Allianz Care

Guide to your Extended Health Plan

Welcome to Allianz Care

Apple has partnered with Allianz Care to provide you and your eligible family members with easy access to supplemental healthcare cover in your country of employment.

Allianz Care specialises in international health cover and is backed by the resources and expertise of Allianz SE, one of the world's leading insurance companies.

Eligibility

If you are eligible and enrolled under your local Apple insurance plan in participating countries, you and your dependants are also entitled to the Extended Health Plan. The Extended Health Plan supplements your local plan covering higher benefit limits and additional treatments and services.

Talk to us, we love to help!

Our dedicated Helpline is available 24 hours a day, 7 days a week, to handle any questions about your policy or to assist you with a claim.

Phone: +353 1 514 8436

Email: apple.helpline@e.allianz.com

If you speak another language, please inform the Helpline when you call us and we will try to locate an interpreter.

How to use your Extended Health Plan

Check your level of cover

First, check that you are covered for the treatment you are seeking. The Table of Benefits below outlines the cover we offer under your policy. Please note that cover is subject to our policy definitions, limitations and exclusions as detailed in this guide.

Table of Benefits

All coverage amounts are in US dollars.

Extended Health Plan - coverage	Limits per insured
Maximum plan limit	US$ 2,000,000
Cancer & Other Serious Medical Conditions	US$ 500,000 per condition
Congenital Conditions and Birth Defects	US$ 500,000 per condition
Autism and other Developmental Disabilities	Non-ABA: US$ 10,000 per annual limit ABA: US$ 25,000 per lifetime
Transgender Treatment and Services	US$ 100,000 per lifetime
Fertility	US$ 10,000 per lifetime
DME, Orthotics, Prosthetics	US$ 10,000 per annual limit (DME & Orthotics)* US$ 25,000 per annual limit (Prosthetics) *US$ 500 Deductible per Device

Are you covered by your local insurer or social security plan?

Prior to submitting any claim to us you will need to contact your local insurance or social security plan provider to request a statement/certificate displaying the cover is active (start/end date of your policy) and the benefits you are covered for including any limits that apply.

In order to appropriately review your request, it is important for us to verify if your local insurance or social security plan fully covers, partially covers, rejects or declines the costs of treatment. In all such cases, please provide us with the declinature statement / explanation of benefits / claims statement of accounts or any other document that supports the verification.

Your first treatment

In order to initiate a first claim for yourself or an eligible dependant, you must call or email us to activate your policy.

1. Contact our 24/7 Helpline (see page 2).

2. Provide us with your personal details for verification purposes:
    - Employer name
    - First and last name
    - Employee ID number
    - Date of Birth (for data privacy reasons a dummy date has been added in our system. We'll update your records when you contact us to activate your policy)
    - Email address (for future communication)

3. Enrol your dependant if treatment is required for them (please refer to Dependant Enrolment paragraph below).

4. We will provide you with your individual policy number by e-mail.

Dependant Enrolment

If one of your eligible dependants needs any treatment covered under this plan please fill out the Extended Health Plan Dependant Enrolment Form and send it to us at your earliest convenience. Once your dependant has been enrolled under your policy, you may initiate a claim or request treatment pre-approval for them. Please note that your individual policy number applies to any eligible dependants that have been enrolled.

Some treatments require our pre-approval

If you (or any of your dependants) are planning to have in-patient or high cost treatment, you will need to request pre-approval from us. Pre-approval is a process whereby we guarantee cover for certain required treatment and costs (where covered) as follows:

- In-patient benefits (treatment received in a hospital where an overnight stay is medically necessary).
- Day-care treatment including chemotherapy and radiotherapy.
- Out-patient surgery.
- PET (Positron Emission Tomography) and CT-PET scans.

Treatment pre-approval process

In the event that you or any of your dependants need to be hospitalised or have high cost treatment, please follow the steps below **at least 5 business days before the planned treatment**. Our Medical Team will then be able to verify your cover and facilitate smooth admission into care:

Contact your local insurance provider to request an insurance statement indicating your renewal date and the benefits you're covered for, including any limits that apply. In order to appropriately review your request it is important for us to verify if your local insurance fully covers, partially covers, rejects or declines the costs of treatment. Please ensure this is clearly indicated in the insurance statement/document provided.

Download an Extended Health Plan Treatment Guarantee Form from your dedicated member hub: **www.allianzcare.com/apple**

Submit the Extended Health Plan Treatment Guarantee Form along with all supporting documentation at least five working days* before treatment to: **apple.helpline@e.allianz.com**

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

Once we receive all the information we need, our Medical Team will assess the case and issue a Guarantee of Payment to the medical provider, authorising the treatment (provided you are eligible for the treatment). If we need more information we may need to contact you, your doctor or your medical provider and this may delay the process.

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 Treatment Guarantee Form details over the phone when you call us.

Pay and claim process

When your treatment has already occurred and you have settled the invoice

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

Contact your local insurance provider to request an insurance statement indicating your renewal date and the benefits you're covered for, including any limits that apply. In order to appropriately review your request it is important for us to verify if your local insurance fully covers, partially covers, rejects or declines the costs of treatment. Please ensure this is clearly indicated in the insurance statement/document provided.

Get an invoice from your medical provider. The invoice must clearly state:

a. Your name
b. Treatment date(s)
c. Medical condition and type of treatment
d. Date you first experienced the symptoms
e. Treatment cost

Claim back your eligible costs via our MyHealth app or online portal (**www.allianzcare.com/en/myhealth.html**)
Simply add your invoice(s), enter a few key details: patient, country of treatment, treatment provider, type of treatment, medical reason, invoice date, currency and amount. Press 'submit' and you're done.

Please send us your claim together with all supporting documentation, invoices and receipts.

Please keep copies of all documentation for additional claims. You will need to submit all items in step #2 each time you file a new claim.

Quick claim processing

Once we have all the information required, we can process and pay a claim within 48 hours*. If your claim does not have all required information, we will need to request more details from you. You can call or email us before you submit your claim to confirm you provide us with all required information.

* Please note that the turnaround time to process your first claim/pre-approval request may be longer than usual as we will need to update your records in our system (or if the treatment is for a dependant, we'll need to set them up in our system first).

Additional information about claiming for your expenses

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

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

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

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

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

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

- **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.

Categories of Coverage

Overall lifetime limit per insured: US$ 2,000,000

Cancer and Other Serious Medical Conditions

Coverage and Limit: US$ 500,000 per condition

Subject to local applicable laws and regulations, the policy provides cover to members for treatments for cancer and any other serious or life threatening conditions (due to sickness or injury), over and above the local plan limits up to an annual limit stated in the Table of Benefit.

Cancer

Coverage is provided for specialist fees, diagnostic tests, radiotherapy, chemotherapy, and hospital charges related to the treatment of cancer from the point of diagnosis. The cost of an external prosthetic device for cosmetic purposes is also covered (e.g. a wig for hair loss or a prosthetic bra after breast cancer treatment).

Other serious life threatening medical conditions examples (the below list is not exhaustive):

- Head injury requiring an in-patient stay
- Spinal cord Injury
- Severe burns over 20% or more of the body
- Multiple injuries due to an accident
- Premature birth and its complications
- CVA or stroke
- Brain damage due to an accident, cardiac arrest, or resulting from a surgical procedure or complication of surgery
- Terminal illness with a prognosis of death within six (6) months
- Acquired Immune Deficiency Syndrome (AIDS)
- Severe Covid cases defined as patients with COVID-19 are considered to have severe illness if they show any of the below symptoms:
  - SpO2 <94% on room air at sea level
  - PaO2/FiO2 <300 mm Hg

- respiratory rate >30 breaths/min
- lung infiltrates >50%

Life Threatening Condition

Means a medical condition suffered by the insured member, which has:

- risk of death at the time of event, or
- has all the following characteristics:
  - markedly unstable vital parameters,
  - acute impairment of one or more vital organs,
  - high complexity critical care being provided in an ICU/Emergency department.

Congenital Conditions and Birth Defects

Coverage and Limit: US$ 500,000 per condition

Subject to local applicable laws and regulations, coverage will be provided for treatment of congenital and birth defects, including expenses related to:

- Practitioner's charges for surgery
- Charges for routine Practitioner's examinations and medically necessary diagnostic tests
- Hospital room and board
- Prescription drugs

Autism and other Developmental Disabilities

Autism and other Developmental Disabilities (non-ABA)

Coverage and Limit: US$ 10,000 (annual limit)

Subject to local applicable laws and regulations, coverage for medically necessary therapies as prescribed through a treatment plan is provided, including but not limited to:

- Expenses related to screening and diagnosis of Autism and other Developmental Disabilities.
- Rehabilitative services, which are those provided to develop rather than restore a function.
- Therapy services (restorative or not) such as:
  - Occupational therapy treatment to develop a member's ability to perform the ordinary tasks of daily living;
  - Physical therapy treatment to develop a member's physical function; and,
  - Speech therapy treatment of a member's speech impairment.

Note: Neurodevelopmental disorders include, but are not limited to: developmental delay of unknown classification with a significant cognitive delay, autism spectrum disorder (ASD), intellectual disability (e.g. Down Syndrome, Apert Syndrome), motor disability (e.g. cerebral palsy), learning and communication disabilities (e.g. dyslexia, language disorders), and attention deficit/hyperactivity disorder (ADD/ADHD). Fetal Alcohol Spectrum Disorders (FASD), including Fetal Alcohol Syndrome (FAS) and related disorders such as Alcohol Related Neurodevelopmental Disorder (ARND) are covered under the definition.

Autism and other Developmental Disabilities (ABA)

Coverage and Limit: US$ 25,000 (lifetime limit)

Applied Behavior Analysis (ABA) is a therapy based on the science of learning and behavior. For more information please review below page:

Applied Behavior Analysis (ABA) | Autism Speaks

For the purpose of this benefit, the definition of treating physician is extended to include either a medical practitioner or an individual accredited to provide ABA therapies (accredited by BCBA, CAS or a relevant body for the treatment country).

Subject to local applicable laws and regulations, coverage for medically necessary therapies as prescribed through a treatment plan is provided, including but not limited to:

- Necessary behavioral interventions based on the principles of Applied Behavior Analysis (ABA) and Related Structured Behavioral programs applicable to the treatment of a member with Autism. Such treatment would be:
  - Prescribed through the treatment plan, signed by the treating physician, and must include a diagnosis, proposed treatment by type, frequency and duration, the anticipated outcomes stated as goals, and the frequency by which the treatment plan will be updated.
  - In addition to any of the therapies covered above, as necessary.
  - ABA treatment and therapies must be provided by or supervised by a medical practitioner or qualified professionals that have appropriate accreditation (for example BCBA, CAS, IBCCES).

Transgender Treatment and Services (Gender Dysphoria)

Coverage and Limit: US$ 100,000 (lifetime limit)

Gender dysphoria is an established medical condition where people have a recognized need to live according to their gender identity, rather than their biological sex.

Subject to local applicable laws and regulations, cover will be provided to members for the process (typically involving a combination, ongoing mental health care, surgical procedures and hormone treatment) undertaken by a transgender person in order to alter their physical sexual characteristics to match their gender identity. The coverage includes but is not limited to the prescribed medications and treatments listed below:

- Feminizing medications; Estradiol and Progestin preparations
- Anti-androgen medications; Spironolactone, Finasteride and Minoxidil
- Masculinizing Medications; Testosterone preparations
- Hormone therapy plan and ongoing care
- Ongoing visits: up to four (4) times per year to monitor health, address goals, review medications and update lab testing as needed.
- Continued psychotherapy will be covered up to fifteen (15) sessions per year.
- Blepharoplasty
- Face/forehead lift
- Facial bone reduction (osteoplasty)
- Hair removal
- Jaw reduction
- Laryngoplasty
- Rhinoplasty
- Skin resurfacing (e.g., dermabrasion, chemical peels)
- Thyroid reduction chondroplasty
- Neck tightening
- Lip enhancement
- Genital reconstructive surgery
- Orchiectomy
- Hysterectomy/salpingo-oophorectomy
- Voice modification therapy
- Breast augmentation including breast tissue removal, chest reconstruction and augmentation mammoplasty

Note: Mastopexy (breast lift), if this is done as part of the initial breast augmentation only.

Exclusions:

- Cheek/malar implants
- Chin/nose implants
- Collagen injections
- Botox and Filler injections
- Hair transplantation

When services are covered for gender reassignment surgery, surgical gender reassignment services will be considered medically necessary and covered if you are diagnosed as having gender dysphoria, and the following criteria are met:

For genital surgery:

- You are at least 18 years old.
- You have two letters of recommendations for surgery from two separate mental health professionals, at least one of which includes an extensive report. A letter from a master's degree-level professional* is acceptable if the second letter is from a psychiatrist or PhD clinical psychologist.
- The recommendation must be based on assessments conducted within the last twenty-four (24) months and must verify that your decision is current and not due to any other treatable condition and/or disorder.
- Each recommendation must state that the surgery is medically necessary according to evidence-based clinical guidelines**.

For breast/chest surgery:

- You are at least 18 years old.
- You have one letter of recommendation for surgery from a mental health professional. The recommendation must be based on an assessment conducted within the last 24 months and must verify that your decision is current and not due to any other treatable condition and/or disorder.
- The surgery is medically necessary according to evidence-based guidelines**.

* For the gender dysphoria services benefit, a mental health professional is defined as any master's degree-level or above mental health practitioner.

** Evidence-based guidelines are based on internationally accepted clinical guidelines issued by relevant scientific organizations.

Fertility Treatment

Coverage and Limits: US$ 10,000 (lifetime limit)

Subject to local applicable laws, regulations and availability of treatment in the country of treatment, please contact Allianz Care for the full list of what is covered in your country. Coverage will be provided for services and supplies furnished in connection with any medically standard ART (Assisted Reproductive Technology) procedures to enhance fertility. Coverage includes prescriptions, surgical procedures, and assisted conception, which also may involve harvesting and storage if permitted*.

Examples of procedures are, but not limited to**:

- In-vitro fertilization
- Gamete Intra-fallopian Transfer (GIFT)
- Zygote Intra-fallopian Transfer (ZIFT)
- Blood pregnancy tests (beta hCG)
- Oocyte fertilization/insemination

The coverage includes any prescription drugs not covered under local insurance, either statutory or the local supplemental policy.

Cover will be provided under this provision over and above local supplemental insurance and/or statutory plans, not to exceed of a life time limit stated in the Table of Benefits.

* The expenses related to storage will be paid until used or the member is no longer eligible or 5 years, whichever occurs first.

** Contact Allianz Care for the full list of what is covered in your country.

Durable Medical Equipment

Coverage and Limits:

- US$ 10,000 for DME & Orthotic (annual limit)
- US$ 25,000 for Prosthetic appliances (annual limit)

Subject to local applicable laws and regulations, the Plan will pay for covered items (as detailed below) and associated charges incurred in obtaining an Orthotic Appliance, Durable Medical equipment or a Prosthetic Appliance that are medically necessary and recognized as part of standard treatment/therapy including pulmonary/respiratory problems, hearing problems, orthopedic and neurological disorders and visual problems. Coverage will be subject to plan limits, deductibles and Reasonable and Customary charges.

Deductible

The deductible will be US$ 500 as applicable per Device/Item for any Orthotic Appliance or Durable Medical Equipment. Deductible is waived for Prosthetic appliances

Durable Medical Equipment (DME)

Durable medical equipment (DME) ordered by a physician. If more than one piece of DME can meet your needs, only the most cost-effective piece of equipment will be covered, except when you or your provider have demonstrated that the device will significantly improve your quality of life.

Replacement of DME for the same or similar type of equipment which is beyond its reasonable useful lifespan and has become irreparable due to normal wear and tear, is covered but limited to once every three years unless the lifespan of the equipment is stated differently.

DME is medical equipment that:

- is designed and able to withstand repeated use.
- is not disposable.
- is used to serve a medical purpose.
- is required due to injury, illness or medical condition to assist with day-to-day physical functions.
- is suitable for use in the home.

Coverage includes, but is not limited to:

- Wheelchair & Scooters
- Hearing aids
- CPAP
- Hospital-type bed
- Mobility aid for the visually impaired

Exclusions:

- Blood sugar meters and strip
- Blood Pressure Monitoring Devices
- Oximeters
- Walker, Crutches,
- Infusion pumps and supplies
- Oxygen, nebulizers
- Compression garments & socks
- Any Repair and Maintenance cost

For clarification, among other things, Durable Medical Equipment does not include adjustments made to vehicles, air conditioners, air purifiers, humidifiers, dehumidifiers, elevators, ramps, stair glides, Emergency Alert equipment, handrails, heat appliances, improvements made to the home or place of business, waterbeds, whirlpool baths and exercise and massage equipment.

Orthotic Braces

Orthotic braces that stabilize an injured body part and braces to treat curvature of the spine are considered DME.

Examples of orthotic braces include, but are not limited to:

- Ankle Foot Orthotic (AFO)
- Knee orthotics (KO)
- Lumbar-sacral orthotic (LSO)
- Necessary adjustments to shoes to accommodate braces
- Thoracic-lumbar-sacral orthotic (TLSO)

Prosthetic appliances

Prosthetic Appliance means any artificial device that is used to replace a missing limb, appendage or any other external human body part including devices such as artificial limbs, hands, fingers, feet and toes, but excluding dental appliances and largely cosmetic devices such as artificial breasts, eyelashes, wigs.

Exclusions: What's Not Covered?

The following items related to DME, Orthotic and Prosthetic Appliances:

- Devices that are not prescribed by a licensed medical provider or that are not under a doctor's direction.
- Experimental devices and supplies.
- Devices and computers to assist in communication and speech, unless they are authorized by your doctor and meet the clinical guidelines as defined by the claims administrator.
- The repair and replacement of devices when lost, stolen, or damaged due to misuse, malicious breakage, or gross neglect.
- Devices used specifically as safety items or to affect performance in sports-related activities (such as but not limited to blood pressure cuff/monitor, enuresis alarm, non-wearable external defibrillator, trusses, and ultrasonic nebulizers).
- Prescribed or non-prescribed medical supplies and disposable supplies, with the exception of disposable syringes, needles, and test strips used for diabetes.

Exclusions

Any benefits that are not in the Table of Benefits are excluded from the plan.

CHEMICAL CONTAMINATION AND RADIOACTIVITY

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

EXPERIMENTAL OR UNPROVEN TREATMENT OR DRUG THERAPY

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

FAILURE TO SEEK OR FOLLOW MEDICAL ADVICE

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

GENETIC TESTING

Genetic testing is excluded under the plan, except in cases where:

- specific genetic tests are included within your plan.
- DNA tests are directly linked to an eligible amniocentesis (e.g. women over 35).
- testing is needed for the genetic receptor of tumours.

INTENTIONALLY CAUSED DISEASES OR SELF-INFLICTED INJURIES

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

MEDICAL ERROR

Treatment required as a result of medical error.

ORTHOMOLECULAR TREATMENT

Orthomolecular treatment is not covered by the Extended Health Plan.

PARTICIPATION IN WAR OR CRIMINAL ACTS

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

PLASTIC SURGERY

Treatment carried out by a plastic surgeon, whether or not for medical/psychological purposes, and any cosmetic or aesthetic treatment to enhance your appearance, even when medically prescribed. The only exceptions are congenital conditions (where medically necessary), approved gender dysphoria services and reconstructive surgery necessary to restore function or appearance after a disfiguring accident or as a result of surgery for cancer, if the accident or surgery occurs during the member's period of cover.

TRAVEL COSTS

Travel costs to and from medical facilities (including parking costs) for treatment.

TREATMENT OUTSIDE THE EMPLOYEE'S COUNTRY OF EMPLOYMENT (GEOGRAPHICAL AREA OF COVER)

Treatment outside the geographical area of cover is not covered unless for emergencies or authorised by us.

The following terms also apply to your cover

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

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 amount reimbursed, whether under this policy, public medical scheme or any other insurance will not exceed the figure stated on the invoice.

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

Subrogation: For events that result in a claim when somebody else is at fault, we have full rights to subrogate any costs for any claim from the relevant third party. The Company and the Insured Persons agree to fully cooperate with us and disclose all relevant information and take any reasonable steps we asks for.

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.allianzcare.com/en/privacy.html

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

+353 1 630 1301

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

AP.EU1DataPrivacyOfficer@allianz.com

Complaints procedure

Our Helpline is always the first port of call if you have any comments or complaints. Please email us at:

@ **apple.helpline@e.allianz.com**

Our focus is on earning and maintaining customer loyalty through superior service. However, we understand that despite our best efforts, we may not always meet our customer's expectations. If you are not satisfied with any aspect of our service, internal complaint handling procedures are in place to deal with your concerns effectively and in a timely manner. Should you wish to register a complaint with us, you can:

@ Email us at **customer.advocacy@e.allianz.com** or

Address your concerns in writing to: **Customer Advocacy Team, Allianz Care, 15 Joyce Way, Park West Business Campus, Nangor Road, Dublin 12, Ireland**

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

www.allianzcare.com/complaints-procedure

You can also contact our Helpline to obtain a copy of this procedure.

Extended Health Plan FAQ

What is the Extended Health Plan?

The Extended Health Plan is a supplemental medical plan for you and your eligible enrolled dependents that provides coverage for specific medical conditions in addition to the coverage you receive from social or government programs and your Apple medical plan. Refer to the Table of Benefits above for the specific medical conditions covered and limits.

Do I have to pay for the Extended Health Plan coverage?

No, the cost of the plan is fully paid by Apple. However, in some countries, you may be taxed on the insurance premium.

Who is eligible?

All employees and dependents enrolled in an eligible Apple medical plan. To confirm eligibility, please reach out to Apple People Support.

How do I enrol in the Extended Health Plan?

You are automatically enrolled in the Extended Health Plan as part of your Apple medical plan. If eligible dependents are enrolled in the local Apple medical plan, they are also eligible for cover under the Extended Health Plan.

What is covered?

For details on what is covered under the Extended Health Plan, including limits and exclusions, please refer to the Table of Benefits at the start of this guide.

Why aren't other conditions covered?

Healthcare provided through the government and your Apple medical plan are still your primary sources of medical insurance coverage. Apple has found that certain coverage is complex and sometimes very difficult for its insurance partners to cover or administer. Additionally, in extreme situations, treatment above the Apple medical plan limits are necessary and this plan allows for a secondary level of coverage. Therefore, Apple has partnered with Allianz Care to provide you with cover for these very specific needs under the Extended Health Plan, where we can centralize the expertise. While other medical conditions may be considered in the future, this will always be a plan for very specific, unique needs that can't be met well with local insurance policies.

Will I receive an individual policy number?

Yes. Before you submit your first claim, please contact our 24/7 Helpline. Our team will verify your details and ensure they correspond to the information received from your employer. We will then provide you with an individual policy number. Any eligible dependants will be enrolled under the same policy number upon submission of the Dependant Enrolment Form. Please refer to "Dependant Enrolment" section above for more information.

For any further claim, pre-approval request or any other communication with us afterwards, please quote your individual policy number when contacting us.

When does cover end?

Coverage under the Extended Health Plan will end if you unenroll or become ineligible for the Apple medical plan or if your employment terminates, whichever is earlier. You have up to six months after your coverage end date to submit any claims for treatment that occurred while you were still eligible for the plan. If you unenroll in the local Apple medical plan, you must notify us of your end date. Failure to do so may result in unpaid claims, which will then become your responsibility.

How will my doctor know I have this coverage?

The Extended Health Plan coverage is only accessible when you have exhausted all coverage available to you through the government and Apple medical plan for covered medical conditions (or if the treatment is not available through the government or Apple medical plan).

For treatment where you pay and claim, your doctor does not need access to the Extended Health Plan information. For treatment requiring pre-approval (direct settlement), once we receive all the information we need, our Medical Team will assess the case and issue a Guarantee of Payment to the medical provider, authorising the treatment (provided you are eligible for it).

In the unlikely event that your medical provider does not accept our Guarantee of Payment, you can still access your Extended Health Plan coverage, but you will need to pay for your treatment and submit a claim for reimbursement.

What if I already have treatment in process?

Services and treatments may be covered if:

1. eligible treatment and services take place in your work country on or after the date you became eligible for the Extended Health Plan. Check the People site for more information on eligibility.
2. you (and your eligible dependents, when applicable) are enrolled in the local Apple medical plan.
3. you are an eligible Apple employee during services/treatment.

How to submit claims for my dependents?

For a first claim submission where the patient is one of your dependents, you will need to get them registered in the plan first.

1. Fill out the Dependent Enrolment Form and send it to apple.helpline@e.allianz.com. We will process your enrolment request and add your dependant under your policy.
2. Once your dependent has been added in the system, they can access treatment by following one of the below processes:
    - For treatments that do not require our pre-approval they/you (in case of a minor) can pay and claim via the MyHeath Digital Services (available as a mobile app or online portal). They/you will need to select the dependant's name under the patient drop down menu, provide a few details, add the invoice along with the required documentation and submit.
    - For a treatment guarantee request, they/you will need to submit a Treatment Guarantee Form along with all the required documentation to us within at least five working days prior to treatment.

For further details on how to access treatment please refer to "How to use your Extended Health Plan".

If the treatment or medicine I need is not covered by my local medical plan, can I use the Extended Health Plan?

Yes, if the treatment or medicine is covered under your Extended Health Plan and is considered medically necessary by our medical team. You'll need to obtain an insurance statement from your local insurance indicating that the treatment or medicine is not available or that cover for such costs has been exhausted.

How can I show I've exhausted my local benefits or that my local plan doesn't cover a service?

Your local insurer will provide you with an insurance statement indicating that you have exhausted your local benefit or that the treatment you are seeking is not covered under the plan. Please ensure the insurance statement also includes the start/renewal date of your cover. Insurance statements are accepted in any language.

You will need to provide this to us when submitting your claim or treatment guarantee request. We know where treatment for these benefits is not available locally.

If I am unsure in relation to the benefits covered under my local insurance plan, can I contact Allianz Care for guidance?

No. The Extended Health Plan works as a supplementary cover to your existing plan and you will need to seek advice from your local insurer in relation to eligibility conditions of your treatment before contacting us with all relevant information to process your claim.

Will the Extended Health Plan reimburse the shortfall on my local insurance resulting from a co-payment or deductible?

No, the plan is only aimed to cover you for the benefits listed in the Table of Benefits on the following scenarios:

- when your local benefits are exhausted.
- when part of the benefit is not covered locally.
- where no cover is available by your local plan.

Any request for reimbursement of local co-payments or deductibles will be declined.

Can I get reimbursed for expenses incurred prior to the start date of the plan?

No, the Extended Health Plan will only cover eligible treatment and services that take place in your work country on or after the date you became eligible for the Extended Health Plan. Check the People site for more information on eligibility.

If my local plan reimburses me for treatment expenses, can I claim that same amount under the Extended Health Plan, too?

No. The Extended Health Plan coverage would begin once you've exhausted your local medical plan coverage with respect to a covered medical condition. Any expenses paid under the local medical plan will not be paid under the Extended Health Plan.

If private hospitals are not covered in my local medical plan, will the Extended Health Plan cover treatment / medicine in private hospitals?

No, the Extended Health Plan does not cover upgrades. If a particular treatment within the Extended Health Plan category of conditions is only available in a private hospital, you may contact us to understand your options (always provide a copy of the local insurance conditions).

Will the Extended Health Plan cover upgraded room and board expenses for in-patient treatment?

The Extended Health Plan covers required room and board expenses related to a covered in-patient treatment according to your local plan, and will not cover upgraded accommodations. Reasonable and customary costs may apply. Please contact Allianz Care for more details.

If a specific treatment is not legally allowed in my area but would otherwise be covered under the Extended Health Plan, can I still get the treatment?

No. We will adhere to local regulations.

If I have enrolled dependents living outside the country, would their medical expenses be covered under the Extended Health Plan?

No, the Extended Health Plan only covers treatment received in the country where you are employed, so your enrolled dependents would not be covered for services received out of your country of employment.

I am moving to a country where the Extended Health Plan is offered, will I still have access to the Extended Health Plan?

Yes, if you are enrolled in the local Apple health plan in an eligible country, you will still have access to the Extended Health Plan. The balance of the benefits available to you will carry over with you.

If you have questions about eligible countries or general eligibly questions, please reach out to Apple People Support.

What happens to my coverage if I relocate to a country where the Extended Health Plan is not an option?

Your coverage under the Extended Health Plan would end on the date you officially transfer to a country where the Extended Health Plan is not available.

For incoming foreign payments, my bank requires evidence that the funds corresponding to a claim reimbursement are legal and relate to the Extended Health Plan. What document can I provide?

Once your claim has been processed, we will send you a statement of account with all the details of the settlement of your claim. This document constitutes formal evidence that the bank should accept.

What languages does the Helpline support?

Our dedicated Helpline provides 24/7 support in English.

If you speak another language, please inform the Helpline when you call us and we will try to locate an interpreter.

You may also refer to the Apple People Site for self-service or to your dedicated member hub: www.allianzcare.com/apple

We can accept medical information and insurance documentation in any language.

How is my personal information protected?

Our Data Protection Notice explains how we protect your privacy and process your personal data. To read it visit: www.allianzcare.com/en/privacy

Alternatively, you can contact us on the phone to request a paper copy: +353 1 630 1301.

If you have any queries about how we use your personal data, please email us at: AP.EU1DataPrivacyOfficer@allianz.com

Who can I contact to learn more about this plan?

For questions about coverage or claims, please contact our 24/7 helpline.

For questions on eligibility, please contact Apple People Support.

Did you know you have access to a dedicated member support hub?

We have created a dedicated member support hub where you can access all the information that will help you make the most of your insurance, including:

- Guide to the Extended Health Plan
- Dependent Enrolment Form
- Frequently Asked Questions
- Contact details

www.allianzcare.com/apple

Contact us, we love to help!

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

Email: apple.helpline@e.allianz.com

Phone: +353 1 514 8436

If you speak another language, please inform the Helpline when you call us and we will try to locate an interpreter.

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

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