Allianz

Employee Benefit Guide

Summit for Singapore
International healthcare plans

Valid from 1st January 2026

Welcome

You and your family can depend on us, as your international health insurer, to give you access to the best care possible.

This guide has two parts: 'How to use your cover' is a summary of all important information you are likely to use on a regular basis; 'Terms and conditions of your cover' explains your cover in more detail. To make the most of your international healthcare plan, please read this guide together with your Insurance Certificate and Table of Benefits.

This insurance policy is underwritten by Allianz Insurance Singapore Pte. Ltd., address 79 Robinson Road #09-01 Singapore 068897. Company Registration No. 201903913C. This policy is supported by AWP Health & Life SA, a limited company governed by the French Insurance Code acting through its Irish Branch. Part of the Allianz Group, AWP Health & Life SA is registered in France: No. 401 154 679 RCS Bobigny. Irish Branch is registered in the Irish Companies Registration Office, registered No.: 907619, address: 15 Joyce Way, Park West Business Campus, Nangor Road, Dublin 12, Ireland. AWP Health & Life SA – Irish Branch provides administration services for the policy.

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How to use your cover

Support services

We believe in providing you with the top-quality service that you deserve. In the following pages we describe the full range of services we offer. Read on to discover what is available to you.

Talk to us, we love to help!

Our multilingual Helpline is available 24 hours a day, 7 days a week, to handle any questions about your policy or if you need assistance in an emergency.

Helpline
Phone: **1800 6709766**
(toll-free when calling from Singapore)

+60 (0)3 92127818
(from outside Singapore)

CHAT WITH US

For our latest list of toll-free numbers, please visit:
www.allianzcare.com/en/pages/toll-free-numbers.html

Email: asia.helpline@e.allianz.com

Did you know...

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

Support when you need it most

Certain circumstances in life can be distressing, and not having the right support can make the insurance journey more challenging.

Our dedicated team is here to support you. We encourage you to disclose any additional support needs you may have with confidence - we will make reasonable adjustments where necessary, ensuring you have easy access to our products and services.

If you need to report a potential need, request specific adjustments in our communication, or nominate someone to interact with us on your behalf, please contact our team at enhancedsupport@e.allianz.com or fill out the online form available at our Enhanced Support page at www.allianzcare.com/en/support/support-when-you-need-the-most.html.

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 claims
Submit your claims in three simple steps and view your claims history.

My contacts
Access our 24/7 multilingual Helpline. Live chat is also available on the online portal.

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

Provider finder
Locate medical providers nearby.

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

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

Emergency contact
Access local emergency numbers worldwide.

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 that is in your Table of Benefits.
- Pay your premium online and view payments received.
- Add or change your 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 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.

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

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

Web-based services

On www.allianzcare.com/members you can:

- search for medical providers. While you are not restricted to using the providers listed in our directory, we recommend doing so to take advantage of direct settlement.
- download forms.
- access our Health and Wellness Library.
- access our 'My expat life' hub – from planning to move, to settling down in your new country, you'll find everything you need to know about moving overseas.

Second Medical Opinion**

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

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

To access our service, simply contact us:
+353 1 630 1301
medical.smo@e.allianz.com

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

Member services included in your cover

Your policy doesn't just cover your medical expenses. It also includes a range of free member services. Check your Table of Benefits to confirm which ones are included in your cover.

Olive – our health and wellness programme

Designed to motivate and guide you towards a healthier life. It includes access to:

- **Health and Wellness Hub**, offering online health assessments, webinars on wellbeing delivered by specialists, articles on topics such as sleep and nutrition, etc.
- **Our fitness app**, connecting with smart phones, wearable devices and other apps to monitor the number of steps taken, calories burned, sleep schedule and more. You can also join challenges with other users, and/or set up wellness goals and plans for yourself.
- **Mind coaching app**, your chat bot buddy to discuss your feelings with. You can also chat with a human coach, if you want a more personal touch.

TeleHealth Hub — video consultation services

If your plan includes cover for video consultation services, you have direct access to online doctor appointments. With TeleHealth Hub, you can save time by seeing a doctor via video from the comfort of your home or office. Offering a secure and confidential service, our telehealth network of doctors can provide medical advice, recommend treatments and offer prescriptions for non-emergency concerns. Prescriptions will be available if your plan covers them and if the local regulation allows.

EAP — Employee Assistance Programme

When challenging situations arise in life or at work, our EAP provides you and your dependants with confidential support. The service includes:

- **Confidential professional counselling** via phone, video or in person on topics such as stress, work/life balance, parenting, anxiety, cultural shock, addiction concerns, etc.
- **Legal and financial referral services**, for example, to help buy a home, handle a legal dispute or create a financial plan.

Please note that this service is not suitable for minors who are below the local legal age of consent, and does not include group therapy, such as family therapy.

Travel Security Services

24/7 access to personal security information and advice for your travels, helpful as the world continues to witness an increase in security treats. You can access:

- **Emergency hotline**, to talk to a specialist for any safety concerns associated with your travel destination.
- **Country intelligence**, which offers information and advice about many countries.
- **Daily security news updates**, to receive email alerts about high-risk events in or near your location, including terrorism or severe weather risks.

To know more or to access the above member services, visit:
www.allianzcare.com/en/support/member-resources.html#care

** Certain services that may be included in your plan are provided by third party providers. 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 your policy's terms and conditions, as well as the service's terms and conditions as set out by the relevant third party service provider. By accepting the third party service providers' terms and conditions, you enter a separate contractual relationship directly with them. Their services may be subject to geographical restrictions.

Full details of the third party service providers' terms and conditions are available in their websites and in the relevant application and/or platform where services may be hosted. The third party service providers are

independent data controllers, and we recommend that you review their privacy notices to understand how they process your personal data. The third party service providers offer non-insurance services that are not intended to be a substitute for in-person medical consultations, diagnosis, treatment, assessment or care. You understand and agree that the insurer, its reinsurer and their administrators are not responsible or liable for any claim, loss or damage, directly or indirectly resulting from your use of any of these third party services.

Understanding how your cover works

What am I covered for?

You and your dependants are covered for medically necessary treatment and related costs, services and/or supplies as indicated in the Table of Benefits. These are subject to:

- Policy definitions and exclusions (available in this guide).
- **For policies with full medical underwriting**: any special conditions shown on your Insurance Certificate (and on the Special Condition Form issued before the policy comes into effect, where relevant).
- **Costs being reasonable and customary**: these are costs that are usual within the country of treatment. We will only reimburse medical providers where their charges are in accordance with standard and generally accepted medical procedures. If we consider a claim to be inappropriate, we reserve the right to decline or reduce the amount we pay.
- **Terms agreed for pre-existing medical conditions**: Cover for pre-existing medical conditions (including pre-existing chronic conditions) depends on the medical underwriting terms of your policy.
    - For policies that were fully medically underwritten, pre-existing conditions are generally covered unless we say otherwise in your policy documents.
    - For policies with moratorium, pre-existing conditions are only eligible for cover once you've completed a continuous 24-month period after your start date and have not had symptoms, needed or received treatment, medication, a special diet or advice, or had any other indications of the condition during that time.

Where can I receive treatment?

You can receive treatment in any country within your area of cover, as shown in your Insurance Certificate.

If the treatment you need is available locally but you choose to travel to another country in your area of cover, we will reimburse all eligible medical costs incurred within the terms of your policy; except for your travel expenses.
If the eligible treatment is not available locally, and your cover includes the appropriate 'Medical evacuation' benefit, we will also cover travel costs to the nearest suitable medical facility. To claim for medical and travel expenses incurred in these circumstances, you will need to complete and submit the Pre-authorisation Form before travelling.

You are covered for eligible costs incurred in your home country, provided that your home country is in your area of cover.

What are benefit limits?

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

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

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

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

In some instances, in addition to the benefit limit, we will only pay a percentage of the costs for the specific benefit (e.g. 20% up to max. US$ 2,000/S$ 2,600).

Benefit limits related to maternity

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

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

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

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

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

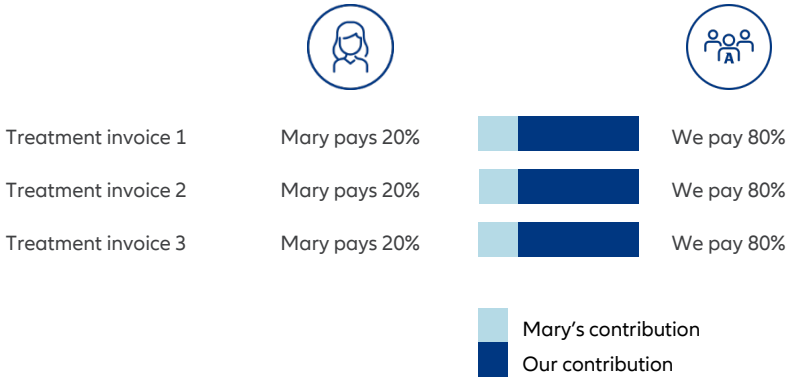
There is a limit for in-patient treatment that takes place in the first three months following birth if the baby:

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

This limit is US$ 40,500/S$ 52,650 per child and it applies before any other benefit in your plan. Out-patient treatment is paid under the terms of the Out-patient Plan.

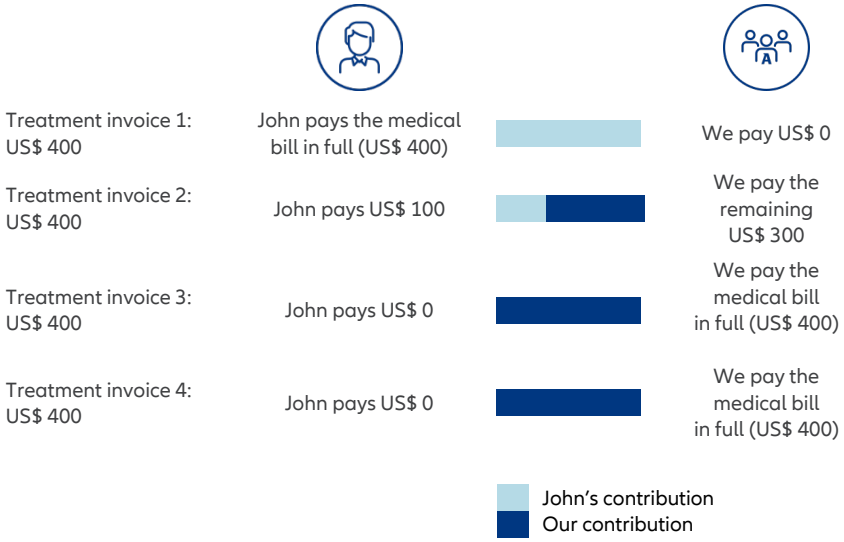
What are co-payments?

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



What are deductibles?

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



Seeking treatment?

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

Step 1. Check your level of cover

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

Step 2. Confirm if your treatment requires our pre-authorisation

Your Table of Benefits will show which treatments and services require our pre-authorisation (via a Pre-authorisation Form). These are mostly in-patient and high-cost treatments. The pre-authorisation process helps us assess each case, organise everything with the medical provider before your arrival and make direct payment of your medical provider bill easier, where possible.

Unless we and your company agree otherwise, if you submit a claim without obtaining our pre-authorisation, the following will apply:

- If the treatment or service is subsequently proven to be ineligible, **we reserve the right to decline your claim**.
- If the treatment or service is subsequently proven to be eligible, we may only pay a portion of an eligible claim, as indicated in your Table of Benefits.

Step 3. Use your medical provider network

We recommend that you use the medical provider network for your treatments, as it gives you the following advantages:

1. If your treatment requires **pre-authorisation**, your network medical provider may be able to request this on your behalf.

2. You will be able to access direct settlement for most treatments.

What is direct settlement?
Direct settlement means that we pay your eligible medical costs directly to your medical provider.

However, please note that there might still be amounts that you will have to pay, if your plan includes deductibles or co-payments, or the cost of treatment or service exceeds the benefit limits of your plan.

What if direct settlement is not available for my treatment?
Not all treatment costs can be settled on a direct settlement basis: your network medical provider will inform you when direct settlement is not available. In such instances, you will need to pay your medical provider and then submit a claim to us, as explained in the 'Claiming reimbursement for your out-patient, dental and other expenses' section.

What providers are included in my medical network?
You can confirm the medical providers included in your network by logging into MyHealth digital services. When scheduling an appointment with a network medical provider, please ensure that you state your policy number. You can find this on your membership card.

How to seek pre-authorisation
If in Step 2 above you have confirmed that your treatment requires pre-authorisation, and you are not attending a medical provider that can organise it for you, please follow the process below:

Download a Pre-authorisation Form from our website: www.allianz.sg/sme-solutions/international-health.html

Complete the form and send it to us at least **five working days before treatment**. You can send it by email to asia.medical@e.allianz.com.

We contact the medical provider to organise direct settlement, where possible.

If it's an emergency

Get the emergency treatment you need and call us if you need any advice or support. If you are hospitalised, either you, your doctor, one of your dependants or a colleague needs to call our Helpline (within 48 hours of the emergency) to inform us of the hospitalisation. We can take Pre-authorisation Form details over the phone when you call us.

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

Claiming reimbursement for your out-patient, dental and other expenses

If your treatment expenses are not settled directly with your medical provider, and your treatment does not require our pre-authorisation, you can simply pay the bill and claim the expenses from us, as follows:

Receive your medical treatment and pay the medical provider.

Get an invoice from your medical provider. This should state your name, treatment date(s), the diagnosis/medical condition that you received treatment for, the date of onset of symptoms, the nature of the treatment and a detailed breakdown of costs.

Claim back your eligible costs via our MyHealth app or online portal (www.allianzcare.com/en/myhealth.html).
Simply enter a few key details, add your invoice(s) and press 'submit'.

Quick claim processing

Once we have all the information required, we can process and pay a claim within 48 hours. However, we can only do this if you have told us your diagnosis, so please make sure you include this with your claim. Otherwise, we will need to request the details from you or your doctor.

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

Evacuations and repatriations

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

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

1800 6709766
(toll-free when calling from Singapore)

+60 (0)3 92127818
(from outside Singapore)

asia.medical@e.allianz.com

Seeking treatment in the USA

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

To access treatment in the USA, simply show your membership card: your medical provider will then contact our third-party partner to sort any paperwork related to your treatment. We will pay the cost of your eligible treatment directly to your medical provider, if applicable; if you are responsible for any part of the costs, your provider will let you know.

For queries or requests for assistance related to treatment in the USA, please find all contact details on the back of your membership card.

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.

Additional information about claiming for your expenses

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

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

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

- **Direct settlement of medical invoices**: If we make a payment directly to your medical provider for your medical costs and later we determine that your direct settlement claim is not eligible, we reserve the right to recover the full claim amount from you.

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

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

  - collect all out-patient receipts until you reach an amount that exceeds this deductible figure.

  - send us each claim every time you receive treatment. Once you reach the deductible amount, we'll start reimbursing you.

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

If you have insurance cover with another healthcare insurer, and the same in-patient or day-care treatment is eligible under both your plan with the other insurer and your healthcare plan with us:

- You can obtain a reimbursement from the other insurer and request that the amount paid by them is accepted as a contribution to the deductible amount on your healthcare plan with us,
- You can also request that any remaining available benefit limit on your healthcare plan with us is used to cover any deductible or co-payment applied by the other insurer on your claim with them.

When making your request, please send us a copy of a detailed invoice from the hospital or day-care facility, along with a statement or official document confirming the costs paid by the other insurer. Please note that in any case the total amount payable by us remains subject to any applicable benefit limit on your plan with us.

- **Currency and charges:** 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. We will cover all charges associated with the payment. However, if your bank applies a fee for receiving funds into your account as part of their terms and conditions, we will not be liable for this fee.

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

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

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

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

- **Payment into a Medisave account**: If you request for claim reimbursement to be made into your Medisave account, this process will fall outside of the usual claims turnaround time, to allow for additional procedures that need to be followed.

Claims for accidental death
If the 'Accidental death' benefit is included in your healthcare plan, the claim must be reported to us within 90 working days following the date of death of the insured person.

Please send us:

- A fully completed Life and Accidental Death Benefit Application Form
- A death certificate
- A medical report indicating the cause of death
- A written statement outlining the date, location and circumstances of the accident
- Official documentation proving the insured person's family status (i.e. whether they are married or have children)
- For the beneficiaries, proof of identity as well as proof of their relationship to the insured person

Beneficiaries are, unless otherwise specified by the insured:

- The insured person's spouse or partner, if not legally separated

- If there is no spouse or partner, the insured person's surviving children including step-children, adopted or foster children and children born less than 300 days after the date of the insured person's death; in equal shares among them
- If there are no children, the insured person's father and mother, in equal shares between them, or to the survivor if one parent has died
- Failing any of the above, the insured person's estate

If you wish to nominate a beneficiary other than those listed above, please contact our Helpline.

Please note that if the insured person and one or all of the beneficiaries die in the same incident, the insured person will be considered the last deceased.

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

Terms and conditions of your cover

Terms and conditions

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

- Your **Insurance Certificate** details the plan(s) and geographical area of cover that your company chose for you and your dependants (if applicable). It also states the start date and renewal date of your cover, as well as any special terms that may apply to your policy. Please note that we will send you a new Insurance Certificate if we need to record any changes to your policy. These may be changes that your company requests, changes we are entitled to make or changes to personal information that you request. Please note that our approval is required for some change requests. You can refer to the 'Administration of your policy' section below for more details.

- Your **Table of Benefits** outlines the plan(s) selected by your company and the benefits available to you. It also specifies any benefits/treatments that require you to submit a Pre-authorisation Form. It confirms any benefits to which specific benefit limits, waiting periods, deductibles and/or co-payments apply. Your Table of Benefits will be in the currency agreed with your company (or with you, if you pay the insurance premium).

For full details of your company's insurance contract, please contact your company's Group Scheme Manager. Please note that the terms and conditions of your cover may be changed from time to time by agreement between your company and us.

Administration of your policy

When cover starts

Your insurance is valid from the start date shown on the Insurance Certificate and will continue until the group renewal date (which is also stated on the Insurance Certificate). Generally, this is one Insurance Year, unless we and your company decide otherwise or if you started your policy mid-year. At the end of this period, your company can renew the insurance on the basis of the policy terms and conditions applicable at that time. You will be bound by those terms.

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

Adding dependants

Are you getting married or having a baby? Congratulations!

You may apply to include any member of your family as a dependant if you are allowed to under the agreement between your company and us. The process is different depending on the type of policy you have:

- Policy with full medical underwriting (FMU), or
- Policy with moratorium (MORI), or
- Non-underwritten policy, or
- Policy with CTT/CPME (previously FMU), or
- Policy with CTT/CPME (previously MORI)

Your Insurance Certificate will indicate which type of policy you have; also, you can find definitions of the above types of policies in the 'Definitions' section of this guide.

To add a dependant, simply follow the process described below for your type of policy. Also, if the dependant you want to add is a newborn, please check the paragraph about 'In-patient treatment limits for newborn dependants' further below.

Policies with full medical underwriting AND policies with CTT/CPME (previously FMU)
To add a family member to your policy, please contact your Group Scheme Manager. Your dependant will need to complete the relevant application form and will be subject to medical underwriting. If accepted, cover will start from the date of acceptance.

However, if the dependant is a newborn, please follow the guidelines below.

How do I add a newborn to my policy?
Please contact your Group Scheme Manager within four weeks of your child's birth to add them to the policy and ensure that you provide the birth certificate. Except for multiple birth babies, we will accept the baby without medical underwriting if the birth parent or intended parent (in the case of surrogacy) has been insured with us for a minimum of eight continuous months. Cover will start at birth.

What happens if I don't notify you within four weeks?
The newborn child will be underwritten and if accepted, cover will start from the date of acceptance.

What if I am adding multiple birth babies?
Multiple birth babies will be underwritten and if accepted, cover will start from the date of acceptance.

Policies with moratorium AND policies with CTT/CPME (previously MORI)
To add a family member to your policy, please contact your Group Scheme Manager. Your dependant will need to complete the relevant application form. If accepted, a new moratorium will apply for that dependant, and cover will start from the date specified by your Group Scheme Manager.

However, if the dependant is a newborn, please follow the guidelines below.

How do I add a newborn to my policy?
Please contact your Group Scheme Manager within four weeks of your child's birth to add them to your policy and ensure that you provide the birth certificate. Except for multiple birth babies, we will accept the baby without a moratorium if the birth parent or intended parent (in the case of surrogacy) has been insured with us for a minimum of eight continuous months. Cover will start at birth.

What happens if I don't notify you within four weeks?
If you notify us late and the application for your newborn dependant is accepted, a new moratorium will apply for that dependant and cover will start from the date we agree to add them.

What if I am adding multiple birth babies?
To add multiple birth babies to your policy, please complete the relevant application form. We will review the application form and, if accepted, we will confirm the date we agree to add the newborn and whether a new moratorium will apply for them.

Non-underwritten policies
To add a family member as a dependant on your policy, simply notify your company and they will organise it with us.

However, if the dependant you want to add is a newborn, please follow the guidelines below.

How do I add a newborn to my policy?
Newborn infants (including multiple birth babies, babies born by surrogacy, adopted and fostered children) will be accepted for cover from birth, provided that we are notified within four weeks of the date of birth. To have a newborn added to the policy, you must ask your company to submit a request in writing (including a copy of the birth certificate) to us.

What happens if I don't notify you within four weeks?
If we are notified four weeks or more after the date of birth, newborn children will be accepted for cover from the date of that notification.

In-patient treatment limits for newborn dependants

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

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

This limit is US$ 40,500/S$ 52,650 per child and it applies before any other benefit in your plan. Out-patient treatment is paid under the terms of the Out-patient Plan.

Changing country of residence

It is important that you contact our Helpline and notify your Group Scheme Manager to let us know when you change your country of residence. This may affect your cover or premium, even if you are moving to a country within your geographical area of cover, as your existing plan may not be valid there. 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.

Changing your postal address or email address

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

Correspondence

When you write to us, please use email or post (with the postage paid). We do not usually return original documents to you, but if you ask us to, we will.

Renewal of cover

If your company pays for your premium, the renewal of your cover (and that of your dependants, if applicable) is the decision of your company.

If you pay your premium and your company renews your cover (and that of your dependants, if applicable), your policy will automatically renew for the next Insurance Year, if:

- we can continue to provide cover in your country of residence.
- all premiums due to us have been paid.
- the payment details we have for you are still valid on the policy renewal date. Please update us if you get a new/replacement card or if your bank account details have changed.

Ending your cover

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

- at the end of the Insurance Year, if the agreement between your company and us is terminated.
- if your company decides to end or not to renew your cover.
- if your company does not pay premiums or any other payment due under the Company Agreement with us.
- if you are an individual payer and you do not pay premiums or any other payment due under the Company Agreement with us.
- when you stop working for your company.
- upon the death of the insured employee.

We can end your cover and that of your dependants if there is reasonable evidence that you or they have misled or attempted to mislead us. For example giving us false information, withholding information, or working with another party to give us false information, either intentionally or carelessly, which may influence us when deciding:

- whether you (or they) can join the scheme.
- what premiums your company has to pay.

- whether we have to pay any claim.

Policy expiry

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

It is your responsibility to ensure that any membership card provided to you or your dependants is destroyed immediately when your membership ends. In case you or your dependants obtain treatment following the expiry of membership, we reserve the right to recover the full amount of any treatment expenses from you and/or the company.

Applying for cover if group membership ends

If your cover under the Company Agreement comes to an end, you can apply for cover under one of our Healthcare Plans for Individuals and Families, by simply sending us an email (details below). You need to submit your application within one month of leaving the group scheme. You may be subject to underwriting. If we accept your application, cover will start on the first day after you leave the group scheme.

Email: internationalhealth@allianz.com

Paying premiums

If your company pays your insurance premium

In most cases, your company is responsible for paying the premiums for you and your dependants, covered under the Company Agreement. Your company may also pay other taxes and charges associated with your cover (such as Goods and Services Tax). However you may be liable to pay tax in respect of the premiums paid by your company. For details, please check with your company.

If you pay your insurance premium

If you are responsible for paying your insurance premium, you need to pay us in advance for the duration of your cover. Your Insurance Certificate shows the amount your company has agreed with us and your selected payment frequency. You need to pay the **initial premium** or first premium instalment immediately after we accept your application. When you receive your invoice, please check that the premium matches the amount shown on your agreed quotation and contact us immediately if there is any difference. We are not responsible for the loss or delay of payments made through third parties. **Subsequent premiums** are due on the first day of the chosen payment period.

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

- Goods and Services Tax
- VAT
- Other taxes, levies or charges relating to your cover that we may have to pay or collect from you by law

These charges may already be in effect when you join but they could be introduced (or change) afterwards. Your invoice will show these taxes. If they change or if new taxes are introduced, we will write to inform you. If you do not accept the changes, you can choose to end your cover. We will not apply any of the changes if you end your membership within 30 days of the date

they take effect, or within 30 days of us telling you about the changes (whichever is later).

Each year on the renewal date, we may change how we calculate your premiums and taxes, the amount you have to pay and/or the method of payment. If so, we will inform you of these changes and they will only apply from your renewal date. If you wish, you can change the way you pay at policy renewal. Please write to us to request this at least 30 days before the renewal date.

If you are unable to pay your premium for any reason, please contact us so that we can discuss this with you, as if you don't pay your premiums on time you may lose your cover.

The following terms also apply to your cover

Applicable law:
Your policy is governed by laws of Singapore unless otherwise required under mandatory legal regulations. Any dispute that cannot otherwise be resolved will be dealt with by courts in Singapore.

Policy Owners' Protection Scheme:
This policy is protected under the Policy Owners' Protection Scheme which is administered by the Singapore Deposit Insurance Corporation (SDIC). Coverage for your policy is automatic and no further action is required from you. For more information on the types of benefits that are covered under the scheme as well as the limits of coverage, where applicable, please contact us or visit the General Insurance Association of Singapore (GIA) or SDIC web-sites *(www.gia.org.sg or www.sdic.org.sg)*.

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

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

The above suspension will continue until such time as we are no longer exposed to any such sanction, prohibition, or restriction.

Who is covered:
Only those group members (and dependants) as described in the Company Agreement are eligible for cover.

The amounts we will pay:
Our liability to you is limited to the amounts indicated in the Table of Benefits and any policy endorsements. The total amount reimbursed for a claim, whether under this policy, public medical scheme and/or any other insurance, will not exceed the costs incurred by you for your claim.

Who can make changes to your policy:
No one, except an appointed representative or the Group Scheme Manager is allowed to make changes to your policy on your behalf. Changes are only valid when agreed by your company and us.

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

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

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

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

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

Circumstances outside of our control (force majeure):
We will always do our best for you, but we are not liable for delays or failures in our obligations to you caused by things that 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.

Cancellation and fraud:

- For **policies with full medical underwriting**, the information you and your dependants give us e.g. on the Application Form or supporting documents, needs to be accurate and complete. If it isn't correct or if you don't tell us about things that may affect our underwriting decision, it may invalidate your policy from the start date. You also need to tell us about any medical conditions that arise between completing the application form and the start date of the policy. Medical conditions that you don't tell us about will most likely not be covered. If you're not sure whether certain information is relevant to underwriting, please call us and we'll be able to clarify that.

- For **policies with moratorium**, moratorium cover will still apply even if you tell us about any pre-existing medical conditions you might have. We may apply new terms to the plan, void or cancel it and/or reduce or reject any related claims, based on your new material facts.

- We will not pay any benefits for a claim if:

  - the claim is false, fraudulent or intentionally exaggerated.
  - you or your dependants or anyone acting on your or their behalf use fraudulent means to obtain benefit under this policy.

  The amount of any claim we paid to you before the fraudulent act or omission was discovered will become immediately owing to us. We reserve the right to inform your company of any fraudulent activity.

Making contact with dependants:

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

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.allianz.sg/Privacy-Policy.html

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

Data Protection Officer
Allianz Insurance Singapore Pte. Ltd.
79 Robinson Road #09-01
Singapore 068897

Email: dpo@allianz.sg

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:

Telephone:	**1800 6709766** (toll-free when calling from Singapore) **+60 (0)3 92127818** (from outside Singapore)
Email:	asia.helpline@e.allianz.com
Address:	**Allianz Insurance Singapore Pte. Ltd., Health Insurance Team, 79 Robinson Road, #09-01, Singapore 068897.**

If you make a complaint, we will make all possible efforts to resolve it as soon as possible. We will assign a complaint officer to handle your

complaint in a fair and reasonable manner in accordance with the following complaint management guidelines:

- Acknowledge your complaint within seven business days.
- Contact you within seven business days from the date of your complaint if we need additional information.
- Update you within 15 business days of our last communication to you if your complaint takes longer to resolve.

If you're not satisfied with the outcome of your complaint, you can escalate it to our Chief Executive Officer at the address provided above. You will be provided with a final response within 15 business days of receipt. If at that point you are still dissatisfied, you can refer it to the Financial Industry Disputes Resolution Centre Ltd (FIDReC). FIDReC is an independent body that mediates in disputes between financial institutions and consumers. They can be contacted as follows:

Address: **Financial Industry Disputes Resolution Centre Ltd (FIDReC), 36 Robinson Road #15-01, City House, Singapore 068877.**

www.fidrec.com.sg/contact-us

Definitions

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

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

Accidental death benefit
Amount shown in the Table of Benefits that becomes payable if an insured person, aged 18 to 70, dies as a result of an accident (including an industrial injury), if the accident occurs during the period of insurance, and the insured person dies within 365 days of the date of the accident.

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

Acute
Sudden onset of symptoms or a medical condition.

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

Annual hearing examination
Examinations/checks performed or prescribed by a specialist and undertaken without any clinical symptom being present. If this benefit is available in your plan, we cover one examination per Insurance Year. The following services are covered under the benefit:

- Consultation

- Pure tone audiometry screening
- Tympanometry

Bariatric surgery

Surgical procedures intended for weight loss due to medical necessity. This includes all pre- and post-surgical assessments, consultations and any complications thereafter, up to the benefit limit. The surgical procedures we cover include gastric bypass surgery, sleeve gastrectomy surgery, biliopancreatic diversion (with or without duodenal switch) and laparoscopic adjustable silicone gastric banding surgery only. Cover is only provided where all the following conditions are met:

- You have a BMI of 40 or above, or a BMI between 35 and 40 in addition to two of the following significant diagnoses that could be improved with weight loss: Hypertension, Type 2 Diabetes Mellitus, Hypercholesterolemia, Ischemic Heart Disease.
- You have tried all appropriate non-surgical measures but have failed to achieve or maintain adequate, clinically beneficial weight loss for at least one year. All efforts and compliance with healthy eating and regular exercise need to be proven to our medical team.
- You have received, or will be receiving, intensive management in a specialist obesity service. We reserve the right to determine if an obesity clinic/bariatric surgeon qualifies as a reasonable specialist obesity service.
- You commit to the need for long-term follow-up and supervision.

We reserve the right to decline cover for bariatric surgery if we determine it is not medically necessary.

Cover for complications is available only if the original bariatric surgery was covered by this policy. We do not cover gastric balloon surgery/treatment, vagus nerve blocking systems or other surgical procedures not listed above.

Burial expenses

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

Cancer screening

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

Chronic condition
Sickness, illness, disease or injury that lasts longer than six months or requires medical attention (such as check-up or treatment) at least once a year. It also has one or more of the following characteristics:

- Is recurrent in nature.
- Is without a known, generally recognised cure.
- Is not generally deemed to respond well to treatment.
- Requires palliative treatment.
- Leads to permanent disability.

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

Company
Your employer as named in the Company Agreement.

Company Agreement
The agreement we have with your employer, through which you and your dependants are insured with us. This agreement sets out who can be covered, when cover begins, how it is renewed and how premiums are paid.

Complementary treatment
Treatment that exists outside of traditional Western medicine. Please refer to your Table of Benefits to confirm whether any of the following complementary treatment methods are covered: chiropractic treatment, osteopathy, podiatry, homeopathy, Chinese herbal medicine (excluding Chinese herbal supplements), acupuncture, Tui na, cupping, bone setting and ayurvedic treatment as practised by approved therapists. If available, consultation costs will also be covered under this benefit.

Your therapist needs to provide a progress report and a treatment plan for your condition after every four sessions.

Complications of childbirth
Medically necessary caesarean sections, post-partum haemorrhage and retained placental membrane only. This includes hospital charges, specialist fees and midwife fees related to the childbirth. For caesarean sections that are not medically necessary, please see the 'Routine maternity' definition.

Complications of pregnancy
Medically necessary treatment for gestational diabetes, pre-eclampsia, stillbirth and hydatidiform mole, where related to the health of the mother during the pre-natal stages of pregnancy. Please note that where an ectopic pregnancy, miscarriage or threatened

miscarriage arises, cover is provided under the member's non-maternity healthcare benefits. Other pre-natal costs are covered under the 'Routine maternity' benefit.

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

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

CPME/CTT
Continuous Personal Medical Exclusions and Continuous Transfer Terms. These acronyms refer to the continuation of the same underwriting terms, including any special exclusions and/or surcharges, that applied with your previous insurer. You will not be subject to any new personal underwriting terms. Cover will still be governed by the benefits, terms and conditions of the plan with us. The underwriting terms with us can be CPME/CTT previously MORI or CPME/CTT previously FMU. See the 'CPME/CTT previously MORI' and 'CPME/CTT previously FMU' definitions for more information.

CPME/CTT previously FMU
The continuation of your full medical underwriting terms that you had with a previous insurer. Cover will still be governed by the benefits, terms and conditions of the plan with us.

CPME/CTT previously MORI
The continuation of your moratorium start date if you had moratorium underwriting terms with a previous insurer. Cover will still be governed by the benefits, terms and conditions of the plan with us.

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

Deductible
Also referred to as 'excess' in health insurance. It is the part of the cost that is payable by you and that we deduct from the amount we will pay.

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

Dental implants
Prostheses that interface with the bone of the jaw or the skull to support a dental prosthesis such as a crown, bridge or denture, along with the related surgical treatment. When submitting claims for dental implants, please include both pre-treatment and post-treatment X-rays.

Dental practitioner
A person who:

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

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

Dental prostheses
Crowns, inlays, onlays, adhesive reconstructions/restorations, bridges and dentures, as well as all necessary and ancillary treatments required. Cover also extends to medically necessary guards/splints, provided they are not related to bruxism or protection against impact injury. Dental implants are not covered under the 'Dental prostheses' benefit, but may be included in your cover under a separate 'Dental implants' benefit.

Dental surgery
Oral and tooth-related surgeries, such as the surgical extraction of teeth (including impacted teeth), apicoectomy and the surgical removal of cysts. This benefit also covers treatment needed to support dental surgery, including dental prescription drugs and investigative procedures like laboratory tests, X-rays, CT and MRI scans that establish the need for dental surgery. Please note that dental surgery does not cover surgical treatment related to dental implants.

Surgical treatment for temporomandibular joint disorders, facial bone fractures, congenital jaw deformities, salivary gland diseases and tumours is covered within the relevant benefit limits of the Core Plan. Orthognathic surgery for the correction of malocclusion is also covered within these limits, but cover is provided only if the 'Orthodontic treatment' benefit is also included on your Dental plan.

Dental treatment
Routine, preventive and restorative dental treatment, including, but not limited to, routine check-ups, routine scaling and polishing, simple fillings for cavities or decay, root canal treatment, simple extractions and dental prescription drugs.

Treatment for temporomandibular joint disorders (excluding guards/splints and orthodontic treatment), facial bone fractures, congenital jaw deformities, salivary gland diseases and tumours is covered within the relevant benefit limits of the Core Plan and the Out-patient Plan (if you have one).

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

Developmental delay
Medical investigations and treatment required because of an established cognitive developmental delay of at least 12 months – these are covered if the 'Developmental delay' benefit is included in your plan. The developmental delay, including speech difficulty, late perception, dyslexia and learning difficulties, must be quantitatively measured and documented by qualified medical professionals.

Costs for psychiatry and psychotherapy, speech therapy and occupational therapy will be covered under this benefit up to the limit stated on your Table of Benefits. Counselling sessions will only be covered if they are provided by a qualified counsellor or psychotherapist. We don't cover daily educational support, admissions, stays or day-care treatment at specialised educational facilities.

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

Dietician fees
Charges for dietary or nutritional advice provided by a health professional who is registered and qualified to practise in the country where the treatment is received. If included in your plan, cover is only provided in respect of eligible diagnosed medical conditions.

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

Direct settlement
Where we settle costs of treatment or services directly with a medical provider in our medical provider network.

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

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

Elective circumcision for newborn males
Costs of the elective circumcision surgical procedure undertaken on newborn males within 30 days from birth, as well as any follow-up consultation required.

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

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

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

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

Emergency treatment outside area of cover
Treatment for medical emergencies that occur during business or holiday trips outside your area of cover. Cover is provided for up to six weeks per trip within the maximum benefit amount. It includes treatment required due to an accident or the sudden beginning or worsening of a severe illness that presents an immediate threat to your health. Treatment by a doctor must start within 24 hours of the emergency event. Cover is not provided for curative or follow-up non-emergency treatment, even if you are deemed unable to travel to a country within your geographical area of cover. Nor does it extend to charges relating to maternity, pregnancy,

childbirth or any complications of pregnancy or childbirth. Please tell your company's Group Scheme Manager if you are going to be outside your area of cover for more than six weeks.

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

Fertility treatment
All invasive investigative procedures necessary to establish the cause of infertility such as hysterosalpingogram, laparoscopy or hysteroscopy. It also covers treatment such as InVitro Fertilisation (IVF), for diagnosed cases of infertility. We will cover the cost of treatment for the insured member who receives it, up to the limit indicated in the Table of Benefits. You can't claim under an insured spouse/partner's cover for costs that exceed your benefit limit.

All non-invasive investigative procedures undertaken to establish the cause of infertility are covered within the relevant benefit limits of the Out-patient Plan (if you have one). Examples of benefits that cover non-invasive investigations procedures are 'Diagnostic tests', 'Medical practitioner fees' and 'Specialist fees'.

For multiple birth babies born as a result of medically assisted reproduction, all babies born by surrogacy, and all adopted and fostered children, in-patient treatment is limited to US$ 40,500/S$ 52,650 per child for the first three months following birth; this limit applies before any other benefit in your plan. Out-patient treatment is paid under the terms of the Out-patient Plan.

Foreseeable
A medical condition that, in our reasonable opinion, could be reasonably anticipated.

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

Gender-affirming care
The following medically necessary treatments and services as required for the care of gender dysphoria, subject to local applicable laws and regulations:

- Behavioural health services such as counselling for gender dysphoria and related psychiatric conditions (e.g. anxiety, depression). Treatment must be prescribed by a psychiatrist, clinical psychologist or licensed psychotherapist.
- Out-patient consultations and treatment, including out-patient pre- and post-hospitalisation treatment for eligible gender-affirming procedures and gender-affirming surgery.
- Hormone therapy.
- Voice lessons, and voice modification surgery and/or therapy.

- The following gender-affirming procedures undertaken to align your physical sexual characteristics with your gender identity, provided they are performed in accordance with internationally accepted clinical practice guidelines:
  - Face/forehead lift
  - Blepharoplasty
  - Facial bone reduction (osteoplasty)
  - Cheek/malar implants
  - Rhinoplasty
  - Chin/nose implants
  - Lip enhancement (initial procedure only)
  - Jaw reduction
  - Laryngoplasty
  - Thyroid reduction (chondroplasty)
  - Neck tightening
  - Skin resurfacing (e.g. dermabrasion and chemical peels)
  - Permanent hair removal
  - Hair transplantation (initial procedure only)

  Cover does not extend to Botox or filler injections, except when required as an integral part of a listed procedure.

- Gender-affirming surgery, as follows, if all the criteria are met:

  For breast/chest surgery (e.g. mastectomy, chest reconstruction, augmentation mammoplasty):
  - You must have one letter of recommendation for surgery from a mental health professional of relevant master's degree level or above.
  - The recommendation must be based on assessments conducted within the last 24 months, indicating that your decision is current and not influenced by any other treatable condition or disorder.
  - The recommendation must state that the surgery is medically necessary according to internationally accepted, evidence-based clinical guidelines.
  - The surgery must be performed in accordance with internationally accepted clinical practice guidelines.

  Note: Mastopexy (breast lift) is covered only if performed as part of the initial breast augmentation.

  For genital surgery (e.g. vaginoplasty, phalloplasty):
  - You must have two letters of recommendation for surgery from two separate mental health professionals, each with a relevant master's degree or higher. At least one letter must include an extensive report.
  - Each recommendation must be based on assessments conducted within the last 24 months, confirming that your decision is current and not influenced by any other treatable condition or disorder.
  - Each recommendation must state that the surgery is medically necessary according to internationally accepted, evidence-based clinical guidelines.

- The surgery must be performed in accordance with internationally accepted clinical practice guidelines.

Cover does not extend to treatment or services for fertility preservation, including the harvesting, cryopreservation, storage and/or transportation of reproductive tissue, embryos, sperm or oocytes.

If you have a policy with moratorium, your underwriting terms will be waived on this benefit. This means that cover is available under this benefit even if your symptoms or diagnosis are pre-existing. However, any applicable benefit waiting period will still apply.

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

Group Scheme Manager
The designated representative of your company, who acts as the point of contact between the company and us for matters relating to the administration of the plan such as enrolment, premium collection and renewal.

Health and wellbeing checks including screening for the early detection of illness or disease
Routine health checks, tests and examinations, performed at appropriate age intervals, without any clinical symptoms being present. To be covered, you need to receive the health and wellbeing screening services at a licensed medical institution or a licensed health examination institution, or under the guidance of a doctor in an appropriate setting and in accordance with the international clinical practice guidelines. We do not cover excessive or unnecessary screening, such as full body ultrasounds, MRIs or CT scans.

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

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

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

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

Hospital accommodation
Standard private or semi-private accommodation as shown in the Table of Benefits. We pay the costs for your hospital accommodation and all eligible in-patient/day-care treatment and services required while using the room, up to the reasonable and customary rates associated with the room type specified in your Table of Benefits. Deluxe, executive rooms and suites are not covered.

We do not cover non-medical or personal expenses charged separately to the hospital accommodation cost, such as phone calls or newspapers. If meals are not included in the hospital accommodation cost, we will only cover up to three full-course meals per day. A full-course meal consists of one appetizer, one main course, one dessert and one drink.

Please note that if your hospital admission is related to another benefit covered under your policy, hospital accommodation may already be included within that benefit. For example, if you are hospitalised for cancer treatment, hospital accommodation will be covered under the 'Oncology' benefit, rather than the separate 'Hospital accommodation' benefit. Other benefits that may include hospital accommodation (if included in your plan) are: 'Psychiatry and psychotherapy', 'Routine maternity', 'Palliative care' and 'Long-term care'. Where your benefit includes hospital accommodation, please note that the room type specified under 'Hospital accommodation' in your Table of Benefits will apply to those other benefits as well. For example, if your 'Hospital accommodation' benefit covers a semi-private room type and you are hospitalised for cancer treatment, your 'Oncology' benefit will include cover for semi-private room accommodation only.

If the room type specified in your Table of Benefits is not available at the hospital, or if you choose a superior room type, we will cover your accommodation, as well as all related in-patient and day-care treatment and services, up to the reasonable and customary rates associated with the room type indicated in your Table of Benefits.

In-patient cash benefit at public hospitals
Amount that we pay to you if you receive in-patient treatment at a public hospital for a medical condition that is covered by us. A public hospital is a hospital that the government owns, runs, and mostly pays for in the country where it's located. This cash benefit is limited to the amount specified in the Table of Benefits and is payable after you are discharged from hospital.

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

Insurance Certificate
A document we issue that outlines the details of your cover. It confirms that your company has a group insurance policy with us.

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

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

Laser eye treatment
The surgical improvement of the refractive quality of the cornea using laser technology, including the necessary pre-operative investigations.

Lifetime limit
The total amount we'll pay for any eligible costs you incur during any time we cover you on any one or more plans with the same or equivalent benefits, even if there's a break in your cover.

Local ambulance
Ambulance transport to the nearest available and appropriate hospital or licensed medical facility when required for an emergency or out of medical necessity to receive treatment you are covered for.

Long-term care
Care over an extended period of time after the initial acute/curative treatment has been completed. This usually occurs for a chronic condition or disability requiring uninterrupted/continuous medical care, or where treatment options are limited to the existing level of care. Long-term care can be provided at home, in the community, in a hospital, a long-term care facility or in a nursing home.

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

Medical evacuation
It applies in the following scenarios:

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

We will evacuate you to the nearest appropriate medical centre (which may or may not be in your home country) by ambulance, helicopter or aeroplane. The medical evacuation should be requested by your doctor and will be carried out in the most economical way that is appropriate

to your medical condition. Following completion of treatment, we will also cover the cost of your return trip at economy rates to your principal country of residence.

If you can't travel or be evacuated for medical reasons following discharge from an in-patient episode of care, we will cover the reasonable cost of hotel accommodation in a private en-suite room for up to 14 days. We do not cover costs for hotel suites, four or five-star hotel accommodation or hotel accommodation for an accompanying person.

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

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

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

In the event of non-emergency treatment, cover is only available if the benefit for 'Medical evacuation in the event of non-emergency treatment' is included in your plan, and if the necessary treatment you are covered for is not available locally.

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

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

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

Medical practitioner fees
Fees charged for non-surgical treatment performed or administered by a medical practitioner, or performed by a medical professional under the supervision of a medical practitioner.

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

Medical provider network
All of the medical providers with whom we have arrangements in place for the direct settlement of our members' medical costs.

Medical repatriation
An optional level of cover and where provided will be shown in the Table of Benefits. If the necessary treatment for which you are covered isn't available locally you can choose to be medically evacuated to your home country for treatment, instead of to the nearest appropriate medical centre. This only applies when your home country is within your geographical area of cover. Where the repatriation relates to non-emergency treatment, cover is only available under this benefit if the benefit for 'Medical evacuation in the event of non-emergency treatment' is also included in your plan.

Following completion of treatment, we will also cover the cost of your return trip at economy rates, to your principal country of residence. The return journey must take place within one month after treatment has been completed.

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

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

Mental health professional
Licensed practitioner working in health care, counselling or social services who offers services for the purpose of treating mental health conditions.

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

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

Natural tooth
Any tooth that is original, not an artificial implant or replacement.

Newborn care
Newborn accommodation and the following essential examinations, diagnostic procedures and treatments as required following birth:

- Customary examinations required to assess the integrity and basic function of the child's organs and skeletal structures
- One hearing examination
- Screening tests for PKU, congenital hypothyroidism and G6PD
- Vitamin K, hepatitis B and BCG vaccinations.

Cover doesn't include further preventive diagnostic procedures, such as routine swabs or blood typing. However, if for medical reasons the child needs any follow-up investigations and treatment, these are covered under the newborn's own policy (if they have been added as a dependant). For multiple birth babies born as a result of medically assisted reproduction, all babies born by surrogacy, and all adopted and fostered children, in-patient treatment is limited to US$ 40,500/S$ 52,650 per child for the first three months following birth; this limit applies before any other benefit in your plan. Out-patient treatment is paid within the terms of the Out-patient Plan.

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

Nursing at home or in a convalescent home
Nursing received immediately after, or instead of, eligible in-patient or day-care treatment. We will pay the benefit listed in the Table of Benefits if the treating doctor decides that it is

medically necessary for you to stay in a convalescent home or have a nurse in attendance at home. This benefit also needs to be approved by our Medical Director. This benefit doesn't cover spas, cure centres, health resorts, palliative care or long-term care.

Occupational therapy

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

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

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

Oncology

Specialist fees, diagnostic tests, radiotherapy, chemotherapy and hospital charges related to the treatment of cancer from the point of diagnosis. We also cover the cost of an external prosthetic device for cosmetic purposes, for example a wig for hair loss or a prosthetic bra after breast cancer treatment.

Organ transplant

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

Orthodontics

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

Medical necessity criteria:

- Increased overjet > 6mm but <= 9 mm
- Reverse overjet > 3.5 mm with no masticatory or speech difficulties
- Anterior or posterior crossbites with > 2 mm discrepancy between the retruded contact position and intercuspal position
- Severe displacements of teeth > 4
- Extreme lateral or anterior open bites > 4 mm
- Increased and complete overbite with gingival or palatal trauma
- Less extensive hypodontia requiring pre-restorative orthodontics or orthodontic space closure to obviate the need for a prosthesis

- Posterior lingual crossbite with no functional occlusal contact in one or more buccal segments
- Reverse overjet > 1 mm but < 3.5 mm with recorded masticatory and speech difficulties
- Partially erupted teeth, tipped and impacted against adjacent teeth
- Existing supernumerary teeth

You will need to send us some supporting information to show that your treatment is medically necessary and therefore covered by your plan. The information we ask for may include, but is not limited to:

- A medical report issued by the specialist, stating the diagnosis (type of malocclusion) and a description of your symptoms caused by the orthodontic problem.
- A treatment plan showing the estimated duration and cost of the treatment and the type/material of the appliance used.
- The payment arrangement agreed with the medical provider.
- Proof of payment for orthodontic treatment.
- Photographs of both jaws clearly showing dentition before the treatment.
- Clinical photographs of the jaws in central occlusion from frontal and lateral views.
- Orthopantomogram (panoramic X-ray).
- Profile X-ray (cephalometric X-ray).
- Any other document we may need to assess the claim.

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

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

Out-patient dental treatment
A benefit that specifically covers out-patient dental treatment required as follow-up to an in-patient stay for accidental damage to natural teeth. Cover is provided when the out-patient dental treatment is required in the 90 days following discharge from the related in-patient treatment. Cover includes the costs to supply and fit dental implants.

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

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

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

Partner
A legal partner or a person you have lived with in a de facto relationship for a continuous period of 12 months.

Periodontics
Dental treatment related to gum disease.

Policies with full medical underwriting
Policies where we ask the insured persons to provide detailed information about their medical history when they apply for cover. We assess the medical history before confirming cover, to determine the type of insurance risk: based on the insurance risk, we might confirm cover with exclusion of certain benefits and/or premium loading. Cover for pre-existing conditions is subject to the terms offered by our Underwriting Team, and governed by the benefits, terms and conditions of the policy.

Policies with moratorium
Policies where we don't consider or assess the medical history of the insured persons when they apply for cover. The insured persons are covered for all eligible expenses included in their plan, subject to the terms and conditions of the policy – however, any claims related to pre-existing conditions are subject to moratorium (see definition).

Post-hospitalisation physiotherapy
Physiotherapy treatment required in the 90 days following discharge from an in-patient or day-care treatment of less than three days in duration.

Post-hospitalisation treatment
Out-patient treatment required in the 90 days following discharge from an in-patient or day-care treatment for the same acute medical condition. This benefit covers medical practitioners' fees, specialists' fees, out-patient surgery, prescribed drugs and dressings, MRI, PET and CT scans, X-rays, pathology and other diagnostic tests and procedures.

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

Pre-existing conditions
Medical conditions for which one or more symptoms presented at some point during your or your dependants' lifetime. This applies regardless of whether you or your dependants sought

any medical advice or treatment. We will consider any medical condition to be pre-existing if we can determine that you or your dependants would have known about it.

The following terms about pre-existing conditions apply if your Insurance Certificate shows that your underwriting terms are Full Medical Underwriting or CPME/CTT previously FMU:

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

- the date we issued your Insurance Certificate, or
- the start date of your policy.

Such pre-existing conditions will also be subject to full medical underwriting and if they are not disclosed, they will not be covered. Please refer to the 'Notes' section of your Table of Benefits to confirm if pre-existing conditions are covered.

The following terms about pre-existing conditions apply if your Insurance Certificate shows that your underwriting terms are Moratorium or CPME/CTT previously MORI:
Your claim will not be paid if it's relating to a pre-existing medical condition, if one or more of the following have applied within the 24-month period before your start date (or the date shown in your Insurance Certificate):

- It could be reasonably foreseen that the medical condition would occur after your start date.
- The condition clearly showed itself to be present by having signs or symptoms, requiring treatment, investigations or medication.
- To the best of your knowledge, you were aware you had the condition.

Once you've completed a continuous 24-month period after your date of joining we may cover your pre-existing medical condition provided you've not had symptoms, needed or received treatment, medication, a special diet or advice, or had any other indications of the condition. If you have had symptoms, needed or received treatment, medication, a special diet or advice or other indications of any condition during the 24-month waiting period, the waiting period will restart for that condition (rolling moratorium).

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

Pre-hospitalisation tests
Out-patient pre-hospitalisation tests carried out in the 72 hours before in-patient or day-care treatment covered under your plan.

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

Prescribed drugs and dressings
Drugs when prescribed by a doctor to:

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

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

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

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

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

We do not cover costs for medical aids that form part of palliative care or long-term care.

Prescribed physiotherapy
Treatment provided by a registered physiotherapist following referral by a doctor. Physiotherapy (either prescribed, or a combination of non-prescribed and prescribed treatment) is initially restricted to 12 sessions per condition, after which treatment must be reviewed by your therapist or the doctor who referred you.

If you need further sessions, your therapist/doctor must send us a new progress report and a treatment plan for your condition, indicating the medical necessity for more treatment. They must also do this after every subsequent set of 12 sessions.

Physiotherapy does not include therapies such as Rolfing, massage, Pilates, Fango and Milta.

Prescribed vitamins, minerals and supplements

Vitamins, minerals and supplements prescribed by a medical practitioner, in conjunction with other treatments, to treat the symptoms of a diagnosed medical condition or aid the recovery process.

This does not include prescriptions for the treatment of deficiency syndromes. Cover for these costs is available under the 'Prescribed drugs and dressings' benefit, provided the benefit is included in your plan.

Similarly, it does not extend to prescriptions during pregnancy or cancer treatment (as required in accordance with medical guidelines). Cover for these costs is available under the 'Routine maternity' and 'Oncology' benefits, provided the relevant benefit is included in your plan.

In all cases, we do not cover vitamins, minerals or supplements obtained without prescription, or where prescribed for preventive purposes.

Preventive surgery

Prophylactic mastectomy or prophylactic oophorectomy. We will pay for preventive surgery when:

- you have a direct family history of a disease that is part of a hereditary cancer syndrome (for example, breast cancer or ovarian cancer), and
- genetic testing has established the presence of a hereditary cancer syndrome.

Preventive treatment

Treatment you receive without any clinical symptoms being present at the time of treatment (e.g. the removal of a pre-cancerous growth). This benefit is covered when the 'Preventive treatment' benefit is listed in your Table of Benefits.

Principal country of residence

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

Professional sports

Any sporting activity that you engage in and from which you derive a salary or other economic compensation.

Psychiatry and psychotherapy

Treatment of mental, behavioural and personality disorders, including autism spectrum and eating disorders. Treatment must be carried out by a psychiatrist, clinical psychologist or licensed psychotherapist. The condition must be clinically significant and the treatment medically necessary.

All day-care or in-patient admissions must include prescription medication related to the condition.

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

Counselling is available through our Employee Assistance Programme (EAP) and refers to short-term, solution-focused interventions, and typically deals with current issues that are easily resolved on the conscious level. This service is not intended for longer-term situations or the treatment of clinical disorders and is not suitable for minors who are below the local legal age of consent.

EAP can help you and your immediate family deal with challenging situations that may arise in life, such as stress, anxiety, bereavement, workplace challenges, relationship issues, cross-cultural transition and coping with isolation and loneliness. Please note that the EAP service does not include group therapy, such as family therapy.

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

Reconstructive surgery
Treatment costs to restore natural function or appearance after a disfiguring accident or surgery for cancer. Cover is available where the treatment for the accident or initial surgery was also covered by this policy.

Rehabilitation treatment
Treatment that combines therapies such as physical, occupational and speech therapy. It aims to restore original form or function after an acute illness, injury or surgery. Treatment must take place in a licensed rehabilitation facility and start within 14 days of discharge from acute medical and/or surgical treatment.

Cover is only provided under this benefit if you've received in-patient treatment for three or more consecutive days/nights for the same medical condition.

We cover in-patient or day-care accommodation costs only if admission to a rehabilitation facility was requested by your doctor and approved by us.

Repatriation of mortal remains
The transportation of the deceased insured person's remains to their home country. If the insured passes away in their home country, we will cover transportation to the location of burial

or cremation in that country, or to another home country where more than one home country exists. We cover costs such as: embalming, a container legally appropriate for transportation, shipping and the necessary government authorisations. Cremation costs will only be covered if the cremation is required for legal purposes. We do not cover costs incurred by anyone accompanying the remains unless this is listed as a specific benefit in your Table of Benefits.

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

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

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

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

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

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

Speech therapy
Treatment carried out by a qualified speech therapist to treat diagnosed physical impairments. This includes conditions such as nasal obstruction, neurogenic impairment (e.g. lingual paresis, brain injury) or articulation disorders involving the oral structure (e.g. cleft palate).

Start date
The date when you first enrolled, or re-enrolled if there is a break in your cover.

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

Therapist
Chiropractor, osteopath, podiatrist, Traditional Chinese Medicine practitioner, homeopath, acupuncturist, ayurvedic practitioner, physiotherapist, speech therapist, occupational therapist or oculomotor therapist, who is qualified and licensed under the laws of the country in which treatment takes place.

Travel costs for one person accompanying an evacuated/repatriated person
Travel costs for one person to accompany the evacuated/repatriated person. If they can't travel in the same vehicle, we will pay for an alternative form of transport at economy rates. Following completion of treatment, we will also cover the cost of the companion's return trip, at economy rates, to the country where the evacuation/repatriation started from.

Cover under these benefits is only available if the associated evacuation/repatriation is also covered under your plan. Cover does not include hotel accommodation or other related expenses.

Travel costs of insured family members in the event of an evacuation/repatriation
The reasonable transportation costs of all insured family members of the evacuated or repatriated person, including minors who might otherwise be left unattended. If all family members can't travel in the same vehicle with the evacuated/repatriated person, we will pay for their round-trip transport at economy rates.

Cover under these benefits is only available if the associated evacuation/repatriation is also covered under your plan. Cover does not include hotel accommodation or other related expenses.

Travel costs of insured family members in the event of the repatriation of mortal remains
The reasonable transportation costs of any insured family members who had been living abroad with the insured person who died, to travel to the country of burial of the deceased. Reasonable transportation costs are considered to be round trip transport costs at economy rates. Cover does not include hotel accommodation or other related expenses.

Travel costs of insured members to be with a close relative who is at peril of death or who has died
The reasonable transportation costs of insured members to be with a close relative who is at peril of death or who has died (up to the amount specified in your Table of Benefits). Cover

includes one round trip per insured member per Insurance Year. If the close relative has passed away, travel must commence within six weeks of their date of death.

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

Reasonable transportation costs are considered to be round trip transport costs at economy rates. When claiming, please include copies of the travel tickets and the death certificate or a doctor's certificate supporting the reason for travel. Cover does not include hotel accommodation or other related expenses.

Treatment

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

Treatment of autism spectrum disorder

A range of therapies to improve the skills of an insured person with autism. This includes specialist medical treatment and accredited behavioural programmes. Treatment is covered as part of the 'Psychiatry and psychotherapy' benefit of your Out-patient Plan, if you have one. If your plan includes the 'Developmental delays' benefit, it also covers prescribed speech therapy and occupational therapy for autism treatment. Please refer to your Table of Benefits for any applicable limits. We don't cover daily educational support, admissions, stays or day-care treatment at specialised educational facilities.

Treatment of eating disorders

A combination of psychotherapies, including cognitive behavioural therapy, medical monitoring, prescribed medication and nutritional counselling to treat anorexia nervosa, bulimia nervosa and binge-eating disorder.

All day-care or in-patient admissions must include prescription medication related to the condition.

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

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

Vaccinations

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

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

*We cover any COVID-19 vaccine when:

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

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

Video consultation services

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

If you access teleconsultation services outside of the TeleHealth Hub, the 'Video consultation services' benefit will not apply. Cover will be subject to the terms of the benefit that would apply if the consultation were received in a face-to-face setting.

Waiting period

A period of time that begins on your policy start date (or effective date if you are a dependant), during which you are not entitled to cover for particular benefits. Your Table of Benefits shows

which benefits are subject to waiting periods. Waiting periods do not apply to you if you have a non-underwritten policy.

We/Our/Us
Allianz Insurance Singapore Pte. Ltd.

You/Your
The person working for the company and any dependants named on the Insurance Certificate.

Exclusions

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

ACQUISITION OF AN ORGAN
Expenses for the acquisition of an organ such as, but not limited to donor search, typing, harvesting, transport and administration costs.

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

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

COMPLICATIONS CAUSED BY CONDITIONS NOT COVERED UNDER YOUR PLAN
Expenses incurred because of complications directly caused by an illness, injury or treatment for which cover is excluded or limited under your plan.

CONSULTATIONS PERFORMED BY YOU OR A FAMILY MEMBER
Consultations performed and any drugs or treatments prescribed by you, your spouse, parents or children.

COSMETIC TREATMENT
Any cosmetic treatment, even when medically prescribed. This includes treatment carried out by a plastic surgeon, whether or not for medical/psychological purposes.

The following exceptions apply:

- **Reconstructive surgery necessary to restore function or appearance after a disfiguring accident or as a result of surgery for cancer, provided the accident or initial surgery was also covered by this policy.**
- **Gender-affirming procedures and surgery, if you meet the criteria for gender-affirming care and the benefit is included in your policy.**

DENTAL VENEERS
Dental veneers and related procedures.

DEVELOPMENTAL DELAY
Delay in cognitive development, unless the person meets the criteria for developmental delay and the benefit is included on your policy. Cover for physical developmental delays is only provided under the 'Prescribed physiotherapy' and 'Occupational therapy' benefits if these are included in your plan, and the delay is confirmed to be at least 12 months based on quantitative measurements as documented by qualified medical professionals. We don't cover daily educational support, admissions, stays or day-care treatment at specialised educational facilities.

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

EXPERIMENTAL OR UNPROVEN TREATMENT OR DRUG THERAPY
Any form of treatment or drug therapy that in our reasonable opinion is experimental or unproven, based on generally accepted medical practice.

FAILURE TO SEEK OR FOLLOW MEDICAL ADVICE
Treatment or services required as a result of failure to seek or follow medical advice.

FAMILY THERAPY AND COUNSELLING
Costs in respect of a family therapist or counsellor for out-patient psychotherapy treatment.

FEES FOR THE COMPLETION OF A CLAIM FORM
Doctor's fees for the completion of a Claim Form or other administration charges.

FERTILITY TREATMENT
Fertility treatment including medically assisted reproduction or treatment for any medical problems arising from it, unless you have a specific benefit for fertility treatment or have the required out-patient benefits that cover non-invasive investigations into the cause of infertility (such as 'Medical practitioner' fees, 'Specialist fees' and 'Diagnostic' tests).

GENETIC TESTING
Genetic testing, except:

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

HOME VISITS
Home visits, unless they are necessary after the sudden onset of an acute illness that leaves you incapable of visiting your doctor or therapist.

INJURIES CAUSED BY PROFESSIONAL SPORTS
Treatment, services or diagnostic procedures for injuries arising from taking part in professional sports.

INTENTIONALLY CAUSED DISEASES OR SELF-INFLICTED INJURIES
Care and/or treatment or services for intentionally caused diseases or self-inflicted injuries, including a suicide attempt.

LOSS OF HAIR AND HAIR REPLACEMENT
Investigations into and treatment for loss of hair, including hair replacement unless the loss of hair is due to cancer treatment.

MEDICAL ERROR
Treatment required as a result of medical error.

MORTAL REMAINS
The purchase of a burial plot, or funeral costs, including, but not limited to, flowers and the funeral director's fees.

ORTHOMOLECULAR TREATMENT
Please refer to the definition of 'Orthomolecular treatment'.

PARTICIPATION IN WAR OR CRIMINAL ACTS
Death from, or treatment or services for any illnesses, diseases or injuries resulting from active participation in the following, whether war has been declared or not:

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

PERSONAL PRODUCTS AND DIETARY SUPPLEMENTS
We do not cover the following products, even if they are prescribed, medically recommended and/or acknowledged as having therapeutic effects:

- Personal products such as mouthwash, toothpaste, shampoo, sunscreen, sanitiser, gloves, masks, visors, thermometers and baby supplies
- Cosmetic products, including moisturisers, emulsions, lotions, gels and oils for the skin that do not contain medicinal components. The only exception is for barrier creams prescribed for the management of clinically recognised skin conditions.
- Children's food, including infant formula given orally

We also do not cover vitamins, minerals or supplements (including nutritional, dietary, organic or herbal preparations) except in the following cases:

- Where prescribed
  - during pregnancy, as required in accordance with medical guidelines
  - during cancer treatment, as required in accordance with medical guidelines

- to treat diagnosed deficiency syndromes
- Where cover is provided under the 'Prescribed vitamins, minerals and supplements' benefit, and this benefit is included in your policy

PRE- AND POST-NATAL
Pre- and post-natal classes.

PRE-EXISTING CONDITIONS (APPLICABLE TO POLICIES WITH FULL MEDICAL UNDERWRITING OR CPME/CTT PREVIOUSLY FMU)
Pre-existing conditions (including pre-existing chronic conditions) when:

- **indicated on a Special Conditions Form that we issue before your policy starts.**
- **conditions were not disclosed on the application form.**
- **conditions arise between completing the application form and the later of the following:**
  - **the date we issue your Insurance Certificate, or**
  - **the start date of your policy.**

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

PRE-EXISTING CONDITIONS (APPLICABLE TO POLICIES WITH MORATORIUM OR CPME/CTT PREVIOUSLY MORI)
Pre-existing medical conditions when one or more of the following have applied within the 24-month period before your date of joining (or the date shown in your Insurance Certificate):

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

Once you've completed a continuous 24-month period after your date of joining your pre-existing medical condition may be covered provided you've not had

symptoms, needed or received treatment, medication, a special diet or advice, or had any other indications of the condition.

PRODUCTS PURCHASED WITHOUT A PRESCRIPTION
Products that are purchased without a doctor's prescription.

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

SLEEP DISORDERS
Treatment of sleep disorders, including insomnia, obstructive sleep apnoea, narcolepsy, snoring and bruxism.

SPEECH THERAPY
Speech therapy related to developmental delay (unless the person meets the criteria for developmental delay and the 'Developmental delay' benefit is included on your policy), dyslexia, dyspraxia or expressive language disorder.

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

STERILISATION, SEXUAL DYSFUNCTION AND CONTRACEPTION
Investigations into, treatment of and complications arising from:

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

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

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

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

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

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

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

TREATMENT OUTSIDE THE GEOGRAPHICAL AREA OF COVER
Treatment outside the geographical area of cover unless for emergencies or authorised by us.

TRIPLE/BART'S, QUADRUPLE OR SPINA BIFIDA TESTS
Triple/Bart's, Quadruple or Spina Bifida tests, except for women aged 35 or over.

VESSEL AT SEA
Medical evacuation/repatriation from a vessel at sea to a medical facility on land.

WEIGHT-RELATED TREATMENT AND SERVICES
Treatment and services for weight control, including bariatric surgery, medication (unless indicated for use in the treatment for established Type 2 Diabetes), supplements, health club memberships, diet programs and residential eating disorder programs.

BENEFITS THAT ARE NOT IN YOUR TABLE OF BENEFITS

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

- Bariatric surgery
- Complications of pregnancy and childbirth
- Dental treatment, dental surgery, periodontics, orthodontics, dental implants and dental prostheses
- Developmental delay
- Dietician fees
- Elective circumcision for newborn males
- Emergency dental treatment
- Fertility treatment
- Gender-affirming care
- Health and wellbeing checks including screening for the early detection of illness or disease
- HIV/AIDS treatment
- Homeopathy, Chinese herbal medicine, Tui na, cupping, bone setting, acupuncture and ayurvedic treatment
- Hormone replacement therapy
- In-patient and day-care treatment of congenital conditions
- In-patient psychiatry and psychotherapy treatment
- Laser eye treatment
- Medical evacuation in the event of non-emergency treatment
- Medical repatriation
- Out-patient psychiatry and psychotherapy treatment
- Out-patient treatment
- Palliative care
- Prescribed glasses and contact lenses including eye examination
- Prescribed medical aids
- Prescribed vitamins, minerals and supplements
- Preventive surgery
- Repatriation of mortal remains or burial expenses
- Routine maternity
- Travel costs for one person accompanying an evacuated/repatriated person
- Travel costs of insured family members in the event of an evacuation/repatriation

- Travel costs of insured family members in the event of the repatriation of mortal remains
- Travel costs of insured members to be with a close relative who is at peril of death or who has died

ACCIDENTAL DEATH BENEFIT

Accidental death benefit, if the death of an insured person has been caused either directly or indirectly by:

- Active participation in war, riots, civil disturbances, terrorism, criminal acts, illegal acts or acts against any foreign hostility, whether war has been declared or not.
- Intentionally caused diseases or self-inflicted injuries, including suicide, within one year of the enrolment date of the policy.
- Active participation in underground or underwater activity such as underground mining or deep-sea diving.
- Above-water activity (such as on oil platforms or oil rigs) and aerial activity, unless specifically covered under the Company Agreement.
- Chemical or biological contamination, radioactivity or any nuclear material contamination, including the combustion of nuclear fuel.
- Passive war risk:
  - Being in a country where the British government has recommended that their citizens leave (this condition will apply regardless of the insured person's nationality) and has advised against 'all travel' to that location; or
  - Travelling to or staying, for a period of more than 28 days per stay, in a country or an area where the British government advises ‘against all but essential travel’.

The passive war risk exclusion applies regardless of whether the claim arises directly or indirectly as a consequence of war, riots, civil disturbances, terrorism, criminal acts, illegal acts or acts against any foreign hostility, whether war has been declared or not.

- Being under the influence of drugs or alcohol.
- Death that takes place more than 365 days after the occurrence of the accident.
- Deliberate exposure to danger, except in an attempt to save human life.

- Intentional inhalation of gas or intentional ingestion of poisons or legally prohibited drugs.
- Flying in an aircraft, including helicopters, unless the insured person is a passenger and the pilot is legally licensed, or is a military pilot and has filed a scheduled flight plan when required by local regulations.
- Active participation in extreme or professional sports or activities including but not limited to:
  - Mountain sports such as abseiling, mountaineering and racing of any kind (except for racing on foot).
  - Snow sports such as bobsleigh, luge, mountaineering, skeleton, skiing off-piste and snowboarding off-piste.
  - Equestrian sports such as hunting on horseback, horse jumping, polo, steeple chasing or horse-racing of any kind.
  - Water sports such as potholing (solo caving) or cave diving, scuba diving to a depth of more than 10 metres, high diving, white water rafting and canyoning.
  - Car and motorcycle sports such as motorcycle riding and quad biking.
  - Combative sports.
  - Air sports such as flying with a microlight, ballooning, hang gliding, paragliding, parascending and parachute jumping.
  - Various other sports such as bungee jumping.

Talk to us, we love to help!

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

24/7 Helpline for general enquiries and emergency assistance.

1800 6709766
(toll-free when calling from Singapore)

+60 (0)3 92127818
(from outside Singapore)

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 their identity.

Email: asia.helpline@e.allianz.com

Address: **Allianz Insurance Singapore Pte. Ltd., Health Insurance Team, 79 Robinson Road, #09-01 Singapore 068897.**

www.allianz.sg/sme-solutions/international-health.html

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