



International Healthcare Plans for Russia
Valid from 1st January 2018

INDIVIDUAL

Benefit Guide

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 consists of 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 in conjunction with your Insurance Certificate and Table of Benefits.

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The insurer is LLC Insurance Company Allianz Life (LLC IC Allianz Life). Registered No. (OGRN): 1037727041483, address: 30 Ozerkovskaya nab, 115184 Moscow, Russia, phone:+7 (495) 232-0014, www.allianz.ru. Central Bank License: No. SL 3828, dated 28/09/2015.

AWP Health & Life Services Limited, a limited liability company registered in Ireland, provides administration services and technical support for the policy. Registered no.: 509216. Registered office 15 Joyce Way, Park West Business Campus, Nangor Road, Dublin 12, Ireland. Allianz Partners is a registered business name of AWP Health & Life Services Limited.

HOW TO USE YOUR COVER





MEMBER SERVICES

We believe in making a difference by providing you with the superior level of service that you deserve, anytime, anywhere!

In the following pages we describe the full range of member services we offer. Discover what is available to you, from our MyHealth app to the Healthline Services.

Talk to us, we love to help!

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

☎ Helpline Inside Russia:	+7 495 956 2900
☎ Helpline Outside Russia:	+353 1 907 5951
@ Email:	client.servicesRU@allianz.com
📠 Fax:	+ 353 1 630 1306

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

Did you know...

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

MyHealth app



Our pioneering MyHealth app has been designed to give you easy and convenient access to your cover, no matter where you are. With MyHealth app you can access the following features from your mobile device:

MY CLAIMS

Submit your claims in 3 simple steps and view your claims history.

MY CONTACTS

Access our 24/7 multilingual Helpline and local emergency numbers.

FIND A HOSPITAL

Locate medical providers nearby and get GPS directions.

SYMPTOM CHECKER

For a quick and easy evaluation of your symptoms.

Other Services - access your policy documents and your Membership Card on the go, look up the local equivalent names of branded drugs and translate common ailments into one of 17 languages.

All personal data within the MyHealth App are encrypted for data protection. Most features are accessible even when offline.

GETTING STARTED:



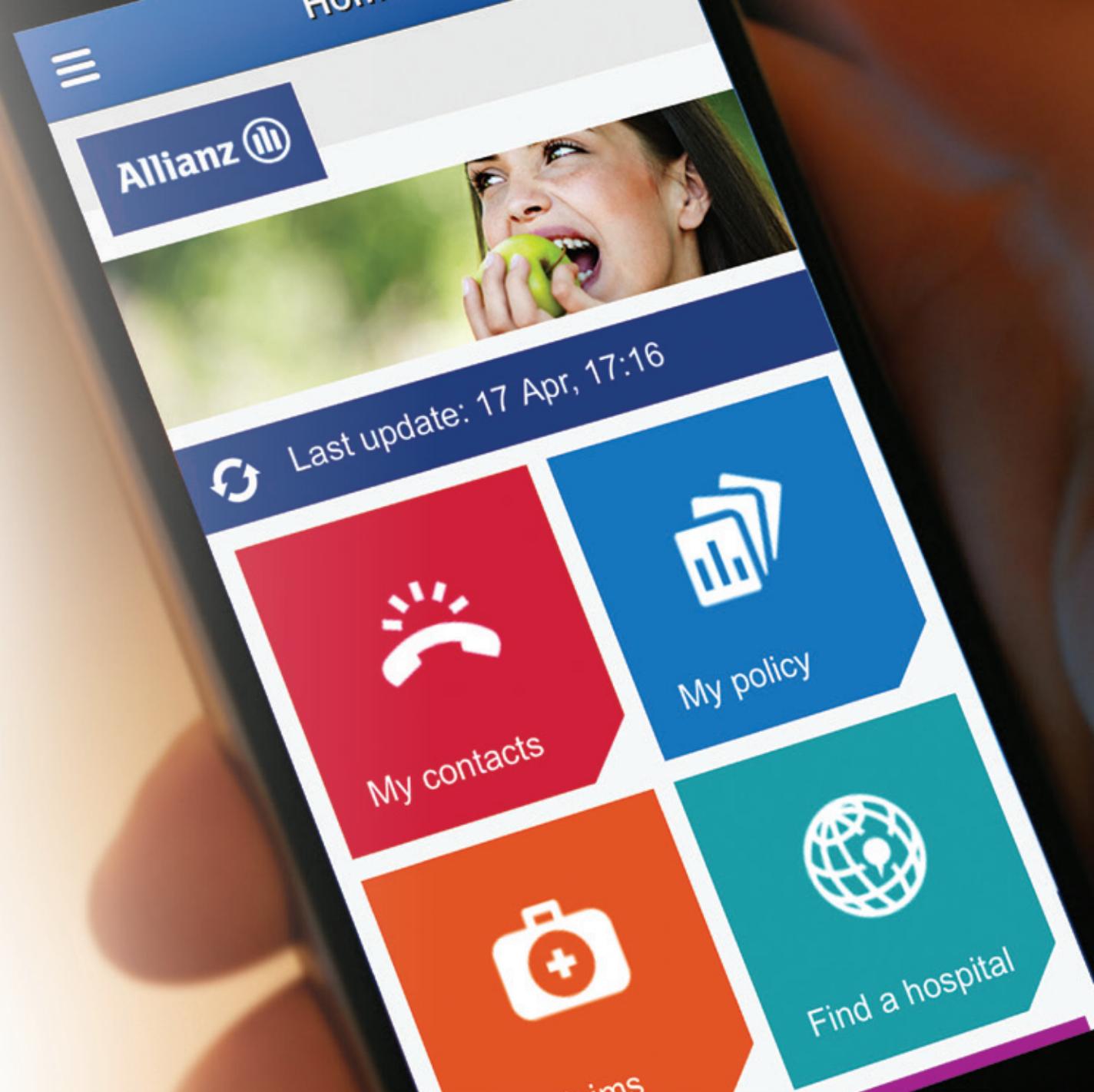
Download - you can download the app from the App Store or Google Play, by simply searching for "Allianz MyHealth" and following the on-screen instructions.



Initial setup - once downloaded, open the app and provide your policy number. Then, if prompted, register to receive a username and temporary password. Otherwise, please insert the login details available from your Membership Pack. When requested, change the temporary password provided to something you can easily remember. If you re-install the app or setup the app on another device, please use this setup information again. Please note that you can also use these details to login to our Online Services.



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



For more information, please visit:
www.allianzworldwidecare.com/myhealth





Online Services

You can access our secure Online Services from the comfort of your home. Our Online Services allow you to:

- View and amend your personal details online
- Download your policy documents, including your Membership Card.
- View your Table of Benefits and check how much remains payable under each benefit.
- Confirm the status of any claims submitted to us and view claims related correspondence.

To access our secure Online Services, please log on to my.allianzworldwidecare.com and:

1. Login using the unique username and temporary password included in your Membership Pack.
2. When requested, change the temporary password provided to something you can easily remember. Please keep this information safe, you'll need it again! Please note that you can also use these details to login to our MyHealth App.
3. Click on "login" and browse away!

If you have not received a Membership Pack, go to my.allianzworldwidecare.com, select "Register" and enter the information requested. Your username and temporary password will be sent to the email address we have on record for you.

Web-based member services

On our website you can **search for medical providers, download forms and access our BMI calculator.** You are not restricted to using the medical providers listed on our website.

 www.allianzworldwidecare.com/members

Healthline Services

24/7 access to wide range of services, including general medical information, support when selecting a medical professional, medical referrals, doctor home visits, medical interpreter services and medical appointment services.

 +7 495 956 2900

Please note this service is only available in Russia.

MediLine

This medical advice service, provided by an experienced English speaking medical team, offers information and advice on a wide range of topics including blood pressure and weight management, infectious diseases, first aid, dental care, vaccinations, oncology, disability, speech, fertility, paediatrics, mental health and general health.

 +44 (0) 208 416 3929

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

COVER OVERVIEW

We understand the importance of your own and your family's health. Below is a summary to help you understand the scope of your health cover.

What am I covered for?

You are covered for all benefits indicated in your Table of Benefits. Pre-existing conditions (including any pre-existing chronic conditions) are generally covered unless we indicate otherwise in your policy documents. If in doubt, please refer to the "Notes" section of your Table of Benefits to confirm if pre-existing conditions are covered.

Where can I receive treatment?

You can avail of treatment in any country within your area of cover (which is indicated in your Insurance Certificate).

If the treatment you require is available locally, but you choose to travel to another country within your area of cover, we will reimburse all eligible medical costs incurred within the terms of your policy; apart from your travel expenses. However, if the eligible treatment is not available locally, and "Medical evacuation" is included in your cover, travel costs to the nearest centre of excellence are also covered. In order to seek reimbursement for medical and travel expenses incurred, you will need to complete and submit the Pre-authorisation Form before travelling.

What are benefit limits?

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

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



Is your family growing? We have you covered!

Are you getting married or going to have a baby? Congratulations!

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

www.allianzworldwidecare.com/russia

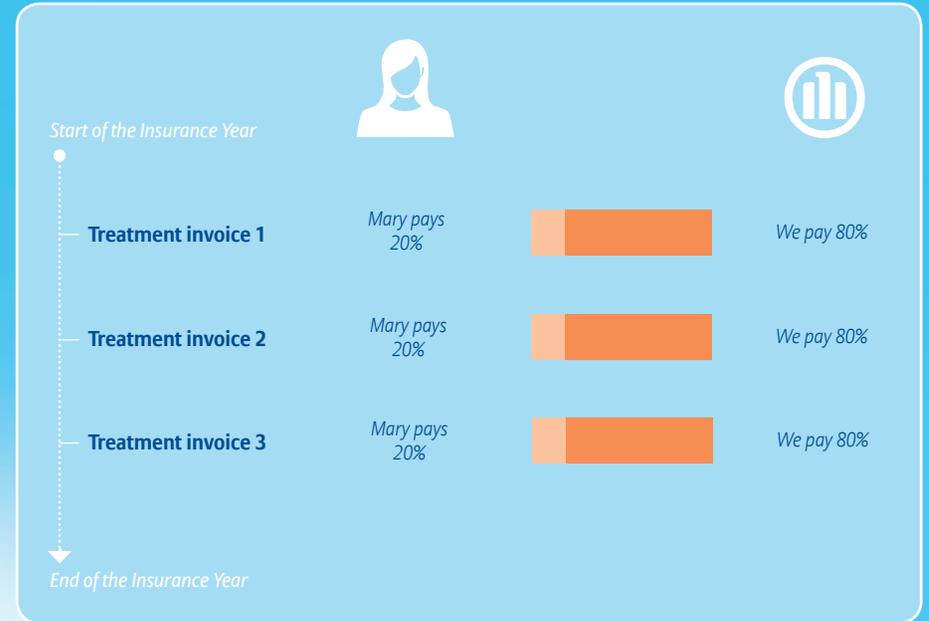
To add a new born child to your policy, simply send an email to our underwriting team, including a copy of the birth certificate. When adding a new born child to your policy, make sure to send your request within four weeks of the date of birth. For further information on how to add a dependant, including important information on how to add multiple babies, babies born to a surrogate, adopted and fostered children, please refer to the "Adding dependants" section of this guide.

AzCareApplication@allianz.ru

What are co-payments?

Some plans and benefits may be subject to co-payments. If your plan includes any, this will be confirmed in your Table of Benefits.

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



■ Insurer contribution
■ Insured person contribution

SEEKING TREATMENT?

We understand that seeking treatment can be stressful. By following the process below, we can look after the administration and you can concentrate on getting better.

Check your level of cover

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

Provider network

We have direct settlement agreements in place with a wide range of clinics in Russia that provide access to treatment on cashless basis. The list of these clinics is available by contacting us on:

+7 495 956 2900

Some treatments require pre-authorisation

Your Table of Benefits will indicate what treatments are subject to pre-authorisation. Usually these are in-patient and high cost treatments. The pre-authorisation process helps us to assess each case, organise everything with the hospital before your arrival and facilitate direct payment of your hospital bill, where possible.

Getting in-patient treatment

(pre-authorisation process applies)



For treatment in Russia, simply call +7 495 956 2900 and obtain pre-authorisation over the phone.



For treatment outside Russia, download a Pre-authorisation Form from the website: www.allianzworldwidecare.com/russia



Send the completed form to us at least **five working days** before treatment. Scan and email, fax or post (*details on the form*).



We contact your medical provider directly to arrange settlement of your bills (where possible).

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. Full details of our pre-authorisation process can be found in the Terms and Conditions section of this document.



If it's an emergency:

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

Either you, your physician, one of your dependants or a colleague needs to call our Helpline (**within 48 hours** of the emergency) to inform us of the hospitalisation. Pre-authorisation Form details can be taken over the phone when you call us.

If you require a private ambulance in Russia, please contact us and we will organise this service for you.

+7 495 956 2900

Claiming your out-patient, dental and other expenses

If your treatment does not require pre-authorization or if you choose a provider outside of our network, just pay the bill and claim the expenses from us. In this case, simply follow these steps:



Receive your treatment and pay the medical provider.



Get an invoice from your medical provider.

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



Claim back your eligible costs via our MyHealth app.

Simply provide a few key details, take a photo of your invoice(s) and press 'submit'.

As an alternative to MyHealth app, you can also claim your treatment costs by completing and submitting a Claim Form, downloadable at:

 www.allianzworldwidecare.com/russia

You will need to complete section 5 and 6 of the Claim Form only if the information requested in those sections is not already provided on your medical invoice.

Please send the Claim Form and all supporting documentation, invoices and receipts to us by email, fax or post (details on the form).

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



Quick claim processing

We can process a claim and issue payment instructions to your bank within 48 hours, when all required information has been submitted.

However, without the diagnosis, we cannot process your claim promptly, as we will need to request these details from you or your doctor. Please make sure you include the diagnosis on your claim!

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



Evacuations and repatriations

At the first indication that a medical evacuation/repatriation is required, please call our 24 hour Helpline and we will take care of everything. Given the urgency of an evacuation/repatriation, we would advise that you call us, however, you can also contact us by email.

When emailing, please include *“Urgent – Evacuation/Repatriation”* in the subject line. Please contact us before talking to any alternative providers, even if approached by them, to avoid potentially inflated charges or unnecessary delays in the evacuation process. In the event that evacuation/repatriation services are not organised by us, we reserve the right to decline the costs.

+353 1 907 5951

medical.services@allianzworldwidecare.com



And if I need treatment in the USA?

If you have "Worldwide" cover and wish to locate a medical provider in the USA, simply go to:

 www.allianzworldwidecare.com/olympus

If you have a query about a medical provider, or if you have selected a provider and wish to arrange an appointment, please call us.

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



You can also apply for a discount pharmacy card which can be used any time your prescription is not covered by your healthcare policy. To register and get your discount pharmacy card, simply go to:

 <http://members.omhc.com/awc/prescriptions.html>

and click on "Print Discount Card".





**TERMS AND
CONDITIONS OF
YOUR COVER**



TERMS AND CONDITIONS

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

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

- The Benefit Guide (this document), which sets out the standard benefits and rules of the health insurance policy and should be read in conjunction with the Insurance Certificate and Table of Benefits.
- The Insurance Certificate. This states the plan(s) chosen, the start date and renewal date of the policy (and effective dates of when dependants were added) as well as the geographical area of cover. Any further special terms unique to your cover will be indicated in the Insurance Certificate (and will have been detailed on a Special Conditions Form issued prior to the inception of your policy). Please note that we will send you a new Insurance Certificate if you request (and we accept) a change such as adding a dependant, or if we apply a change which we are entitled to make.
- The Table of Benefits. This shows the plan(s) selected, the associated benefits available to you, and specifies which benefits/treatments require submission of a Pre-authorisation Form. It also confirms any benefits to which specific benefit limits, waiting periods, deductibles and/or co-payments apply.
- Information provided to us by, or on behalf of, the insured person(s) in the signed Application Form, Confirmation of Health Status Form or others (hereafter referred to collectively as the “relevant application form”) or other supporting medical information.

YOUR COVER EXPLAINED

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

Your benefits are also subject to:

- Policy definitions and exclusions (also available in this document).
- Any special conditions indicated on your Insurance Certificate (and on the Special Condition Form issued prior to policy inception, where relevant).

What we cover

- a) The extent of your cover is determined by your Table of Benefits, the Insurance Certificate, any policy endorsements, these policy terms and conditions, as well as any other legal requirements. We will reimburse, in accordance with your Table of Benefits and individual terms and conditions, medical costs arising from the occurrence or worsening of a medical condition.
- b) This insurance agreement provides the insured persons cover for medical treatment, related costs, services and/or supplies that we determine to be medically necessary and appropriate to treat a patient’s condition, illness or injury. Treatments and procedures are only covered if they have a palliative, curative and/or diagnostic purpose, are medically necessary, appropriate and performed by a licensed physician, dentist or therapist. Claims/costs will be paid/reimbursed if the medical diagnosis and/or prescribed treatment are fair and reasonable and at the level customarily charged in the specific country and for the treatment provided, in accordance with standard and generally accepted medical procedures. If a claim is deemed by us to be inappropriate, we reserve the right to reduce or decline the amount payable by us.
- c) This insurance policy may not provide any cover or benefit to the extent that either the cover or benefit would violate any applicable sanction, law or regulations of the United Nations, the European Union or any other applicable economic or trade sanction, law or regulations.

When cover starts for you and your dependants

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

Benefit limits

There are two kinds of benefit limits shown in the Table of Benefits:

- The **maximum plan benefit**, which applies to certain plans, is the maximum we will pay for all benefits in total, per member, per Insurance Year, under that particular plan.
- Some benefits also have a **specific benefit limit**, which may be provided on a “per Insurance Year” basis, a “per lifetime” basis or on a “per event” basis, such as per trip, per visit or per pregnancy. In some instances we will pay a percentage of the costs for the specific benefit e.g. “65% refund, up to €5,000”. Where a specific benefit limit applies or where the term “Full refund” appears next to certain benefits, the refund is subject to the maximum plan benefit, if one applies to your plan(s). All limits are per member, per Insurance Year, unless otherwise stated in your Table of Benefits.

Where a specific benefit limit applies or where the term “Full refund” appears next to certain benefits, the refund is subject to the maximum plan benefit, if one applies to your plan(s). All limits are per member, per Insurance Year, unless otherwise stated in your Table of Benefits.

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

- All eligible expenses incurred in the first year will be subject to the benefit limit that applies in year one.
- All eligible expenses incurred in the second year will be subject to the updated benefit limit that applies in year two, less the total benefit amount reimbursed in year one.
- In the event that the benefit limit decreases in year two and this updated amount has been reached or exceeded by eligible costs incurred in year one, no additional benefit amount will be payable.

CLAIMS AND PRE-AUTHORISATION PROCESS



Medical claims

If you need to be admitted to hospital for in-patient or day care treatment please contact us and we will arrange a guarantee of payment with the medical provider so you don't need to pay anything.

Inside Russia we also provide cashless access to out-patient treatment through a network of direct billing providers. In cases where we don't have direct billing arrangements in place we offer a pay and claim reimbursement service. You can pay the provider up front and then claim the costs back from us.

In relation to medical claims, please note that:

- a) All claims should be submitted (via our MyHealth app or Claim Form) no later than three years from the date of treatment. Beyond this time we are not obliged to settle the claim.
- b) Submission of a separate claim (via our MyHealth app or Claim Form) is required for each person claiming and for each medical condition being claimed for. Please note that as well as our hard and soft copy claim forms, members can now avail of our MyHealth app for fast and easy claims submission.
- c) It is your responsibility to retain any original supporting documentation (e.g. medical receipts) where copies are submitted to us, as we reserve the right to request original supporting documentation/receipts up to 36 months after claims settlement, for auditing purposes. We also reserve the right to request a proof of payment by you (e.g. bank or credit card statement) in respect of your medical receipts. We advise that you keep copies of all correspondence with us as we cannot be held responsible for correspondence that does not reach us for any reason that is outside of our reasonable control.
- d) If the amount to be claimed is less than the deductible figure under your plan, keep collecting all out-patient receipts and Claim Forms until you reach an amount in excess of your plan deductible, then forward to us all completed Claim Forms together with supporting receipts/invoices.
- e) If we have to make a conversion from one currency to another, we will use the exchange rate that applies on the date on which the invoices were issued.
- f) Only costs incurred as a result of eligible treatment will be reimbursed within the limits of the insurance policy, after taking into consideration any Pre-authorisation requirements. Any deductibles or co-payments outlined in the Table of Benefits will be taken into account when calculating the amount to be reimbursed.
- g) If you are required to pay a deposit in advance of any medical treatment, the cost incurred will only be reimbursed after treatment has taken place.
- h) You and your dependants agree to assist us in obtaining all necessary information to process a claim. We have the right to access all medical records and to have direct discussions with the medical provider or the treating physician. We may, at our own expense, request a medical examination by our medical representative when we deem this to be necessary. All information will be treated in strict

confidence. We reserve the right to withhold benefits if you or your dependants have not honoured these obligations.

Pre-authorisation

Certain treatments and costs require our approval in advance.

In the Table of Benefits, benefits which require Pre-authorisation are indicated by either a 1 or a 2. For your convenience, see below the treatments/benefits which normally require Pre-authorisation (this may vary depending on the cover selected for you, so please check your Table of Benefits to confirm):

- All in-patient benefits¹ listed.
- Day-care treatment².
- Expenses for one person accompanying an evacuated/repatriated person².
- HIV or AIDS²
- Kidney dialysis².
- Long term care²
- Medical evacuation² (or repatriation where covered).
- MRI (Magnetic Resonance Imaging) scan. Pre-authorisation may be required for this test if you would like us to settle the bill directly with the medical provider.
- Newborn care²
- Nursing at home or in a convalescent home².
- Occupational therapy² (out-patient treatment only).
- Oncology² (in-patient and day-care treatment only).
- Out-patient surgery².
- Palliative care²
- PET² (Positron Emission Tomography) and CT-PET² scans.
- Preventative surgery²
- Rehabilitation treatment².
- Repatriation of mortal remains².
- Routine maternity² and complications of pregnancy and childbirth² (in-patient treatment only).
- Travel costs of insured family members in the event of an evacuation/repatriation².
- Travel costs of insured family members in the event of the repatriation of mortal remains².

In addition, inside Russia, pre-authorisation is required for the following benefits (marked with an asterisk in your Table of Benefits):

- Laser eye treatment*
- Emergency out-patient treatment*
- Emergency out-patient dental treatment*
- Infertility treatment*
- Health and wellbeing checks including screening for the early detection of illness or disease*
- Psychiatry and psychotherapy*
- Vaccinations*

How can I obtain pre-authorisation?

In Russia

If the benefit you require is marked with a 1, 2, or an asterisk, simply call +7 495 956 2900 and obtain Pre-authorisation over the phone. When calling our local Helpline please quote your **local policy number** that can be found on your Insurance Certificate.

If you wish to pay and claim for costs incurred as a result of eligible treatment marked with an asterisk, you will be reimbursed within the limits of your policy and pre-authorisation is not required.

Outside Russia

If the benefit you require is marked with a 1 or 2, you will need to complete and submit our Pre-authorisation Form available at www.allianzworldwidecare.com/russia.

And if pre-authorisation is not obtained?

Please note if pre-authorisation is not obtained, the following will apply:

- If the treatment received is subsequently proven to be medically unnecessary, **we reserve the right to decline your claim**.
- For the benefits listed with a **1**, **we reserve the right to decline your claim**. If the respective treatment is subsequently proven to be medically necessary, we will pay only **80%** of the eligible benefit. Please note remaining 20% of the eligible cost will have to be paid by insured person.
- For the benefits listed with a **2**, **we reserve the right to decline your claim**. If the respective treatment is subsequently proven to be medically necessary, we will pay only **50%** of the eligible benefit. Please note remaining 50% of the eligible cost will have to be paid by insured person.

PAYING PREMIUMS

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

By accepting cover you have agreed to pay the premium amount shown on your quotation, by the payment method stated. You are required to pay the premium due to us in advance for the duration of your membership. The initial/first premium instalment is payable immediately after our acceptance of your application. Subsequent premiums are due on the first day of the chosen payment period. You may choose between quarterly, half-yearly or annual payments depending on the payment method you choose. Please note that if there is any difference between the agreed quotation and your invoice, you should contact us immediately. We are not responsible for payments made through third parties.

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

+353 1 907 5951

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

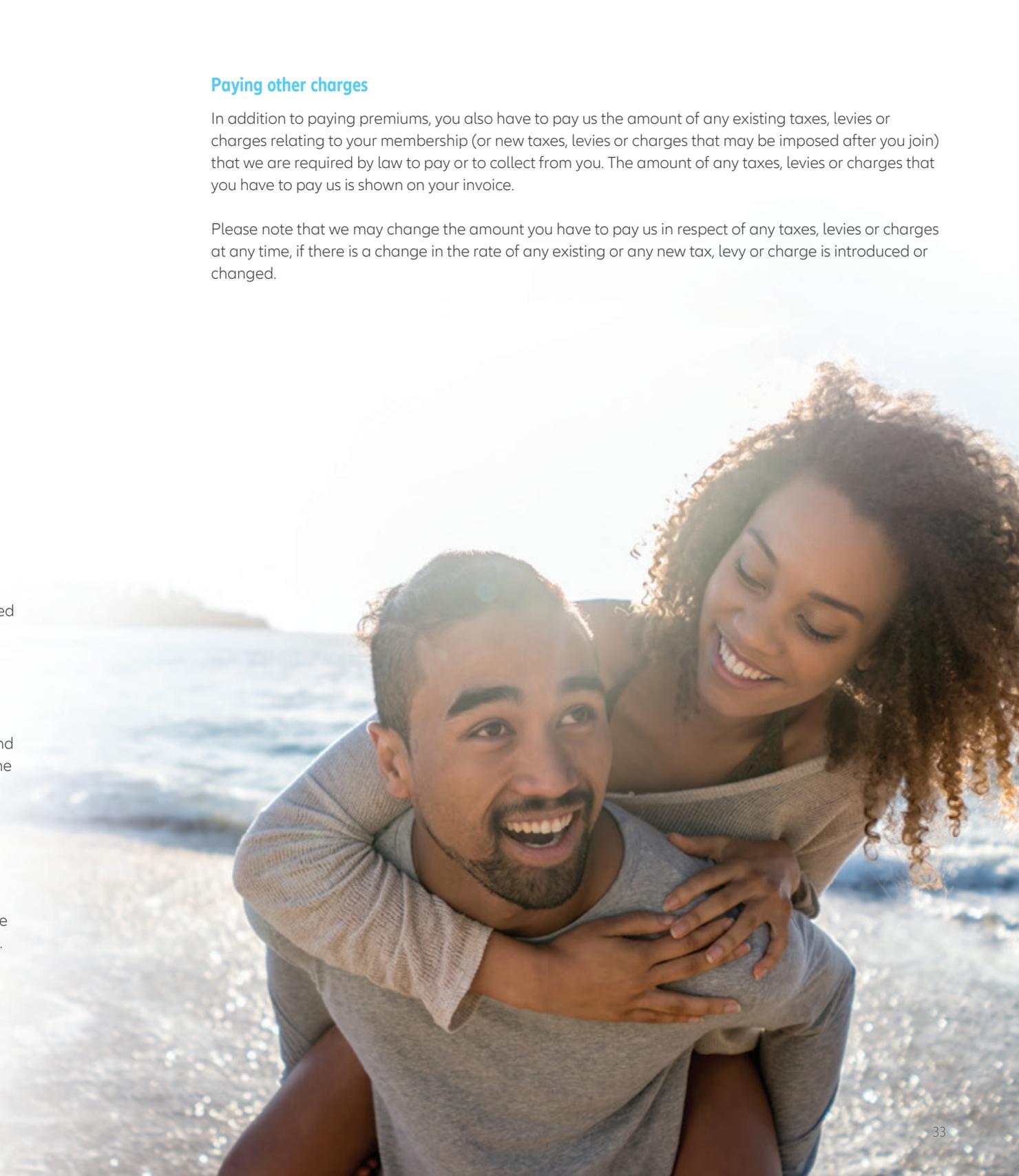
If you do not pay the premium by the due date we reserve the right to suspend your insurance cover and deny claims. If the initial premium is not paid in time, we are entitled to withdraw from the insurance contract for as long as the payment remains outstanding. The insurance contract is deemed to be 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 insurance contract in writing with immediate effect and shall thereby be exempt to pay benefits.

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

Paying other charges

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

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



ADMINISTRATION OF YOUR POLICY

Adding dependants

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

Newborn infants (with the exception of multiple birth babies, babies born to a surrogate, adopted and fostered babies) will be covered from date of acceptance without medical underwriting, provided that we are notified within four weeks of the date of birth and the birth parent, has been insured with us for a minimum of 10 continuous months. To notify us of your intention to have your newborn child included on your policy, please email your request with a copy of the birth certificate to our Underwriting Team at:

@ AzCareApplication@allianz.ru

Notification of the birth after four weeks will result in newborn infants being underwritten and cover will only commence from the date of acceptance. Please note that multiple birth babies born as a result of medically assisted reproduction, babies born to a surrogate or babies who have been adopted will be subject to full medical underwriting and can only get their own insurance cover 90 days after birth or/and their adoption. Cover will only commence from the date of acceptance.

Following acceptance by our Underwriting Team, we will issue a new Insurance Certificate to reflect the addition of a dependant.

Changes to policyholder

If a request is made at renewal to change the policyholder, the proposed replacement policyholder will be required 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 this 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 current year's premium will be made if no claims have been filed (please note that we reserve the right to request a death certificate before a refund is issued). Alternatively, if they wish to, the next named dependant on the Insurance Certificate may apply to become the policyholder in his/her own right (if they meet the minimum age requirements), and include the other dependants under his/her membership. If they apply

to do this within 28 days we will, at our discretion, not add any further special restrictions or exclusions applicable to them, in addition to those which already applied to them at the time of the policyholder's death.

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

Changing your level of cover

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

Changing country of residence

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

Changing your address/email address

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

Correspondence

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

Renewing membership

Subject to the provisions on "Reasons your membership would end", your annual policy will renew for the next Insurance Year provided that the plan/plan combination selected is still available, we can continue to provide cover in your country of residence, all premiums due to us have been paid and the payment details we have for you are still valid on the renewal date. Please update us if your bank account details have changed.

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

Changes that we may apply at renewal

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

We will write to tell you about any changes. If you do not accept any of the changes we make, you can end your membership and we will treat the changes as not having been made if you end your membership within 14 days of the date on which the changes take effect, or within 14 days of us telling you about the changes, whichever is later.

Your right to cancel

Cooling off period: you can cancel the insurance contract in relation to all insured persons, or only in relation to one or more dependants, within 14 days from the start/renewal date of your policy. Please note that you cannot backdate the cancellation of your membership.

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

@ AzCareApplication@allianz.ru

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

If you cancel your insurance contract within this 14 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.

In line with Article 958 of the Insurance Act, you may cancel the insurance contract at any time by providing us with written notice and we will not refund any premiums you have paid which relate to a period after your membership has been cancelled, subject to certain exceptions permitted under the Insurance Act.

Reasons your membership would end

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

- If you do not pay any of your premiums on, or before, the date they are due. However, we may allow your membership to continue without you having to complete a Confirmation of Health Status Form, if you pay the outstanding premiums within five days after the due date.

- If you do not pay the amount of any taxes, levies or charges that you have to pay under your agreement with us on or before the due date.
- Upon the death of the policyholder. Please see the section on "Death of the policyholder or a dependant" (page 34) for further details.
- If there is reasonable evidence that the policyholder or any dependants misled or attempted to mislead us i.e. giving false information, withholding pertinent information from us, or working with another party to give us false information, either intentionally or carelessly, which may influence us when deciding whether they can join the scheme, the applicable premium to pay or whether we have to pay a claim.
- If you choose to cancel your policy, after giving us written notice within 14 days from the start/renewal date of your policy. Please see section on "Your right to cancel" (page 36) for further details.

Unless otherwise specified in this policy, if your membership ends we will refund any premiums you have paid which relate to a period after your membership has ended.

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

Policy expiry

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

ADDITIONAL TERMS

The following are important additional terms that apply to your insurance cover:

1. **Applicable law:** The insurance cover is governed by the law of Russian Federation. Any dispute that cannot otherwise be resolved will be dealt with by courts in Russia.
2. **Liability:** Our liability to you is limited to the amounts indicated in insurance policy and any subsequent policy endorsements (as indicated in the Table of Benefits). In no event will the amount of reimbursement, whether under this policy, public medical schemes and any other insurance, exceed the amount of the invoice.
3. **Other parties:** No other person (except an appointed representative) is allowed to make or confirm any changes to your membership on your behalf, or decide not to enforce any of our rights. No change to your membership will be valid unless it is confirmed in writing by the insurer.
4. **Third party liability:** If you or any of your dependants are eligible to claim benefits under a public scheme or any other insurance policy or from any other third party, which pertains to a claim submitted to us, we reserve the right to decline to pay benefits. You must inform us and provide all necessary information if and when you are entitled to claim benefits under a public scheme or any other insurance policy or from any other third party. You and the third party may not agree any final settlement or waive our right to recover outlays without our prior written agreement. Otherwise, we are entitled to recover the amounts paid from you.
5. **Force majeure:** We shall not be liable for any failure or delay in the performance of our obligations under the terms of the insurance policy, caused by, or resulting from, force majeure which shall include, but is not limited to: events which are unpredictable, unforeseeable or unavoidable, such as extremely severe weather, floods, landslides, earthquakes, storms, lightning, fire, subsidence, epidemics, acts of terrorism, outbreaks of military hostilities (whether or not war is declared), riots, explosions, strikes or other labour unrest, civil disturbances, sabotage, expropriation by governmental authorities and any other act or event that is outside of our reasonable control.
6. **Fraud:**
 - a) Incorrect disclosure/non-disclosure of any material facts, by you or your dependants, which may affect our assessment of the risk, including, but not limited to, those material facts declared on the relevant application form will render the contract void from the commencement date, unless we confirm otherwise in writing. Conditions arising between completing the relevant application form and the start date of the policy will be deemed to be pre-existing and will not be covered if not disclosed. If the applicant is not sure whether something is material, the applicant is obliged to inform us. If the insurance contract is rendered void due to incorrect disclosure or non-disclosure of any material facts, we will refund the premium amount(s) paid to date minus the cost of any medical claims already paid. If the cost of claims exceeds the balance of the premium, we will seek reimbursement of this amount from the principal member.
 - b) If a claim is, in any respect, false, fraudulent, intentionally exaggerated or if fraudulent means/devices have been used by you or your dependants or anyone acting on your or their behalf to obtain benefit under this policy, we will not pay any benefits for that claim. The amount of any claim settlement made to you, before the fraudulent act or omission was discovered, will become immediately due and owing to us. If the insurance 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 insurance contract will be cancelled from the date of our discovery of the fraudulent event.
7. **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 insurance contract shall be deemed cancelled from the date that the premium payment became due and payable. However, if the premium is paid within five days after the due date, the insurance cover will be reinstated and we will cover any claims which occurred during the period of delay. If the outstanding premium is paid after the five day limit, you must complete a Confirmation of Health Status Form before your policy can be reinstated, subject to underwriting.
8. **Making contact with dependants:** In order to administer your insurance policy in accordance with the insurance contract, there may be circumstances when we will need to request further information. If we need to make contact in relation to a dependant into an insurance policy (e.g. where further information is required to process a claim), the policyholder, acting for and on behalf of the dependant, may be contacted by us and asked to provide the relevant information. Similarly, all information in relation to any person covered by the insurance policy, for the purposes of administering claims, may be sent directly to the policyholder.
9. **Use of MediLine:** Please note that the MediLine and its health-related information and resources are not intended to be a substitute for professional medical advice or for the care that patients receive from their doctors. It is not intended to be used for medical diagnosis or treatment and information should not be relied upon for that purpose. Always seek the advice of your doctor before beginning any new treatment or if you have any questions regarding a medical condition. You understand and agree that we are not responsible or liable for any claim, loss or damage directly or indirectly resulting from your use of this advice line or the information or the resources provided through this service. Calls to the MediLine will be recorded and may be monitored for training, quality and regulatory purposes.

DATA PROTECTION AND RELEASE OF MEDICAL RECORDS

We are entitled to process the personal data of an insured person once he/she has been included in the insurance agreement. According to the Federal Law "On personal data" dated July 27th, 2006 No.152-FZ data can be processed for the following purposes: compliance with laws and other regulations related to personal data; performance of obligations under the insurance agreement, control of the quality of services rendered and/or protecting the insurer's interests.

The company guarantees that transfer of the insured persons' personal data to us is performed only upon receipt of the insured person's written consent in line with provisions of the article. Such consent will be effective during the entire period of insurance coverage and 5 years following its expiration or termination. Please note you may withdraw your consent by giving us 60 days written notice.

Processing of the Insured persons' personal data includes all activities listed in article 3 of the Federal Law dated July 27th, 2006 No.152-FZ «On personal data» (including all activities (operations) with personal data performed with or without use of automation facilities such as collecting, recording, systematization, accumulation, storage, specification (update, amendment), extraction, use, transfer (circulation, provision of access to) depersonalization, blocking, deletion of data). Along with this, the Insurer is entitled to transfer personal data to Allianz Group companies including cross-border transfer of personal data to the administrator.



COMPLAINTS AND DISPUTE RESOLUTION PROCEDURE

Making a complaint

Our Helpline is always the first number to call if you have any comments or complaints. If we have not been able to resolve the problem on the telephone, please email or write to us.

Inside Russia

To make a complaint in relation to treatment(s) that took place inside Russia please contact us :

☎ +7 495 956 2900

@ dk@allianz.ru

✉ LLC IC Allianz Life, 30, Ozerkovskaya emb, Moscow, 115184, Russia.

Alternatively you can submit your feedback by using web-form available at:

🌐 <http://allianz.ru/ru/contacts/feedback/>.

Outside Russia

To make a complaint in relation to treatment(s) that took place outside Russia please contact us :

☎ +353 1 907 5951

@ client.servicesRU@allianz.com

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

Mediation

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

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

- c) Any dispute, controversy or claim which is:
 - Arising out of or relating to this Agreement (or the breach, termination or invalidity thereof) with a value in excess of €500,000, or
 - Referred to mediation pursuant to Clause "b" but not voluntarily settled by mediation within three months of the ADR Notice dateshall be determined exclusively by the Courts of Russia and the parties will submit to the exclusive jurisdiction of those courts. Any proceedings brought pursuant to this Clause "c" shall be issued within nine calendar months of the expiration date of the aforementioned three month period.

Legal action

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



DEFINITIONS

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



A

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

Accommodation costs for one parent staying in hospital with an insured child refers to the hospital accommodation costs of one parent for the duration of the insured child's admission to hospital for eligible treatment. If a suitable bed is not available in the hospital, we will contribute the equivalent of a three star hotel daily room rate towards any hotel costs incurred. We will not, however, cover sundry expenses including, but not limited to, meals, telephone calls or newspapers. Please check your Table of Benefits to confirm whether an age limit applies with regard to your child.

Acute refers to sudden onset.

Administrator of your insurance policy is AWP Health & Life Services Limited, a limited liability company registered in Ireland.

Ambulance services cover the cost of a local road ambulance which will transport insured person from home or the location of an accident to a hospital or from one hospital to another.

C

Child preventive care covers routine check ups and immunisations for children up to the age of 13.

Chronic condition is defined as a sickness, illness, disease or injury that either lasts longer than six months or requires medical attention (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.
- Requires prolonged supervision or monitoring.
- Leads to permanent disability.

Please refer to the “Notes” section of your Table of Benefits to confirm whether chronic conditions are covered.

Complementary treatment refers to therapeutic and diagnostic treatment that exists outside the institutions where conventional Western medicine is taught. Please refer to your Table of Benefits to confirm whether any of the following complementary treatment methods are covered:

chiropractic treatment, osteopathy, Chinese herbal medicine, homeopathy, acupuncture and podiatry as practiced by approved therapists.

Complications of childbirth refer only to the following conditions that arise during childbirth and that require a recognised obstetric procedure: post-partum haemorrhage, retained placental membrane and medically necessary caesarean sections. Complications of childbirth are only payable where your cover also includes a routine maternity benefit.

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

Co-payment is the percentage of the costs which the insured person must pay. These apply per person, per Insurance Year, unless indicated otherwise in the Table of Benefits. Some plans may include a maximum co-payment per insured person, per Insurance Year, and if so, the amount will be capped at the amount stated in your Table of Benefits. Co-payments may apply individually to the Core, Out-patient, Maternity, Dental or Repatriation Plan, or to a combination of these plans and if Pre-authorisation is not obtained.

D

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

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

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

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

Dental surgery includes the surgical extraction of teeth, as well as other tooth related surgical procedures such as apicoectomy and dental prescription drugs. All investigative procedures necessary to establish the need for dental surgery such as laboratory tests, X-rays, CT scans and MRI(s) are

included under this benefit. Dental surgery does not cover any surgical treatment that is related to dental implants.

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

Dependant is your spouse or partner (including same sex partner) and/or unmarried children (including any step, foster or adopted children) financially dependant on the policyholder up to the day before their 18th birthday; or up to the day before their 24th birthday if in full time education, and also named in your Insurance Certificate as one of your dependants.

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

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

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

E

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

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

Emergency out-patient dental treatment is treatment received in a dental surgery/hospital emergency room for the immediate relief of dental pain caused by an accident or an injury to a sound natural tooth, including pulpotomy or pulpextomy and the subsequent temporary fillings, limited to three fillings per Insurance Year. The treatment must be received within 24 hours of the emergency event. This does not include any form of dental prostheses, permanent restorations or the continuation of root canal treatment. If a Dental plan was selected, you will be covered under the terms of this plan for dental treatment in excess of the (Core Plan) emergency out-patient dental treatment benefit limit.

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

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

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

F

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

H

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

- Physical examination.
- Blood tests (full blood count, biochemistry, lipid profile, thyroid function test, liver function test, kidney function test).

- Cardiovascular examination (physical examination, electrocardiogram, blood pressure).
- Neurological examination (physical examination).
- Cancer screening:
 - Annual pap smear.
 - Mammogram (every two years for women aged 45+, or earlier where a family history exists).
 - Prostate screening (yearly for men aged 50+, or earlier where a family history exists).
 - Colonoscopy (every five years for members aged 50+, or 40+ where a family history exists).
 - Annual faecal occult blood test.
- Bone densitometry (every five years for women aged 50+).
- BRCA1 and BRCA2 genetic test (where a direct family history exists and where included in your Table of Benefits).

HIV or AIDS benefit covers the cost of consultations, investigations, testing, inpatient and/or outpatient treatment of Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS). Please note 48 months waiting period applies.

Home care services refer to care provided by doctors including ECG screening and treatment at your home. Please note this service is only available in Russia.

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

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

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

I

Infertility treatment refers to treatment for the insured person including all invasive investigative procedures necessary to establish the cause for infertility such as hysterosalpingogram, laparoscopy or hysteroscopy. In the case of InVitro Fertilization (IVF), cover is limited to the

amount specified in the Table of Benefits. If your Table of Benefits does not have a specific benefit for infertility treatment, cover is limited to non-invasive investigations into the cause of infertility, within the limits of your Out-patient Plan (if selected). If however, there is a specific benefit for infertility treatment, the cost for infertility treatment will be covered for the insured member who receives the treatment, up to the limit indicated in the Table of Benefits. Any costs exceeding the benefit limit cannot be claimed under the cover of the spouse/partner (if included in the policy). In the case of InVitro Fertilisation (IVF), cover is limited to the amount specified in the Table of Benefits. Please note that multiple birth babies born as a result of medically assisted reproduction, babies born to a surrogate or babies who have been adopted, can only get their own insurance cover 90 days after birth or/and their adoption which will be subject to full medical underwriting.

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

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

Insurance Year applies from the effective date of the insurance, as indicated on the Insurance Certificate and ends exactly one year later.

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

L

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

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

M

Medical evacuation applies where the necessary treatment for which the insured person is covered is not available locally or if adequately screened blood is unavailable in the event of an emergency. The administrator will evacuate the insured person to the nearest appropriate medical centre (which may or may not be located in the insured person's home country) by ambulance, helicopter or aeroplane. The medical evacuation, which should be requested by your physician, will be carried out in the most economical way having regard to

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

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

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

Where adequately screened blood is not available locally, the administrator will, where appropriate, endeavour to locate and transport screened blood and sterile transfusion equipment, where this is advised by the treating physician. The administrator will also endeavour to do this when our medical experts so advise. Neither we nor our agents accept no liability in the event that such endeavours are unsuccessful or in the event that contaminated blood or equipment is used by the treating authority.

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

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

- (a) Essential to identify or treat a patient's condition, illness or injury.
- (b) Consistent with the patient's symptoms, diagnosis or treatment of the underlying condition.
- (c) In accordance with generally accepted medical practice and professional standards of medical care in the medical community at the time. This does not apply to complementary treatment methods if they form part of your cover.
- (d) Required for reasons other than the comfort or convenience of the patient or his/her physician.
- (e) Proven and demonstrated to have medical value. This does not apply to complementary treatment methods if they form part of your cover.
- (f) Considered to be the most appropriate type and level of service or supply.

- (g) Provided at an appropriate facility, in an appropriate setting and at an appropriate level of care for the treatment of a patient's medical condition.
- (h) Provided only for an appropriate duration of time.

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

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

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

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

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

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

N

Newborn care includes customary examinations required to assess the integrity and basic function of the child's organs and skeletal structures. These essential examinations are carried out immediately following birth. Further preventive diagnostic procedures, such as routine swabs, blood typing and hearing tests, are not covered. Any medically necessary follow-up investigations and treatment are covered under the newborn's own policy. Please note that multiple birth babies born as a result of medically assisted reproduction, babies born to a surrogate or babies who have been adopted, can only get their own insurance cover 90 days after birth

or/and their adoption which will be subject to full medical underwriting. The first seven days of routine care for your baby will be paid from the mothers maternity benefit whether the baby is entitled to newborn care benefits or not.

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

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



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

Occupational therapy refers to treatment that addresses the individual's development of fine and gross motor skills, sensory integration, coordination, balance and other skills such as dressing, eating, grooming, etc. in order to aid daily living and improve interactions with the physical and social world. A progress report is required after 20 sessions.

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

Oncology refers to specialist fees, diagnostic tests, radiotherapy, chemotherapy and hospital charges incurred in relation to the planning and carrying out of treatment for cancer, from the point of diagnosis. We will also cover the cost of an external prosthetic device for cosmetic purpose, for example a wig in the event of hair loss or a prosthetic bra as a result of cancer treatment.

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

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

Orthodontics is the use of devices to correct malocclusion and restore the teeth to proper alignment and function. Orthodontic treatment is covered only in cases of medical necessity, and for this reason, at the point of claiming, we will ask you to submit supporting information to determine that your treatment is medically necessary and therefore eligible for cover. The supporting information required (depending on your case) may include, but is not limited to, the following documents:

- Medical report issued by the specialist, stating the diagnosis (type of malocclusion) and a description of the patient's symptoms caused by the orthodontic problem.
- Treatment plan indicating the estimated treatment duration, estimated cost and type/material of the appliance used.
- The payment arrangement agreed with the medical provider.
- Proof that payment has been made in respect of the orthodontic treatment.
- Photographs of both jaws clearly showing dentition prior to treatment.
- Clinical photographs of the jaws in central occlusion from frontal and lateral views.
- Orthopantomogram (panoramic x-ray).
- Profile x-ray (cephalometric x-ray).

Please note that we will only cover orthodontic treatment where the standard metallic braces and/or standard removable appliances are used. Cosmetic appliances such as lingual braces and invisible aligners are covered up to the cost of metallic braces, subject to the "Orthodontic treatment and dental prostheses" benefit limit.

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

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

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

P

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

Periodontics refers to dental treatment related to gum disease.

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

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

Pre-existing conditions are medical conditions or any related conditions for which one or more symptoms have been displayed at some point during your lifetime, irrespective of whether any medical treatment or advice was sought. Any such condition or related condition, about which you or your dependants could reasonably have been assumed to have known, will be deemed to be pre-existing. Pre-existing conditions which have not been declared on the relevant application form are not covered. Plus, conditions arising between completing the relevant application form and the start date of the policy will equally be deemed to be pre-existing. Such pre-existing conditions will also be subject to medical underwriting and if not disclosed, they will not be covered. Please refer to the "Notes" section of your Table of Benefits to confirm if pre-existing conditions are covered.

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

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

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

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

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

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

Prescribed physiotherapy refers to treatment by a registered physiotherapist following referral by a medical practitioner. Physiotherapy is initially restricted to 12 sessions per condition, after which the treatment must be reviewed by the referring medical practitioner. Should further sessions be required, a new progress report must be submitted to us after every set of 12 sessions, which indicates the medical necessity for any further treatment. Physiotherapy does not include therapies such as Roling, Massage, Pilates, Fango and Milta therapy.

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

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

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

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

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

Psychiatry and psychotherapy is the treatment of mental disorders carried out by a psychiatrist or clinical psychologist. The condition must be clinically significant and not related to bereavement, relationship or academic problems, acculturation difficulties or work pressure. All day-care or

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

R

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

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

Routine maternity refers to any medically necessary costs incurred during pregnancy and childbirth, including hospital charges, specialist fees, the mother's pre- and post-natal care, midwife fees (during labour only) as well as routine newborn care for the first seven days. Please note costs related to non-routine newborn care including neonatal special care unit or neonatal intensive care will not be covered under this benefit. Costs related to complications of pregnancy or complications of childbirth are not payable under routine maternity. In addition, any non-medically necessary caesarean sections will be covered up to the cost of a routine delivery in the same hospital, subject to any benefit limit in place. If the home delivery benefit is included in your plan, a lump sum up to the amount specified in the Table of Benefits will be paid in the event of a home delivery. Please note that multiple birth babies born as a result of medically assisted reproduction, babies born to a surrogate or babies who have been adopted, can only get their own insurance cover 90 days after birth or/and their adoption which will be subject to full medical underwriting.

S

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

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

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

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

T

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

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

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

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

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

V

Vaccinations refer to all basic immunisations and booster injections required under regulation of the country in which treatment is being given, any medically necessary travel vaccinations and malaria prophylaxis. The cost of consultation for administering the vaccine, as well as the cost of the drug, is covered. Please note cost of child immunisations for children up to the age of 13 are not covered under this benefit. If you have selected the Out-patient plan we will pay for these immunisations from the child preventative care benefit.

W

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

We/Our/Us refers to the LLC IC Allianz Life.

Y

You/Your refers to the eligible individual stated on the insurance policy as an insured person and reflected in the Insurance Certificate.



EXCLUSIONS

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



The following exclusions apply to all our plans, unless stated otherwise:

Acquisition of an organ

Expenses for the acquisition of an organ including, 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, unless indicated otherwise in the Table of Benefits.

Chemical contamination and radioactivity

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

Complementary treatment

Complementary treatment, with the exception of those treatments indicated 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, as well as any drugs or treatments prescribed, by you, your spouse, parents or children.

Dental veneers

Dental veneers and related procedures, unless medically necessary.

Developmental delay

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

Drug addiction or alcoholism

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

Experimental or unproven treatment or drug therapy

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

Failure to seek or follow medical advice

Treatment 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.

Fees for the completion of a Claim Form

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

Genetic testing

Genetic testing, except: a) where specific genetic tests are included within your plan; b) where DNA tests are directly linked to an eligible amniocentesis i.e. in the case of women aged 35 or over; c) testing for genetic receptor of tumours is covered.

Infertility treatment

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

Injuries caused by professional sports

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

Intentionally caused diseases or self-inflicted injuries

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

Loss of hair and hair replacement

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

Medical error

Treatment required as a result of medical error.

Obesity treatment

Investigations into, and treatment of, obesity.

Orthomolecular treatment

For the orthomolecular treatment, please refer to Orthomolecular definition.

Participation in war or criminal acts

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

Plastic surgery

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

Pre- and post-natal

Pre- and post-natal classes.

Pre-existing conditions

Pre-existing conditions (including any pre-existing chronic conditions) which are indicated on a Special Conditions Form that is issued prior to policy inception (if relevant) and conditions which have not been declared on the relevant application form. In addition, conditions arising between completing the relevant application form and the start date of the policy will equally be deemed to be pre-existing. Such pre-existing conditions will also be subject to medical underwriting and if not disclosed, they will not be covered.

Products sold without prescriptions

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

Sex change

Sex change operations and related treatments.

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 this condition is as a result of total prostatectomy following surgery for cancer) and contraception including the insertion and removal of contraceptive devices and all other contraceptives, even if prescribed for medical reasons. The only exception in relation to costs for contraception is where contraceptives are prescribed by a dermatologist for the treatment of acne.

Surrogacy

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

Termination of pregnancy

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

Travel costs

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

Treatment in the USA

Treatment in the USA if we know or suspect that cover was acquired for the purpose of travelling to the USA to receive treatment for a condition, when the symptoms of the condition were apparent to the insured person prior to acquiring cover. If any claims have been paid by us in these circumstances, we reserve the right to seek reimbursement from the insured person of any amounts which have already been paid in claims.

Treatments not indicated in your Table of Benefits

The following treatments, expenses, procedures 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 with the exception of oral and maxillofacial surgical procedures, which are covered within the overall limit of your Core Plan.
- 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 including eye examination.
- Prescribed medical aids.
- Preventive treatment.
- Rehabilitation treatment.
- Routine maternity 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.

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 you have previously been diagnosed with the specific cancer in question, in which case, cover will be provided under the Oncology benefit.

Vessel at sea

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

Vitamins or minerals

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

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

-  Inside Russia: +7 495 956 2900
- Outside Russia: +353 1 907 5951

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

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

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

- @ Email: client.servicesRU@allianz.com

-  Fax: + 353 1 630 1306

-  www.facebook.com/AllianzCare/
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-  www.youtube.com/c/allianzcare
-  www.instagram.com/allianzcare/
-  www.snapchat.com/add/allianzcare

This Agreement does not provide any cover or benefit for any business or activity to the extent that either the cover or benefit or the underlying business or activity would violate any applicable sanction law or regulations of the United Nations, the European Union or any other applicable economic or trade sanction law or regulations.

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