GlobalPass Healthcare Plans for Latin America
Valid from 1st May 2020

# Benefit Guide

Allianz Care

# Welcome

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

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

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


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# HOW TO USE YOUR COVER

# SUPPORT SERVICES

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

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

## Talk to us, we love to help!

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

Helpline

Phone: +353 1 630 1301
For our latest list of toll-free numbers, please visit:
www.allianzcare.com/toll-free-numbers

@ Email: client.services@allianzworldwidecare.com

Fax: +353 1 630 1306

**Did you know...**

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

## MyHealth Digital Services

Our MyHealth Digital Services gives you easy and convenient access to your cover, no matter where you are or what device you are using.

**MyHealth app and online portal features:**

**MY POLICY**
Access your policy documents and membership card on the go.

**MY CLAIMS**
Submit your claims in 3 simple steps and view your claims history.

**MY CONTACTS**
Access our 24/7 Helpline.

**MyHealth app additional features:**

- **Symptom checker:** Get a quick and easy assessment of your symptoms
- **Find a hospital:** Locate medical providers nearby and get GPS directions
- **Pharmacy Aid:** Look up the local equivalent names of branded drugs
- **Medical term translator:** Translate names of common ailments into 17 languages
- **Emergency contact:** access local emergency numbers worldwide

Most features are available offline but you must be online to submit a claim and use some health services.

**MyHealth online portal additional features:**

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

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

**Getting started:**

Login to MyHealth online portal to register. Go to https://my.allianzcare.com/myhealth, click on "REGISTER HERE" near the bottom of the page and follow the on-screen instructions.

Once setup, you can use the email (username) and password you provided during registration to login to MyHealth online portal, or go further and setup the MyHealth app too. The same login details are used for both and in the future, if you change login details for one, it will automatically apply to the other. You don't need to change them in both places.

To download the MyHealth app, search for "Allianz MyHealth" on the Apple App Store or Android's Google Play service.

Once installed, follow the on-screen instructions and enter your policy number when prompted. The MyHealth app will ask you for the email (username) and password you provided earlier. Simply enter these details and follow the on-screen instructions.

Set your PIN – finally, set your own unique PIN number. In the future, this PIN number will be all you need to access the Allianz MyHealth app and all its features.

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

Download on the App Store

GET IT ON Google Play

## Web-based services

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

- Search for medical providers. You are not restricted to using the providers listed in our directory, unless your plan has a specific network.
- Download forms
- Access our BMI calculator
- Access our Health Guides

## Medi24

Medi24 is a medical advice service provided by an experienced medical team. It provides information and advice on a wide range of topics, including blood pressure and weight management, infectious diseases, first aid, dental care, vaccinations, cancer, disability, speech, fertility, pediatrics, mental health and general health.

Medi24 is available 24/7 in English, German, French and Italian.

+44 (0) 208 416 3929

Remember – for policy or cover related queries (e.g. benefit limits or the status of a claim), please contact our Helpline.

## Expat Assistance Program (EAP)

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

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

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

Support services include:

**CONFIDENTIAL PROFESSIONAL COUNSELING**
Receive 24/7 support with a clinical counselor through live online chat, face to face, phone, video or email.

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

**LEGAL AND FINANCIAL SUPPORT SERVICES**
Whether it's help buying a home, handling a legal dispute or creating a comprehensive financial plan, we offer consultations to help you answer questions and reach your goals.

**ACCESS TO THE WELLNESS WEBSITE AND APP**
Discover online support, tools and articles for help and advice on health and wellbeing.

**LET US HELP:**

+1 905 886 3605
This is not a free phone number. If you need a local number, please access the wellness website and you will find the full list of our 'International Numbers'.

http://awcsexpat.lifeworks.com
(available in English, French and Spanish)

Download the Lifeworks app in Google Play or Apple Store

GET IT ON Google Play

Download on the App Store

Login on the website or the app using the following details:
**Username: AllianzCare**
**Password: Expatriate**

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

*The EAP is made available by Morneau Shepell Limited, subject to your acceptance of our terms and conditions. You understand and agree that AWP Health & Life SA – Irish Branch and/or AWP Health & Life Services Limited are not responsible or liable for any claim, loss or damage directly or indirectly resulting from your use of EAP services.*

## Travel Security Services

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

You can access:


**EMERGENCY SECURITY ASSISTANCE HOTLINE**
Talk to a security specialist for any safety concerns associated with a travel destination

**COUNTRY INTELLIGENCE AND SECURITY ADVICE**
Security information and advice about many countries


**DAILY SECURITY NEWS UPDATES AND EMAIL TRAVEL SAFETY ALERTS**
Sign up and receive alerts about high-risk events in or near your current location, including terrorism, civil unrest and severe weather risks

To access the travel security services, please contact us:

+44 207 741 2185
This is not a free phone number

allianzcustomerenquiries@worldaware.com

https://my.worldaware.com/awc
Register by entering your policy number (shown in your Insurance Certificate)

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

Download on the App Store | GET IT ON Google Play

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

*Travel Security Services are made available by WorldAware Ltd, subject to your acceptance of our Terms and Conditions. You understand and agree that AWP Health & Life SA – Irish Branch and/or AWP Health & Life Services Limited are not responsible or liable for any claim, loss or damage directly or indirectly resulting from your use of the Travel Security Services.*

## Allianz HealthSteps

**First Steps towards a healthier life**

Did you know that by maintaining a healthy lifestyle, you may reduce the risk of developing medical conditions? The Allianz HealthSteps app was designed to give personalized guidance and help you reaching your health and fitness goals. By connecting to smart phones, wearable devices and other apps, HeathSteps monitors the number of steps taken, calories burned, sleep schedule and more. Your Table of Benefits shows whether HealthSteps is included in your plan.

**HealthSteps features:**

**PLAN**
Choose a health goal and use the action plans to adopt and maintain good health habits:
- Lose Weight
- Improve posture
- Sleep better
- Healthy eating
- Get moving & energized
- Stay healthy
- Body shape change
- Reduce stress
- Lower blood pressure

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

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

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

Download the "Allianz HealthSteps" app from App store or Google Play

Download on the App Store | GET IT ON Google Play

*HealthSteps is provided by a third party provider outside of the Allianz Group. It is made available to you subject to your acceptance of our terms and conditions. It is also subject to AWP Health & Life Services Limited terms as they appear on our HealthSteps app. You understand and agree that AWP Health & Life SA (Irish Branch) and AWP Health & Life Services Limited are not responsible or liable for any claim, loss or damage, directly or indirectly resulting from your use of the above named services.*

# COVER OVERVIEW

**Here is a summary of your health cover.**

## What am I covered for?

You are covered for all the benefits listed in your Table of Benefits. We generally cover pre-existing conditions (including pre-existing chronic conditions) unless we say otherwise in your policy documents. If in doubt, please see the "Notes" section of your Table of Benefits to confirm if pre-existing conditions are covered.

We cover the treatment of congenital and hereditary conditions, as outlined in the "Definitions" section of this guide. The maximum limit for congenital and hereditary conditions is stated in the Table of Benefits.

You must declare all congenital and hereditary conditions in the relevant application form at application stage. Please note that cover may not include pre-existing congenital and hereditary conditions if pre-existing conditions are not covered under your plan (please see the "Pre-existing conditions" definition for further information).

Please note that cover of congenital and hereditary conditions is subject to the in-patient and out-patient benefits listed in your Table of Benefits. We require pre-authorization for in-patient treatment

## Where can I receive treatment?

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

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

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

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

## What are benefit limits?

Your cover may be subject to a maximum plan benefit. This is the maximum we will pay in total for all benefits included in the plan. Although many benefits included in your Table of Benefits are covered in full, some are capped to a specific amount (e.g. US$30,000). This specific amount is a benefit limit.

For further information on benefit limits please see the "Benefit limits" section of this guide.

## Is your family growing?

Are you getting married or having a baby? Congratulations!

You can request to add your spouse or partner to your policy by simply completing our Application Form, available at:

https://www.allianzcare.com/en/docs/gpapp

To add a newborn child to your policy, simply send an email to our underwriting team, including a copy of the birth certificate. You should send your request within six weeks of the date of birth, to ensure that the child is accepted for cover without medical underwriting and for cover to start from birth.

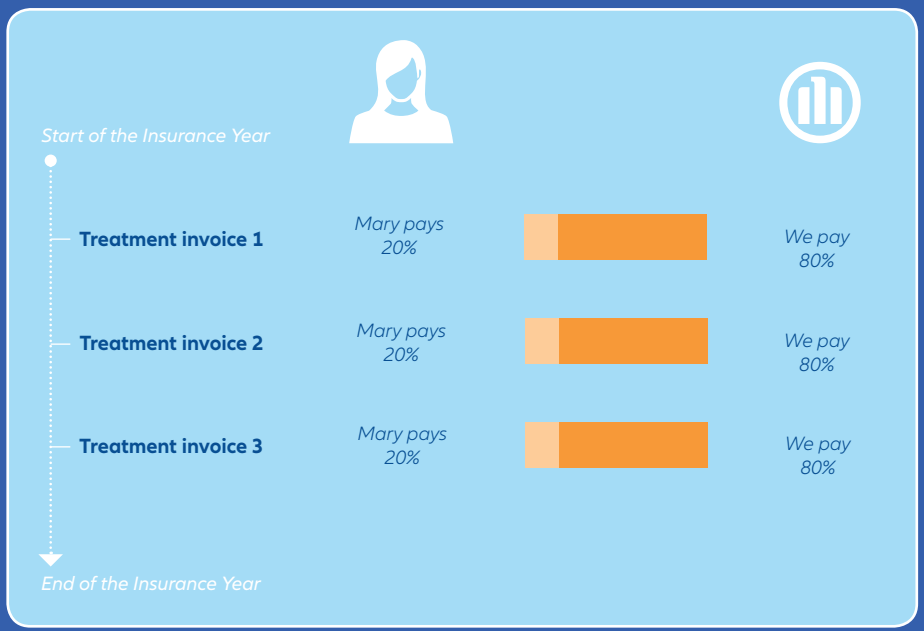
For further information on how to add dependents, including important information on how to add multiple babies, adopted and foster children, please see the 'Adding dependents' section of this guide.

Following acceptance, we will issue a new Insurance Certificate to reflect the addition of a dependent. This new certificate will replace any earlier version(s) you may have from the start date shown on it.

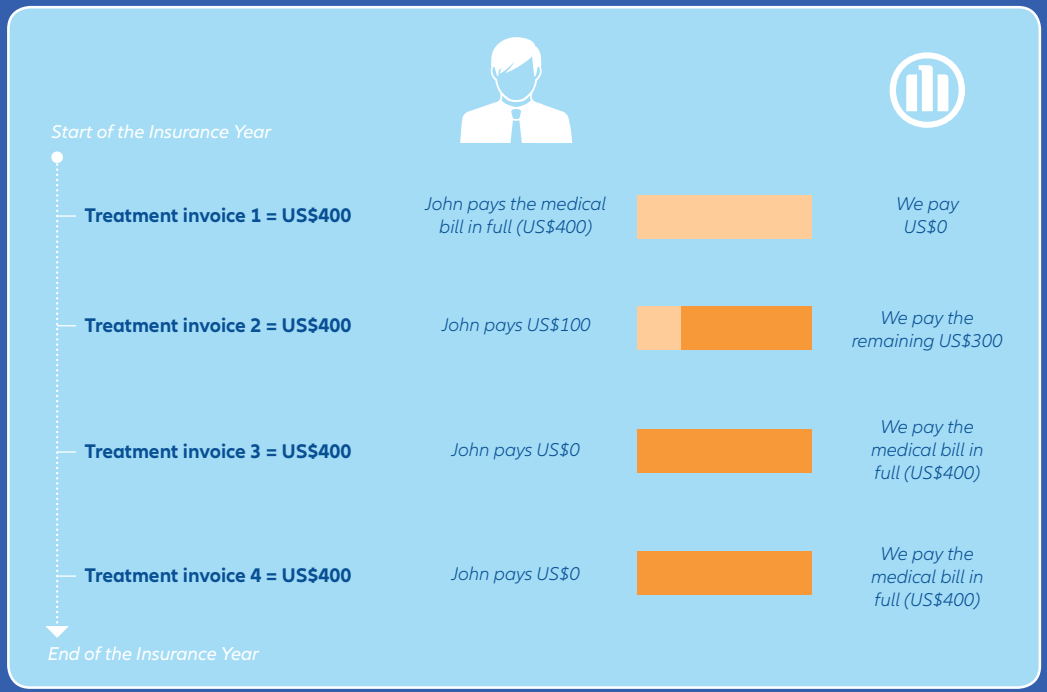
## What are deductibles and co-payments?

Some plans and benefits may be subject to a deductible or co-payments or both. Your Table of Benefits will show whether this applies to your plan.

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



A deductible is a fixed amount you need to pay towards your medical bills per period of cover before we begin to contribute. In the following example, John needs to receive medical treatment throughout the year. His plan includes a US$500 deductible.




Benefits subject to a deductible are marked in your Table of Benefits with an A. Where the deductible applicable to your policy is "per family", it will apply to the first claim(s) submitted by any person covered under your plan.

*Insurer contribution*
*Insured person contribution*

# SEEKING TREATMENT?

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

## Check your level of cover

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

## Some treatments require pre-authorization

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

## Getting in-patient treatment

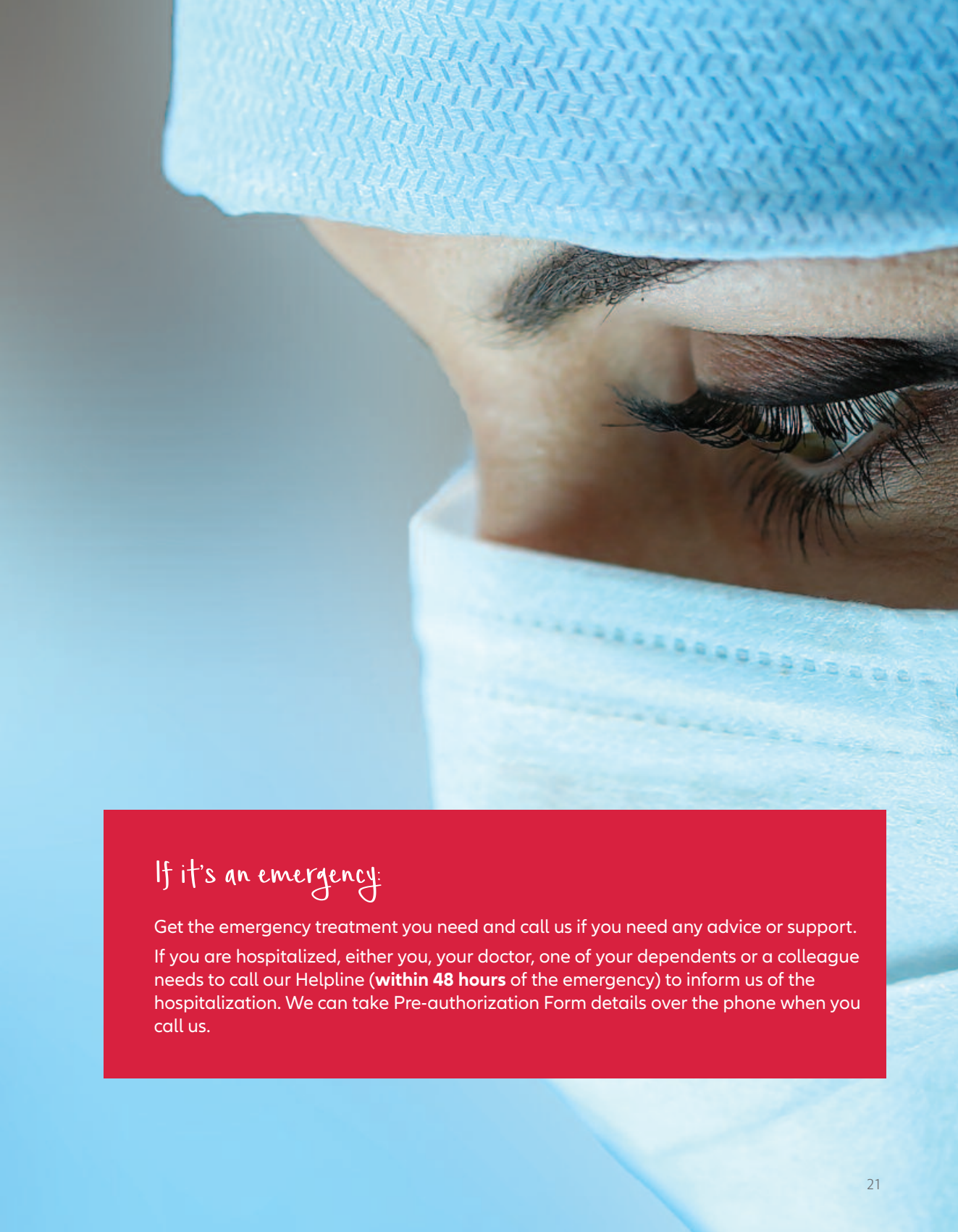
(pre-authorization process applies)

Download a Pre-authorization Form from our website:
**www.allianzcare.com/members**

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

We contact the hospital to organize payment of your bills directly, where possible.

*We can also take Pre-authorization Form details over the phone if treatment is taking place within 72 hours. Please note that we may decline your claim if Pre-authorization is not obtained. For full details of our Pre-authorization process see the 'Terms and Conditions' section of this guide.*



## If it's an emergency:

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

If you are hospitalized, either you, your doctor, one of your dependents or a colleague needs to call our Helpline (**within 48 hours** of the emergency) to inform us of the hospitalization. We can take Pre-authorization Form details over the phone when you call us.

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

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

Receive your medical treatment and pay the medical provider

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


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

Please refer to "Medical Claims" in the Terms and Conditions section of this guide for more information about our claims process.


### Quick claim processing

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

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

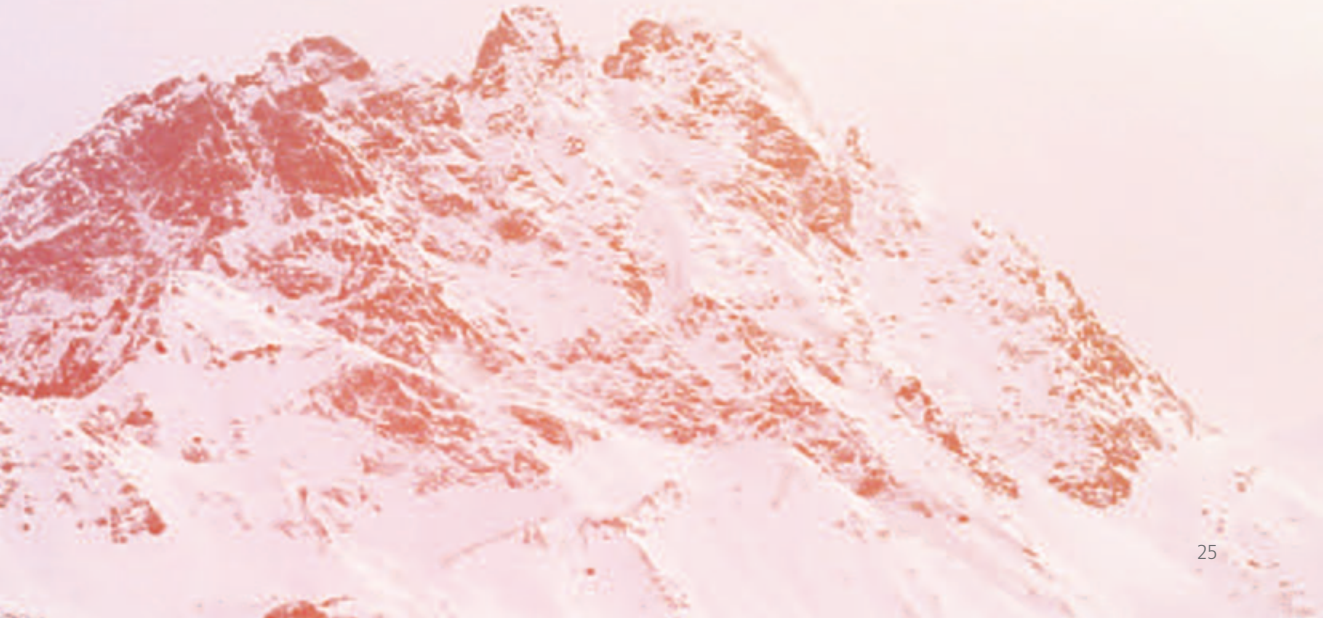
## Evacuations

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

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

+353 1 630 1301

@ medical.services@allianzworldwidecare.com



## Seeking treatment in the USA

You have access to an exclusive network of medical facilities and healthcare providers in the USA on a direct billing basis. A full list of providers in this network is available online.

globalpass.omhc.com

You are not restricted to using this network. However, if you have a GlobalPass Connect plan and choose a provider outside of the network, we will only reimburse 60% of the medical expenses (for in-patient and day-care only).

If you have "Worldwide" cover and wish to locate a medical provider in the USA, simply contact us on our USA number:

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

Alternatively, you can request a call back by clicking on “Contact me” at **globalpass.omhc.com** and following the instructions on screen.

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

You can also apply for a discount pharmacy card which can be used any time your prescription is not covered by your plan. To register and obtain your discount pharmacy card, simply go to the following website and click on “Print Discount Card”.

**http://members.omhc.com/awc/prescriptions.html**

# TERMS AND CONDITIONS OF YOUR COVER

# TERMS AND CONDITIONS

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

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

- The **Benefit Guide** (this document), which explains the standard benefits and rules of your health insurance policy. You should read it together with your Insurance Certificate and Table of Benefits.
- The **Insurance Certificate** details the plan(s) and geographical area of cover that you chose for you and your dependents (if applicable). It also states the start date and renewal date of your cover (and effective dates when dependents were added). This document will state any special terms that may apply to your cover. They will also appear on a Special Conditions letter that we send you before your cover starts. We'll send you a new Insurance Certificate if we need to record any changes to your policy. These may be changes that we are entitled to make. They may also be changes that you request (such as adding a dependent) – provided we accept.
- The **Table of Benefits** outlines the plan(s) selected and the benefits available to you. It also specifies any benefits/treatments that require you to submit a Pre-authorization Form. It confirms any benefits to which specific benefit limits, waiting periods, deductibles and/or co-payments apply.
- Information that you (or someone on your behalf) gave us in the signed Application Form, Confirmation of Health Status Form or others (we'll refer to all of these collectively as the "relevant application form") or other supporting medical information.

# YOUR COVER EXPLAINED

**The plans that you selected are indicated in your Table of Benefits, which lists all the benefits you are covered for and any applicable limits. For an explanation of how your benefit limits apply to your plan, please see the "Benefit limits" paragraph below.**

Your benefits are also subject to:

- Policy definitions and exclusions (also available in this guide).
- Any special conditions shown on your Insurance Certificate (and on the Special Conditions letter issued before the policy comes into effect, where relevant).

## What we cover

- The scope of what's covered in your policy is set out on your Table of Benefits, Insurance Certificate, any policy endorsements, these policy terms and conditions and any other legal requirements. We will reimburse medical costs arising from the occurrence or worsening of a medical condition, in accordance with your Table of Benefits and individual terms and conditions.
- Within the scope of your policy, you are covered for medical treatment, costs, services or supplies that:
  - We determine to be medically necessary, appropriate for the patient's condition, illness or injury.
  - Have a palliative, curative and/or diagnostic purpose.
  - Are performed by a licensed doctor, dentist or therapist.

  We will only reimburse if charges are reasonable and customary and in accordance with standard and generally accepted medical procedures. If we consider a claim to be inappropriate, we have the right to decline or reduce the amount we pay.

## When cover starts

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

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

## Benefit limits

The Table of Benefits shows two kinds of benefit limits:

- The **maximum plan benefit** (which applies to certain plans) is the maximum we will pay for all benefits in total, per member, per Insurance Year, under that particular plan.
- Some benefits also have a **specific benefit limit**, which may be provided on a "per Insurance Year" basis, on a "per lifetime" basis or on a "per event" basis (such as per trip, per visit or per pregnancy). In some instances, in addition to the benefit limit, we will only pay a percentage of the costs for the specific benefit e.g. "80% refund, up to US$3,000".

The amount we refund is subject to the maximum plan benefit (if one applies to your plan), even where:

- a specific benefit limit applies, or
- the term "Full refund" appears next to the benefit.

All limits are per member and per Insurance Year, unless your Table of Benefits states otherwise.

If you're covered for maternity benefits, these will be stated in your Table of Benefits along with any benefit limit and/or waiting period which applies. Maternity benefits are paid on either a "per pregnancy" or "per Insurance Year" basis. Your Table of Benefits will confirm this.

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

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

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

For multiple-birth babies born as a result of medically assisted reproduction, in-patient treatment is limited to US$42,500 per child for the first three months following birth. Out-patient treatment is paid under the terms of the Out-patient Plan.

# CLAIMS AND PRE-AUTHORIZATION PROCESS

## Medical claims

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

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

- **Supporting documents:** When you send us copies of supporting documents (e.g. medical receipts), please make sure you keep the originals. We have the right to request original supporting documents/receipts for auditing purposes up to 12 months after settling your claim. We may also request proof of payment by you (e.g. a bank or credit card statement) for medical bills you have paid. We advise that you keep copies of all correspondence with us as we cannot be held responsible for correspondence that fails to reach us for any reason outside of our control.
- **Deductibles:** If the amount you are claiming is less than the deductible figure in your plan, you can either:
  - Collect all out-patient receipts until you reach an amount that exceeds this deductible figure, or
  - Send us each claim every time you receive treatment. Once you reach the deductible amount, we'll start reimbursing you.

  Attach all supporting receipts and/or invoices with your claim. We cannot accept credit card receipts without invoices.

  Please note that if you have local cover in place (with another healthcare insurer), you can request that any eligible in-patient/ day-care paid by the other insurer are accepted as a contribution to the deductible amount on your healthcare plan with us. This applies only to eligible in-patient/ day-care treatment received in a hospital or clinic. Please send us a copy of a detailed invoice from the hospital along with a statement or official document confirming contribution from your local insurer.
- **Currency:** Please specify the currency you wish to be paid in. On rare occasions, we may not be able to make a payment in that currency due to international banking regulations. If this happens, we will identify a suitable alternative currency. If we have to make a conversion from one currency to another, we will use the exchange rate that applied on the date the invoices were issued, or on the date that we pay your claim.

  Please note that we reserve the right to choose which currency exchange rate to apply.
- **Reimbursement:** we will only reimburse (within the limits of your policy) eligible costs after considering any pre-authorization requirements, deductibles or co-payments outlined in the Table of Benefits.
- **Reasonable and customary cost:** We will only reimburse charges that are reasonable and customary in accordance with standard and generally accepted medical procedures. If we consider a claim to be inappropriate, we reserve the right to decline your claim or reduce the amount we pay.
- **Deposits:** If you have to pay a deposit in advance of any medical treatment, we will reimburse this cost only after treatment has taken place.
- **Providing information:** You and your dependents agree to help us get all the information we need to process a claim. We have the right to access all medical records and to have direct discussions with the medical provider or the treating doctor. We may, at our own expense, request a medical examination by our doctors if we think it's necessary. All information will be treated confidentially. We reserve the right to withhold benefits if you or your dependents do not support us in getting the information we need.
- **Claiming as a result of an accident:** If your claim is in relation to treatment needed as a result of an accident, please make sure you send us copy of the Police report. In certain cases we may ask you to send us additional information

## Treatment needed as a result of somebody else's fault

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

## Pre-authorizationTreatment

Some of the benefits available to you need pre-authorization. These are usually marked with a 1 or a 2 in your Table of Benefits. To get pre-authorization, please send us a Pre-authorization Form.

Here are the treatments/benefits which normally need pre-authorization. This may vary depending on your cover, so please check your Table of Benefits to confirm:

- All in-patient benefits[1] listed (where you need to stay overnight in a hospital).
- Bariatric surgery or gastric bypass[2].
- Day-care treatment[2].
- Expenses for one person accompanying an evacuated person[2].
- Kidney dialysis[2].
- Long term care[2].
- Medical evacuation[2] (or repatriation[2], where covered).
- MRI (Magnetic Resonance Imaging) scan. Pre-authorization is only needed for MRI scans if you wish us to settle your bill directly with the hospital.
- Nursing at home or in a convalescent home[2].
- Occupational therapy[2] (only out-patient treatment requires pre-authorization).
- Oncology[2] (only in-patient or day-care treatment requires pre-authorization).
- Organ transplant[1].
- Out-patient surgery[2].
- Palliative care[2].
- PET[2] (Positron Emission Tomography) and CT-PET[2] scans.
- Rehabilitation treatment[2].
- Repatriation of mortal remains[2].
- Routine maternity[2], complications of pregnancy and childbirth[2] (only in-patient treatment requires pre-authorization).
- Specialized out-patient drugs[2].
- Travel costs of insured family members in the event of an evacuation[2] (or repatriation, where covered).
- Travel costs of insured family members in the event of the repatriation of mortal remains[2].

Using the Pre-authorization Form helps us to settle your bill directly with hospitals, clinics and other medical facilities.

If you make a claim without obtaining pre-authorization, the following will apply:

- If the treatment received is subsequently proven to be medically unnecessary, **we reserve the right to decline your claim**.
- For the benefits listed with a **1 in your Table of Benefits, we reserve the right to decline your claim**. If the respective treatment is subsequently proven to be medically necessary, we will pay only **80%** of the benefit.
- For the benefits listed with a **2 in the Table of Benefits, we reserve the right to decline your claim**. If the respective treatment is subsequently proven to be medically necessary, we will pay only **50%** of the benefit.

# PAYING PREMIUMS

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

By accepting cover you have agreed to pay the premium amount shown on your quotation, by the payment method stated. You are required to pay the premium due to us in advance for the duration of your membership. The **initial premium** or first 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. When you receive your invoice, please check that the premium matches the amount shown on your agreed quotation and contact us immediately if there is any difference. We are not responsible for payments made through third parties.

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

+353 1 630 1301

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

If the initial premium is not paid in time, we are entitled to withdraw from the contract for as long as the payment remains outstanding. The insurance contract is deemed to be null and void unless we assert a claim to the premium in court within three months of the commencement date, the policy start date or the conclusion of the insurance contract. If a subsequent premium is not paid in time, we may, in writing and at the policyholder's expense, set a time limit of not less than two weeks for the policyholder 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 policyholder makes a payment within one month after the termination or, if the termination was combined with the setting of a time limit, within one month after the expiration of the time for payment, provided that no claims have been incurred in the intervening period.

## Paying other charges

If applicable, you may also need to pay the amount of any taxes, levies or charges relating to your cover that we may have to pay or collect from you by law.

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

# ADMINISTRATION OF YOUR POLICY

## Adding dependents

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

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

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

*What if I am adding multiple birth babies, adopted and fostered children?*
Multiple birth babies, born as a result of medically assisted reproduction, adopted and fostered children will be underwritten and if accepted, cover will start from the date of acceptance.

## Changes to policyholder

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

## Death of the policyholder or a dependent

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

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

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

## Changes to premium, other charges or your cover

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

Please note that we may change the amount you have to pay us in respect of taxes, levies or charges at any time, if there is a change in the rate of any new tax, levy or charge is introduced or changed.

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

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

## Changing country of residence

It is important to let us know when you change your country of residence. This may impact your cover or premium, even if you are moving to a country within your geographical area of cover. If you move to a country outside of your geographical area of cover, your existing cover will not be valid there. Cover in some countries is subject to local health insurance restrictions, particularly for residents of that country. It is your responsibility to ensure that your healthcare cover is legally appropriate. If you are not sure, please get independent legal advice, as we may no longer be able to cover you. The cover we provide is not a substitute for local compulsory health insurance.

Please also note that GlobalPass Plans are only available to residents of Latin America and the Caribbean. Therefore, treatment received after you have moved residence outside of Latin America and the Caribbean will not be covered.

## Changing your postal address or email address

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

## Correspondence

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

## Renewing your cover

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

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

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

## Changes that we may apply at renewal

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

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

## Your right to cancel

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

Should you wish to cancel, please complete the "Right to change your mind" form which was included in your welcome/renewal pack. This form can be sent to us via email.

@ underwriting@allianzworldwidecare.com

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

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

## Reasons your membership would end

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

- If you do not pay any of your premiums on, or before, the date they are due. However, we may allow your membership to continue without you having to complete a Confirmation of Health Status Form, if you pay the outstanding premiums within 30 days after the due date.
- If you do not pay the amount of any IPT, taxes, levies or charges that you have to pay under your agreement with us on or before the due date.
- Upon the death of the policyholder. Please see the section on "Death of the policyholder or a dependant" for further details.
- If there is reasonable evidence that the policyholder or any dependants misled or attempted to mislead us i.e. giving false information, 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 they can join the scheme, the applicable premium to pay or whether we have to pay a claim. Please see the section on "Additional terms" for further details.
- If you choose to cancel your policy, after giving us written notice within 30 days of receiving the full terms and conditions or from the start/renewal date of your policy, whichever is later. Please see section on "Your right to cancel" for further details.

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

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

## Policy expiry

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

# THE FOLLOWING TERMS ALSO APPLY TO YOUR COVER

1. **Applicable law:** Your membership is governed by the Irish law unless otherwise required under mandatory legal regulations. Any dispute that cannot otherwise be resolved will be dealt with by courts in Ireland.
2. **Economic sanctions:** Cover is not provided if any element of the cover, benefit, activity, business or underlying business violates any applicable sanction law or regulations of the United Nations, the European Union or any other applicable economic or trade sanction law or regulations.
3. **The amounts we will pay:** Our liability to you is limited to the amounts indicated in the Table of Benefits and any policy endorsements. The amount reimbursed, whether under this policy, public medical scheme or any other insurance will not exceed the figure stated on the invoice.
4. **Who can make changes to your policy:** No one, except an appointed representative is allowed to make changes to your policy on your behalf. Changes are only valid when confirmed in writing by us.
5. **When cover is provided by someone else:** We may decline a claim if you or any of your dependents are eligible to claim benefits from:

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

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

   We have the right to claim back from a third party any amount we paid for a claim, if the costs were due from or also covered by them. This is called subrogation. We may take legal proceedings in your name, at our expense, to achieve this.
6. **Circumstances outside of our control (force majeure):** We will always do our best for you, but we are not liable for delays or failures in our obligations to you caused by things which are outside of our reasonable control. Examples are extremely severe weather, floods, landslides, earthquakes, storms, lightning, fire, subsidence, epidemics, acts of terrorism, outbreaks of military hostilities (whether or not war is declared), riots, explosions, strikes or other labor unrest, civil disturbances, sabotage and expropriation by governmental authorities.

7. **Fraud:**

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

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

8. **Cancellation:** We will cancel the policy where you have not paid the full premium due and owing. We will notify you of this cancellation and the contract will be deemed cancelled from the date that the premium payment became due and payable. However, if the premium is paid within 30 days after the due date, the insurance cover will be reinstated and we will cover any claims which occurred during the period of delay. If the outstanding premium is paid after the 30-day limit, you must complete a Confirmation of Health Status Form before your policy can be reinstated, subject to underwriting.

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

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

# DATA PROTECTION

Our Data Protection Notice explains how we protect your privacy and process your personal data. You must read it before sending us any personal data. To read our Data Protection Notice visit:

www.allianzcare.com/en/privacy.html

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

+353 1 630 1301

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

AP.EU1DataPrivacyOfficer@allianz.com

# COMPLAINTS AND DISPUTE RESOLUTION PROCEDURE

## Making a complaint

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

+353 1 630 1301

client.services@allianzworldwidecare.com

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

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

www.allianzcare.com/complaints-procedure

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

## Mediation

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

2. If differences cannot be resolved in accordance with Clause "a" above, 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 will try to agree on the appointment of an agreed Mediator. If the parties fail to agree the appointment of an agreed Mediator within 14 days, either party, upon written notice to the other party, may apply to CEDR for the appointment of a Mediator.

To initiate the mediation, a party must give notice in writing (Alternative Dispute Resolution (ADR) Notice) to the other Party to the dispute, requesting mediation. A copy of the request should be sent to CEDR. The mediation will start no later than 14 days after the date of the ADR notice. No Party may commence court proceedings/arbitration relating to any dispute in relation to this Clause "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 the country of the Applicable Law. The Mediation Agreement referred to in the Model Procedure will be governed by, and construed and take effect in accordance with the laws of the country of the Applicable Law. The Courts of the country of the Applicable Law will have exclusive jurisdiction to settle any claim, dispute or matter of difference which may arise out of, or in connection with, the mediation.

3. Any dispute, controversy or claim which is:

   - Arising out of or relating to this Agreement (or the breach, termination or invalidity thereof) with a value in excess of US$600,000, or

   - Referred to mediation in relation to to Clause "b" but not voluntarily settled by mediation within three months of the ADR Notice date

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

## Legal action

You will not institute any legal proceedings to recover any amount under the policy 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.

# DEFINITIONS

**The following definitions apply to the benefits in our Healthcare Plans and to some other commonly used terms. The benefits you are covered for are listed in your Table of Benefits. If any specific benefits apply to your plan(s), the definition will appear in the "Notes" section at the end of your Table of Benefits. Wherever these words/phrases appear in your policy documents, they will always have the following meanings:**

# A

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

**Accommodation costs for one parent staying in hospital with an insured child under 18** refers to the hospital accommodation costs of one parent for the duration of the insured child's admission to hospital for eligible treatment. If a suitable bed is not available in the hospital, we will contribute the equivalent of 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.

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

# B

**Bariatric Surgery** refers to surgical procedures aimed to achieve weight loss, out of medical necessity. The surgical procedures we cover are: gastric bypass surgery, sleeve gastrectomy surgery, biliopancreatic diversion (with or without duodenal switch) and laparoscopic adjustable silicone gastric banding surgery. It also refers to all pre and post-surgery assessments, consultations and any complications thereafter, up to the benefit limit. Cover is only provided where all the following conditions are met:

a) You have a BMI of 40 or above, or a BMI between 35 and 40 in addition to two of the following significant diagnoses that could be improved with weight loss: Hypertension, Type 2 Diabetes Mellitus, Hypercholesterolemia, Ischemic Heart disease.
b) You have tried all appropriate non-surgical measures but have failed to achieve or maintain adequate, clinically beneficial weight loss for at least one year. All efforts and compliance with healthy eating and regular exercise need to be proven to Allianz Care.
c) You have received, or will be receiving intensive management in a specialist obesity service. We have the right to decide if an obesity clinic/bariatric surgeon is operating as a reasonable specialist obesity service.
d) You are deemed fit for anesthesia and surgery as decided by our medical director.
e) You commit to the need for long-term follow up and supervision.

Our medical director reserves the right to decline cover for Bariatric surgery if considered as non-medically necessary.

# C

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

**Complications of childbirth** refer to conditions that arise during childbirth and that require a recognized obstetric procedure. Complications of childbirth also refer to medically necessary Cesarean sections.

**Complications of pregnancy** relate to the health of the mother and to the conditions that arise during the pre-natal stages of pregnancy.

**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.

**Co-payment** is the percentage of the costs which you must pay. These apply per person, per Insurance Year, unless the Table of Benefits states otherwise. Some plans may include a maximum co-payment per insured person, per Insurance Year, and if so, the amount will be capped at the figure stated in your Table of Benefits.

# D

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

**Deductible** is the part of the cost that is payable by you and that we deduct from the amount we will pay. We offer two types of deductibles: "per person" and "per family".

The "per person" deductible applies to policies covering a single insured person with up to one dependent; this deductible applies separately to each person included in the policy.

The "per family" deductible applies to policies covering a family (i.e. three or more insured people); this deductible is applied collectively to all people included in the policy. Please note that both types of deductible apply per Insurance Year: therefore, if your claim is towards the end of the Insurance Year and treatment continues over the renewal date, the

annual deductible will be payable for treatment received in each Insurance Year.

Benefits that are subject to the deductible are listed in your Table of Benefits with an A.

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

Please refer to the Claims section for more information.

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

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

**Dental surgery** includes the surgical extraction of teeth, as well as other tooth-related surgical procedures such as apicectomy and dental prescription drugs. All investigative procedures that establish the need for dental surgery such as laboratory tests, X-rays, CT scans and MRI(s) are included under this benefit. Dental surgery does not cover surgical treatment that relates to dental implants.

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

**Dependent** is your spouse or partner (including same-sex partner) and unmarried children (including any step, fostered or adopted children) who are financially dependent on you and are named as dependents on your Insurance Certificate. Children are covered up to the day before their 18th birthday; or up to the day before their 24th birthday if they are in full-time education.

**Diagnostic tests** refers to investigations such as x-rays or blood tests, undertaken to determine the cause of the presented symptoms.

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

**Doctor** is a person who is licensed to practice medicine under the law of the country in which treatment is given and where they are practicing within the limits of their license.

**Doctor Fees** refer to fees for consultations, including medical practitioner and specialist fees, incurred in respect of out-patient treatment.

# E

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

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

**Emergency out-patient dental treatment** is treatment received in a dental surgery or hospital emergency room for the immediate relief of dental pain caused by an accident or an injury to a sound natural tooth. Treatment may include pulpotomy or pulpectomy and the subsequent temporary fillings, limited to three fillings per Insurance Year. Treatment must take place within 24 hours of the emergency event. It does not include any form of dental prostheses, permanent restorations or the continuation of root canal treatment.

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

**Expenses for one person accompanying an evacuated person** refer to the travel costs for one person accompanying the evacuated person. If they can't travel in the same vehicle, we will pay for an alternative form of transport at economy rates. Following completion of treatment, we will also cover the cost of the companion's return trip, at economy rates, to the country where the evacuation started from. Cover is not provided for hotel accommodation or other related expenses.

# F

**Family** refers to the policyholder with two or more legal dependents.

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

# H

**Health and wellbeing checks including screening for the early detection of illness or disease** are health checks, tests and examinations, performed at appropriate age intervals, that are undertaken without any clinical symptoms being present. Checks are limited to:

- Physical examination.
- Blood tests (full blood count, biochemistry, lipid profile, thyroid function test, liver function test, kidney function test).
- Cardiovascular examination (physical examination, electrocardiogram, blood pressure).
- Neurological examination (physical examination).
- Cancer screening:
  - Annual pap smear.
  - Mammogram (every two years for women aged 45+, or younger where a family history exists).
  - Prostate screening (yearly for men aged 50+, or from an earlier age where a family history exists).
  - Colonoscopy (every five years for members aged 50+, or 40+ where a family history exists).
  - Annual fecal occult blood test.
- Bone densitometry (every five years for women aged 50+).
- Well child test (for children up to the age of six years, up to a maximum of 15 visits per lifetime).
- BRCA1 and BRCA2 genetic test (where a direct family history exists and where included in your Table of Benefits).

**Hereditary condition** refers to any abnormality, deformity, disease or illness that has been passed down through the generations of your family. This includes, but is not limited to, Sickle Cell anemia and Huntington's Chorea.

**Home country** is a country for which you hold a passport/personal identification (ID), your birth country or your principal country of residence.

**Home visits** are consultations provided by a doctor or therapist in your home. We will reimburse home visits will at the same rate as a visit to the doctor/therapist's office. We will only reimburse amounts over and above this if it is deemed that a home visit was medically necessary. For example, following the sudden onset of an acute illness, you were rendered incapable of visiting the doctor or therapist at their office.

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

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

# I

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

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

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

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

# L

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

**Living donor medical costs** refer to donor medical expenses for organ transplants carried out as in-patient or day-care treatment. It also includes all necessary testing to determine compatibility, once a potential donor has been identified. We will cover the costs only in cases where you are the recipient of the donor's organ.

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

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

# M

**Medical evacuation** applies in the following scenarios:

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

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

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

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

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

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

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

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

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

**Medical practitioners** are doctors who are licensed to practice medicine under the law of the country in which treatment is given and where they are practicing within the limits of their license.

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

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

# N

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

Cover doesn't include further preventive diagnostic procedures, such as routine swabs, blood typing and hearing tests. However, if for medical reasons the child needs any follow-up investigations and treatment, these are covered under the newborn's own policy (if they have been added as a dependent). For multiple birth babies born as a result of medically assisted reproduction, in-patient treatment is limited to US$42,500 per child for the first three months following birth. Out-patient treatment is paid within the terms of the Out-patient Plan.

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

**Nutritionist** is a qualified individual holding a degree or postgraduate degree recognized for state registration or who is qualified and licensed under the law of the country in which the treatment is being given.

## O

**Obesity** is diagnosed when a person has a Body Mass Index (BMI) of over 30 (you can find a BMI calculator at: www.allianzcare.com/members).

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

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

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

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

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

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

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

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

**Organ transplant** is the surgical procedure in performing organ and/or tissue transplants that has been approved by the Food and Drug Administration (FDA), and is subject to all the terms, provisions and exclusions of the policy. This benefit covers medically necessary prescribed medication needed for pre- and post-transplant treatment and the surgical procedure, up to the benefit limit stated in your Table of Benefits. The costs associated with organ, cell or tissue procurement, transportation and harvesting are also covered. Please note that a separate benefit limit may apply to these and to any complications or consequences of them. We only pay for organ transplants that are required as a result of an eligible condition.

**Orthodontics** is the use of devices to correct malocclusion (misalignment of your teeth and bite). We will ask you to submit supporting information with your claim to show that your treatment is medically necessary and therefore eligible for cover. The information we ask for may include, but is not limited to:

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

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

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

**Out-patient surgery** is a surgical procedure performed in a surgery, hospital, day-care facility or out-patient department that does not require you to stay overnight out of medical necessity. Cover includes exploratory examinations and diagnostic tests carried out under anesthesia.

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

# P

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

**Periodontics** refers to dental treatment related to gum disease.

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

**Policyholder** is the person appearing first in the Insurance Certificate.

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

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

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

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

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

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

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

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

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

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

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

**Prescribed physiotherapy** refers to treatment provided by a registered physiotherapist following referral by a doctor. Our medical services department must review an initial assessment report before treatment to decide if treatment is medically necessary. Physiotherapy is initially restricted to 12 sessions per condition, after which the referring doctor must review the treatment. If you need further sessions, you must send us a new progress report after every set of 12 sessions, indicating the medical necessity for more treatment. Physiotherapy does not include therapies such as Rolfing, Massage, Pilates, Fango and Milta therapy.

**Prescription drugs** refers to products which you can't buy without a prescription and are to treat a confirmed diagnosis or medical condition or to compensate a lack of vital bodily substances. Examples are antibiotics, sedatives, etc. Prescription drugs must be clinically proven to be effective for the diagnosed condition. They must also be recognized by internationally accepted medical guidelines.

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

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

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

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

**Psychiatry and psychotherapy** refers to the treatment of mental disorders carried out by a psychiatrist or clinical psychologist.

The condition must be clinically significant and not related to:

- Bereavement
- Relationship or academic problems
- Acculturation difficulties
- Work pressure

All day-care or in-patient admissions must include prescription medication related to the condition. We will cover psychotherapy (on an in-patient or out-patient basis) in cases where you or your dependents are initially diagnosed by a psychiatrist or clinical psychologist and send us a psychiatric report. In addition, out-patient psychotherapy treatment (where covered) is for 10 sessions per condition initially. After every 10 sessions, your psychiatrist or clinical psychologist must review the treatment. If you need more sessions, your clinical psychologist or psychiatrist must send us a progress report that indicates the medical necessity for further treatment. We reserve the right to request a second medical opinion as appropriate.

# R

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

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

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

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

# S

**Second Medical Opinion** refers to the process of seeking an evaluation by another medical professional to confirm the diagnosis and treatment plan of a primary doctor, or to offer an alternative diagnosis and/or treatment.

**Specialist** is a licensed doctor possessing the additional qualifications and expertise necessary to practice as a recognized specialist in diagnostic techniques, treatment and prevention in a particular field of medicine. 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.

**Specialist fees** refers to non-surgical treatment performed or administered by a specialist.

**Specialized out-patient drugs** refers to highly specialized drugs that are used to treat the following chronic conditions: multiple sclerosis, rheumatoid arthritis, hemophilia, H.I.V., psoriasis, inflammatory bowel disease (IBD) and Hepatitis C. The prescription drugs must be clinically proven to be effective for the diagnosed condition. They must also be recognized by the pharmaceutical regulator in the country where you use the prescription. The benefit excludes any form of treatment or drug therapy which in our reasonable opinion is experimental or unproven based on generally accepted medical practice.

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

**Stem cell storage** refers to the costs for extraction and one year preservation of stem cells. The benefit limit applies to the insured mother per pregnancy. We don't cover travel or accommodation costs if the stem cell storage service is not available in the country where the baby is being delivered.

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

# T

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

**Travel costs of insured family members in the event of an evacuation** refers to the reasonable transportation costs of all insured family members of the evacuated person, including minors who might otherwise be left unattended. If all family members can't travel in the same vehicle with the evacuated person, we will pay for their round-trip transport at economy rates. Cover does not include hotel accommodation or other related expenses.

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

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

# W

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

**We/Our/Us** Is Allianz Care.

# Y

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

# EXCLUSIONS

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

### Acquisition of an organ and technical or animal organs
Organ transplants involving technical or animal organs and expenses incurred during the acquisition of an organ relating to stem cell storage and banking.

### Behavioral and personality disorders
Treatment for conditions such as conduct disorder, attention deficit hyperactivity disorder, autism spectrum disorder, oppositional defiant disorder, antisocial behavior, obsessive-compulsive disorder, phobic disorders, attachment disorders, adjustment disorders, eating disorders, personality disorders or treatments that encourage positive social-emotional relationships, such as family therapy.

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

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

### Complications caused by conditions not covered under your plan
Expenses incurred because of complications directly caused by an illness, injury or treatment for which cover is excluded or limited under your plan.

### Consultations performed by you or a family member
Consultations performed and any drugs or treatments prescribed, by you, your spouse, parents or children.

### Dental veneers
Dental veneers and related procedures.

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

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

### Experimental or unproven treatment or drug therapy
Any form of treatment or drug therapy which 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.

### Eye examinations
Eye examinations carried out by optometrists or ophthalmologists, unless otherwise stated in the Table of Benefits.

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

### Family therapy and counseling
Costs in respect of a family therapist or counselor for out-patient psychotherapy treatment.

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

### Gastric balloon
Gastric balloon surgery/treatment, vagus nerve blocking/Maestro rechargeable system or any complications of bariatric surgery where the original surgery was not covered by us.

### Genetic testing
Genetic testing, except:

a) Where specific genetic tests are included within your plan;

b) Where DNA tests are directly linked to an eligible amniocentesis i.e. in the case of women aged 35 or over;

c) Where testing for genetic receptor of tumors is covered.

### General nursing care
Hospitalization that is required for the purpose of general nursing care or any other purpose other than for receiving treatment covered by your membership.

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

### Injuries caused by professional sports
Treatment or diagnostic procedures for injuries arising from taking part in professional sports.

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

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

### Medical error
Treatment required as a result of medical error.

### Moving residence outside of Latin America
Treatment received after the policyholder has moved residence outside of Latin America and the Caribbean, as GlobalPass Plans are only available to residents of Latin America and the Caribbean.

### Obesity treatment
Investigations into, and treatment of, obesity except where the Bariatric surgery benefit forms part of your plan.

### Out-patient treatment
Treatment received on an out-patient basis when an Out-patient Plan does not form part of your cover (i.e. treatment 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.

### Orthomolecular treatment
Please refer to the definition of Orthomolecular treatment.

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

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

### Plastic surgery
Treatment carried out by a plastic surgeon, whether or not for medical/psychological purposes, and any cosmetic or aesthetic treatment to enhance your appearance, even when medically prescribed. The only exception is reconstructive surgery necessary to restore function or appearance after a disfiguring accident or as a result of surgery for cancer, if the accident or surgery occurs during your period of cover.

### Pre- and post-natal
Pre- and post-natal classes.

### Pre-existing conditions

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

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

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

### Prescribed medical aids

Costs related to the supplying and fitting of prescribed medical aids, unless stated otherwise in your Table of Benefits.

### Products sold without prescriptions

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

### Refractive surgery

Treatment to change the refraction of one or both eyes, including but not limited to refractive keratectomy (RK) and photorefractive keratectomy (PRK), unless otherwise indicated in your Table of Benefits.

### Sex change

Sex change operations and related treatments.

### Sleep disorders

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

### Speech therapy

Speech therapy related to developmental delay, dyslexia, dyspraxia or expressive language disorder.

### Stays in a cure center

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

### Sterilization, sexual dysfunction and contraception

Investigations into, treatment of and complications arising from:

- Sterilization.
- Sexual dysfunction (unless as a result of a total prostatectomy following cancer surgery).

- Contraception (including the insertion and removal of contraceptive devices and all other contraceptives, even if prescribed for medical reasons). The only exception is where contraceptives are prescribed by a dermatologist for the treatment of acne.

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

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

### Travel costs
Travel costs to and from medical facilities (including parking costs) for eligible treatment, except any travel costs covered under local ambulance and medical evacuation benefits.

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

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

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

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

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

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

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

### Vitamins or minerals
Products classified as:

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

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

### Benefits that are not in your Table of Benefits

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

- Complications of pregnancy and complications of childbirth.
- Dental treatment, dental surgery, periodontics, orthodontics and dental prostheses with the exception of oral and maxillofacial surgical procedures, which are covered within the overall limit of your Core Plan.
- Diagnostic tests.
- Doctor fees.
- Emergency dental treatment.
- Health and wellbeing checks including screening for the early detection of illness or disease.
- Nursing at home or in a convalescent home.
- Nutritionist consultations.
- Out-patient psychiatry and psychotherapy treatment.
- Out-patient treatment.
- Palliative care.
- Prescribed glasses and contact lenses including eye examination.
- Prescribed medical aids.
- Prescribed physiotherapy, speech therapy, oculomotor therapy, occupational therapy, chiropractic therapy, osteopathy, homeopathy, acupuncture and podiatry.
- Prescription drugs.
- Preventive treatment.
- Rehabilitation treatment.
- Routine maternity.
- Travel costs of insured family members in the event of an evacuation.
- Travel costs of insured family members in the event of the repatriation of mortal remains.

# NOTES

# Talk to us, we love to help!

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

24/7 Helpline for general enquiries and emergency assistance

| | |
|---|---|
| English: | +353 1 630 1301 |
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| French: | +353 1 630 1303 |
| Spanish: | +353 1 630 1304 |
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Toll free numbers: www.allianzcare.com/toll-free-numbers

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

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

Email: client.services@allianzworldwidecare.com

Fax: + 353 1 630 1306

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