Allianz Care

Benefit Guide

International Healthcare Plans
Aon ICare Plans powered by Allianz Care

Valid from 1st November 2021

AON

Welcome

Thanks to a comprehensive benefit package created by Aon in partnership with Allianz Care, you and your family will now have access to the best health care possible wherever you are in the world.

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, to provide you a service that is fast, flexible and totally reliable.

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

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

Allianz Care is the international health brand of Allianz Partners. Allianz Partners has a number of business lines, including international health, assistance, travel and automotive.

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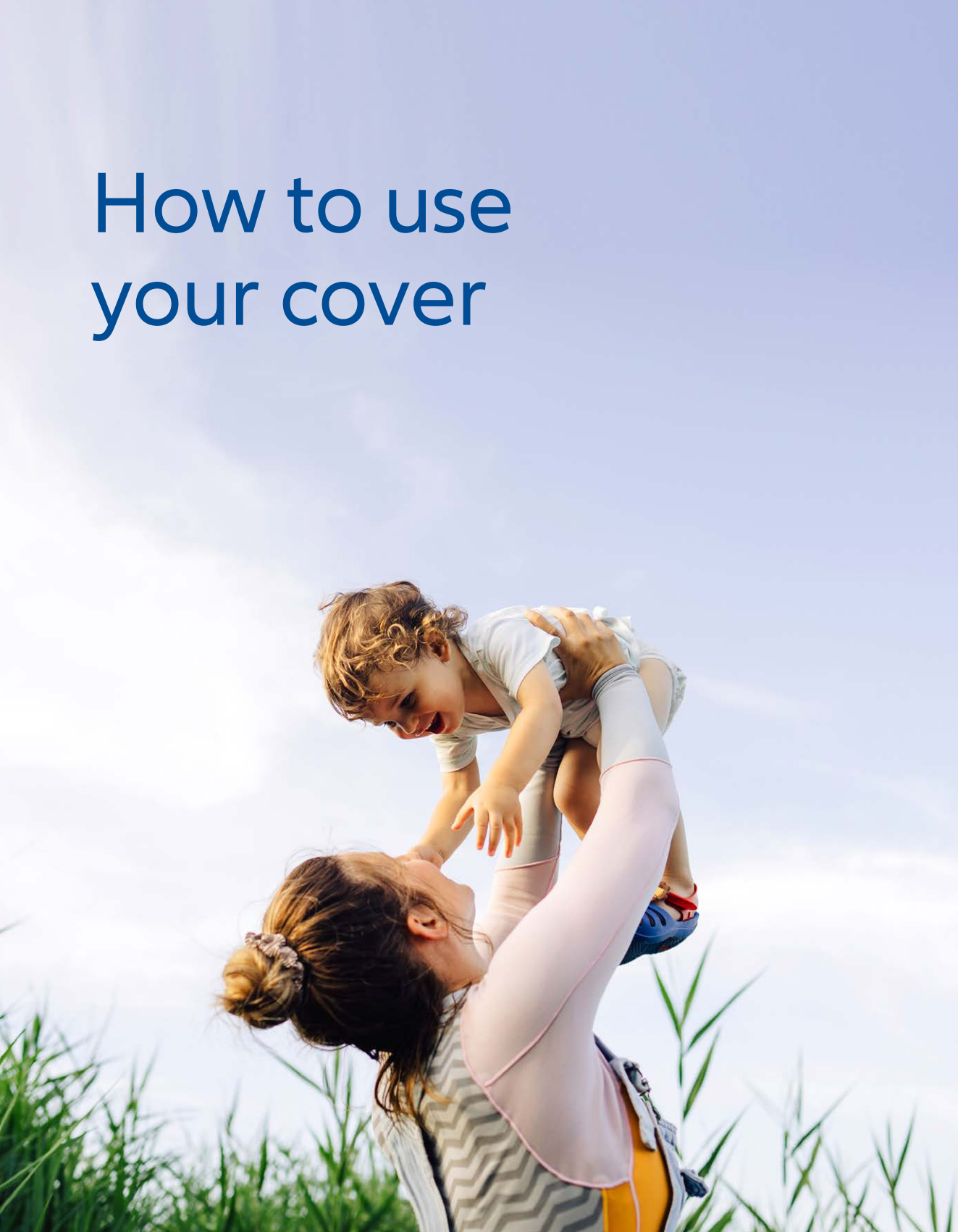
AWP Health & Life SA is regulated by the French Prudential Supervisory Authority located at 4 place de Budapest, CS 92459, 75 436 Paris Cedex 09.

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

How to use your cover



Support services

We believe in providing you with the top-quality service that you deserve.

In the following pages we describe the full range of services we offer. Read on to discover what is available to you, from our MyHealth Digital Services to the Expat Assistance Programme.

Talk to us, we love to help!

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

Helpline

Phone: **+353 1 630 1301**

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

Email: **client.services@allianzworldwidecare.com**

Fax: **+353 1 630 1306**

Did you know...

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

MyHealth Digital Services

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

MyHealth app and online portal features

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

My claims
Submit your claims in 3 simple steps and view your claims history.

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

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

Find a hospital
Locate medical providers nearby.

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

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

Emergency contact
Access local emergency numbers worldwide.

Additional useful features

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

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

Getting started:

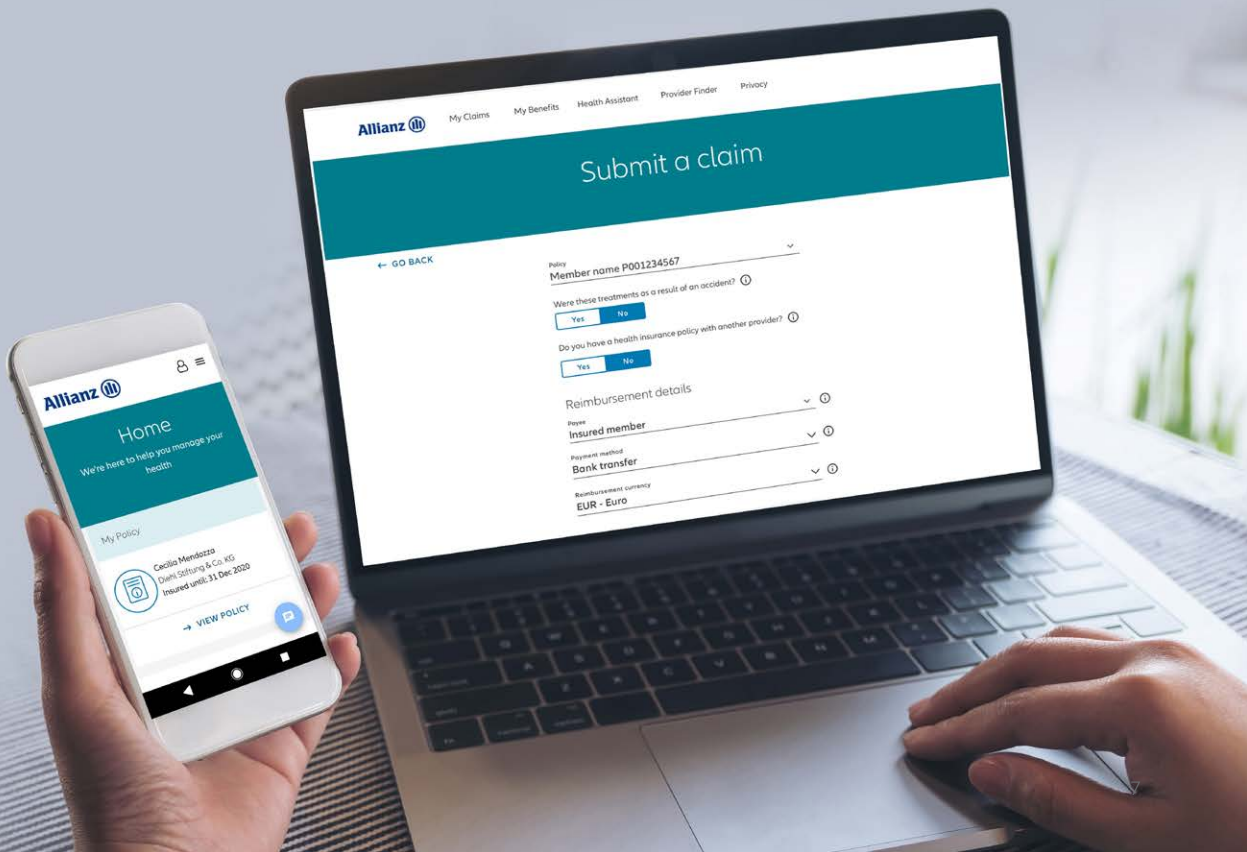
1. Login to MyHealth online portal to register. Go to **https://my.allianzcare.com/myhealth**, click on "REGISTER HERE" near the bottom of the page and follow the on-screen instructions. Be ready to provide your policy number, which you can find in your Insurance Certificate.

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

   Download on the App Store GET IT ON Google Play

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

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



Web-based services

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

- Search for medical providers (you are not restricted to using the providers listed in our directory)
- Download forms
- Access our Health Guides
- Access our "My expat life" hub – from planning to move, to settling down in your new country, you'll find everything you need to know about moving overseas

Second Medical Opinion**

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

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

To access our service, simply call our 24/7 Helpline on:

+ 353 1 630 1301

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

Olive - Allianz Care's Health and Wellness support program

Your first steps towards a healthier life.

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

1. Health and Wellness hub

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

On the Hub you will have access to:

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

2. HealthSteps app**

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

HealthSteps features:

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

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

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

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

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

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

Download on the App Store

GET IT ON Google Play

Video consultation services via Telehealth Hub**

If an Out-patient plan is included in your cover, you have direct access to online doctor appointments (video consultation services) where a provider is available in your geographical location.

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

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

www.allianzcare.com/telehealthhub

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

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

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

Expat Assistance Programme (EAP)**

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

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

- Work/Life balance
- Family/Parenting
- Relationships
- Stress, depression, anxiety
- Workplace challenges
- Cross-cultural transition
- Cultural shock
- Coping with isolation and loneliness
- Addiction concerns

Support services include:

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

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

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

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

Let us help:

+1 905 886 3605

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

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

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

Download the Lifeworks app in Google Play or Apple Store:

Download on the App Store

GET IT ON Google Play

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

Username: AllianzCare
Password: Expatriate

Travel Security Services**

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

You can access:

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

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

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

To access the travel security services, please contact us:

+44 207 741 2185

This is not a free phone number.

allianzcustomerenquiries@worldaware.com

https://my.worldaware.com/awc

Register by entering your policy number (shown in your Insurance Certificate)

Download 'TravelKit' app from App Store or Google Play.

Download on the App Store

GET IT ON Google Play

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

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

Understanding how your cover works

What am I covered for?

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

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

Your cover is also subjected to:

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

We generally cover pre-existing conditions (including pre-existing chronic conditions) unless we say otherwise in your policy documents. If in doubt, please check your Table of Benefits to confirm if pre-existing conditions are covered. If you are uncertain whether your planned medical treatment is covered under your plan, please contact our Helpline.

This insurance policy may not provide any cover or benefit to the extent that either the cover or benefit would violate any applicable sanction, law or regulations of the United Nations, the European Union or any other applicable economic or trade sanction, law or regulations.

Where can I receive treatment?

You can receive treatment in any country within your area of cover, as shown in your Insurance Certificate. If the treatment you need is available locally but you choose to travel to another country in your area of cover, we will reimburse all eligible medical costs incurred within the terms of your policy; except for your travel expenses.

If the eligible treatment is not available locally, and your cover includes "Medical evacuation", we will also cover travel costs to the nearest suitable medical facility. To claim for medical and travel expenses incurred in these circumstances, you will need to complete and submit the Treatment Guarantee Form before travelling.

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

What are benefit limits?

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

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

- The term "Full refund" appears next to the benefit.
- A specific benefit limit applies – this is when the benefit is capped to a specific amount (e.g. €10,000).

Benefit limits may be provided on a "per Insurance Year" basis, on a "per lifetime" basis or on a "per event" basis (such as per trip, per visit or per pregnancy). In some instances, in addition to the benefit limit, we will only pay a percentage of the costs for the specific benefit e.g. "65% refund, up to £4,150/€5,000/US$6,750/ CHF 6,500".

Benefit limits related to maternity

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

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

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

- In year one – the benefit limits apply to all eligible expenses.

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

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

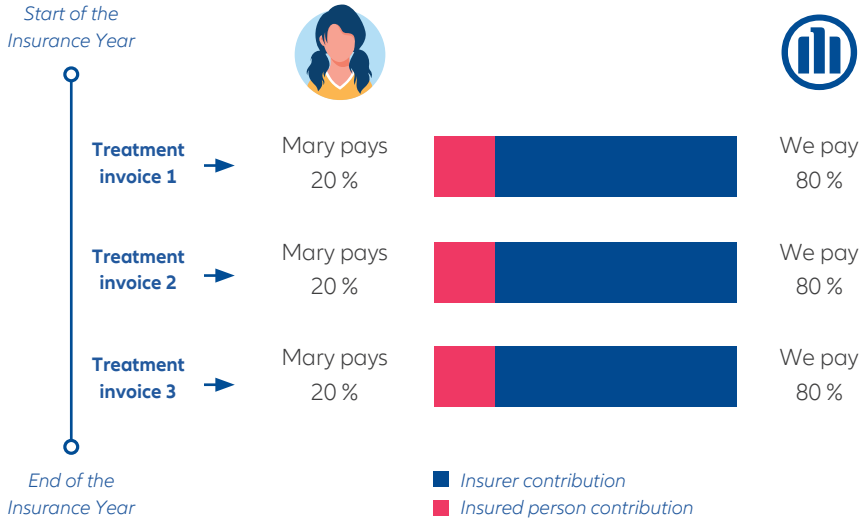
There is a limit for in-patient treatment that takes place in the first three months following birth if the baby:

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

This limit is £24,900/€30,000/US$40,500/CHF39,000 per child. Out-patient treatment is paid under the terms of the Out-patient Plan.

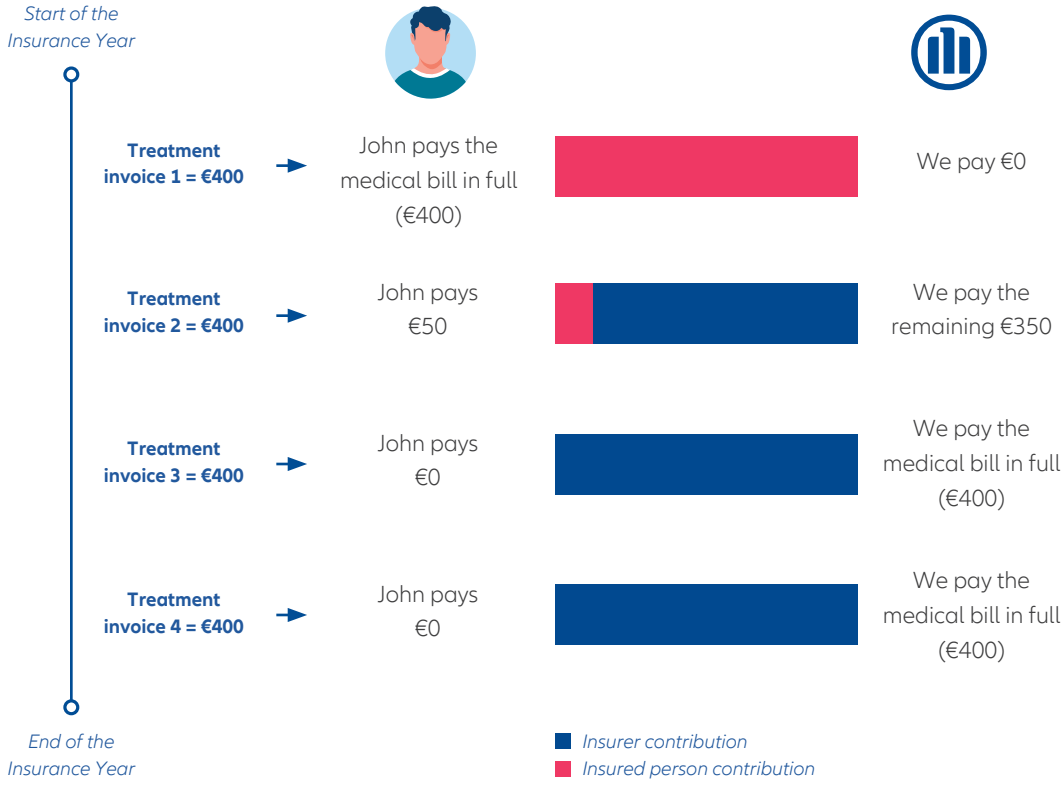
What are co-payments?

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



What are deductibles?

A **deductible** is a fixed amount you need to pay towards your medical bills per period of cover before we begin to contribute. In the following example, John needs to receive medical treatment throughout the year. His plan includes a €450 deductible.



Seeking treatment?

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

Check your level of cover

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

Some treatments require our pre-approval

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

Unless we agree otherwise, if you make a claim without obtaining our pre-approval, the following will apply:

- If the treatment received is subsequently proven to be medically unnecessary, **we reserve the right to decline your claim.**
- If the treatment is subsequently proven to be medically necessary, we will pay 80% of in-patient benefits and 50% of other benefits.

Getting in-patient treatment (pre-approval applies)

Download a Treatment Guarantee Form from our website:
www.allianzcare.com/members

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

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

If it's an emergency:

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

If you are hospitalised, either you, your doctor, one of your dependants or a colleague needs to call 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.

We can also take Treatment Guarantee Form details over the phone if treatment is taking place within 72 hours.
Please note that we may decline your claim if pre-approval is not obtained.

Claiming for your out-patient, dental and other expenses

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

Receive your medical treatment and pay the medical provider.

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

Claim back your eligible costs via our MyHealth app or online portal (**www.allianzcare.com/en/myhealth.html**).

Simply enter a few key details, add your invoice(s) and press 'submit'.

Quick claim processing

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

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

If you are French and your contract is a top up to the CFE, we will process fully completed Claim Forms and issue payment instructions to your bank **within five working days**.

Evacuations and repatriations

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

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

+353 1 630 1301

medical.services@allianzworldwidecare.com

Seeking treatment in the USA

To find a provider

If you have worldwide cover and are looking for a provider in the USA, go to:

https://azc.globalexcel.com/

For more information or an appointment

If you have a query about a medical provider, or if you have selected a provider and wish to arrange an appointment, please call us.

(+1) 800 541 1983 (toll-free from the USA)

For a prescription

You can apply for a discount pharmacy card, which you can use for any prescription that is not covered by your plan. To register and obtain your discount pharmacy card, simply go to the following website and click on "Print Discount Card":

https://azc.globalexcel.com/find-a-pharmacy/

Additional information about claiming for your expenses

Medical claims

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

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

- **Cerfa form:** If your contract is a top-up to the CFE or if you are affiliated to the French social security, we require the "Cerfa" treatment form ("Feuille de soins", supplied by your medical provider) for all treatments received in France.

- **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 (or for up to two years for claims on CFE or French social security policies). We may also request proof of payment by you (e.g. a bank or credit card statement) for medical bills you have paid. We advise that you keep copies of all correspondence with us as we cannot be held responsible for correspondence that fails to reach us for any reason outside of our control.

- **Deductibles:** If the amount you are claiming is less than the deductible figure in your plan, you can either:
  - Collect all out-patient receipts until you reach an amount that exceeds this deductible figure.
  - Send us each claim every time you receive treatment. Once you reach the deductible amount, we'll start reimbursing you.

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

- **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.

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

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

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

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

Reimbursement of eligible expenses under your policy incurred in respect of an illness, maternity or an accident, will not exceed the costs that the insured person paid, following any additional reimbursement to which the insured person is entitled to receive. This includes payments made under article L.861-3 of the French Social Security Code.

In addition, insurance cover of the same kind taken out with multiple insurers will only take effect within the limit of each insurance cover, regardless of the start date of each insurance policy.

Claims for accidental death

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

Please send us:

- A fully completed Life and Accidental Death Benefit Application Form.
- A death certificate.

- A medical report indicating the cause of death.
- A written statement outlining the date, location and circumstances of the accident.

- Official documentation proving the insured person's family status (i.e. whether they are married or have children).
- For the beneficiaries, proof of identity as well as proof of their relationship to the insured person.

Beneficiaries are, unless otherwise specified by the insured:

- The insured person's spouse or partner, if not legally separated.
- If there is no spouse, the insured person's surviving children including step-children, adopted or foster children and children born less than 300 days after the date of the insured person's death; in equal shares among them.
- If there are no children, the insured person's father and mother, in equal shares between them, or to the survivor if one parent has died.
- Failing any of the above, the insured person's estate.

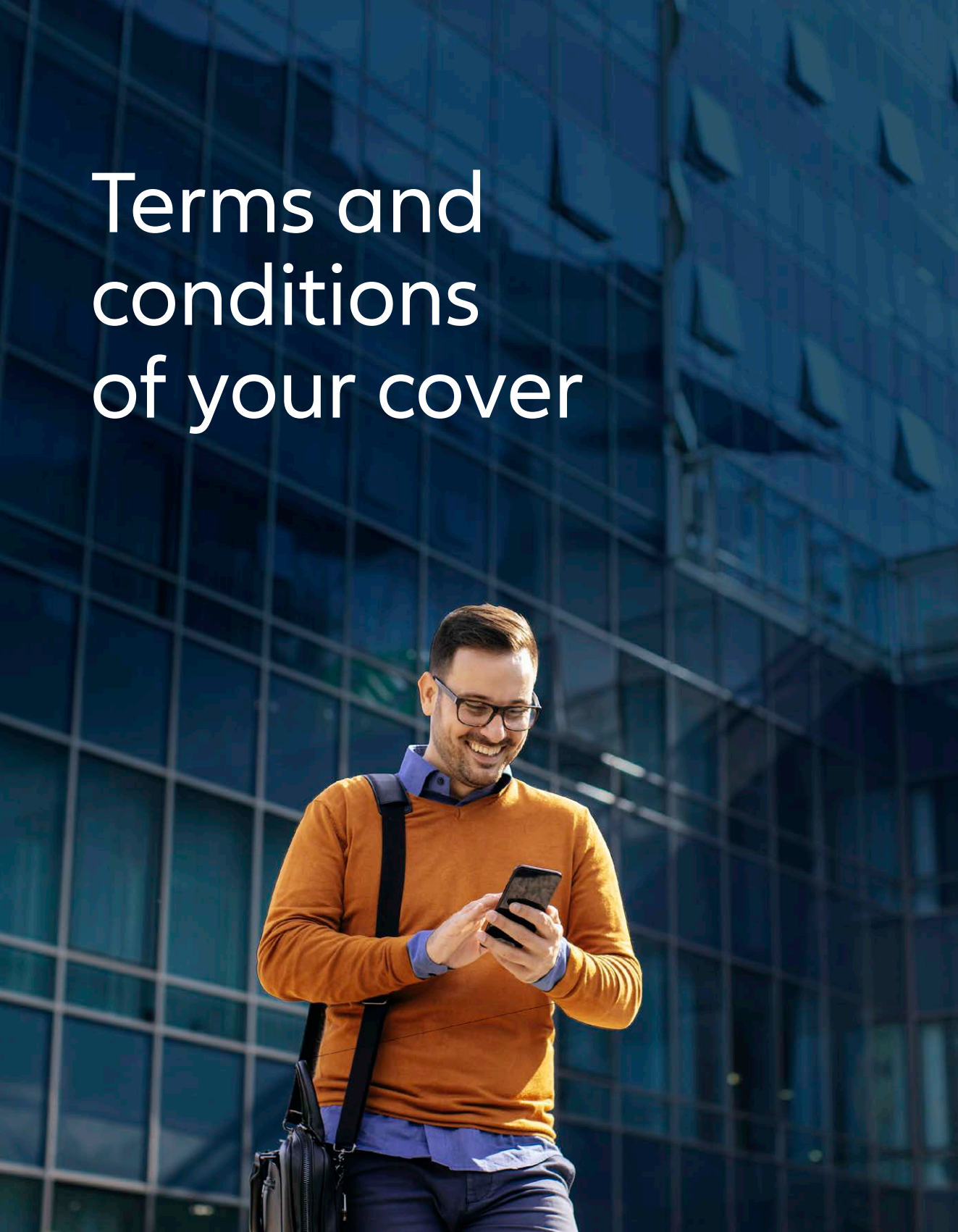
If you wish to nominate a beneficiary other than those listed above, please contact our Helpline.

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

Treatment needed as a result of someone else's fault

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

Terms and conditions of your cover



Terms and conditions

This section describes the benefits and rules of your health insurance policy.

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

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

- The **Insurance Certificate**. This states the plan(s) chosen, the start date and renewal date of the policy (and effective dates of when dependants were added), and the geographical area of cover. If any other terms apply which are specific to your cover, these will be stated in the Insurance Certificate. They will also have been detailed on a Special Conditions Form which we send you before you're placed on cover. We'll send you an updated Insurance Certificate if you request a change which we accept, such as adding a dependant, or if we apply a change that we're entitled to make.

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

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

Administration of your policy

When cover starts

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

Cover for dependants (if applicable) will start on the effective date shown on the most recent Insurance Certificate which lists them as your dependants. Their membership may continue for as long as you are the policyholder and, for children, as long as they remain under the defined age limit. Child dependants can be covered under your policy up until the day before their 18th birthday or up until the day before their 24th birthday if they are in full-time education. At that time, they may apply for their own cover.

Adding dependants

You may apply to include any member of your family as a dependant by completing the relevant application form.

How do I add a newborn to my policy?
Please send an email to **underwriting@allianzworldwidecare.com** within four weeks from birth and attach the birth certificate. With the exception of multiple birth babies, we will accept the baby without medical underwriting if the birth parent or intended parent (in the case of surrogacy) has been insured with us for a minimum of eight continuous months. Cover will start at birth.

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

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

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

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

This limit is £24,900/€30,000/US$40,500/CHF39,000 per child. Out-patient treatment is paid under the terms of the Out-patient Plan.

Changes to policyholder

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

Death of the policyholder or a dependant

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

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

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

Changing your level of cover

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

Changing country of residence

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

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

@ underwriting@allianzworldwidecare.com

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

Changing your postal address or email address

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

Continuation of cover

If you are in receipt of continued coverage from us in accordance with Article 4 of Law No. 89-100 dated 31st December, 1989 (as amended by Act No. 94-678 dated 8th August 1994) ('Loi Evin'), we may require, at our discretion, you (or any dependant benefitting from such continued coverage) to prove your/their entitlement to such continued cover. If you are in receipt of continued coverage you shall immediately notify us in the event that your entitlement to continued cover changes, including where you lose your entitlement to disability, incapacity, retirement or income substitution benefits. You should notify us of any such changes by registered letter within 14 days of the date you became aware of same.

Correspondence

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

Renewing your cover

Subject to "Reasons your membership would end", your policy will automatically renew at the end of every Insurance Year, if:

- The plan or plan combination selected is still available
- We can still provide cover in your country of residence
- All premiums due to us have been paid
- The payment details we have for you are still valid on the policy renewal date. Please update us if you get a new/replacement credit card or if your bank account details have changed.

As part of this automatic process, one month before the renewal date, you will receive a new Insurance Certificate along with details of any policy changes. If you don't receive your Insurance Certificate one month before your renewal date, please notify us.

Changes that we may apply at renewal

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

We will write to tell you about any changes. If you do not accept any of the changes we make, you can end your membership and we will treat the changes as not having been made if you end your membership within 30 days of the date on which the changes take effect, or within 30 days of us telling you about the changes, whichever is later.

Your right to cancel

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

The contract may also be terminated, on the initiative of the Policyholder, at any time , without fees or penalties at the expiration of a period of 1 year, starting from the first subscription.

The termination takes effect 1 month after the Insurer has received notification by registered letter, single letter, e-mail or other durable medium.

If you wish to cancel, please complete the "Right to change your mind" form which was included in your welcome/renewal pack. You can send us this form via email:

@ underwriting@allianzworldwidecare.com

Alternatively, you can post this form to the Client Services Team, using the address provided at the back of this guide.

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

Reasons your membership would end

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

- If you do not pay any of your premiums on, or before, the date they are due. However, we may allow your membership to continue without you having to complete a Confirmation of Health Status Form, if you pay the outstanding premiums within 30 days after the due date.

- If you do not pay the amount of any special tax on insurance contract , taxes, levies or charges that you have to pay under your agreement with us on or before the due date.

- Upon the death of the policyholder. Please see the section on 'Death of the policyholder or a dependant' for further details.

- If there is reasonable evidence that the policyholder or any dependants misled or attempted to mislead us. Examples are: giving false information, withholding pertinent information from us, working with another party to give us false information - either intentionally or carelessly - which may influence us when deciding:

  - whether we accept the application for cover
  - the applicable premium to pay
  - whether we have to pay a claim

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

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

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

Please note that if your membership ceases, your dependants' cover will also end.

Policy expiry

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

Paying premiums

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

By accepting cover you have agreed to pay the premium amount shown on your quotation, by the payment method stated. You need to pay us in advance for the duration of your cover. The **initial premium** or first premium instalment is payable immediately after we accept your application. **Subsequent premiums** are due on the first day of the chosen payment period. You may choose between monthly, quarterly, half-yearly or annual payments depending on the payment method you choose. When you receive your invoice, please check that the premium matches the amount shown on your agreed quotation and contact us immediately if there is any difference. We are not responsible for payments made through third parties.

You should pay your premium in the currency you selected when applying for cover. If you are unable to pay your premium for any reason, please contact us on:

+353 1 630 1301

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

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

The effects of termination will cease if you make a payment within one month after the termination or, if the termination was combined with the setting of a time limit, within one month after the expiration of the time for payment, provided that no claims have been incurred in the intervening period.

Paying other charges

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

- Insurance Premium Tax (IPT)
- VAT
- Other taxes such as the Taxe de solidarité additionnelle (TSA), levies or charges relating to your cover that we may have to pay or collect from you by law

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

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

The following terms also apply to your cover

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

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.

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

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

- A public scheme
- Any other insurance policy
- Any other third-party

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

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

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

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

Fraud:

a) The information you and your dependants give us, e.g. on the Application Form or supporting documents, needs to be accurate and complete. If it isn't correct or if you don't tell us about things that may affect our underwriting decision, it may invalidate your policy from the start date. You also need to tell us about any medical conditions that arise between completing the Application Form and the start date of the policy. Medical conditions that you don't tell us about will most likely not be covered. If you're not sure whether certain information is relevant to underwriting, please call us and we'll be able to clarify that. If the contract is rendered void due to incorrect disclosure or non-disclosure of any material facts, we will refund the premium amount(s) paid to date minus the cost of any medical claims already paid. If the cost of claims exceeds the balance of the premium, we will seek reimbursement of this amount from the principal member.

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

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

Cancellation: We are entitled to cancel your policy where you have not paid the full premium due and owing as set out in the 'Paying premiums' section. In the event of cancellation in the above case, we will refund the premium paid on a pro rata basis. You are entitled to cancel your policy:

a) With effect from the next renewal date by giving us a minimum of 2 month notice by registered letter. Termination will take effect from the next renewal date.

b) In the event of a reduction in insurance risk, if we do not agree to a consequent reduction of the premium. Termination will take effect 30 days following such refusal by us. This clause does not apply in circumstances where an insured person's state of health has changed.

You may notify us of your intention to cancel your policy either by "déclaration faite contre récépissé" (a declaration which confirms your intention to cancel the policy), or "acte extrajudiciaire" (written confirmation by a notary, confirming your intention to cancel your policy), or by registered letter.

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.

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

Data protection

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 and dispute resolution procedure

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

+353 1 630 1301

client.services@allianzworldwidecare.com

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

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

www.allianzcare.com/complaints-procedure

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

Mediation

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

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

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

3. Any dispute, controversy or claim which is:

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

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

Legal action

The provisions relating to the limitation of actions arising from the insurance policy are laid down by Articles L.114-1 to L.114-3 of the French Insurance Code reproduced below:

Article L.114-1 of the French Insurance Code:
All legal actions arising from an insurance policy will be barred two years as from the event that gave rise thereto.

However, such a period will run:

1. in the event of non-disclosure, omission, fraudulent representation or misrepresentation of the risk incurred, only as from the date on which the Insurer is aware thereof;
2. in the event of a claim, only as from the date the persons concerned are aware thereof, if they prove that they were unaware of such facts until then.

When the Covered Person's action against the Insurer arises from a third party's recourse, the limitation period will run only from the date on which such third party brings a legal action against the Covered Person or this one has paid its compensation.

Article L.114-2 of the French Insurance Code:
The limitation period will be interrupted by one of the ordinary causes that interrupt the limitation period and by the designation of experts following a claim. The limitation period of the legal action may also be interrupted by the Insurer sending the Covered Person a registered letter with acknowledgement of receipt in respect of the action for payment of the premium and by the Covered Person to the Insurer in respect of the settlement of the claim.

Article L.114-3 of the French Insurance Code:
By way of derogation from Article 2254 of the French Civil Code, under no circumstance will the limitation period be amended or further causes of suspension or interruption be added by the contracting parties, even if agreed by mutual agreement.

Further information

The ordinary causes of interruption of the limitation period are set out in Articles 2240 et seq. of the French Civil Code; they include in particular: the debtor's acknowledgement of the right of the person against whom he/she applies the limitation period; a service of process, even provisionally; enforcement proceedings. For more information about the completeness of the ordinary causes of interruption of the limitation period, see the aforementioned Articles of the French Civil Code.

Definitions

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

A

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

Accidental death benefit refers to an amount shown in the Table of Benefits which becomes payable if an insured person (aged 18 to 70) dies during the period of insurance as a result of an accident (including an industrial injury).

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

Acute refers to the sudden onset of symptoms or a medical condition.

Allergy testing refers to a visit to a licensed practitioner to test for and discover if your symptoms are related to an allergy. If included in your plan as a specific benefit, cover is limited to the amount shown in your Table of Benefits.

B

Breastfeeding consultation provides a contribution towards the cost of a consultation with a qualified breastfeeding consultant. When submitting a claim, please attach a dated invoice from the provider. This benefit is payable to insured mothers availing of the service.

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

C

Cancer screening for the early detection of illness or disease are health checks, tests and examinations, performed at appropriate age intervals, that are undertaken without any clinical symptoms being present. Please refer to your Table of Benefits to confirm what tests and checks are covered under this benefit.

Child hearing exam provides a contribution towards the services of a suitably qualified and recognised hearing care professional in the country of treatment. To be eligible for this benefit, your child must be 16 years or younger and covered at the time they receive the service. When submitting a claim, please attach a dated invoice from the provider.

Child home nursing provides a contribution towards the cost of nursing care at home for an insured dependant aged 16 or younger. Cover is provided if the treating doctor decides that the child needs to receive care at home for medical reasons, following an in-patient treatment of five days or more. The nursing care must:

- Start within two weeks of discharge from hospital
- Be completed within six weeks of discharge
- Be provided by a qualified nurse, registered in the country of treatment

The 'Child home nursing' benefit only applies when your claim is not eligible under the 'Nursing at home or in a convalescent home' benefit or when you have already reached the limit under this benefit. When submitting a claim, please attach a dated invoice from the provider.

Child speech and language therapy provides a contribution towards the cost of treatment for dyslexia and dyspraxia for children aged 16 and younger. The services must be provided by a certified speech-language therapist or pathologist in the country of treatment. To be eligible for this benefit, the child must be covered under the policy at the time they receive the service. This benefit is limited to the treatment of dyslexia and dyspraxia only. When submitting a claim, please attach a dated invoice from the provider.

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

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

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

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

Complications of childbirth refers only to post-partum haemorrhage and retained placental membrane. Where your plan also includes the benefits 'Routine maternity' or 'Routine delivery and newborn care', 'Complications of childbirth' includes medically necessary caesarean sections.

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

Co-payment is the percentage of the costs which you must pay. E.g. if a benefit has a 80% refund, this means that a co-payment of 20% applies, therefore we will pay 80% of the costs of each eligible treatment per insured person, per insurance year.

D

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

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

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

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

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

Dental surgery includes the 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 treatment includes an annual check-up, simple fillings related to cavities or decay, root canal treatment and dental prescription drugs.

Dependant is your spouse or partner and unmarried children that are named as dependants on your Insurance Certificate. Children are covered up to the day before their 18th birthday; or up to the day before their 24th birthday if they are in full-time education.

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

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

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

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

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

Drug and alcohol addiction treatment provides a contribution towards the cost of a dependent child receiving treatment in a recognised drug and alcohol addiction treatment facility. The prescribed treatment can include detoxification, medication, therapy and counselling. To be eligible for this benefit your child must be insured at the time they receive the service.

E

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

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

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

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

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

Expenses for one person accompanying an evacuated/repatriated person refer to the travel costs for one person accompanying the evacuated/repatriated person. If they can't travel in the same vehicle, we will pay for an alternative form of transport at economy rates. Following completion of treatment, we will also cover the cost of the companion's

return trip, at economy rates, to the country where the evacuation/repatriation started from. Cover is not provided for hotel accommodation or other related expenses.

F

Family expenses during childbirth provides a contribution towards the following costs, when you travel to be with your partner while they are admitted to hospital to give birth:

- Costs of hotel accommodation
- Your travel costs to and from your home to the hospital
- The costs of a professional child minder while you are visiting your partner in hospital
- Car parking expenses while you are visiting your partner in a medical facility

The contribution can only be claimed for costs incurred on:

- the day your baby is born
- the day before your baby is born
- the day after your baby is born

To be eligible for this benefit, you must be covered at the time the costs arise. When submitting a claim, please attach the dated invoices for each expense.

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

First aid course provides a contribution towards a first aid course for insured parents who have a child insured as a dependant. To be eligible for this benefit, you must be covered at the time you attend the course. This benefit is only available where the course is carried out by qualified and recognised professionals. Insured parents can claim this benefit once per policy year. When submitting a claim, please attach a dated invoice from the provider.

Fitness assessment provides a contribution towards the costs of assessing fitness levels of the policyholder and their insured spouse or partner. This includes cardiovascular, whole body power and strength assessments. The costs incurred may include VO2 max testing and a prescribed program of exercise suitable to help members achieve their goals and ambitions. This benefit is only available where the assessment is carried out under the direct supervision of a qualified doctor in the country of treatment. To be eligible for this benefit, you must be covered at the time of the assessment. When submitting a claim, please attach a dated invoice from the provider.

H

Health and wellbeing checks including screening for the early detection of illness or disease are health checks, tests and examinations, performed at appropriate age intervals, that are undertaken without any clinical symptoms being present. Please refer to your Table of Benefits to confirm what tests and checks are covered under this benefit.

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

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

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

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

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

I

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

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

For multiple birth babies born as a result of medically assisted reproduction, all babies born by surrogacy, adopted and fostered children, in-patient treatment is limited to £24,900/€30,000/US$40,500/CHF39,000 per child for the first three months following birth. Out-patient treatment is paid under the terms of the Out-patient Plan.

In-patient cash benefit is payable when you receive in-patient treatment for a medical condition that is covered by us but is free of charge for you, i.e. when the full cost of your treatment is funded by your national health service and no claim is made or paid by us under any section of this policy. In-patient cash benefit is limited to the amount specified in the Table of Benefits and is payable after you are discharged from hospital.

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

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

Insurance Year applies from the effective date of your policy, as shown on the Insurance Certificate and ends exactly one year later.

Insured person is you and your dependants as stated on your Insurance Certificate.

L

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

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

Long-term care refers to care over an extended period of time after the acute treatment has been completed, usually for a chronic condition or disability requiring periodic, intermittent or continuous care. Long-term care can be provided at home, in the community, in a hospital or in a nursing home.

M

Medical evacuation applies in the following scenarios:

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

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

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

If you are evacuated to the nearest appropriate medical centre for ongoing treatment, we will cover the reasonable cost of hotel accommodation in a private en-suite room. This cost must be more economical than the cost of a series

of journeys between the nearest appropriate medical centre and your principal country of residence. Hotel accommodation for an accompanying person is not covered.

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

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

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

a) Essential to identify or treat your condition, illness or injury
b) Consistent with your symptoms, diagnosis or treatment of the underlying condition
c) 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)
d) Required for reasons other than the comfort or convenience of you or your doctor
e) Proven and demonstrated to have medical value (this does not apply to complementary treatment methods if they form part of your cover)
f) Considered to be the most appropriate type and level of service or supply
g) Provided at an appropriate facility, in an appropriate setting and at an appropriate level of care for the treatment of your medical condition
h) Provided only for an appropriate duration of time

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

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

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

Medical repatriation is an optional level of cover and where provided will be shown in the Table of Benefits. If the necessary treatment for which you are covered isn't available locally you can choose to be medically evacuated to your home country for treatment, instead of to the nearest appropriate medical centre. This only applies when your home country is within your geographical area of cover. Following completion of treatment, we will also cover the cost of your return trip at economy rates, to your principal country of residence. The return journey must take place within one month after treatment has been completed.

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

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

Midwife fees refers to 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.

N

Newborn care includes customary examinations required to assess the integrity and basic function of the child's organs and skeletal structures. These essential examinations are carried out immediately following birth.

Cover doesn't include further preventive diagnostic procedures, such as routine swabs, blood typing and hearing tests. However, if for medical reasons the child needs any follow-up investigations and treatment, these are covered under the newborn's own policy (if they have been added as a dependant). For multiple birth babies born as a result of medically assisted reproduction, all babies born by surrogacy, adopted and fostered children, in-patient treatment is limited to £24,900/€30,000/US$40,500/CHF39,000 per child for the first three months following birth. Out-patient treatment is paid within the terms of the Out-patient Plan.

Non-prescribed physiotherapy refers to treatment provided by a registered physiotherapist without being referred by a doctor in advance. Cover is limited to the number of sessions indicated in your Table of Benefits. A doctor must prescribe any additional sessions over this limit, which will be covered under the 'Prescribed physiotherapy' benefit. Physiotherapy does not include therapies such as Rolfing, Massage, Pilates, Fango and Milta.

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

O

Obesity is diagnosed when a person has a body mass index (BMI) of over 30 (you can find a BMI calculator at: www.allianzcare.com/members).

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

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

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

Oculomotor therapy is a specific type of occupational therapy that aims to synchronise eye movement when there is a lack of coordination between eye muscles.

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

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

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

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

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

Orthodontics is 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:

a) Increased overjet > 6mm but <= 9 mm
b) Reverse overjet > 3.5 mm with no masticatory or speech difficulties
c) Anterior or posterior crossbites with > 2 mm discrepancy between the retruded contact position and intercuspal position
d) Severe displacements of teeth > 4
e) Extreme lateral or anterior open bites > 4 mm
f) Increased and complete overbite with gingival or palatal trauma
g) Less extensive hypodontia requiring pre-restorative orthodontics or orthodontic space closure to obviate the need for a prosthesis
h) Posterior lingual crossbite with no functional occlusal contact in one or more buccal segments
i) Reverse overjet > 1 mm but < 3.5 mm with recorded masticatory and speech difficulties
j) Partially erupted teeth, tipped and impacted against adjacent teeth
k) Existing supernumerary teeth

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

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

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

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

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

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

Over-the-counter drugs refers to medication that can be purchased in a pharmacy without a prescription. The drugs must be clinically proven to be effective for the condition and recognised by the pharmaceutical regulator in a given country.

P

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

Partner refers to a person you have lived with in a conjugal relationship for a continuous period of 12 months.

Periodontics refers to dental treatment related to gum disease.

Podiatry refers to medically necessary treatment carried out by a State Registered podiatrist.

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

Post-natal counselling provides a contribution towards the cost of post-natal counselling received within 12 months from the date on which your baby was born. To be eligible for this benefit, you must be covered at the time your baby is born and at the time you receive the service. The counsellor must be qualified and registered in the country of treatment. When submitting a claim, please attach a dated invoice from the provider.

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

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

- The date we issued your Insurance Certificate or
- The start date of your policy

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

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

Pregnancy Yoga or Pilates provides a contribution towards the cost of Yoga or Pilates classes by a qualified instructor for insured members during pregnancy. When submitting a claim, please attach a dated invoice from the provider. We can only reimburse classes that take place during pregnancy.

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

Prescribed ancillary nursing care refers to services medically prescribed and carried out by a qualified nurse at home or in an appropriate medical centre on an Out-patient basis. This includes but is not limited to, acts such as dressing changes or insulin injections. Only acts that are deemed to be medically necessary will be covered.

Prescribed drugs refers to over the counter drugs when prescribed by a doctor to:

- Treat a confirmed diagnosis or medical condition
- Compensate a lack of vital bodily substances

Examples are aspirins, vitamins and hypodermic needles. Prescribed drugs must be clinically proven to be effective for the diagnosed condition. They must also be recognised by the pharmaceutical regulator in the country where you use the prescription. Even if you can legally buy a medication without a doctor's prescription in that country, you must get a prescription for these costs to be covered.

Prescribed glasses and contact lenses refers to cover for prescribed lenses and glasses to correct vision. Routine eye examination carried out by an optometrist or ophthalmologist (one check-up per Insurance Year) is covered under specialist fees benefit.

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

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

We do not cover costs for medical aids that form part of palliative care or long-term care (see the definitions of 'Palliative care' and 'Long-term care').

Prescribed physiotherapy refers to treatment provided by a registered physiotherapist following referral by a doctor. Physiotherapy (either prescribed, or a combination of non-prescribed and prescribed treatment) is initially restricted to 12 sessions per condition, after which treatment must be reviewed by the doctor who referred you. If you need further sessions, you must send us a new progress report after every set of 12 sessions, indicating the medical necessity for more treatment. Physiotherapy does not include therapies such as Rolfing, massage, Pilates, Fango and Milta.

Prescription drugs refers to products which you can't buy without a prescription and are to treat a confirmed diagnosis or medical condition or to compensate a lack of vital bodily substances. Examples are antibiotics, sedatives, etc. Prescription drugs must be clinically proven to be effective for the diagnosed condition. They must also be recognised by internationally accepted medical guidelines. You can claim for a supply of up to 3 months from the prescription date, subject to length of time remaining on the policy.

Preventative surgery refers to prophylactic mastectomy or prophylactic oophorectomy. We will pay for preventative surgery when:

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

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

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

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

All day-care or in-patient admissions must include prescription medication related to the condition. Out-patient psychotherapy treatment (where covered) requires referral by a doctor and is limited for 10 sessions per condition

initially. After every 10 sessions, a psychiatrist must review the treatment. If you need more sessions, you must send us a progress report that indicates the diagnosis and the medical necessity for further treatment.

Counselling is available through our Expat Assistance Programme (EAP) and refers to short-term, solution-focused interventions, and typically deals with current issues that are easily resolved on the conscious level. This is not meant for longer-term situations or the treatment of clinical disorders. EAP can help you and your immediate family deal with challenging situations that may arise in life, such as stress, anxiety, bereavement, workplace challenges, relationship issues, cross-cultural transition, coping with isolation and loneliness. For more information see the 'Expat Assistance Programme (EAP)' section of this guide.

R

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

Rehabilitation is 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.

Repatriation of mortal remains is the transportation of the insured deceased remains from the principal country of residence to the country of burial. We cover costs such as: embalming, a container legally appropriate for transportation, shipping and the necessary government authorisations. Cremation costs will only be covered if the cremation is required for legal purposes. We do not cover costs incurred by anyone accompanying the remains unless this is listed as a specific benefit in your Table of Benefits.

Routine delivery refers to medically necessary costs incurred during childbirth. This includes hospital charges, specialist fees, midwife fees (during labour only) and newborn care (see the definition of 'Newborn care' for what we cover under this benefit and for in-patient treatment limits that apply to adopted and fostered children, all babies born by surrogacy and multiple birth babies born as a result of medically assisted reproduction). We do not cover costs of complications of pregnancy and childbirth under the 'Routine delivery' benefit. Caesarean sections that are not medically necessary are covered up to the cost of a routine delivery in the same hospital, subject to any benefit limits. Medically-necessary caesarean sections are paid for under the 'Complications of childbirth' benefit.

In case of home deliveries, we will pay up to the amount specified in the Table of Benefits if your plan includes the 'Home delivery' benefit.

Routine maternity refers to medically necessary costs incurred during pregnancy and childbirth. This includes hospital charges, specialist fees, the mother's pre-natal and post-natal care, midwife fees (during labour only) and newborn care (see the definition of 'Newborn care' for what we cover under this benefit and for in-patient treatment limits that apply to adopted and fostered children, all babies born by surrogacy and multiple birth babies born as a result of medically assisted reproduction). We do not cover costs of complications of pregnancy and childbirth under the 'Routine maternity' benefit. Caesarean sections that are not medically necessary are covered up to the cost of a routine delivery in the same hospital, subject to any benefit limits. Medically-necessary caesarean sections are paid for under the 'Complications of childbirth' benefit.

In case of home deliveries, we will pay up to the amount specified in the Table of Benefits if your plan includes the 'Home delivery' benefit.

S

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

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

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

T

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

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

The "Travel costs of insured family members in the event of a repatriation" benefit is covered if you have a repatriation plan. Cover does not include hotel accommodation or other related expenses.

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

Travel costs of insured members to be with a family member who is at peril of death or who has died refers to the reasonable transportation costs of insured family members to be with a first-degree relative who is at peril of death or who has died (up to the amount specified in your Table of Benefits). In the case of a deceased relative, travel must commence within 6 weeks of their date of death. Reasonable transportation costs are considered to be round trip transport costs at economy rates. A first-degree relative is a spouse or partner, parent, brother, sister or child, including adopted children, fostered children or step-children. When claiming, please include copies of the travel tickets and the death certificate or a doctor's certificate supporting the reason for travel. Cover does not include hotel accommodation or other related expenses.

Treatment refers to a medical procedure needed to cure or relieve illness or injury.

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

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

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

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

V

Vaccinations refer to:

- All basic immunisations and booster injections that are required by law in the country in which they are administered.
- Vaccination against Covid-19*, where this is not offered for free or only partially sponsored by the government in your country of residence.
- Medically necessary travel vaccinations.
- Malaria prevention tablets.

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

*We cover any Covid-19 vaccine when:

- The vaccine has completed the necessary clinical development process, including all pre-licensure vaccine clinical trials (phase I, II and III) which demonstrate its efficacy and safety.
- The vaccine has completed the multi-step approval process for the relevant regulating authority and is approved for use in the jurisdiction where you require it.

- The vaccine is not offered for free or only partially sponsored by the government of the country in which you reside.

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

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

W

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

We/Our/Us is Allianz Care.

Y

You/Your refers to the policyholder and any dependants named on the Insurance Certificate.

Exclusions

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

THE FOLLOWING EXCLUSIONS APPLY TO ALL OUR PLANS, UNLESS STATED OTHERWISE:

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

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

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

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

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

DENTAL VENEERS AND RELATED PROCEDURES
Dental veneers and related procedures.

DEVELOPMENTAL DELAY
Delay in cognitive or physical development, unless a child has not achieved the developmental milestones expected for a child of that age. We do not cover conditions in which a child is slightly or temporarily lagging in development. The developmental delay must have been quantitatively measured by qualified medical professionals and documented as a delay in development of at least 12 months.

DRUG ADDICTION OR ALCOHOLISM

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

EXPERIMENTAL OR UNPROVEN TREATMENT OR DRUG THERAPY

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

FAILURE TO SEEK OR FOLLOW MEDICAL ADVICE

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

FAMILY THERAPY AND COUNSELLING

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

FEES FOR THE COMPLETION OF A CLAIM FORM

Doctor's fees for the completion of a Claim Form or other administration charges.

GENETIC TESTING

Genetic testing, except:

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

HOME VISITS

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

INFERTILITY TREATMENT

Infertility treatment including medically assisted reproduction or treatment for any medical problems arising from it, unless you have a specific benefit for infertility treatment or have an Out-patient Plan. If you have an Out-patient Plan we will only cover non-invasive investigations into the cause of infertility (within the limits of your Out-patient Plan).

INJURIES CAUSED BY PROFESSIONAL SPORTS

Treatment or diagnostic procedures for injuries arising from taking part in professional sports.

INTENTIONALLY CAUSED DISEASES OR SELF-INFLICTED INJURIES

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

LOSS OF HAIR AND HAIR REPLACEMENT

Investigations into and treatment for loss of hair, including hair replacement unless the loss of hair is due to cancer treatment.

MEDICAL ERROR

Treatment required as a result of medical error.

OBESITY TREATMENT

Investigations into and treatment for obesity.

ORTHOMOLECULAR TREATMENT

Please refer to the definition of 'Orthomolecular treatment'.

PARTICIPATION IN WAR OR CRIMINAL ACTS

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

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

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 exception is reconstructive surgery necessary to restore function or appearance after a disfiguring accident or as a result of surgery for cancer, if the accident or surgery occurs during your period of cover.

PRE- AND POST-NATAL

Pre- and post-natal classes.

PRE-EXISTING CONDITIONS

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

- Indicated on a Special Conditions Form that we issue before your policy starts
- Conditions were not disclosed on the Application Form
  - The date we issue your Insurance Certificate or
  - The start date of your policy

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

PRODUCTS SOLD WITHOUT PRESCRIPTIONS

Products that can be purchased without a doctor's prescription, except where a specific benefit covering these costs appears in the Table of Benefits.

SLEEP DISORDERS

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

STAYS IN A CURE CENTRE

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

STERILISATION, SEXUAL DYSFUNCTION AND CONTRACEPTION

Investigations into, treatment of and complications arising from:

- Sterilisation.
- Sexual dysfunction (unless as a result of a total prostatectomy following cancer surgery).
- Contraception (including the insertion and removal of contraceptive devices and all other contraceptives, even if prescribed for medical reasons). The only exception is where contraceptives are prescribed by a dermatologist for the treatment of acne.

SURROGACY

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

TERMINATION OF PREGNANCY

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

TREATMENT IN THE USA IN THE FOLLOWING CASES

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

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

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

TREATMENT OUTSIDE THE GEOGRAPHICAL AREA OF COVER

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

TRIPLE/BART'S, QUADRUPLE OR SPINA BIFIDA TESTS

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

TUMOUR MARKER TESTING

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

VESSEL AT SEA

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

VITAMINS OR MINERALS

Products classified as:

- Vitamins and minerals (except during pregnancy or to treat diagnosed vitamin deficiency syndromes).
- Supplements such as, infant formula and cosmetic products.

These products are excluded even if they are medically recommended, prescribed or acknowledged as having therapeutic effects. Costs incurred as a result of nutritional or dietary consultations are also not covered, unless a specific benefit shows in your Table of Benefits.

TRAVEL COSTS

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

BENEFITS THAT ARE NOT IN YOUR TABLE OF BENEFITS

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

- Complications of pregnancy.
- Dental treatment, dental surgery, periodontics, orthodontics and dental prostheses. The only exception is oral and maxillofacial surgical procedures, which are covered within the overall limit of your Core Plan.
- Dietician fees.
- Emergency dental treatment.
- Expenses for one person accompanying an evacuated/repatriated person.
- Health and wellbeing checks including screening for the early detection of illness or disease.
- Home delivery.
- Infertility treatment.
- In-patient psychiatry and psychotherapy treatment.
- Laser eye treatment.
- Medical repatriation.
- Organ transplant.
- Out-patient psychiatry and psychotherapy treatment.
- Out-patient treatment.
- Prescribed glasses and contact lenses including eye examination.
- Prescribed medical aids.
- Preventive treatment.
- Rehabilitation treatment.
- Routine maternity, routine delivery and newborn care and complications of childbirth.
- Travel costs of insured family members in the event of an evacuation/repatriation.
- Travel costs of insured family members in the event of the repatriation of mortal remains.
- Travel costs of insured members to be with a family member who is at peril of death or who has died.
- Vaccinations.

ACCIDENTAL DEATH BENEFIT

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

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

  The passive war risk exclusion applies regardless of whether the claim arises directly or indirectly as a consequence of war, riots, civil disturbances, terrorism, criminal acts, illegal acts or acts against any foreign hostility, whether war has been declared or not.
- Being under the influence of drugs or alcohol.
- Death that takes place more than 365 days after the occurrence of the accident.
- Deliberate exposure to danger, except in an attempt to save human life.
- Intentional inhalation of gas or intentional ingestion of poisons or legally prohibited drugs.
- Flying in an aircraft, including helicopters, unless the insured person is a passenger and the pilot is legally licensed, or is a military pilot and has filed a scheduled flight plan when required by local regulations.
- Active participation in extreme or professional sports including, but not limited to:
  - Mountain sports such as abseiling, mountaineering and racing of any kind (except for racing on foot).
  - Snow sports such as bobsleigh, luge, mountaineering, skeleton, skiing off-piste and snowboarding off-piste.
  - Equestrian sports such as hunting on horseback, horse jumping, polo, steeple chasing or horse-racing of any kind.

- **Water sports such as potholing (solo caving) or cave diving, scuba diving to a depth of more than 10 metres, high diving, white water rafting and canyoning.**
- **Car and motorcycle sports such as motorcycle riding and quad biking.**
- **Combative sports.**
- **Air sports such as flying with a microlight, ballooning, hang gliding, paragliding, parascending and parachute jumping.**
- **Various other sports such as bungee jumping.**

Talk to us, we love to help!

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

24/7 Helpline for general enquiries and emergency assistance

English:	+353 1 630 1301
German:	+353 1 630 1302
French:	+353 1 630 1303
Spanish:	+353 1 630 1304
Italian:	+353 1 630 1305
Portuguese:	+353 1 645 4040
Toll free numbers:	www.allianzcare.com/en/pages/toll-free-numbers.html

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

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

Email: client.services@allianzworldwidecare.com

Fax: +353 1 630 1306

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www.allianzcare.com

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