

Individual Benefit Guide

International healthcare plans for CERN MPAs

Valid from 1st January 2026

Welcome

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

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

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

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How to use your cover

Support services

We believe in providing you with the top-quality service that you deserve. In the following pages we describe the full range of services we offer. Read on to discover what is available to you.

Talk to us, we love to help!

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

Phone from France, Belgium, Switzerland, Luxembourg and the Netherlands:

00 800 66 302 302



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

www.allianzcare.com/en/pages/toll-free-numbers.html

Email: IGOhelpline@e.allianz.com

Did you know...

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

Support when you need it most

Certain circumstances in life can be distressing, and not having the right support can make the insurance journey more challenging.

Our dedicated team is here to support you. We encourage you to disclose any additional support needs you may have with confidence - we will make reasonable adjustments where necessary, ensuring you have easy access to our products and services.

If you need to report a potential need, request specific adjustments in our communication, or nominate someone to interact with us on your behalf, please contact our team at enhancedsupport@e.allianz.com or fill out the online form available on our Enhanced Support page on our website: www.allianzcare.com/en/support/support-when-you-need-the-most/enhanced-support-services-.html.

MyHealth digital services

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

MyHealth app and online portal features



My policy

Access your policy documents and membership card on the go.



My claims

Submit your claims in three simple steps and view your claims history.



My contacts

Access our 24/7 multilingual Helpline. Live chat is also available on the online portal.



Symptom checker

Get a quick and easy assessment of your symptoms.



Provider finder

Locate medical providers nearby.



Pharmacy aid

Look up the local equivalent names of branded drugs.



Medical term translator

Translate names of common ailments into 17 languages.



Emergency contact

Access local emergency numbers worldwide.

Additional useful features

- Update your details online: email, phone number, password, address (if it's the same country as the previous address), marketing preferences, etc.
- View the remaining balance of each benefit that is in your Table of Benefits.

All personal data within MyHealth digital services is encrypted for data protection.

Getting started:

1. Login to MyHealth online portal to register. Go to my.allianzcare.com/myhealth, click on 'REGISTER HERE' near the bottom of the page and follow the on-screen instructions. Be ready to provide your policy number, which you can find in your Insurance Certificate.
2. As an alternative, you can register via our MyHealth app. To download it, search for 'Allianz MyHealth' on the Apple App Store or Android's Google Play service.



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

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

Web-based services

On www.allianzcare.com/members you can:

- search for medical providers. While you are not restricted to using the providers listed in our directory, we recommend doing so to take advantage of direct settlement.
- download forms.
- access our Health and Wellness Library.
- access our 'My expat life' hub – from planning to move, to settling down in your new country, you'll find everything you need to know about moving overseas.

Second Medical Opinion**

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

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

To access our service, simply contact us:

+353 1 630 1301

medical.smo@e.allianz.com

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

Member services included in your cover

Your policy doesn't just cover your medical expenses. It also includes a range of free member services. Check your Table of Benefits to confirm which ones are included in your cover.



Olive – our health and wellness programme**

Designed to motivate and guide you towards a healthier life. It includes access to:

- **Health and Wellness Hub**, offering online health assessments, webinars on wellbeing delivered by specialists, articles on topics such as sleep and nutrition, etc.
- **Our fitness app**, connecting with smart phones, wearable devices and other apps to monitor the number of steps taken, calories burned, sleep schedule and more. You can also join challenges with other users, and/or set up wellness goals and plans for yourself.



TeleHealth Hub — video consultation services**

If your plan includes cover for video consultation services, you have direct access to online medical professional appointments. With TeleHealth Hub, you can save time by speaking to a medical professional via video or phone from the comfort of your home or office. Offering a secure and confidential service, our telehealth network of medical providers can provide medical advice, recommend treatments and offer prescriptions for non-emergency concerns. Prescriptions will be available if your plan covers them and if the local regulation allows.



EAP — Expat Assistance Programme**

When challenging situations arise in life or at work, our EAP provides you and your dependants with immediate confidential support. The service includes:

- **Counselling** – confidential and professional support in-person, phone and video on topics such as stress, work/life balance, parenting, anxiety, cultural shock, addiction concerns, etc.

- **Legal and financial referral services**, for example to help buying a home, handling a legal dispute or creating a financial plan.

Please note that this service is not suitable for minors who are below the local legal age of consent, and does not include group therapy, such as family therapy.



Travel Security Services**

24/7 access to personal security information and advice for your travels, helpful as the world continues to witness an increase in security treats. You can access:

- **Emergency hotline**, to talk to a specialist for any safety concerns associated with your travel destination.
- **Country intelligence**, which offers information and advice about many countries.
- **Daily security news updates**, to receive email alerts about high-risk events in or near your location, including terrorism or severe weather risks.

To know more or to access the above member services, visit:

www.allianzcare.com/en/support/member-resources.html#care

** Certain services that may be included in your plan are provided by third party providers. If included in your plan, these services will show in your Table of Benefits.

These services are made available to you subject to your acceptance of your policy's terms and conditions, as well as the service's terms and conditions as set out by the relevant third party service provider. By accepting the third party service providers' terms and conditions, you enter a separate contractual relationship directly with them. Their services may be subject to geographical restrictions.

Full details of the third party service providers' terms and conditions are available in their websites and in the relevant application and/or platform where services may be hosted. The third party service providers are independent data controllers, and we recommend that you review their privacy notices to understand how they process your personal data. The third party service providers offer non-insurance services that are not intended to be a substitute for in-person medical consultations, diagnosis, treatment, assessment or care. You understand and agree that the insurer, its reinsurer and their administrators are not responsible or liable for any claim, loss or damage, directly or indirectly resulting from your use of any of these third party services.

Understanding how your cover works

What am I covered for?

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

Where can I receive treatment?

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

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

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

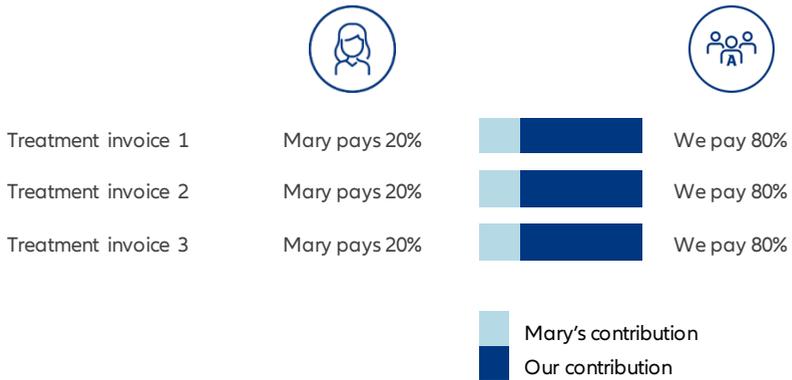
You are covered for eligible costs incurred in your home country, provided that your home country is in your area of cover.

What are benefit limits?

Your cover may be subject to a **maximum plan limit**. This is the maximum we will pay in total for all benefits included in the plan. Although many benefits included in your Table of Benefits are covered in full, some are capped to a specific amount (e.g. € 3,000). This specific amount is a benefit limit. For further information on benefit limits please see the 'Benefit limits' section of this guide.

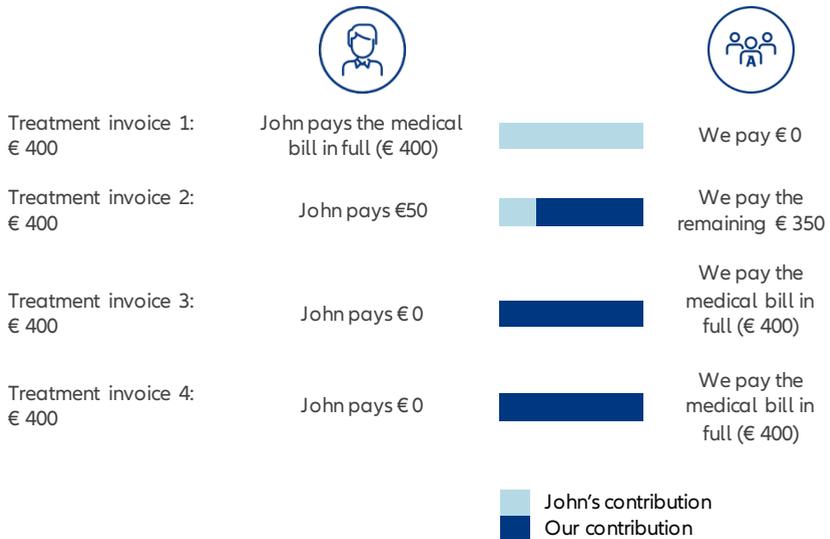
What are co-payments?

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



What are deductibles?

A deductible (also known in health insurance as an 'excess') is a fixed amount you need to pay towards your medical bills per period of cover before we begin to contribute. Your Table of Benefits will show whether this applies to your plan. In the following example, John needs to receive medical treatment throughout the year. His plan includes a € 450 deductible.



Seeking treatment?

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

Step 1. Check your level of cover

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

Step 2. Confirm if your treatment requires our pre-authorisation

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

Step 3. Use your provider network

We recommend that you use the medical provider network for your treatments, as it gives you the following advantages:

1. If your treatment requires pre-authorisation, your network medical provider may be able to request this on your behalf.
2. You will be able to access direct settlement for most treatments.

What is direct settlement?

Direct settlement means that we pay your eligible medical costs directly to your medical provider. However, please note that there might still be amounts that you will have to pay, if your plan includes deductibles or co-payments, or the cost of treatment or service exceeds the benefit limits of your plan.

What if direct settlement is not available for my treatment?

Not all treatment costs can be settled on a direct settlement basis: your network medical provider will inform you when direct settlement is not available. In such instances, you will need to pay your medical provider and then submit a claim to us, as explained in the 'Claiming reimbursement for your out-patient, dental and other expenses' section.

What providers are included in my medical network?

You can confirm the medical providers included in your network by logging into MyHealth digital services. When scheduling an appointment with a network medical provider, please ensure that you state your policy number. You can find this on your membership card.

How to seek pre-authorisation

If in Step 2 above you have confirmed that your treatment requires pre-authorisation, and you are not attending a medical provider that can organise it for you, please follow the process below.



Download a Pre-authorisation Form from our website:

www.allianzcare.com/cernmpa



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



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

If it's an emergency

Get the emergency treatment you need and call us if you need any advice or support. If you are hospitalised, either you, your doctor, one of your dependants or a colleague needs to call our Helpline (within 48 hours of the emergency) to inform us of the hospitalisation. We can take Pre-authorisation Form details over the phone when you call us.

We can also take Pre-authorisation Form details over the phone if treatment is taking place within 72 hours. Please note that we may decline your claim if pre-authorisation is not obtained, where required.

Claiming reimbursement for your out-patient and other expenses

If your treatment expenses are not settled directly with your medical provider, and your treatment does not require our pre-authorisation, you can simply pay the bill and claim the expenses from us as follows:



Receive your medical treatment and pay the medical provider.



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



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

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

Evacuations and repatriations

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

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

+32 2 210 6597

IGOMedical@e.allianz.com

Seeking treatment in the USA

To access medical care in the USA, we strongly recommend that you contact us before planning any treatment.

This allows us to instruct our local third-party partner in the USA. Based on your medical condition, they will guide you through an extensive network of U.S. medical facilities that provide quality treatment on a direct billing basis and help avoid unnecessary or unexpectedly high costs.

In emergencies, where it is not possible to contact us in advance, simply show your membership card: your medical provider will then contact our third-party partner to initiate the necessary approvals in order for your treatment to proceed.

We will pay the cost of your eligible treatment directly to your medical provider, if you are responsible for any part of the costs, your provider will let you know.

For queries or requests for assistance related to treatment in the USA, please find all contact details on the back of your membership card.

Terms and conditions of your cover

Terms and conditions

This section describes the benefits and rules of your health insurance policy. Please read it together with your Insurance Certificate and Table of Benefits.

Your health insurance policy is an annual contract between Allianz and the insured person(s) named on the Insurance Certificate for the Period of Cover. The purpose of the health insurance policy is to provide health insurance for the benefit of all insured persons. The contract is made up of:

- The **Benefit Guide** (this document), which explains the standard benefits and rules of your health insurance policy. It should be read together with your Insurance Certificate and Table of Benefits.
- The **Insurance Certificate**. This states the Period of Cover selected and the effective date of your insurance cover under the Allianz International Healthcare Plan for CERN MPAs. We'll send you an updated Insurance Certificate if you request a change which we accept, such as adding a dependant, or if we apply a change that we're entitled to make.
- The **Table of Benefits**. This shows the benefits available to you under the Allianz International Healthcare Plan for CERN MPAs, and states which benefits/treatments require submission of a Pre-Authorisation Form. It also confirms any benefits where specific benefit limits, waiting periods, deductibles and/or co-payments apply.
- Information provided to us by (or on behalf of) the insured person(s) in the submitted Online Application Form.

Your cover explained

The Allianz International Healthcare Plan for CERN MPAs available to you is indicated in your Table of Benefits, which lists all the benefits you are covered for and any limits that apply. For an explanation of how your benefit limits apply to your plan, please see the section 'Benefit limits'.

Your benefits are also subject to:

- Policy definitions and exclusions (also available in this guide).
- Any special conditions as set out in this guide and in the Table of Benefits.

Eligibility for cover

The below conditions must be satisfied to be eligible for insurance cover under the Allianz International Healthcare Plan for CERN MPAs:

- The MPA's age of entry does not exceed 75 years.
- The MPA has a valid contract of association with CERN.

Dependants accompanying the MPA to reside in the French or Swiss region around CERN may be covered during the MPA's period of cover. Please refer to the definition of 'Period of Cover' for more details.

For MPAs located in Switzerland, the following categories are eligible for cover under a Healthcare Plan:

- MPAs domiciled in Switzerland who hold a valid 'P' legitimisation card, and MPAs who are not resident/domiciled in Switzerland and so are not subject to the obligation to obtain LAMal/KVG.
- Additionally, cover for members residing in Switzerland without a valid Swiss 'P' legitimisation card is limited to an overall maximum period of 90 days.
- You are no longer eligible for cover under the Healthcare Plan for CERN MPAs if you cease to be an MPA. Your cover will come to an end. Please contact us to advise of any change of your status.

The cover provided by Allianz is not a substitute for compulsory health insurance in your home country or host country, in France or Switzerland. Please note that it is your responsibility to ensure that you are compliant with any statutory compulsory health insurance requirements.

What we cover

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

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

When cover starts

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

If any of your dependants are included in your policy, they will be listed in the Insurance Certificate, along with the start date of their cover. They can remain on cover as long as you are the policyholder and as long as any children remain under the defined age limit. Children can stay on your policy until the day before their 18th birthday; or until the day before their 24th birthday if they are in full time education. Cover cannot be bought retroactively.

Benefit limits

The Table of Benefits shows two kinds of benefit limits:

- The **maximum plan limit** (which applies to certain parts of the Allianz International Healthcare Plan for CERN MPAs) is the maximum we will pay for all benefits in total, per member, per Insurance Year, under that particular part. If more than one Period of Cover is taken out in an Insurance Year, the maximum plan limit will apply from the date of the first Period of Cover in that Insurance Year and will apply to all the Periods of Cover taken out during that Insurance Year.
- Some benefits also have a **specific benefit limit**, which may be provided on a 'Period of Cover' basis, on a 'per lifetime' basis or on a "per event" basis (such as per trip, per visit or per pregnancy). In some instances, in addition to the benefit limit, we will only pay a percentage of the costs for the specific benefit e.g. '€ 500'.

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

- a specific benefit limit applies.
- the term 'Full refund' appears next to the benefit.

All limits are per member and Period of Cover, unless your Table of Benefits states otherwise.

If more than one Period of Cover is taken out in an Insurance Year, the benefit limits will apply from the date of the first Period of Cover in that Insurance Year and will apply to all the Periods of Cover taken out during that Insurance Year.

Claims and Pre-Authorisation process

Medical claims

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

- **Claiming deadline:** You must submit all claims (via our MyHealth app or online portal) no later than six months after the end of your Period of Cover. If cover is cancelled during the selected Period of Cover, you should submit your claim no later than six months after the date that your cover ended. After this time, we are not obliged to settle the claim.
- **Claim submission:** You must submit a separate claim for each person claiming and for each medical condition being claimed for.
- **Direct settlement of medical invoices:** If we make a payment directly to your medical provider for your medical costs and later we determine that your direct settlement claim is not eligible, we reserve the right to recover the full claim amount from you.
- **Supporting documents:** When you send us copies of supporting documents (e.g. medical receipts), please make sure you keep the originals. We have the right to request original supporting documents/receipts for auditing purposes up to 12 months after settling your claim. We may also request proof of payment by you (e.g. a bank or card statement) for medical bills you have paid. We advise that you keep copies of all correspondence with us as we cannot be held responsible for correspondence that fails to reach us for any reason outside of our control.
- **Deductibles:** If the amount you are claiming is less than the deductible figure in your plan, you can either:
 - collect all out-patient receipts until you reach an amount that exceeds this deductible figure.
 - send us each claim every time you receive treatment. Once you reach the deductible amount, we'll start reimbursing you.

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

- **Currency and charges:** Please specify the currency you wish to be paid in. On rare occasions, we may not be able to make a payment in that currency due to international banking regulations. If this happens, we will identify a suitable alternative currency. If we have to make a conversion from one currency to another, we will use the exchange rate that applied on the date the invoices were issued. We will cover all charges associated with the payment. However, if your bank applies a fee for receiving funds into your account as part of its terms and conditions, we will not be liable for this fee.
- **Reimbursement:** We will only reimburse (within the limits of your policy) eligible costs after considering any pre-authorisation requirements, deductibles or co-payments outlined in the Table of Benefits.
- **Reasonable and customary cost:** We will only reimburse charges that are reasonable and customary in accordance with standard and generally accepted medical procedures. If we consider a claim to be inappropriate, we reserve the right to decline your claim or reduce the amount we pay.
- **Deposits:** If you have to pay a deposit in advance of any medical treatment, we will reimburse this cost only after treatment has taken place.
- **Providing information:** You and your dependants agree to help us get all the information we need to process a claim. We have the right to access all medical records and to have direct discussions with the medical provider or the treating doctor. We may, at our own expense, request a medical examination by our doctors if we think it's necessary. All information will be treated confidentially. We reserve the right to withhold benefits if you or your dependants do not support us in getting the information we need.

Treatment needed as a result of someone else's fault

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

Pre-authorisation

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

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

- All in-patient benefits¹ listed (where you need to stay overnight in a hospital).
- Day-care treatment².
- Medical evacuation² (or repatriation², where covered).
- MRI (Magnetic Resonance Imaging) scan. Pre-authorisation is only needed for MRI scans if you wish us to settle your bill directly with the hospital.
- Out-patient surgery².
- PET² (Positron Emission Tomography) and CT-PET² scans.
- Repatriation of mortal remains².
- Routine maternity², Routine delivery and newborn care² and complications of pregnancy and childbirth² (only in-patient treatment requires pre-authorisation).

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

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

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

Paying premiums

By accepting cover you have agreed to pay the premium amount shown on your quotation, by the payment method stated. You can choose a payment method in the application form and depending on this, you may have to pay the premium in advance.

The full premium is payable immediately after we accept your application. Cover starts on the day indicated in the Insurance Certificate and only once the funds have been received on our side if you are paying by bank transfer.

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

+32 2 210 6501

If the full premium is not paid in time, we are entitled to withdraw from the contract for as long as the payment remains outstanding. The insurance contract is deemed to be null and void unless we assert a claim to the premium in court within three months of the commencement date, the policy start date or the conclusion of the insurance contract. If a subsequent premium is not paid in time, we may, in writing and at the policyholder's expense, set a time limit of not less than two weeks for the policyholder to

pay the amount due. Thereafter, we may terminate the contract in writing with immediate effect and will thereby be exempt to pay benefits.

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

Paying other charges

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

- Insurance Premium Tax (IPT)
- VAT
- Other taxes, levies or charges relating to your cover that we may have to pay or collect from you by law

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

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

Administration of your policy

Adding dependants

Are you getting married or having a baby? Congratulations!

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

How do I add a newborn to my policy?

Please send an email to IGOServices@e.allianz.com within four weeks from birth and attach the birth certificate. We will accept the baby without medical underwriting if the birth parent or intended parent (in the case of surrogacy) has been insured with us for the same period of cover. Cover will start at birth with the same Period of Cover as the policyholder.

What happens if I don't notify you within four weeks?

Notification of the birth after four weeks will result in newborn children not being covered under the Allianz International Healthcare Plan for CERN MPAs.

What if I am adding multiple birth babies?

Multiple birth babies will be underwritten and if accepted, cover will start from the date of acceptance. There is a limit for in-patient treatment that takes place in the first three months following birth if the baby:

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

This limit is 30,000 € per child and it applies before any other benefit in your plan. Out-patient treatment is paid under the terms of the Out-patient Plan.

Private and occupational accident cover

Medical expenses incurred as a result of a private or occupational accident are covered within the terms of your policy.

Hospital accommodation

In the event that the member chooses an accommodation which is outside the 'General Ward' level of cover provided (for example, semi-private or private room), treatment will be covered up to the cost that would apply if the equivalent treatment was received under 'General Ward' accommodation. Any additional costs must be covered by the member.

Applying for cover if your cover ends (end of Eligibility)

If your insurance cover comes to an end, you may apply for a transfer to a standard individual plan that we offer by sending us an email to individual.sales@allianzworldwidecare.com.

You need to send the email for transfer of cover within one month of the end of your cover. There must be no break in cover. Transfer of cover cannot be offered to dependants only.

Waiting periods will not apply if the chosen plan offers fewer or similar benefits to those of your existing cover under the Allianz International Healthcare Plan for CERN MPAs.

We reserve the right to accept or reject your application. The acceptance may be subject to premium surcharges, the exclusion of certain benefits from the cover or other special conditions.

Cover is subject to Allianz being able to offer you cover depending on your circumstances and country of residence. For certain countries special agreements are in place with regards to continuation of cover.

The cover provided by Allianz is not a substitute for local compulsory health insurance. Please note that it is your responsibility to ensure that you are compliant with any applicable statutory, in particular compulsory health insurance requirements, of your country of residence.

Retention of Legitimation Cards and Insurance Coverage Extension

The Federal Department of Foreign Affairs (FDFA) allows holders of legitimation cards to keep them for up to two or three months after their

contract ends to help them settle their affairs in Switzerland. During this period, all residents in Switzerland must maintain valid health insurance coverage. Therefore, members have the option to extend their insurance for this additional period to comply with Swiss regulations.

Changes to policyholder

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

Death of the policyholder or a dependant

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

If the policyholder dies, the policy will be terminated and a pro rata repayment of the premium will be made if no claims have been filed. We may request a death certificate before a refund is issued.

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

Changing country of residence

It is important to let us know when you change your country of residence.

Changing your postal address or email address

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

Correspondence

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

Changes that we may apply at renewal

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

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

Your right to cancel

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

If you wish to cancel, please contact us via email:
group.admin@e.allianz.com

If you cancel your contract within this 30 day period, you will be entitled to a full refund of the cancelled member(s) premiums paid for the new Insurance

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

Reasons your membership would end

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

- if you do not pay any of your premiums on, or before, the date they are due. However, we may allow your cover to continue, if you pay the outstanding premiums within 30 days after the due date.
- if you do not pay the amount of any IPT, taxes, levies or charges that you have to pay under your agreement with us on or before the due date.
- if you cease to be an official of CERN (holder of a valid 'P' legitimisation card) or no longer have a valid contract of association with CERN.
- after you have been insured under the Allianz International Healthcare Plan for CERN MPAs for a maximum consecutive period of 90 days (if you are residing in Switzerland and are not a holder of a valid 'P' legitimisation card).
- upon the death of the policyholder. Please see the section on 'Death of the policyholder or a dependant' for further details.
- if there is reasonable evidence that the policyholder or any dependants misled or attempted to mislead us. Examples are: giving false information, withholding pertinent information from us, working with another party to give us false information (either intentionally or carelessly) which may influence us when deciding:
 - whether we accept the application for cover.
 - the applicable premium to pay.
 - whether we have to pay a claim.

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

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

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

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

Policy expiry

Please note that upon the expiry of your policy, your right to reimbursement ends for costs incurred after expiry of your policy. For up to six months after the expiry date, we will reimburse any eligible expenses incurred during the Period of Cover. MPAs, whose contract of association has expired, may purchase a new Period of Cover provided that MPAs hold a valid contract of association with CERN. This is subject to the rules on eligibility of cover as set out in the 'Eligibility for cover' section under the Terms and Conditions outlined in this Guide. Pre-existing conditions which arose during the Period of Cover under the Allianz International Healthcare Plan for CERN MPAs will be covered during the new insurance cover within the terms and conditions of your cover.

The following terms also apply to your cover

Applicable law:

- **If you live in the European Economic Area:** Your policy is governed by the laws and courts of your country of residence, unless otherwise required by law.
- **If you live outside of the European Economic Area:** Your policy is governed by the laws and courts of Ireland, unless otherwise required by law.

Sanctions suspension clause:

Any benefits, cover and claims payments are suspended if any element of the cover, benefit, activity, business, or underlying business exposes the us to:

- any applicable sanction, prohibition or restriction under the United Nations' resolutions, or
- the trade or economic sanctions, laws or regulations of the European Union, United Kingdom, or United States of America.

The above suspension will continue until such time as we will no longer be exposed to any such sanction, prohibition, or restriction.

The amounts we will pay:

Our liability to you is limited to the amounts indicated in the Table of Benefits and any policy endorsements. The amount reimbursed, whether under this policy, public medical scheme or any other insurance will not exceed the figure stated on the invoice.

Who can make changes to your policy:

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

When cover is provided by someone else:

We may decline a claim if you or any of your dependants are eligible to claim benefits from:

- a public scheme.

- any other insurance policy.
- any other third party.

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

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

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

Circumstances outside of our control (force majeure):

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

Fraud:

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

we will refund the premium amount(s) paid to date minus the cost of any medical claims already paid. If the cost of claims exceeds the balance of the premium, we will seek reimbursement of this amount from the principal member.

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

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

Cancellation:

We will cancel the policy where you have not paid the full premium due and owing. We shall notify you of this cancellation and the contract shall be deemed cancelled from the date that the premium payment became due and payable. However, if the premium is paid within 30 days after the due date, the insurance cover will be reinstated and we will cover any claims which occurred during the period of delay.

Making contact with dependants:

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

Data protection

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

www.allianzcare.com/en/privacy

Alternatively, you can contact us on the phone to request a paper copy:
+32 2 210 6501

If you have any queries about how we use your personal data, please email us at: AP.EU1DataPrivacyOfficer@allianz.com

Complaints and dispute resolution procedure

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

Phone: **+32 2 210 6501**

Toll-free numbers: www.allianzcare.com/en/pages/toll-free-numbers.html

Email: IGOhelpline@e.allianz.com

Address: **Customer Advocacy Team, Allianz, Bd Roi Albert II 32,
1000 Brussels, Belgium**

We will handle your complaint according to our internal complaint management procedure. For details see: www.allianzcare.com/complaints-procedure

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

Mediation

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

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

3. Any dispute, controversy or claim which is:
 - arising out of or relating to this agreement (or the breach, termination or invalidity thereof) with a value in excess of € 500,000, or
 - referred to mediation pursuant to Clause 2 but not voluntarily settled by mediation within three months of the ADR Notice date

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

Legal action

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

Definitions

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

Accident

Sudden, unexpected event that causes injury and is due to a cause external to the insured person. The cause and symptoms of the injury must be medically and objectively definable, allow for a diagnosis and require therapy. This includes accidents that incur at the place of work. Medical expenses incurred as a result of a private or occupational accident are covered within the terms of your policy.

Accidental death benefit

Amount shown in the Table of Benefits that becomes payable if an insured person, aged 18 to 70, dies during the period of insurance as a result of an accident (including an industrial injury), if the accident occurs during the period of insurance, and the insured person dies within 365 days of the date of the accident.

Accommodation costs for one parent staying in hospital with an insured child

Hospital accommodation costs of one parent or legal guardian for the duration of the insured child's admission to hospital for eligible treatment. If a suitable bed is not available in the hospital, we will contribute the equivalent of the daily room rate in a three-star hotel towards any hotel costs incurred. We do not cover sundry expenses such as meals, phone calls or newspapers.

Acute

Sudden onset of symptoms of a medical condition.

Acute medical condition

Medical condition that is brief, has a definite end point, and, in our reasonable opinion, based on advice or general advice can be cured by treatment.

Annual hearing examination

Examinations/checks performed or prescribed by a specialist and undertaken without any clinical symptom being present. If this benefit is available in your plan, we cover one examination per Insurance Year. The following services are covered under the benefit:

- Consultation
- Pure tone audiometry screening
- Tympanometry

Burial expenses

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

Chronic condition

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

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

Chronic conditions are covered within the limits of the Allianz International Healthcare Plan for CERN MPAs.

Complementary treatment

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

Complications of childbirth

Post-partum haemorrhage and retained placental membrane only. 'Complications of childbirth' includes medically necessary caesarean sections.

Complications of pregnancy

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

Congenital conditions

Any abnormality, deformity, disease, disorder, illness, malformation, defect, anomaly or injury that is hereditary or acquired before or during birth. A congenital condition can be diagnosed at birth or later in life.

Co-payment

The percentage of the costs that you must pay. E.g. if a benefit has an 80% refund, this means that a co-payment of 20% applies, therefore we will pay 80% of the costs of each eligible treatment per insured person, per Insurance Year. Video consultation services are not subject to co-payment when accessed via the Telehealth Hub.

Deductible

Also referred to as 'excess' in health insurance. It is the part of the cost that is payable by you and that we deduct from the amount we will pay.

Where deductibles apply, they are applicable to all benefits and are payable per person per Insurance Year, unless your Table of Benefits states otherwise.

Dental practitioner

A person who:

- has attained primary degrees in dentistry and/or dental surgery by attending a dental and/or medical school recognised by a relevant accredited professional body, and
- is licensed by the relevant authority to practice dentistry and/or dental surgery in the country where the treatment is given.

Dental surgery

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

Dependant

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

Diagnostic tests

Investigations such as x-rays or blood tests, undertaken to determine the cause of the presented symptoms.

Direct family history

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

Direct settlement

Where we settle costs of treatment or services directly with a medical provider in our medical provider network.

Doctor

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

Effective date

The first day we cover you under the plan during the Insurance Year, as shown on your Insurance Certificate.

Emergency

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

Emergency in-patient dental treatment

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

Emergency out-patient dental treatment

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

Emergency out-patient treatment

Treatment received in a casualty ward or emergency room within 24 hours of an accident or sudden illness, where there is no medical necessity for you to occupy a hospital bed.

Emergency treatment outside area of cover

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

Family history

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

Foreseeable

A medical condition that, in our reasonable opinion, could be reasonably anticipated.

General advice

Any medical opinion or medical recommendation from a relevant accredited professional body in relation to a medical condition or treatment that confirms, in our reasonable opinion, an established medical practice or opinion.

Health and wellbeing checks including screening for the early detection of illness or disease

Routine health checks, tests and examinations, performed at appropriate age intervals, without any clinical symptoms being present. To be covered, you need to receive the health and wellbeing screening services at a licensed medical institution or a licensed health examination institution, or under the guidance of a doctor in an appropriate setting and in accordance with the international clinical practice guidelines.

Home country

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

Hospital

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

Hospital accommodation

Standard private or semi-private accommodation as shown in the Table of Benefits.

We pay the costs for your hospital accommodation and all eligible in-patient/day-care treatment and services required while using the room, up to the reasonable and customary rates associated with the room type specified in your Table of Benefits. Deluxe, executive rooms and suites are not covered.

We do not cover non-medical or personal expenses charged separately to the hospital accommodation cost, such as phone calls or newspapers. If meals are not included in the hospital accommodation cost, we will only cover up to three full-course meals per day. A full-course meal consists of one appetizer, one main course, one dessert and one drink.

Please note that if your hospital admission is related to another benefit covered under your policy, hospital accommodation may already be included within that benefit. For example, if you are hospitalised for cancer treatment, hospital accommodation will be covered under the 'Oncology' benefit, rather than the separate 'Hospital accommodation' benefit. Other benefits that may include hospital accommodation (if included in your plan) are: 'Psychiatry and

psychotherapy', 'Routine maternity', 'Palliative care' and 'Long-term care'. Where your benefit includes hospital accommodation, please note that the room type specified under 'Hospital accommodation' in your Table of Benefits will apply to those other benefits as well. For example, if your 'Hospital accommodation' benefit covers a semi-private room type and you are hospitalised for cancer treatment, your 'Oncology' benefit will include cover for semi-private room accommodation only.

If the room type specified in your Table of Benefits is not available at the hospital, or if you choose a superior room type, we will cover your accommodation, as well as all related in-patient and day-care treatment and services, up to the reasonable and customary rates associated with the room type indicated in your Table of Benefits.

In-patient cash benefit

Amount that we pay to you if you receive in-patient treatment for a medical condition that would be covered by your plan, but in your country of treatment you access it free of charge: this happens when the full cost of your hospital admission and in-patient treatment is government-funded. As you don't receive any invoice or pay any amount to your medical provider, you can't claim a reimbursement with us or any other insurer you may have, as there is no expenditure on your side. In this case you can claim the payment of the in-patient cash benefit, which is limited to the amount specified in the Table of Benefits and is payable after you are discharged from hospital.

In-patient treatment

Treatment received in a hospital where an overnight stay is medically necessary.

Insurance Certificate

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

Insurance Year

It applies from the effective date of your policy, as shown on the Insurance Certificate and ends exactly one year later. Your exact period of cover (number of days) is confirmed in the selected plan mentioned in your Insurance Certificate.

Insured person

You and your dependants as stated on your Insurance Certificate.

Lifetime limit

The total amount we'll pay for any eligible costs you incur during any time we cover you on any one or more plans with the same or equivalent benefits, even if there's a break in your cover.

Local ambulance

Ambulance transport to the nearest available and appropriate hospital or licensed medical

facility when required for an emergency or out of medical necessity to receive treatment you are covered for.

Long-term care

Care over an extended period of time after the initial acute/curative treatment has been completed. This usually occurs for a chronic condition or disability requiring uninterrupted/continuous medical care, or where treatment options are limited to the existing level of care. Long-term care can be provided at home, in the community, in a hospital, a long-term care facility or in a nursing home.

Maternity/paternity cash benefit

It applies to the Channel Islands Plan only and if provided under your plan, an amount will be paid to each parent insured with us, following the birth of a child dependant. This benefit is only payable where treatment is received free of charge and the amount payable will be indicated in your Table of Benefits. To claim the maternity/paternity cash benefit, please send us a copy of the baby's birth certificate within three months of the birth. To be eligible for this benefit, the mother/father must be covered under our Healthcare Plan for the Channel Islands for a minimum of 10 continuous months before the baby is born.

Medical advice

Any medical opinion, medical recommendation or information given by a medical professional.

Medical evacuation

It applies in the following scenarios:

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

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

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

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

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

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

Medical necessity

Medical treatment, services or supplies that fulfil all of the following:

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

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

Medical practitioners

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

Medical practitioner fees

Fees charged for non-surgical treatment performed or administered by a medical practitioner, or performed by a medical professional under the supervision of a medical practitioner.

Medical provider network

All of the medical providers with whom we have arrangements in place for the direct settlement of our members' medical costs.

Medical repatriation

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

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

Midwife fees

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

MPAs

Associated Members of the Personnel who are appointed by the Director-General of CERN on the basis of a contract of association.

Natural tooth

Any tooth that is original, not an artificial implant or replacement.

Newborn care

Newborn accommodation and the following essential examinations, diagnostic procedures and treatments as required following birth:

- Customary examinations required to assess the integrity and basic function of the child's organs and skeletal structures
- One hearing examination
- Screening tests for PKU, congenital hypothyroidism and G6PD
- Vitamin K, hepatitis B and BCG vaccinations

Cover doesn't include further preventive diagnostic procedures, such as routine swabs or blood typing. However, if for medical reasons the child needs any follow-up investigations and treatment, these are covered under the newborn's own policy (if they have been added as a dependant).

For multiple birth babies born as a result of medically assisted reproduction, all babies born by surrogacy, and all adopted and fostered children, in-patient treatment is limited to € 30,000 per

child for the first three months following birth; this limit applies before any other benefit in your plan. Out-patient treatment is paid within the terms of the Out-patient Plan.

Non-prescribed physiotherapy

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

Nursing at home or in a convalescent home

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

Obesity

It is diagnosed when a person has a body mass index (BMI) of over 30 (you can find a BMI calculator at: my.allianzcare.com/bmi-calc).

Occupational therapy

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

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

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

Oculomotor therapy

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

Oncology

Specialist fees, diagnostic tests, radiotherapy, chemotherapy and hospital charges related to the treatment of cancer from the point of diagnosis.

Oral surgical procedures

Surgical procedures, such as, but not limited to, the removal of impacted wisdom teeth, when carried out in a hospital by an oral or maxillofacial surgeon. We do not cover procedures that can be carried out by a dentist.

Organ transplant

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

Orthodontics

The use of devices to correct malocclusion (misalignment of your teeth and bite). We only cover orthodontic treatment that meets the medical necessity criteria described below. As the criteria are very technical, please contact us before starting treatment so we can verify if your treatment meets the criteria.

Medical necessity criteria:

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

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

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

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

Orthomolecular treatment

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

Out-patient surgery

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

Out-patient treatment

Treatment provided in the practice or surgery of a medical practitioner, therapist or specialist that does not require you to be admitted to hospital.

Palliative care

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

Partner

A legal partner or a person you have lived with in a de facto relationship for a continuous period of 12 months.

Period of Cover

The exact period (number of days) during which the insured persons are covered under the Healthcare Plan for CERN MPAs as indicated in the Insurance Certificate. Depending on your duration of association with CERN, at any one time you can take out insurance cover for a minimum period of 30 days and up to a maximum period of a year. Cover will be taken out for a minimum of 30 days and one Period of Cover will not exceed a maximum period of 180 days. If your contract of association with CERN is extended, you can buy an additional Period of Cover under the Healthcare Plan for CERN MPAs provided you satisfy the eligibility conditions. There is no limit as regards the number of additional Periods of Cover you can buy, always provided that you hold a valid contract of association with CERN and satisfy the eligibility conditions. Where the MPA contract of association covers multiple calendar months, the Period of Cover means coverage of the entire month(s).

Periodontics

Dental treatment related to gum disease.

Post-natal care

Routine post-partum medical care received by the mother for up to six weeks after delivery.

Pre-existing conditions

Medical conditions for which one or more symptoms presented at some point during your or your dependants' lifetime. This applies regardless of whether you or your dependants sought any medical advice or treatment. We will consider any medical condition to be pre-existing if we can determine that you or your dependants would have known about it. Pre-existing conditions and chronic conditions are covered within the terms of your policy.

Pregnancy

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

Pre-natal care

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

Prescribed drugs and dressings

Drugs when prescribed by a doctor to:

- treat a confirmed diagnosis or medical condition.
- compensate a lack of vital bodily substances.

Prescribed drugs and dressings must be clinically proven to be effective for the diagnosed condition. They must also be recognised by the pharmaceutical regulator in the country where you use the prescription. Even if you can legally buy a medication without a doctor's prescription in that country, you must get a prescription for these costs to be covered. You can claim for a supply of prescribed drugs and dressings for up to three months from the prescription date, subject to the length of time remaining on the policy.

Prescribed glasses and contact lenses (only in case of breakage)

Cover to replace damaged lenses or broken glasses.

Prescribed medical aids

Any device that is prescribed and medically necessary to enable you to carry out everyday activities. Examples include:

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

- Long-term wound aids such as dressings and stoma supplies

We do not cover costs for medical aids that form part of palliative care or long-term care.

Prescribed physiotherapy

Treatment provided by a registered physiotherapist following referral by a doctor.

Physiotherapy (either prescribed, or a combination of non-prescribed and prescribed treatment) is initially restricted to 12 sessions per condition, after which treatment must be reviewed by your therapist or the doctor who referred you. If you need further sessions, your therapist/doctor must send us a new progress report and treatment plan for your condition, indicating the medical necessity for more treatment. They must also do this after every subsequent set of 12 sessions. Physiotherapy does not include therapies such as Rolwing, massage, Pilates, Fango and Milta.

Prescription drugs

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

Preventive treatment

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

Principal country of residence

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

Professional sports

Any sporting activity that you engage in and from which you derive a salary or other economic compensation.

Psychiatry and psychotherapy

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

Out-patient psychotherapy treatment requires referral by a doctor and is limited to six sessions per year.

Counselling is available through our Expat Assistance Programme (EAP) and refers to short-term, solution-focused interventions, and typically deals with current issues that are easily resolved on the conscious level. This service is not intended for longer-term situations or the treatment of clinical disorders and is not suitable for minors who are below the local legal age of consent.

EAP can help you and your immediate family deal with challenging situations that may arise in life, such as stress, anxiety, bereavement, workplace challenges, relationship issues, cross-cultural transition, coping with isolation and loneliness.

Reasonable and customary

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

Rehabilitation treatment

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

We cover in-patient or day-care accommodation costs only if admission to a rehabilitation facility was requested by your doctor and approved by us.

Repatriation of mortal remains

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

There are types of cover:

- Within Europe: includes coming from or going to Europe.
- Outside of Europe: includes coming from or going to outside of Europe.

Routine delivery

Medically necessary costs incurred during childbirth. This includes hospital charges, specialist fees, midwife fees (during labour only) and newborn care (see the definition of 'Newborn care' for what we cover under this benefit and for in-patient treatment limits that apply to adopted and fostered children, all babies born by surrogacy and multiple birth babies born as a result of medically assisted reproduction).

Please note that 3D and 4D ultrasound scans are covered up to the cost of a 2D scan only.

Caesarean sections that are not medically necessary are covered up to the cost of a routine

delivery in the same hospital, subject to any benefit limits. Medically-necessary caesarean sections are paid for under the 'Complications of childbirth' benefit.

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

Routine maternity

Medically necessary costs for the routine care of pregnancy and childbirth. This includes hospital charges, specialist fees, the mother's pre-natal and post-natal care, midwife fees (during labour only) and newborn care (see the definition of 'Newborn care' for what we cover under this benefit and for in-patient treatment limits that apply to adopted and fostered children, all babies born by surrogacy and multiple birth babies born as a result of medically assisted reproduction).

Please note that 3D and 4D ultrasound scans are covered up to the cost of a 2D scan only.

Caesarean sections that are not medically necessary are covered up to the cost of a routine delivery in the same hospital, subject to any 'Routine maternity' benefit limits. Medically-necessary caesarean sections are paid for under the 'Complications of childbirth' benefit.

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

Specialist

A licensed doctor possessing the additional qualifications and expertise necessary to practise as a recognised specialist in diagnostic techniques, treatment and prevention in a particular field of medicine.

Specialist fees

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

Speech therapy

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

Surgical appliances and materials

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

Therapist

Chiropractor, osteopath, podiatrist, Traditional Chinese Medicine practitioner, homeopath, acupuncturist, ayurvedic practitioner, physiotherapist, speech therapist, occupational therapist or oculomotor therapist, who is qualified and licensed under the laws of the country in which treatment takes place.

Travel costs for one person accompanying an evacuated/repatriated person

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

Cover under these benefits is only available if the associated evacuation/repatriation is also covered under your plan. Cover does not include hotel accommodation or other related expenses.

Travel costs of insured family members in the event of an evacuation/repatriation

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

Cover under these benefits is only available if the associated evacuation/repatriation is also covered under your plan. Cover does not include hotel accommodation or other related expenses.

Travel costs of insured family members in the event of the repatriation of mortal remains

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

Travel costs of insured members to be with a family member who is at peril of death or who has died

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

Treatment

Medical, surgical or therapeutic interventions received to diagnose, prevent, cure or relieve illness and injury, or physical and mental disorder.

Treatment of autism spectrum disorder

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

Treatment of eating disorders

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

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

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

Treatment is covered as part of the 'Psychiatry and psychotherapy' benefit of your Out-patient Plan, if you have one. Check your Table of Benefits for any limits that may apply.

Vaccinations

- All basic immunisations and booster injections in line with the international medical guidelines that apply in the country where they are administered.
- Vaccination against COVID-19*, where this is not offered for free or only partially sponsored by the government in your country of residence.
- Medically necessary travel vaccinations.
- Malaria prevention tablets.

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

*We cover any COVID-19 vaccine when:

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

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

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

Video consultation services

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

If you access teleconsultation services outside of the TeleHealth Hub, the 'Video consultation services' benefit will not apply. Cover will be subject to the terms of the benefit that would apply if the consultation were received in a face-to-face setting.

Waiting period

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

We/Our/Us

AWP Health & Life SA, the insurer.

Well child tests

Examinations undertaken by a family doctor or paediatrician to assess a child's wellbeing and their progress against generally accepted developmental milestones. Clinical symptoms do not need to be present to conduct these tests, Cover is limited to the benefit and benefit limits as stated in the Table of Benefits and does not extend to the treatment of any possible developmental delays identified.

You/Your

The policyholder and any dependants named on the Insurance Certificate.

Exclusions

Although we cover most medically necessary treatment, we do not cover the following expenses under Allianz International Healthcare Plan for CERN MPAs.

ACQUISITION OF AN ORGAN

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

BEHAVIOURAL AND PERSONALITY DISORDERS

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.

COMPLEMENTARY TREATMENT

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

COMPLICATIONS CAUSED BY CONDITIONS NOT COVERED UNDER YOUR PLAN

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

CONSULTATIONS PERFORMED BY YOU OR A FAMILY MEMBER

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

COSMETIC TREATMENT

Any cosmetic treatment, even when medically prescribed. This includes treatment carried out by a plastic surgeon, whether or not for medical/psychological purposes. The only exception is reconstructive surgery necessary to restore function or appearance after a disfiguring accident or as a result of surgery for cancer, provided the accident or initial surgery was also covered by this policy.

DEVELOPMENTAL DELAY

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

DRUG ADDICTION OR ALCOHOLISM

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

EXPERIMENTAL OR UNPROVEN TREATMENT OR DRUG THERAPY

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

FAILURE TO SEEK OR FOLLOW MEDICAL ADVICE

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

FAMILY THERAPY AND COUNSELLING

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

FEEES FOR THE COMPLETION OF A CLAIM FORM

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

FERTILITY TREATMENT

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

GENDER DYSPHORIA

Care and/or treatment or services for gender dysphoria.

GENETIC TESTING

Genetic testing, except:

- where specific genetic tests are included within your plan.
- where DNA tests are directly linked to an eligible amniocentesis i.e. in the case of women aged 35 or over.

HOME VISITS

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

INJURIES CAUSED PROFESSIONAL SPORTS

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

INTENTIONALLY CAUSED DISEASES OR SELF-INFLICTED INJURIES

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

LASER EYE TREATMENT

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

LOSS OF HAIR AND HAIR REPLACEMENT

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

MEDICAL ERROR

Treatment required as a result of medical error.

ORGAN TRANSPLANT

ORTHOMOLECULAR TREATMENT

Please refer to the definition of 'Orthomolecular treatment'.

PARTICIPATION IN WAR OR CRIMINAL ACTS

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

- War
- Riots

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

PERSONAL PRODUCTS AND DIETARY SUPPLEMENTS

Substances, personal products and dietary supplements including vitamins and minerals (except during pregnancy or to treat diagnosed vitamin deficiency syndromes), mouthwash, toothpaste, antiseptic lozenges and sprays, shampoo, sunscreen, cosmetic products, sanitiser, gloves, masks, visors, thermometers, children's food, baby supplies and infant formula given orally.

We also do not cover vitamins, minerals or supplements (including nutritional, dietary, organic or herbal preparations) except in the following cases:

- where prescribed:
 - during pregnancy, as required in accordance with medical guidelines.
 - during cancer treatment, as required in accordance with medical guidelines.
 - to treat diagnosed deficiency syndromes.

These products are excluded even if they are medically recommended, prescribed or acknowledged as having therapeutic effects.

PRE- AND POST-NATAL

Pre- and post-natal classes.

PRODUCTS SOLD WITHOUT PRESCRIPTIONS

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

SEARCH AND/OR RESCUE OPERATIONS

Claims relating to search and/or rescue operations, for example on land or down from a mountain, to find and transport a member back to a safe location. Please note that in the case of medical evacuation, we only cover activities that begin after the search and/or rescue operations conclude.

SLEEP DISORDERS

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

SPEECH THERAPY

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

STAYS IN A CURE CENTRE

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

STERILISATION, SEXUAL DYSFUNCTION AND CONTRACEPTION

Investigations into, treatment of and complications arising from:

- sterilisation.
- sexual dysfunction (unless as a result of a total prostatectomy following cancer surgery).
- contraception (including the insertion and removal of contraceptive devices and all other contraceptives), unless prescribed for medical reasons that are unrelated to birth control.

SURROGACY

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

TERMINATION OF PREGNANCY

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

TRAVEL COSTS

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

TREATMENT IN THE USA IN THE FOLLOWING CASES

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

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

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

TREATMENT OUTSIDE THE GEOGRAPHICAL AREA OF COVER

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

TRIPLE/BART'S, QUADRUPLE OR SPINA BIFIDA TESTS

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

TUMOUR MARKER TESTING

Tumour marker testing, unless included as part of a health screening package or you have previously been diagnosed with the specific cancer in question, in which case cover is provided under the 'Oncology' benefit.

VESSEL AT SEA

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

WEIGHT-RELATED TREATMENT AND SERVICES

Treatment and services for weight control, including bariatric surgery, medication (unless indicated for use in the treatment for established Type 2 Diabetes), supplements, health club memberships, diet programs and residential eating disorder programs.

BENEFITS THAT ARE NOT IN YOUR TABLE OF BENEFITS

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

- Complications of pregnancy.
- Dental treatment, dental surgery, periodontics, orthodontics and dental prostheses.
- Dietician fees.
- Emergency dental treatment.
- Expenses for one person accompanying an evacuated/repatriated person.

- Health and wellbeing checks including screening for the early detection of illness or disease.
- Home delivery.
- Infertility treatment.
- In-patient psychiatry and psychotherapy treatment.
- Laser eye treatment.
- Medical repatriation.
- Organ transplant.
- Out-patient psychiatry and psychotherapy treatment.
- Out-patient treatment.
- Prescribed glasses and contact lenses.
- Prescribed medical aids.
- Preventive treatment.
- Rehabilitation treatment.
- Routine maternity, Routine Delivery and newborn care and Complications of childbirth.
- Travel costs of insured family members in the event of an evacuation/repatriation.
- Travel costs of insured family members in the event of the repatriation of mortal remains.
- Travel costs of insured members to be with a family member who is at peril of death or who has died.
- Vaccinations.

ACCIDENTAL DEATH BENEFIT

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

- Accidents which happen while the insured member is engaged in aviation activities of any description, including entering and alighting from aircraft, other than as a fare paying passenger in a standard multi-engine aircraft operated by a recognised airline or air charter company.
- Mountaineering including caving and potholing which requires the use of ropes or guides.
- Taking part in motor sports of any kind, including boating, in any boat designed to travel at a speed in excess of 30 knots.
- Taking part in speed or duration tests or races of any kind.

- **White water rafting and canoeing, scuba diving and yachting or boating outside coastal waters (12 miles or more from the coast).**

Our standard conditions, exclusions and limitations also apply to the accidental death benefit.

Talk to us, we love to help!

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

24/7 Helpline for general enquiries and emergency assistance

+32 2 210 6501



CHAT WITH US

Toll free numbers: www.allianzcare.com/toll-free-numbers

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

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

Email: IGOhelpline@e.allianz.com

Address: **Allianz, Bd Roi Albert II 32, 1000 Brussels, Belgium**

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