



GlobalPass Choice
Individual Healthcare Plans for Latin America

Individual Benefit Guide

Valid from 1st May 2010

Allianz 
Allianz Worldwide Care

Welcome to Allianz Worldwide Care

This guide describes in detail how we offer you access to the care you need, when you need it most. It sets out the standard benefits and rules of your Allianz Worldwide Care plan. Please read this Individual Benefit Guide in conjunction with your Membership Certificate and Table of Benefits to ensure that you fully understand your level of cover.

Thank you for selecting Allianz Worldwide Care as your preferred healthcare provider. It is strongly advised that you read all documentation in relation to your chosen plan, to ensure you are fully satisfied with the selection of cover that you have made. Under the terms of your contract, you have 30 days from the date you receive your contract documents to change your mind and to cancel the contract with Allianz Worldwide Care.

You and your family can depend on Allianz Worldwide Care, as your healthcare company, to give you access to the best medical care possible. As specialists in international healthcare cover, we can provide you with a service that is fast, flexible and totally reliable.

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Introduction

Details of your healthcare contract with us.

Your contract is an annual contract between Allianz Worldwide Care and the members named in the Membership Certificate. The contract is composed of:

- The Individual Benefit Guide, the Membership Certificate, the Table of Benefits and any contract endorsements.
- Information provided to Allianz Worldwide Care in the signed Application Form including the “health declaration” section, or other supporting medical information provided by or on behalf of the members.

To ensure that you understand the details of your healthcare contract, please read this document carefully in conjunction with your Table of Benefits and your Membership Certificate. Your contract documentation details the benefits and limitations of your plan (i.e. the cover you have with us), explains how to make a claim and details all the terms and conditions of your contract with us.

The plan(s) you have chosen will be indicated in your Membership Certificate and in your Table of Benefits, which have both been included with this guide as part of your Membership Pack. Any further endorsements or special conditions unique to your cover will be indicated in the Membership Certificate (and will have been detailed in a Special Conditions Form issued prior to the inception of your contract).

Member services

Please find details of our member services below.

Helpline Service 24/7

Allianz Worldwide Care's in-house team of professional, multilingual staff are available 24 hours a day, seven days a week to handle your healthcare contract enquiries. Our Helpline staff have instant access to your healthcare contract details and any historical communication with us so that we can provide you with the assistance you require e.g. confirmation of cover or an update on the status of your claim. You can contact us by phone, fax or email as follows:

Helpline

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
Fax: + 353 1 630 1306
Email: client.services@allianzworldwidecare.com

Toll-free from Argentina: 0 800 444 2615
Toll-free from Brazil: 0 800 882 1545
Toll-free from Colombia: 1 800 518 1081
Toll-free from Mexico: 1 800 514 9887
Toll-free from the USA: 1 866 266 2182

For our **latest list of toll-free numbers**, please go to:
www.allianzworldwidecare.com/toll-free-numbers

Calls to our Helpline will be recorded and may be monitored for training, quality and regulatory purposes.

Please note that in some instances the toll-free numbers are not accessible from a mobile phone. In this case, please dial one of the Helpline numbers listed.

Emergency Assistance Service 24/7

In the event that you require emergency medical treatment in a hospital or clinic, you should, where possible, contact our Helpline as soon as possible (contact details on page 6). Our emergency assistance service is available 24 hours a day, 365 days a year to provide you with a range of emergency assistance services, such as arranging an emergency medical evacuation or providing pre-authorization to your hospital (see pages 53 to 56 for details on pre-authorization).

For emergency cases, pre-authorization is not required in advance of in-patient treatment, however, we should be advised within 48 hours of the event. At that point, for emergency

treatment only, please note that our Helpline can take Pre-authorization Form details over the telephone, giving us the opportunity to arrange for the direct settlement of your hospital bills, where possible.

MediLine Medical Advice Service 24/7

Our medical advice service, MediLine, offers you immediate telephone access to an experienced, English speaking medical team that provide comprehensive medical advice and information, such as:

- Pre- and post-operative treatment advice.
- Advice and information on a range of lifestyle issues e.g. nutrition and dietary

information, sports injuries, advice on smoking and alcohol consumption.

- Travel health information pre- and post-travel e.g. vaccinations.
- Patient drug information e.g. advice on medication usage and reaction.

You can access this medical advice service 24 hours a day, 365 days a year on

Tel: + 44 (0) 208 403 9970

Please be advised that for contract or claims queries, you should contact the Allianz Worldwide Care Helpline directly (contact details on page 6).

Please note that the MediLine and its health-related information and resources are not intended to be a substitute for professional medical advice or for the care that patients receive from their doctors. It is not intended to be used for medical diagnosis or treatment and information should not be relied on for that purpose.

Always seek the advice of your doctor before beginning any new treatment or if you have any questions regarding a medical condition. You understand and agree that Allianz Worldwide Care is not responsible or liable for any claim, loss or damage directly or indirectly resulting from your use of this advice line or the information or the resources provided through this service. Calls to the MediLine will be recorded and may be monitored for training, quality and regulatory purposes.

Membership Pack

Once you and Allianz Worldwide Care have signed a contract guaranteeing healthcare cover for you and your dependants (if relevant), a full Membership Pack will be provided. The Membership Pack contains the following items:

- **Your personalized Membership Card**
We supply a personalized Membership Card to every member, which contains our

essential contact numbers and addresses.

We suggest that you keep this card with you at all times. If you lose the card, or if a correction is required (e.g. the spelling of a name), don't worry, simply contact our Helpline via email or telephone and we will arrange for a new card to be sent to you.

- **Your Membership Certificate**

Your Membership Certificate details the plan that you have chosen for you and your dependants (if applicable). It also states the start date and renewal date of your cover (and effective dates of when dependants were added) as well as any endorsements or special conditions unique to your cover. It is important that you check that the information is correct. Please let us know as soon as possible, if any corrections are required.

- **Your Table of Benefits**

Your Table of Benefits will outline the cover available to you under your chosen plan as well as specify which benefits require pre-authorization. It is important that you read your Table of Benefits in conjunction with this guide and your Membership Certificate to ensure that you fully understand your cover.

- **Your Individual Benefit Guide**

This guide sets out the benefits and rules of your healthcare plan. The Individual Benefit Guide should be read in conjunction with your Membership Certificate and Table of Benefits.

- **A Pre-authorization Form**

It is important that the relevant sections of this form are completed by you and your

physician, and are submitted for approval prior to any treatment which requires pre-authorization. Pre-authorization is required for all treatments listed on pages 54 to 55 of this guide and marked with a **1** or a **2** in your Table of Benefits.

- **A Claim Form**

To ensure that your claim is paid quickly and without delay, please follow the guidelines on “How to claim” (see pages 49 to 57). Fully completed Claim Forms, once received in Dublin, will be processed within 48 to 60 hours of receipt, i.e. payment instructions will be sent to your bank. Where further information is required to complete the claim, this will be requested from you/your medical practitioner.

Hospital, Doctor and Health Practitioner Finder

Our medical provider directory is available on the Allianz Worldwide Care website:

www.allianzworldwidecare.com. This online directory allows you to search for hospitals, clinics, doctors and specialists on a country by country basis, with the ability to narrow down the search to specific regions and cities. Users can also search under medical practitioner categories e.g. Internal Medicine, as well as on specialism e.g. Neurosurgery. **You are not restricted to using the providers listed in this directory.**

What you are covered for

The following is an overview of your healthcare cover.

To ensure that you have all the information and documents that you need, your Membership Certificate and Table of Benefits have been included in your Membership Pack. Both of these specify the plan(s) selected by you. To understand the benefits for which you are covered, please read this guide carefully along with your Membership Certificate and your Table of Benefits.

This section provides an outline of the cover we provide under each plan. Please be aware that this cover is subject to our contract definitions (pages 61 to 70), exclusions (pages 26 to 33) and any special conditions indicated in the Membership Certificate (and in the Special Conditions Form issued prior to the inception of your contract). If you have any queries regarding the cover provided under your plan, simply contact our Helpline for confirmation of your entitlements.

Benefit limits

There are two kinds of benefit limits shown in the Table of Benefits. The maximum plan benefit, which applies to certain plans, is the maximum we will pay for all benefits in total, per member, per Membership Year, under that particular plan. Some benefits also have a specific benefit limit which is applied separately, for example “Nursing at home or in a convalescent home”.

Specific benefit limits may be provided on a “per Membership Year” basis or on a “per event” basis, such as per trip, per visit or per pregnancy. In some instances we will pay a percentage of the costs for the specific benefit e.g. “80% refund, max. US\$3,000”. Where the term “Full refund” appears next to certain benefits, please note that this refund is subject to the maximum plan benefit, if one applies to your plan(s).

Medical necessity and reasonable and customary charges

As a healthcare company, our clients expect us to control medical costs, where possible, in order to maintain affordable healthcare premiums. To do this, our team of highly experienced medical professionals ensures that planned medical interventions are appropriate and medically necessary. By medically necessary we mean treatment that is the most appropriate type and level of service required to treat a patient's condition, illness or injury.

In addition, our team of claims experts will ensure that we only reimburse medical providers where their charges are reasonable and customary. By reasonable and customary

we mean that the charges are in accordance with standard and generally accepted medical procedures of the country in which treatment is provided. If a claim is deemed by us to be inappropriate, we reserve the right to reduce the amount payable by us.

Pre-existing conditions

Pre-existing conditions are medical conditions or any related conditions for which symptom(s) have been shown at some point during the five years prior to commencement of cover, irrespective of whether any medical treatment or advice was sought. Any such condition or related condition about which you or your dependants could reasonably have been assumed to have known, or where pre-existence is clearly supported by one of three pre-defined sources of internationally published medical

evidence (PubMed:
www.ncbi.nlm.nih.gov/PubMed, ELSEVIER:
www.elsevier.com or Uptodate:
www.uptodate.com) will be deemed to be pre-
existing.

Please refer to the “Notes” section of your Table of Benefits to confirm if pre-existing conditions are covered within the limits of your plan(s).

Pre-existing conditions which have not been declared on the Application Form are not covered by us. In addition, conditions arising between completing the Application Form and confirmation of acceptance by our Underwriting Department will equally be deemed to be pre-existing and will not be covered if not disclosed.

Congenital and hereditary conditions

Cover is provided for the treatment of congenital and hereditary conditions as outlined in the “Definitions” section of this guide, up to an overall lifetime maximum of US\$750,000. Please note that cover is subject to the in-patient and out-patient benefits listed in the Table of Benefits and that pre-existing congenital and hereditary conditions are excluded. Pre-authorization is required for in-patient treatment.

Waiting periods

A waiting period is a period of time commencing on your contract 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 will indicate which benefits are subject to waiting periods. Please note that if plan or region of cover upgrades are requested and agreed to at contract renewal, waiting periods may apply.

Co-payments or deductibles

A deductible is an amount which is payable by you and which will be deducted by us from the eligible reimbursable sum. The deductible for a single member with up to one dependant applies separately to each person included under your membership. The deductible for a family (three or more contract members) applies collectively for all persons included under your membership. Please note that the deductible will apply per Membership Year.

Therefore if your claim is towards the end of the Membership Year and treatment continues over the renewal date, the annual deductible will be payable for treatment received in each Membership Year.

If you also have local cover in place (with another healthcare cover provider), you can request that any eligible in-patient/day-care claims paid for by the local healthcare cover provider be accepted as a contribution to the deductible amount on your Allianz Worldwide Care healthcare plan. This only applies to eligible in-patient/day-care treatment received in a hospital or clinic.

A co-payment is a percentage of the eligible costs incurred, which is payable by you. Some plans may include a maximum co-payment per

member, per Membership Year, and if so, the amount you have to pay will be capped at the amount stated in your Table of Benefits.

Please refer to your Table of Benefits to determine if any co-payments or deductibles apply to benefits within your chosen plan(s).

Where you are covered

Your Membership Certificate will confirm your chosen geographical area of cover.

Please note that if you relocate or return to your home country to make it your principal country of residence, your contract can continue as long as your home country is within your geographical area of cover. The only exception is where a member returns or relocates to the United States to make it their principal country

of residence, in which case cover cannot continue.

It should also be noted that cover in some countries is subject to legal restrictions, particularly for nationals of that country. It is your responsibility to ensure that your healthcare cover is legally appropriate and we would recommend that you seek independent legal advice with regard to this matter.

Your Core Plan explained

In-patient benefits

In the case of in-patient treatment, you will be reimbursed within the limits of your cover for the benefits included under your Core Plan. In-patient benefits include things like hospital accommodation, anesthesia and theatre

charges, surgical fees, surgical appliances, prostheses and diagnostic tests. Please refer to your Table of Benefits for details of the in-patient benefits available to you.

Pre-authorization is required for all in-patient benefits listed in your Table of Benefits (for details on pre-authorization, please refer to pages 53 to 56).

Organ transplant

This benefit covers you and your dependants for organ transplants (including medically necessary prescribed medication needed for pre and post transplant treatment) within the overall maximum benefit of the plan as stated in your Table of Benefits. Please note that a separate benefit limit may apply to the costs associated with organ, cell or tissue

procurement, transportation and harvesting, as well as any complications arising from procurement, transportation and harvesting or any consequences thereof. Please refer to your Table of Benefits for details of any benefit limits which apply.

We only pay for organ transplants that are required as a result of an eligible condition. We do not pay for transplants involving technical or animal organs. We also do not pay for expenses related to bone marrow, stem cell or cord blood storage and banking.

In-patient psychiatry and psychotherapy

This benefit provides you and your dependants with cover for psychiatry and psychotherapy, up to the limit shown in the Table of Benefits. A waiting period of 24 months applies. You can

claim a maximum of 90 days treatment over the lifetime of your membership.

Accommodation costs for one parent staying in hospital with a member aged under 18

In the event of a member requiring hospitalization, the cost of one parent's accommodation staying with a member under 18 years of age will be covered for the duration of the admission to hospital. In the event that no suitable bed is available in the hospital we will cover the equivalent of a three star hotel daily room rate. This benefit is fully covered within the overall maximum benefit of the plan.

Emergency in-patient dental treatment

This benefit provides you and your dependants with full refund for emergency in-patient dental

treatment received in a hospital after a serious accident. Please note that cover under this benefit does not extend to follow-up dental treatment, dental surgery, dental prostheses, orthodontics or periodontics. If cover is provided for these benefits, they will be listed separately in your Table of Benefits.

Other benefits under your Core Plan

Some or all of the following benefits are included in your chosen plan(s). To confirm your benefit entitlement and to check which benefits require submission of a Pre-authorization Form, please refer to your Table of Benefits. If you would like any further clarification, our Helpline team will be happy to assist you.

Day-care treatment

Cover is provided under our Core Plan for planned day-care treatment received in a hospital or day-care facility. Please refer to the “Definitions” section of this guide for further details on the day-care treatment benefit. Please note that pre-authorization is required.

Out-patient surgery

Cover is also provided for surgical procedures performed in a surgery, hospital, day-care facility or out-patient department. Cover includes exploratory examinations and diagnostic tests carried out under anaesthesia. Please note that pre-authorization is required.

Nursing at home or in a convalescent home

Where this benefit is provided, you are covered for nursing received at home or in a convalescent home, if the nursing is provided immediately after or instead of hospitalization. The maximum number of days and amount per day covered are indicated in the Table of Benefits. Please note that pre-authorization is required. It should also be noted that this benefit is not payable in respect of palliative care or long term care, which, where provided, are under separate benefits.

Rehabilitation treatment

If cover is provided under your plan, this is for treatment which takes place in a licensed rehabilitation facility immediately after the acute medical treatment ceases. The level of

cover provided will be stated in your Table of Benefits. Please note that pre-authorization is required.

Local ambulance

Cover is provided for ambulance transport, required for an emergency or due to medical necessity, to the nearest available and appropriate hospital or licensed medical facility, up to the maximum amount shown in the Table of Benefits.

Medical evacuation

This benefit provides for ambulance, helicopter or airplane transportation to the nearest appropriate medical center (which may or may not be located in your home country), if the necessary treatment for which you are covered

is not available locally or if adequately screened blood is unavailable in the event of an emergency.

The medical evacuation will be carried out in the most economical way, having regard to your medical condition. Your physician should request the medical evacuation. Please note that submission of a Pre-authorization Form will be required.

Following completion of treatment, we will also cover the cost of the return trip, at economy rates, for the evacuated member to return to his/her principal country of residence.

If medical necessity prevents the member from undertaking the evacuation or transportation following discharge from an **in-patient episode of care**, we will cover the reasonable cost of hotel

accommodation up to a maximum of seven days, comprising of a private room with en-suite facilities. We do not cover costs for hotel suites, four or five star hotel accommodation or hotel accommodation for an accompanying person.

Where a member has been evacuated to the nearest appropriate medical center and is subsequently discharged from hospital yet requires **ongoing treatment**, we will agree to cover the reasonable cost of hotel accommodation comprising of a private room with en-suite facilities. The cost of such accommodation must be more economical than successive transportation costs to/from the nearest appropriate medical center and the 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, endeavor to locate and transport screened blood and sterile transfusion equipment, where this is advised by the treating physician. We will also endeavor to do this when our medical experts so advise. Allianz Worldwide Care and its agents accept no liability in the event that such endeavors are unsuccessful or in the event that contaminated blood or equipment is used by the treating authority.

Expenses for one person accompanying an evacuated person

This benefit enables one person to travel with an evacuated person. If this cannot take place in the same transportation vehicle, round trip transport at economy rates will be paid for. There is a maximum amount that can be

claimed under this benefit, as shown in the Table of Benefits. Please note that accommodation and other related expenses are not covered and that pre-authorization is required.

Repatriation of mortal remains

In the event of death we will cover the cost of transportation of the member's mortal remains from the principal country of prior residence to the country of burial.

Covered expenses include, but are not limited to, expenses for embalming, a container legally appropriate for transportation, shipping costs and the necessary government authorizations. Cremation costs will only be covered in the event that this is required for legal purposes. Costs incurred by any accompanying persons

are not covered. All covered expenses in connection with the repatriation of mortal remains must be pre-approved by us using the Pre-authorization Form.

CT, MRI, PET and CT-PET scans

CT, MRI, PET and CT-PET scans carried out on an in-patient or out-patient basis, are fully covered within the limits of your Core Plan. Submission of a Pre-authorization Form is required for MRI, PET and CT-PET scans (but not for CT scans).

Oncology

We provide cover for specialist fees, diagnostic tests, radiotherapy, chemotherapy and hospital charges incurred in relation to the planning and carrying out of treatment for cancer, from the point of diagnosis. Submission of a Pre-

authorization Form is required for in-patient and day-care treatment only.

Palliative care

Where applicable to your Core Plan, we will provide cover for palliative care, subject to the benefit limit stated in your Table of Benefits, for in-patient, day-care or out-patient treatment following the diagnosis that the condition is terminal and treatment can no longer be expected to cure the condition. As part of this benefit, we will also pay for your physical care, psychological care as well as hospital or hospice accommodation, nursing care and prescription drugs. Please note that pre-authorization is required.

Long term care

Cover is provided for long term care, subject to the benefit limit stated in your Table of Benefits for 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. Please note that pre-authorization is required.

Routine maternity

If included in your plan, cover includes any medically necessary costs incurred during pregnancy and childbirth, including hospital charges, specialist fees, the mother's pre- and post-natal care, mid-wife fees (during labour

only) as well as newborn care. Costs related to complications of pregnancy and complications of childbirth are not payable under routine maternity. In addition, any non-medically necessary caesarean sections will be covered up to the cost of a routine delivery in the same hospital, subject to any benefit limit in place.

Please note that a benefit limit and waiting period may apply to routine maternity. Please refer to your Table of Benefits for details. Submission of a Pre-authorization Form is required for in-patient treatment only.

Complications of pregnancy

Where covered, complications of pregnancy relate to the health of the mother and refer to conditions that arise during the pre-natal stages of pregnancy.

Please note that a waiting period may apply to cover for complications of pregnancy. Please refer to your Table of Benefits for details. Submission of a Pre-authorization Form is required.

Complications of childbirth

If included in your plan, complications of childbirth refer to conditions that arise during childbirth that require a recognized obstetric procedure. Complications of childbirth also refer to medically necessary caesarean sections.

Please note that a benefit limit and waiting period may apply to complications of childbirth. Please refer to your Table of Benefits for details. Submission of a Pre-authorization Form is required.

Cover for newborn children

Newborn children (with the exception of multiple birth babies born as a result of medically assisted reproduction) will be accepted for cover from birth without the need for medical underwriting, provided that we are notified within four weeks of the date of birth and that the birth mother has been covered by us for a minimum of six continuous months prior to the birth. Notification of the birth after four weeks will result in the newborn child being underwritten and cover will only commence from the date of acceptance.

Single birth babies born as a result of medically assisted reproduction will be accepted for cover from birth without the need for medical underwriting, provided that we are notified

within four weeks of the date of birth and that the birth mother has been covered by us for a minimum of six continuous months prior to the birth.

Multiple birth babies born as a result of medically assisted reproduction will be subject to full medical underwriting. If accepted on cover, in-patient treatment for multiple birth babies born as a result of medically assisted reproduction will be covered up to US\$37,500 per child for the first three months following birth. Out-patient treatment will be covered under the limits of the Out-patient Plan.

Your Out-patient Plan explained

Your Out-patient Plan, if selected, includes some or all of the following benefits:

- Doctor fees.
- Prescription drugs.
- Diagnostic tests, including X-rays.
- Prescribed physiotherapy, speech therapy, oculomotor therapy, occupational therapy, chiropractic treatment, osteopathy, homeopathy and acupuncture.
- Psychiatry and psychotherapy.
- Routine health checks including cancer screening.

Please note that submission of a Pre-authorization Form may be required for some of these benefits. A waiting period may also apply. For details of cover, please refer to your Table of Benefits in conjunction with this guide.

Your Dental Plan explained

If you have selected a Dental Plan, this will be indicated in your Table of Benefits. Please note that your Dental Plan may contain an overall maximum plan benefit. To confirm the details of your dental cover, including the level of refund and whether waiting periods apply, please refer to your Table of Benefits in conjunction with this guide.

What your healthcare cover does not pay for

Although we cover most illnesses, expenses incurred for the following treatments, medical conditions and procedures are not covered under the contract unless they are confirmed in the Table of Benefits or in any written contract endorsement.

1. Treatment **outside the geographical area of cover** as stated on your Membership Certificate, unless authorized by us.
2. **Pre-existing conditions** are covered under this contract, unless indicated otherwise in a Special Conditions letter that issues with your Membership Certificate, if relevant.
3. Products classified as **vitamins** or **minerals** (except during pregnancy or to treat diagnosed, clinically significant vitamin deficiency syndromes), nutritional or dietary consultations and supplements, including, but not limited to, special infant formula and cosmetic products, even if medically recommended or prescribed, or acknowledged as having therapeutic effects.

However, please note that any pre-existing conditions that were not declared by you on the Application Form will not be covered under the contract. Conditions arising between completing the Application Form and confirmation of acceptance by the Underwriting Department of Allianz Worldwide Care will equally be deemed to be pre-existing, and if not declared will not be covered.

4. Products that can be purchased without a **doctor's prescription**.
5. Unless stated otherwise in the Table of Benefits, cover is not provided for investigations into, treatment and complications arising from **infertility, sterilization, sexual dysfunction** and **contraception**, including insertion and

removal of contraceptive devices and all other contraceptives, even if prescribed for medical reasons. The only exception is the prescribing of contraceptives for the treatment of acne where prescribed by a dermatologist.

6. **Termination of pregnancy** except in the event of danger to the life of the pregnant woman.
7. In-patient treatment for **multiple birth babies born as a result of medically assisted reproduction** is limited to US\$37,500 per child for the first three months following birth. Out-patient treatment will be covered under the limits of the Out-patient Plan.
8. Any treatment carried out by a **plastic surgeon**, whether or not for medical/psychological purposes. The only exception is re-constructive 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 membership.
9. Stays in a **cure center, bath center, spa, health resort or recovery center**, even if the stay is medically prescribed.
10. Care and/or treatment of **intentionally caused diseases or self-inflicted injuries**, including a suicide attempt.
11. Care and/or treatment of **drug addiction or alcoholism**.
12. Illnesses, accidents and the consequences thereof, as well as instances of death that are

related to the misuse of **alcohol** or **drugs** by the covered member.

13. **Developmental delay** unless a child has not attained developmental milestones expected for a child of that age, in cognitive or physical development. 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 personnel and documented as a 12 month delay in cognitive and/or physical development.
14. We do not cover treatment for conditions such as **conduct disorder**, **attention deficit hyperactivity disorder**, **autism spectrum disorder**, **oppositional defiant disorder**, **antisocial behavior**, **obsessive-compulsive**

disorder, **attachment disorders**, **adjustment disorders**, **eating disorders** or treatments that encourage positive social-emotional relationships, such as **communication therapies**, **floor time** and **family therapy**.

15. **Speech therapy** is only eligible for reimbursement in the context of a diagnosed physical impairment such as, but not limited to, nasal obstruction, neurogenic impairment (e.g. lingual paresis, brain injury) or articulation disorders involving the oral structure (e.g. cleft palate). We do not pay for speech therapy related to developmental delay, dyslexia, dyspraxia or expressive language disorder.
16. **Psychotherapy treatment** on an in-patient or out-patient basis, is only covered where you or your dependants are initially diagnosed

by a psychiatrist and referred to a clinical psychologist for further treatment.

17. Where covered, **out-patient psychotherapy treatment** is initially restricted to 10 sessions per condition, after which treatment must be reviewed by the referring psychiatrist. Should further sessions be required, a progress report must be submitted to us, which indicates the medical necessity for any further treatment. Costs in respect of a family therapist or counselor are not covered.
18. Treatment for any illnesses, diseases or injuries resulting from **active participation in war, riots, civil disturbances, terrorism, criminal acts or acts against any foreign hostility**, whether war has been declared or not.
19. Treatment for any medical conditions arising directly or indirectly from **chemical contamination, radioactivity or any nuclear material** whatsoever, including the combustion of nuclear fuel.
20. Investigations into or treatment of **sleep disorders**, including insomnia.
21. Expenses incurred during the acquisition of an organ relating to **bone marrow, stem cell or cord blood storage and banking**.
22. Treatments or diagnostic procedures of **injuries arising from an engagement in professional sports**.
23. Any form of **treatment or drug therapy** which is **experimental**, or **unproven** from an evidence based perspective and/or is **not**

- approved by the Food and Drug Administration of the USA for the medical condition in question.
24. **Orthomolecular treatment** (please refer to definition 1.45).
25. **Consultations** performed as well as **any drugs or treatments prescribed** by you, your spouse, parents or children.
26. **Medical practitioner fees** for the **completion of a Claim Form** or other administration charges.
27. **Genetic testing** except for DNA tests when directly linked to an eligible amniocentesis i.e. in the case of women aged 35 or over.
28. **Pre- and post-natal classes**.
29. **Triple/Bart's, Quadruple or Spina Bifida tests**, except for women aged 35 and over.
30. Investigations into and treatment of **obesity**.
31. Investigations into and treatment of **loss of hair** and any hair replacement unless the loss of hair is due to cancer treatment.
32. **Complementary treatment** with the exception of those treatments indicated in the Table of Benefits.
33. Treatment required as a result of **failure to seek or follow medical advice**.

- 34. Elective treatment required as a result of medical error.
- 35. Treatment to change the **refraction of one or both eyes (laser eye correction)**, including refractive keratectomy (RK) and photorefractive keratectomy (PRK).
- 36. **Sex change operations** and related treatments.
- 37. **Treatment in the USA** is not covered, if we know or suspect that cover was purchased for the purpose of traveling to the USA to receive treatment for a condition, when the symptoms of the condition were apparent to the member prior to the purchase of cover.
- 38. Hospitalization that is required for the purpose of **general nursing care** or **any other purpose, other than for receiving treatment covered by your membership.**
- 39. Treatment for or arising from **AIDS, HIV** or any **sexually transmitted disease** except when AIDS or HIV are contracted as a result of a blood transfusion which takes place during your membership.
- 40. Treatment directly related to **surrogacy** whether you are acting as surrogate, or are the intended parent.
- 41. Costs related to the supplying and fitting of **prescribed medical aids**, including, but not limited to, hearing aids, speaking aids (electronic larynx), crutches, walking sticks, wheelchairs, orthopedic supports/braces, artificial limbs, stoma supplies, graduated compression stockings, orthopedic arch-

- supports as well as spectacles and contact lenses.
42. **Eye examinations** carried out by optometrists or ophthalmologists.
43. **Travel costs** to and from medical facilities (including parking costs) for eligible treatment except any travel costs covered under local ambulance and evacuation benefits.
44. Treatment for or arising from **deafness** caused by maturing or ageing.
45. Expenses incurred because of **complications directly caused by an illness, injury or treatment for which cover is excluded or limited** under your plan.
46. The following treatments, medical conditions or procedures, or any adverse consequences thereof, are **not covered** unless otherwise indicated in your Table of Benefits:
- 46.1 **Dental treatment, dental surgery, periodontics, orthodontics and dental prostheses** with the exception of **oral surgical procedures**, which are covered within the overall limit of your Core Plan.
 - 46.2 **Out-patient treatment.**
 - 46.3 **Emergency out-patient dental treatment.**
 - 46.4 **Routine maternity.**
 - 46.5 **Complications of pregnancy and complications of childbirth.**
 - 46.6 **Preventive treatment.**

- 46.7 Routine health checks including cancer screening.
 - 46.8 Out-patient psychiatry and psychotherapy treatment.
 - 46.9 Palliative care.
 - 46.10 Nursing at home or in a convalescent home.
47. If an Out-patient Plan does not form part of your chosen cover, you will not be covered for **treatment received on an out-patient basis** (i.e. in the practice or surgery of a medical practitioner, therapist or specialist or emergency room that does not require the patient to be admitted to hospital) except for out-patient treatment that is included as part of the Core Plan e.g. CT, MRI and PET scans.

Paying premiums and general information

The following section provides you with general information on paying your premiums and details on other important aspects of your membership.

Paying premiums

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

You are required to pay the premium due to us in advance for the duration of your membership. The amount you have agreed to pay and the method of payment you have chosen will be shown on your quotation prior to the issue of your contract. The **initial premium** or the first premium instalment is payable immediately after our acceptance of 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. Please note that if there is any difference between the agreed quotation and your payment details letter/invoice, you should contact us immediately. We are not responsible for payments made through third parties.

Your premium should be paid in US Dollars. If you are unable to pay your premium for any reason, please contact our Helpline. Changes in payment terms can be made at contract 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 healthcare 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 healthcare contract is deemed to be null and void, unless we assert a claim to the premium in court within three months of the contract start date or the conclusion of the healthcare contract.

If a **subsequent premium** is not paid in time, we may, in writing and at the principal member's expense, set a time limit of not less than two weeks for the principal member to pay the amount due. Thereafter we may terminate the contract in writing with immediate effect and shall thereby be exempt to pay benefits.

The effects of termination shall cease if the principal member makes a payment within one month after the termination or, if the

termination was combined with the setting of time, within one month after the expiration of the time for payment, provided that **no claims have been incurred** in the intervening period.

The **premium** will be adjusted once a year at the renewal date, at which time we also reserve the right to alter our contract terms and conditions.

Paying other charges

In addition to paying premiums, you also have to pay us the amount of any taxes, levies or charges relating to your membership that may be imposed after you join and that we are required by law to pay or to collect from you. The amount of any taxes, levies or charges that you have to pay us is shown on your payment details letter/invoice.

You are required to pay to us any such taxes, levies and charges when you pay your premiums, unless otherwise required by law.

Changes to premiums and other charges

Each year on the renewal date, we may change how we calculate your premiums, how we determine the premiums, what you have to pay and the method of payment. Please be assured that if we do make changes, they will only apply from your renewal date.

We may change the amount you have to pay us in respect of taxes, levies or charges at any time if any such tax, levy or charge is introduced or if there is a change in the rate of any such tax, levy or charge.

If we do make any changes to your premiums or to the amount you have to pay in respect of any taxes, levies or charges, we will write to tell you about the changes. If you do not accept any 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.

Important events

Throughout this guide, you will see references to important events such as when you start, renew or end your membership, or include other people as your dependants. This section

explains exactly when, and how, these events take place. Our aim is to continuously improve our service to our members. In order to help us do this, if for any reason you cancel your membership, please let us know the reason why.

Starting your membership

The contract shall be valid as of the start date (or effective date if you are a dependant) stated on the Membership Certificate. The cover will continue for 12 months and is strictly conditional upon our acceptance of the Application Form, as indicated by your receipt of the Membership Certificate. No benefit will be payable under your contract until the initial premium has been paid, with subsequent premiums being paid when due.

When cover starts and ends for dependants included in your membership

If any other person is included as a dependant under your membership, their membership will start on the effective date shown on your most recent Membership Certificate which lists them as a dependant. Their membership will continue for as long as you remain the principal member (and as long as any child dependants remain under the defined age limit).

If your membership ceases, your dependants' cover will also end; however the dependants on the Membership Certificate can apply for cover in their own right should they wish to do so and if they meet the minimum age requirements. Cover will also cease for any dependants who exceed the defined age limit for a dependant; however they can also apply for cover in their

own right, should they wish to do so. No further underwriting will apply if the same level of cover is continued.

Adding dependants

You may apply to include any of your family members under your membership as one of your dependants, providing you complete the necessary Application Form.

Newborn infants (with the exception of multiple birth babies born as a result of medically assisted reproduction) will be accepted for cover from birth without the need for medical underwriting, provided that we are notified within four weeks of the date of birth and that the mother has been covered with us for a minimum of six continuous months prior to the

birth. Notification of the birth after four weeks will result in the newborn child being underwritten and cover will only commence from the date of acceptance.

Single birth babies born as a result of medically assisted reproduction will be accepted for cover from birth without the need for medical underwriting, provided that we are notified within four weeks of the date of birth and that the birth mother has been covered by us for a minimum of six continuous months prior to the birth.

Multiple birth babies born as a result of medically assisted reproduction will be subject to full medical underwriting. If accepted on cover, in-patient treatment for multiple birth babies born as a result of medically assisted

reproduction will be covered up to US\$37,500 per child for the first three months following birth. Out-patient treatment will be covered under the limits of the Out-patient Plan.

Renewing your membership

The duration of the healthcare contract is 12 months. The contract is automatically renewed for the next Membership Year provided the plan you (and your dependants if applicable) have is still available, all premiums due to us have been paid and the payment details we have for you are still valid on the contract renewal date. For example, we would need to have up-to-date credit card details for credit card payers. Please note that when you receive a new credit card with a new expiry date, you will need to notify us of this change.

One month before the renewal date, you will receive a new Membership Certificate indicating the premium for the next Membership Year. If you do not receive your Membership Certificate within one month prior to your renewal date, it is important that you notify us.

You may terminate the contract by giving us 30 days written notice, from the date that the renewal Membership Certificate is made available to you. We have the right to make the renewal subject to special conditions. Contract terms and conditions, as well as the Table of Benefits existing on the renewal date, will apply for the entire new Membership Year.

Please note that if a request is made at renewal to change the principal member, the proposed replacement principal member will be required to complete an Application Form and full

medical underwriting will apply. The death of the existing principal member is the only exception to this rule (please see the next section: 'Ending your membership' for further details).

Ending your membership

Please remember that your membership will automatically 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 new Application Form, if you pay the outstanding premiums within 30 days. If you are unable to pay your premiums for any reason, please contact our Helpline.
- If you do not pay the amount of any taxes, levies or charges that you have to pay under your agreement with us on or before the date they are due.
- Upon the death of the principal member. If the principal member dies, the next named dependant on the Membership Certificate may apply to us to become the principal member in his/her own right and include the other dependants under his/her membership. If they apply to do this within 28 days we will, at our discretion, not add any further special restrictions or exclusions to their cover that are personal to them, in addition to those which applied to them under the scheme when the principal member died.
- If you become ordinarily resident in the USA.

If you return to your home country to make it your principal country of residence, your contract can continue as long as your home country is within your area of cover. The only exception is where a member returns or relocates to the United States to make it their principal country of residence, in which case cover cannot continue. Please note that cover in some countries is subject to legal restrictions, particularly for nationals of that country. It is your responsibility to ensure that your healthcare cover is legally appropriate and we would recommend that you seek independent legal advice in this regard.

We can end a person's membership and that of all the other people listed on the Membership Certificate if there is reasonable evidence that the person concerned has misled, or attempted to mislead us. By this, we mean giving false

information or withholding pertinent information from us, or working with another party to give us false information, either intentionally or carelessly, which may influence us when deciding:

- Whether you (or they) can join the scheme.
- What premiums you have to pay.
- Whether we have to pay any claim.

Please see the following section entitled "Cancellation and fraud" for further details.

General information

Cancellation and fraud

- a. We will cancel the contract where you have not paid the full premium due and owing. We shall notify you of this cancellation and

the contract shall be deemed cancelled from the date that the said premium payment became due and payable. However, if the premium is paid within 30 days of the due date, the healthcare cover will be reinstated and we will cover any claims which occurred during the period of delay. However, if the outstanding premium is paid after the 30 day limit, you must complete a Switch Form before your contract can be re-instated and cover will be subject to underwriting.

- b. Incorrect disclosure/non-disclosure of any material facts, by you or your dependants, which may affect our assessment of the risk, including, but not limited to, those relating to the questions on the Application Form, will render the contract void from the commencement date, unless we confirm otherwise in writing. Conditions arising

between signing the Application Form and confirmation of acceptance by the Underwriting Department of Allianz Worldwide Care will be deemed to be pre-existing. If the applicant is not sure whether something is material, the applicant is obliged to inform us. 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.

- c. If a claim is in any respect false, fraudulent, intentionally exaggerated or if fraudulent means/devices have been used by you or your dependants or anyone acting on your or

their behalf, to obtain benefit under this contract, we will not pay any benefits for that claim. The amount of any claim settlement made to you, before the fraudulent act or omission was discovered, will become immediately due and 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.

Death

Upon the death of the principal member or a dependant, we should be notified in writing **within four weeks**. The corresponding healthcare

cover will be terminated and a pro rata repayment of the premium will be made if no claims have been filed. We reserve the right to request a death certificate before a refund is issued. Upon the death of the principal member, a dependant on the contract can apply to become the new principal member, if they wish to do so, and if they meet the minimum age requirements.

Your right to cancel

Under the terms of your contract, you have 30 days from the date you receive the terms and conditions of your inception/renewal contract documents to change your mind and to cancel the contract. Such notification of your intention to cancel should be addressed to the Client Services Team. You cannot backdate the cancellation of your membership.

Provided that we receive your cancellation notice within 30 days (of receipt of your inception/renewal Membership Certificate), you will be entitled to a full refund of premiums paid relating to the most recent annual contract period, provided that no claim has been made under the contract. If you choose not to exercise your right to cancel within 30 days, the contract will be binding on both parties and the premium for that Membership Year will be payable, according to the payment frequency chosen by you.

Upon contract inception/renewal, you may also cancel the membership of any dependants listed on your inception/renewal Membership Certificate, for any reason, within this 30 day period, by writing to us at:

Client Services Team
Allianz Worldwide Care
18B Beckett Way
Park West Business Campus
Nangor Road
Dublin 12, Ireland

If you do so, you will be entitled to a full refund of all premiums paid relating to the dependant(s), subject to no claims having been made on their behalf.

Making changes to your cover

Changes to cover can only be made at contract renewal. If you want to change your level of cover, please **contact us before your contract renewal date** to discuss your options. If you want to increase your level of cover, we may ask you to complete a medical history questionnaire form,

and/or to agree to certain exclusions or restrictions to your cover before we accept your application. An additional premium amount will be payable and waiting periods may apply.

If you move to a country within your existing area of cover, there is nothing to do except to inform us of your new address, contact details and bank account/credit card details (depending on how you have opted to pay your premiums) as soon as possible. Your cover will continue as before at no additional cost. The only exception is where a member returns or relocates to the United States to make it their principal country of residence, in which case cover cannot continue.

If, however, you move to a country outside your area of cover (for example, if your area of cover is “Latin America and Caribbean only” and you

move to France), you will need to contact us to extend your area of cover. An additional premium amount will be payable.

If we make changes

We may change the benefits and rules of your membership on your renewal date. Any changes we make will only apply from your renewal date, regardless of when the change is made. These changes could affect, for example:

- How much your premiums will be.
- How often you have to pay them.
- The cover you receive.

We will not add any restrictions or exclusions which apply uniquely to an individual's cover for medical conditions that started after they joined the scheme, provided:

- They gave us the information we asked them for before joining and
- They have not applied for an increased level of cover.
- You add a dependant, such as a newborn child, to your membership.
- We need to record any other changes which you have requested, or that we are entitled to make, such as changing the way you pay your premium.

We will of course 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 takes effect, or
- Within 30 days of us telling you about the changes, whichever is later.

Amending your membership details

We will provide you with a new Membership Certificate if either of the following occur:

Your new Membership Certificate will replace any earlier version(s) you possess as from the issue date shown on the new Membership Certificate.

Other parties

No other person is allowed to make or confirm any changes to your membership on our behalf, or decide not to enforce any of our rights. No change to your membership will be valid unless it is confirmed in writing. Any confirmation of your cover will only be valid if it is confirmed in writing by us.

Contract expiry

Please note that upon the expiry of your healthcare cover, your right to reimbursement ends. Any expenses covered under the contract and incurred during the period of cover shall be reimbursed up to six months after the expiry of the healthcare cover. However, any ongoing or further treatment that is required after the expiry date of your contract will no longer be covered.

If your treatment is needed as a result of somebody else's fault

You must write and tell us as soon as possible, if you are claiming for treatment that is needed when somebody else is at fault. For example, if you need treatment for an injury suffered in a

road accident in which you are a victim. If so, you will need to take any reasonable steps we ask of you to obtain the contract details of the person at fault so that we can recover, from the other provider, the cost of the treatment paid for by us.

If you are able to recover the cost of any treatment for which we have paid, you must repay that amount (and any interest) to us.

If you hold other relevant contracts of cover

You must write to tell us if you have any other contracts which would provide cover for the cost of the treatment or benefits you have claimed from us. If you do have other contracts of cover, we will only pay our share of the cost of the treatment.

If you change your address/email address

Any change in your home, business or email address should be communicated to us as soon as possible. This information will help us to keep in contact with you.

Correspondence

Letters between us must be sent by post (with the postage paid) or email. We usually do not return original documents to you. However, if you ask us at the time you send the original documents to us, we will of course return them to you.

Applicable law

Your membership is governed by Irish law. Any dispute that cannot otherwise be resolved will be dealt with by courts in Ireland.

How to claim

Before you make a claim, **please check that your plan covers the treatment you are seeking.** Please refer to your Table of Benefits and call our Helpline if you have any queries.

In-patient claims

If you have to go to a hospital, we will, where possible and with sufficient notice, arrange for direct settlement with the medical provider subject to any co-payments, deductibles and benefit limits i.e. where possible, Allianz Worldwide Care will settle the bill for you by dealing directly with the hospital.

All in-patient treatment requires submission of a Pre-authorization Form prior to commencement of treatment. Further important details on **pre-authorization** can be found on pages 53 to 56.

To arrange for direct settlement, we can assist you more quickly and efficiently if the following steps are taken:

For **planned** treatment:

1. Please bring a Pre-authorization Form with you. You and your physician will need to complete the relevant sections of the Pre-authorization Form.
2. Once fully completed, please send the Pre-authorization Form to us at least five working days prior to treatment so that we can ensure there will be no delays at the time of admission. You can submit it in the following ways:
 - Scan and email to medical.services@allianzworldwidecare.com
or
 - Fax to + 353 1 653 1780 or

- Post to the address shown on the Pre-authorization Form.

For **emergency** treatment:

While pre-authorization is not required in advance of emergency treatment, either you, your physician, one of your dependants or a colleague needs to inform us about the hospital admission **within 48 hours** of the event to ensure that no pre-authorization penalty is applied.

At that point, **for emergency treatment only**, our Helpline can accept submission of Pre-authorization Forms over the phone. This way, after you have informed us about the emergency, it gives us the opportunity to arrange for the direct settlement of your hospital bills, where possible. Please have as many

details as possible ready to give over the phone, including the contact details of your doctor.

Out-patient or dental claims

For out-patient or dental treatment, unless you have been informed of a different settlement arrangement, you will need to pay the medical provider for these costs at the time of treatment and then seek reimbursement from us, which will be subject to the benefit limits of your plan.

When you visit a medical practitioner, dentist, physician or specialist on an out-patient basis, please take a Claim Form with you and follow the steps below:

1. You will need to get an invoice from the doctor/medical provider which states the

diagnosis or medical condition treated, the nature of the treatment and the fees charged.

2. Please complete the relevant sections of the Claim Form. The sections to be completed by your doctor only need to be filled in if the invoice does not state the diagnosis and nature of the treatment (if these details are not shown on the invoice, you are responsible for ensuring that your doctor provides them in the Claim Form).
3. When submitting your Claim Form (to the address stated on the form), please attach all original supporting documentation, invoices and receipts e.g. medical practitioner/physician invoices and pharmacy receipts with related prescriptions (if available).

Claims will be paid promptly by cheque or bank wire transfer in US\$ only. Where further information is required to complete the claim, this information will be requested from you/your medical practitioner.

Please note the following important points:

- It is your responsibility to keep copies of correspondence (in particular, copies of Claim Forms and medical receipts) as we cannot be held responsible for correspondence lost in the post.
- No benefit will be payable under your contract until the initial premium has been paid with subsequent premiums being paid when due.

- We cannot accept credit card receipts without invoices.
- A separate Claim Form is required for each person claiming and for each medical condition being claimed for.
- Please note that some out-patient treatments require submission of a Pre-authorization Form prior to treatment taking place. Please refer to the Table of Benefits to check which benefits require pre-authorization.
- If the amount to be claimed is less than the deductible figure under your plan, please remember to retain the Claim Form and receipts - **do not destroy or dispose of them.** Keep collecting all out-patient receipts and Claim Forms until you reach an amount in excess of your plan deductible. Then forward all completed Claim Forms together with original receipts/invoices.
- Please ensure that the **payment details that you supply on the Claim Form are correct**, to avoid delays to claims settlement.
- Please note that **only costs for incurred treatment will be reimbursed** within the limits of your contract, after taking into consideration any required pre-authorization, and this will be net of any deductibles or co-payments mentioned in the Table of Benefits.
- Claims should be **submitted no later than six months after the end of each Membership Year, or if cover is cancelled within the Membership Year, no later than six months after the end of the contract cover.** Beyond

this time we are not obliged to settle the claim.

- **Upon expiry of your contract, your right to reimbursement ends** (for more details, please refer to the section on “Contract expiry” on page 47).

You and your dependants agree to assist us in obtaining all necessary information 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 physician. We may, at our own expense, request a medical examination by our medical representative when we deem this to be necessary. All information will be treated in strict confidence. We reserve the right to withhold benefits if you or your dependants have not honored these obligations.

Pre-authorization

What is pre-authorization?

Certain treatments and costs require you to submit a Pre-authorization Form in advance. Following approval by Allianz Worldwide Care, cover for these required treatments or costs can then be guaranteed. In the Table of Benefits, benefits which require pre-approval through submission of a Pre-authorization Form are indicated by either a 1 or a 2. When required, the relevant sections of a Pre-authorization Form need to be completed by you and your physician, and then submitted to us for approval prior to treatment.

Please contact us **at least five working days prior to receiving treatment** so that we can ensure that

there will be no delays at the time of admission. We will respond within 60 hours of receipt of a fully completed form.

Pre-authorization is not required in advance of emergency treatment, however you do need to inform us within 48 hours of the emergency event. At that point, for emergency treatments only, if you call our Helpline, we can accept Pre-authorization Form details over the phone. This gives us the opportunity to arrange for the direct settlement of your medical expenses, providing more convenience to you. Please have as many details as possible ready to give over the phone, including the contact details of your doctor.

When is pre-authorization required?

Pre-authorization is required for the following benefits, which may or may not be included in your plan:

- All in-patient benefits¹ as listed in your Core Plan.
- MRI² (Magnetic Resonance Imaging), PET² (Positron Emission Tomography) and CT-PET scans.
- Nursing at home or in a convalescent home².
- Rehabilitation treatment².
- Routine maternity², complications of pregnancy² and complications of childbirth² (in-patient treatment only).
- Oncology² (in-patient and day care treatment only).
- Treatment of congenital and hereditary conditions² (in-patient treatment only).

- Palliative care².
- Long term care².
- Occupational therapy² (out-patient treatment only).
- Day-care treatment².
- Out-patient surgery².
- Medical evacuation².
- Expenses for one person accompanying an evacuated person².
- Repatriation of mortal remains².

Your Table of Benefits will indicate which benefits require submission of a Pre-authorization Form prior to treatment.

Why is pre-authorization required?

As with all healthcare cover, your plan with us will only cover treatment that is medically

necessary and charges that are reasonable and customary. Therefore, it is vital that you contact us prior to treatment so that we can confirm medical necessity and appropriateness of costs.

In addition, pre-authorization will help us to provide you with a better service in the following ways:

- In the case of planned treatment, we will have time to communicate with the hospital to facilitate smooth admission and, where possible, arrange for direct settlement, offering you cashless access to hospitals for in-patient treatment.
- Your treatment can be overseen by our medical professionals.

- In the case of an evacuation, we will be able to organize and co-ordinate the evacuation on your behalf. Please contact the Helpline team for assistance with this process.

What happens if pre-authorization is not obtained?

It is important to note that if pre-authorization is not obtained where required, and the treatment received is subsequently proven to be medically unnecessary, **we reserve the right to decline your claim.**

If pre-authorization is not obtained for benefits listed with a **1**, **we reserve the right to decline a claim.** If the respective treatment is subsequently proven to be medically necessary, we will pay only **80%** of the eligible benefits.

If pre-authorization is not obtained for benefits listed with a **2**, **we reserve the right to decline a claim.** If the respective treatment is subsequently proven to be medically necessary, we will pay only **50%** of the eligible benefits.

While pre-authorization is not required in advance of emergency treatment, we should be informed **within 48 hours of the event** to ensure that no pre-authorization penalty is applied. In the case of **emergency treatment only**, we can take the details over the phone that will enable us to complete a Pre-authorization Form. This will give us the opportunity to arrange the direct settlement of your hospital bills, where possible, and will ensure that your claim can be processed without any delays.

Treatment in the USA

For treatment in the USA, members with “worldwide” cover should instruct their medical provider to contact our **toll-free number** in order to verify eligibility of cover. We can then arrange direct settlement for in-patient and out-patient treatment where possible

When traveling to the USA for treatment, it is recommended that you contact us at least 10 working days prior to travel so that we can ensure there will be no delays at the time of admission.

Please note that treatment in the USA is not covered, if we know or suspect that cover was purchased for the purpose of traveling to the USA to receive treatment for a condition, when

the symptoms of the condition were apparent to the member prior to the purchase of cover.

Questions answered

We have selected a few questions which may be of interest to you. If you have further questions, please do not hesitate to contact us.

Q. In which countries can I receive treatment?

- A. Where the necessary medical treatment for which you are covered is not available locally, you can avail of treatment in any country within your geographical area of cover which is confirmed on your Membership Certificate. In order to seek reimbursement for medical treatment and travel expenses incurred, you will need to submit a Pre-authorization Form for approval prior to travel.

Where the necessary medical treatment for which you are covered is available locally, but you choose to travel to another country within your area of cover for treatment, we will reimburse all eligible costs incurred within the terms of your plan, however we will not pay for travel expenses incurred.

Q. What happens if I move country?

- A. If you move to a country within your existing area of cover, there is nothing to do except to inform us of your new address, contact details and bank account/credit card details (depending on your chosen method of premium payment) as soon as possible. Your cover will continue as before at no additional cost. The only exception is where a member returns or relocates to the United States to make it their principal country of residence, in which case cover cannot continue.

However, if you move to a country outside your geographical area of cover (for example, if your cover is "Latin America and Caribbean only" and you move to France), you will need to contact us to extend your area of cover. An additional premium amount will be payable.

Q. When can I make changes to my payment terms?

- A. Changes in payment terms (e.g. method or frequency) can only be made at contract renewal. You will need to provide us with written instructions 30 days prior to your renewal date.

Q. What happens if I don't pay my premiums when due?

- A. We will cancel the contract if you have not paid the full premium when due. We shall notify you of this cancellation and the contract shall be deemed cancelled from the premium due date. However, if the premium is paid within 30 days after the due date, we will reinstate your healthcare cover and pay any claims which occurred during the period of delay. However, if the outstanding premium is only paid after this 30-day limit, you must complete a Switch Form before your contract can be re-instated, and cover will be subject to underwriting.

Q. Is my premium affected if I change residence mid-year?

A. Premiums will be reviewed at renewal, should changes in residence take place mid-year.

Q. Which hospitals can I go to?

A. You can use our online Hospital, Doctor and Health Practitioner Finder to search for providers worldwide. However, you are not restricted to using providers from this directory. Please note that pre-authorization is required prior to in-patient treatment, as well as certain other treatments as specified in your Table of Benefits. We will, where possible, try to arrange the direct settlement of your in-patient medical expenses with your medical provider.

Q. What do I do in an emergency?

A. In case of an emergency, always seek medical care immediately. Where possible, you should contact the Allianz Worldwide Care Helpline within 48 hours of the event.

Making a complaint

Please find guidelines on our complaints procedure below.

We are always pleased to hear about aspects of your membership that you have particularly appreciated, or that you have had problems with. If something does go wrong, here is a simple procedure to ensure your concerns are dealt with as quickly and effectively as possible.

The Allianz Worldwide Care Helpline is always the first number to call if you have any comments or complaints. In cases where we were not able to solve the problem on the phone, please email, fax or write to us at:

Allianz Worldwide Care
18B Beckett Way
Park West Business Campus
Nangor Road
Dublin 12
Ireland

Fax: + 353 1 630 1306
Email: client.services@allianzworldwidecare.com

If we have been unable to resolve the problem to your satisfaction and you wish to take your complaint further, you can refer your complaint to the **Irish Financial Services Ombudsman**.

The Financial Services Ombudsman is a statutory official who acts as an impartial arbiter of unresolved disputes that customers may have with financial services providers.

Financial Services Ombudsman
3rd Floor, Lincoln House
Lincoln Place
Dublin 2
Ireland

Tel: + 353 1 662 0899
Fax: + 353 1 662 0890
Email: enquiries@financialombudsman.ie
Website: www.financialombudsman.ie

Definitions

These definitions apply to the benefits included in our range of healthcare plans and may or may not form part of your specific plan. Please refer to your Table of Benefits to clarify which benefits apply to your cover with us, subject to any endorsements or special conditions unique to your cover. Wherever the following words and phrases appear in your contract documentation, they will always have the meanings as defined below.

- 1.1 **Accident** is an injury which is the result of an unexpected event independent of the will of the member and which arises from a cause outside the individual's control. The cause and symptoms must be medically and objectively definable, allow for a diagnosis and require therapy.
- 1.2 **Accommodation costs for one parent staying in hospital with a member aged under 18** refer to the hospital accommodation costs of one parent for the duration of the child's admission to hospital for eligible treatment. If a suitable bed is not available in the hospital, we will contribute the equivalent of a three star hotel daily room rate towards any hotel costs incurred. We will not, however, cover sundry expenses including, but not limited to, meals, telephone calls or newspapers.
- 1.3 **Complementary treatment** refers to therapeutic and diagnostic treatment that exists outside the institutions where conventional medicine is taught. Such medicine includes chiropractic treatment, osteopathy, homeopathy and acupuncture as practiced by approved therapists.
- 1.4 **Complications of childbirth** refer to conditions that arise during childbirth that require a recognized obstetric procedure. Please note that complications of childbirth also refer to medically necessary caesarean sections.
- 1.5 **Complications of pregnancy** relate to the health of the mother and refer to conditions that arise during the pre-natal stages of pregnancy.
- 1.6 **Congenital condition** refers to any abnormality, deformity, disease, illness or injury present at birth whether diagnosed or not. This includes, but is not limited to, conditions such as hair lip or cleft palate.
- 1.7 **Co-payment** is the percentage of the costs which the member must pay.

- 1.8 **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. Day-care treatment includes, but is not limited to, kidney dialysis.
- 1.9 **Deductible** is that part of the cost which remains payable by you and which has to be deducted from the reimbursable sum.
- 1.10 **Dental prostheses** include crowns, inlays, onlays, etc. adhesive reconstructions/restorations, bridges, dentures and implants as well as all necessary and ancillary treatment required.
- 1.11 **Dental surgery** includes the extraction of teeth, apicoectomy, as well as the treatment of other oral problems such as congenital jaw deformities (e.g. cleft jaw), fractures and tumors. Dental surgery does not cover any surgical treatment that is related to dental implants.
- 1.12 **Dental treatment** includes an annual dental check up, simple fillings related to cavities or decay and root canal treatment.
- 1.13 **Dependant** is your spouse or partner (including same sex partner) and/or unmarried children (including any step, foster or adopted child) financially dependant on the principal member up to the day before their 18th birthday; or up to the day before their 24th birthday if in full time education, and also named on your Membership Certificate as one of your dependants.
- 1.14 **Diagnostic tests** are investigations such as but not limited to x-rays or blood tests, undertaken in order to determine the cause of the presented symptoms.
- 1.15 **Doctor fees** refer to fees for consultations, including medical practitioner and specialist fees, incurred in respect of out-patient treatment.
- 1.16 **Emergency** constitutes 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.
- 1.17 **Emergency in-patient dental treatment** refers to acute emergency dental treatment due to a serious accident requiring hospitalization. The treatment must be received within 24 hours of the emergency event. Please note that cover under this benefit 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.
- 1.18 **Emergency out-patient dental treatment** is treatment received in a dental surgery/hospital emergency room for the immediate relief of dental pain, including temporary fillings limited to three fillings per Membership Year, and/or the repair of damage caused in an accident. The treatment must be received within 24 hours of the emergency event. This does not include any form of dental prostheses or root canal treatment.
- 1.19 **Expenses for one person accompanying an evacuated person** refer to the cost of one person traveling with the evacuated person. If this cannot take place in the same transportation vehicle, transport at economy rates will be paid for. Following completion of treatment, we will also cover the cost of the return trip, at economy rates, for the accompanying person to return to the country from where the evacuation originated. Cover does not extend to hotel accommodation or other related expenses.
- 1.20 **Family** refers to the principal member with two or more legal dependants.
- 1.21 **Hereditary condition** refers to any abnormality, deformity, disease or illness that has been passed down through the generations of the person's family. This includes, but is not limited to, Sickle Cell anemia and Huntingdon's Chorea.
- 1.22 **Home country** is the declared country to which the member would want to be repatriated.
- 1.23 **Home visits** are consultations provided by a medical practitioner, physician or therapist in the home of the member. Home visits will be reimbursed at the same rate as a visit to the medical practitioner/physician/therapist's office. Amounts over and above this will only be reimbursed if it is deemed that a home visit was medically necessary i.e. following the sudden onset of an acute illness, the member was rendered incapable of visiting the medical practitioner, physician or therapist at their office.
- 1.24 **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 medical practitioner. The following establishments are not considered hospitals: rest and nursing homes, spas, cure-centers and health resorts.

- 1.25 **Hospital accommodation** refers to standard private or semi-private accommodation as indicated in the Table of Benefits. Cover also includes a stay in an intensive care unit. Deluxe, executive rooms and suites are not covered.
- 1.26 **Infertility treatment** refers to treatment for both sexes including all invasive investigative procedures necessary to establish the cause for infertility such as hysterosalpingogram, laparoscopy or hysteroscopy.
- 1.27 **In-patient treatment** refers to treatment received in a hospital where an overnight stay is medically necessary.
- 1.28 **Local ambulance** is ambulance transport required for an emergency or out of medical necessity, to the nearest available and appropriate hospital or licensed medical facility.
- 1.29 **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.
- 1.30 **Medical evacuation** applies where the necessary treatment for which the member is covered is not available locally or if adequately screened blood is unavailable in the event of an emergency. We will evacuate the member to the nearest appropriate medical center (which may or may not be located in the member's home country). The medical evacuation will be carried out in the most economical way having regard to the medical condition.
- Following completion of treatment, we will also cover the cost of the return trip, at economy rates, for the evacuated member to return to his/her principal country of residence.
- If medical necessity prevents the member from undertaking the evacuation or transportation following discharge from an **in-patient episode of care**, we will cover the reasonable cost of hotel accommodation up to a maximum of seven days, comprising of a private room with en-suite facilities. We do not cover costs for hotel suites, four or five star hotel accommodation or hotel accommodation for an accompanying person.
- Where a member has been evacuated to the nearest appropriate medical center and is subsequently discharged from hospital yet requires **ongoing**

treatment, we will agree to cover the reasonable cost of hotel accommodation comprising of a private room with en-suite facilities. The cost of such accommodation must be more economical than successive transportation costs to/from the nearest appropriate medical center and the principal country of residence. Hotel accommodation for an accompanying person is not covered.

1.31 **Medical necessity** refers to those medical services or supplies that are determined to be medically necessary and appropriate. They must be:

- (a) Essential to identify or treat a patient's condition, illness or injury.
- (b) Consistent with the patient's symptoms, diagnosis or treatment of the underlying condition.
- (c) In accordance with generally accepted medical practice and professional standards of medical care in the medical community at the time.
- (d) Required for reasons other than the comfort or convenience of the patient or his/her physician.
- (e) Proven and demonstrated to have medical value.
- (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 a patient's medical condition.
- (h) Provided only for an appropriate duration of time.

As used in this definition, the term "appropriate" shall mean taking patient safety and cost effectiveness into consideration. When specifically applied to in-patient treatment, medically necessary also means that diagnosis cannot be made, or treatment cannot be safely and effectively provided, on an out-patient basis.

1.32 **Medical practitioner** is a physician who is licensed to practice medicine under the law of the country in which treatment is given and where he/she is practicing within the limits of his/her license.

1.33 **Member** is you and your dependants as stated on your Membership Certificate.

1.34 **Membership Certificate** is a document outlining the details of your cover and is issued by us. It confirms that a contractual relationship exists between you and us.

1.35 **Membership Year** applies from the start date of the contract, as indicated on the Membership Certificate, and ends exactly one year later.

- 1.36 **Midwife fees** refer to fees incurred by a midwife or birth assistant, who, according to the law of the country in which treatment is given, has fulfilled the necessary training and passed the necessary state examinations.
- 1.37 **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. Further preventive diagnostic procedures, such as routine swabs, blood typing and hearing tests, are not covered. Any medically necessary follow-up investigations and treatment are covered under the newborn's own contract.
- 1.38 **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 only pay the benefit listed in the Table of Benefits where the treating doctor decides (and our Medical Director agrees) that it is medically necessary for the member to stay in a convalescent home or have a nurse in attendance at home. Cover is not provided for spas, cure centers and health resorts or in relation to palliative care or long term care (see definitions 1.48 and 1.29).
- 1.39 **Obesity** is diagnosed when a person has a BMI (Body Mass Index) of over 30 (a BMI calculator can be found at www.allianzworldwidecare.com).
- 1.40 **Occupational therapy** refers to treatment that addresses the individual's development of fine motor skills, sensory integration, coordination, balance and other skills such as dressing, eating, grooming etc. in order to aid daily living and improve interactions with the physical and social world. Out-patient occupational therapy requires pre-authorization.
- 1.41 **Oncology** refers to specialist fees, diagnostic tests, radiotherapy, chemotherapy and hospital charges incurred in relation to the planning and carrying out of treatment for cancer, from the point of diagnosis.
- 1.42 **Oral surgical procedures** refers to surgical procedures, such as, but not limited to, the removal of impacted wisdom teeth, when carried out in a hospital by an oral or maxillofacial surgeon.
- 1.43 **Organ transplant** is the surgical procedure in performing the following organ and/or tissue transplants: heart, heart/valve, heart/lung, liver, pancreas, pancreas/kidney, kidney, bone marrow, parathyroid, muscular/skeletal and cornea transplants.

The costs associated with organ, cell or tissue procurement, transportation and harvesting are covered up to a maximum of US\$25,000 per diagnosis. Any complications arising from procurement, transportation and harvesting or any consequences thereof are also covered within the US\$25,000 limit.

- 1.44 **Orthodontics** is the use of devices to correct malocclusion and restore the teeth to proper alignment and function.
- 1.45 **Orthomolecular treatment** refers to treatment which aims to restore the optimum ecological environment for the body's cells by correcting deficiencies on the molecular level based on individual biochemistry. It uses natural substances such as vitamins, minerals, enzymes, hormones etc.
- 1.46 **Out-patient surgery** is a surgical procedure performed in a surgery, hospital, day-care facility or out-patient department that does not require the patient to stay overnight out of medical necessity. Cover also includes exploratory examinations and diagnostic tests carried out under anaesthesia.
- 1.47 **Out-patient treatment** refers to treatment provided in the practice or surgery of a medical practitioner, therapist or specialist that does not require the patient to be admitted to hospital.
- 1.48 **Palliative care** refers to in-patient, day-care or out-patient treatment following the diagnosis that your condition is terminal and treatment can no longer be expected to cure your condition. Included within your benefit we will pay for your physical care, psychological care as well as hospital or hospice accommodation, nursing care and prescription drugs.
- 1.49 **Periodontics** refers to dental treatment related to gum disease.
- 1.50 **Post-natal care** refers to the routine post-partum medical care received by the mother, up to six weeks after delivery.
- 1.51 **Pre-existing conditions** are medical conditions or any related conditions for which symptom(s) have been shown at some point during the five years prior to commencement of cover, irrespective of whether any medical treatment or advice was sought. Any such condition or related condition about which you or your dependants could reasonably have been assumed to have known, or where pre-existence is clearly supported by one of three pre-defined sources of

internationally published medical evidence (PubMed: www.ncbi.nlm.nih.gov/PubMed, ELSEVIER: www.elsevier.com or Uptodate: www.uptodate.com) will be deemed by us to be pre-existing. Pre-existing conditions which have not been declared on the Application Form are not covered by us. In addition, conditions arising between completing the Application Form and confirmation of acceptance by the Underwriting Department of Allianz Worldwide Care will equally be deemed to be pre-existing and will not be covered if not disclosed.

- 1.52 **Pregnancy** refers to the period of time, from the date of the first diagnosis, until delivery.
- 1.53 **Pre-natal care** includes common screening and follow-up tests, as required during a pregnancy. For women aged 35 and over, this includes Triple/Bart's, Quadruple or Spina Bifida tests, amniocentesis and DNA-analysis, if directly linked to an eligible amniocentesis.
- 1.54 **Prescribed physiotherapy** refers to treatment by a registered physiotherapist following referral by a medical practitioner. Physiotherapy is initially restricted to 12 sessions per condition, after which the treatment must be reviewed by the referring medical practitioner.

Should further sessions be required, a progress report must be submitted to us, which indicates the medical necessity for any further treatment. Physiotherapy does not include therapies such as Rolwing, Massage, Pilates, Fango and Milta therapy.

- 1.55 **Prescription drugs** refer to products, including, but not limited to, insulin, hypodermic needles or syringes, which require a prescription for the treatment of a confirmed diagnosis or medical condition or to compensate vital bodily substances. The prescription must be clinically proven to be effective, and recognized by the pharmaceutical regulator in a given country.
- 1.56 **Preventive treatment** refers to treatment that is undertaken without any clinical symptoms being present at the time of treatment. An example of such treatment is the removal of a pre-cancerous growth (e.g. mole on the skin).
- 1.57 **Principal country of residence** is the country where you and your dependants live for more than 6 months of the year.

- 1.58 **Principal member** is the first person named on the Membership Certificate and who is the person who purchased the cover.
- 1.59 **Psychiatry and psychotherapy** refers to treatment of a mental or nervous disorder carried out by a psychiatrist or clinical psychologist. The disorder must be associated with present distress or substantial impairment of the individual's ability to function in a major life activity (e.g. employment). The aforementioned condition must be clinically significant and not triggered by a particular event such as bereavement, relationship or academic problems or acculturation. The disorder must meet the criteria for classification under an international classification system such as the Diagnostic and Statistical Manual (DSM-IV) or the International Classification of Diseases (ICD-10).
- 1.60 **Rehabilitation** is treatment aimed at the restoration of a normal form and/or function after an acute illness or injury. The rehabilitation benefit is payable only for treatment that starts immediately after the acute medical treatment ceases.
- 1.61 **Repatriation of mortal remains** is the transportation of the deceased's mortal remains from the principal country of residence to the country of burial. Covered expenses include, but are not limited to, expenses for embalming, a container legally appropriate for transportation, shipping costs and the necessary government authorizations. Cremation costs will only be covered in the event that this is required for legal purposes. Costs incurred by any accompanying persons are not covered. All covered expenses in connection with the repatriation of mortal remains must be pre-approved by us.
- 1.62 **Routine health checks including cancer screening** are tests/screenings that are undertaken without any clinical symptoms being present. Such tests include the following examinations, performed at an appropriate age interval, for the early detection of illness or disease:
- Vital signs (blood pressure, cholesterol, pulse, respiration, temperature etc).
 - Cardiovascular exam.
 - Neurological exam.
 - Cancer screening.
 - Well child test (for children up to the age of 6 years, up to a maximum of 15 visits per lifetime).
- 1.63 **Routine maternity** refers to any medically necessary costs incurred during pregnancy and childbirth,

- including hospital charges, specialist fees, the mother's pre- and post-natal care, midwife fees (during labour only) as well as newborn care. Costs related to complications of pregnancy and childbirth are not payable under routine maternity. In addition, any non-medically necessary caesarean sections will be covered up to the cost of a routine delivery in the same hospital, subject to any benefit limit in place. The level of cover provided is shown under the routine maternity benefit within your Table of Benefits.
- 1.64 **Specialist** is a qualified and licensed medical physician possessing the necessary additional qualifications and expertise to practice as a recognized specialist of diagnostic techniques, treatment and prevention in a particular field of medicine. This benefit does not include cover for psychiatrist or psychologist fees. Where covered, a separate benefit for psychiatry and psychotherapy will appear in the Table of Benefits.
- 1.65 **Specialist fees** refer to non-surgical treatment performed or administered by a specialist.
- 1.66 **Speech therapy** refers to treatment carried out by a qualified speech therapist to treat diagnosed physical impairments, including but not limited to nasal obstruction, neurogenic impairment (e.g. lingual paresis, brain injury) or articulation disorders involving the oral structure (e.g. cleft palate).
- 1.67 **Surgical appliances and prostheses** refer to artificial body parts or devices, which are an integral part of a surgical procedure or part of any medically necessary treatment following surgery.
- 1.68 **Therapist** is a chiropractor, osteopath, homeopath, acupuncturist, physiotherapist, speech therapist, occupational therapist or oculomotor therapist, who is qualified and licensed under the law of the country in which treatment is being given.
- 1.69 **Treatment** refers to a medical procedure needed to cure or relieve illness or injury.
- 1.70 **Waiting period** is a period of time starting on your contract commencement date (or effective date if you are a dependant), during which you are not entitled to cover for particular benefits. Your Table of Benefits will indicate which benefits are subject to waiting periods.
- 1.71 **We/Our/Us** is Allianz Worldwide Care.
- 1.72 **You/Your** refers to the eligible individual stated on the Membership Certificate.

Additional contract terms

The following are important additional terms that apply to your contract with us.

1. **What we cover:**

- a) The extent of your cover is determined by your Table of Benefits, the Membership Certificate, any contract endorsements, these contract terms and conditions, as well as any other legal requirements. We will reimburse, in accordance with your Table of Benefits and individual terms and conditions, medical costs arising from the occurrence or worsening of a medical condition.
- b) Treatments and procedures are only covered if they have a palliative, curative and/or diagnostic purpose, are medically necessary, appropriate and performed by a licensed physician, dentist or therapist. Claims/costs will be paid/reimbursed if the medical diagnosis and/or prescribed treatment are in accordance with generally accepted medical procedures. Costs resulting from the member knowingly acting against medical advice will not be paid/reimbursed.
- c) Claims will be settled if we deem the charges in the invoices and receipts to be fair and reasonable, and at the level customarily charged in the specific country and for the treatment provided. If a claim is deemed by us to be inappropriate we reserve the right to reduce the amount reimbursed by us.
- d) Where adequately screened blood is not available locally, we will, where appropriate, endeavor to locate and transport screened blood and sterile transfusion equipment where this is advised by the treating physician. We will also endeavor to do this when our own medical experts so advise. Allianz Worldwide Care and its agents accept no liability in the event that such endeavors are unsuccessful or in the event that contaminated blood or equipment is used by the treating authority.

2. **Liability:** Our liability to the member is limited to the amounts indicated in the Table of Benefits and any subsequent contract endorsements. In no event will the amount of reimbursement, whether under this contract, public medical schemes and any other contract of cover, exceed the amount of the invoice.

3. **Third party liability:** If you or any of your dependants are eligible to claim benefits under a public scheme or any other contract of cover, which pertains to a claim submitted to us, we reserve the right to decline to pay benefits.

You must inform us and provide all necessary information if and when you are entitled to a claim from a third party. You and the third party may not agree any final settlement or waive our right to recover

outlays without our prior written agreement. Otherwise we are entitled to recover the amounts paid from you and cancel the contract.

We have full rights of subrogation and may institute proceedings in your name, but at our expense, to recover, for our benefit, the amount of any payment made under another contract.

4. **Legal action:** You shall not institute any legal proceedings to recover any amount under the contract until at least 60 days after the claim has been submitted to us and not more than two years from the date of this submission, unless otherwise required by mandatory legal regulations.
5. **Arbitration:**
 - a) 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.
 - b) The Parties shall 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 US\$600,000 or less and which cannot be settled amicably between the Parties. The Parties shall endeavor to agree on the appointment of an agreed Mediator. Should 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 (“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 5.b 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 Dublin, Ireland and the language of the mediation will be English. The Mediation Agreement referred to in the Model Procedure shall be governed by, and

construed and take effect in accordance with the laws of Ireland. The Courts of Ireland shall have exclusive jurisdiction to settle any claim, dispute or matter of difference which may arise out of, or in connection with, the mediation.

- c) 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 US\$600,000, or
 - Referred to mediation pursuant to Clause 5.b but not voluntarily settled by mediation within three months of the ADR Notice date shall be determined exclusively by the Courts of Ireland and the Parties will submit to the exclusive jurisdiction of those courts. Any proceedings brought pursuant to Clause 5.c shall be issued within nine calendar months of the expiration date of the aforementioned three month period.

6. **Data protection:** Allianz Worldwide Care, a member of the Allianz Group, is an Irish registered company. We obtain and process personal information for the purposes of preparing quotations, underwriting contracts, collecting premium, paying claims and for any other purpose which is directly related to administering the healthcare cover contract. The confidentiality of patient and member information is of

paramount concern to us. We comply fully with European Data Protection Legislation and International Medical Confidentiality Guidelines. You have a right to access the personal data that is held about you. You also have the right to request that we amend or delete any information which you believe is inaccurate or out of date. We will not retain your data for longer than is necessary for the purposes for which it was obtained.

Notes

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

Allianz Worldwide Care

18B Beckett Way

Park West Business Campus

Nangor Road

Dublin 12

Ireland

www.allianzworldwidecare.com

Helpline

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

Fax: + 353 1 630 1306

Email:
client.services@allianzworldwidecare.com

Toll-free from Argentina:

0 800 444 2615

Toll-free from Brazil:

0 800 882 1545

Toll-free from Colombia:

1 800 518 1081

Toll-free from Mexico:

1 800 514 9887

Toll-free from the USA:

1 866 266 2182

For our latest list of toll-free numbers,
please go to:

[www.allianzworldwidecare.com/
toll-free-numbers](http://www.allianzworldwidecare.com/toll-free-numbers)

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