Talent Trust

Alpha Medical Benefits

Effective 02 May, 2025

This policy is an annual policy underwritten by Mangrove Insurance SPC (Cayman) Ltd. FBO Barnabas Segregated Portfolio (Talent Trust), registered in the Cayman Islands (hereinafter referred to as the "Insurer").

This Table of Benefits provides an overview of the coverage included in this plan. All limits apply per insured person, per period of cover, unless otherwise specified.

The benefits outlined are subject to the maximum aggregate limit, the sums insured as stated in this benefits schedule, applicable medical underwriting, and exclusions. Coverage is governed by our policy terms and conditions.

Please read this benefit alongside your 'Insurance Certificate' and the 'How to Use Your Policy' document to ensure a full understanding of your coverage.

Cover	Alpha
Maximum Annual Aggregate Limit We provide coverage for the treatment of medical conditions that first arise during the period of cover and where treatment is provided within the same period of cover. Coverage also extends to medical conditions that occurred before the date of entry, provided they were declared to and accepted by us in writing, or if the policyholder has purchased the Medical History Disregarded policy. Please review your insurance certificate to see if pre-existing conditions are covered by your policy. All costs incurred must be medically necessary and subject to reasonable and customary charges based on the average treatment costs applicable to the region where the treatment was received, as determined by us.	US$1,000,000 per insured person per period of cover
Area of Cover Your insurance certificate will show your geographical area of cover.	
Policy Excess & Coinsurance – Member's Responsibility **Excess:** Your insurance certificate will show the amount of excess you will be obliged to pay before receiving any benefits under this policy. **Coinsurance:** For accident and emergency treatment received in the US, members will be liable for 20% of any admissible cost up to an annual limit of US$5,000 per insured person per period of cover. The coinsurance is applied after any deduction for excess applicable to the policy.	
Pre-authorization The following items will require pre-authorization: a) Planned inpatient or day patient treatment *(hospitalization)* b) Any pregnancy or childbirth treatment c) Planned surgery (including outpatient surgery) d) Evacuation e) Psychiatric treatment – inpatient or day patient f) Home nursing charges	

g) Planned inpatient, day patient or outpatient PET & CT-PET scans h) Planned outpatient treatment above US$1,000. Eligible treatment requiring pre-authorization which is not pre-authorized, will be subject to a coinsurance of 40% and will not be subject to the coinsurance limit. **Application of Limits:** Any overall benefit limits in your policy *(per visit, number of days, monetary limit, etc.)* will be applied after the application of any excess or coinsurance.	

Plan Benefits

Accident & Emergency Treatment Outside Area of Cover The benefit covers medical treatment arising from an emergency outside your geographical area of cover that requires you to seek immediate treatment (including outpatient treatment) at a hospital's accident and emergency unit. This applies only to medical conditions for which you had no prior symptoms, no consultations for treatment or advice, and no treatment before arrival in the country. In the event of an accident or emergency treatment outside your geographical area of cover, please contact us either before or as soon as possible after being admitted to the hospital's accident and emergency unit. Cover does not extend to curative or follow-up non-emergency treatment, even if you are deemed unable to travel. It also excludes pre-existing conditions, and any treatment related to complications of pregnancy and/or childbirth.	Limited to 60 days per period of cover and a maximum of US$50,000 (whichever comes first) Subject to coinsurance for treatment received in the US
Cash Benefit for Using Free Medical Services This benefit is payable when you receive inpatient treatment for a medical condition covered by your plan, but the treatment is accessed free of charge in your country of treatment—this usually happens when the hospital admission and inpatient care are fully government-funded. To qualify for this benefit, no claims should be submitted for the eligible medical condition, including any costs incurred for travel, accommodation, or treatment. To claim this benefit, the member should ask the hospital to sign and stamp his/her claim form to verify their hospital admission and discharge dates. This benefit is not applicable to admissions into the accident and emergency facility of the hospital.	Limited to US$125 per night for a maximum of 20 nights Policy excess & coinsurance do not apply
Organ Transplant The benefit covers organ transplants for: heart, heart/valve, heart/lung, lung, kidney, kidney/pancreas, pancreas, liver, allogenic bone marrow, autologous bone marrow parathyroid, muscular/skeletal and cornea. Cover does not include the costs associated with acquiring organs, removal of the organ from the donor, transportation cost, or any related administrative expenses.	Limited to US$250,000 per lifetime
Parental Accommodation The benefit covers hospital accommodation costs for a parent or legal guardian staying with a member under 18 years old who is admitted as an inpatient. If a suitable bed is unavailable at the hospital, we will contribute an amount equivalent to the daily room rate of a three-star hotel toward any hotel expenses incurred. Cover does not include sundry expenses including but not limited to meals, phone calls, Wi-Fi or laundry services.	Covered in full

Alternative Treatments

Alternative Treatment This benefit covers the costs of treatment provided by registered chiropractors, osteopaths, homeopaths, practitioners of Chinese herbal medicine, podiatrists, and acupuncturists, when administered under the direct supervision of, and following a referral by, a medical practitioner or specialist. A referral letter or report must be submitted with the first claim for such treatment.	Limited to 20 sessions in aggregate per medical condition
Physiotherapy and Occupational Therapy This benefit covers the costs of physiotherapy or occupational therapy by registered physiotherapist, and occupational therapists, following a referral by a medical practitioner. A referral letter or report must be submitted with the first claim for such treatment. Coverage is limited to 20 sessions per medical condition. After every 20 sessions, a specialist must review the treatment. If additional sessions are necessary, a progress report must be submitted, indicating the diagnosis and medical necessity for continued treatment.	Covered in full

Death/Body Repatriation/Burial/Cremation

This benefit covers the transportation of a member's body or ashes to their country of domicile or residence, or the costs of burial or cremation at the place of death, in the event of death due to an eligible medical condition. If the member passes away in their home country, we will cover transportation to their chosen burial or cremation site within that country and the necessary burial or cremation fees. If the member has multiple home countries, transportation to an alternative home country is also covered. Cover for necessary burial or cremation fees include: a) The cost of reopening a grave and burial costs, or b) The cost of opening a new grave and burial costs, including any exclusive right of burial fee, c) Embalming d) A container legally appropriate for transportation e) Shipping f) Necessary government authorization or In the case of cremation: a) Cremation fees b) The cost of required doctor's certificates c) The cost of removing a pacemaker or other medical device that must be removed prior to cremation This benefit does not cover other funeral-related expenses, such as: a) Funeral director's fees b) Flowers c) The cost of documents required for the release of money, savings, or property of the deceased.	Limited to US$15,000 per insured person Policy excess & coinsurance do not apply to this benefit

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Dental

Dental Surgery The benefit covers treatment for surgical extraction of teeth, as well as other tooth-related surgical procedures such as apicoectomy and dental prescription drugs. All investigative procedures that establish the need for dental surgery, such as laboratory tests, X-rays, CT scans and MRI(s), are included under this benefit. Dental surgery does not cover surgical treatment that relates to dental implants.	Limited to US$2,500 per period of cover
Emergency Dental Treatment The benefit covers treatment received in an accident and emergency ward of a hospital or dental clinic within 24 hours of an emergency event due to an accident or injury. Cover does not extend to follow-up dental treatment, dental surgery, dental prostheses, permanent restorations or the continuation of root canal treatment, orthodontics or periodontics. Accidental damage to teeth caused through eating is not covered under this benefit.	Limited to US$2,500 per period of cover

Disease & Chronic Condition Management

Congenital Anomalies The benefit covers treatment of congenital anomalies that manifest after the member's cover commences with us.	Limited to US$100,000 per medical condition
Home Nursing or Convalescent Care The benefit covers nursing care provided outside a hospital, which must be received immediately after inpatient or day patient treatment. Your treating doctor must determine that it is medically necessary for you to stay in a convalescent home or have a qualified nurse attend to you at home. Nursing care must be administered by a certified nurse and cannot be provided for domestic reasons or personal convenience. This benefit doesn't cover spas, cure centers, health resorts or palliative care.	Limited to 30 days per medical condition
Hormone Replacement Therapy This benefit covers medical practitioner or specialist consultations and the associated costs of using female hormones to alleviate symptoms caused by the cessation of ovarian function. This may occur naturally during menopause or following the surgical removal of the ovaries. The benefit includes coverage for medical practitioner fees, specialists fees as well as prescription drug expenses.	Limited to a maximum period of 3 months per lifetime of cover
Investigations into Infertility This benefit covers the costs of investigations into the causes of infertility, including procedures such as hysterosalpingogram, laparoscopy, or hysteroscopy. Cover under this benefit only applies to members who have been: a) continuously covered by us for at least two years at the time the costs are incurred and b) unaware of the existence of infertility at the time of their original enrolment.	Limited to US$2,500 per lifetime per insured person

Oncology The benefit covers all medically necessary treatment received, including specialist fees, diagnostic tests, radiotherapy, chemotherapy and hospital charges for, or related to, the diagnosis of cancer when received as an inpatient, day patient or outpatient, including palliative treatment.	Covered in full
Palliative Care The benefit covers accommodation and associated charges for hospice care upon a member's diagnosis of a terminal illness. Care must be recommended and directed by a specialist and must be received immediately after inpatient or day patient treatment in a hospital. This benefit includes coverage for: a) Inpatient, day-care, and outpatient treatment following the diagnosis of a terminal condition. b) Physical and psychological care. c) Hospital or hospice accommodation. d) Nursing care. e) Prescription medications.	Limited to costs incurred in the first 30 days
Prescribed Medical Aids The benefit covers prescribed and medically necessary devices to enable you to carry out everyday activities. The following benefits are covered: a) Medically necessary durable medical equipment prescribed by a treating medical practitioner, which is necessary to deliver or facilitate the delivery of prescribed drugs and dressings, such as dressings and stoma supplies. b) Biochemical aids such as insulin pumps, glucose meters and peritoneal dialysis machines. c) Ancillary charges following treatment as an inpatient or day patient, including the purchase or rental of crutches and costs associated with the initial purchase or rental of a wheelchair. d) External prosthetics required following surgery, including orthopaedic supports/braces and calipers, and the initial purchase and fitment of an artificial limb and prostheses. e) Orthotic supplies, including insoles and orthotic supports. f) Medically graduated compression stockings. This benefit excludes provision, modifications and fitment of furniture or adaptations to the home, hearing and visual/speaking aids such as electronic larynx and the costs of medical aids associated with palliative care.	Limited to US$1,000 per medical condition
Routine Management of Chronic Conditions The benefit covers routine check-ups, drugs and dressings prescribed for management of the condition, hospital accommodation, nursing, renal dialysis, surgery, and palliative treatment of chronic conditions (excluding cancer). Cover under this benefit further includes medical expenses which arise from or are in any way related to Human Immunodeficiency Virus (HIV) and/or related HIV illnesses, including Acquired Immune Deficiency Syndrome (AIDS) or Aids Related Complex (ARC) and/or any mutant derivative or variations. Expenses are limited to: a) Pre and post diagnosis consultations b) Routine check-ups for this condition c) Prescribed drugs and dressings (except experimental or investigational)	Limited to US$3,000 per insured person per period of cover

d) Hospital accommodation and nursing fees Cover under this benefit applies to new chronic conditions arising from your commencement date.	

Emergency Room Treatment

This benefit covers the costs of treatment received in a dedicated emergency room of a hospital or urgent care clinic where the condition is considered a true medical emergency.	Covered in full

Evacuation & Transportation

Emergency Evacuation This benefit covers the cost of emergency evacuation in the event of an emergency, where treatment or adequately screened blood is unavailable at the place of incident. The evacuation will be to the nearest appropriate medical facility, as determined by us, which may or may not be in your home country. It will be carried out using the most appropriate method of transportation, as determined by us, for the purpose of admission to a hospital as an inpatient or day patient. The evacuation must be requested by your doctor, who must confirm that the required treatment is unavailable at the place of incident. Following completion of treatment, we will also cover the cost of your return trip to your principal country of residence at economy rates. If you are not medically fit to travel home following discharge from an inpatient episode, we will cover the reasonable cost of a non-hospital accommodation for up to seven days. Cover is limited to 3-star hotels and does not extend to hotel suites. If you are evacuated to a medical center for ongoing treatment, we will cover the reasonable cost of hotel accommodation in a private en-suite room, provided this cost is more economical than multiple journeys between the medical center and your principal country of residence. Hotel accommodation for an accompanying person is not covered. You must contact us at the first indication that evacuation is needed. From that point, we will organize and coordinate the evacuation to ensure your safe arrival at your destination of care. If evacuation services are not organized by us, we reserve the right to decline any costs incurred. This benefit does not cover medical evacuation from a vessel at sea to a land-based medical facility and cost related to air-sea or mountain rescue. It also excludes all maternity and childbirth related costs except where these are covered under the 'Complications of Pregnancy' benefit.	Covered in Full Policy excess & coinsurance do not apply to this benefit
Evacuation Additional Travel Expenses This benefit covers the reasonable travel costs associated with an emergency medical evacuation.	Limited to US$2,500 per person per evacuation Policy excess & coinsurance do not apply to this benefit

a) Travel costs for one person accompanying an evacuated person, if medically necessary. b) Following completion of treatment, we will also cover the cost of the companion's return trip, at economy rates, to the country where the evacuation started. c) Travel costs for one accompanying person to and from medical appointments when treatment is being received on a day-care basis. d) Travel costs for one accompanying person (to and from the hospital), to visit the insured person receiving in-patient treatment. e) Non-hospital accommodation costs for the insured person and any accompanying person, where required in the period immediately preceding or following hospital admission (where the insured person is under the care of a specialist).	e) is limited to US$80 per person per day (subject to the overall benefit limit of US$2,500 above)
Local Ambulance This benefit covers the cost of ambulance transport required for an emergency or out of medical necessity to the nearest available and appropriate hospital or licensed medical facility to receive treatment as an inpatient or day patient.	Limited to US$1,500 per event Policy excess & coinsurance do not apply to this benefit

Inpatient, Day Patient, Emergency Care & Diagnostics

Diagnostic tests, including but not limited to pathology tests, ultrasound and x-rays, MRI, CT, PET and CT-PET scans	Covered in full
Hospital accommodation	Limited to standard private room
Intensive care	Covered in full
Medical practitioner fees including surgeon, consultations and specialist fees	Covered in full
Nursing by a qualified nurse.	Covered in full
Physiotherapy, occupational therapy, and manipulative treatment	Covered in full
Prescribed drugs and materials, including traditional Chinese medicine	Covered in full
Reconstructive surgery (including outpatient treatment) a) To restore natural function or appearance after a disfiguring accident or surgery for cancer. b) Covered only it the accident or initial surgery occurs during your period of cover.	Covered in full
Rehabilitation treatment a) In-patient, day-care and out-patient treatment; must commence within 14 days of discharge after the acute medical and/or surgical treatment ceases. b) Covered only if you've received in-patient treatment for three or more consecutive days/nights for the same medical condition. c) Treatment includes the use of special treatment rooms, physical, occupational and/or speech therapy fees, and other services usually provided by a rehabilitation unit including qualified nurse care but not including private or special nursing or specialist services.	Limited to 120 days per medical condition

Surgical appliances and materials	Covered in full
Surgical fees, including anesthesia and theatre charges	Covered in full

Mother & Child

Complications of Pregnancy This benefit covers the treatment of medical conditions arising during the antenatal stages of pregnancy, medical conditions occurring during childbirth that require a recognized obstetric procedure, and post-natal check-ups related to complications of pregnancy for up to six weeks. Complications resulting from assisted conception, including but not limited to premature or multiple births, are excluded from this benefit. Cover is subject to a 10-month waiting period.	Covered in full Coinsurance does not apply to this benefit
Newborn Accommodation This benefit covers the hospital accommodation costs for a newborn baby (up to 16 weeks old) to accompany its mother (being a member) while she is receiving inpatient treatment in the hospital.	Covered in full
Newborn Care This benefit covers inpatient treatment for an acute medical condition in a newborn baby that manifests within 30 days following birth. Complications resulting from assisted conception, including but not limited to premature or multiple births, are excluded from this benefit. In cases where a congenital anomaly is identified in a newborn baby, coverage will fall under the Congenital Anomalies Benefit. Following the 30-day new born benefit period (except for medical conditions that occur or manifest during the 30-day period immediately following birth), the member's dependent will be eligible for cover up to the full provision of this policy, subject to written notification within 60 days of birth and all premiums being paid in full within 30 days of the due date. A declaration of health is required for dependents who are born following infertility treatment (assisted conception).	Limited to US$100,000 per insured person per period of cover and to a maximum of 90 days of hospital stay

Outpatient Care

Medical practitioner fees including consultations and specialist fees	Covered in full
Surgical fees, including anesthesia and theatre charges	Covered in full
Nursing by a qualified nurse.	Covered in full
Surgical appliances and materials	Covered in full
Diagnostic tests, including but not limited to pathology tests, ultrasound and x-rays	Covered in full
CT and MRI scans	Covered in full
PET and CT-PET scans	Covered in full
Prescribed drugs and materials, including traditional Chinese medicine	Covered in full

Physiotherapy, occupational therapy, and manipulative treatment	Covered in full

Psychiatric Illness

Outpatient Psychiatric Treatment The benefit covers treatment carried out by a psychiatrist, clinical psychologist or licensed psychotherapist for the treatment of mental, behavioral and personality disorders, including an eating disorder. The condition must be clinically significant, and the treatment must be medically necessary. Outpatient psychotherapy treatment requires a 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.	Limited to US$5,000 per period of cover
Inpatient Psychiatric Treatment The benefit covers treatment received in a registered psychiatric unit of a hospital for behavioral and personality disorders, including eating disorders. Treatment must be carried out by a psychiatrist, clinical psychologist or licensed psychotherapist. The condition must be clinically significant, and the treatment must be medically necessary. All day-care or inpatient admissions must include prescription medication related to the condition. All benefits are conditional on pre-authorization from us. Without our written confirmation prior to such treatment, we will not be liable to pay any benefit. However, the initial consultation with the medical practitioner (not a psychiatric specialist) that results in a psychiatric referral is covered without the requirement for pre-authorization.	Limited to US$5,000 for a maximum of 30 days per period of cover

Wellness Check-Ups & Preventive Care

Wellness Benefit This benefit covers the cost of routine medical check-ups and associated tests for insured persons aged 6 years and above, including: a) blood and cholesterol checks b) Neurological examination (physical examination) c) resting blood pressure d) urine analysis e) cardiac examination f) testicular/prostate examination g) exercise electrocardiogram (ECG) h) Chest x-ray i) Neurological examination (physical examination) j) Bone densitometry (every five years for women aged 50+) Cancer screening checks are limited to: a) Annual gynecological exam b) Mammogram (every two years for women aged 45+, or younger where a family history exists) c) Annual prostate screening (yearly for men aged 50+, or younger where a family history exists)	Limited to US$400 per insured person per period of cover and subject to 20% coinsurance Policy excess does not apply to this benefit

d) Colonoscopy (every five years for members aged 50+, or 40+ where a family history exists) e) Annual faecal occult blood test f) BRCAl and BRCA2 genetic test (where a direct family history exists) This benefit also extends to preventative dental services, including: a) up to two routine dental examinations in the plan year b) routine x-rays c) cleaning, scraping and polishing d) fluoride treatment for insured persons between the ages of 6 and 19 years	
Well Child Care This benefit covers preventative care and testing as recommended by a medical practitioner or specialist for insured individuals under the age of 6, including: physical examinations a) measurements b) sensory screenings c) neuropsychiatric evaluations d) developmental screenings e) hereditary and metabolic screenings at birth f) urine analysis g) tuberculin tests h) haematocrit, haemoglobin, and other blood tests, including tests to screen for sickle haemoglobinopathy This benefit also extends to preventative dental services, including: a) up to two routine dental examinations in the plan year b) routine x-rays c) cleaning, scraping and polishing	Limited to US$400 per insured person per period of cover and subject to 20% coinsurance Policy excess does not apply to this benefit
Vaccination This benefit covers the cost of medically necessary vaccinations and inoculations including Covid-19 vaccination. This benefit covers the cost of: a) All basic immunizations and booster injections in line with the international medical guidelines that apply in the country where they are administered. b) Vaccination against COVID-19, where this is not offered for free or only partially sponsored by the government in your country of residence. c) Medically necessary travel vaccinations. d) Malaria prevention tablets. We cover the cost of consultation for administering the vaccine and the cost of the drug.	Limited to US$250 per insured person per period of cover Policy excess & coinsurance do not apply to this benefit
Digital Health App This benefit covers the cost for one digital health app of your choice per period of cover. The app should assist with the prevention, detection or management of a disease or condition such as back pain, diabetes or mental health issues. Cover is provided when the insured member is the subscriber to the app, covered under a valid policy at the time of purchase. When submitting a claim, please attach a dated receipt.	Limited to US$70 per insured person per period of cover Policy excess & coinsurance do not apply to this benefit

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Options To Upgrade Cover

The following benefits only apply if they are specifically noted in your Insurance Certificate.

Additional Chronic Conditions Cover This benefit extends the coverage provided under the 'Routine Management of Chronic Conditions' benefit to US$50,000 per insured person, per period of cover. It applies solely to new medical conditions that were not previously suffered, whether diagnosed or undiagnosed, and that occur after the purchase date of this benefit. The benefits payable under this option is subject to the policy being maintained throughout the period of the claim. Note: This option is applied to all dependents on the policy.	Limited to US$50,000 per insured person per period of cover
Dental Treatment Cover under this policy is extended to include: a) **Routine Dental Treatment** An annual check-up, simple fillings related to cavities or decay, root canal treatment, simple extractions and dental prescription drugs. Cover is subject to a 6-month waiting period. b) **Dental surgery** Surgical extraction of teeth, as well as other tooth-related surgical procedures such as apicoectomy and dental prescription drugs. All investigative procedures that establish the need for dental surgery such as laboratory tests, X-rays, CT scans and MRI(s) are included under this benefit. Dental surgery does not cover surgical treatment that relates to dental implants. Dental surgery does not cover surgical treatment that relates to dental implants. Cover is subject to a 6-month waiting period. c) **Periodontics** Dental treatment related to gum disease. Subject to a 6-month waiting period. d) **Orthodontic Treatment** 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 prerestorative 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	a) Limited to US$500 per insured person per period of cover and subject to 20% coinsurance b) Limited to US$500 per insured person per period of cover and subject to 20% coinsurance c) Limited to US$500 per insured person per period of cover and subject to 20% coinsurance d) & e) Limited to US$2,000 per insured person per period of cover and subject to 50% coinsurance Policy excess does not apply to this benefit

• 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. Cover is subject to a 10-month waiting period. e) **Dental prostheses** Crowns, inlays, onlays, adhesive reconstructions/restorations, bridges, dentures and implants as well as all necessary and ancillary treatment required. Cover is subject to a 10-month waiting period. Note: This option is applied to all dependents on the policy.	
Non-Emergency Travel This benefit covers the cost of return economy-class travel to the nearest country with appropriate medical facility, if a member requires inpatient or day-patient non-emergency treatment that is unavailable at their current location. Coverage is subject to written agreement from us, and certified instructions from the attending medical practitioner or specialist including confirmation that the required treatment is unavailable at the place of incident. This benefit does not apply to medical conditions that predate the purchase of this option.	Limited to US$500 per period of cover and subject to 20% coinsurance
Normal Pregnancy, Childbirth & Elective Caesarean Sections This benefit covers costs related to normal pregnancy, childbirth, elective caesarean sections, home birth, and any related conditions. Cover is subject to a 10-month waiting period.	Limited to US$4,000 per pregnancy, US$10,000 per pregnancy or US$25,000 per pregnancy (depending on your chosen limit)

Coverage is limited to childbirth, pre and post-natal check-ups (up to 6 weeks following delivery, subject to the benefit limit not being exhausted), midwife and delivery costs and the following costs for a new born baby within 30 days after birth: a) One physical examination to assess the integrity and basic function of the child's organs and skeletal structures b) Vitamin K, hepatitis B, and BCG vaccinations c) Circumcision and follow-up consultation (within 30 days from birth) d) Routine blood tests for phenylketonuria (PKU), congenital hypothyroidism, and glucose-6-phosphate dehydrogenase deficiency (G6PD) e) One hearing examination f) Reasonable accommodation costs for up to 4 nights following delivery if the mother is admitted and not suffering from complications This benefit does not include additional preventive diagnostic procedures such as routine swabs or blood typing. However, if the child requires any follow-up investigations or treatment for medical reasons, these will be covered under the newborn's own policy, provided they have been added as a dependent. Coverage for complications arising from pregnancy and/or childbirth due to assisted conception is limited to this benefit. Any expenses related to pregnancy that occurred or manifested before a change to a higher maximum limit will be subject to the prior lower limit. Note: This option applies only to the female main insured or female spouse included in the policy.	If the selected coverage is US$25,000 per pregnancy, a 10% coinsurance applies without any limit
Stay Alive Policy This option enables the insured person to retain the benefits of maintaining continuous coverage as a Talent Trust member without purchasing a full annual policy, but it is subject to payment of premium. It is ideal for members with temporary alternative cover from a government sponsored source or through employment but intends to return to their Talent Trust policy at a later stage. This option offers no medical benefits. **Membership is subject to the following requirements:** a) The insured person has not submitted any claims 12 months prior to switching from the Alpha Policy to the Stay Alive Policy. b) The insured person would need to pre-notify Talent Trust 30 days before switching from the Stay Alive Policy back to the Alpha Policy. c) Existing date of entry and No Claims Bonus (if any) under the Alpha Policy will be transferred to the Stay Alive Policy. d) New medical conditions that start during the Stay Alive policy will be classified as pre-existing once a member resumes an Alpha policy. e) The minimum period of cover allowed under the Stay Alive Policy is 6 months. f) The maximum period of cover allowed under the Stay Alive Policy is 2 years.	
Travel	

This option is a travel insurance policy that works while you're away from your home country and overseas country of residence. Refer here for full benefit details. Note: This option is only necessary for children if they are travelling without their parents.	
Travel Costs of Insured Members to Be with a Close Relative Who Is at Peril of Death or Who Has Died This benefit covers reasonable transportation and accommodation costs for insured members to visit a near relative who is in peril of death or who has passed away. Coverage includes one round trip per insured member. Limited to US$1,500 per period of cover and limited to no more than 2 claims in any 5-year period. If the close relative has passed away, travel must commence within six weeks of their date of death. The benefit does not apply to medical conditions that predate the purchase of this option. Note: This option is applied to all dependents on the policy.	Limited to US$3,000 in any 5-year period Policy excess & coinsurance do not apply to this benefit
Vision Care This benefit covers the cost of routine eye exam carried out by an optometrist or ophthalmologist and the purchase of vision hardware, including contact lenses, spectacles lenses and frame when the member's prescription has changed. This benefit is limited to 1 consultation and sight examination for the signs or symptoms, or management of, natural or non-medical degenerative sight disorders including, but not limited to, myopia, hypermetropia and astigmatism. Note: This option is applied to all dependents on the policy.	Limited to US$250 per insured person per period of cover and subject to 20% coinsurance Policy excess does not apply to this benefit

DEFINITIONS

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

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

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

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

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

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

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

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

Chronic: 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 recognized cure
- Is not generally deemed to respond well to treatment
- Requires palliative treatment
- Leads to permanent disability

Coinsurance: The percentage of costs you are responsible for paying. For example, if a benefit has a 20% coinsurance, you will pay 20% of the incurred expenses and the insurance will cover the remaining 80%.

Commencement Date: The date shown on the Insurance Certificate on which the policy first came into effect.

Congenital Anomaly: 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.

Country of Nationality: A country for which you hold a current passport.

Country of Residence: The country where you and your dependents (if applicable) live for more than six months of the year.

Date of Entry: The date your coverage begins under the plan, as indicated on your Insurance Certificate.

Day patient: Medical care where you are admitted to a hospital or clinic for treatment but are not required to stay overnight.

Dental Practitioner: A person who is licensed by the relevant authority to practice dentistry and/or dental surgery in the country where the treatment is given.

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

Drugs and Dressings: Drugs and dressings prescribed by a doctor to:

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

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

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

Emergency: A sudden and unforeseen medical condition requiring medical care, where if a person does not get urgent medical assistance, could result in death or serious health complications. Coverage is limited to treatment that begins within 24 hours of the emergency event.

Evacuation: In the event of an emergency, where treatment or adequately screened blood is not readily available at the place of the incident, to the nearest appropriate medical facility as determined by us (which may or may not be in your home country), by the most appropriate method of transportation as determined by us, for the purpose of admission to hospital as an Inpatient or Day patient. Airline tickets are limited to economy class.

Excess:	The amount you must pay out of pocket before your insurance coverage starts contributing, as specified in your Insurance Certificate. The excess applies per medical condition and per person.
General Advice:	Any medical opinion or medical recommendation from a relevant accredited professional body in relation to a medical condition or treatment which confirms, in our reasonable opinion, an established medical practice or opinion.
Hereditary:	Transmitted from parents to offspring; inherited, and which presents symptoms at birth.
Hospice:	A hospital or part of a hospital, or facility licensed as a hospice, which is devoted to the care of patients with progressive diseases, where curative treatment is no longer possible on an Inpatient or domiciliary basis.
Hospital:	An establishment that is legally licensed as a medical or surgical hospital under the laws of the country in which it is situated. The following are not considered hospitals: rest and nursing homes, spas, cure-centers, and health resorts.
Inpatient:	Medical care where you are admitted to a hospital or clinic for treatment and are required to stay overnight.
Insured Person/You/Your:	You and your dependents as stated on your Insurance Certificate.
Insurer:	Mangrove Insurance SPC (Cayman) Ltd. FBO Barnabas Segregated Portfolio (Talent Trust)
Medical Condition:	Any injury, illness or disease including psychiatric illness.
Medical Practitioner:	Doctors who are licensed to practice medicine under the law of the country in which treatment is given and where they are practicing within the limits of their license.
Medically Necessary:	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 Inpatient treatment, 'medically necessary' also means that diagnosis can't be made or treatment can't be safely and effectively provided on an outpatient basis.
Midwife:	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
Near Relative:	Spouse, child, brother, sister, parents, parents-in-law, sister-in-law, brother-in-law and fiancé.
New Born:	A baby who is within the first 16 weeks of its life following delivery.
Organ Transplant:	The replacement of vital organs (including bone marrow) as a consequence of an underlying medical condition.
Outpatient:	Medical care where you receive treatment at a hospital or clinic without being admitted or requiring an overnight stay.

Palliative Treatment:	Any treatment given, on advice or general advice, for the purpose of offering temporary relief of symptoms. Palliative treatment is not given to cure the medical condition causing the symptoms. For the purposes of this policy, palliative treatment will include renal dialysis.
Period of Cover:	The period of cover set out in the Insurance Certificate. This will be a 12-month period starting from the date of entry or any subsequent renewal date as applicable.
Physiotherapist:	A person who is registered as a physiotherapist and licensed to practice in the country in which treatment is being given.
Policy:	The Insurance cover effected with Talent Trust and as provided to you as detailed in this document.
Premature Birth:	A birth that takes place before 37 weeks of gestation has passed, counting from the first day of the last menstrual period.
Principal Insured:	The main insured person named as such within the Insurance Certificate.
Private Room:	Single occupancy accommodation in a private hospital.
Qualified Nurse:	A nurse whose name is currently on any register or roll of nurses, maintained by any Statutory Nursing Registration Body within the country in which they are resident.
Reasonable & Customary Charges:	Treatment costs that are usual within the country of treatment. We will only reimburse the cost of 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.
Related Condition:	Refers to any injury, illness or disease that, based on medical advice or general advice, we determine is the result of any one or more other medical conditions.
Rehabilitation:	Treatment that combines therapies such as physical, occupational and speech therapy. It aims to restore original form or function after an acute illness, injury or surgery. Treatment must take place in a licensed rehabilitation facility and start within 14 days of discharge from acute medical and/or surgical treatment. We cover Inpatient or day-care accommodation costs only if admission to a rehabilitation facility was requested by your doctor and approved by us.
Renewal Date:	The date on which your insurance policy is scheduled to be renewed for continued coverage.
Insurance Certificate:	A document that includes details of you chosen plan, the start and renewal date of cover (and effective dates of when dependents were added). Any other specific policy terms for your policy will be included in the insurance certificate.
Specialist:	A licensed doctor possessing the additional qualifications and expertise necessary to practice as a recognized specialist in diagnostic techniques, treatment and prevention in a particular field of medicine.
Treatment:	Surgical, medical, or other procedures, the sole purpose of which is the diagnosis, cure, or relief of a medical condition.
We/Our/Us:	Talent Trust
Waiting Period:	Refers to the period a policyholder (or dependent) must wait before specific benefits or coverage take effect. Coverage begins from the effective date of your entry into the policy or the date of purchase of an additional option (benefit), whichever is later.
Professional Sport:	Any sporting activity which derives salary or other economic compensation.

EXCLUSIONS

This policy does not cover expenses arising from:

1 Any medical condition or related condition for which you have received treatment, taken medication, followed a special diet, had symptoms of, to the best of your knowledge existed, or sought advice for before your date of entry (pre-existing medical condition), except where such medical conditions have been declared to us and accepted in writing. After 2 years of continuous membership, any pre-existing medical conditions (and related conditions) will become eligible for coverage provided (in respect of that condition) you have not during that period:
a) consulted any medical practitioner or specialist for treatment or advice (including check-ups except for non-prescribed wellness checks)
or
b) experienced further symptoms
or
c) taken medication (including drugs, medicines, special diets or injections).

2 Alternative medicines including, but not limited to, optometrists, hypnotherapists, and lactation examiners. Cover is extended to include chiropractors, osteopaths, homeopaths, Chinese herbal medicine, acupuncturists, and podiatrists as provided for under the Alternative Treatment Benefit.

3 Any form of assisted conception, except as expressly covered under the 'Investigations into Infertility' benefit, or any complications arising from it, including but not limited to premature or multiple births following assisted conception. A health declaration is required for all dependents born through assisted conception. We reserve the right to decline any application without providing a reason.

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

5 The first 20% of any admissible cost for treatment received in the USA, up to a maximum of US$5,000 per insured person per period of cover. The coinsurance is applied after any deduction for excess applicable to the policy. Also, the first 20% of any admissible cost incurred under the 'Well Child Care' and 'Wellness Benefit' benefits.

6 Complications of pregnancy costs arising within the first 10 months from the insured person's date of entry.

7 Any congenital anomalies and birth injuries where symptoms exist or where advice has been sought before your date of entry except as provided for under the Congenital Anomalies Benefit.

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

9 Treatment directly or indirectly related to male or female birth control, infertility, fertility treatments, contraception, sterilization (including reversals), sexual dysfunction, cryopreservation or any associated consequences. Coverage is extended for sexual dysfunction resulting from a total prostatectomy following cancer surgery.

10 Any cosmetic or aesthetic treatment to enhance your appearance.

11 Dental veneers and related procedures.

12 Treatment for delay in cognitive or physical development, learning difficulties, hyperactivity, attention deficit disorder, speech therapy, and developmental, social, or behavioral problems in children.

13 Treatment for alcoholism, drug or substance abuse, or any addictive condition of any kind (including detoxification programs and treatments to stop smoking) and any injury or illness arising directly or indirectly from such abuse or addiction (e.g. organ failure or dementia).

14 The excess (as shown in your Insurance Certificate) will be deducted from all eligible outpatient medical expenses in respect of each new medical condition.

15 Treatment or drug therapy, which we determine on general advice, is either experimental or unproven.

16 Claims arising from taking part in extreme or professional sports or activities, including but not limited to:
a) base jumping
b) tombstoning
c) cliff jumping
d) mountaineering high altitudes above 6,000 meters
e) rock climbing
f) paragliding
g) potholing
h) motorsports racing, including motocross and dirt bike racing
i) bull riding or bull running
j) parkour
k) scuba-diving at a depth of more than 30 meters
l) off-piste skiing

17 Normal eye or hearing tests, non-medical/natural degenerative eye defects, including but not limited to myopia, presbyopia, astigmatism except as provided for under the 'Additional option - Vision Care', and any corrective surgery for non-medical/natural degenerative sight or hearing defects.

18 Costs and expenses incurred where an insured person has travelled against medical advice.

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

20 Genetic testing, except:
a) where DNA tests are directly linked to an eligible amniocentesis i.e. in the case of women aged 35 or over.
b) where testing for genetic receptor of tumors is covered.

21 Home visits by a medical practitioner, specialist, or qualified nurse unless specifically agreed by us in writing prior to consultation.

22 Treatment required as a result of medical error.

23 Treatment received in a hospital emergency room, which is not an emergency.

24 Normal pregnancy, childbirth, voluntary caesarean section costs or medically necessary caesarean section costs due to any previous non-emergency caesarean sections undertaken, pre-and post-natal classes, antenatal classes, and midwifery costs except as provided for under Additional Option - Normal Pregnancy, Childbirth & Elective Caesarean Sections.

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

26 a) Treatment of a medical condition which we, on advice or general advice, determine is palliative or is for a chronic medical condition except as provided for under the Routine Management of Chronic Conditions Benefit.
b) We will, however, pay for the stabilization of acute exacerbations of chronic medical conditions that are not pre-existing medical conditions.

27 Death from or treatment for any illnesses, diseases, or injuries resulting from active participation in the following, whether war has been declared or not:
a) War
b) Riots
c) Civil disturbances
d) Terrorism
e) Criminal acts
f) Illegal acts
g) Acts against any foreign hostility

28 Substances, personal products, and dietary supplements, including vitamins and minerals (except during pregnancy or to treat diagnosed vitamin deficiency syndromes), mouthwash, toothpaste, antiseptic lozenges and sprays, shampoo, sunscreen, cosmetic products, sanitizer, gloves, masks, visors, thermometers, children's food, baby supplies and infant

formula given orally. These products are excluded even if they are medically recommended, prescribed, or acknowledged as having therapeutic effects.

29 Costs of providing, maintaining, or fitting any external prostheses or appliance, including but not limited to hearing and/or visual aids or other equipment, medical or otherwise, except as is specified in the Prescribed Medical Aids Benefit.

30 Products that are purchased without a doctor's prescription.

31 Costs in respect of a psychiatrist, clinical psychotherapist, licensed psychologist (except as provided for under the 'Inpatient Psychiatric Treatment' and 'Outpatient Psychiatric Treatment' benefit), family therapist, or bereavement counsellor.

32 Rehabilitation except as provided under the 'Rehabilitation' benefit.

33 Chronic supportive treatment of renal failure, including dialysis, except as provided for under the 'Routine Management of Chronic Conditions' benefit. We will, however, pay for the cost of renal dialysis incurred:
a) immediately pre and post-operatively.
b) in connection with acute secondary failure when dialysis is part of intensive care.

34 Routine physical examination by a medical practitioner, including gynecological investigations, routine tests, newborn care, inoculations, vaccinations, and preventative medicines except as provided for under 'Well Child Care', 'Wellness Benefit', 'Vaccination' and 'Additional Option - Normal Pregnancy, Childbirth & Elective Caesarean Sections' benefits.

35 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.

36 Suicide or attempted suicide, bodily injury or illness, which is willfully self-inflicted or due to negligent or reckless behavior. Any injury sustained directly or indirectly as a result of the insured person acting illegally or committing or helping to commit a criminal offence.

37 Treatment related to insomnia, sleep disorders (including sleep apnea, narcolepsy, and bruxism), snoring, fatigue, jet lag, work-related stress, or any related condition.

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

39 Pregnancy terminations on non-medical grounds.

40 Treatment received in health spas, nature cure clinics, hydrotherapy centers, or similar establishments, including private beds registered as nursing homes attached to such facilities, or in a hospital where the facility effectively becomes the insured person's home or permanent residence or where admission is arranged, in whole or in part, for domestic reasons.

41 Treatment directly or indirectly associated with a sex change and any consequence thereof.

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

43 Treatment of impotence or any related condition or consequence thereof.

44 Elective treatment outside the geographical area of cover.

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

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

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

48 Routine or restorative dental treatment, whether or not performed by a medical practitioner or, dental practitioner or a, specialist or an oral and maxillofacial surgeon, including but not limited to root canal treatment, false teeth, dentures, semi-precious and precious crowns/filling, any orthodontic treatment, or any related condition except as provided for under 'Emergency Dental Treatment', 'Dental Surgery', 'Well Child Care', 'Wellness Benefit' and under 'Additional Option - Dental Treatment' benefits.

49 Travel and accommodation costs, unless specifically agreed by us in writing prior to travel. No travel and accommodation costs are payable where treatment is obtained solely as an outpatient, including the costs of a hire car. Travel costs to and from medical facilities (including parking costs) for treatment, except when covered under the 'Local ambulance', 'Medical evacuation' and 'Medical repatriation' benefits.

50 The cost of obtaining medical reports, including but not limited to doctor's statements, specialist reports, diagnostic summaries, or any other documentation required for claims processing or policy administration.