the diagnosis and the medical necessity for further treatment.

Treatment is covered as part of the 'Psychiatry and psychotherapy' benefit of your Out-patient Plan, if you have one. Check your Table of Benefits for any limits that may apply.

V

Vaccinations
- All basic immunisations and booster injections in line with the international medical guidelines that apply in the country where they are administered.
- Vaccination against COVID-19*, where this is not offered for free or only partially sponsored by the government in your country of residence.
- Medically necessary travel vaccinations.
- Malaria prevention tablets.

We cover the cost of consultation for administering the vaccine and the cost of the drug.

*We cover any COVID-19 vaccine when:

- The vaccine has completed the necessary clinical development process, including all pre-licensure vaccine clinical trials (phase I, II and III) that demonstrate its efficacy and safety.
- The vaccine has completed the multi-step approval process for the relevant regulating authority and is approved for use in the jurisdiction where you require it.
- The vaccine is not offered for free or only partially sponsored by the government of the country in which you reside.

We cover the reasonable and customary cost of the COVID-19 vaccine, including the administration of the injection, in line with local public health policies related to the allocation of vaccines. We do not pay towards the travel cost if you decide to travel to a different country from where you normally reside in order to get the vaccination. Please note that cover is not intended to give you priority access to vaccines.

Video consultation services
They provide direct access to a doctor via a telecommunication platform. This benefit covers the costs of video consultations, as indicated in your Table of Benefits and offers medical advice, diagnosis and issuance of a prescription, if needed, for non-urgent medical care. Access to teleconsultation services and prescriptions will depend on your geographical location and local country regulations. You can make an appointment to speak to a medical practitioner in English, subject to availability. Some third party providers may offer additional core languages. Cost of medicines are not included, but delivery of medicine or referrals may or may not be included under this benefit, even when prescribed or recommended during the video consultation.

Vision care (upgrade option)
Cover for a routine eye examination carried out by an optometrist or ophthalmologist (one check-up per Insurance Year) and for lenses and glasses to correct vision.

Vocational groups
Groups or associations with a common charitable or vocational purpose or calling who are members of TT.

W

Waiting period
A period of time that begins on your policy start date (or effective date if you are a dependant), during which you are not entitled to cover for particular benefits. Your Table of Benefits shows which benefits are subject to waiting periods. Waiting periods do not apply to you if you have a non-underwritten policy (with the exception of Optional benefits).

We/Our/Us
Allianz Care.

Well Child Test
Examinations undertaken by a family doctor or paediatrician without any clinical symptoms being present, to assess a child's wellbeing and their progress against generally accepted developmental milestones. Cover is limited to the benefit and benefit limits as stated in the Table of Benefits and does not extend to the treatment of any possible developmental delays identified.

Y

You/Your
The principal member of TT who is eligible for cover and any dependants named on the Insurance Certificate.

Exclusions

Although we cover most medically necessary treatment, we do not cover the following expenses unless indicated otherwise in the Table of Benefits or in any written policy endorsement.

ACQUISITION OF AN ORGAN

Expenses for the acquisition of an organ such as, but no limited to donor search, typing, harvesting, transport and administration costs.

CHEMICAL CONTAMINATION AND RADIOACTIVITY

Treatment for any medical conditions arising directly or indirectly from chemical contamination, radioactivity or any nuclear material, including the combustion of nuclear fuel.

COMPLEMENTARY TREATMENT

Complementary treatment, with the exception of those treatments shown in the Table of Benefits.

COMPLICATIONS CAUSED BY CONDITIONS NOT COVERED UNDER YOUR PLAN

Expenses incurred because of complications directly caused by an illness, injury or treatment for which cover is excluded or limited under your plan.

CONGENITAL CONDITIONS

Any congenital anomalies and birth injuries where symptoms exist or where advice has been sought prior to your date of entry, unless stated otherwise on your Table of Benefits.

CONSULTATIONS PERFORMED BY YOU OR A FAMILY MEMBER

Consultations performed and any drugs or treatments prescribed by you, your spouse, parents or children.

COSMETIC TREATMENT

Any cosmetic or aesthetic treatment to enhance your appearance, even when medically prescribed. This includes treatment carried out by a plastic surgeon, whether or not for medical/psychological purposes.

The only exception is reconstructive surgery necessary to restore function or appearance after a disfiguring accident or as a result of surgery for cancer, if the accident or initial surgery was also covered by this policy.

COVER IN THE USA

Cover in the USA, unless you have the 'Worldwide' geographical area of cover, in which case cover in the USA is restricted to 180 days in any one calendar year.

DENTAL VENEERS

Dental veneers and related procedures.

DEVELOPMENTAL DELAY AND RELATED CONDITIONS

Delay in cognitive or physical development, hyperactivity, attention deficit disorder, speech therapy and developmental, social or behavioural conditions in children.

DRUG ADDICTION OR ALCOHOLISM

Care and/or treatment of drug addiction or alcoholism (including detoxification programmes and treatments to stop smoking), death associated with drug addiction or alcoholism, or the treatment of any condition that in our reasonable opinion is related to, or a direct consequence of, alcoholism or addiction (e.g. organ failure or dementia).

EXPERIMENTAL OR UNPROVEN TREATMENT OR DRUG THERAPY

Any form of treatment or drug therapy which in our reasonable opinion is experimental or unproven, based on generally accepted medical practice.

EXTREME OR PROFESSIONAL SPORTS OR ACTIVITIES

Claims arising from taking part in extreme or professional sports or activities, including but not limited to:

- base jumping
- tombstoning
- cliff jumping
- mountaineering high altitudes above 6,000 meters
- rock climbing
- paragliding
- potholing
- motorsports racing, including motocross and dirt bike racing
- bull riding or bull running
- parkour
- scuba-diving at a depth of more than 30 meters
- off-piste skiing

EYE EXAMINATIONS/HEARING TESTS

Normal eye or hearing tests for non-medical/natural degenerative eye defects, including but

not limited to, myopia, presbyopia, astigmatism, unless stated otherwise on your Table of Benefits.

FAILURE TO SEEK OR FOLLOW MEDICAL ADVICE

Treatment required as a result of failure to seek or follow medical advice.

GENETIC TESTING

Genetic testing, except:

- where specific genetic tests are included within your plan.
- where DNA tests are directly linked to an eligible amniocentesis i.e. in the case of women aged 35 or over.
- where testing for genetic receptor of tumours is covered.

INTENTIONALLY CAUSED DISEASES OR SELF-INFLICTED INJURIES

Care and/or treatment of intentionally caused diseases or self-inflicted injuries, including a suicide attempt.

MEDICAL ERROR

Treatment required as a result of medical error.

OBESITY TREATMENT

Investigations into and treatment for obesity.

ORTHOMOLECULAR TREATMENT

Please refer to the definition of "Orthomolecular treatment".

PALLIATIVE TREATMENT

Treatment of a medical condition which we, on advice or on general advice, determine is palliative, unless stated otherwise in your Table of Benefits. We will, however, pay for the stabilisation of acute exacerbations of chronic medical conditions that are not pre-existing medical conditions.

PARTICIPATION IN WAR OR CRIMINAL ACTS

Death from or treatment for any illnesses, diseases or injuries resulting from active participation in the following, whether war has been declared or not:

- **War**
- **Riots**
- **Civil disturbances**
- **Terrorism**
- **Criminal acts**
- **Illegal acts**
- **Acts against any foreign hostility**

PRE- AND POST-NATAL

Pre- and post-natal classes.

PRE-EXISTING CONDITIONS

Pre-existing conditions (including pre-existing chronic conditions) when:

- **indicated on a Special Conditions e-mail that is issued to you before your policy starts.**
- **conditions were not disclosed on the application form.**
- **conditions arise between completing the application form and the later of the following:**
  - **the date the Insurance Certificate is issued or**
  - **the start date of your policy.**

Such conditions will also be subject to medical underwriting and if not disclosed, will not be covered.

If you have a policy with Moratorium, pre-existing medical conditions are also not covered when one or more of the following have applied within the 24-month period before your date of joining (or the date shown in your Insurance Certificate):

- **It could be reasonably foreseen that the medical condition would occur after your start date.**
- **The condition clearly showed itself.**
- **You had signs or symptoms of the condition.**
- **You asked for advice about the condition.**
- **You received treatment for the condition.**
- **To the best of your knowledge, you were aware you had the condition.**

Once you've completed a continuous 24-month period after your date of joining your pre-existing medical condition may be covered provided you've not had symptoms, needed or received treatment, medication, a special diet or advice, or had any other indications of the condition.

PRESCRIBED MEDICAL AIDS

Costs of providing, maintaining or fitting any external prostheses or appliance, including but not limited to, hearing and/or visual aids or other equipment, medical or otherwise, unless stated otherwise in your Table of Benefits.

PRODUCTS PURCHASED WITHOUT A PRESCRIPTION

Products that are purchased without a doctor's prescription.

REASONABLE ADDITIONAL TREATMENT AND ACCOMMODATION CHARGES FOR UP TO SIX MONTHS AFTER THE EXPIRY OF THE PERIOD OF INSURANCE

Any expenses incurred more than six months after the expiry of the Insurance Year or after you are fit to return to your usual country of residence whichever is the earlier (please refer to your Table of Benefits).

RENAL FAILURE

Chronic supportive treatment of renal failure, including dialysis, unless the 'Routine management of chronic conditions' benefit is included in your cover. We will, however, pay for the cost of renal dialysis incurred: a) immediately pre and post operatively b) in connection with acute secondary failure when dialysis is part of intensive care.

ROUTINE OR RESTORATIVE DENTAL TREATMENT

Any routine or restorative dental treatment, whether or not performed by a medical practitioner or dental practitioner or a specialist or an oral and maxillofacial surgeon, including but not limited to root canal treatment, false teeth, denture, semi-precious and precious crowns/filling, any orthodontic treatment, or any related condition, unless stated otherwise in your Table of Benefits.

SEARCH AND/OR RESCUE OPERATIONS

Claims relating to 'search and/or rescue' operations, for instance on land or down from a mountain, to find and transport a member back to a safe location. Please note that in the case of medical evacuation, we only cover activities that begin after the 'search and/or rescue' operations conclude.

SEX CHANGE

Sex change operations and related treatments.

SLEEP DISORDERS

Treatment of sleep disorders, including insomnia, narcolepsy, snoring and bruxism.

STAYS IN A CURE CENTRE

Stays in a cure centre, bath centre, spa, health resort and recovery centre, even if the stay is medically prescribed.

STERILISATION, SEXUAL DYSFUNCTION AND CONTRACEPTION

Investigations into, treatment of and complications arising from:

- Sterilisation
- Sexual dysfunction (unless as a result of a total prostatectomy following cancer surgery)
- Contraception (including the insertion and removal of contraceptive devices and all other contraceptives), unless prescribed for medical reasons that are unrelated to birth control.

SUBSTANCES, PERSONAL PRODUCTS AND DIETARY SUPPLEMENTS

Substances, personal products and dietary supplements including vitamins and minerals (except during pregnancy or to treat diagnosed vitamin deficiency syndromes), mouthwash, toothpaste, antiseptic lozenges and sprays, shampoo, sunscreen, cosmetic products, sanitiser, gloves, masks, visors, thermometers, children's food, baby supplies and infant formula given orally. These products are excluded even if they are medically recommended, prescribed or acknowledged as having therapeutic effects. Costs incurred as a result of nutritional or dietary consultations are also not covered, unless a specific benefit shows in your Table of Benefits.

SURROGACY

Treatment directly related to surrogacy whether you are acting as a surrogate, or are the intended parent.

TERMINATION OF PREGNANCY

Termination of pregnancy, except where the life of the pregnant woman is in danger.

TRAVEL COSTS

Travel costs to and from medical facilities (including parking costs) for treatment, except when covered under 'Local ambulance', 'Medical evacuation' and 'Medical repatriation' benefits.

TREATMENT OF AUTISM SPECTRUM DISORDER

The range of therapies required to improve the skills of a person with autism. This includes specialist medical treatment and accredited behavioural programmes.

TREATMENT IN THE USA IN THE FOLLOWING CASES

Treatment in the USA if we believe that cover was taken out with the purpose of travelling to the USA to get treatment for a condition or symptoms you were aware of:

- before being insured with us
- before having the USA in your region of cover

If we paid any claims in these circumstances, we reserve the right to seek reimbursement from you.

TREATMENT OUTSIDE THE GEOGRAPHICAL AREA OF COVER

Treatment outside the geographical area of cover unless for emergencies or authorised by us.

TRIPLE/BART'S, QUADRUPLE OR SPINA BIFIDA TESTS

Triple/Bart's, Quadruple or Spina Bifida tests, except for women aged 35 or over.

TUMOUR MARKER TESTING

Tumour marker testing, unless you have previously been diagnosed with the specific cancer in question, in which case cover is provided under the 'Oncology' benefit.

VESSEL AT SEA

Medical evacuation from a vessel at sea to a medical facility on land.

BENEFITS THAT ARE NOT IN YOUR TABLE OF BENEFITS

The following benefits or any adverse consequences or complications relating to them, unless otherwise indicated in your Table of Benefits:

- Complications of pregnancy.
- Dental treatment, dental surgery, periodontics, orthodontics and dental prostheses. The only exception is oral and maxillofacial surgical procedures, which are covered within the overall limit of your Core Plan.
- Dietician fees.
- Emergency dental treatment.
- Expenses for one person accompanying an evacuated/repatriated person.

- **Health and wellbeing checks including screening for the early detection of illness or disease.**
- **Home delivery.**
- **Infertility treatment.**
- **In-patient psychiatry and psychotherapy treatment.**
- **Laser eye treatment.**
- **Organ transplant.**
- **Out-patient psychiatry and psychotherapy treatment.**
- **Out-patient treatment.**
- **Prescribed medical aids.**
- **Preventive treatment.**
- **Rehabilitation treatment.**
- **Routine maternity, Routine delivery and newborn care and Complications of childbirth.**
- **Sleep apnoea**
- **Travel costs of insured family members in the event of an evacuation.**
- **Travel costs of insured family members in the event of the repatriation of mortal remains.**
- **Travel costs of insured members to be with a family member who is at peril of death or who has died.**
- **Vaccinations.**
- **Vision Care.**

Talk to us, we love to help!

If you have any queries, please do not hesitate to contact us:

Allianz Care's 24/7 Helpline for general enquiries and emergency assistance

Phone: **+ 1 (877) 499 4809** (available 24 hours a day, 7 days of the week)

Calls to the Allianz Care Helpline will be recorded and may be monitored for training, quality and regulatory purposes. Please note that only the member (or an appointed representative) can make changes to the policy. Security questions will be asked of all callers to verify their identity.

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