EXECUTIVE HEALTHCARE SOLUTIONS

Powered by Allianz Care

Executive Healthcare Plan

Benefit Guide

Effective date: 1st November 2022

Welcome

You and your family can depend on Allianz Care as your international health insurer. EHS are Allianz Care's principal representatives for the Executive Healthcare Plan in Africa.

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

Executive Healthcare Plan overview

The Executive Healthcare Plan is designed to work as hard as you do

Your Allianz Care Executive Healthcare Plan provides the medical cover you require, with a level of service you can rely on. It also gives you the flexibility to receive treatment by the doctor of your choice, within your geographic coverage area. And should you require emergency care at a facility outside of your area, we may be able to assist you in a timely manner.

Things to consider when accessing care

1. Research what the quality of care is like in your location
   Make a plan in advance on how to deal with a medical situation should you be faced with one.
2. Ask trusted locals or co-workers for referrals to doctors or medical facilities
3. Consider the environment when visiting a medical facility
   Does it look clean? Are the doctors wearing gloves and masks when appropriate? Trust your instincts and seek care elsewhere if you feel uncomfortable.
4. Don't be afraid to ask questions
   In non-emergency situations, ask questions about the service or procedure you are having. Ask the facility about their sterilisation practices, how many years the doctor has been practicing, how many times he/she has performed the needed procedure and any other questions.
5. Know the cost
   Paying medical expenses up front can be expensive — but it doesn't have to be. Allianz Care may be able to cover your eligible out-of-pocket expenses up-front if you choose a facility from our direct-settlement community. Seeking care at a facility that's not in our direct-settlement community? We may be able to set up a one-time direct-settlement arrangement for you.

Need extra help? *Turn to our 24/7 Helpline. We can help you find providers, coordinate direct-settlement requests, provide health information and much more. Think of us as your personal guide to making the most out of your Allianz Care plan.*

Olive - Allianz Care's Health and 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 reach 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 on the App Store GET IT ON Google Play

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

Oncology Management

We understand that a cancer diagnosis can be extremely shocking and worrying. As your health partner we want to support members in the unfortunate event of a cancer diagnosis. That is why we will assign a dedicated case manager – a healthcare professional from our own Medical Team to guide and assist members going through cancer treatment. The dedicated case manager will help the member understand their cover, contacting regularly to check how treatment is going. The case manager will also proactively look after all insurance administration in advance of treatment.

For details about your specific medical plan cover, please refer to your official plan documents and its terms and conditions. You may also contact the 24/7 Helpline by dialling the number on your member ID card.

Our service philosophy

We work daily to connect you to the care you need

24/7 member services

Our multilingual, multicultural member service professionals are available to assist you around-the-clock. Personalised support is available by phone, e-mail or fax to:

- Help you find healthcare
- Answer your questions about claims, benefits and cover levels
- Process claims in many languages

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 policy
Access your policy documents and membership card on the go.

My contacts
Access our 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.

Find a hospital
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.

Additional useful features

- Update your details online: email, phone number, password, address (if it's the same country as the previous address), marketing preferences, etc.
- View the remaining balance of each benefit which is in your Table of Benefits
- Pay your premium online and view payments received
- Add or change your credit card details (if you are responsible for paying your own premium, rather than your employer)

All personal data within MyHealth Digital Services is encrypted for data protection.

Getting started:

1. Login to MyHealth online portal to register. Go to **https://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, which you can find in your Insurance Certificate.

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**

Accessing quality care

We are committed to building strong, secure partnerships with health care professionals around the globe

We have negotiated simplified prepayment procedures with thousands of medical facilities worldwide. Called "direct-settlement" arrangements, these agreements make accessing care easier and cover any eligible up-front costs associated with your care or treatment, such as planned in-patient treatment, a maternity stay or day-care treatment services. This is a significant benefit if you're faced with a more expensive medical procedure.

If you're unable to find a health care professional in our direct-settlement database, and require hospitalisation, simply send us a request.

To facilitate a direct-settlement transaction:

For preplanned treatment/non-emergency:

Contact Allianz Care to initiate pre-approval for a direct- settlement to a selected facility at least five business days prior to planned treatment. If you choose to seek treatment at a direct-settlement provider without notifying Allianz Care in advance, the provider will expect payment in full at the time of service.

While we work as closely as possible with our network providers to ensure that direct-settlement remains available for low-cost out-patient treatments, most providers ask for a credit card swipe or cash deposit to cover deductibles or co-payments.

For emergency treatment:

In the case of an emergency, please proceed immediately to a hospital or designated medical facility. If, as a result of the emergency, you are admitted to a hospital, a direct-settlement will be initiated on your behalf, for all covered conditions, the following business day. However, if you're discharged following your emergency visit, you will be responsible for all charges up front and will need to submit a claim to Allianz Care for reimbursement.

To request a one-time direct-settlement arrangement:

If you are unable to find a provider in our direct-settlement listing, simply contact the 24/7 Allianz Care Helpline at the number listed on your member ID card, and we can attempt to arrange for a one-time direct- settlement on your behalf.

To access our U.S. provider network:

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 treatment in the US, 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.

For a prescription

If your plan includes access to the Caremark's pharmacy network, you can obtain certain drugs and pharmacy products at these US pharmacies on a cashless basis. All details you need to access the Caremark pharmacy network will be shown either on your membership card or on a separate Caremark card.

Show your membership card (or the separate Caremark card) to the Caremark network pharmacy. The pharmacist will tell you if you need to pay any part of the costs, for example if there is a co-payment. Please ensure that the prescriptions have the date of birth of the person that the prescription is for.

Important note: *Pre-approval and/or referrals may be required when accessing care in the U.S. Please check your plan documents for details and to ensure that you have the U.S. cover benefit.*

How to file a claim

1 Download a claim form

You can download a claim form here:
https://www.allianzcare.com/en/welcome/ehs.html

2 Fill out your claim form

Complete all sections of the claim form in full for each treated condition, including all hospitalisation claims

3 Include all necessary documentation

Attach the following to your claim form (as appropriate):

- All paid receipts (or other proof of payment). We accept soft copies of original receipts to process your claim (i.e., if you submit claims via e-mail); however, we request that 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.
- All supporting documents relating to the claim for all treatments referred to in the claim, including the diagnosis.
- Any laboratory test results and/or X-rays relating to the claim.
- A referral letter from your specialist (if the claim includes charges for diagnostic tests).
- A copy of the referral letter from your medical practitioner (if treatment was provided by a registered physiotherapist).

4 Sign and date the form

This must be done by the insured member in order to validate the claim

5 Submit your claim

Claim submission can be done by any method listed below.

Email submission:

@ E-mail address (for covered services received outside the U.S.): claims@executive-healthcare.com

Postal submission:

For covered services received outside the U.S., submit your claim to:

Executive Healthcare Solutions Limited, 6th Floor, 9 West, Ring Road Parklands, P.O. Box 14680, 00800, Westlands, Nairobi, Kenya.

OR

Allianz Care, 15 Joyce Way, Park West Business Campus, Nangor Road, Dublin 12, Ireland.

Common insurance terminology

Co-payment

Co-payment is the cost sharing between a member and Allianz Care. It refers to the portions of a covered medical expense that the insurer and member must pay. For example, if a benefit states that there is a 25% co-payment, the insurer pays 75% of covered expenses and the member pays 25%. Refer to your plan documents to find out the co-payment rate on your plan.

Day-care and in-patient treatment

Day-care and in-patient treatment is care received in a hospital. It must be medically necessary for you to be admitted to a hospital bed. It is not dependent on whether or not you need an overnight stay.

Out-patient treatment

An insured person who receives treatment at a recognised medical facility, but is not admitted to a hospital bed as an in-patient or day-care patient.

Deductible

Deductible is the amount that a member must pay for covered services before the insurer will begin to pay. For example, if a covered expense of U.S. $831 is submitted for payment under a plan with a $250 deductible, the member must pay the first $250 of covered expenses. Please refer to your plan documents to find out the deductible on your plan.

Statement of Account/Settlement Letter

A Statement of Account, or Settlement Letter, is a document that explains a member's health claims. It is generated by the insurer and includes information about:

- Services received
- Health provider
- Date of service
- How much the provider charges for the services received
- The amount the insurer has paid to the health care provider
- How much the member may be responsible for paying (if applicable)

A Statement of Account/Settlement Letter is not an actual bill. It is provided for your information and convenience.

Pre-approval

Pre-approval (via a Treatment Guarantee Form) may be required for certain health care services received in or out of the U.S., to ensure that your plan covers those services. Examples of services that may require pre-approval are hospitalisation and out-patient surgery. Health care providers who participate in the Allianz Care network generally obtain pre-approval for you. However, if your plan covers out-of-network benefits and you seek care from an out-of-network provider, you are responsible for obtaining the pre-approval. Pre-approval is obtained by contacting the Allianz Helpline on the number on your membership card.
You must contact Allianz Care to obtain pre-approval before beginning the following treatments:

- Planned in-patient or day-care treatment (hospitalisation)
- Pregnancy or childbirth treatment
- Planned surgery
- Evacuation/Out of Country Transportation
- Psychiatric treatment — in-patient and day-care treatment
- Home nursing charges
- Planned MRI, CT and PET scans
- Evacuations are supervised by your medical practitioner or specialist at the place of incident. They are also coordinated by our Medical Services Team and its related support network or the Emergency Assistance Medical Helpline. Allianz Care must agree to any Evacuation before it takes place.

Referral

In some health plans, members must get a referral from their general practitioner (GP) to receive covered services from a specialist or other practitioner. A referral is a specific set of instructions that direct an individual to a specialist or facility for medically necessary care. A referral may be written or electronic. The term "referral" can refer both to (1) the act of sending you to another doctor or specialist, and (2) the actual paper authorising your visit.

A doctor's referral is required and must be included when filing a claim for physiotherapy.

Table of benefits

All limits and deductibles noted in the table of benefits expressed in $ shall in all instances mean US$. All benefits shown are per insured person, per period of cover (unless specifically stated).

Benefits

	Major Medical	Major Medical Plus	Foundation	Lifestyle
Maximum plan benefit	$1,600,000	$1,600,000	$2,500,000	$5,000,000
Geographical **area of coverage*** • Africa plus India, Pakistan, Bangladesh and Sri Lanka • Worldwide excluding USA • Worldwide** ** 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.* *** Worldwide cover available with Foundation and Lifestyle plans only. Deductible options for Worldwide cover are limited to $40, $80 and $150.*	As noted on your Insurance certificate	As noted on your Insurance certificate	As noted on your Insurance certificate	As noted on your Insurance certificate
Deductible Each product option carries a deductible that each member needs to pay towards claims in the plan year. Your Insurance Certificate will show you the deductible applicable.	Nil / $250 / $750 / $1,500 / $4,000	Nil / $250 / $750 / $1,500 / $4,000	Nil / $40 / $80 / $150 / $250	Nil / $40 / $80 / $150 / $250
In-patient treatment				
General in-patient charges Hospital charges, room and board, drugs and dressings, surgeon and anaesthetist fees, theatre charges, intensive care unit and pathology.	✓	✓	✓	✓
Hospital cash benefit When treatment is received as an in-patient for an eligible medical condition for a maximum of 30 nights and no costs are incurred for accommodation and/or treatment. This benefit is not applicable to accident and emergency admissions.	$450 per night	$450 per night	$450 per night	$450 per night
Parent accommodation Hospital accommodation costs in respect of a parent or legal guardian staying with an insured person who is under 18 years of age and is admitted to a hospital as an in-patient.	✓	✓	✓	✓
Newborn cover In-patient treatment of an acute medical condition and any associated costs which presents symptoms at birth or which manifests itself within 30 days following birth.	$100,000, max 90 days	$100,000, max 90 days	$100,000, max 90 days	$100,000, max 90 days

	Major Medical	Major Medical Plus	Foundation	Lifestyle
Newborn accommodation Hospital accommodation costs relating to a newborn baby to accompany its mother (being an insured person) whilst she is receiving treatment as an in-patient in a hospital.	✓	✓	✓	✓
In-patient psychiatric treatment In a registered psychiatric unit of a hospital. All benefits are conditional upon pre-approval from us and all treatment being administered under the direct control of a registered psychiatrist.	✓ (up to 30 days)	✓ (up to 30 days)	✓ (up to 30 days)	✓ (up to 30 days)
Organ transplant The entire cost incurred to perform an organ transplant, including accommodation, intensive care unit, hospital charges, surgeon fees, anaesthetist fees, operating theatre fees, specialist fees whilst an in-patient in a hospital.	✓	✓	✓	✓
Reconstructive surgery Reconstructive surgery following an accident or following surgery for an eligible medical condition.	✓	✓	✓	✓
In-patient and day-care treatment of chronic conditions Treatment of a chronic medical condition requiring in-patient or day-care treatment in a hospital.	✓	✓	✓	✓
Out-patient treatment				
Out-patient charges including: • Medical practitioner fees including consultations. • Specialist fees. • Diagnostic procedures. • Physiotherapy on referral by a medical practitioner/ specialist. • Prescribed drugs and dressings for acute conditions.	Up to $3,000 per medical condition for out-patient consultative & diagnostic costs for treatment 30 days prior to hospitalisation and for up to 90 days immediately following hospitalisation	Up to $5,000	✓	✓
Alternative medicine Alternative medicine administered by a registered chiropractor, osteopath, homeopath, ayurvedic medicine practitioner, podiatrist and acupuncturists.	✗	✗	✓ up to $1,500	✓ up to $2,000
Out-patient surgery	✓	✓	✓	✓
Out-patient psychiatric treatment Including specialist consultations. All treatments must be administered under the direct control of a registered psychiatrist.	✗	✗	✓ up to $4,500 per medical condition	✓ up to $4,500 per medical condition
Home nursing Immediately following hospital discharge on the recommendation of a specialist and must be provided by a qualified nurse. All treatments under this benefit must be pre-approved by us.	✓ up to 60 days per medical condition	✓ up to 60 days per medical condition	✓ up to 90 days per medical condition	✓ up to 120 days per medical condition
Emergency out-patient treatment inside area of coverage Emergency treatment received as an out-patient received in the accident and emergency unit of a hospital.	Up to $2,000 per period of cover	Up to $2,000 per period of cover	✓	✓

	Major Medical	Major Medical Plus	Foundation	Lifestyle
Other general benefits				
Oncology All treatments for, or related to, a diagnosed cancer. This includes palliative treatment and care during the end stages of a cancer.	✓	✓	✓	✓
Ancillary charges The purchase or rental of crutches or wheelchairs following treatment as an in-patient or day-care patient.	Up to $1,500 per medical condition	Up to $1,500 per medical condition	Up to $1,500 per medical condition	Up to $1,500 per medical condition
Durable medical equipment Durable medical equipment including prosthetic and orthotic supplies. We will pay for: • Items prescribed by a medical practitioner or specialist, which are needed to deliver, or facilitate the delivery of prescribed drugs and dressings. • The purchase and fitting of devices or items medically necessary for treatment, including, but not limited to, spinal supports, orthopaedic braces and air-cast boots • The initial purchase and fitting of external prostheses needed following surgery, including, but not limited to, artificial eyes and limbs • The purchase and fitting of medically necessary orthotic supplies, including, but not limited to, insoles and orthotic supports • This benefit does not extend to sight or hearing aids, the supply, modification or fitting of furniture, or any modifications to your personal or work environment.	Up to $1,000	Up to $1,000	Up to $1,000	Up to $2,000
Hospice care charges Treatment provided by a hospice for the care of an insured person with a terminal illness.	✓ (up to 30 days) where treatment is received as an in-patient only	✓ (up to 30 days) where treatment is received as an in-patient only	✓	✓
Rehabilitation Rehabilitation (including out-patient treatment) in a recognised rehabilitation unit of a hospital subsequent to in-patient treatment lasting 3 days or more. The rehabilitation must take place within 14 days of discharge from the in-patient admission and must be recommended and under the direct control of a Medical Practitioner. Treatment includes the use of special treatment rooms, physical and/or speech therapy fees, and other services usually given by a rehabilitation unit.	Limited to 120 days per medical condition	Limited to 120 days per medical condition	Limited to 120 days per medical condition	Limited to 120 days per medical condition
Congenital anomalies Treatment of congenital anomalies that manifest after the member's cover commences with us, or that manifest in a dependant child born in the year prior to cover commencing.	Up to $100,000 per medical condition	Up to $100,000 per medical condition	Up to $100,000 per medical condition	Up to $100,000 per medical condition
CT, MRI and PET scans Scans received as an in-patient, day-care patient or out-patient and pre-approved by us.	✓	✓	✓	✓

	Major Medical	Major Medical Plus	Foundation	Lifestyle
Evacuation/transportation				
Emergency transportation Emergency transportation costs to and from hospital, for the purpose of admission as in-patient or day-care patient, by the most appropriate transport method when considered medically necessary by a medical practitioner or specialist.	✓	✓	✓	✓
Evacuation Evacuation of an insured person in the event of emergency treatment not being readily available at the place of the incident, to an appropriate medical facility in an alternative country of your choice, within the geographical area of coverage, for the purpose of admission to hospital as an in-patient or day-care patient. Extended to cover the costs for one other person to travel with the insured person as an escort.	✓	✓	✓	✓
Out of country transportation The costs of moving an insured person in the event of non-emergency treatment not being readily available at the place of the incident, to an appropriate facility, within the geographical area of coverage, for the purpose of admission to hospital as an in-patient or day-care patient. Extended to cover the costs for one other person to travel with the insured person as an escort. Cover under this benefit is restricted to economy class flight tickets only.	✓	✓	✓	✓
Additional travel expenses (following evacuation or out-of-country transportation) Reasonable travel costs:				
• Incurred by the insured person to and from medical appointments when treatment is being received as a day-care patient.	✓	✓	✓	✓
• For an accompanying person to travel to and from the hospital to visit the insured person following admission as an in-patient.	✓	✓	✓	✓
• For an accompanying person (where applicable) for non-hospital accommodation where the insured person has been admitted as an in-patient and for the duration of the insured person's stay as an in-patient. • For the insured person and one other accompanying person (where applicable) for non-hospital accommodation only for immediate pre- and post-hospital admission periods, provided that the insured person is under the care of a specialist.	Up to a daily limit of $120 per insured person and to an overall benefit limit of $5,000 per insured person, per evacuation	Up to a daily limit of $120 per insured person and to an overall benefit limit of $5,000 per insured person, per evacuation	Up to a daily limit of $120 per insured person and to an overall benefit limit of $5,000 per insured person, per evacuation	Up to a daily limit of $120 per insured person and to an overall benefit limit of $5,000 per insured person, per evacuation
• Economy class airline ticket to return the insured person and accompanying person who has travelled as an escort to the country of residence or to the country from where evacuation occurred.	✓	✓	✓	✓

	Major Medical	Major Medical Plus	Foundation	Lifestyle
Mortal remains In the event of death from an eligible medical condition: transportation of the body of a member or his/her ashes to the country of nationality or country of residence or burial or cremation costs at the place of death in accordance with reasonable and customary practice.	✓	✓	✓	✓
Compassionate Emergency Visit Costs you have to pay for an economy class return travel ticket from a country within your area of cover for you to visit a direct family member: • If their medical condition is critical, or • To attend their burial or cremation following their death. You are limited to one return journey per Insurance Year.	✗	✗	✓	✓
Condition management				
Routine management of chronic conditions Routine check-ups, drugs and dressings prescribed for management of the condition, nursing and palliative treatment for chronic conditions.	✗	Covered up to $2,000 within the Out-patient limit (nil deductible)	Up to $5,000 per Insurance Year (nil deductible)	Up to $5,000 per Insurance Year (nil deductible)
AIDS Medical expenses which arise from or are in any way related to Human Immunodeficiency Virus (HIV) and/or HIV related illnesses, including Acquired Immune Deficiency Syndrome (AIDS) or AIDS related complex (ARC) and/or any mutant derivative or variation thereof.	Up to $10,000	Up to $10,000	Up to $10,000	Up to $10,000
Hormone replacement therapy Medical practitioner or specialist consultation and the cost of prescribed tablets, implants or patches, when treatment is prescribed for the female menopause which has been induced artificially and/or through early onset (by early onset we mean prior to age 40 years).	✗	✗	✗	✓ up to 18 months per condition
Renal dialysis Covers the cost of renal dialysis needed as a result of chronic and irreversible End Stage Renal Disease or renal failure in both kidneys caused by illness or injury unrelated to alcohol or drug abuse. Also covers 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 Treatment must be received as an in-patient, day-care patient or out-patient in a hospital, or in a legally registered and licensed dialysis centre.	✓	✓	✓	✓

	Major Medical	Major Medical Plus	Foundation	Lifestyle
Maternity benefits				
Complications of Pregnancy Treatment of a defined medical condition arising during the antenatal stages of pregnancy or during childbirth. The conditions covered are ectopic pregnancy, gestational diabetes, hydatidiform mole, miscarriage (actual or threatened), pre-eclampsia, failure to progress in labour or stillbirth. Post-partum haemorrhage and retained placental membrane that occur during childbirth are also covered by this benefit. Complications arising as a result of assisted conception, including, but not limited to, premature or multiple births are excluded from this benefit. Post-natal check-ups needed as a result of one of the above complications of pregnancy are covered for a period of 6 weeks. This benefit is payable after the first 12 months from the Start Date or Effective Date, whichever is the later.	✓	✓	✓	✓
Dental benefits				
Accidental damage to teeth Treatment received in a dental surgery or in an accident and emergency room in a hospital within seven days of incurring accidental damage caused to sound, natural teeth.	Up to $3,750 when treatment received as in-patient only per event	Up to $3,750 when treatment received as in-patient only per event	Up to $3,750 per event	Up to $3,750 per event
Routine and Major Restorative Dental Treatment Examinations, tooth cleaning, normal compound fillings, simple or non-surgical extractions. Removal of impacted, buried or unerrupted teeth, removal of roots, removal of solid odontomes, apicetomy, new or repair of bridge work, new or repair of crowns, root canal treatment, new or repair of upper or lower dentures. This benefit is subject to a six months waiting period from Start Date of this benefit or your Effective Date, whichever is the later.	✗	✗	✗	Up to $1,000 and subject to 25% co-payment (nil deductible)
Preventative care				
Vaccinations/Inoculations Medically necessary vaccinations and inoculations	✗	✗	✗	✓
Optional benefits				
Routine pregnancy and childbirth Costs associated with normal pregnancy and childbirth, pre and postnatal checkups and delivery costs. This benefit is payable after the first 12 months from your purchase date or Start Date, whichever is the later.	Optional for groups of 20+ employees with a limit of $2,500 (nil deductible)	Optional for groups of 20+ employees with a limit of $2,500 (nil deductible)	✓ Up to $4,500 (nil deductible)	✓ Up to $8,000 (nil deductible)
Elective treatment excluding USA Cover is extended to provide elective treatment worldwide excluding USA.	Optional	Optional	Optional	Optional

	Major Medical	Major Medical Plus	Foundation	Lifestyle
USA elective treatment Costs will be reimbursed on a covered in full basis, where in-patient or day-care treatment is received within our provider network or for any out-patient treatment. In-patient or day-care treatment received outside our provider network will be subject to a 50% co-payment and an annual maximum of $750,000.	⊗	⊗	Optional	Optional
Medical history disregarded Cover for treatment for any medical condition or related condition where symptoms have existed or advice has been sought prior to your Start Date under this policy (Only available to compulsory group schemes of 10 or more employees).	Optional	Optional	Optional	Optional
Wellness Routine medical check-ups, associated tests, medically necessary vaccinations and inoculations.	⊗	⊗	Optional up to $400	Optional up to $400
Routine dental treatment Examinations, tooth cleaning, normal compound fillings, simple or non-surgical extractions and root canal treatment incurred after six months from the purchase date of this benefit or your Start Date, whichever is the later.	⊗	⊗	Optional Up to $400 subject to 25% co-payment (nil deductible)	✓ Up to US$1,000 and subject to 25% co-payment (nil deductible)
Vision care Includes cover for one routine eye exam per Insurance Year and the purchase of Vision Hardware when the member's prescription has changed, up to the amount listed in the insurance certificate. Vision Hardware covers prescribed spectacle lenses and frames or prescribed contact lenses.	⊗	⊗	Optional for groups of 5 or more employees, up to $250	Optional for groups of 5 or more employees, up to $250
Health services				
Travel Security Services** Offers 24/7 access to personal security information and advice for all your travel safety queries. This includes: • Emergency Security Assistance Hotline (not a free phone number) • Country intelligence and security advice • Daily security news updates and travel safety alerts	✓	✓	✓	✓
Employee Assistance Programme** Offers access to a range of 24/7 multilingual support services as follows: • Confidential, professional counselling (in-person, phone, video and chat) • Legal and financial support services • Critical incident support • Wellness website access	✓	✓	✓	✓

*** Certain services which may be included in your plan are provided by third party providers, such as the Employee 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 the insurer, its reinsurer and its administrator 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.*

What is covered

We will provide cover for the treatment of medical conditions which first manifest themselves during any period of cover and where treatment is actually given during the current period of cover or where such medical conditions have manifested themselves prior to the effective date but have been declared to and accepted by us in writing.

We will provide benefits for the following, subject to the level of cover chosen and the benefits detailed in Table of Benefits and in your Insurance Certificate. Any benefits listed below which do not appear in the Table of Benefits or your Insurance Certificate are not covered. All costs incurred must be medically necessary and subject to reasonable and customary charges.

In-patient charges

1. General in-patient charges

a) Hospital accommodation, limited to a standard private room and associated charges, including admittance to the intensive care unit as an in-patient or day-care patient, and charges for nursing by a qualified nurse.
b) Medical practitioner/specialist fees.
c) Surgeon fees.
d) Anaesthetist fees.
e) Drugs and dressings and appliances.
f) Theatre fees and other charges incurred for the treatment of a medical condition.
g) Diagnostic procedures including pathology, X-rays, MRI scans, CT Scans and PET scans.

2. Hospital cash benefit

Where you receive treatment for an eligible medical condition as an in-patient and no costs are incurred for accommodation and treatment. To claim this benefit please ask the hospital to sign and stamp your claim form. This benefit is not applicable to admissions into the accident and emergency facility of the hospital.

3. Parent Accommodation

Standard private room accommodation in respect of one parent or legal guardian staying with an insured person who is under 18 years of age and is admitted as an in-patient to a hospital.

4. Newborn cover

In-patient treatment of an acute medical condition being suffered by a newborn baby which manifests itself within 30 days following birth. Following the 30 day newborn benefit period, excepting any medical conditions occurring or manifesting themselves during the 30 day period immediately following birth, your dependant will be eligible for cover up to the full provision of this policy. Cover is subject to the child being included under their parent(s) policy and all premiums due being paid in full.

5. Newborn accommodation

Hospital accommodation costs relating to a newborn baby to accompany its mother (being an insured person) whilst she is receiving treatment as an in-patient in a hospital.

6. In-patient psychiatric care

In-patient treatment in a recognised psychiatric unit of a hospital and where treatment is under the direct care of a registered psychiatrist.

No benefits are payable in respect of this benefit for any medical condition, or any related condition, which existed at any time prior to your join date.

All treatments under this benefit must be pre-approved by us. Without our written confirmation prior to such treatment, we will not be liable to pay any benefit.

7. Organ transplant

The entire cost incurred to perform an organ transplant, including accommodation, intensive care unit, hospital charges, surgeon fees, anaesthetist fees, operating theatre fees, specialist fees whilst an in-patient in a hospital.

Organ transplants covered under this policy are:
a) Heart
b) Heart/lung
c) Lung
d) Kidney
e) Kidney/pancreas
f) Liver
g) Allogenic bone marrow
h) Autologous bone marrow

8. Reconstructive surgery

Reconstructive surgery required as a result of an accident or illness which occurred during the period of cover and is undertaken within 12 months of the accident/illness occurring to restore natural function or appearance, subject to the cover being in force at the time of the reconstructive treatment.

9. In-patient and day-care treatment of chronic conditions

Treatment of a chronic medical condition requiring in-patient or day-care treatment in a hospital.

Out-patient charges

10. General out-patient charges

a) Medical practitioner fees including consultations.
b) Specialist fees.
c) Diagnostic procedures including pathology, X-rays, MRI Scans, CT Scans and PET Scans.

d) Physiotherapy on referral by a medical practitioner is restricted to 10 sessions per medical condition, after which it must be further reviewed by a specialist. A medical report will be required for out-patient physiotherapy after 10 sessions. A referral letter/report must be submitted with the first claim for such treatment.
e) Prescribed drugs and dressings, medicines and appliances prescribed by a medical practitioner or specialist to treat an acute condition.

11. Alternative medicine

Alternative medicine administered by a registered chiropractor, osteopath, homeopath, ayurvedic medicine practitioner, podiatrist and acupuncturist.

12. Out-patient surgery

Surgical procedures undertaken as an out-patient in a hospital or licensed medical facility.

13. Out-patient psychiatric treatment

Out-patient treatment, including specialist consultations, where treatment is under the direct care of a registered psychiatrist.

All treatments under this benefit must be pre-approved by us. Without our written confirmation prior to such treatment, we will not be liable to pay any benefit. However, the initial consultation with a medical practitioner (not a psychiatric specialist), which results in a psychiatric referral is covered without the requirement for pre-approval.

No benefits are payable in respect of this benefit for any medical condition, or any related condition, which existed at any time prior to your join date.

14. Home nursing

Nursing care given outside a hospital which is immediately received subsequent to treatment as an in-patient or day-care patient on the recommendation of a specialist and must be provided by a qualified nurse. All treatment under this benefit is conditional upon pre-approval from us. Without our written confirmation prior to such treatment, we will not be liable to pay any benefit.

15. Emergency out-patient treatment

Treatment administered as a result of an emergency for an eligible medical condition received in the accident and emergency unit of a hospital.

Other general benefits

16. Oncology

All treatment for, or related to, a diagnosed cancer. This includes palliative treatment and care during the end stages of a cancer.

17. Ancillary expenses

The purchase or rental of crutches or wheelchairs following treatment as an in-patient or day-care patient.

18. Durable medical equipment

Durable medical equipment including prosthetic and orthotic supplies. We will pay for:

- Items prescribed by a medical practitioner or specialist, which are needed to deliver, or facilitate the delivery of, prescribed drugs and dressings.
- The purchase and fitting of devices or items medically necessary for treatment, including, but not limited to, spinal supports, orthopaedic braces and air cast boots
- The initial purchase and fitting of external prostheses needed following surgery, including, but not limited to, artificial eyes and limbs
- The purchase and fitting of medically necessary orthotic supplies, including, but not limited to, insoles and orthotic supports
- This benefit does not extend to sight or hearing aids, the supply, modification or fitting of furniture, or any modifications to your personal or work environment.

19. Hospice care charges

Treatment provided by a hospice for the care of an insured person with a terminal illness.

Such treatment will cover:
a) Palliative treatment and other acute and chronic symptom management
b) Medical social services under the direction of a medical practitioner or specialist
c) Nursing care and home nursing (for up to eight hours in any one day)
d) Physiological and dietary counselling

20. Rehabilitation

Rehabilitation (including out-patient treatment) in a recognised rehabilitation unit of a hospital subsequent to in-patient treatment lasting three days or more. The rehabilitation must take place within 14 days of discharge from the in-patient admission and must be recommended and under the direct control of a Medical Practitioner. Treatment includes:

a) Use of special treatment rooms
b) Physical therapy fees
c) Speech therapy fees
d) Other services usually given by a rehabilitation unit including qualified nurse care but not including private or special nursing or specialist services.

21. Congenital anomalies

Treatment of congenital anomalies that manifest after the member's cover commences with us, or that manifest in a dependant child born in the year prior to cover commencing.

22. CT, MRI and PET scans

Diagnostic Scans received as an in-patient, day-care patient or out-patient and pre-approved by us.

Evacuation/transportation benefits

23. Emergency transportation

Emergency Transportation costs to and from hospital, for the purpose of admission as in-patient or day-care patient, by the most appropriate transport method when considered medically necessary by a medical practitioner or specialist.

24. Evacuation

Evacuation costs of moving an insured person in the event of emergency treatment not being readily available at the place of the incident, to an appropriate medical facility in an alternative country of your choice, within the geographic area of coverage, for the purpose of admission to hospital as an in-patient or day-care patient (excluding all maternity or childbirth costs, except for the 'Complications of Pregnancy' benefit). Evacuation is subject to written agreement from us prior to travel and certified instructions from the attending medical practitioner or specialist including confirmation that the required treatment is unavailable at the place of incident. Extended to cover the costs for one other person to travel with the insured person, as escort, if medically necessary. Our medical advisors will decide the most appropriate method of transportation for the evacuation and the most appropriate hospital to which you will be evacuated.

Costs of evacuation do not extend to include any Air-Sea rescue or mountain rescue costs that are not incurred at recognised ski resorts or similar winter sports resorts.

25. Out of country transportation

The costs of moving an insured person in the event of non-emergency treatment not being readily available at the place of the incident, to an appropriate medical facility in an alternative country of your choice, within the geographic area of coverage, for the purpose of admission to hospital as an in-patient or day-care patient (excluding all maternity or childbirth costs, except for the 'Complications of Pregnancy' benefit). Cover under this benefit is subject to written agreement from us prior to travel and certified instructions from the attending medical practitioner or specialist including confirmation that the required treatment is unavailable at the place of incident.

Cover under this benefit is restricted to economy class flight tickets only.

26. Additional travel expenses (following evacuation and out of country transportation)

Reasonable travel costs:

a) Incurred by the insured person to and from medical appointments when treatment is being received as a day-care patient.
b) For an accompanying person to travel to and from the hospital to visit the insured person following admission as an in-patient.
c) For an accompanying person (where applicable) for non-hospital accommodation where the insured person has been admitted as an in-patient and for the duration of the insured persons stay as an in-patient.
d) For the insured person and one other accompanying person (where applicable) for non-hospital accommodation only for immediate pre- and post-hospital admission periods provided that the insured person is under the care of a specialist.
e) Economy class airline ticket to return the insured person and accompanying person who has travelled as an escort to the country of residence or to the country from where evacuation occurred.

27. Mortal remains

In the event of death from an eligible medical condition: transportation of the body of a member or his/her ashes to the country of nationality or country of residence or burial or cremation costs at the place of death in accordance with reasonable and customary practice.

Necessary burial or cremation fees including

- The cost of reopening a grave and burial costs, or
- The cost of opening a new grave and burial costs, including any exclusive right of burial fee, or
- In the case of cremation:
  a) The cremation fee
  b) The cost of any doctor's certificates
  c) The cost of removing a pacemaker or other medical device which must be removed before the cremation

But not including costs related to other funeral expenses, such as:

- Funeral director's fees
- Flowers
- The cost of any documents needed for the release of the money, savings and property of the deceased
- The necessary cost of a return journey for you to either
  a) Arrange the funeral, or
  b) Attend the funeral

28. Compassionate Emergency Visit

Costs you have to pay for an economy class return travel ticket from a country within your area of cover for you to visit a direct family member:

- If their medical condition is critical, or
- To attend their burial or cremation following their death

You are limited to one return journey per insurance year.

Condition management

29. Routine management of chronic conditions

Cover under the policy is extended to include routine management and palliative treatment incurred in connection with a chronic medical condition.

Expenses are limited to routine check-ups associated with the chronic medical condition, drugs and dressings prescribed for management of the medical condition and nursing care.

For this benefit only, exclusions 2 and 38 are deleted.

30. AIDS

Medical expenses which arise from or are in any way related to Human Immunodeficiency Virus (HIV) and/or HIV related illnesses, including Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) and/or any mutant derivative or variations thereof.

Expenses are limited to pre- and post-diagnosis consultations, routine check-ups for this condition, drugs and dressings (except experimental or those unproven), hospital accommodation and nursing fees.

For this benefit only, exclusions 2 and 36 are deleted.

31. Hormone replacement therapy

Medical practitioner or specialist consultations and the cost of prescribed tablets, implants or patches when treatment is for the female menopause which has been induced artificially and/or through early onset (by early onset we mean prior to age 40 years).

For this benefit only, exclusion 37 is deleted.

32. Renal dialysis

Covers the cost of renal dialysis needed as a result of chronic and irreversible End Stage Renal Disease or renal failure in both kidneys caused by illness or injury unrelated to alcohol or drug abuse.

Also covers 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

Treatment must be received as an in-patient, day-care patient or out-patient in a hospital, or in a legally registered and licensed dialysis centre.

Maternity benefits

33. Complications of pregnancy

Treatment of a defined medical condition arising during the antenatal stages of pregnancy or during childbirth. The conditions covered are ectopic pregnancy, gestational diabetes, hydatidiform mole, miscarriage (actual or threatened), pre- eclampsia, failure to progress in labour or stillbirth. Post-partum haemorrhage and retained placental membrane that occur during childbirth are also covered by this benefit. Complications arising as a result of assisted conception, including, but not limited to, premature or multiple births are excluded from this benefit. Post natal check-ups needed as a result of one the above complications of pregnancy are covered for a period of 6 weeks. This benefit is payable after the first 12 months from the start date or effective date, whichever is the later.

Dental benefits

34. Accidental damage to teeth

Treatment initially received in a dental surgery or in an accident and emergency ward of a hospital within seven days of incurring accidental damage caused to sound, natural teeth, except when the accidental damage has been caused through eating, when given by a medical practitioner or dental practitioner.

35. Dental treatment

a) *Routine dental treatment*
Fees of a dental practitioner carrying out routine dental treatment in a dental surgery. Routine dental treatment is defined as:
- Examinations
- Tooth cleaning
- Normal compound fillings
- Simple or non-surgical extractions
- Root canal treatment, new or repair of upper or lower dentures

b) *Major restorative dental treatment*
Fees of a dental practitioner and associated costs for the following specified procedures:
- Removal of impacted, buried or un-erupted teeth
- Removal of roots, removal of solid odontomes
- Apicectomy, new or repair of bridge work, new or repair of crowns

Costs incurred within the first six months from the purchase date of this benefit or your effective date, whichever is the later, are excluded, unless otherwise noted on the insurance certificate.

For this benefit only, exclusions 1, 23 and 38 are deleted.

Preventative care

36. Vaccinations/inoculations

The costs associated with recognised medically necessary preventative vaccinations and immunisations.

Optional benefits

37. Routine pregnancy and childbirth

Costs associated with normal pregnancy and childbirth, including normal deliveries as a result of infertility treatment (assisted conception), voluntary caesarean section costs and medically necessary caesarean costs due to any previous caesarean sections.

This benefit also covers the cost of pre-natal and post-natal check-ups for up to six weeks after delivery prescribed pre-natal vitamins and delivery costs, including costs associated with qualified midwives. All costs relating to complications of pregnancy or childbirth following infertility treatment (assisted conception) will be limited to this benefit.

This benefit extends to include only the following for a newborn child:

- one physical examination;
- vitamin K, hepatitis B and BCG vaccinations;
- circumcision;
- routine blood tests for PKU, congenital hypothyroidism and G6PD;

- one hearing examination; and
- reasonable accommodation costs for no more than four nights, if the mother is admitted and not suffering any complications.

The policy deductible does not apply to this benefit. This benefit is payable after the first 12 months from the start date or effective date, whichever is the later. The new born must be enrolled as a member within 30 days after birth in order to be eligible for any benefits (as per Policy terms) after the first 24 hours.

38. Worldwide elective treatment excluding the USA

Cover under this policy is extended to provide elective treatment worldwide excluding USA. All planned in-patient and day-care patient cover must be notified to us prior to commencement of treatment. Accident and emergency treatment required in the USA will be reimbursed on a covered in full basis unless such treatment is as a result of where symptoms existed immediately prior to the first date of travel, or where such medical condition would otherwise be excluded under exclusion 1 of this policy or for any medical condition specifically excluded from cover as noted in your insurance certificate. Cover is for a maximum of 90 days during the period of cover and limited to a maximum of 60 days of treatment per event.

For this option only, the first paragraph of exclusion 32 is deleted and replaced with:

Accident and emergency treatment in the USA is covered unless as a result of a medical condition where symptoms existed immediately prior to the first date of travel, or where such medical condition would otherwise be excluded under exclusion 1 of this policy or for any medical condition specifically excluded from cover as noted in your insurance certificate. In the event of emergency treatment being required in the USA, you should contact us or our 24 hour Medical Helpline either before or as soon as possible after admission to the accident and emergency unit of the hospital.

Complications of maternity and/or childbirth are not deemed to be accident and emergency treatment for the purposes of this policy.

39. USA elective treatment

Cover under this policy is extended to provide elective treatment in the USA.

Costs will be reimbursed on a covered in full basis, subject to the level of deductible shown in your insurance certificate, where in-patient or day-care patient treatment is received within our provider network, or where out-patient treatment is provided. In-patient or day-care treatment received outside our provider network will be subject to 50% co-payment and an annual maximum of US$750,000 per insured person per period of cover. All planned in-patient or day-care treatment cover must be notified to us prior to commencement of treatment.

For this option only, exclusion 32 is deleted.

40. Medical history disregarded

This option is only applicable to group schemes of 10 employees or more enrolled in a compulsory company policy (compulsory means ALL employees and their dependants are enrolled within 30 days of eligibility, ALL employees and their dependants are deleted within 30 days of leaving the company employment. Any employee or dependant not covered within 30 days of eligibility will be subject to individual underwriting).

Cover under this policy is extended to include treatment for medical conditions from which you have previously suffered, or related conditions.

Cover can be offered subject to a declaration of material facts being submitted by the group administrator on behalf of the employees and their dependants, and cover on a medical history disregarded basis will be at our discretion.

Continuous transfer terms will be the only option available where the scheme was accepted by the previous insurer on a fully underwritten basis.

For this option only exclusion 1 is removed. Any waiting periods applicable to any of the benefits noted in your policy and in the Table of Benefits are removed under this option.

41. Wellness

a) The cost of one annual routine medical check-up and associated tests. Such routine check-ups/tests to include:
   - Blood and cholesterol checks
   - Height/weight body mass index
   - Resting blood pressure
   - Urine analysis
   - Cardiac examination
   - Exercise electrocardiogram (ECG)
   - Other Vital organ function tests
   - Chest X-ray

b) Well-child checks, effective from 24 hours after birth and as recommended by a medical practitioner or specialist. This includes physical examinations, measurements, sensory screening, neuropsychiatric evaluation, development screening, as well as hereditary and metabolic screening, immunisations, urine analysis, tuberculin tests and hematocrit, haemoglobin and other blood tests, including tests to screen for sickle haemoglobinopathy.
c) Vaccinations, including those medically necessary for travel.
d) Bilateral mammogram/breast examination
e) Testicular/prostate examination/PSA/DRE Tests
f) Routine gynaecological tests, including PAP tests.

42. Routine dental treatment

Fees of a dental practitioner carrying out routine dental treatment in a dental surgery. Routine dental treatment is defined as:

- Examinations
- Tooth cleaning
- Normal compound fillings
- Simple or non-surgical extractions
- Root canal treatment

Benefit is limited to maximum of five visits and/or services per insured person per period of cover. Costs incurred within six months from the date of purchase of this option or your effective date, whichever is the later, are excluded.

For this option only exclusions 1, 23 and 38 are deleted.

43. Vision care

Includes cover for one routine eye exam per period of cover and the purchase of vision hardware when the member's prescription has changed, up to the amount listed in the insurance certificate.

Vision hardware covers prescribed spectacle lenses and frames or prescribed contact lenses.

For this option only, exclusions 6 and 38 are deleted.

44. 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 https://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.

  https://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.

45. Employee Assistance Programme (EAP)**

When challenging situations arise in life or at work, our Employee 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
- Workplace challenges
- Cross-cultural transition
- Cultural shock
- Coping with isolation and loneliness
- Addiction concerns

Support services include:

CONFIDENTIAL PROFESSIONAL COUNSELLING
Receive 24/7 support with a clinical counsellor through live online chat, face to face, phone, video or email.

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.

https://www.allianzcare.com/eap-login
(available in English, French and Spanish)

Download the Lifeworks app in Google Play or Apple Store

Download on the App Store | GET IT ON Google Play

Login on the website or the app using the following details:
Username: AllianzCare
Password: Expatriate

***Certain services which may be included in your plan are provided by third party providers, such as the Employee 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 the insurer, its reinsurer and its administrator 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.*

What is not covered

This policy does not cover expenses arising from:

1. Any medical condition or related condition for which you have received treatment, had symptoms of, and to the best of your knowledge existed or you sought advice for prior to your effective date (pre-existing medical condition), except where such medical conditions have been declared to us and accepted in writing. After two years of continuous membership, any pre- existing medical conditions (and related conditions), with the exception of congenital conditions, will become eligible for benefit provided (in respect of that condition) that you have not during that period:

   1.1 Consulted any medical practitioner or specialist for treatment or advice (including checkups).

   1.2 Experienced further symptoms.

   1.3 Taken medication (including drugs, medicines, special diets or injections).

1a. A medical condition or symptom that you were aware of before your start date and not declared or if declared, We have excluded cover. This exclusion applies if your underwriting terms are FMU or CTT previously FMU, as shown on your Insurance Certificate.

2. Treatment of a medical condition which we, on advice or general advice determine is palliative treatment or a chronic medical condition, unless the benefit for 'Routine Management of Chronic Conditions' is included within the policy.

   We will, however, pay for treatment of chronic medical conditions requiring in-patient or day-care treatment in a hospital that are not pre-existing medical conditions.

3. Treatment, which we determine on medical advice is either experimental or unproven.

4. Birth injuries, congenital anomalies, genetic deformities or diseases except as provided in the 'Congenital anomalies' benefit of the policy and where cover is specifically noted in the Table of Benefits.

5. Routine physical examination by a medical practitioner, including gynaecological investigations, routine tests, normal hearing tests, newborn neonatal care, inoculations, vaccinations and preventative medicines, except as provided in the 'Vaccinations/inoculations' benefit and the Optional 'Wellness' benefit, and where cover is specifically noted in the Table of Benefits and/or as shown in the insurance certificate.

6. Normal eye tests, non-medical/natural degenerative eye defects, including but not limited to myopia, presbyopia and astigmatism and any corrective surgery for non- medical/ natural degenerative sight defects, except as provided under the optional 'vision care' benefit and where cover is specifically noted in the Table of Benefits and/or as shown in the insurance certificate.

7. Rehabilitation except as provided in the 'Rehabilitation' benefit of the policy.

8. Treatment received in health hydros, nature cure clinics, spas, or similar establishments. Services such as massages, hydrotherapy, reiki, or other non-medical treatments. Treatment given at establishments or a hospital where that facility has become the member's home or permanent abode or where admission is arranged wholly or partly for domestic reasons.

9. Cosmetic treatment, and any consequence thereof.

10. Any treatment for weight loss or weight problems including but not limited to bariatric procedures, diet pills or supplements, health club memberships, diet programs and treatment in a residential treatment facility for eating disorders. Any complications arising from weight loss or other excluded procedures are not covered.

11. Costs of providing, maintaining or fitting any external prostheses or appliance, hearing and/or visual aids, or other equipment, medical or otherwise except as specified in the 'ancillary charges' benefit and the 'durable medical equipment' benefit where cover is specifically noted in the Table of Benefits and/or as shown in the insurance certificate.

12. Costs incurred in connection with locating a replacement organ or any costs incurred for removal of the organ from the donor, transportation costs of same and all associated administration costs.

13. Any second or subsequent medical opinions from a medical practitioner or specialist for the same medical condition unless it has been approved by us in writing.

14. Costs associated with normal pregnancy and childbirth and any related condition within the first 12 months from purchase date of this benefit or effective date whichever is later.

15. Voluntary caesarean section costs or medically necessary caesarean section costs due to any previous voluntary caesarean sections undertaken, unless the benefit for Routine Maternity has been purchased.

16. Pregnancy terminations on non-medical grounds, antenatal classes, midwifery costs when not associated with delivery.

17. Complications of pregnancy costs arising within the first 12 months from purchase date of this benefit or effective date, whichever is later.

18. Treatment directly or indirectly arising from or required in connection with male and female birth control, infertility and/or fertility and sterilisation (or its reversal).

19. Infertility treatment (assisted conception) is excluded. Any complications of pregnancy and routine pregnancy costs resulting from infertility treatment (assisted conception) will be limited to the amount of your selected routine pregnancy and childbirth benefit. A declaration of health is required in respect of all dependants who are born following assisted conception.

    We reserve the right to reject any application without giving any reason.

20. Treatment of impotence or any related condition or consequence thereof.
21. Treatment directly or indirectly associated with a sex change and any consequence thereof.
22. Venereal disease or any other sexually transmitted diseases or any related condition.
23. 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, except as provided in the 'Routine and major restorative dental treatment' benefit or under the optional 'Routine dental' benefit of the policy, and where such cover is specifically noted in the Table of Benefits and/or as shown in the insurance certificate.
24. Orthodontic treatment, gingivitis, and periodontitis or any related condition.
25. Costs in respect of a psychotherapist, psychologist, (unless referred to by and under the control of a psychiatrist under the 'In-patient psychiatric treatment' benefit and the 'Out-patient psychiatric treatment' of this policy), a family therapist or bereavement counselor.
26. Treatment for learning difficulties, hyperactivity, attention deficit disorder, speech therapy and developmental, social or behavioural problems unless provided in the 'Rehabilitation' benefit of this policy.
27. Treatment for alcoholism, drug or substance abuse or any addictive condition of any kind and any injury or illness arising directly or indirectly from such abuse or addiction.
28. Suicide or attempted suicide, or any bodily injury or illness which is wilfully self-inflicted or due to negligent or reckless behaviour.
29. Any injury sustained directly or indirectly as a result of the insured person acting illegally or committing or helping to commit a criminal offence.
30. Travel and accommodation costs unless specifically agreed by us in writing prior to travel. The costs of a hire car are also not payable.

    No travel and accommodation costs are payable where treatment is obtained solely as an out-patient.
31. Costs and expenses incurred where an insured person has travelled against medical advice.
32. Elective treatment received outside the area of coverage. However, accident and emergency treatment is covered unless as a result of a medical condition where symptoms existed immediately prior to the first date of travel, or where such medical condition would otherwise be excluded under exclusion 1 of this policy or for any medical conditions specifically excluded from cover as noted in your insurance certificate. In the event of emergency treatment being required in the USA, you should contact us or our 24 hour Helpline either before or as soon as possible after admission to the accident and emergency unit of the hospital. Complications of maternity and/or childbirth are not deemed to be accident or emergency treatment for the purposes of this policy.

    Additionally benefit is payable for the medical expenses which arise as a result of an emergency, which do not require you to seek treatment in the accident and emergency unit of a hospital whilst you are temporarily travelling in the USA and where the medical condition did not exist prior to travel. Benefit is limited to US$500 per insured person and a deductible of US$80 per medical condition.

    Cover for accident and emergency treatment outside your selected area of coverage is for a maximum of 90 days during the period of cover and limited to a maximum of 60 days of treatment per event.
33. Treatment received in connection with insomnia, sleep disorders, sleep apnoea, fatigue, jet lag, work related stress or any related condition.
34. Dietary supplements and substances that can be purchased without prescription, including, but not limited to, vitamins, minerals, organic substances, and infant formula given orally. We will however pay for prescribed pre natal vitamins under the Routine Pregnancy benefit if purchased.
35. Home visits by a medical practitioner, specialist or qualified nurse unless specifically agreed by us in writing prior to consultation.
36. Human Immunodeficiency Virus (HIV) and/or HIV related illness including Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) and/or any mutant derivative or variations thereof, however caused, except as provided in the 'AIDS' benefit of the policy, and where such cover is specifically noted in the Table of Benefits and/or as shown in the insurance certificate.
37. Hormone Replacement Therapy (HRT) or any similar or associated medication or treatment, except as provided in the 'Hormone replacement therapy' benefit of the policy, and where such cover is specifically noted in the Table of Benefits and/or as shown in the insurance certificate.
38. The deductible amount as shown in your insurance certificate will be applied per insured person per period of cover.
39. Treatment for complications arising from any uncovered and/or excluded procedures or treatments.
40. Self-treatment, or treatment provided by a Direct Family Member. This includes but is not limited to prescribed or non-prescribed medication, diagnostic tests and surgical procedures.
41. Hazardous Sports/Activities: The following Hazardous Activities are excluded: playing professional sports; mountaineering, including potholing, spelunking or caving; high-altitude trekking over 5000 metres; skiing off-piste or any other winter sports activity carried out off-piste; and Arctic or Antarctic expeditions.
42. Treatment directly related to surrogacy whether you are acting as a surrogate, or are the intended parent.
43. Cover is not provided if any element of the cover, benefit, activity, business or underlying business violates any applicable sanction law or regulations of the United Nations, the European Union or any other applicable economic or trade sanction law or regulations.

General conditions

1. Policy

Your application form, our written acceptance, your table of benefits, your Insurance certificate and the benefit guide must be read as one as they form the basis of your contract with us.

2. Contribution

If you, or any dependant named on your policy, are entitled to claim from any other insurance policy for any of the costs, charges or fees for which you are insured under this contract, you must disclose the same to us and we shall not be liable to pay or contribute more than our rateable proportion.

If it is found that you were repaid for all or some of those expenses by another source including any other insurance policy (as outlined in General Condition 16), we will have the right to a refund from you. Where necessary we retain the right to deduct such refund from any impending or future claim settlements or to cancel your policy void from commencement, without a refund of premium — see General Condition 21.

3. Transfers

a) Where you transfer to the Executive Healthcare Plan from any other of our existing plans or, whilst covered under the Executive Healthcare Plan, you apply for and receive any enhanced benefits or cover (such as inclusion of an endorsement at any renewal date), any enhanced benefits, cover or maximum refundable amounts are restricted to new medical conditions which have not been previously suffered from, whether or not diagnosed, occurring after the date of transfer.

b) Transfer from a group to an individual policy is subject to written approval from us. Terms of cover may be subject to variation.

c) Transfer from any other similar private medical cover provided by any other insurer is subject to completion of a continuous transfer terms declaration form, submission of a copy of the expiring policy and subject to there being no break in cover. We reserve the right at all times to decline an application without giving any reason and/or to offer alternative terms.

4. Family/dependant cover

You and your dependants are required to be covered under the same policy with identical benefits. Where we find that this is not the case, you will be asked to comply with this request at your next renewal. Failure to comply with this condition will result in the termination of your policy.

5. Acceptance clause

We are entitled to refuse to accept an application from any person without giving a reason. We maintain the right to ask you to provide proof of age and/or state of health of any person included in your application. We reserve the right to apply additional endorsements, exclusions or premium increases to reflect any circumstances you advise in your application form or declared to us as a material fact.

6. Eligibility

The policy is designed for expatriates based in countries in Africa*. Local nationals can only be considered subject to our approval**. New applicants will be eligible for cover up until the age of 65. Individuals over the age of 65 are not eligible for cover unless the insured person's effective date was prior to their 65th birthday.

For compulsory group schemes, ALL employees and their dependants must be enrolled within 30 days of eligibility, ALL employees and their dependants must be deleted within 30 days from when their employment ceased.

Any employee or their dependant not enrolled within 30 days of eligibility will be subject to individual underwriting.

Under the terms of this policy, cover is not available to persons where the country of residence is outside any of the African countries, irrespective of their country of nationality.

If during the insurance year your country of residence is outside any of the African countries, we will not be able to offer you renewal.

** 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.*

*** Subject to local requirements.*

7. Compliance with policy terms and conditions

We shall not be liable under this policy in the event of any failure by an insured person to comply with its terms and conditions, except where the circumstances of any claim are unconnected with such failure and no fraud is involved.

8. Medical evaluation

We reserve the right to request further tests and/or evaluation where we decide that the condition being claimed for may be directly or indirectly related to an excluded condition.

9. Change of risk

The policyholder must inform us as soon as reasonably possible of any material changes relating to any insured person which affect information given in connection with the application for cover under this policy. We reserve the right to alter the policy terms or cancel cover for an insured person following a change of risk.

10. Policy duration and premiums

a) The policy is for one year and is renewable for successive one year periods, subject to the terms in force at the time of each renewal date and to payment of the premium.

b) The premium payable may be changed by us from time to time. If you move into a higher age band, the premium will increase at the next renewal date. However, this policy will not be subject to any alteration in premium rates generally introduced until the next renewal date.

c) All premiums are payable in advance of any cover under this policy being provided.

d) Your policy is an annual contract and you are responsible for the whole year's premium even if we have agreed that you may pay by instalments.

11. Government taxes

Unless we state otherwise on the invoice, the premium charged shall be paid in cleared funds, without any deductions or set-off of any current or future taxes, levies, import duties, charges and fees of any nature whatsoever. If you are required to make any such deduction, you shall pay us such additional amounts as are necessary to ensure receipt by us of the full amount which we would have received prior to deductions.

We reserve the right to modify our products, services, rates and fees, during the insurance year, in response to any change in the applicable laws and regulations or to any requests of government authorities resulting in changes to policy benefits. We also reserve the right to add, apply and/or recover any fees, levies and/or taxes, during the insurance year, in light of any changes in the applicable laws and regulations, even if no benefit or policy changes are mandated.

12. Break in cover

Where there is a break in cover, for whatever reason, we reserve the right to reapply exclusion 1 in respect of pre-existing medical conditions.

13. Children

Newborn children will be accepted for cover (subject to the limitations of the 'Newborn cover' benefit) from birth. Acceptance of newborn babies is subject to written notification within 30 days of birth and receipt of the full premium within a further 30 days following notification.

Children who are not more than 18 years old residing with you, or 26 years old if in full-time education, at the date of joining or at any annual renewal date, will be accepted for cover as your dependants. Children will not be accepted for cover, unless on a policy with a legal parent or guardian and subject to the identical benefits applying to all parties.

A declaration of health is required in respect of all dependants who are born following assisted conception. We reserve the right to reject any application without giving any reason.

14. Alterations

a) We may alter the terms and conditions of this policy at any renewal date. A copy of the current policy terms will be sent to you at such time. You may cancel your policy within 30 days following any renewal date and provided you have not made a claim, we will refund your premium. We will give you reasonable notice of such alterations. We will send details of such alterations to the address we have for you. However, the alterations will take effect even if you do not receive them for any reason.

b) No alteration or amendment to the policy terms will be valid unless it is in writing from us.

15. Waiver

Waiver by us in any instance of any term or condition of this policy will not prevent us from relying on such term or condition in other instances.

16. Cancellation

In the event of any non-payment of premium, we shall be entitled to cancel this policy. We may at our discretion reinstate the cover if the premium is subsequently paid, though terms of cover may be subject to variation. Whilst we shall not cancel this policy because of eligible claims made by any insured person, we may at any time terminate an insured person's cover if he/she or the policyholder has at any time:

a) Misled us by misstatement.

b) Knowingly claimed benefits for any purpose other than as are provided for under this policy.

c) Agreed to any attempt by a third party to obtain an unreasonable pecuniary advantage to our detriment.

d) Otherwise failed to observe the terms and conditions of this policy or failed to act with utmost good faith. If the policy is cancelled by the policyholder at any time other than following the renewal date there will be no return of premium.

17. Unpaid or late premiums

We will write to tell you if we haven't received or haven't been able to collect your premium on time.

We will cancel your plan if we don't receive payment within 28 days of the premium due date. You will then have to apply for a new plan if you would still like us to cover you.

18. Applicable Law

The law applicable to this policy shall be as specified in the insurance certificate, unless you have requested an alternative, which has been accepted in writing by us. If no law is specified then the policy shall be construed according to the laws of Ireland and shall be subject to the non-exclusive jurisdiction of the courts of Ireland.

19. Fraudulent/unfounded claims

If any claim under this policy is in any respect fraudulent or unfounded, all benefits paid and/or payable in relation to that claim shall be forfeited and (if appropriate) recoverable. In addition, all cover in respect of the Insured person shall be cancelled void from effective date without refund of premiums.

20. Liability

Our liability shall cease immediately upon termination of the policy for whatever reason, including without limitation non-renewal and non-payment of premium.

21. Premium refunds

After the first 30 days of cover from your effective date you will not be entitled to any refund of premium, either in full or in part, for whatever reason.

22. Re-assignment

If there is more than one insured person over the age of 18 and the policyholder dies, this policy will automatically be transferred to the oldest insured person over the age of 18 years who shall upon the date of death of the policyholder become the policyholder for the purposes of this policy and be responsible for paying the premium.

23. Third parties

The only parties to this contract are the policyholder and us.

No other person, including any insured person, has any right to enforce this policy or any part of it.

24. Subrogation

The policy shall be subrogated to all rights of recovery that you have against any other party with respect to any payment made by that party to you due to any injury, illness or medical condition you sustain to the full extent of the benefits provided or to be provided by the policy. If you receive any payment from any other party or from any other insurance cover as a result of an injury, illness or medical condition, we have the right to recover from, and be reimbursed by you, for all amounts we have paid and will pay as a result of that injury, illness or medical condition, from such payment, up to and including the full amount you receive.

We shall be entitled to full reimbursement from any other party's payments, even if such payment will result in a recovery which is insufficient to fully compensate you in part or in whole for the damages sustained.

You are required to fully cooperate with us in our efforts to recover any payments made under the policy including any legal proceedings which we may conduct and proceed on your behalf at our sole discretion. You are required to notify us within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness or medical condition sustained by you the insured person. Other than with our written consent you have no entitlement to admit liability for any eventuality or give promise of any undertaking which is binding upon you, your dependants or any other person named in the policy. In the event that any claim or dispute is made in respect of this subrogation or any part thereof including but not limited to any right of recovery provision which is ambiguous or questions arise concerning the meaning or intent of any of its terms, we shall for the avoidance of doubt have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

25. Currency

The monetary limits applicable to your policy will be expressed in the same currency as your premium. 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, or on the date that we pay your claim.

Please note that we reserve the right to choose which currency exchange rate to apply.

26. Conflict or Civil Unrest, Chemical or Radioactivity Contamination

Treatment and expenses directly or indirectly arising from or required as a consequence of conflict or civil unrest, chemical or radioactivity contamination from any chemical and nuclear material or from the combustion of nuclear fuel or any related condition are covered by this policy provided the member:

a) Is not an active participant in any conflict or civil unrest

b) Is not involved in any illegal activities which directly or indirectly lead to injury or illness

c) Does not knowingly enter or remain in a country, region or location where there is conflict, civil unrest, natural disaster, chemical, nuclear or radioactive contamination

d) Does not intentionally put him/herself at risk of illness or injury resulting from conflict, civil unrest, natural disaster, chemical, nuclear or radioactive contamination

e) Is not a member of any armed forces, security services including personal protection, chemical, nuclear or radioactive contamination cleaning crews of any kind or type (including governmental workers or private teams).

Based on the information provided at inception or renewal Allianz will assess the current, future or developing risk exposure of members located in high risk areas and will notify the policyholder of any actions, limitations, exclusions or premium loadings required to ensure on going cover and member safety.

27. Claim Notification

Please ensure that your claim form is completed in full and returned within 180 days of the date of treatment. Refer to page 11 on How to file a claim and the claims procedure on page 32 for more detail.

28. 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.

29. Economic Sanctions

Cover is not provided if any element of the cover, benefit, activity, business or underlying business violates any applicable sanction law or regulations of the United Nations, the European Union or any other applicable economic or trade sanction law or regulations.

30. Data protection

Our 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 our Data Protection Notice visit:

www.allianzcare.com/en/privacy

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

+353 1 630 1301

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

AP.EU1DataPrivacyOfficer@allianz.com

31. 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.

Claims procedure

Important

In order to ensure that you receive the best possible claims service the procedures noted below should be followed in the event of treatment being required by you or one of your dependants.

The settlement of your claim may be delayed if you fail to complete your claim form properly. Please note the requirements under the claim form section of this claims procedure.

Helpline

All insured persons have access to our Helpline which is available 24 hours a day, 365 days a year and is staffed by multilingual operators who can arrange admission to hospital, ambulance transfers and air evacuation where considered an emergency. To obtain medical assistance, please use the Helpline number nearest to you as shown on your membership card. You will need to provide your name, reference number, telephone and/or fax number, location and medical condition. In any given situation, if you are unsure what to do, contact the Medical Helpline.

Out of country transportation

All non-emergency out of country transportation costs are subject to pre-approval by us and in the first instance the insured person should contact Executive Healthcare Solutions for authorisation to travel. Contact details are on page 11 of this member guide.

Outpatient treatment

Outpatient treatment is treatment received in a doctor's office and does not require admission to a hospital bed.

1. Outside the USA

Where your policy allows, outpatient services and treatment received within our provider network can be billed to us directly. In most cases, you will be required to show your membership card to the provider who will contact us to confirm direct billing. This may not immediately happen and, should you be asked to pay for the treatment, please ensure you state clearly to the facility that you wish to have your bill settled directly by us, and for them to contact the number on the reverse of your membership card. Outpatient services and treatment received outside the direct settlement network are required to be paid by you at the time of treatment. After paying for your treatment you must submit a claim form to us to be processed. To ensure prompt settlement of these expenses, please make sure to take your claim form with you in order for it to be completed by the treating general practitioner, specialist or dental practitioner.

Exceptions may be made for high cost procedures. In this case you will be required to contact us prior to receiving your treatment, in order for us to arrange direct payment with the medical facility concerned. Please note that not all medical facilities may accept direct payment with us. In these instances you will be required to settle the bill and submit a claim to us for reimbursement.

Providing all relevant information is submitted to support your claim, we will reimburse you accordingly by the payment method of your choice. Please clearly state your preferred payment method on your claim form. Where this is by bank transfer clearly state the name of your bank, account number and SWIFT (or IBAN) code.

2. Inside the USA

Some policies allow for treatment to be undertaken in the USA. Please check your policy to ensure that you have the appropriate cover before undertaking any treatment in the USA.

Where your policy allows, outpatient services and treatment received within our provider network can be billed to us directly. In most cases, you will be required to show your membership card to the provider who will contact us to confirm direct billing. This may not immediately happen and, should you be asked to pay for the treatment, please ensure you state clearly to the facility that you wish to have your bill settled directly by us, and for them to contact the number on the reverse of your membership card.

If you are still required to pay your bill, please follow the steps as outlined on page 32, point 1.

Our claims department will process the claim according to the applicable portion payable by us taking into account your deductible and any co-payment applicable. Once our portion is paid, we will send both you and the provider a Statement of Account with details of settlement and statement of what you are responsible for.

Day-care and in-patient treatment

Day-care and in-patient treatment are those that are received in a hospital, and where it is medically necessary for you to be admitted to a hospital bed, whether or not you need an overnight stay. We require that our pre-approval be obtained for all planned day-care and in-patient treatment.

For emergency admissions, you, the hospital or a family member are recommended to contact us to obtain pre-approval prior to your leaving the hospital. Failure to pre-notify your in-patient or day-care treatment will mean that you may only be eligible for reimbursement of a proportion of the costs incurred.

1. Outside the USA

When we have been pre-notified of an eligible day-care/in-patient stay we will attempt to arrange direct billing with the hospital and the medical practitioners or specialists concerned. We will send the hospital a guarantee of payment to the value of the estimated cost of treatment advised to us by the relevant facility/provider, which will confirm to them that the treatment is covered under your policy.

Treatment Guarantee Form

The hospital is required to complete a Treatment Guarantee Form outlining details of the medical condition and treatment to be undertaken.

We cannot place a guarantee of payment without this document so please ensure that the hospital confirms with you that the Treatment Guarantee Form has been sent to us. We will verbally confirm with you should your treatment be covered under the terms of the policy. However, completion of pre-approval is conditional on the submission of our guarantee of payment. We will notify you as soon as possible if the condition or treatment required is not covered under the terms of your policy.

It may be that we are unable to implement a guarantee of payment before your treatment is undertaken. This may be due to delays in the hospital providing us with the appropriate medical information for us to be able to confirm cover. It is therefore important to contact us as soon as possible prior to your treatment taking place to ensure we are able to place a guarantee of payment in due time. We would recommend that you do not delay your treatment if a guarantee of payment is not in place at the time your treatment is due.

In the event that we are unable to implement a guarantee of payment, you will be required to pay the bill and reclaim the amount from us by submitting a claim form.

2. Inside the USA

Some policies allow for treatment to be undertaken in the USA. Please check your policy to ensure that you have the appropriate cover before undertaking any treatment in the USA.

Treatment received within the provider network will be billed to us directly. Our claims department will determine what portion of the invoice is applied to your deductible and any co-payment applicable and which portion is payable by us. We will send you and the provider copies of the statement of account detailing how the bill was settled and what amount you are responsible for.

We will notify you as soon as possible if the medical condition or treatment required is not covered under the terms of your policy.

Pre-approval

We require members to obtain pre-approval from us before commencing the following treatments:

- Planned in-patient or day-care treatment (hospitalisation)
- Any pregnancy or childbirth treatment
- Planned surgery
- Evacuation/Out of Country Transportation
- Psychiatric treatment – in-patient and day-care treatment
- Home nursing charges
- Planned MRI, CT and PET Scans

Evacuations are supervised by your medical practitioner or specialist at the place of incident and by our Medical Helpline and must be agreed by us before evacuation takes place.

Referral from a medical practitioner

We will require a doctor's referral to be included whenever filing a claim for physiotherapy.

Claim form

When submitting any claim forms and any other documents pertaining to the claim, please ensure that:

- The first page of the claim form has been completed in full by you for each medical condition treated. The declaration must be signed by the insured person and dated to enable the claim to be validated
- You attach to your claim form the original paid receipts and any other documents pertaining to the claim (or other proof of payment) for all treatment for which you are making a claim
- Where applicable laboratory tests results and/or X-rays were provided, please include the test results with your claim
- ALL sections MUST be completed in full for all claims. A referral letter from your specialist should be attached when you are claiming for diagnostic tests.

To ensure prompt settlement of any eligible claims please ensure that you submit all necessary documents at the time of the claim. We accept copies of original receipts however we require that 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.

All claims should be submitted by mail to the nearest Allianz Care claims centre noted on the next page.

General claims information

We reserve the right to reject any claim which is not submitted within 180 days of the date treatment took place. All documents and materials (including but not limited to original accounts, certificates and X-rays) that we require to support a claim, shall be provided without expense to us (including if requested by us a medical report from your medical practitioner or specialist and details of your medical history).

In cases where medical information is required by us for consideration of a claim but it is not made available to us, it is your responsibility to obtain such information from your current or previous medical practitioner, as appropriate. Claims may only be made for treatment actually given during a period of cover and benefit will be available only for expenditure incurred prior to expiry or termination of such cover.

An insured person must, without delay, give us written notification of any claim or right of action against any third party arising out of circumstances which gave rise to a claim under this policy and must continue to keep us fully informed in writing and take all steps we reasonably require in making a claim upon that other party. We shall be entitled to take legal action in any insured person's name for our own benefit and claim for indemnity or damages or otherwise which relates to any benefits and costs paid or payable under this policy. We shall have full discretion in the conduct of any such proceedings and in the settlement of any such claim.

If you have any questions concerning the above or any other aspect of your policy please do not hesitate to contact your local Allianz Care office.

Claims submission

For covered services received anywhere (except the U.S.), submit your claim to:

Post/Courier: Executive Healthcare Solutions Limited, 6th Floor, 9 West, Ring Road Parklands, P.O. Box 14680, 00800, Westlands, Nairobi, Kenya.

Tel: +230 464 5100

Email: claims@executive-healthcare.com

Emergency Claims Helpline: +254 737 786 121

Post/Courier: Allianz Care, 15 Joyce Way, Park West Business Campus, Nangor Road, Dublin 12, Ireland.

Contact details

Helpline

For all general enquiries, including claims information, in the event of a medical emergency or evacuation, contact the Helpline on

+27 21 4276359

If you need similar assistance while you are out of Africa, you may dial +353 1 9075900 to connect to our Service Centre.

Complaints procedure

Our Helpline is always the first number to call if you have any comments or complaints. If we can't resolve the problem on the phone, please email or write to us:

+353 1 9075900

Africa.helpline@allianz.com

Customer Advocacy Team, Allianz Care, 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 our Helpline to obtain a copy of this procedure.

Definitions

To help you understand your policy the following words and phrases used anywhere within your policy have specific meanings, which are set out in this section.

Accident

An unexpected, unforeseen and involuntary external event resulting in injury occurring whilst your policy is in force.

Acute

A medical condition which is brief, has a definite end point and which we, on advice or general advice determine can be cured by treatment.

Act of terrorism

An act, including but not limited to the use of force or violence and/or the threat thereof, of any person or group(s) of persons, whether acting alone or on behalf of or in conjunction with any organisation(s) or government(s), committed for political, religious, ideological or ethnic purposes or reasons including the intention to influence any government and/or to put the public or any section of the public in fear.

Advice

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

Appliances

Devices, implants and equipment when used as an integral part of a surgical procedure administered by a medical practitioner or specialist.

Area of coverage*

- Africa plus India, Pakistan, Bangladesh and Sri Lanka
- Worldwide excluding USA
- Worldwide**

The applicable area of coverage will be stated on the Insurance certificate.

** 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.*

*** This product is not recognized as meeting minimum essential cover (as defined under the comprehensive health care reform law enacted in March 2010 (also referred to as ACA, PPACA, or "Obamacare")) for US citizens inside or outside the USA. Members who require minimum essential cover should move onto US domestic health insurance plans. It is the member's responsibility to ensure that their healthcare cover is legally appropriate and they are fulfilling their reporting requirements. We strongly recommend that independent advice be sought in this regard.*

Benefits

The insurance cover provided by this policy and any extensions or restrictions shown in the Insurance Certificate or in any endorsements (if applicable).

Bodily injury

Injury which is caused solely by an accident which results in the insured person's dismemberment, disablement or other physical injury.

Chronic

A disease, illness or injury that has at least one of the following characteristics:

- It continues indefinitely and has no known cure
- It comes back or is likely to come back
- It is permanent
- You need to be rehabilitated or specially trained to cope with it
- It needs long-term monitoring, consultations, checkups examinations or tests.

Co-payment

The percentage of the total value of the incurred expenses for which the policyholder/insured person is responsible.

Congenital anomaly

Any genetic, physical, or biochemical (metabolic) defect, disease, or malformation, and which may or may not be obvious at birth.

Continuous transfer terms

The acceptance by us of your original effective date as shown by your current insurer will be applied to your policy with us. We will maintain your existing underwriting or special acceptance terms, as offered by your existing insurer, such as any moratoria or specific exclusions and your policy with us will be governed by the terms and conditions of our policy.

Any transfer will be subject to no enhanced benefits being provided. We reserve the right at all times to decline a continuous transfer terms application without giving any reason.

Country of nationality

For the purpose of this policy this will be the country for which you hold a passport.

Country of residence

The country in which you have your habitual residence (residing for a period of no less than six months per period of cover) at the time this policy is first taken out or at each subsequent renewal date/ review date.

Critical

A medical condition that is, in our reasonable opinion, unstable and serious, where the outcome cannot be medically predicted, the prognosis is uncertain and the person may die.

Day-care patient

An insured person who is admitted to a hospital bed but does not stay overnight.

Deductible

The amount payable by an insured person in respect of expenses incurred before any benefits are paid under the policy, as specified in your Insurance Certificate.

Dental practitioner

A person who is licensed by the relevant licensing authority to practice dentistry in the country where the dental treatment is given.

Dependants

One spouse or adult partner and/or unmarried children who are not more than 18 years old and residing with you, or 26 years old if in full-time education, at the effective date or any subsequent renewal date/review date. The term partner shall mean husband, wife or the person permanently living with you in a similar relationship.

All dependants must be named as insured persons in the Insurance Certificate.

Direct Family Member

Spouse, child, parent, sibling.

Direct settlement network/provider network

(Only available in certain countries):

The medical providers where you are able to obtain treatment for valid medical conditions and where the expenses will be settled directly by us. You are still responsible for any co-payment or deductible applicable to your policy, which must be settled directly with the medical providers at the time of treatment.

Please Note: Where you receive treatment for a medical condition that is not covered within the terms of your policy, You remain liable for the costs of such treatment, which must be settled in full upon request. Failure to act accordingly will result in the suspension or cancellation of your policy, without refund of premium.

Drugs and dressings

Essential drugs, dressings and medicines prescribed by a medical practitioner or specialist and which are not available without prescription.

Effective date

The date shown on the Insurance Certificate on which an insured person was included under this policy.

Elective

Planned treatment which is medically necessary, but which is not required in an emergency.

Emergency

A sudden, serious, and unforeseen acute medical condition or injury requiring immediate medical care.

Evacuation

Where treatment is not available at the place of the incident, the costs incurred in moving an insured person from the place of incident to a country of your choice within your area of coverage with appropriate medical facilities, as determined by the attending medical practitioner or specialist in conjunction with our medical advisors. All airline tickets are limited to economy class.

Expatriate

Any persons living or working outside of the country for which they hold a passport, for a period exceeding six months per period of cover.

General advice

Advice from the relevant professional body to establish medical practice and/or established medical opinion in relation to any medical condition or treatment.

Group

A compulsory enrolment of all employees (minimum of three employees) covered under a single insurance agreement, purchased by their employer as an employee benefit, and where identical benefits have been provided to each member and accepted as such by us.

Hereditary

A disease or disorder that is inherited genetically.

Hospital

An establishment that is legally licensed as a medical or surgical hospital under the laws of the country in which it is situated.

In-patient

An Insured person who stays in a hospital bed and is admitted for one or more nights solely to receive treatment.

Insurance certificate

The schedule giving details of the policyholder and the insured persons, policy details and endorsements (if applicable).

Insured person/you/your

The policyholder and/or the dependants named on the insurance certificate

Local national

Any persons living or working in the country for which they hold a passport for a period exceeding six months per period of cover.

Medical condition

Any injury, illness or disease, including psychiatric illness.

Medical practitioner

A person who has attained primary degrees in medicine or surgery by attending a medical school recognised by the World Health Organisation and who is licensed by the relevant authority to practice medicine in the country where the treatment is given.

Medically necessary

A medical service or treatment, which in the opinion of a qualified medical practitioner is appropriate and consistent with the diagnosis and which in accordance with generally accepted medical standards could not have been omitted without adversely affecting the insured person's condition or the quality of medical care rendered.

Newborn

A baby who is within the first 16 weeks of its life following delivery.

Organ transplant

The replacement of vital organs (including bone marrow) as a consequences of an underlying eligible medical condition.

Out-patient

An insured person who receives treatment at a recognised medical facility, but is not admitted to a hospital bed as an in-patient or day-care patient.

Palliative treatment

Any treatment given, on advice or general advice, for the purpose of offering temporary relief of symptoms. Palliative treatment is not given to cure the medical condition causing the symptoms. For the purposes of this policy, palliative treatment will include renal dialysis.

Period of cover

The period of cover set out in the insurance certificate.

This will be a 12 month period starting from the effective date or any subsequent renewal date/review date as applicable.

Policy

Our contract of insurance with you providing cover as detailed in this document.

Policyholder

The person or company named as policyholder in the insurance certificate.

Private Room

Single occupancy accommodation in a private hospital.

Qualified Nurse

A nurse whose name is currently on any register or roll of nurses, maintained by any Statutory Nursing Registration Body within the country in which they are resident.

Reasonable and Customary Charges

The average amount charged in respect of valid services or treatment costs, as determined by our experience in any particular country, area or region and substantiated by an independent third party, being a practising surgeon/medical practitioner/specialist or government health department.

Related Condition

Any injuries, illnesses or diseases are related conditions if we, on general advice, determine that one is a result of the other or if each is a result of the same injury, illness or disease.

Rehabilitation

Assisting an insured person who, following a medical condition, requiring physical therapy and assistance in independent living to restore them, as much as medically necessary or practically able, to the position in which they were in prior to such medical condition occurring.

Renewal Date

The anniversary of the start date of the policy.

Sound Natural Teeth

Teeth that were stable, functional, free from decay and advanced periodontal disease, and in good repair at the time of the accident.

Specialist

A registered medical practitioner who currently holds a substantive consultant appointment in that speciality, which is recognised as such by the statutory bodies of the relevant country.

Treatment

Surgical, medical or other procedures the sole purpose of which is the cure or relief of a medical condition.

We/Our/Us

Allianz Care.

Talk to us, we love to help!

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

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Email: info@executive-healthcare.com

https://www.allianzcare.com/en/welcome/ehs.html

Toll free numbers: www.allianzcare.com/toll-free-numbers

If you are not able to access the toll-free numbers from a mobile phone, please dial one of the Helpline numbers listed above.

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

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www.youtube.com/c/allianzcare
www.instagram.com/allianzcare/
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