Employee Benefit Guide

Notice of Information

Valid from 1st January 2017

Your healthcare cover

This Benefit Guide sets out the standard benefits and rules of your group health insurance policy. Please read this guide in conjunction with your Insurance Certificate and Table of Benefits.

Your Insurance Certificate details the plan(s) and geographical area of cover that your company has chosen for you and your dependants (if relevant) as well as the start date and renewal date of your cover. For underwritten policies, this document will also state any special terms that apply to your cover. Please note that we will send you a new Insurance Certificate if we need to record any changes requested by your company or which we are entitled to make, or if, with your company's approval and our acceptance, you request a change such as adding a dependant.

Your Table of Benefits outlines the plan(s) selected by your company and the associated benefits available to you. In addition, it specifies any benefits/treatments which require submission of a Treatment Guarantee Form and confirms any benefits to which specific benefit limits, waiting periods, deductibles and/or co-payments apply. Your Table of Benefits will be issued using the currency agreed with your company (or with you, if you pay for the insurance premium).

For full details of your company's insurance contract, please contact your company's Group Scheme Manager. Please note that the terms and conditions of your membership may be changed from time to time by agreement between your company and Allianz Worldwide Care.

AWP Health & Life SA is regulated by the French Prudential Supervisory Authority located at 61, rue Taitbout, 75436 Paris Cedex 09, France.

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

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Your cover

Overview

Your Table of Benefits specifies the plan(s) selected by your company and the associated benefits available to you. This could be one of our standard Core Plans, which might have been chosen in combination with one of our standard Out-patient, Dental or Repatriation Plans, or your plan may have been designed specifically for your company. Cover is subject to our policy definitions, exclusions and benefit limits and for underwritten groups, cover is also subject to any special conditions indicated on the Insurance Certificate (and on the Special Conditions Form issued prior to policy inception).

You will find further details about our benefits in the "Definitions" section of this guide, however if you have any queries regarding what you are covered for, please do not 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 Insurance Year, under that particular plan. Some benefits also have a **specific benefit limit**, which may be provided on a "per Insurance 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. "65% refund, up to £4,150/€5,000/US$6,750/CHF6,500". 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 Insurance Year, unless otherwise stated in your Table of Benefits.

Benefit limits for "Routine maternity" and "Complications of pregnancy and childbirth" are payable on either a "per pregnancy" or "per Insurance Year" basis (this will be confirmed in your Table of Benefits). If your benefit is payable on a "per pregnancy" basis and a pregnancy spans two Insurance Years, please note that if a change is applied to the benefit limit at policy 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.

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

Medical necessity and customary charges

This policy 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 reimburse medical providers where their charges are reasonable and customary in accordance with standard and generally accepted medical procedures. If the costs of a claim are deemed by us to be too high, or the claim is not deemed to be medically necessary 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 dependants could reasonably have been assumed to have known before the start date of the policy, will be deemed to be pre-existing.

Pre-existing conditions (including any pre-existing chronic conditions) are covered within the limits of your plan(s).

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 policy documents, they will always be defined as follows:

All treatments are covered in line with those treatments covered by the French Social Security System, for insured persons who are affiliated to the French Social Security System.

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

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

1.3 **Accommodation costs for one parent staying in hospital with an insured child** refer 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. Please check your Table of Benefits to confirm whether an age limit applies with regard to your child.

1.4 **Acute** refers to sudden onset.

1.5 **Chronic condition** is defined as a sickness, illness, disease or injury which has one or more of the following characteristics:

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

1.6 **Company** is your employer whose name is mentioned in the Company Agreement.

1.7 **Company Agreement** is the agreement we have with your employer, which allows you and your dependants to be insured with us. This agreement sets out who can be covered, when cover begins, how it is renewed and how premiums are paid.

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

1.9 **Complications of childbirth** refer only to the following conditions that arise during childbirth and that require a recognised obstetric procedure: post-partum haemorrhage and retained placental membrane. Where the insured's plan also includes a routine maternity benefit, complications of childbirth shall also refer to medically necessary caesarean sections.

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

1.11 **Co-payment** is the percentage of the costs which the insured person must pay. These apply per person, per Insurance Year, unless indicated otherwise in the Table of Benefits. Some plans may include a maximum co-payment per insured person, per Insurance Year, and if so, the amount will be capped at the amount stated in your Table of Benefits. Co-payments may apply individually to the Core, Out-patient, Dental, Maternity or Repatriation Plans, or to a combination of these plans.

1.12 **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.

1.13 **Deductible** is that part of the cost which remains payable by you and which has to be deducted from the reimbursable sum. Where applied, deductibles are payable per person per Insurance Year, unless indicated otherwise in the Table of Benefits. Deductibles may apply individually to the Core, Out-patient, Dental, Maternity or Repatriation Plans, or to a combination of these plans.

1.14 **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 recognised by the pharmaceutical regulator in a given country. This does not include mouthwashes, fluoride products, antiseptic gels and toothpastes.

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

1.16 **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

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

1.18 **Dependant** is your spouse or partner (including same sex partner) and/or unmarried children (including any step, foster or adopted children) financially dependant on the policyholder 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 in your Insurance Certificate as one of your dependants.

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

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

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

1.22 **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.

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

1.24 **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 Insurance Year. The treatment must be received within 24 hours of the accident. This does not include any form of dental prostheses, permanent restorations or the continuation of root canal treatment. If your company also selected a Dental Plan for you, you will be covered under the terms of this plan for dental treatment in excess of the (Core Plan) emergency out-patient dental treatment benefit limit.

1.25 **Emergency out-patient treatment** is treatment received in a casualty ward/emergency room within 24 hours of an accident or sudden illness, where the insured does not, out of medical necessity, occupy a hospital bed. If your company also selected an Out-patient Plan for you, you are covered under the terms of this plan for out-patient treatment in excess of the (Core Plan) emergency out-patient treatment benefit limit.

1.26 **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. You should advise your company's Group Scheme Manager if you are moving outside your area of cover for more than six weeks.

1.27 **Expenses for one person accompanying an evacuated/repatriated person** refer to the cost of one person travelling with the evacuated/repatriated 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/repatriation originated. Cover does not extend to hotel accommodation or other related expenses.

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

1.29 **Group Scheme Manager** is the designated representative of the company acting as the key point of contact between the company and us for matters relating to the administration of the plan such as enrolment, premium collection and renewal.

1.30 **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 faecal 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).

1.31 **Home country** is a country for which the insured person holds a current passport or is their principal country of residence.

1.32 **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-centres and health resorts.

1.33 **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.

1.34 **Infertility treatment** refers to treatment for the insured person 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 have 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 your company selected one). If however, there is a specific benefit for infertility treatment, the cost for infertility treatment will be covered for the insured member who receives the treatment, up to the limit indicated in the Table of Benefits. Any costs exceeding the benefit limit cannot be claimed under the cover of the spouse/partner (if included in the policy). In the case of InVitro Fertilisation (IVF), cover is limited to the amount specified in the Table of Benefits. Please note that for multiple birth babies born as a result of medically assisted reproduction, in-patient treatment is limited to £24,900/€30,000/US$40,500/CHF39,000 per child for the first three months following birth. Out-patient treatment is paid within the terms of the Out-patient Plan.

1.35 **In-patient cash benefit** is payable when treatment and accommodation for a medical condition, that would otherwise be covered under the insured's plan, is provided in a hospital where no charges are billed. Cover is limited to the amount and the maximum number of nights specified in the Table of Benefits and is payable upon discharge from hospital.

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

1.37 **Insurance Certificate** is a document outlining the details of your cover and is issued by us. It confirms that an insurance relationship exists between your company and us.

1.38 **Insurance Year** applies from the effective date of the insurance, as indicated on the Insurance Certificate and ends at the expiry date of the Company Agreement. The following Insurance Year coincides with the year defined in the Company Agreement.

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

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

1.41 **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.

1.42 **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.

1.43 **Medical evacuation** applies where the necessary treatment for which the insured person is covered is not available locally or if adequately screened blood is unavailable in the event of an emergency. We will evacuate the insured person to the nearest appropriate medical centre (which may or may not be located in the insured person's home country) by ambulance, helicopter or aeroplane. 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 insured person 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, up to the amounts specified in the Table of benefits. We do not cover costs for hotel suites, four or five star hotel accommodation or hotel accommodation for an accompanying person.

Where an insured person has been evacuated to the nearest appropriate medical centre for **ongoing treatment**, we will agree to cover the reasonable cost of hotel accommodation comprising of a private room with en-suite facilities up to the amounts specified in the Table of Benefits. The cost of such accommodation must be more economical than successive transportation costs to/from the nearest appropriate medical centre 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, endeavour to locate and transport screened blood and sterile transfusion equipment, where this is advised by the treating physician. We will also endeavour to do this when our medical experts so advise. Allianz Worldwide Care and its agents accept no liability in the event that such endeavours 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 organise and coordinate all stages of the evacuation until the insured person is safely received into care at their destination. In the event that evacuation services are not organised by Allianz Worldwide Care, we reserve the right to decline all costs incurred.

1.44 **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 medical and/or scientific knowledge at the time of treatment.
(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.

In this definition, the term "appropriate" means 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.

1.45 **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 practising within the limits of his/her licence.

1.46 **Medical practitioner fees** refer to non-surgical treatment performed or administered by a medical practitioner.

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

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

1.48 **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.

1.49 **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. Unless the child is included on the policy as an eligible dependant, 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 policy. Please note that for multiple birth babies born as a result of medically assisted reproduction, in-patient treatment is limited to £24,900/ €30,000/ US$40,500/CHF39,000 per child for the first three months following birth. Out-patient treatment is paid within the terms of the Out-patient Plan.

1.50 **Non-prescribed physiotherapy** refers to treatment by a registered physiotherapist where referral by a medical practitioner has not been obtained prior to undergoing treatment. Where this benefit applies, cover is limited to the number of sessions indicated in your Table of Benefits. Additional sessions required over and above this limit must be prescribed in order for cover to continue; these sessions will be subject to the prescribed physiotherapy benefit limit. Physiotherapy (either prescribed, or a combination of non-prescribed and prescribed treatment) is initially restricted to 12 sessions per condition, after which the treatment must be reviewed by the referring medical practitioner. Should further sessions be required, a progress report must be submitted to us, which indicates the medical necessity for any further treatment. Physiotherapy does not include therapies such as Rolfing, Massage, Pilates, Fango and Milta therapy.

1.51 **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 insured person to stay in a convalescent home or have a nurse in attendance at home. Cover is not provided for spas, cure centres and health resorts or in relation to palliative care or long term care (see definitions 1.63 and 1.42).

1.52 **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).

1.53 **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 and grooming, etc. in order to aid daily living and improve interactions with the physical and social world. A progress report is required after 20 sessions.

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

1.55 **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.

1.56 **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 tumours. Please note that surgical removal of impacted teeth, the surgical removal of cysts 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.

1.57 **Organ transplant** is the surgical procedure in performing the following organ and/or tissue transplants: heart, heart/valve, heart/lung, small intestine, liver, pancreas, pancreas/kidney, kidney, bone marrow, parathyroid, skin/muscular/skeletal and cornea transplants. Expenses incurred in the acquisition of organs are not reimbursable.

1.58 **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.

1.59 **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 and hormones.

1.60 **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.

1.61 **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.

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

1.63 **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.

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

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

1.66 **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 dependants could reasonably have been assumed to have known before the start date of the policy, will be deemed to be pre-existing. Conditions arising between completing the relevant application form and the start date of the policy 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.

1.67 **Pregnancy** refers to the period of time from conception to delivery.

1.68 **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 and Spina Bifida tests, amniocentesis and DNA-analysis, if directly linked to an eligible amniocentesis.

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

1.70 **Prescribed drugs** refer to products prescribed by a physician for the treatment of a confirmed diagnosis or medical condition, or to compensate vital bodily substances including, but not limited to, insulin, hypodermic needles or syringes. The prescribed drugs must be clinically proven to be effective for the condition and recognised by the pharmaceutical regulator in a given country. Prescribed drugs do not legally have to be prescribed by a physician in order to be purchased in the country where the insured person is located; however, a prescription must be obtained for these costs to be considered eligible.

1.71 **Prescribed glasses and contact lenses including eye examination** refer to cover for one eye examination per Insurance Year, carried out by an optometrist or ophthalmologist and for lenses or glasses to correct vision.

1.72 **Prescribed medical aids** refer to any device which is prescribed and medically necessary to enable the insured person 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, orthopaedic supports/braces, artificial limbs and prostheses.

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

Costs for medical aids that form part of palliative care or long term care (see definitions 1.63 and 1.42) are not covered.

1.73 **Prescribed physiotherapy** refers to treatment by a registered physiotherapist following referral by a medical practitioner. Physiotherapy is initially restricted to 12 sessions per condition, after which the treatment must be reviewed by the referring medical practitioner. Should further sessions be required, a new 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.

1.74 **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 recognised by the pharmaceutical regulator in a given country.

1.75 **Preventative 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.

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

1.77 **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 dependants 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.

1.78 **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, injury or surgery. 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.

1.79 **Repatriation of mortal remains** is the transportation of the insured person'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 authorisations. 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.

1.80 **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 as well as newborn care. Costs related to complications of pregnancy and complications of childbirth are not payable under routine maternity. In addition, any non-medically necessary caesarean sections will be covered up to the cost of a routine delivery in the same hospital, subject to any benefit limit in place. If the home delivery benefit is included in your plan, a lump sum up to the amount specified in the Table of Benefits will be paid in the event of a home delivery.

1.81 **Specialist** is a qualified and licensed medical physician possessing the necessary additional qualifications and expertise to practice as a recognised 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.

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

1.83 **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).

1.84 **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.

1.85 **Therapist** is a chiropractor, osteopath, Chinese herbalist, 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.

1.86 **Travel costs of insured family members in the event of an evacuation/repatriation** refer to the reasonable transportation costs of all insured family members of the evacuated or repatriated person. If this cannot take place in the same transportation vehicle, round trip transport at economy rates will be paid for. In the event of an insured person's repatriation, the reasonable transportation costs of insured family members will only be covered if the relevant Repatriation Plan benefit forms part of your cover. Cover does not extend to hotel accommodation or other related expenses.

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

1.88 **Travel costs of insured members to be with a family member who is at peril of death or who has died** refer to the reasonable transportation costs (up to the amount specified in your Table of Benefits) so that insured family members can travel to the location of a first degree relative who is at peril of death or who has died. A first degree relative is a spouse, parent, brother, sister or child, including adopted children, fostered children or step children. Claims are to be accompanied by a death certificate or doctor's certificate supporting the reason for travel as well as copies of the flight tickets, and cover will be limited to one claim per lifetime of the policy. Cover does not extend to hotel accommodation or other related expenses.

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

1.90 **Vaccinations** refer to all basic immunisations and booster injections required under regulation of the country in which treatment is being given, any medically necessary travel vaccinations and malaria prophylaxis. The cost of consultation for administering the vaccine, as well as the cost of the drug, is covered.

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

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

1.93 **You/Your** refers to the person working for the Company and stated on the Insurance Certificate.

Exclusions

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

All treatments listed below are excluded unless otherwise covered by the French Social Security System, for insured persons who are affiliated to the French Social Security System.

1. Any form of **treatment** or **drug therapy** which is **experimental or unproven**, based on generally accepted medical practice.

2. Any **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 membership of the scheme.

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 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 counsellor** for out-patient psychotherapy treatment.

8. **Dental veneers** and related procedures.

9. **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.

10. Expenses for the **acquisition of an organ** including, but not limited to, donor search, typing, harvesting, transport and administration costs.

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

12. **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 tumours is covered.

13. **Home visits**, unless they are necessary following the sudden onset of an acute illness, which renders the insured incapable of visiting their medical practitioner, physician or therapist.

14. **Infertility treatment** including medically assisted reproduction or any adverse consequences thereof, unless you have a specific benefit for infertility treatment, or an Out-patient Plan has been selected (whereby you are covered for non-invasive investigations into the cause of infertility within the limits of your Out-patient Plan).

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

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

17. Investigations into, treatment of and complications arising from **sterilisation, 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.

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

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

20. **Orthomolecular treatment** (please refer to definition 1.59).

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

22. Products classified as **vitamins** or **minerals** (except during pregnancy or to treat diagnosed, clinically significant vitamin deficiency syndromes) and supplements, such as 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.

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

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

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

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

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

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

29. 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.

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

31. Treatment for conditions such as **conduct disorder, attention deficit hyperactivity disorder, autism spectrum disorder, oppositional defiant disorder, antisocial behaviour, 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.

32. **Treatment in the USA** if we know that cover was purchased for the purpose of travelling to the USA to receive treatment for a condition, when the symptoms of the condition were apparent to the insured person prior to the purchase of cover.

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

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

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

36. Treatment to change the **refraction of one or both eyes (laser eye correction).**

37. Treatment required as a result of **failure to follow medical advice**.

38. Treatment required as a **result of medical error**.

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

40. **Tumour 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.

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

    41.1 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.
    41.2 Dietician fees.
    41.3 Emergency dental treatment.
    41.4 Expenses for one person accompanying an evacuated/repatriated person.
    41.5 Health and wellbeing checks including screening for the early detection of illness or disease.
    41.6 Home delivery.
    41.7 Infertility treatment.
    41.8 In-patient psychiatry and psychotherapy treatment.
    41.9 Medical repatriation.
    41.10 Organ transplant.
    41.11 Out-patient psychiatry and psychotherapy treatment.
    41.12 Out-patient treatment.
    41.13 Prescribed glasses and contact lenses including eye examination.
    41.14 Prescribed medical aids.
    41.15 Preventive treatment.
    41.16 Rehabilitation treatment.
    41.17 Routine maternity.
    41.18 Travel costs of insured family members in the event of an evacuation/repatriation.
    41.19 Travel costs of insured family members in the event of the repatriation of mortal remains.
    41.20 Travel costs of insured members to be with a family member who is at peril of death or who has died.
    41.21 Vaccinations.

42. The **accidental death benefit**, in circumstances where the death of an insured person has been caused either directly or indirectly by:

42.1 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.

42.2 Intentionally caused diseases or self-inflicted injuries, including suicide, within one year of the enrolment date of the policy.

42.3 Active participation in underground/underwater activity such as underground mining or deep sea diving.

42.4 Above water activity (such as oil platforms, oil rigs) and aerial activity, unless otherwise specified in the Company Agreement.

42.5 Chemical or biological contamination, radioactivity or any nuclear material contamination, including the combustion of nuclear fuel.

42.6 Passive war risk:

- Being in a country where the French or British government has recommended their citizens to leave (this criteria will apply regardless of the insured person's nationality) and advised against 'all travel' to that location; or
- Travelling to or staying, for a period of more than 28 days per stay, in a country or an area where the French or British government advises "against all but essential travel".

The passive war risk exclusion applies regardless of whether the claim arises directly or indirectly as a consequence of war, riots, civil disturbances, terrorism, criminal acts, illegal acts or acts against any foreign hostility, whether war has been declared or not.

42.7 Being under the influence of drugs or alcohol.

42.8 Death that takes place more than 365 days after the occurrence of the accident.

42.9 Deliberate exposure to danger, except in an attempt to save human life.

42.10 Intentional inhalation of gas or intentional ingestion of poisons or legally prohibited drugs.

42.11 Flying in an aircraft, including helicopters, unless the insured person is a passenger and the pilot is legally licensed, or is a military pilot and has filed a scheduled flight plan when required by local regulations.

42.12 Active participation in extreme or professional sports including, but not limited to:

- Mountain sports such as abseiling, mountaineering and racing of any kind (other than on foot).
- Snow sports such as bobsleigh, luge, mountaineering, skeleton, skiing off-piste and snowboarding off-piste.
- Equestrian sports such as hunting on horseback, horse jumping, polo, steeple chasing or horse-racing of any kind.
- Water sports such as potholing (solo caving) or cave diving, scuba diving to a depth of more than 10 metres, high diving, white water rafting and canyoning.
- Car and motorcycle sports such as motorcycle riding and quad biking.
- Combative sports.
- Air sports such as flying with a microlight, ballooning, hang gliding, paragliding, parascending and parachute jumping.
- Various other sports such as bungee jumping.

Additional terms

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

1. **Applicable law and dispute resolution:** 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. **Data protection:** Allianz Worldwide Care, a member of the Allianz Group, is a French authorised insurance company. We obtain and process personal information for the purposes of preparing quotations, underwriting policies, collecting premium, paying claims and for any other purpose which is directly related to administering policies in accordance with the insurance contract. The confidentiality of patient and member information is of paramount concern to us. 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.

3. **Eligibility:** Only those group members (and dependants) as described in the Company Agreement.

4. **Fraud and non-disclosure**
   a) **For groups that require medical underwriting, any incorrect disclosure/non-disclosure or any intentional false statement of any material facts, by you or your dependants, which changes the nature or affects our assessment of the risk may render your cover void from the start date.** This includes, but is not limited to material facts declared on the relevant application form or in relation to an increased risk during the term of the policy.

      Where incorrect disclosure/non-disclosure is established, but is not intentional, the insurer is entitled to either increase the amount of your premium, or terminate your policy 10 days after we have provided you with written notice to this effect. In the latter case, we will refund the portion of the premium paid for the time where you are no longer on cover. If a valid claim has been submitted, we shall reduce the amount of the claim payment in proportion to the rate of the premium which would have been paid if the facts had been fully and accurately stated.

      Conditions arising between completing the relevant application form and the start date of the policy 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. If the applicant is not sure whether something is relevant, the applicant is obliged to inform us.

   b) **If any claim is false, fraudulent, intentionally exaggerated or if fraudulent means or devices have been used by you or your dependants or anyone acting on your or their behalf to obtain benefit under this policy, 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, and any pending claims settlements will be forfeited. We reserve the right to inform the company of any fraudulent activity on the part of you or your dependants.

5. **Force majeure:** We shall not be liable for any failure or delay in the performance of our obligations under the terms of this policy, 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 labour unrest, civil disturbances, sabotage, expropriation by governmental authorities and any other act or event that is outside of our reasonable control.

6. **Legal action:** All legal actions arising from an insurance policy shall have a time limit of two years from the date of the event that gave rise to the action.

   However, the limitation period shall not apply in the following circumstances:

   - in the event of non-disclosure, omission, fraudulent representation or misrepresentation of the risk incurred. In this instance the time period shall begin from the date on which we become aware of the non-disclosure, omission, fraudulent representation or misrepresentation.
   - if the relevant party proves that they were unaware of such facts that gave rise to the action. The limitation period shall start from the date the party becomes aware of such facts that led to the action.

   If a legal action is due to a third party claim, the limitation period shall only run from the date on which the third party initiates a legal action against an insured person or was compensated by the insured person.

   In case of accidental death, the limitation period is extended to ten years for insurance contracts covering personal accidents, where the persons entitled to benefit are the beneficiaries of the deceased insured person.

   The limitation period is interrupted by one of the common causes:

   - Any legal proceedings, including summary proceedings and cases brought before a court that does not have jurisdiction;
   - Any enforcement action, or any protective measure brought under the Civil Enforcement Procedures Code;
   - Any acknowledgement by us of an insured person's right to claim under the policy, or any acknowledgement of debt of an insured person towards us.

The limitation period is also interrupted when:

- An expert is appointed following a claim;
- A registered letter in relation to the payment of a premium is sent by the insurer and receipt is acknowledged by the insured person.
- A registered letter in relation to the payment of a premium is sent by the insured person and receipt is acknowledged by the insurer.

In accordance with article L.114-3 of the French Insurance Code, the parties involved in an insurance contract shall not modify the duration of the limitation period or add further causes of suspension or interruption, even if mutually agreed.

7. **Liability:** Our liability to the insured person is limited to the amounts indicated in the Table of Benefits and any subsequent policy endorsement. In no event will the amount of reimbursement, whether under this policy, public medical scheme or any other insurance, exceed the amount of the invoice.

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

9. **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.

10. **Third party liability:** If you or any of your dependants are eligible to claim benefits under a public scheme or any other insurance policy which pertains to a claim submitted to us, we reserve the right to decline to pay benefits. The insured person must inform us and provide all necessary information, if and when entitled to claim from a third party. The insured person and the third party may not agree to 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 the insured person and to cancel the policy. 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 policy.

General information

Adding dependants

You may apply to include any of your family members as a dependant provided that you are allowed to do so under the agreement between your company and us. Notification to add a dependant should be made through your company unless otherwise stated.

For non-underwritten groups, newborn infants will be accepted for cover from birth, provided that we are notified within four weeks of the date of birth. To have a newborn added to the policy, you must ask your company to submit a request in writing to its usual Allianz Worldwide Care contact person for membership changes. If we are notified four weeks or more after the date of birth, newborn children will be accepted for cover from the date of that notification.

For groups with full medical underwriting, newborn infants (except multiple birth babies, adopted and fostered children) will be accepted for cover from birth without medical underwriting, provided that we are notified within four weeks of the date of birth and the birth parent or intended parent has been insured with us for a minimum of six continuous months. To have a newborn added to the policy, you must ask your company to submit a request in writing and send it by email to our Underwriting Team at: **underwriting@allianzworldwidecare.com**. If we are notified four weeks or more after the date of birth, newborn children will be underwritten and cover will only start from the date of acceptance. Please note that all multiple birth babies, 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 Insurance Certificate to reflect the addition of a dependant, and this certificate will replace any earlier version(s) you may have from the start date shown on the new Insurance Certificate.

Applying for cover if group membership ends

If your cover under the Company Agreement comes to an end, you can apply for cover under one of our Healthcare Plans for Individuals. Your policy may be subject to underwriting. We reserve the right to decide on the acceptance of your application. The application must be submitted within one month of leaving the group scheme. The commencement date, if accepted for cover, will be the first day after leaving the group scheme.

Changing country of residence

It is important that you let us know if you change your country of residence as it may impact the cover or premium, even if you remain within your current geographical region of cover. 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 and we would recommend that you seek independent legal advice in this regard, as we may no longer be able to provide you with cover. Notification of change of residence should be made through your company unless otherwise stated.

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 two years after the treatment date. Beyond this time we are not obliged to settle the claim.

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

c) A separate Claim Form is required for each person claiming and for each medical condition being claimed for. Please note that as well as our hard and soft copy claim forms, if your company has selected our Online Services facility, members can now avail of our mobile MyHealth app for fast and easy claims submission.

d) 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 (or for up to two years for claims on CFE or French social security policies) after claims settlement, for auditing 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. 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.

e) 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.

f) Please specify on the Claim Form the currency in which you wish to be paid. 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 review each case individually to identify a suitable alternative currency option. If we have to make a conversion from one currency to another, we will use the exchange rate that applies on the date on which the invoices were issued, or we will use the exchange rate that applies on the date that claims payment is made. Please note that 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 policy, after taking into consideration any Treatment Guarantee 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 dependants agree to assist us in obtaining all necessary information to process a claim, and agree to waive any rights that you/they have to medical secrecy/confidentiality in respect of any medical records pertaining to your/their medical condition. You also authorise medical practitioners, doctors, dentists, healthcare professionals, hospital employees and health services to communicate any relevant information relating to your medical condition to our medical adviser(s) or to any third party expert(s) in case of disputes, subject to any legal restrictions which may apply. We may, at our own expense, request a medical examination by our medical representative when we deem this to be necessary. All information will be treated in strict confidence. We reserve the right to withhold benefits if you or your dependants have not honoured these obligations.

Reimbursement of eligible expenses under your policy incurred in respect of an illness, maternity or an accident, shall not exceed the costs that the insured person paid, following any additional reimbursement to which the insured person is entitled to receive. This includes payments made under article L.861-3 of the French Social Security Code. In addition, insurance cover of the same kind taken out with multiple insurers will only take effect within the limit of each insurance cover, regardless of the start date of each insurance policy.

Claims for accidental death

If this benefit is included on the healthcare plan selected, please note that claims must be reported within 90 working days following the date of death and the following documents must be provided:

- A fully completed Accidental Death Claim Form.
- A death certificate.
- A medical report indicating the cause of death.
- A written statement outlining the date, location and circumstances of the accident.
- Official documentation proving the insured person's family status, and for the beneficiaries, proof of identity as well as proof of relationship to the insured person.

Beneficiaries are, unless otherwise specified by the insured:

- The insured person's spouse, if not legally separated.
- Failing the spouse, the insured person's surviving children including step-children, adopted or foster children and children born less than 300 days from the date of the insured person's death; in equal shares among them.
- Failing the children, the insured person's father and mother, in equal shares between them, or to the survivor of them.
- Failing them, the insured person's estate.

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

Please note that in the specific case of the death of the insured person and one or all of the beneficiaries in the same occurrence, the insured person shall be considered the last deceased.

Continuation of cover

We shall continue to provide cover for your medical costs expenses (and, where applicable, your dependants) in certain circumstances, as outlined in the following sections below.

Where required, continuation of cover for your medical expenses will be provided by us under a new policy. This continuation of cover must be compliant with the Evin Act ("Loi Evin"), the applicable provisions of the French Insurance Code, the Social Security Code, the terms and conditions of the new policy issued by us (including premium payment terms) and the conditions as outlined in the sections:

Section A – Temporary cover

According to article L.911-8 of the French Social Security Code, in the event that your contract of employment terminates, you and any dependants covered under your policy shall be entitled to continued coverage under the French unemployment insurance system, provided the termination was not as a result of your gross negligence.

This only applies:
- From the date your employment is terminated. Cover will be provided for the duration of your French unemployment benefit period, limited to the duration of your last employment contract (or last contracts, in cases of consecutive contracts with the same employer), subject to a maximum period of 12 months. The period is assessed in months, rounded up if required.
- if you have initiated your rights to additional reimbursement with your last employer;
- if the continued coverage is the same as that in force within the company;
- if the continued coverage does not give you the right to collect indemnity payments of an amount greater than that of the unemployment benefit that you would receive for the same period;
- if you prove to us your entitlement to such continued cover under this section;
- if the employer specifies this continued coverage in the "Work Certificate" and informs us of the termination of the contract of employment referred to in the first bullet point.

Section B – Permanent continuation of cover if you are affiliated to the French Social Security and your employment contract is terminated.

In accordance with Article 4 of the Loi Evin, we shall continue to provide coverage for medical expenses to you and your dependants should your employment end. This only applies when:

- you were in receipt of cover as a member under the Company Agreement at the date of termination of your employment contract; and
- you are in receipt of disability, incapacity benefits, retirement pension or if you are not employed, in receipt of "revenue de remplacement" (income substitution benefit); and
- you continue to be affiliated to the French Social Security System.

You must request continuation of cover from us within six months following the termination of your employment contract, or if applicable, within six months following the expiry of the period when you benefitted from a temporary continuation of cover, in accordance with section A.

Section C – Permanent continuation of cover upon the request from dependants of a deceased employee who was affiliated to the French Social Security

In the event of your death whilst you are a member under the Company Agreement, any dependant(s) covered under your policy (as at the date of your death) will be entitled to continued coverage for medical expenses on the same terms as before. This only applies if:

- the dependant(s) request continuation of cover from us within six months following the date of your death; and
- you were affiliated to the French Social Security System at the date of your death.

In the event that such a request is made, the dependant(s) will be entitled to continued coverage for a maximum of 12 months following your death.

Section D – Permanent continuation of cover upon your request if you are affiliated to the French Social Security and if the Company Agreement is terminated

If your cover comes to an end due to the termination of the Company Agreement, you will be entitled to continued coverage under one of our Healthcare Plans for Individuals. This only applies if:

- you request continued coverage within one month of your cover ending under the Company Agreement, and
- you continue to be affiliated to the French Social Security System.

In all cases outlined previously we may require, at our discretion, any person who requests continued coverage to prove their entitlement to such continued cover. If you are in receipt of continued coverage you shall immediately notify us in the event that your circumstances change, including where you lose your entitlement to the benefits outlined above. Also for sections B to D, the premium rate charged by us for the first Insurance Year of the continued coverage shall not be more than 50% above the average rate applied to members under the Company Agreement for equivalent cover at the time the new insurance policy for continued coverage commences.

Section E – In all other cases, if the insurance cover terminates

If you are not affiliated to the French Social Security System and your cover under the Company Agreement comes to an end, you can apply for cover under one of our Healthcare Plans for Individuals. Your policy may be subject to underwriting and we reserve the right to decide on the acceptance of your application. The application must be submitted within one month of leaving the group scheme. If you are accepted for cover, the commencement date will be the first day after leaving the group scheme.

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 Insurance Certificate). In order to seek reimbursement for medical treatment and travel expenses incurred, Treatment Guarantee 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 policy; 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.

Ending your membership

Your company can end your membership or that of any of your dependants by notifying us in writing. Your membership will automatically end:

- At the end of the Insurance Year, if the agreement between Allianz Worldwide Care and your company is terminated.
- If your company decides to end the cover or does not renew your membership.
- If your company does not pay premiums or any other payment due to Allianz Worldwide Care in accordance with the Company Agreement.
- If you are an individual payer and you do not pay premiums or any other payment due under the Company Agreement with Allianz Worldwide Care. Should this happen, your company may exclude you from the group scheme after providing you with 40 days written notice. This notice shall only be sent 10 days after the premium payment due date.
- When you stop working for the company.
- Upon the death of the policyholder.

Allianz Worldwide Care can end a person's membership and that of their dependants if there is reasonable evidence that the person concerned has 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 you (or they) can join the scheme.
- What premiums your company has to pay.
- Whether we have to pay any claim.

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 or the Group Scheme Manager) 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 specifically agreed between your company and Allianz Worldwide Care.

Paying premiums

In most cases, your company is responsible for the payment of premiums to Allianz Worldwide Care for your membership and for the membership of any dependants also covered under the Company Agreement, together with any amount that may be due and payable in respect of membership (such as special tax on insurance contract (Taxe de Solidarité Additionnelle (TSA))). Please be aware that you may be liable for payment of tax in respect of the premiums paid by your company. For details, please check with your company.

If you are responsible for paying your insurance premium

If you are responsible for paying your insurance premium, you are required to pay the premium due to us in advance, for the duration of your membership. The amount your company has agreed with us and the payment frequency you have chosen, will be shown on your Insurance Certificate. The **initial premium** or the first premium instalment is payable immediately after our acceptance of your application. 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. **Subsequent premiums** are due on the first day of the chosen payment period.

Please note that you also have to pay us the amount of any special tax on insurance contract, other taxes, levies or charges relating to your membership that we are required by law to pay or to collect from you. These may already be in effect when you join but they could also be introduced (or change in the future) after you join. Any such charges will be shown on your invoice.

If any changes are applied to your premiums, TSA, other taxes, levies or charges, we will write to inform you.

Each year on the renewal date, we may change how we calculate or determine your premiums, the amount you have to pay and/or the method of payment. If so, you will be informed of these changes by your company at least three months before they take effect, and they will only apply from your renewal date. Changes in payment terms can be made by you at policy renewal. Please write to us to request this at least 30 days before the renewal date.

If you are unable to pay your premium for any reason, please contact us so that we can discuss this with you.

Policy expiry

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

Renewing membership

If your company pays for your premium, the renewal of your membership (and that of your dependants, if applicable) is subject to your company renewing your membership under the Company Agreement.

If you pay for your premium and your company renews your membership (and that of your dependants, if applicable) under the Company Agreement, your policy will be automatically renewed for the next Insurance Year, provided that 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 policy renewal date. Please update us if you get a new/replacement credit card or if your bank account details have changed.

Treatment Guarantee

Your Table of Benefits will confirm which benefits available to you require pre-authorisation through submission of a Treatment Guarantee Form. Please note that unless agreed otherwise between your company and us, if a Treatment Guarantee Form is not submitted to us, 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.

Treatment in the USA

If you have "Worldwide" cover and wish to locate a medical provider in the USA, simply go to: **www.allianzworldwidecare.com/olympus**. If you have a query about a medical provider, or if you have selected a provider and wish to arrange an appointment, please call (toll-free from the USA) **(+1) 800 541 1983**. Your company may have opted to provide you with a Caremark pharmacy card. If there is any amount to be paid by you, the pharmacy will confirm this. Please ensure that the

prescriptions you present have the date of birth of the person that the prescription is for. You can also apply for a discount pharmacy card which can be used any time your prescription is not covered by your healthcare policy. To register and obtain your discount pharmacy card, simply go to: http://members.omhc.com/awc/prescriptions.html and click on "Print Discount Card".

Please note that treatment in the USA is not covered, if we know that cover was purchased for the purpose of travelling to the USA to receive treatment for a condition, when the symptoms of the condition were apparent to the insured person 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 insured person 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 insurance details of the person at fault so that we can recover, from the other insurer, 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 dependants

Your insurance is valid from the start date on the Insurance Certificate and will continue until the group renewal date (also stated on the Insurance Certificate). Generally, this is one Insurance Year, unless agreed otherwise between your company and us or if you started your policy mid-year. At the end of this period, your company can renew the insurance on the basis of the policy terms and conditions applicable at that time. You will be bound by those terms.

Cover for dependants (if relevant) will start on the effective date shown on your most recent Insurance Certificate which lists them as a dependant. Their membership may continue for as long as you remain a member of the group scheme and as long as any child dependants remain under the defined age limit. Child dependants can be covered under your policy up until the day before their 18th birthday; or up until the day before their 24th birthday if they are in full time education. At that time, they may apply for cover in their own right under one of our Healthcare Plans for Individuals, should they wish to do so.

Notes

Quick start guide

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

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-authorisation

The following treatments/benefits require pre-authorisation through submission of a Treatment Guarantee 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/repatriated person.
- Kidney dialysis.
- Long term care.
- Medical evacuation (or repatriation, where covered).
- MRI (Magnetic Resonance Imaging) scan. Treatment Guarantee 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-authorisation).
- Oncology (only in-patient or day-care treatment requires pre-authorisation).
- 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-authorisation).
- Travel costs of insured family members in the event of an evacuation (or repatriation, where covered).
- Travel costs of insured family members in the event of the repatriation of mortal remains.

Use of the Treatment Guarantee Form helps us to assess each case and facilitate direct settlement with the hospital. Please note that we may decline your claim if a Treatment Guarantee is not obtained. You can find full details on page 29 of this guide.

Evacuations and repatriations

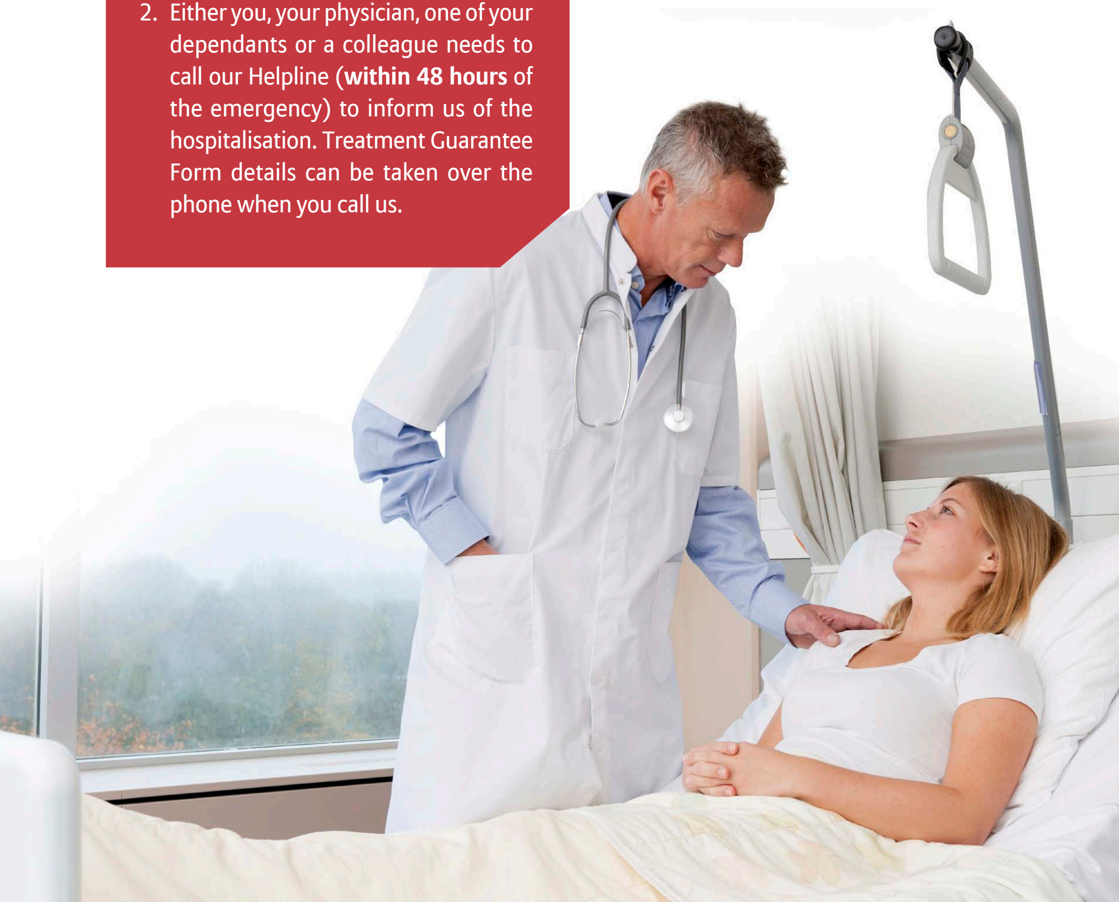
At the first indication that a medical evacuation/repatriation is required, please call our 24 hour Helpline (details on the back cover of this guide) and we will take care of everything. Given the urgency of an evacuation/repatriation, we would advise that you call us, however, you can also contact us by email at: **medical.services@allianzworldwidecare.com**. When emailing, please include "*Urgent – Evacuation/ Repatriation*" 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/repatriation services are not organised by Allianz Worldwide Care, we reserve the right to decline all costs incurred.

Getting in-patient treatment

1. Download a Treatment Guarantee Form from our website:
   www.allianzworldwidecare.com/members
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.
   - Our Helpline can take Treatment Guarantee Form details over the phone if treatment is taking place within 72 hours.

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 dependants or a colleague needs to call our Helpline (**within 48 hours** of the emergency) to inform us of the hospitalisation. Treatment Guarantee 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. If your company has selected our Online Services facility, claims can be submitted quickly and easily through our *MyHealth* app: simply provide a few key details, take a photo of your invoice(s) and press 'submit'. **www.allianzworldwidecare.com/myhealth**

Alternatively, simply download a Claim Form from our website: **www.allianzworldwidecare.com/members** 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.

We can process a claim and issue payment instructions to your bank within 48 hours, when all required information has been submitted. We will email or write to you to advise you of when the claim has been processed.

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

Please refer to the "Claims" section on pages 22-23 of this guide for additional important information about our claims process. You can find information about getting treatment in the USA on pages 29-30.

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.

- If your company has requested this facility, you will receive a username and password in your Membership Pack giving you access to our **Online Services** at: my.allianzworldwidecare.com. Alternatively, on the same page, select "Register" and provide the information requested (available on your Insurance Certificate). Via Online Services you can download key policy documents, check remaining benefit limits and the status of claims. If you are responsible for paying your own premium, you can pay your premiums by credit card and update your credit card details. Plus you can also make use of the great range of services available on our *MyHealth* app. www.allianzworldwidecare.com/myhealth

- 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, paediatrics, mental health and general health. For policy 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:
French: + 353 1 630 1303

English: + 353 1 630 1301
German: + 353 1 630 1302
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 policyholder (or an appointed representative) or the Group Scheme Manager can make changes to the policy. 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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Rating effective from 17th December 2015. For the latest rating, please visit www.ambest.com

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