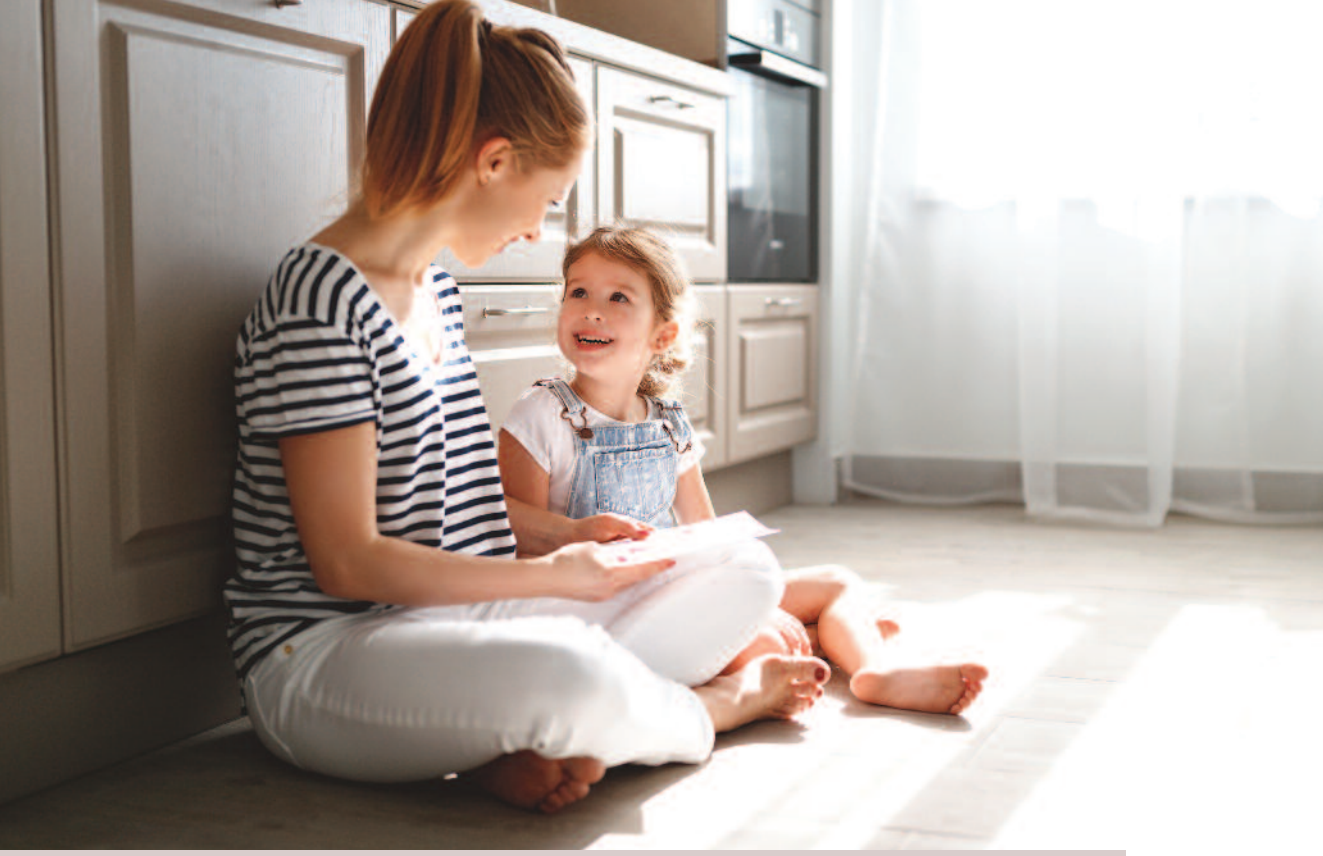


EuroSanté Healthcare Plans
Valid from 1st August 2019

INDIVIDUAL
Benefit Guide

Allianz Care

Welcome

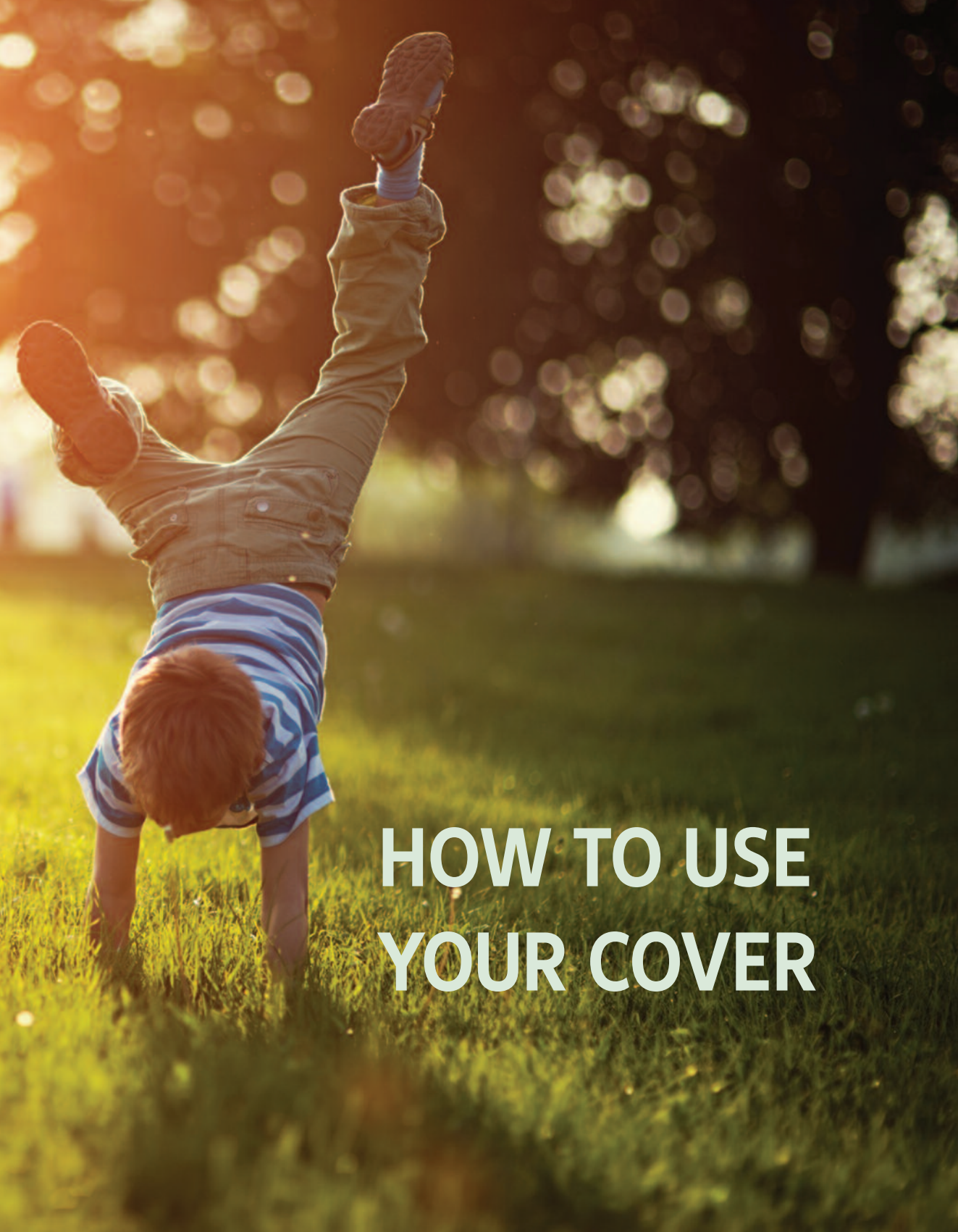
You and your family can depend on Allianz Care, as your international health insurer, to give you access to the best care possible.

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.

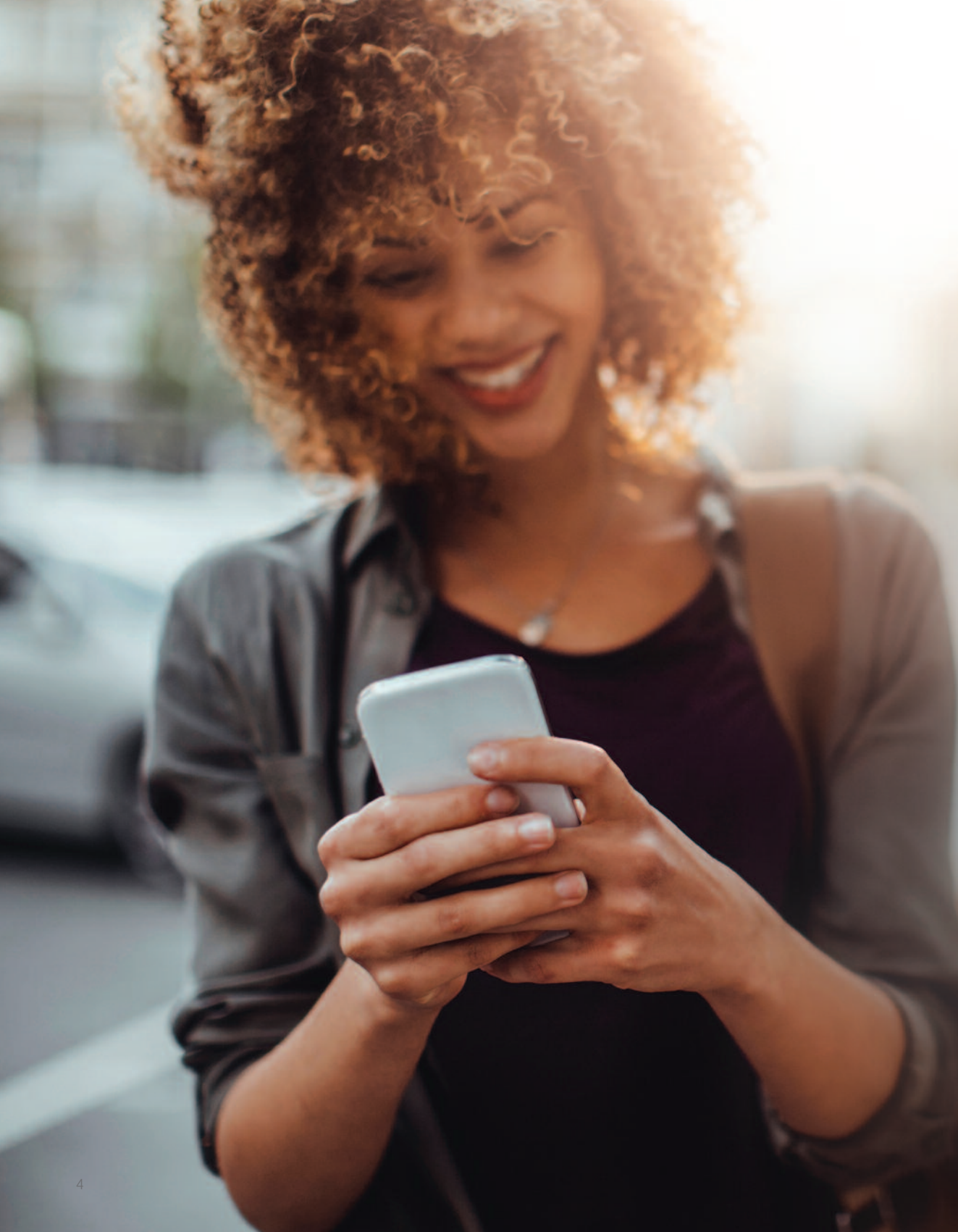
To make the most of your international healthcare plan, please read this guide in conjunction with your Insurance Certificate.

HOW TO USE YOUR COVER

TERMS AND CONDITIONS OF YOUR COVER



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.

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 case of an emergency.

Helpline

Phone: +32 2 210 6501
For our latest list of toll-free numbers, please visit:
www.allianzworldwidecare.com/toll-free-numbers

Email: IGOhelpline@allianzworldwidecare.com

Fax: +32 2 210 6506

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.*

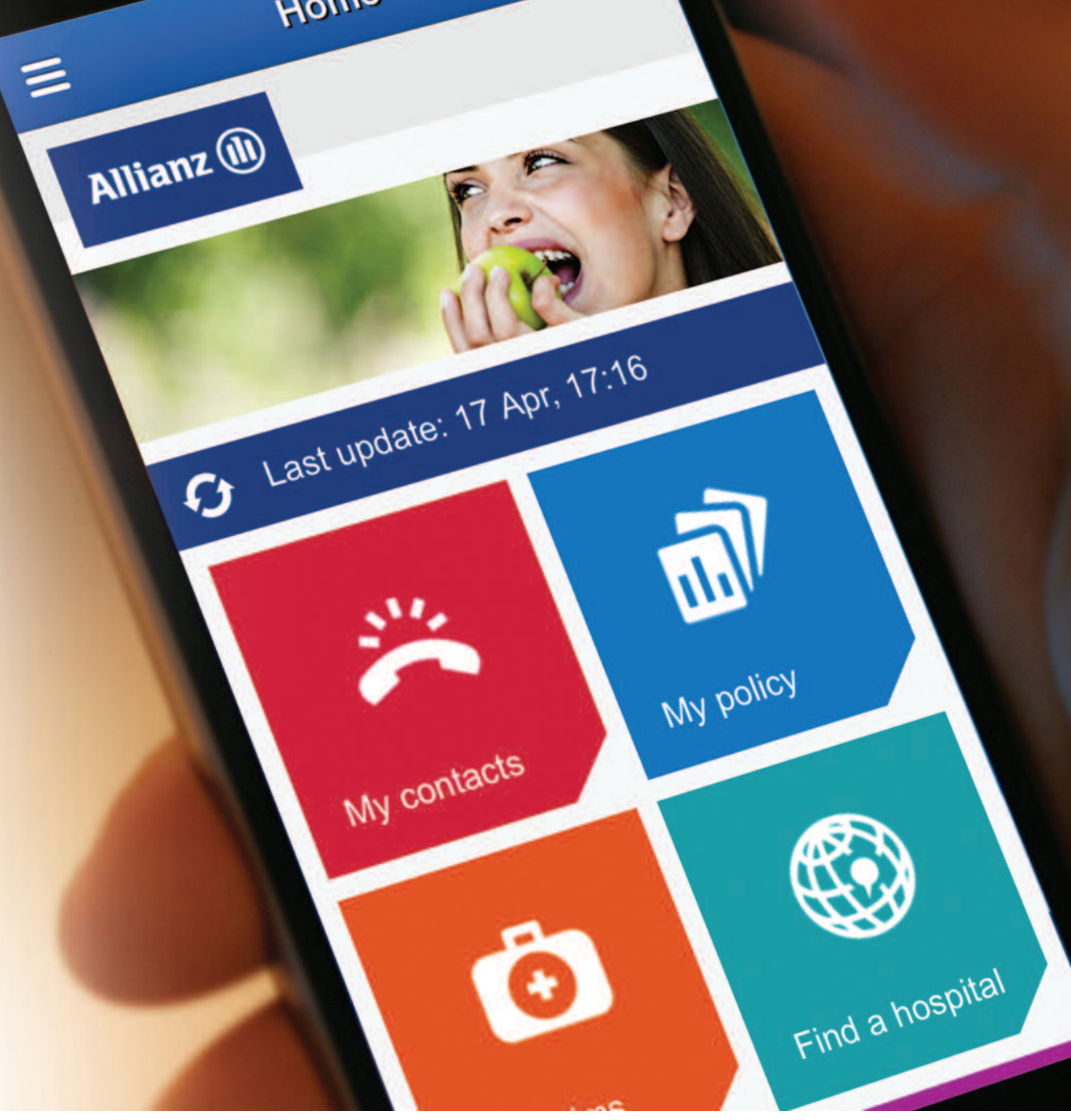
All personal data within the MyHealth App are encrypted for data protection. Most features are accessible even when offline.

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

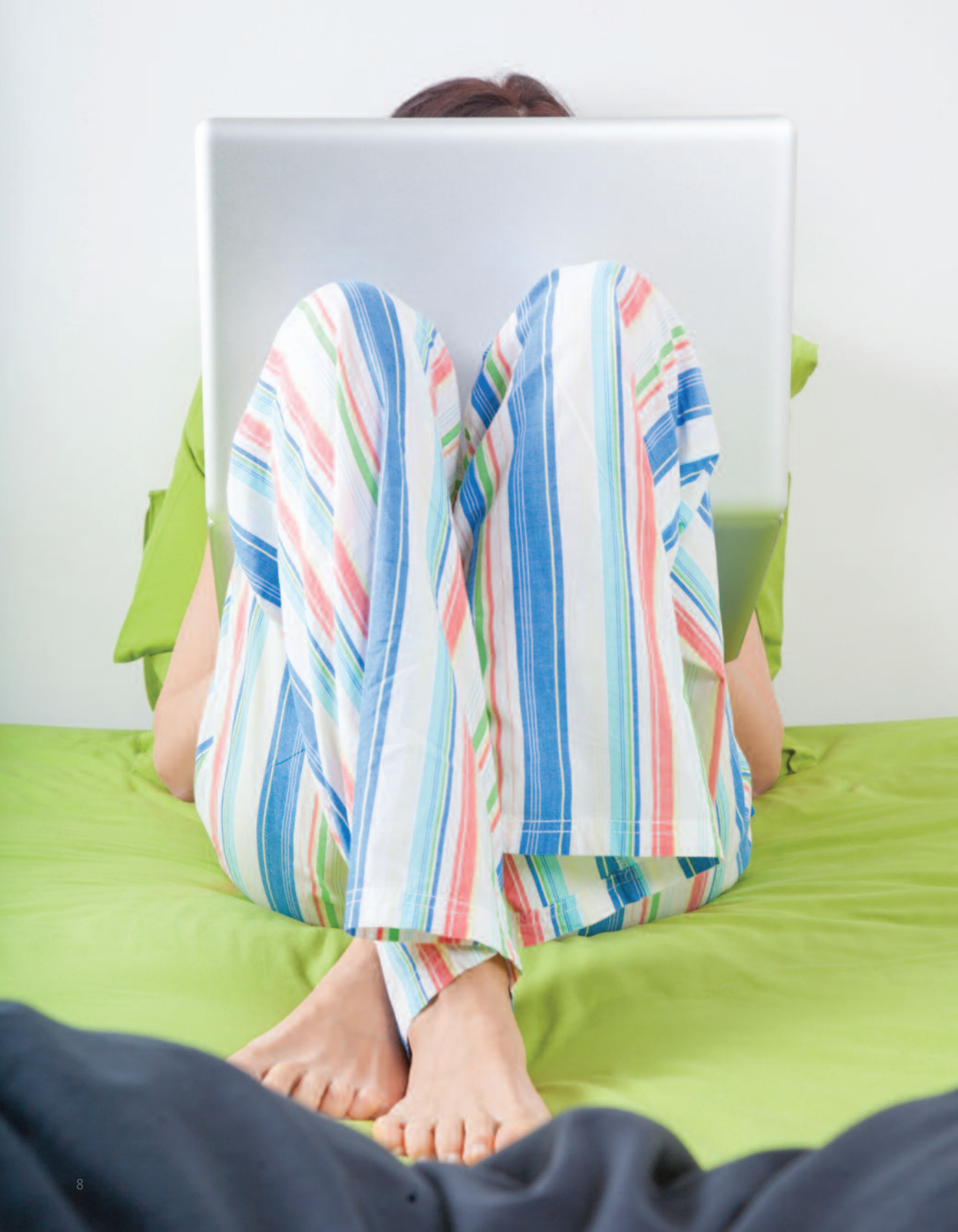


For more information, please visit:

www.allianzworldwidecare.com/myhealth

Download on the App Store

GET IT ON Google Play



MyHealth Online Services

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

- Download your policy documents, including your Membership Card.
- View your Table of Benefits and check how much remains payable under each benefit.
- Submit claims and confirm the status of any claims submitted to us.
- View claims related correspondence.
- Download and submit forms such as the Prior Authorisation Form.

To access our secure Online Services, please use the following link: **my.allianzcare.com/myhealth**

To create your account, please follow these steps:

1. Access the page **my.allianzcare.com/myhealth/register**, enter your Policy number, Date of Birth and the first 3 characters of your surname. Click on 'Begin Setup'.
2. Enter the email address you would like to use as your 'Username'.
3. You will receive an email with a 6-digit PIN. Insert this PIN in the Online Services PIN Entry page*. Once submitted, you will be prompted to enter a password (please choose something you can easily remember and keep this information safe, you'll need it again). Please note that you can also use these details to log in to our MyHealth app.
4. Click on "Let's go" and you will then be logged in. When you first log in you will be asked for your Contact Preferences. Once you indicate them, you won't be asked again.

   You are now free to browse away!

   * In order to guarantee the safety of your data, the PIN will expire after 30 minutes. If needed, please request a new PIN.

Access to our Online Services is only available after you create your personal account
If you have any difficulties logging in please contact the Allianz Care Helpline and we will guide you through the process.
Registering to the Online Services will give you 24/7 access to your cover from anywhere in the world. Please ensure that your personal data such as email addresses and bank details are kept up to date at all times to ensure you can avail of all our services (e.g. a smooth and swift online claims reimbursement).

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

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.

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, some are capped to a specific amount (e.g. €250). 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 your policy by simply completing our Application Form, available at:

https://www.allianzworldwidecare.com/en/international-individual-health-insurance/other-plans/eurosante/

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, to ensure that the child is accepted for cover without medical underwriting and for cover to start from birth. For further information in how to add a dependant, including important information in how to add multiple babies, adopted and foster children, please refer to the "Adding dependants" section of this guide.

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.

Claiming for your medical expenses

In order to claim under your EuroSanté plan, simply follow these steps:

Receive your medical treatment and pay the medical provider.

All claims should initially be submitted to JSIS (as detailed in your JSIS policy documentation).
Following receipt of a reimbursement and a Settlement Note, please submit the Settlement Note along with a copy of the invoices and receipts to us. The invoice 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.

You can submit your claim 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/eurosante

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.

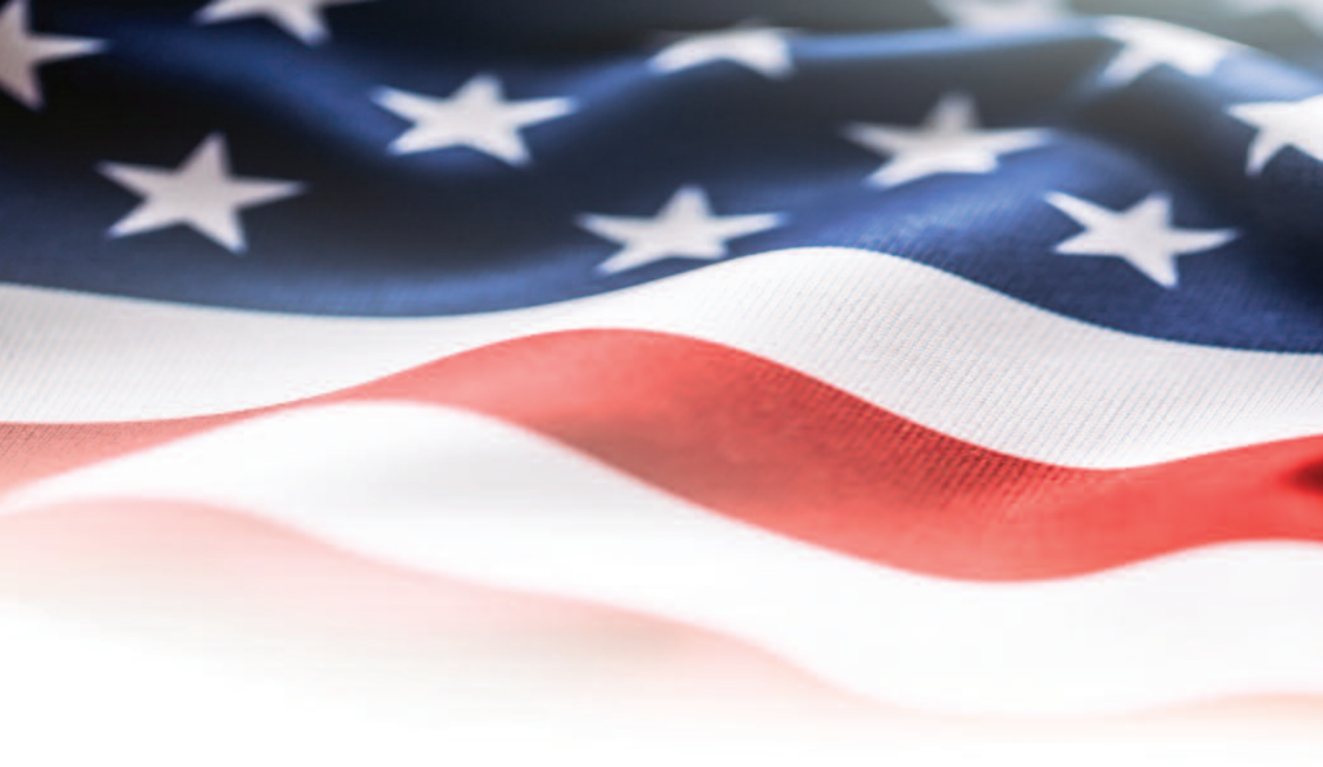
Please send the Claim Form and all supporting documentation, invoices and receipts to us by email, fax or post (details on the form).

Please refer to "Medical Claims" in the Terms and conditions of your cover 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.



And if I need treatment in the USA?

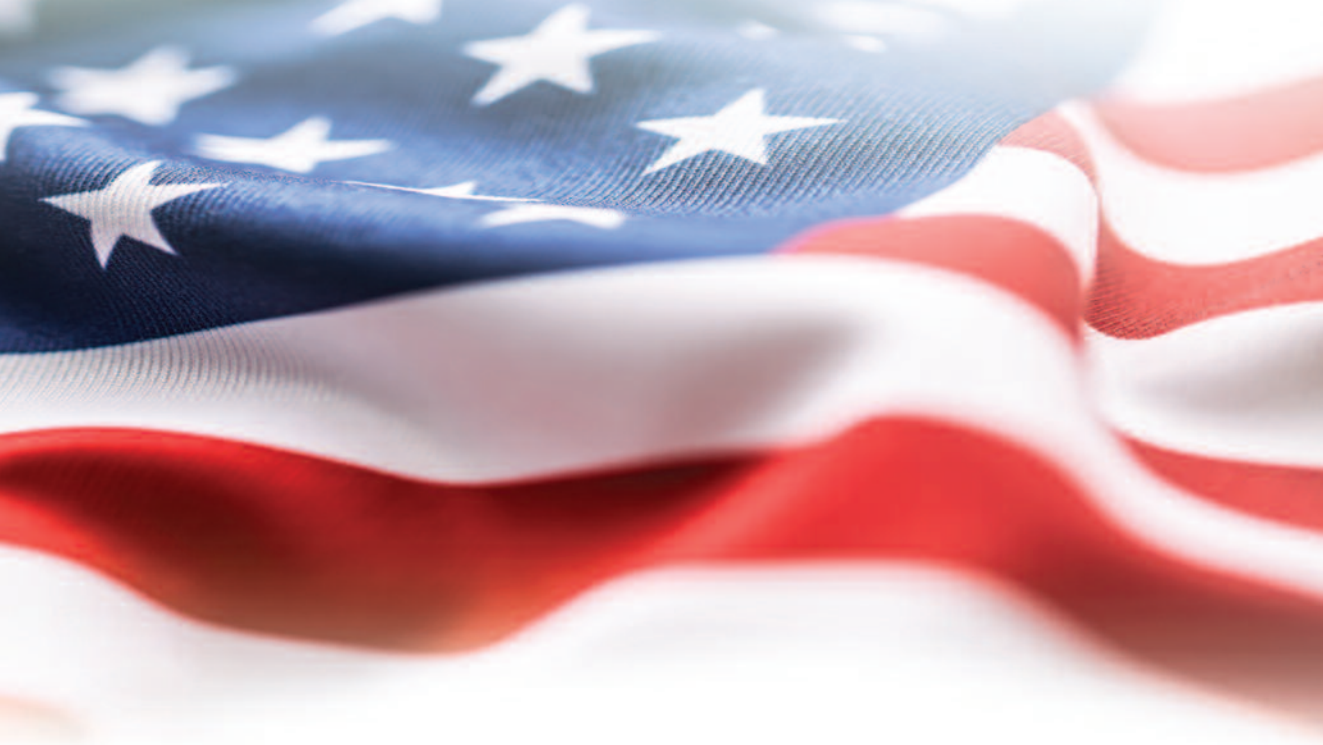
If you wish to locate a medical provider in the USA, simply go to:

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)

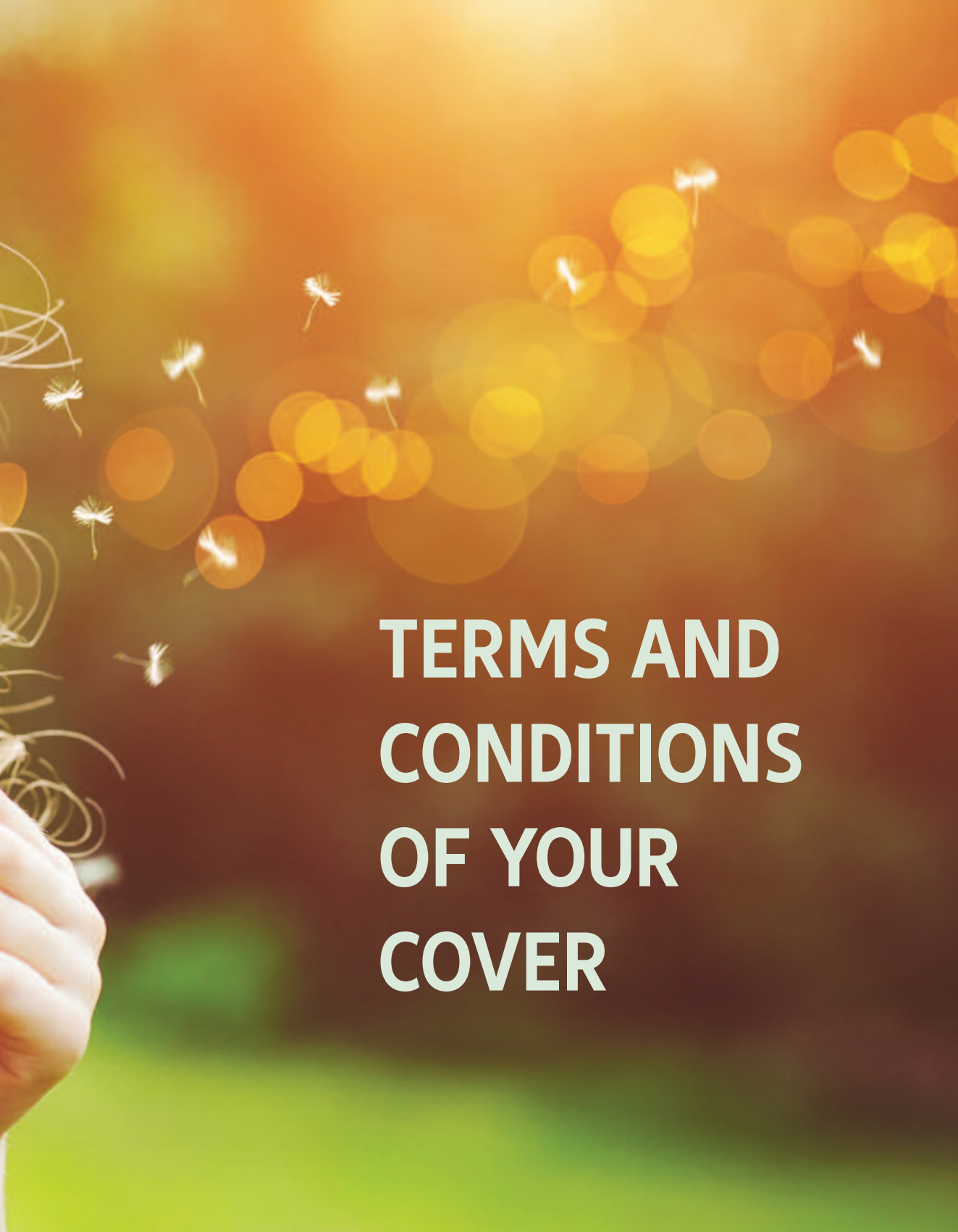
OLYMPUS



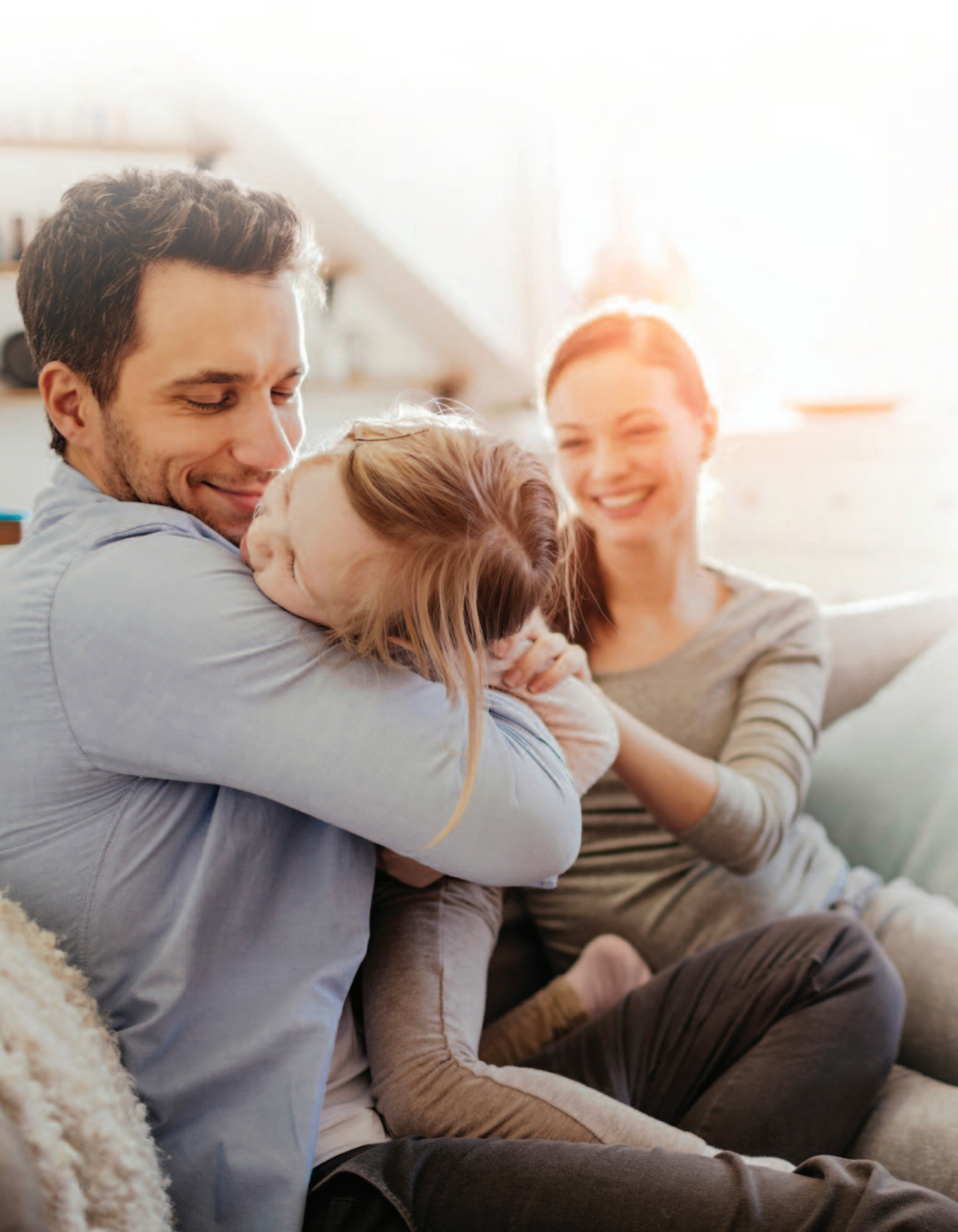
You can also apply for a discount pharmacy card which can be used any time your prescription is not covered by your healthcare policy. To register and get your discount pharmacy card, simply go to:

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

and click on “Print Discount Card”.



TERMS AND CONDITIONS OF YOUR COVER

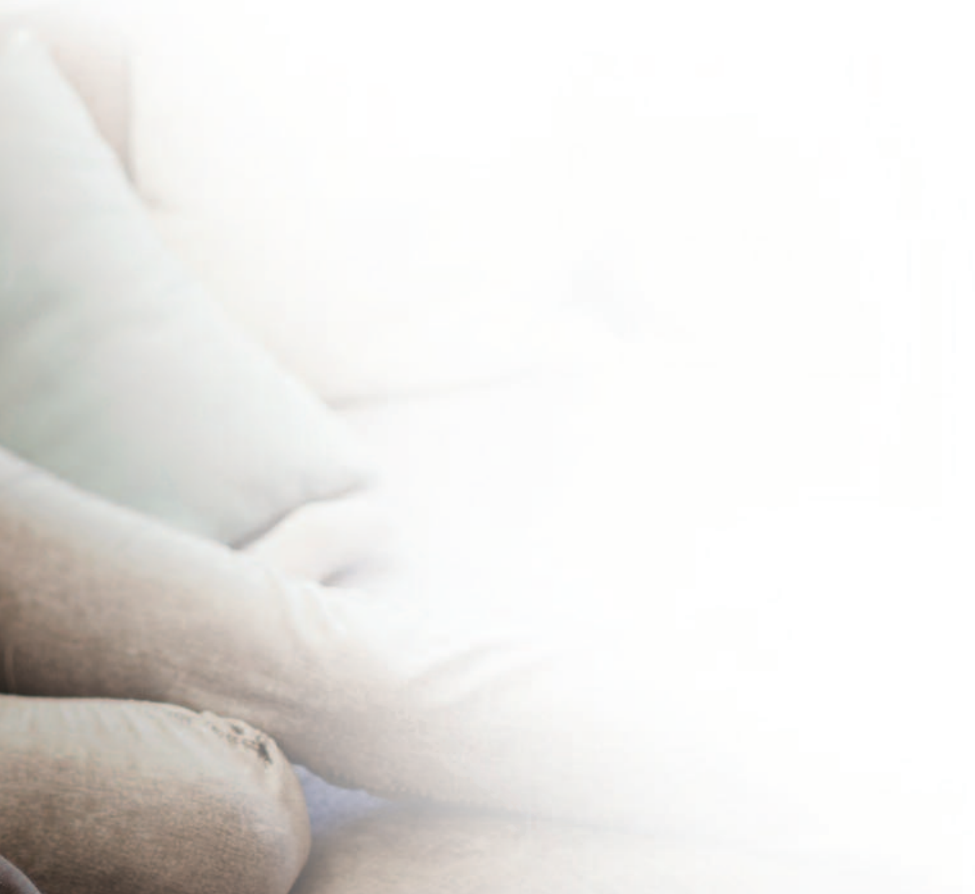


TERMS AND CONDITIONS

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

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

- The **Benefit Guide** (this document), which sets out the standard benefits and rules of your supplementary health insurance policy and should be read in conjunction with your 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.
- Information provided to us by, or on behalf of, the insured person(s) in the signed Application Form, Medical Questionnaire or others (hereafter referred to collectively as the "relevant application form") or other supporting medical information.



YOUR COVER EXPLAINED

As an official and other agent of the European Union you will have a primary health insurance cover provided by the Joint Sickness Insurance Scheme (JSIS). The EuroSanté plan provides supplementary cover according to the benefits outlined in the Table of Benefits. Allianz Care will only process claims for supplementary cover once a reimbursement has been made by the JSIS.

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 policy provides cover for medical treatment, related costs, services and/or supplies that we determine to be medically necessary and appropriate to treat a patient's condition, illness or injury. 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 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 (where relevant).

If any other person is included as a dependant under your membership, their membership will start on the effective date as shown on your most recent Insurance Certificate which lists them as a dependant. Their membership may continue for as long as you remain the policyholder and as long as any child dependants remain under the defined age limit. Child dependants can be covered under your policy up

until the day before their 26th birthday. At that time, they may apply for cover in their own right, on one of our Standard International Healthcare Plans, should they wish to do so.

Benefit limits

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

- The **maximum plan benefit**, which 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. In some instances we will pay a percentage of the costs for the specific benefit e.g. "80% refund, up to €250".

Where a specific benefit limit applies or where the term "covered" appears next to certain benefits, the refund is subject to the maximum plan benefit. All limits are per member, per Insurance Year, unless otherwise stated in your Table of Benefits.

For multiple birth babies born as a result of medically assisted reproduction, in-patient treatment is limited to €25,000 per child for the first three months following birth. Out-patient treatment is paid within the terms of the Out-patient Plan.

TABLE OF BENEFITS

The table below shows details of the cover provided under the EuroSanté Supplementary Healthcare plans. Benefit amounts shown are per insured person, per Insurance Year. The difference between the cost of the eligible treatment and the reimbursement made by the Joint Sickness Insurance Scheme is reimbursed in full for the benefits listed below, up to the maximum plan benefit.

Maximum plan benefit EUR within EEA (€)	€1,500,000	€1,250,000	€1,000,000
Maximum plan benefit EUR outside EEA (€)	€25,000	€25,000	€25,000
Core Plan Benefits	Optimum	Equilibre	Tranquilité
In-patient Benefits			
Hospital accommodation	Private room	Private room	Private room
Prescription drugs and materials (in-patient and day-care treatment only) (prescription drugs are those which legally can only be purchased when you have a doctor's prescription)	Covered	Covered	Covered
Surgical fees, including anaesthesia and theatre charges	Covered	Covered	Covered
Physician and therapist fees (in-patient and day-care treatment only)	Covered	Covered	Covered
Surgical appliances and materials	Covered	Covered	Covered
Diagnostic tests (in-patient and day-care treatment only)	Covered	Covered	Covered
Psychiatry and psychotherapy (in-patient and day-care treatment only)	Covered	Covered	Covered
Accommodation costs for one parent staying in hospital with an insured child under 14	Covered	Covered	Covered
Emergency in-patient dental treatment	Covered	Covered	Covered

Other benefits			
Day-care treatment	Covered	Covered	Covered
Out-patient surgery	Covered	Covered	Covered
Post-surgical rehabilitation treatment (within three months following the covered hospitalisation)	Covered	Covered	Covered
Local ambulance	Covered	Covered	Covered
CT and MRI scans (in-patient and day-care treatment only)	Covered	Covered	Covered
PET and CT-PET scans (in-patient and day-care treatment only)	Covered	Covered	Covered
Out-patient treatment related to hospitalization/surgical procedures (for treatment that takes place within two months prior to and up to six months following related hospitalisation and/or surgical procedures)	Covered	Covered	Covered
Routine maternity (in-patient and out-patient treatment)	Covered	Covered	Covered
Complications of pregnancy and childbirth	Covered	Covered	Covered

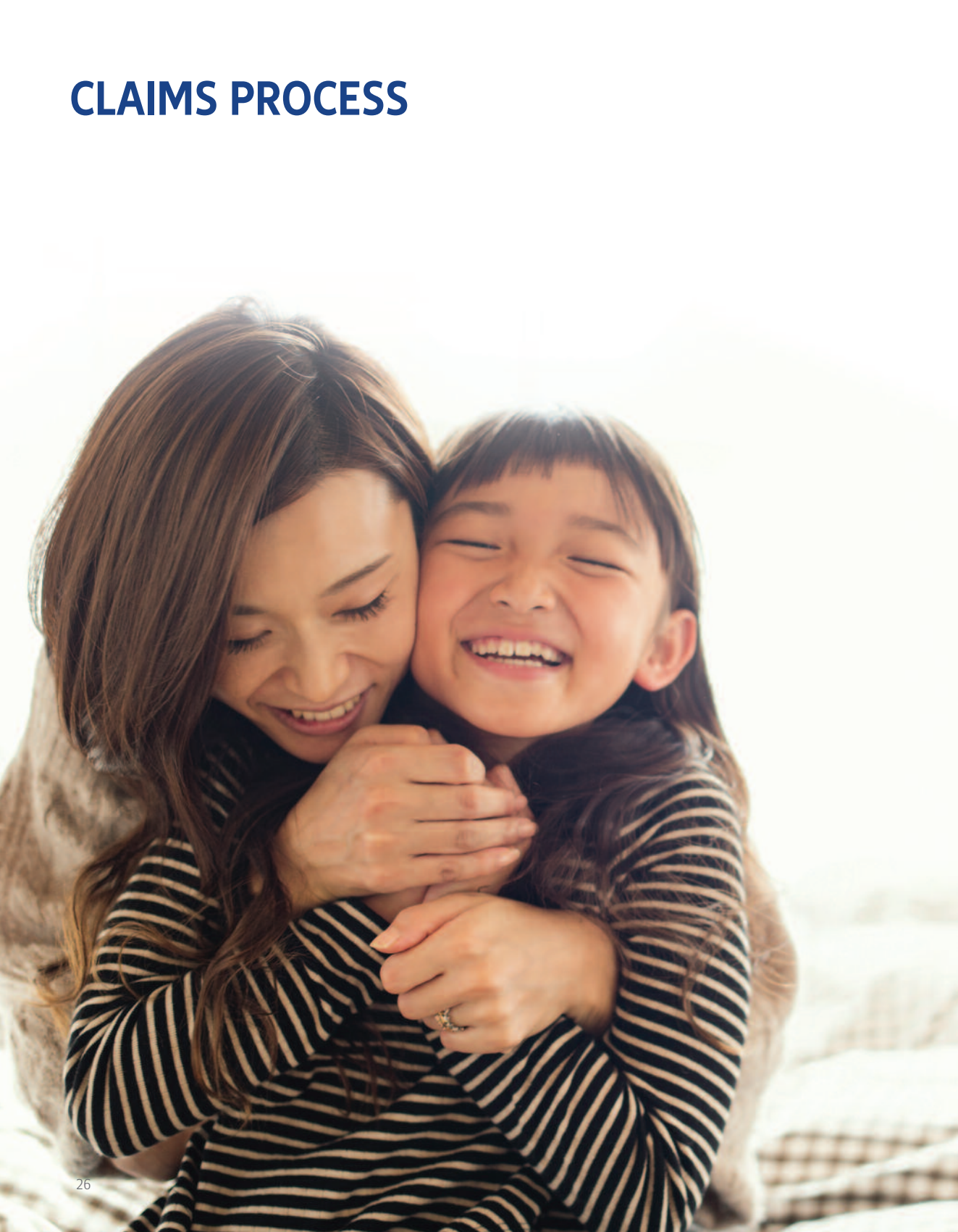
We cover the difference of the cost paid by your primary insurance cover (the Joint Sickness Insurance) and the actual treatment costs. This supplementary reimbursement cannot exceed 20% of the total costs (with the exception of the benefits indicated with an asterisk *). We will reimburse this difference at 80%, for the benefits listed in the table of benefits. Please refer to our exclusions section for costs that your supplementary insurance plan does not cover.

Out-patient Plan Benefits	Optimum	Equilibre	Tranquilité
Medical practitioner fees	Covered	Covered	N/A
Specialist fees	Covered	Covered	N/A
Medication: Drugs and medicines when partially covered by JSIS	Covered	Covered	N/A
Chiropractic treatment, osteopathy, acupuncture and chiropody	Covered	Covered	N/A
Prescribed physiotherapy (including medical massage, remedial gymnastics, mobilisation, mechanotherapy, traction, mud baths, hydromassage, hydrotherapy, electrotherapy, diadynamic currents, microwave therapy, ionisation, short-wave therapy, special forms of electrotherapy, infrared rays and ultrasound)	Covered	Covered	N/A
Prescribed speech therapy, logopaedic assessment and occupational therapy	Covered	Covered	N/A
Prescribed medical aids*	Covered	Covered	N/A
Multidisciplinary functional rehabilitation in an out-patient clinic	Covered	Covered	N/A
Full psychological examination/assessments by a single practitioner	Covered	Covered	N/A
Multidisciplinary neuropsychological assessment	Covered	Covered	N/A
Prescribed glasses and contact lenses including eye examination*	Covered. Max. €250 for frames	Covered. Max. €250 for frames	N/A
Hearing examination and hearing aids*	Covered	Covered	N/A
Psychotherapy	Covered	N/A	N/A
Psychomotor therapy and graphomotor therapy	Covered	N/A	N/A
Dietician fees	Covered	N/A	N/A
Rehabilitation using MedX machine	Covered	N/A	N/A
Aerosol therapy	Covered	N/A	N/A
Mesotherapy	Covered	N/A	N/A
Ultraviolet radiation	Covered	N/A	N/A
Hyperbaric chamber	Covered	N/A	N/A
Lymphatic drainage	Covered	N/A	N/A
Hair removal (in the case of pathological hypertrichosis of the face)	Covered	N/A	N/A
Laser or dynamic phototherapy	Covered	N/A	N/A
Shock wave therapy (rheumatology)	Covered	N/A	N/A
Oculomotor therapy	Covered	N/A	N/A
Ocular prostheses*	Covered	N/A	N/A

The difference between the cost of the eligible treatment and the reimbursement made by the Joint Sickness Insurance Scheme is reimbursed at 80% for the benefits listed below.

Dental Plan Benefits	Optimum	Equilibre	Tranquilité
Maximum plan benefit	€800	N/A	N/A
Dental treatment	Covered	N/A	N/A
Dental surgery	Covered	N/A	N/A
Periodontics	Covered.	N/A	N/A
Orthodontic treatment and dental prostheses	Covered	N/A	N/A

CLAIMS PROCESS



Medical claims

In relation to medical claims, please note that:

a) All claims should be submitted (via our MyHealth app or Claim Form) no later than six months after the date indicated on the JSIS settlement note. 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 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 12 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) Please specify on the Claim Form the currency in which you wish to be paid. Unfortunately, on rare occasions, we may not be able to make a payment in the currency you requested on the Claim Form due to international banking regulations. In this instance we will review each case individually to identify a suitable alternative currency option. If we have to make a conversion from one currency to another, we will use the exchange rate that applies on the date on which the invoices were issued, or we will use the exchange rate that applies on the date that claims payment is made. Please note that we reserve the right to choose which currency exchange rate to apply.

e) Only costs incurred as a result of eligible treatment will be reimbursed within the limits of your policy.

f) 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.

g) 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.

Treatment needed as a result of somebody else's fault

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

PAYING PREMIUMS

Premiums for each Insurance Year are based on each member's age on the first day of the Insurance Year, 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. The EuroSanté Tranquillité plan is an annual payment plan and the EuroSanté Equilibre and Optimum plans can be paid on an annual, semi-annual or quarterly basis. 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 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

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.

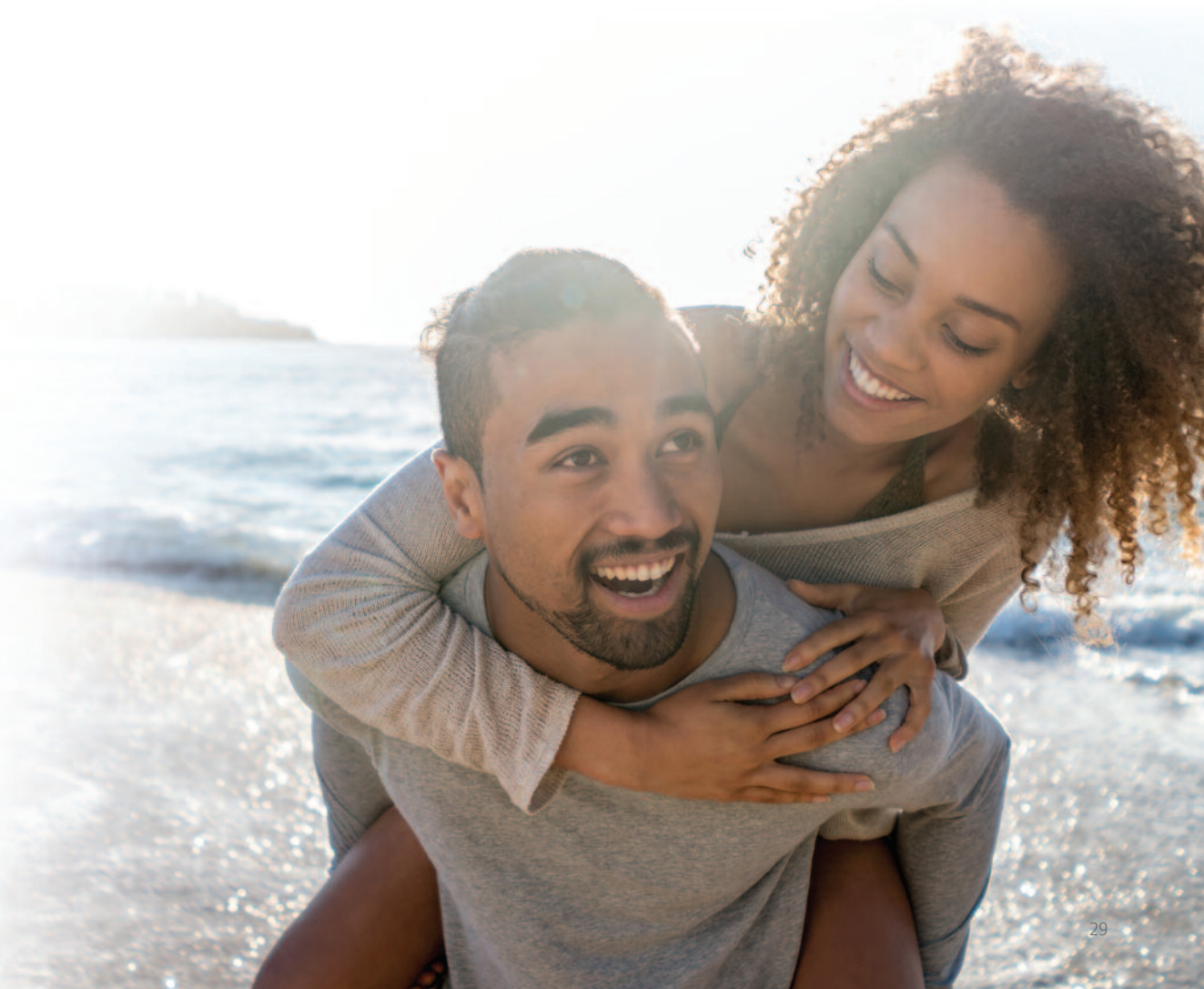
If the initial premium is not paid in time, we are entitled to withdraw from the contract for as long as the payment remains outstanding. The insurance contract is deemed to be null and void unless we assert a claim to the premium in court within three months of the commencement date, the policy start date or the conclusion of the insurance contract. If a subsequent premium is not paid in time, we may, in writing and at the policyholder's expense, set a time limit of not less than two weeks for the policyholder to pay the amount due. Thereafter, we may terminate the contract in writing with immediate effect and 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 Insurance Premium Tax (IPT), 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 IPT or 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 Insurance Premium Tax (IPT) or other taxes, levies or charges at any time, if there is a change in the rate of IPT 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 policy by completing the relevant application form.

Spouses will be accepted for cover without medical underwriting provided that they join at the same time as the Policyholder and the Policyholder qualifies for cover without the requirement for medical underwriting. Addition of a spouse at a later date than the Policyholder's start date will automatically require medical underwriting.

Newborn infants (with the exception of multiple birth babies, adopted and fostered babies) will be accepted for cover from birth without medical underwriting, provided that we are notified within four weeks of the date of birth and the birth parent or intended parent (in the case of surrogacy), has been insured with us for a minimum of six 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:

@ underwriting@allianzworldwidecare.com

Notification of the birth after four weeks will result in newborn children being underwritten and cover will only commence from the date of acceptance. Please note that all multiple birth babies, adopted and fostered children will be subject to full medical underwriting and cover will only commence from the date of acceptance.

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

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 is automatically renewed for the next Insurance Year provided that the plan/plan combination selected is still available, all premiums due to us have been paid and the payment details we have for you are still valid on the renewal date. If you are paying your premium by credit card, please update us if you get a new/replacement credit card as we will need details of the new card number and/or expiry date etc.

One month before the renewal date, you will receive a new Insurance Certificate indicating the premium for the next Insurance Year. 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 30 days of the date on which the changes take effect, or within 30 days of us telling you about the changes, whichever is later.

Your right to cancel

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

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.

@ underwriting@allianzworldwidecare.com

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

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

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 30 days after the due date.
- If you do not pay the amount of any IPT, taxes, levies or charges that you have to pay under your agreement with us on or before the due date.
- 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 i.e. giving false information, withholding pertinent information from us, or working with another party to give us false information, either intentionally or carelessly, which may influence us when deciding whether they can join the scheme, the applicable premium to pay or whether we have to pay a claim. Please see the section on "Additional terms" for further details.
- If you choose to cancel your policy, after giving us written notice within 30 days of receiving the full terms and conditions or from the start/renewal date of your policy, whichever is later. Please see section on "Your right to cancel" for further details.
- If you are no longer eligible for cover under the Joint Sickness Insurance Scheme. Allianz Care must be notified of this in writing within seven days of the JSIS becoming invalid. In such situations, the end date of the Allianz Care policy will match the end date of the JSIS policy.

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 dependant's cover will also end.

Policy expiry

Please note that upon the expiry of your policy, your right to reimbursement ends. Any eligible expenses incurred during the period of cover shall be reimbursed up to six months after the expiry date indicated on the JSIS settlement note. 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 policy with us:

1. **Applicable law:** Your membership is governed by French law unless otherwise required under mandatory legal regulations. Any dispute that cannot otherwise be resolved will be dealt with by courts in France.
2. **Economic sanctions:** This policy does not provide any cover or benefit for any business or activity to the extent that either the cover, benefit, 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.
3. **Liability:** Our liability to the insured person is limited to the amounts indicated in the Table of Benefits and any subsequent policy endorsements. In no event will the amount of reimbursement, whether under this policy, public medical scheme or any other insurance, exceed the amount of the invoice.
4. **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 us.
5. **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 and to cancel the policy. We have full rights of subrogation and may institute proceedings in your name, but at our expense, to recover, for our benefit, the amount of any payment made or due under a public scheme or any other insurance policy or made by or due from any other third party. We will not make any contribution, wholly or in part, to any third-party insurer if any claim under this insurance is also covered wholly or in part under any other insurance, except in respect of any excess beyond the amount which would have been covered under such other insurance had this insurance not been effected. In the event that you or any of your dependants qualify for a Special Reimbursement under your JSIS cover, we reserve the right to recover the amounts from you relating to any claims which were paid by us but subsequently become payable under the Special Reimbursement clause by the JSIS.
6. **Force majeure:** We shall not be liable for any failure or delay in the performance of our obligations under the terms of this policy, caused by, or resulting from, force majeure which shall include, but is not limited to: events which are unpredictable, unforeseeable or unavoidable, such as extremely severe weather, floods, landslides, earthquakes, storms, lightning, fire, subsidence, epidemics, acts of terrorism, outbreaks of military hostilities (whether or not war is declared), riots, explosions, strikes or other labour unrest, civil disturbances, sabotage, expropriation by governmental authorities and any other act or event that is outside of our reasonable control.

7. 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 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 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.

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

9. Making contact with dependants: In order to administer your policy in accordance with the insurance contract, there may be circumstances when we will need to request further information. If we need to make contact in relation to a dependant on a policy (e.g. when we need to collect an email address for an adult dependant), the policyholder, acting for and on behalf of the dependant, may be contacted by us and asked to provide the relevant information, provided that this is non-sensitive information relating to a dependant. Similarly, any non-sensitive information in relation to a person covered by the insurance policy, for the purposes of administering claims, may be sent directly to the policyholder.

DATA PROTECTION

Our Data Protection Notice explains how we protect your privacy. This is an important notice which outlines how we will process your personal data and should be read by you before the submission of any personal data to us. To read our Data Protection Notice visit:

www.allianzworldwidecare.com/en/privacy

Alternatively, you can contact us on the phone to request a paper copy of our full Data Protection Notice.

+353 1 630 1301

If you have any queries about how we use your personal data, you can always contact us by email.

AP.EU1DataPrivacyOfficer@allianz.com

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 at:

+32 2 210 6501

@ IGOhelpline@allianzworldwidecare.com

✉ Customer Advocacy Team, Allianz Care, 1 place du Samedi, 1000 Brussels, Belgium.

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 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 "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 Paris (France). The Mediation Agreement referred to in the Model Procedure shall be governed by, and construed and take effect in accordance with the laws of France. The Courts of France shall have exclusive jurisdiction to settle any claim, dispute or matter of difference which may arise out of, or in connection with, the mediation.

3. Any dispute, controversy or claim which is:

   - Arising out of or relating to this Agreement (or the breach, termination or invalidity thereof) with a value in excess of €500,000, or

- Referred to mediation pursuant to Clause "2" but not voluntarily settled by mediation within three months of the ADR Notice date

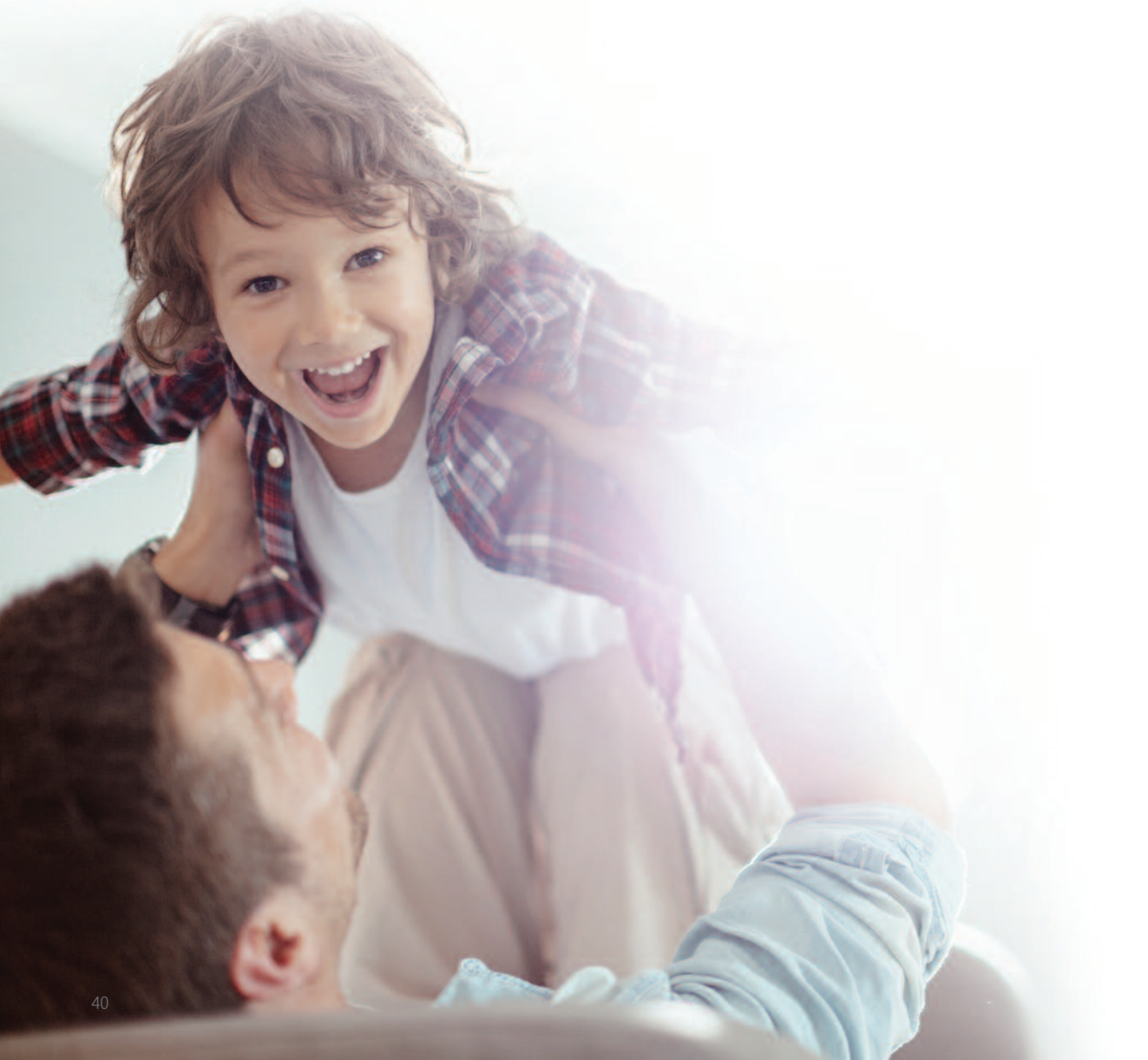
shall be determined exclusively by the Courts of France and the parties will submit to the exclusive jurisdiction of those courts. Any proceedings brought pursuant to this Clause "3" shall be issued within nine calendar months of the expiration date of the aforementioned three month period.

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 EuroSanté Healthcare Plans and to some other commonly used terms. The benefits you are covered for are listed in 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.

Aerosol therapy refers to the use of an aerosol for respiratory care in the treatment of bronchopulmonary diseases.

C

Complementary treatment refers to therapeutic and diagnostic treatment that exists outside the institutions where conventional Western medicine is taught. Such medicine includes chiropractic treatment, osteopathy, acupuncture, chiropody and mesotherapy as practiced by approved therapists.

Complications of childbirth refer to complications that arise during childbirth and treatment partially covered by JSIS, which is related to any complications during childbirth. Complications of childbirth shall also refer to medically necessary caesarean sections.

Complications of pregnancy relate to the health of the mother or foetus. Only treatment partially covered by JSIS and related to complications that arise during the pre-natal stages of pregnancy is covered.

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.

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, fostered or adopted child) financially dependant on the policyholder up to the day before their 26th birthday, 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.

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.

G

Graphomotor therapy refers to treatment that addresses the individual's development of the muscular movements used or required in writing.

H

Hair removal refers to treatment to remove excessive abnormal hair growth. Cover will be provided for hair removal from the face in the case of pathological hypertrichosis only.

Home country is a country for which the insured person holds a current passport and 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; e.g. Psychiatry and psychotherapy.

Hyperbaric chamber refers to the use of a highly pressurised sealable compartment in order to treat diagnosed medical conditions such as, but not limited to, decompression sickness and carbon monoxide poisoning.

I

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.

J

JSIS refers to the Joint Sickness Insurance Scheme applicable to officials and other agents of the European Union.

L

Laser or dynamic phototherapy refers to light therapy which is the administration of doses of bright light in order to treat certain medical conditions, such as but not limited to, skin disorders, sleep disorders and psychiatric disorders.

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

Lymphatic drainage refers to a type of gentle massage which is aimed at encouraging the natural drainage of the lymph from the tissues in the body.

M

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. Where covered, a separate benefit for Medical practitioner fees will appear in the Table of Benefits.

Medication refers to products prescribed on an out-patient basis by a physician for the treatment of a confirmed diagnosis or medical condition, or to compensate vital bodily substances including, but not limited to, insulin, hypodermic needles or syringes. The prescribed drugs must be clinically proven to be effective for the condition and recognised by the pharmaceutical regulator in a given country. Prescribed drugs do not legally have to be prescribed by a physician in order to be purchased in the country where the insured person is located; however, a prescription must be obtained and the costs need to be partially covered by JSIS to be considered eligible, Where covered, a separate benefit for medication will appear in the Table of Benefits.

Mesotherapy involves multiple injections of pharmaceutical, homeopathic and other substances that penetrate the skin's surface and are aimed at the treatment of a broad spectrum of injuries, illnesses and medical conditions. Cover is not provided for cosmetic treatments.

Multidisciplinary functional rehabilitation in an out-patient clinic refers to treatment by a registered physiotherapist following referral by a medical practitioner. 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.

Multidisciplinary neuropsychological assessment seeks to define cognitive disability in a person with acquired brain damage.

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

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.

Ocular prostheses refer to artificial eyes (or their component materials) that are used to restore appearance after a disfiguring accident or illness. Cover is provided where the accident or illness occurs during your membership with Allianz Care.

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.

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 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.

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.

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.

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.

Out-patient treatment relating to hospitalisation/surgical procedures refers to treatment carried out on an out-patient basis which has a direct correlation to hospitalisation/surgical treatment that is either due to take place in the following two months, or relates to hospitalisation or surgical treatment that has taken place in the previous six months. In order to claim under this benefit, please attach a copy of the admission form, hospital invoice, medical report or another appropriate document which verifies the relating hospitalisation/surgical procedure that is either due to take place or has already taken place. Out-patient treatment undertaken outside of these parameters is not covered by this benefit, however may be covered elsewhere by other out-patient benefits in the Table of Benefits.

P

Periodontics refers to dental treatment related to gum disease.

Post-surgical rehabilitation treatment refers to rehabilitation treatment required following a surgical procedure. This benefit is only payable for treatment that starts within three months of discharge after the acute surgical treatment ceases and where it takes place in a licensed rehabilitation facility. In order to claim under this benefit, please attach a copy of the hospital invoice, medical report or another appropriate document which verifies the relating surgical procedure that has taken place.

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. 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.

Prescribed glasses and contact lenses including eye examination refers to cover for an 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.

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 progress report must be submitted to us, which indicates the medical necessity for any further treatment. Physiotherapy includes the following treatments: medical massage, remedial gymnastics, mobilisation, mechanotherapy, traction, mud baths, hydromassage, hydrotherapy, electrotherapy, diadynamic currents, microwave therapy, ionisation, short-wave therapy, special forms of electrotherapy, infrared rays and ultrasound.

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.

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.

Psychomotor therapy refers to treatment that uses body awareness and physical activities in order to treat physical, cognitive, perceptual, affective and behavioural disorders.

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 or injury. The rehabilitation benefit is only payable for treatment that starts within 90 days of discharge after the acute medical and/or surgical treatment ceases and where it takes place in a licensed rehabilitation facility.

Rehabilitation using MedX machine refers specifically to the use of a MedX machine and is aimed at the restoration of a normal form and/or function after an acute illness or injury.

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 newborn care. Costs related to complications of pregnancy and 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. Cover will be provided to all costs partially covered by JSIS.

S

Shock wave therapy (rheumatology) refers to non-invasive treatment involving the delivery of radial shockwaves through the surface of the skin to treat injured tissue. Such therapy is used in the treatment of chronic disorders of the muscles, connective tissues and soft tissues around joints and bones. Cover is only provided where this therapy is recommended as an effective treatment in the country in which treatment is received.

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. Where covered, a separate benefit for specialist fees will appear in the Table of Benefits.

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, 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.

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

U

Ultraviolet radiation refers to the use of artificial sunlight in the treatment of specific diagnosed medical conditions.

W

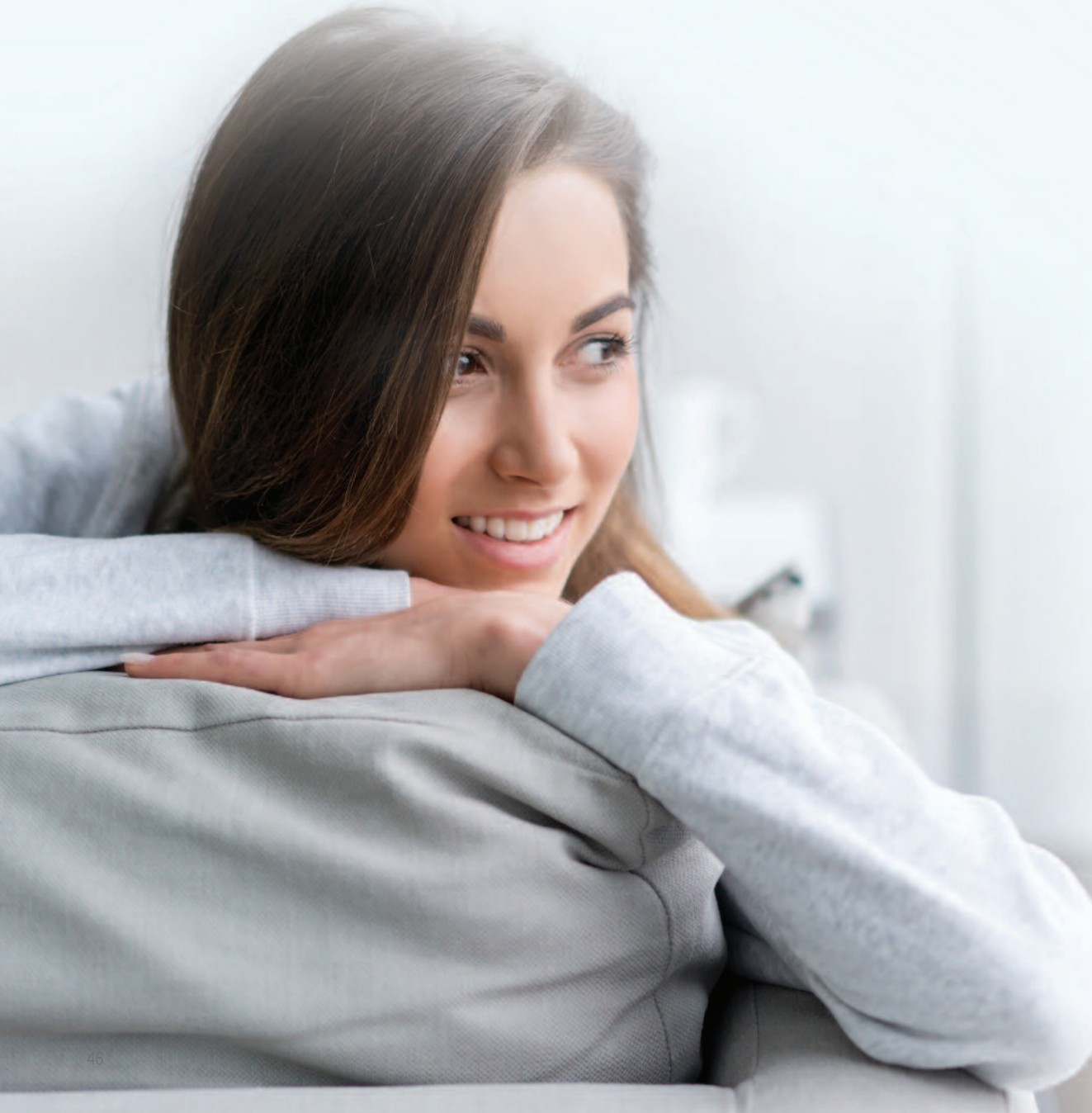
We/Our/Us Is Allianz Care.

Y

You/Your refers to the eligible individual stated on 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 policy unless confirmed otherwise in the Table of Benefits or in any written policy endorsement.



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 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.

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).

Expenses declined by the JSIS
Any expenses which have been declined for reimbursement by the JSIS.

Expenses for already ongoing hospitalisation
Expenses for hospitalisation that is already ongoing on the policyholder's start date (and effective dates of when dependants were added).

Expenses relating to maternity and childbirth
Expenses relating to maternity and childbirth including pre- and post-natal classes and neonatal accommodation.

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.

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.

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

Infertility treatment
Infertility treatment including medically assisted reproduction or any adverse consequences thereof.

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.

Medical evacuation or repatriation
Medical evacuation or repatriation and any associated costs including medical evacuation or repatriation from a vessel at sea to a medical facility on land.

Nursing costs
Nursing costs for care provided in the home, with the exception of medically prescribed treatments such as but not limited to the administering of injections or changing of dressings where covered within the limits of the policy.

Obesity treatment
Investigations into, and treatment of, obesity.

Organ transplant
Expenses for organ transplantation as well as the acquisition of an organ including, but not limited to, donor search, typing, harvesting, transport and administration costs.

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-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.

Prescription drugs, Medical practitioner fees and Specialist
Prescription drugs, Medical practitioner fees and Specialist fees except where directly related to a hospitalisation event or a surgical procedure. Only expenses incurred for treatment taking place within two months prior to and up to six months following the relevant hospitalisation or surgical procedure will be covered.

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

Serious illness
Expenses for the treatment of a medical condition that is classified as a 'serious illness' by the JSIS and as such are fully covered.

Sex change
Sex change operations and related treatments.

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 local ambulance 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:

- 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.
- Out-patient treatment.
- Out-patient psychiatry and psychotherapy treatment.
- Prescribed glasses and contact lenses including eye examination.
- Prescribed medical aids.
- Preventive treatment.
- Rehabilitation treatment.

Sleep disorders

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

Treatment related to an accident or an occupational illness

Any treatment related to an accident or an occupational illness suffered by an official or other agent of the European Union, which result in a full reimbursement under the JSIS.

Vitamins or minerals

Products classified as vitamins or minerals 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

Telephone: +32 2 210 6501

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 the number listed above.

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

Email: IGOhelpline@allianzworldwidecare.com

Fax: + 32 2 210 6506

Address: Allianz Care, 1 place du Samedi, 1000 Brussels, Belgium.

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