GlobalPass Choice and Option

Individual Healthcare Plans for Latin America

Individual Benefit Guide

Valid from 1st May 2016

Allianz

Allianz Worldwide Care

Your healthcare cover

Your healthcare cover is based on an annual contract between Allianz Worldwide Care and the member(s) named on the Membership Certificate. The contract is composed of:

- The Benefit Guide (this document). This sets out the standard benefits and rules of your healthcare contract and should be read in conjunction with your Membership Certificate and Table of Benefits.

- The Membership Certificate. This states the plan(s) chosen, the start date and renewal date of the contract (and effective dates of when dependents were added) as well as the geographical area of cover. Any further special terms unique to your cover will be indicated in the Membership Certificate (and will have been detailed on a Special Conditions Form issued prior to the inception of your cover). Please note that we will send you a new Membership Certificate if you request (and we accept) a change such as adding a dependent, or if we apply a change which we are entitled to make.

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

- Information provided to us by, or on behalf of, the member(s) in the relevant application form or other supporting medical information.

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Your cover

Overview

Your Table of Benefits specifies the plan(s) selected and the associated benefits available to you. You will find further details about our benefits in the "Definitions" section of this guide. Not all of the benefits listed in our "Definitions" section are necessarily covered under your contract, which is why it's important to check which ones are listed in your Table of Benefits. Your cover is subject to our contract definitions, exclusions, benefit limits and any special conditions indicated on the Membership Certificate. If you have any queries about what you are covered for, please don't hesitate to call us.

We would like to bring your attention to the following important points:

Benefit limits

There are two kinds of benefit limits shown in the Table of Benefits. The **maximum plan benefit**, which applies to certain plans, is the maximum we will pay for all benefits in total, per member, per Membership Year, under that particular plan. Some benefits also have a **specific benefit limit**, which may be provided on a "per Membership Year" basis, a "per lifetime" basis or on a "per event" basis, such as per trip, per visit or per pregnancy. In some instances we will pay a percentage of the costs for the specific benefit e.g. "80% refund, up to US$5,000". Where a specific benefit limit applies, or where the term "Full refund" appears next to certain benefits, the refund is subject to the maximum plan benefit, if one applies to your plan(s). All limits are per member, per Membership Year, unless otherwise stated in your Table of Benefits.

If you are covered for maternity benefits, these will be stated in your Table of Benefits along with any benefit limit and/or waiting period which applies. Benefit limits for "Routine maternity" and "Complications of childbirth" are payable on either a "per pregnancy" or "per Membership Year" basis (this will also be confirmed in your Table of Benefits). If your benefit is payable on a "per pregnancy" basis and a pregnancy spans two Membership Years, please note that if a change is applied to the benefit limit at contract renewal, the following will apply:

- All eligible expenses incurred in the first year will be subject to the benefit limit that applies in year one.
- All eligible expenses incurred in the second year will be subject to the updated benefit limit that applies in year two, less the total benefit amount reimbursed in year one.

- In the event that the benefit limit decreases in year two and this updated amount has been reached or exceeded by eligible costs incurred in year one, no additional benefit amount will be payable.

In-patient treatment for multiple birth babies born as a result of medically assisted reproduction will be covered up to US$42,500 per child for the first three months following birth. Out-patient treatment will be covered under the limits of the Out-patient Plan (if included in your cover).

Change to country of residence

It is important that you advise us when you change country of residence, as it 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.

Please note that cover in some countries is subject to local health cover restrictions, particularly for residents of that country. It is your responsibility to ensure that your healthcare cover is legally appropriate. If you are in any doubt, please seek independent legal advice as we may no longer be able to provide you with cover. The cover provided by Allianz Worldwide Care is not a substitute for local compulsory health cover.

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

Medical necessity and reasonable and customary charges

This contract provides cover for medical treatment, related costs, services and/or supplies that we determine to be medically necessary and appropriate to treat a patient's condition, illness or injury. Plus we will only pay for medical costs which are fair and reasonable and at the level customarily charged in the specific country and for the treatment provided, in accordance with standard and generally accepted medical procedures. If a claim is deemed by us to be inappropriate, we reserve the right to reduce the amount payable by us.

Pre-existing conditions

Pre-existing conditions are medical conditions or any related conditions for which one or more symptoms have been displayed at some point during your lifetime, irrespective of whether any medical treatment or advice was sought. Any such condition or related condition, about which you or your dependents could reasonably have been assumed to have known, or where pre-existence is clearly supported by one of three pre-defined sources of internationally published medical evidence (**PubMed:** www.ncbi.nlm.nih.gov/PubMed, **ELSEVIER:** www.elsevier.com or **Uptodate:** www.uptodate.com), will be deemed to be pre-existing.

Please refer to the "Notes" section of your Table of Benefits to confirm if pre-existing conditions are covered. Pre-existing conditions which have not been declared on the relevant application form are not covered. Plus, conditions arising between completing the relevant application form and the start date of the contract will equally be deemed to be pre-existing. Such pre-existing conditions will also be subject to medical underwriting and, if not disclosed, they will not be covered.

Congenital and hereditary conditions

Cover is provided for the treatment of congenital and hereditary conditions, as outlined in the "Definitions" section of this guide, up to an overall lifetime maximum of US$750,000.

All congenital and hereditary conditions must be declared 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. Pre-authorization is required for in-patient treatment.

Definitions

The following definitions apply to the benefits included in our range of healthcare plans and to some other commonly used terms. The benefits you are covered for are listed in your Table of Benefits. If any unique benefits apply to your plan(s), the definition will appear in the "Notes" section at the end of your Table of Benefits. Wherever the following words/ phrases appear in your contract documents, they will always be defined as follows:

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

1.2 **Accommodation costs for one parent staying in hospital with a member aged under 18** refers to the hospital accommodation costs of one parent for the duration of the child's admission to hospital for eligible treatment. If a suitable bed is not available in the hospital, we will contribute the equivalent of a three star hotel daily room rate towards any hotel costs incurred. We will not, however, cover sundry expenses including, but not limited to, meals, telephone calls or newspapers. The age limit applicable to the child may vary: please check your Table of Benefits for confirmation.

1.3 **Acute** refers to sudden onset.

1.4 **Complementary treatment** refers to therapeutic and diagnostic treatment that exists outside the institutions where conventional Western medicine is taught. This benefit only includes chiropractic treatment, osteopathy, Chinese herbal medicine, homeopathy, acupuncture and podiatry as practiced by approved therapists.

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

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

1.7 **Congenital condition** refers to any abnormality, deformity, disease, illness or injury present at birth whether diagnosed or not. This includes, but is not limited to, conditions such as hair lip or cleft palate.

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

1.9 **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.

1.10 **Deductible** is that part of the cost which remains payable by you and which has to be deducted from the reimbursable sum. We offer two types of deductibles: "per person" and "per family". The "per person" deductible applies to contracts covering a single member with up to one dependent; this deductible applies separately to each person included in the contract. The "per family" deductible applies to contracts covering a family (i.e. three or more members); this deductible is applied collectively to all persons included in the contract. Please note that both types of deductible apply per Membership Year: therefore, if your claim is towards the end of the Membership Year and treatment continues over the renewal date, the annual deductible will be payable for treatment received in each Membership Year.

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

If you also have local cover in place (with another healthcare cover provider), you can request that any eligible in-patient/day-care claims paid for by the local healthcare cover provider are accepted as a contribution to the deductible amount on your Allianz Worldwide Care healthcare plan. This only applies to eligible in-patient/day-care treatment received in a hospital or clinic. Please refer to the Claims section on pages 24 and 25 for more information.

1.11 **Dental prescription drugs** are those prescribed by a dentist for the treatment of a 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. This does not include mouthwashes, fluoride products, antiseptic gels and toothpastes.

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

1.13 **Dental surgery** includes the surgical extraction of teeth, as well as other tooth related surgical procedures such as apicoectomy and dental prescription drugs. All investigative procedures necessary to 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 any surgical treatment that is related to dental implants.

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

1.15 **Dependent** is your spouse or partner (including same sex partner) and/or unmarried children (including any step, foster or adopted child) financially dependent on the principal member up to the day before their 18th birthday; or up to the day before their 24th birthday if in full time education, and also named on your Membership Certificate as one of your dependents.

1.16 **Diagnostic tests** are investigations such as, but not limited to, x-rays or blood tests, undertaken in order to determine the cause of the presented symptoms.

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

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

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

1.20 **Emergency in-patient dental treatment** refers to acute emergency dental treatment due to a serious accident requiring hospitalization. The treatment must be received within 24 hours of the emergency event. Please note that cover under this benefit does not extend to follow-up dental treatment, dental surgery, dental prostheses, orthodontics or periodontics. If cover is provided for these benefits, it will be listed separately in the Table of Benefits.

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

1.22 **Emergency treatment outside area of cover** is treatment for medical emergencies which occur during business or holiday trips outside your area of cover. Cover is provided 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 physician, medical practitioner or specialist must commence 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. Please advise us if you are moving outside your area of cover for more than six weeks.

1.23 **Expenses for one person accompanying an evacuated person** refers to the cost of one person traveling with the evacuated person. If this cannot take place in the same transportation vehicle, transport at economy rates will be paid for. Following completion of treatment, we will also cover the cost of the return trip, at economy rates, for the accompanying person to return to the country from where the evacuation originated. Cover does not extend to hotel accommodation or other related expenses.

1.24 **Family** refers to the principal member with two or more legal dependents.

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

1.26 **Health and wellbeing checks including screening for the early detection of illness or disease** are health checks, tests and examinations, performed at an appropriate age interval, 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 earlier where a family history exists).
  - Prostate screening (yearly for men aged 50+, or earlier 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).

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

1.28 **Home country** is the declared country to which the member would want to be repatriated.

1.29 **Home visits** are consultations provided by a medical practitioner, physician or therapist in the home of the member. Home visits will be reimbursed at the same rate as a visit to the medical practitioner/physician/therapist's office. Amounts over and above this will only be reimbursed if it is deemed that a home visit was medically necessary i.e. following the sudden onset of an acute illness, the member was rendered incapable of visiting the medical practitioner, physician or therapist at their office.

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

1.31 **Hospital accommodation** refers to standard private or semi-private accommodation as indicated in the Table of Benefits. Deluxe, executive rooms and suites are not covered. Please note that the hospital accommodation benefit only applies where no other benefit included in your plan covers the required in-patient treatment. In this case, hospital accommodation costs will be covered under the more specific in-patient benefit, up to the benefit limit stated. Psychiatry and psychotherapy, organ transplant, oncology, routine maternity, palliative care and long term care are examples of in-patient benefits which include cover for hospital accommodation costs, up to the benefit limit stated, where included in your plan.

1.32 **Infertility treatment** refers to treatment for the member including all invasive investigative procedures necessary to establish the cause for infertility such as hysterosalpingogram, laparoscopy or hysteroscopy. If your Table of Benefits does not list a specific benefit for infertility treatment, cover is limited to non-invasive investigations into the cause of infertility, within the limits of your Out-patient Plan (if selected). Please note that 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 (if selected).

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

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

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

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

1.37 **Medical evacuation** applies where the necessary treatment for which the member is covered is not available locally or if adequately screened blood is unavailable in the event of an emergency. We will evacuate the member to the nearest appropriate medical center (which may or may not be located in the member's home country) by ambulance, helicopter or airplane. The medical evacuation, which should be requested by your physician, will be carried out in the most economical way having regard to the medical condition. Following completion of treatment, we will also cover the cost of the return trip, at economy rates, for the evacuated member to return to his/her principal country of residence.

If medical necessity prevents the member from undertaking the evacuation or transportation following discharge from an **in-patient episode of care**, we will cover the reasonable cost of hotel accommodation up to a maximum of seven days, comprising of a private room with en-suite facilities. We do not cover costs for hotel suites, four or five star hotel accommodation or hotel accommodation for an accompanying person.

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

Where adequately screened blood is not available locally, we will, where appropriate, endeavor to locate and transport screened blood and sterile transfusion equipment, where this is advised by the treating physician. We will also endeavor to do this when our medical experts so advise. Allianz Worldwide Care and its agents accept no liability in the event that such endeavors are unsuccessful or in the event that contaminated blood or equipment is used by the treating authority.

Members must contact Allianz Worldwide Care at the first indication that an evacuation is required. From this point onwards Allianz Worldwide Care will organize and coordinate all stages of the evacuation until the member is safely received into care at their destination. In the event that evacuation services are not organized by Allianz Worldwide Care, we reserve the right to decline all costs incurred.

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

(a) Essential to identify or treat a patient's condition, illness or injury.
(b) Consistent with the patient's symptoms, diagnosis or treatment of the underlying condition.

(c) In accordance with generally accepted medical practice and professional standards of medical care in the medical community at the time.
(d) Required for reasons other than the comfort or convenience of the patient or his/her physician.
(e) Proven and demonstrated to have medical value.
(f) Considered to be the most appropriate type and level of service or supply.
(g) Provided at an appropriate facility, in an appropriate setting and at an appropriate level of care for the treatment of a patient's medical condition.
(h) Provided only for an appropriate duration of time.

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

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

1.40 **Member** is you and your dependents as stated on your Membership Certificate.

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

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

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

1.44 **Newborn care** includes customary examinations required to assess the integrity and basic function of the child's organs and skeletal structures. These essential examinations are carried out immediately following birth. Further preventive diagnostic procedures, such as routine swabs, blood typing and hearing tests, are not covered. Any medically necessary follow-up investigations and treatment are covered under the newborn's own contract. Please note that 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 (if selected).

1.45 **Nursing at home or in a convalescent home** refers to nursing received immediately after or instead of, eligible in-patient or day-care treatment. We will only pay the benefit listed in the Table of Benefits where the treating doctor decides (and our Medical Director agrees) that it is medically necessary for the member to stay in a convalescent home or have a nurse in attendance at home. Cover is not provided for spas, cure-centers and health resorts or in relation to palliative care or long term care (see definitions 1.57 and 1.36).

1.46 **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.

1.47 **Obesity** is diagnosed when a person has a Body Mass Index (BMI) of over 30 (a BMI calculator can be found on our website: www.allianzworldwidecare.com).

1.48 **Occupational therapy** refers to treatment that addresses the individual's development of fine and gross motor skills, sensory integration, coordination, balance and other skills such as dressing, eating, grooming, etc. in order to aid daily living and improve interactions with the physical and social world. An initial assessment report must be reviewed by our medical services department in advance of treatment to decide if treatment is medically necessary. A progress report is required after every set of 20 sessions.

1.49 **Oculomotor therapy** is a specific type of occupational therapy that aims to synchronize eye movement in cases where there is a lack of coordination between the muscles of the eye.

1.50 **Oncology** refers to specialist fees, diagnostic tests, radiotherapy, chemotherapy and hospital charges incurred in relation to the planning and carrying out of treatment for cancer, from the point of diagnosis. We will also cover the cost of a wig in the event of hair loss as a result of cancer treatment.

1.51 **Oral and maxillofacial surgical procedures** refer to surgical treatment performed by an oral and maxillofacial surgeon in a hospital as a treatment for: oral pathology, temporomandibular joint disorders, facial bone fractures, congenital jaw deformities, salivary gland diseases and tumors. Please note that surgical removal of impacted teeth and orthognathic surgeries for the correction of malocclusion, even if performed by an oral and maxillofacial surgeon, are not covered unless a Dental Plan has also been selected.

1.52 **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 contract. 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, as well as to any complications or consequences of them. We only pay for organ transplants that are required as a result of an eligible condition.

1.53 **Orthodontics** is the use of devices to correct malocclusion and restore the teeth to proper alignment and function. We only cover orthodontic treatment where the standard metallic braces and/or standard removable appliances are used. Cosmetic appliances such as lingual braces and invisible aligners are covered up to the cost of metallic braces, subject to the 'Orthodontic treatment and dental prostheses' benefit limit.

1.54 **Orthomolecular treatment** refers to treatment which aims to restore the optimum ecological environment for the body's cells by correcting deficiencies on the molecular level based on individual biochemistry. It uses natural substances such as vitamins, minerals, enzymes, hormones, etc.

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

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

1.57 **Palliative care** refers to ongoing treatment aimed at alleviating the physical/psychological suffering associated with progressive, incurable illness and maintaining quality of life. It includes in-patient, day-care or out-patient treatment following the diagnosis that the condition is terminal and treatment can no longer be expected to cure the condition. We will also pay for physical care, psychological care as well as hospital or hospice accommodation, nursing care and prescription drugs.

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

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

1.60 **Pre-existing conditions** are medical conditions or any related conditions for which one or more symptoms have been displayed at some point during your lifetime, irrespective of whether any medical treatment or advice was sought. Any such condition or related condition, about which you or your dependents could reasonably have been assumed to have known, or where pre-existence is clearly supported by one of three pre-defined sources of internationally published medical evidence (**PubMed:** www.ncbi.nlm.nih.gov/PubMed, **ELSEVIER:** www.elsevier.com or **Uptodate:** www.uptodate.com), will be deemed to be pre-existing. Conditions arising between completing the relevant application form and the start date of the contract will equally be deemed to be pre-existing. Such pre-existing conditions will also be subject to medical underwriting and if 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.

1.61 **Pregnancy** refers to the period of time, from the date of the first diagnosis, until delivery.

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

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

1.64 **Prescribed medical aids** refers to any device which is prescribed and medically necessary to enable the member to function to a capacity consistent with everyday living where reasonably possible. This includes:

- 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.
- Speaking aids such as an electronic larynx.
- Medically graduated compression stockings.
- Long term wound aids such as dressings and stoma supplies.

Costs for medical aids that form part of palliative care or long term care (see definitions 1.57 and 1.36) are not covered.

1.65 **Prescribed physiotherapy** refers to treatment by a registered physiotherapist following referral by a medical practitioner. An initial assessment report must be reviewed by our medical services department in advance of treatment to decide if treatment is medically necessary. Physiotherapy is initially restricted to 12 sessions per condition, after which the treatment must be reviewed by the referring medical practitioner. Should further sessions be required, a progress report must be submitted to us after every set of 12 sessions, which indicates the medical necessity for any further treatment. Physiotherapy does not include therapies such as Rolfing, Massage, Pilates, Fango and Milta therapy.

1.66 **Prescription drugs** refer to products, including, but not limited to, insulin, hypodermic needles or syringes, which require a prescription for the treatment of a confirmed diagnosis or medical condition or to compensate vital bodily substances. The prescription drugs must be clinically proven to be effective for the condition and recognized by the pharmaceutical regulator in a given country.

1.67 **Preventive treatment** refers to treatment that is undertaken without any clinical symptoms being present at the time of treatment. An example of such treatment is the removal of a pre-cancerous growth.

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

1.69 **Principal member** is the first person named on the Membership Certificate and who is the person who purchased the cover.

1.70 **Psychiatry and psychotherapy** is 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 or work pressure. All day-care or in-patient admissions must include prescription medication related to the condition. Psychotherapy treatment (on an in-patient or out-patient basis) is only covered where you or your dependents are initially diagnosed by a psychiatrist and referred to a clinical psychologist for further treatment. In addition, out-patient psychotherapy treatment (where covered) is initially restricted to 10 sessions per condition, after which treatment must be reviewed by the referring psychiatrist. Should further sessions be required, a progress report must be submitted to us, which indicates the medical necessity for any further treatment.

1.71 **Rehabilitation** is treatment in the form of a combination of therapies such as physical, occupational and speech therapy and is aimed at the restoration of a normal form and/or function after an acute illness or injury. The rehabilitation benefit is only payable for treatment that starts within 14 days of discharge after the acute medical and/or surgical treatment ceases and where it takes place in a licensed rehabilitation facility.

1.72 **Repatriation of mortal remains** is the transportation of the member's mortal remains from the principal country of residence to the country of burial. Covered expenses include, but are not limited to, expenses for embalming, a container legally appropriate for transportation, shipping costs and the necessary government authorizations. Cremation costs will only be covered in the event that this is required for legal purposes. Costs incurred by any accompanying persons are not covered, unless this is listed as a specific benefit in your Table of Benefits.

1.73 **Routine maternity** refers to any medically necessary costs incurred during pregnancy and childbirth, including hospital charges, specialist fees, the mother's pre- and post-natal care, midwife fees (during labor only) as well as newborn care. Costs related to complications of pregnancy or complications of childbirth are not payable under routine maternity. In addition, any non-medically necessary Cesarean sections will be covered up to the cost of a routine delivery in the same hospital, subject to any benefit limit in place. Please note that 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 (where selected).

1.74 **Specialist** is a qualified and licensed medical physician possessing the necessary additional qualifications and expertise to practice as a recognized specialist of diagnostic techniques, treatment and prevention in a particular field of medicine. This benefit does not include cover for psychiatrist or psychologist fees. Where covered, a separate benefit for psychiatry and psychotherapy will appear in the Table of Benefits.

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

1.76 **Speech therapy** refers to treatment carried out by a qualified speech therapist to treat diagnosed physical impairments, including, but not limited to, nasal obstruction, neurogenic impairment (e.g. lingual paresis, brain injury) or articulation disorders involving the oral structure (e.g. cleft palate).

1.77 **Surgical appliances and materials** are those which are required for the surgical procedure. These include artificial body parts or devices such as joint replacement materials, bone screws and plates, valve replacement appliances, endovascular stents, implantable defibrillators and pacemakers.

1.78 **Therapist** is a chiropractor, osteopath, homeopath, acupuncturist, physiotherapist, speech therapist, occupational therapist or oculomotor therapist, who is qualified and licensed under the law of the country in which treatment is being given.

1.79 **Travel costs of covered family members in the event of an evacuation** refers to the reasonable transportation costs of all covered family members of the evacuated person, including, but not limited to, minors who might otherwise be left unattended. If this cannot take place in the same transportation vehicle, round trip transport at economy rates will be paid for. Cover does not extend to hotel accommodation or other related expenses.

1.80 **Travel costs of covered family members in the event of the repatriation of mortal remains** refers to the reasonable transportation costs of any covered family members who had been residing abroad with the deceased member, to return to the home country/chosen country of burial of the deceased. Cover does not extend to hotel accommodation or other related expenses.

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

1.82 **Waiting period** is a period of time commencing on your contract 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 will indicate which benefits are subject to waiting periods.

1.83 **We/Our/Us** is Allianz Worldwide Care.

1.84 **You/Your** refers to the eligible individual stated on the Membership Certificate.

Exclusions

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

1. 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.

2. Any **treatment carried out by a plastic surgeon**, whether or not for medical/psychological purposes and any cosmetic or esthetic 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 membership.

3. **Care and/or treatment of drug addiction or alcoholism** (including detoxification programmes and treatments related to the cessation of smoking), instances of death, 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).

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

5. **Complementary treatment**, with the exception of those treatments indicated in the Table of Benefits.

6. **Consultations performed**, as well as **any drugs or treatments prescribed, by you, your spouse, parents or children**.

7. Costs in respect of a **family therapist or counselor** for out-patient psychotherapy treatment.

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

9. **Dental veneers** and related procedures.

10. **Developmental delay**, unless a child has not attained developmental milestones expected for a child of that age, in cognitive or physical development. We do not cover conditions in which a child is slightly or temporarily lagging in development. The developmental delay must have been quantitatively measured by qualified personnel and documented as a 12 month delay in cognitive and/or physical development.

11. Elective treatment required as a **result of medical error**.

12. Expenses incurred because of **complications directly caused by an illness, injury or treatment for which cover is excluded or limited** under your plan.

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

14. **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) testing for genetic receptor of tumors is covered.

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

16. Investigations into, and treatment of, **loss of hair** and any **hair replacement** unless the loss of hair is due to cancer treatment.

17. Investigations into, and treatment of, **obesity**.

18. Investigations into, treatment of and complications arising from **infertility, sterilization, sexual dysfunction** (unless this condition is as a result of total prostatectomy following surgery for cancer) and **contraception** including the insertion and removal of contraceptive devices and all other contraceptives, even if prescribed for medical reasons. The only exception in relation to costs for contraception is where contraceptives are prescribed by a dermatologist for the treatment of acne.

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

20. **Medical practitioner fees** for the **completion of a Claim Form** or other administration charges.

21. Organ transplants involving **technical or animal organs** and expenses incurred during the acquisition of an organ relating to **cord blood** storage and banking.

22. **Orthomolecular treatment** (please refer to definition 1.54).

23. **Pre-** and **post-natal** classes.

24. **Pre-existing conditions** which are indicated on a Special Conditions Form that is issued prior to cover inception (if relevant) and conditions which have not been declared on the relevant application form. In addition, conditions arising between completing the relevant application

form and the start date of the contract will equally be deemed to be pre-existing. Such pre-existing conditions will also be subject to medical underwriting and if not disclosed, they will not be covered.

25. Products classified as **vitamins** or **minerals** (except during pregnancy or to treat diagnosed, clinically significant vitamin deficiency syndromes) and supplements including, but not limited to, special infant formula and cosmetic products, even if medically recommended, prescribed or acknowledged as having therapeutic effects. Costs incurred as a result of nutritional or dietary consultations are not covered, unless a specific benefit is included within your Table of Benefits.

26. Products that can be purchased without a **doctor's prescription**.

27. **Sex change operations** and related treatments.

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

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

30. **Termination of pregnancy**, except in the event of danger to the life of the pregnant woman.

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

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

33. Treatment for any illnesses, diseases or injuries, as well as instances of death resulting from **active participation in war, riots, civil disturbances, terrorism, criminal acts, illegal acts** or **acts against any foreign hostility**, whether war has been declared or not.

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

35. 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**, unless indicated otherwise in the Table of Benefits.

36. Treatment for or arising from **deafness** caused by maturing or ageing.

37. **Treatment in the USA** if we know or suspect that cover was purchased for the purpose of traveling to the USA to receive treatment for a condition, when the symptoms of the condition were apparent to the member prior to the purchase of cover.

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

39. Treatment or diagnostic procedures for **injuries arising from an engagement in professional sports**.

40. Treatment **outside the geographical area of cover**, as stated on your Membership Certificate, unless authorized by us.

41. Treatment received after the principal member has moved residence outside of **Latin America and the Caribbean**, as GlobalPass Plans are only available to residents of Latin America and the Caribbean.

42. **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.

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

44. 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.

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

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

47. The following **treatments, expenses, procedures or any adverse consequences** or complications relating to them, unless otherwise indicated in your Table of Benefits:

    47.1 Complication of pregnancy and complications of childbirth.
    47.2 Dental treatment, dental surgery, periodontics, orthodontics and dental prostheses with the exception of oral surgical procedures, which are covered within the overall limit of your Core Plan.

47.3 Diagnostic tests.
47.4 Doctor fees.
47.5 Emergency dental treatment.
47.6 Health and wellbeing checks including screening for the early detection of illness or disease.
47.7 Nursing at home or in a convalescent home.
47.8 Nutritionist consultations.
47.9 Out-patient psychiatry and psychotherapy treatment.
47.10 Out-patient treatment.
47.11 Palliative care.
47.12 Prescribed glasses and contact lenses including eye examination.
47.13 Prescribed medical aids.
47.14 Prescribed physiotherapy, speech therapy, oculomotor therapy, occupational therapy, chiropractic treatment, osteopathy, homeopathy, acupuncture and podiatry.
47.15 Prescription drugs.
47.16 Preventive treatment.
47.17 Rehabilitation treatment.
47.18 Routine maternity.
47.19 Travel costs of covered family members in the event of an evacuation.
47.20 Travel costs of covered family members in the event of the repatriation of mortal remains.

Additional terms

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

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

2. Mediation:

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

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

      To initiate the mediation, a party must give notice in writing (Alternative Dispute Resolution (ADR) Notice) to the other party to the dispute, requesting mediation. A copy of the request should be sent to CEDR. The mediation will start no later than 14 days after the date of the ADR notice. No party may commence court proceedings/arbitration relating to any dispute pursuant to this Clause 2.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 Paris (France). The Mediation Agreement referred to in the Model Procedure shall be governed by, and construed and take effect in accordance with the laws of France. The Courts of France shall have exclusive jurisdiction to settle any claim, dispute or matter of difference which may arise out of, or in connection with, the mediation.

   c) Any dispute, controversy or claim which is:
      - Arising out of or relating to this Agreement (or the breach, termination or invalidity thereof) with a value in excess of US$600,000, or
      - Referred to mediation pursuant to Clause 2.b but not voluntarily settled by mediation within three months of the ADR Notice date

shall be determined exclusively by the Courts of France and the parties will submit to the exclusive jurisdiction of those courts. Any proceedings brought pursuant to this Clause 2.c shall be issued within nine calendar months of the expiration date of the aforementioned three month period.

3. Cancellation: We will cancel the contract where you have not paid the full premium due and owing. We shall notify you of this cancellation and the contract shall be deemed cancelled from the date that the premium payment became due and payable. However, if the premium is paid within 30 days after the due date, the healthcare 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 contract can be reinstated, subject to underwriting.

4. Data protection: Allianz Worldwide Care, a member of the Allianz Group, is a French authorized company. We obtain and process personal information for the purposes of preparing quotations, underwriting contracts, collecting premium, paying claims and for any other purpose which is directly related to administering the healthcare contract. The confidentiality of patient and member information is of paramount concern to us. We comply fully with European Data Protection Legislation. You have a right to access the personal data that is held about you. You also have the right to request that we amend or delete any information which you believe is inaccurate or out of date. We will not retain your data for longer than is necessary for the purposes for which it was obtained.

5. Force majeure: We shall not be liable for any failure or delay in the performance of our obligations under the terms of this contract, caused by, or resulting from, force majeure which shall include, but is not limited to: events which are unpredictable, unforeseeable or unavoidable, such as 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, expropriation by governmental authorities and any other act or event that is outside of our reasonable control.

6. Fraud:

   a) Incorrect disclosure/non-disclosure of any material facts, by you or your dependents, which may affect our assessment of the risk, including, but not limited to, those material facts declared on the relevant application form will render the contract void from the commencement date, unless we confirm otherwise in writing. Conditions arising between completing the relevant application form and the start date of the contract will be deemed to be pre-existing and will not be covered if not disclosed. If the applicant is not sure whether something is material, the applicant is obliged to inform us. If the contract is rendered void due to incorrect disclosure or non-disclosure of any material facts, we will refund the premium amount(s) paid to date minus the cost of any medical

claims already paid. If the cost of claims exceeds the balance of the premium, we will seek reimbursement of this amount from the principal member.

b) If any claim is, in any respect, false, fraudulent, intentionally exaggerated or if fraudulent means/devices have been used by you or your dependents or anyone acting on your or their behalf to obtain benefit under this contract, we will not pay any benefits for that claim. The amount of any claim settlement made to you, before the fraudulent act or omission was discovered, will become immediately due and owing to us. If the contract is rendered void due to false, fraudulent, intentionally exaggerated claims or if fraudulent means/devices have been used, premium will not be refunded, in part or in whole, and any pending claims settlements will be forfeited. In the event of fraudulent claims, the contract will be cancelled from the date of our discovery of the fraudulent event.

7. **Legal action:** You shall not institute any legal proceedings to recover any amount under the contract until at least 60 days after the claim has been submitted to us and not more than two years from the date of this submission, unless otherwise required by mandatory legal regulations.

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

9. **Making contact with dependents:** In order to administer your membership in accordance with the healthcare contract, there may be circumstances when we will need to request further information. If we need to make contact in relation to a dependent on a contract (e.g. where further information is required to process a claim), the principal member, acting for and on behalf of the dependent, may be contacted by us and asked to provide the relevant information. Similarly, all information in relation to any person covered by the contract, for the purposes of administering claims, may be sent directly to the principal member.

10. **Third party liability:** If you or any of your dependents are eligible to claim benefits under a public scheme or any other contract of cover which pertains to a claim submitted to us, we reserve the right to decline to pay benefits. You must inform us and provide all necessary information if and when you are entitled to a claim from a third party. You and the third party may not agree any final settlement or waive our right to recover outlays without our prior written agreement. Otherwise, we are entitled to recover the amounts paid from you and to cancel the contract. We have full rights of subrogation and may institute proceedings in your name, but at our expense, to recover, for our benefit, the amount of any payment made under another contract.

11. **Use of MediLine:** Please note that the MediLine and its health-related information and resources are not intended to be a substitute for professional medical advice or for the care that patients receive from their doctors. It is not intended to be used for medical diagnosis or treatment and information should not be relied upon for that purpose. Always seek the advice of your doctor before beginning any new treatment or if you have any questions regarding a medical condition. You understand and agree that Allianz Worldwide Care is not responsible or liable for any claim, loss or damage directly or indirectly resulting from your use of this advice line or the information or the resources provided through this service. Calls to the MediLine will be recorded and may be monitored for training, quality and regulatory purposes.

12. **What we cover:**

a) The extent of your cover is determined by your Table of Benefits, the Membership Certificate, any contract endorsements, these contract terms and conditions, as well as any other legal requirements. We will reimburse, in accordance with your Table of Benefits and individual terms and conditions, medical costs arising from the occurrence or worsening of a medical condition.

b) Treatments and procedures are only covered if they have a palliative, curative and/or diagnostic purpose, are medically necessary, appropriate and performed by a licensed physician, dentist or therapist. Claims/costs will be paid/reimbursed if the medical diagnosis and/or prescribed treatment are in accordance with generally accepted medical procedures.

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

General information

Adding dependents

You may apply to include any of your family members on the contract by completing the relevant application form.

Newborn infants (with the exception of multiple birth babies born as a result of medically assisted reproduction, adopted and fostered babies) will be accepted for cover from birth without medical underwriting, provided that we are notified within six weeks of the date of birth and the birth parent or intended parent (in the case of surrogacy), has been covered by us for a minimum of six continuous months, immediately prior to the birth. To notify us of your intention to have your newborn child included on your contract, please email your request with a copy of the birth certificate to our Underwriting Team at: **underwriting@allianzworldwidecare.com**.

Notification of the birth after six weeks will result in newborn children being underwritten and cover will only commence from the date of acceptance. Please note that multiple birth babies born as a result of medically assisted reproduction, adopted and fostered children will be subject to full medical underwriting and cover will only commence from the date of acceptance.

Following acceptance by our Underwriting Team, we will issue a new Membership Certificate to reflect the addition of a dependent, and this certificate will replace any earlier version(s) you may have from the start date shown on the new Membership Certificate.

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 cover'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 contract renewal date to discuss your options, as changes to cover can only be made at contract 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.

Changes to principal member

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

Changing your address/email address

All correspondence will be sent to the details we have on record for you unless requested otherwise. Any change in your home, business or email address should be communicated to us in writing as soon as possible.

Claims

In relation to medical claims, please note that:

a) All claims should be submitted no later than six months after the end of each Membership Year. If cover is cancelled during the Membership Year, claims should be submitted no later than six months after the date that your cover ended. Beyond this time we are not obliged to settle the claim.

b) A separate Claim Form is required for each person claiming and for each medical condition being claimed for.

c) It is your responsibility to retain any original supporting documentation (e.g. medical receipts) where copies are submitted to us, as we reserve the right to request original supporting documentation/receipts up to 12 months after claims settlement, for fraud detection purposes. We also reserve the right to request a proof of payment by you (e.g. bank or credit card statement) in respect of your medical receipts. In addition, we advise that you keep copies of all correspondence with us as we cannot be held responsible for correspondence that does not reach us for any reason that is outside of our reasonable control.

d) If the amount to be claimed is less than the deductible figure under your plan, keep collecting all out-patient receipts and Claim Forms until you reach an amount in excess of your plan

deductible, then forward to us all completed Claim Forms together with supporting receipts/ invoices. Please note that if you have local cover in place (with another healthcare cover provider), you can request that any eligible in-patient/day-care claims paid for by the other provider are accepted as a contribution to the deductible amount on your Allianz Worldwide Care healthcare plan. This only applies to eligible in-patient/day-care treatment received in a hospital or clinic. Please send us a copy of a detailed invoice from the hospital along with a statement or official document confirming contribution from your local cover provider.

e) We cannot accept credit card receipts without invoices.

f) Please specify on the Claim Form the currency in which you wish to be paid (and ensure that your bank account supports it). Unfortunately, on rare occasions, we may not be able to make a payment in the currency you requested, due to international banking regulations. In this instance we will reimburse in US$. If we have to make a conversion from one currency to another, we reserve the right to choose which currency exchange rate to apply.

g) Only costs incurred as a result of eligible treatment will be reimbursed within the limits of your plan, after taking into consideration any pre-authorization requirements. Any deductibles or co-payments outlined in the Table of Benefits will be taken into account when calculating the amount to be reimbursed.

h) If you are required to pay a deposit in advance of any medical treatment, the cost incurred will only be reimbursed after treatment has taken place.

i) You and your dependents agree to assist us in obtaining all necessary information to process a claim. We have the right to access all medical records and to have direct discussions with the medical provider or the treating physician. We may, at our own expense, request a medical examination by our medical representative when we deem this to be necessary. All information will be treated in strict confidence. We reserve the right to withhold benefits if you or your dependents have not honored these obligations.

Contract expiry

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

Correspondence

Written correspondence between us must be sent by email or post (with the postage paid). We do not usually return original documents to you, unless you specifically request us to do so at the time of submission.

Countries where you can receive treatment

If the necessary medical treatment for which you are covered is not available locally, you can avail of treatment in any country within your geographical area of cover (your area of cover is confirmed in your Membership Certificate). In order to seek reimbursement for medical treatment and travel expenses incurred, pre-authorization is required prior to travel.

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

Please note that as an expatriate living abroad you are covered for eligible costs incurred in your home country, provided that your home country is within your area of cover.

Death of the principal member or a dependent

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

If the principal member dies, the healthcare cover will be terminated and a pro rata repayment of the current year's premium will be made if no claims have been filed (please note that we reserve the right to request a death certificate before a refund is issued). Alternatively, if they wish to, the next named dependent on the Membership Certificate may apply to become the principal member in his/her own right (if they meet the minimum age requirements), and include the other dependents under his/her membership. If they apply to do this within 28 days we will, at our discretion, not add any further special restrictions or exclusions applicable to them, in addition to those which already applied to them at the time of the principal member's death.

If a dependent dies, they will be taken off the contract and a pro rata repayment of the current year's premium for that member will be made, if no claims have been filed (please note that we reserve the right to request a death certificate before a refund is issued).

Making a complaint

The Allianz Worldwide Care Helpline (**+353 1 630 1301**) is always the first number to call if you have any comments or complaints. If we have not been able to resolve the problem on the telephone, please email or write to us at:

client.services@allianzworldwidecare.com

Customer Advocacy Team
Allianz Worldwide 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 detailed at: **www.allianzworldwidecare.com/complaints-procedure**. You can also contact our Helpline to obtain a copy of this procedure.

Other parties

No other person (except an appointed representative) is allowed to make or confirm any changes to your membership on your behalf, or decide not to enforce any of our rights. No change to your membership will be valid unless it is confirmed in writing by Allianz Worldwide Care.

Paying premiums

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

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/first premium instalment is payable immediately after our acceptance of your application. Subsequent premiums are due on the first day of the chosen payment period. You may choose between monthly, quarterly, half-yearly or annual payments depending on the payment method you choose. Please note that if there is any difference between the agreed quotation and your invoice, you should contact us immediately. We are not responsible for payments made through third parties.

Your premium should be paid in US Dollars. If you are unable to pay your premium for any reason, please contact us on: **+353 1 630 1301**. Changes in payment terms can be made at contract renewal, via written instructions, which must be received by us a minimum of 30 days prior to the renewal date. Failure to pay an initial premium or subsequent premium on time may result in loss of healthcare cover.

If the initial premium is not paid in time, we are entitled to withdraw from the contract for as long as the payment remains outstanding. The healthcare contract is deemed to be null and void unless we assert a claim to the premium in court within three months of the commencement date, the contract start date or the conclusion of the healthcare contract. If a subsequent premium

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

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

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

Pre-authorization

Your Table of Benefits will confirm which benefits available to you require pre-authorization through submission of a Pre-authorization Form. If pre-authorization is not obtained, 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 in the Table of Benefits with a **1, 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 eligible benefit.
- For the benefits listed in the Table of Benefits with a **2, 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 eligible benefit.

Reasons your membership would end

Please remember that your membership (and that of all the other people listed on the Membership 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 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 principal member. Please see the section on "Death of the principal member or a dependent" (page 26) for further details.

- If there is reasonable evidence that the principal member or any dependents 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" (pages 19-22) for further details.

- If you choose to cancel your contract, after giving us written notice within 30 days of receiving the full terms and conditions or from the start/renewal date of your contract, whichever is later. Please see section on "Your right to cancel" (page 31) 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 dependent's cover will also end.

Renewing your contract

Your annual contract is automatically renewed for the next Membership Year provided that the plan/plan combination selected is still available, we can continue to provide cover in your country of residence, all premiums due to us have been paid and the payment details we have for you are still valid on the renewal date. Please update us if you get a new/replacement credit card or if your bank account details have changed.

As part of this automatic process, one month before the renewal date, you will receive a new Membership Certificate along with details of any contract changes. If you do not receive your Membership Certificate one month before your renewal date, it is important that you notify us.

We have the right to apply revised membership terms and conditions, effective from the renewal date. The contract terms and conditions and the Table of Benefits that exist at renewal will apply for the duration of the Membership Year.

Treatment in the USA

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

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

Please note that treatment in the USA is not covered, if we know or suspect that cover was purchased for the purpose of traveling to the USA to receive treatment for a condition, when the symptoms of the condition were apparent to the member prior to the purchase of cover. If any claims have been paid by us in relation to the treatment described above, we reserve the right to seek reimbursement from the member of any amounts which have already been paid in claims.

Treatment needed as a result of somebody else's fault

If you are claiming for treatment that is needed when somebody else is at fault, you must write and tell us as soon as possible e.g. if you need treatment for an injury suffered in a road accident in which you are a victim. Please take any reasonable steps we ask of you to obtain the contract details of the person at fault so that we can recover, from the other provider, the cost of the treatment paid for by us. If you are able to recover the cost of any treatment for which we have paid, you must repay that amount (and any interest) to us.

When cover starts for you and your dependents

Our acceptance of your application for cover is confirmed when we issue your Membership Certificate and your cover is valid from the start date shown on the certificate. Please note that no benefit will be payable under your contract until the initial premium has been paid, with subsequent premiums being paid when due.

If any other person is included as a dependent under your membership, their membership will start on the effective date as shown on your most recent Membership Certificate which lists them as a dependent. Their membership may continue for as long as you remain the principal member and as long as any child dependents remain under the defined age limit. Child dependents can be covered under your contract 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 cover in their own right, should they wish to do so.

Your right to cancel

You can cancel the contract in relation to all covered members, or only in relation to one or more dependents, within 30 days of receiving the full terms and conditions of your cover or from the start/renewal date of your contract, 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 to: 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 Membership Year, provided that no claims have been made. If you choose not to cancel (or amend) your contract within this 30 day period, the contract will be binding on both parties and the full premium owing for the selected Membership Year will be due for payment, according to the payment frequency selected by you.

Notes

Quick start guide

You can detach this part of the Individual Benefit Guide, if you just wish to have the most commonly referenced information to hand. Your cover remains subject to our contract definitions, exclusions and benefit limits, as detailed in the full Individual Benefit Guide.

Allianz

Allianz Worldwide Care

Getting treatment

First, please check that your plan covers the treatment you are seeking. Your Table of Benefits will confirm which benefits are available to you, however you can always call our Helpline if you have any queries.

Remember, some treatments require pre-authorization

The following treatments/benefits require pre-authorization through submission of a Pre-authorization Form:

- All in-patient benefits listed (where you need to stay overnight in a hospital).
- Day-care treatment.
- Expenses for one person accompanying an evacuated person.
- Kidney dialysis.
- Long term care.
- Medical evacuation.
- MRI (Magnetic Resonance Imaging) scan. Pre-authorization is not needed for MRI scans unless you wish to have direct settlement.
- Nursing at home or in a convalescent home.
- Occupational therapy (only out-patient treatment requires pre-authorization).
- Oncology (only in-patient or day-care treatment requires pre-authorization).
- Out-patient surgery.
- Palliative care.
- PET (Positron Emission Tomography) and CT-PET scans.
- Rehabilitation treatment.
- Repatriation of mortal remains.
- Routine maternity, complications of pregnancy and childbirth (only in-patient treatment requires pre-authorization).
- Travel costs of covered family members in the event of an evacuation.
- Travel costs of covered family members in the event of the repatriation of mortal remains.

Use of the Pre-authorization Form helps us to assess each case and facilitate direct settlement with the hospital. Please note that we may decline your claim if pre-authorization is not obtained. You can find full details on page 28 of this guide.

Please also note that some benefits are subject to a deductible

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

Evacuations

At the first indication that a medical evacuation is required, please call our 24 hour Helpline (contact details can be found on the back of this detachable section) and we will take care of everything. Given the urgency of an evacuation, we would advise that you call us, however, you can also contact us by email at: **medical.services@allianzworldwidecare.com**. When emailing, please include "*Urgent – Evacuation*" in the subject line. Please contact us before talking to any alternative providers, even if approached by them, to avoid potentially inflated charges or unnecessary delays in the evacuation process. **In the event that evacuation services are not organized by Allianz Worldwide Care, we reserve the right to decline all costs incurred.**

Getting in-patient treatment

1. Download a Pre-authorization Form from our website: **www.allianzworldwidecare.com/gppf**
2. Send the completed form to us at least **five working days before** treatment, by:
   - Scan and email to: **medical.services@allianzworldwidecare.com**
   - Fax to: **+ 353 1 653 1780** or post to the address shown on the form.

If it's an **emergency:**

1. Get the emergency treatment you need and call us if you need any advice or support.
2. Either you, your physician, one of your dependents or a colleague needs to call our Helpline (**within 48 hours** of the emergency) to inform us of the hospitalization. Pre-authorization Form details can be taken over the phone when you call us.

Getting out-patient or dental treatment

When you visit a doctor, dentist, physician or specialist on an out-patient basis, please settle the bill with them and claim back the eligible expenses from us. Simply download a Claim Form from our website: **www.allianzworldwidecare.com/gpcf** and follow the steps below:

1. Get an invoice from the doctor/dentist which states 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.
2. Complete sections 1-4 and 7 of the Claim Form. Sections 5 and 6 only need to be completed by the doctor/ dentist if their invoice does not state the diagnosis and nature of treatment.
3. Send the Claim Form and all supporting documentation, invoices and receipts to us via:
   - Scan and email to: **claims@allianzworldwidecare.com** or
   - Fax to: **+ 353 1 645 4033** or post to the address shown on the form.

Without the diagnosis, we cannot process your claim promptly, as we will need to request these details from you or your doctor.

Claims will be paid promptly by cheque or bank wire transfer.

Please refer to the "Claims" section on pages 24 and 25 of this guide for additional important information about our claims process. You can find information about getting treatment in the USA on page 30.

Useful services

Please find details below of some useful services available to you:

- You can access our web-based member services at: **www.allianzworldwidecare.com/members**. Here you can **search for medical providers, download forms and access a range of health and wellbeing resources**. Please be aware that you are not restricted to using the medical providers listed on our website.

- The **24/7 MediLine Medical Advice Service** can be accessed on: **+44 (0) 208 416 3929**. This service, provided by an experienced English speaking medical team, offers information and advice on a wide range of topics including, but not limited to, blood pressure and weight management, infectious diseases, first aid, dental care, vaccinations, oncology, disability, speech, fertility, pediatrics, mental health and general health. For contract or cover related queries (e.g. benefit limits or the status of a claim), please contact our Helpline.

Contact details

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

24/7 Helpline for general enquiries and emergency assistance

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

Telephone:

English:	+ 353 1 630 1301
German:	+ 353 1 630 1302
French:	+ 353 1 630 1303
Spanish:	+ 353 1 630 1304
Italian:	+ 353 1 630 1305
Portuguese:	+ 353 1 645 4040

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

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

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

www.allianzworldwidecare.com

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