Allianz

Individual Benefit Guide

Flexicare

Short-term healthcare plans for you and your family

Valid from 1st June 2026

Welcome

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

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

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

We are the international health brand of Allianz Partners. Allianz Partners has a number of business lines, including international health, assistance, travel and automotive.

Contents

How to use your cover

Support services

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

Talk to us, we love to help!

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

Helpline
Phone: **+353 1 630 1301**

For our latest list of toll-free numbers, please visit:
www.allianzcare.com/en/pages/toll-free-numbers.html

Email: client.services@e.allianz.com

Did you know...

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

Support when you need it most

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

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

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

Web-based services

On www.allianzcare.com/members you can:

- download forms.
- access our Health and Wellness Library.
- access our 'My expat life' hub – from planning to move, to settling down in your new country, you'll find everything you need to know about moving overseas.

Member services included in your cover

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

EAP — Expat Assistance Programme**

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

- **Counselling** – confidential and professional support in-person, phone and video on topics such as stress, work/life balance, parenting, anxiety, cultural shock, addiction concerns, etc.
- **Legal and financial referral services**, for example to help buying a home, handling a legal dispute or creating a financial plan.

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

If you have EAP as part of your insurance policy, you can access counselling services by following these steps:

- Download the TELUS Health One app from the App Store or Google Play and log in using the following credentials:
  Username: AllianzCare
  Password: Expatriate
- Alternatively, you can access the EAP portal via website: www.allianzcare.com/eap-login

Travel Security Services**

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

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

If you have Travel Security Services as part of your insurance policy, you can register by following these steps:

- Download the Crisis24 Horizon app from the App Store or Google Play, or visit crisis24horizon.com/allianztravsec.
- Register with your email address and click 'Proceed'.
- Enter your details and add the Member ID 'ALLIANZTSS'.
- Follow the instructions in the email to reset their password.
- For assistance, you can contact support@crisis24.com.

To know more or to access the above member services, visit:
www.allianzcare.com/en/support/member-resources.html#care

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

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

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

Understanding how your cover works

What am I covered for?

You and your dependants are covered for medically necessary treatment and related costs, services and supplies arising from the occurrence or worsening of a medical condition, in accordance with your Table of Benefits. Within the scope of your policy, you are covered for medical treatment, costs, services or supplies that:

- we determine to be medically necessary, appropriate for the patient's condition, illness or injury.
- have a palliative, curative and/or diagnostic purpose.
- are performed by a licensed doctor, dentist or therapist.

Your cover is also subject to:

- **Policy definitions and exclusions** (also available in this guide).
- Any **special conditions** shown on your Insurance Certificate.
- Any **policy endorsements**, these **policy terms and conditions** and any other **legal requirements**.
- Costs being reasonable and customary – these are costs that are usual within the country of treatment. We will only reimburse medical providers where their charges are in accordance with standard and generally accepted medical procedures. If we consider a claim to be inappropriate, we reserve the right to decline or reduce the amount we pay. Treatment being performed by, or under the supervision of, a licensed medical practitioner, dental practitioner or therapist.

Please note that we do not cover pre-existing conditions within the terms of this policy.

Where can I receive treatment?

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

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

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

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

What are benefit limits?

Your cover may be subject to a **maximum plan limit**. This is the maximum we will pay in total for all benefits included in the plan per member, per Insurance Period, i.e. three, six, nine or 12 months (depending on your selection).

If your plan has a maximum plan limit, it will apply even where:

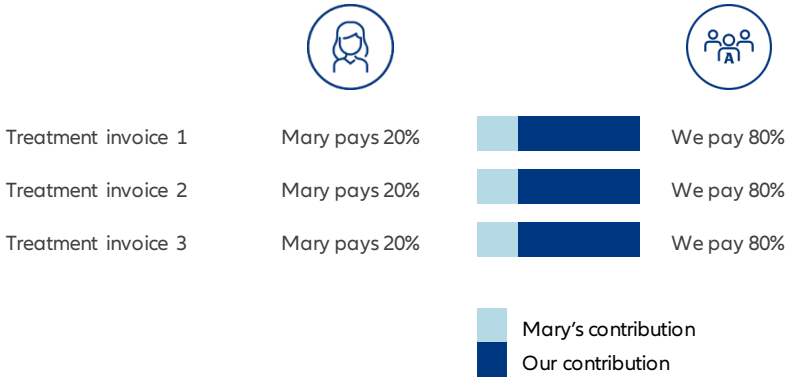
- the term 'Full refund' appears next to the benefit.
- a specific benefit limit applies – this is when the benefit is capped to a specific amount (e.g. £ 2,490 / € 3,000 / US$ 4,050 / CHF 3,900).

Benefit limits are provided on a 'per Insurance Period' basis.

In some instances indicated in the Table of Benefits, in addition to the benefit limit, we will only pay a percentage of the costs for the specific benefit (e.g. 80% refund, max € 300).

What are co-payments?

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



Seeking treatment?

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

Step 1. Check your level of cover

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

Step 2. Confirm if your treatment requires pre-authorisation

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

Unless we agree otherwise, if you submit a claim without obtaining our pre-authorisation, the following will apply:

- If the treatment or service received is subsequently proven to be ineligible, **we reserve the right to decline your claim**.

- If the treatment or service is subsequently proven to be eligible, we will pay **80%** of in-patient benefits and **50%** of other benefits.

Step 3. Use your provider network

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

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

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

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

How to seek pre-authorisation

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

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

Complete the form and send it to us at least **five working days before treatment**. You can send it by email to medical.services@e.allianz.com

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

If it's an emergency

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

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

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

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

Receive your medical treatment and pay the medical provider.

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

Send your fully completed claim form together with invoice(s)/receipt(s) to: claims@allianzworldwidecare.com

Quick claim processing

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

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

Evacuations and repatriations

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

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

+353 1 630 1301
medical.services@e.allianz.com

Seeking treatment in the USA

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

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

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

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

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

Additional information about claiming for your expenses

Medical claims

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

- **Claiming deadline:** You must submit all claims no later than six months after the end of the Insurance Period. After this time, we are not obliged to settle the claim.

- **Claim submission:** You must submit a separate claim for each person claiming and for each medical condition being claimed for.

- **Supporting documents:** When you send us copies of supporting documents (e.g. medical receipts), please make sure you keep the originals. We have the right to request original supporting documents/receipts for auditing purposes up to 12 months after settling your claim. We may also request proof of payment by you (e.g. a bank or card statement) for medical bills you have paid. We advise that you keep copies of all correspondence with us as we cannot be held responsible for correspondence that fails to reach us for any reason outside of our control.

- **Currency and charges:** Please specify the currency you wish to be paid in. On rare occasions, we may not be able to make a payment in that currency due to international banking regulations. If this happens, we will identify a suitable alternative currency. If we have to make a conversion from one currency to another, we will use the exchange rate that applied on the date the invoices were issued. We will cover all charges associated with the payment. However, if your bank applies a fee for receiving funds into your account as part of its terms and conditions, we will not be liable for this fee.

- **Reimbursement:** We will only reimburse (within the limits of your policy) eligible costs after considering any pre-authorisation requirements, deductibles or co-payments outlined in the Table of Benefits.

- **Reasonable and customary cost:** We will only reimburse charges that are reasonable and customary in accordance with standard and

generally accepted medical procedures. If we consider a claim to be inappropriate, we reserve the right to decline your claim or reduce the amount we pay.

- **Deposits:** If you have to pay a deposit in advance of any medical treatment, we will reimburse this cost only after eligible treatment has taken place.

- **Providing information:** You and your dependants agree to help us get all the information we need to process a claim. We have the right to access all medical records and to have direct discussions with the medical provider or the treating doctor. We may, at our own expense, request a medical examination by our doctors if we think it's necessary. All information will be treated confidentially. We reserve the right to withhold benefits if you or your dependants do not support us in getting the information we need.

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

Terms and conditions of your cover

Terms and conditions

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

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

- The **Benefit Guide** (this document), which explains the standard benefits and rules of your health insurance policy. It should be read together with your Insurance Certificate and Table of Benefits.

- The **Insurance Certificate**. This states the plan(s) chosen, the start date and end date of the policy, and the geographical area of cover. If any other terms apply which are specific to your cover, these will be stated in the Insurance Certificate. They will also have been detailed on a Special Conditions Form which we send you before you're placed on cover. We'll send you an updated Insurance Certificate if we apply a change that we're entitled to make.

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

- **Information provided to us by (or on behalf of) the insured person(s)** in the signed Application Form, submitted Online Application Form, Confirmation of Health Status Form or others (we'll refer to all of these collectively as the 'relevant application form') or other supporting medical information.

Administration of your policy

When cover starts

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

Cover for dependants (if applicable) will start on the effective date shown on the most recent Insurance Certificate that lists them as your dependants. Their membership may continue for as long as you are the policyholder and, for children, as long as they remain under the defined age limit. Child dependants can be covered under your policy up until the day before their 18th birthday or up until the day before their 26th birthday if they are in full-time education. At that time, they may apply for cover in their own right under one of our healthcare plans for individuals and families.

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. We may request a death certificate before a refund is issued. Alternatively, if they wish to, the next named dependant on the Insurance Certificate can apply to become the policyholder and keep the other dependants on their policy. If they apply to do this within 28 days, we will, at our discretion, not add any further special restrictions or exclusions that didn't already apply at the time of the policyholder's death.

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

Changing country of residence

It is important to let us know when you change your country of residence. This may affect your cover or premium, even if you are moving to a country within your geographical area of cover, as your existing plan may not be valid there.

Contact us to check if your cover is valid in the country you are moving to: individual.admin@e.allianz.com

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 health cover is legally appropriate. If you are not sure, please get independent legal advice, as we may no longer be able to cover you. The cover we provide is not a substitute for local compulsory health insurance.

Changing your postal address or email address

You need to inform us in writing as soon as possible of any change in your home, business or email address.

Correspondence

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

Extension of cover
Please note that your membership (and that of any dependants listed on your Insurance Certificate) will end at the conclusion of the cover period you selected when applying (three, six, nine or 12 months).

Our Flexicare plans are not automatically renewed. If you need to spend more time abroad, you can extend your cover by re applying online for an additional three, six or nine months.

If you originally purchased 12 months of Flexicare cover, it isn't possible to extend this plan further. In this case, we recommend applying for one of our Care Plans, which are designed for longer term international health cover.

Your right to withdraw

You can withdraw from your policy if you change your mind, and this will apply to all persons insured under it. You will be entitled to a full refund of the premium paid for the Insurance Year/Period, provided that no claims have been made.

You can withdraw **within 30 days** of the date when:

- you receive the full terms and conditions of your policy, or
- you conclude the insurance contract (i.e. when you sign the Application Form, or when you click on the acceptance button on our website – if you purchase online)

...whichever is later.

After the 30-day period has passed, the insurance contract will be binding on both parties, and the full premium for the selected Insurance Year/Period will be due for payment, according to the payment frequency that you selected.

How to withdraw
The easiest way to withdraw is **digitally**:

- Visit www.allianzcare.com/en/support/withdraw-your-contract.html.
- Click the **'Withdraw from your policy'** button.
- Submit your request within the **30-day** period specified above.

Once we process your request, we will send you a written confirmation via email.

Alternatively to the digital process above, you can also contact us, using the details at the end of this guide, and request to withdraw. Please ensure you do this within the 30-day period specified above.

Reasons your membership would end

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

- at the end of the period of cover you selected when applying for cover (three, six, nine or 12 months), because our Flexicare plans are not automatically renewed. If you need to spend more time abroad, you can extend your cover by re-applying online for an additional **three, six or nine months**. If you originally purchased **12 months of Flexicare cover**, it isn't possible to extend this plan further. In this case, we recommend applying for one of our **Care Plans**, which are designed for longer-term international health cover.

- if you do not pay any of your premiums on, or before, the date they are due.

- if you do not pay the amount of any IPT, taxes, levies or charges that you have to pay under your agreement with us on or before the due date.

- upon the death of the policyholder. Please see the section on 'Death of the policyholder or a dependant' for further details.

- if there is reasonable evidence that the policyholder or any dependants misled or attempted to mislead us. Examples are: giving false information, withholding pertinent information from us, working with another party to give us false information (either intentionally or carelessly) which may influence us when deciding:

  - whether we accept the application for cover.
  - the applicable premium to pay.
  - whether we have to pay a claim.

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

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

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

Policy expiry

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

Paying premiums

Premiums for each Insurance Period are based on each member's age on the first day of the Insurance Period, 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 need to pay your premium immediately after we accept your application, in advance for the duration of cover.

When you receive your invoice, please check that the premium matches the amount shown on your agreed quotation and contact us immediately if there is any difference. We are not responsible for the loss or delay of payments made through third parties.

You should pay your premium in the currency you selected when applying for cover. If you are unable to pay your premium for any reason, please contact us on: **+353 1 630 1301**.

Failure to pay your initial premium on time may result in loss of insurance cover.

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

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

Paying other charges

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

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

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

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

The following terms also apply to your cover

Applicable law:

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

Sanctions suspension clause:

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

- any applicable sanction, prohibition or restriction under the United Nations' resolutions, or

- the trade or economic sanctions, laws or regulations of the European Union, United Kingdom, or United States of America.

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

The amounts we will pay:

Our liability to you is limited to the amounts indicated in the Table of Benefits and any policy endorsements. The total amount reimbursed for a claim, whether under this policy, public medical scheme and/or any other insurance will not exceed the costs incurred by you for your claim.

Who can make changes to your policy:

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

When cover is provided by someone else:

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

- a public scheme.

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

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

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

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

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

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

If the contract is rendered void due to incorrect disclosure or non-disclosure of any material facts, we will refund the premium amount(s) paid to date minus the cost of any medical claims already paid. If the cost of claims exceeds the balance of the premium, we will seek reimbursement of this amount from the policyholder.

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

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

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

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

Data protection

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

Alternatively, you can contact us on the phone to request a paper copy.
+353 1 630 1301

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

Complaints and dispute resolution procedure

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

Phone: **+353 1 630 1301**

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

Email: customer.resolution@e.allianz.com

Address: **Customer Resolution Team, Allianz, 15 Joyce Way, Park West Business Campus, Nangor Road, Dublin 12, Ireland**

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

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

Mediation

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

2. If differences cannot be resolved in accordance with Clause 1 above, the parties will attempt to settle by mediation in accordance with the Centre for Effective Dispute Resolution (CEDR) Model Mediation Procedure any dispute, controversy or claim arising out of or relating to this agreement or the breach, termination or invalidity thereof where the value is € 500,000 or less and which cannot be settled amicably between the parties. The parties will endeavour to agree on the appointment of an agreed Mediator. If the parties fail to agree the appointment of an agreed Mediator within 14 days, either party, upon written notice to the other party, may apply to CEDR for the appointment of a Mediator.

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

3. Any dispute, controversy or claim which is:
   a) arising out of or relating to this agreement (or the breach, termination or invalidity thereof) with a value in excess of € 500,000, or
   b) referred to mediation pursuant to Clause 2 but not voluntarily settled by mediation within three months of the ADR Notice date will be determined exclusively by the Courts of the country of the Applicable Law and the parties will submit to the exclusive jurisdiction of those courts. Any proceedings brought pursuant to this Clause 3 will be issued within nine calendar months of the expiration date of the aforementioned three-month period.

Legal action

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

Definitions

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

Accident

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

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

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

Acute

Sudden onset of symptoms or a medical condition.

Acute medical condition

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

Burial expenses

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

Chronic condition

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

- Is recurrent in nature.

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

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

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

Day-care treatment
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.

Dependant
Your spouse or partner and unmarried children that are named as dependants on your Insurance Certificate. Children are covered up to the day before their 18th birthday; or up to the day before their 26th birthday if they are in full-time education.

Diagnostic tests
Investigations such as x-rays or blood tests, carried out for diagnostic purposes. These tests are covered when you are already displaying symptoms or when needed following other medical test results. This benefit does not cover annual check-ups or routine screenings.

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

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

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

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

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

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

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

Emergency out-patient dental treatment
Treatment received in a dental surgery or hospital emergency room for the immediate relief of dental pain caused by an accident or an injury to a sound natural tooth. Treatment may include pulpotomy or pulpectomy and the subsequent temporary fillings, limited to three fillings per Insurance Year. Treatment must take place within 24 hours of the emergency event. It does not include any form of dental prostheses, permanent restorations or the continuation of root canal treatment. However, if your policy also includes a Dental Plan, it will cover dental treatment in excess of the limit on 'Emergency out-patient dental treatment' benefit. In that case, the Dental Plan terms will apply.

Emergency out-patient treatment
Treatment received in a casualty ward or emergency room within 24 hours of an accident or sudden illness, where there is no medical necessity for you to occupy a hospital bed. If your policy includes an Out-patient Plan, it will cover you for out-patient treatment in excess of the limit on 'Emergency out-patient treatment' benefit. In that case, the Out-patient Plan terms will apply.

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

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

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

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

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

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

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

Please note that if your hospital admission is related to another benefit covered under your policy, hospital accommodation may already be included within that benefit. For example, if you are hospitalised for cancer treatment, hospital accommodation will be covered under the 'Oncology' benefit, rather than the separate 'Hospital accommodation' benefit. Other benefits that may include hospital accommodation (if included in your plan) are: 'Psychiatry and psychotherapy', 'Routine maternity', 'Palliative care' and 'Long-term care'. Where your benefit includes hospital accommodation, please note that the room type specified under 'Hospital accommodation' in your Table of Benefits will apply to those other benefits as well. For example, if your 'Hospital accommodation' benefit covers a semi-private room type and you are hospitalised for cancer treatment, your 'Oncology' benefit will include cover for semi-private room accommodation only.

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

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

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

Insurance Period
It applies from the effective date of your policy, as shown on the Insurance Certificate.

Insured person
You and your dependants as stated on your Insurance Certificate.

Local ambulance
Ambulance transport to the nearest available and appropriate hospital or licensed medical facility when required for an emergency or out of medical necessity to receive treatment you are covered for.

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

Medical evacuation
It applies in the following scenarios:

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

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

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

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

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

You must contact us at the first indication that you need an evacuation. From this point onwards, we will organise and coordinate the evacuation until you arrive safely at your

destination of care. If evacuation services are not organised by us, we reserve the right to decline all costs incurred.

Medical provider network

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

Medical necessity

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

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

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

Medical practitioners

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

Medical practitioner fees

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

Medical repatriation

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

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

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

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

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

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

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

Pre-existing conditions
Any physical or mental illness, injury, condition, or disorder for which you or your dependants have ever experienced signs or symptoms, or for which medical advice, diagnostic findings, investigation, or treatment have ever been received or recommended, regardless of whether a formal diagnosis was made.

We will consider any medical condition to be pre-existing if we can determinate that you or your dependants would have known about it. Your policy will not cover pre-existing conditions.

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

- the date we issued your Insurance Certificate, or
- the start date of your policy.

Such pre-existing conditions will also be subject to medical underwriting and will not be covered.

Prescribed physiotherapy

Treatment provided by a registered physiotherapist following referral by a doctor. Physiotherapy (either prescribed, or a combination of non-prescribed and prescribed treatment) is initially restricted to 12 sessions per condition, after which treatment must be reviewed by your therapist or the doctor who referred you.

If you need further sessions, your therapist/doctor must send us a new progress report and treatment plan for your condition, indicating the medical necessity for more treatment. They must also do this after every subsequent set of 12 sessions.

Physiotherapy does not include therapies such as Rolfing, massage, Pilates, Fango and Milta.

Prescribed drugs and dressings

Drugs when prescribed by a doctor to:

- Treat a confirmed diagnosis or medical condition
- Compensate a lack of vital bodily substances

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

Principal country of residence

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

Professional sports

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

Reasonable and customary

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

Repatriation of mortal remains

The transportation of the deceased insured person's remains to their home country. If the insured passes away in their home country, we will cover transportation to the location of burial or cremation in that country, or to another home country where more than one home country exists. We cover costs such as: embalming, a container legally appropriate for transportation, shipping and the necessary government authorisations. Cremation costs will only be covered if

the cremation is required for legal purposes. We do not cover costs incurred by anyone accompanying the remains unless this is listed as a specific benefit in your Table of Benefits.

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

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

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

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

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

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

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

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

Travel costs of insured persons to be with a close relative who is at peril of death or who has died

The reasonable transportation costs of insured members to be with a close relative who is at peril of death or who has died (up to the amount specified in your Table of Benefits). Cover includes one round trip per insured member per Insurance Year. If the close relative has passed away, travel must commence within six weeks of their date of death.

A **close relative** is a spouse/partner, parent (including legally adoptive parent), stepparent, legal guardian, parent-in-law, brother or sister (including stepbrother/stepsister and brother/sister-in-law), child (including adopted child, fostered child or stepchild), son or daughter in law, grandparent or grandchild.

Reasonable transportation costs are considered to be round trip transport costs at economy rates. When claiming, please include copies of the travel tickets and the death certificate or a doctor's certificate supporting the reason for travel. Cover does not include hotel accommodation or other related expenses.

Treatment

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

Vaccinations

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

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

*We cover any COVID-19 vaccine when:

- The vaccine has completed the necessary clinical development process, including all pre-licensure vaccine clinical trials (phase I, II and III) that demonstrate its efficacy and safety.
- The vaccine has completed the multi-step approval process for the relevant regulating authority and is approved for use in the jurisdiction where you require it.
- The vaccine is not offered for free or only partially sponsored by the government of the country in which you reside.

We cover the reasonable and customary cost of the COVID-19 vaccine, including the administration of the injection, in line with local public health policies related to the allocation of vaccines. We do not pay towards the travel cost if you decide to travel to a different country

from where you normally reside in order to get the vaccination. Please note that cover is not intended to give you priority access to vaccines.

Waiting period

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

We/Our/Us

AWP Health & Life SA, Irish Branch – the insurer.

You/Your

The policyholder and any dependants named on the Insurance Certificate.

Exclusions

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

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

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

CHEMICAL CONTAMINATION AND RADIOACTIVITY
Treatment or services for any medical conditions arising directly or indirectly from chemical contamination, radioactivity or any nuclear material, including the combustion of nuclear fuel.

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

COMPLICATIONS CAUSED BY CONDITIONS NOT COVERED UNDER YOUR PLAN
Expenses incurred because of complications directly caused by an illness, injury or treatment for which cover is excluded or limited under your plan.

CONSULTATIONS PERFORMED BY YOU OR A FAMILY MEMBER
Consultations performed and any drugs or treatments prescribed by you, your spouse, parents or children.

COSMETIC TREATMENT

Any cosmetic treatment, even when medically prescribed. This includes treatment carried out by a plastic surgeon, whether or not for medical/psychological purposes. The only exception is:

- Reconstructive surgery necessary to restore function or appearance after a disfiguring accident or as a result of surgery for cancer, provided the accident or initial surgery was also covered by this policy.

DENTAL VENEERS

Dental veneers and related procedures.

DEVELOPMENTAL DELAY

Delay in cognitive development, unless the person meets the criteria for developmental delay and the benefit is included on your policy. Cover for physical developmental delays is only provided under the 'Prescribed physiotherapy' and 'Occupational therapy' benefits if these are included in your plan, and the delay is confirmed to be at least 12 months based on quantitative measurements as documented by qualified medical professionals. We don't cover daily educational support, admissions, stays or day-care treatment at specialised educational facilities.

DRUG ADDICTION OR ALCOHOLISM

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

EXPERIMENTAL OR UNPROVEN TREATMENT OR DRUG THERAPY

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

FAILURE TO SEEK OR FOLLOW MEDICAL ADVICE

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

FAMILY THERAPY AND COUNSELLING

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

FEES FOR THE COMPLETION OF A CLAIM FORM

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

GENDER DYSPHORIA

Care and/or treatment or services for gender dysphoria.

GENETIC TESTING

Genetic testing, except:

- where specific genetic tests are included within your plan.
- where DNA tests are directly linked to an eligible amniocentesis i.e. in the case of women aged 35 or over.
- genetic receptor testing of tumours, where medically appropriate and the 'Oncology' benefit is included in your plan.

HOME VISITS

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

FERTILITY TREATMENT

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

INJURIES OR ILLNESSES CAUSED BY EXTREME OR PROFESSIONAL SPORTS OR ACTIVITIES

Claims arising from taking part in extreme or professional sports or activities, including but not limited to:

- base jumping
- tombstoning
- cliff jumping

- mountaineering high altitudes above 3,000 meters
- rock climbing
- paragliding
- potholing
- motorsports racing, including motocross and dirt bike racing
- bull riding or bull running
- parkour
- scuba-diving at a depth of more than 30 meters
- off-piste skiing

INTENTIONALLY CAUSED DISEASES OR SELF-INFLICTED INJURIES
Care and/or treatment or services of intentionally caused diseases or self-inflicted injuries, including a suicide attempt.

LOSS OF HAIR AND HAIR REPLACEMENT
Investigations into and treatment for loss of hair, including hair replacement unless the loss of hair is due to cancer treatment.

MEDICAL ERROR
Treatment required as a result of medical error.

ORTHOMOLECULAR TREATMENT
Please refer to the definition of 'Orthomolecular treatment'.

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

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

PERSONAL PRODUCTS AND DIETARY SUPPLEMENTS

We do not cover the following products, even if they are prescribed, medically recommended and/or acknowledged as having therapeutic effects:

- **Personal products such as mouthwash, toothpaste, antiseptic lozenges and sprays, shampoo, sunscreen, sanitiser, gloves, masks, visors, thermometers and baby supplies**
- **Cosmetic products, including moisturisers, emulsions, lotions, gels and oils for the skin that do not contain medicinal components**
- **Children's food, including infant formula given orally**

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

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

PRE- AND POST-NATAL

Pre- and post-natal classes.

PRE-EXISTING CONDITIONS

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

- **indicated on a Special Conditions Form that we issue before your policy starts.**
- **conditions were not disclosed on the Application Form.**
- **the conditions arise between completing the Application Form and the later of the following:**
  - **the date we issue your Insurance Certificate; or**
  - **the start date of your policy.**

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

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

SEARCH AND/OR RESCUE OPERATIONS
Costs for 'search and/or rescue' operations:

- to locate a member, and/or
- to access, extract or transport a member from water, underground, a mountain or any other location on land that is not easily accessible by road or on foot.

Please note that where local ambulance, medical evacuation and/or medical repatriation benefits are included in your plan, we will only cover eligible costs for activities that begin after the 'search and/or rescue' operations conclude and you have already been transported to a safe location on land.

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

SPEECH THERAPY
Speech therapy related to developmental delay (unless the person meets the criteria for developmental delay and the 'Developmental delay' benefit is included on your policy), dyslexia, dyspraxia or expressive language disorder.

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

STERILISATION, SEXUAL DYSFUNCTION AND CONTRACEPTION
Investigations into, treatment of and complications arising from:

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

- Contraception (including the insertion and removal of contraceptive devices and all other contraceptives), unless prescribed for medical reasons that are unrelated to birth control.

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

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

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

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

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

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

TREATMENT OUTSIDE THE GEOGRAPHICAL AREA OF COVER
Treatment or services received, provided or obtained from 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 is provided under the 'Oncology' benefit.

VESSEL AT SEA

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

WEIGHT-RELATED TREATMENT AND SERVICES

Treatment and services for weight control, including:

- Medication prescribed or medically recommended solely or primarily for the purpose of weight-management.
- Medication prescribed or medically recommended in relation to any medical condition or symptom, regardless of whether the condition is classified as weight-related; or could be prevented, improved or relieved by weight-management (except as indicated for use in the treatment of established Type 2 Diabetes).
- Bariatric surgery (unless you have a specific benefit).
- Supplements.
- Health club memberships.
- Diet programs.
- Residential eating disorder programs

BENEFITS THAT ARE NOT IN YOUR TABLE OF BENEFITS

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

- Bariatric surgery
- Complications of pregnancy and childbirth.
- Dental treatment, dental surgery, periodontics, orthodontics and dental prostheses.
- Developmental delay.
- Dietician fees.
- Emergency dental treatment.
- Travel costs for one person accompanying an evacuated/repatriated person.
- Health and wellbeing checks including screening for the early detection of illness or disease.

- Home delivery.
- Homeopathy, Chinese herbal medicine, acupuncture and ayurvedic treatment.
- Fertility 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
- 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 close relative who is at peril of death or who has died.
- Vaccinations.

ACCIDENTAL DEATH BENEFIT

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

- 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.
- Intentionally caused diseases or self-inflicted injuries, including suicide, within one year of the enrolment date of the policy.
- Active participation in underground or underwater activity such as underground mining or deep sea diving.
- Above water activity (such as oil platforms, oil rigs) and aerial activity, unless otherwise specified.
- Chemical or biological contamination, radioactivity or any nuclear material contamination, including the combustion of nuclear fuel.

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

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

- Being under the influence of drugs or alcohol.
- Death that takes place more than 365 days after the occurrence of the accident.
- Deliberate exposure to danger, except in an attempt to save human life.
- Intentional inhalation of gas or intentional ingestion of poisons or legally prohibited drugs.
- Flying in an aircraft, including helicopters, unless the insured person is a passenger and the pilot is legally licensed, or is a military pilot and has filed a scheduled flight plan when required by local regulations.
- Active participation in extreme or professional sports or activities including but not limited to:
  - Mountain sports such as abseiling, mountaineering and racing of any kind (except for racing on foot).
  - Snow sports such as bobsleigh, luge, mountaineering, skeleton, skiing off-piste and snowboarding off-piste.
  - Equestrian sports such as hunting on horseback, horse jumping, polo, steeple chasing or horse-racing of any kind.
  - Water sports such as potholing (solo caving) or cave diving, scuba diving to a depth of more than 10 metres, high diving, white water rafting and canyoning.
  - Car and motorcycle sports such as motorcycle riding and quad biking.
  - Combative sports.

- Air sports such as flying with a microlight, ballooning, hang gliding, paragliding, parascending and parachute jumping.
- Various other sports such as bungee jumping.

Talk to us, we love to help!

If you have any queries, please do not hesitate to contact us:
24/7 Helpline for general enquiries and emergency assistance

English:	**+353 1 630 1301**
German:	**+353 1 630 1302**
French:	**+353 1 630 1303**
Spanish:	**+353 1 630 1304**
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CHAT WITH US

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

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

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

Email: client.services@e.allianz.com
Address: **Allianz, 15 Joyce Way, Park West Business Campus, Nangor Road, Dublin 12, Ireland**

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