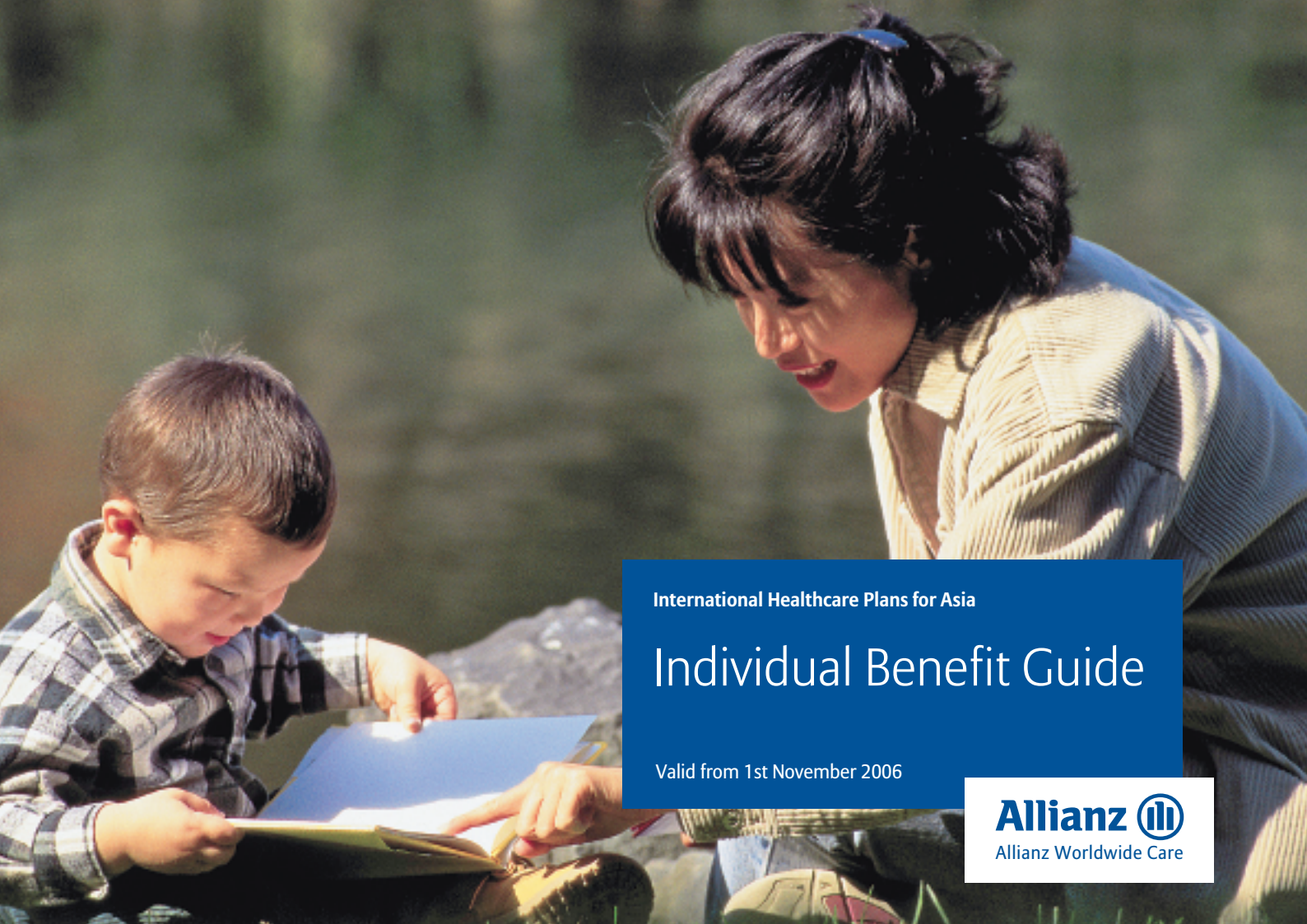

International Healthcare Plans for Asia

Individual Benefit Guide

Valid from 1st November 2006

Allianz

Allianz Worldwide Care

Welcome to Allianz Worldwide Care.

This guide sets out the benefits and rules of your Allianz Worldwide Care plan.

Thank you for selecting Allianz Worldwide Care as your preferred healthcare provider. It is strongly advised that you read all documentation in relation to your chosen plan, to ensure you are fully satisfied in the selection of cover that you have made. Under the terms of your policy, you have 30 days from the date you receive your policy documents to change your mind about selecting your Allianz Worldwide Care policy and cancel the contract.

You and your family can depend on Allianz Worldwide Care, as your health insurer, to give you access to the very best care possible - wherever you are in the world.

Because we specialise solely in international health insurance and are backed by the resources and expertise of Allianz AG, one of the world's leading insurance companies, you can depend on a service that's fast, flexible and totally reliable.

This brochure describes in detail exactly how we offer you access to the care you need, when you need it most.

Allianz Worldwide Care Limited, part of the Allianz Group, is registered in Ireland and regulated by the Irish Financial Services Regulatory Authority. Registered Office: 18B Beckett Way, Park West Business Campus, Nangor Road, Dublin 12, Ireland. Registered No.: 310852

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Introduction.

Details of your insurance policy with us.

If you need any further assistance, please do not hesitate to contact us. Please see page 11 for full list of contact details.

Your policy is an annual contract between Allianz Worldwide Care and the insured named in the Insurance Certificate. The contract is composed of:

- The Individual Benefit Guide, the Insurance Certificate and any Policy Endorsements
- Information provided to Allianz Worldwide Care in the signed Application Form, or submitted Online Application Form, including the Health Declaration section or other supporting medical information by or on behalf of the insured persons

To understand your insurance policy, please read this document very carefully in conjunction with the Insurance Certificate when received on the issuing of the policy. This guide details the benefits and limitations of your plan (i.e. the cover you have with us), explains how you can make a claim and details all the terms and conditions of your policy with us.

Table of Benefits.

The following tables show details of the cover provided under each of our standard healthcare plans.

The plan(s) you have chosen will be indicated in your Insurance Certificate. Please confirm your cover by referring to your Insurance Certificate and reading the details of your chosen plan(s). To fully understand the cover provided, please refer to the "Definitions" and the "What your Healthcare Cover does not Pay for" sections.

Please note that **treatment guarantee is required for all in-patient benefits and may be required for other benefits**. If you do not obtain treatment guarantee for any treatment for which it is required, we may decline payment of the claim. For more details on treatment guarantee please refer to pages 51 to 53.

Benefits amounts shown are per insured person per Insurance Year. This means that once a benefit limit has been reached, this benefit will no longer be available until your policy has been renewed and a new Insurance Year starts.

Core Plan Benefits	Elite	Select	Essential	Vital
Overall Maximum Benefit US$	$1,562,500	$937,500	$625,000	$100,000
In-patient benefits[1]				
Hospital accommodation[1]	Private room	Private room	Semi-private room	Semi-private room
Prescription drugs and materials[1]	Full refund	Full refund	Full refund	Full refund
Surgical fees, including anaesthesia and theatre charges[1]	Full refund	Full refund	Full refund	Full refund
Physician, surgeon and anaesthetist fees[1]	Full refund	Full refund	Full refund	Full refund
Surgical appliances and prostheses[1]	Full refund	Full refund	Full refund	Full refund
Diagnostic tests[1]	Full refund	Full refund	Full refund	Full refund
Physiotherapy[1]	Full refund	Full refund	Full refund	Full refund
Organ transplantation[1]	Full refund	$62,500	$12,500	$10,000
Psychiatry and psychotherapy[1] (10 month waiting period applies)	$25,000	$12,500	$6,250	N/A
Accommodation costs for one parent staying in hospital with an insured child under 18[1]	Full refund	Full refund	Full refund	N/A
Emergency in-patient dental treatment	Full refund	Full refund	Full refund	$5,000
Other benefits[2] - please refer to note 2 for treatment guarantee				
Day-care treatment	Full refund	Full refund	Full refund	Full refund
Out-patient surgery	Full refund	Full refund	Full refund	Full refund

Continued overleaf

Core Plan Benefits (continued)	Elite	Select	Essential	Vital
Nursing at home or in a convalescent home[2] (immediately after or instead of hospitalisation)	$3,125	$3,125	$3,125	N/A
Local ambulance	Full refund	$625	$625	$400
Emergency treatment outside area of cover (for trips of a maximum period of 6 weeks)	Max. 42 nights Full refund	Max. 42 nights Up to $12,500	Max. 42 nights Up to $12,500	Max. 42 nights Up to $12,500
Medical evacuation[2]	Full refund	Full refund	Full refund	Full refund
Expenses for one person accompanying an evacuated/repatriated person[2]	$3,750	$3,750	$3,750	$2,000
Repatriation of mortal remains[2]	$12,500	$12,500	$12,500	$10,000
CT, MRI[2] and PET[2] scans (in-patient and out-patient treatment)	Full refund	Full refund	Full refund	Full refund (PET scans not covered)
Oncology[2]	Full refund	Full refund	Full refund	Full refund
Routine maternity[2] (in-patient and out-patient treatment) (10 month waiting period applies)	$10,000	$5,000	N/A	N/A
Complications of pregnancy and childbirth[2] (10 month waiting period applies)	$31,250	$10,000	N/A	$5,000
In-patient cash benefit (per night) (where treatment has been received free of charge)	$190 Max. 25 nights	$190 Max. 25 nights	$190 Max. 25 nights	$75 Max. 25 nights

Optional Out-patient Plan Deductibles	Discount
No deductible:	0% premium discount
$125 deductible:	10% premium discount
$250 deductible:	20% premium discount
$625 deductible:	45% premium discount
$1,250 deductible:	70% premium discount
The above optional Out-patient Plan Deductibles are payable per person per Insurance Year.	

Out-patient Plan Benefits	OP1	OP2	OP3
Overall Maximum Benefit	$6,250	$3,125	$2,500
Reimbursement	100%	100%	80%
Benefits			
Medical practitioner fees	$1,250	$625	80% refund max $1,000
Prescription drugs	$1,250	$625	
Specialist fees	Full refund	Full refund	
Diagnostic tests	Full refund	Full refund	80% refund, max $800
Vaccinations	Full refund	N/A	N/A
Chiropractic treatment, osteopathy, homeopathy, Chinese herbal medicine and acupuncture	$1,250	$625	80% refund, max $500
			Continued overleaf

Out-patient Plan Benefits (continued)	OP1	OP2	OP3
Prescribed physiotherapy	$1,250	$625	80% refund, max $500
Speech therapy, oculomotor therapy and occupational therapy[2]			N/A
Emergency out-patient dental treatment	Full refund	Full refund	N/A
Routine dental treatment (10 month waiting period applies)	$625	N/A	N/A
Prescribed medical aids	$1,250	N/A	N/A
Prescribed glasses and contact lenses	$250	N/A	N/A

Repatriation Plan	
Medical repatriation[2]	Full refund

[1] If treatment guarantee is not obtained for the benefits listed with [1], we reserve the right to decline a claim. If in the aftermath the respective treatment is proven medically necessary, we will pay only 80% of the eligible benefits.

[2] If treatment guarantee is not obtained for the benefits listed with [2], we reserve the right to decline a claim. If in the aftermath the respective treatment is proven medically necessary, we will pay only 50% of the eligible benefits.

Member Services.

Please find details of all our Member Services below.

Please note that calls to our Helpline will be recorded and may be monitored for training and quality purposes.

Helpline Service 24/5.

Allianz Worldwide Care's in-house team of professional, multilingual staff are available 24 hours, 5 days a week (Sunday 6.00pm GMT to Friday 7.00pm GMT), to handle your policy enquiries. Wherever you are in the world, and whatever time of the day, we are available over the phone or by email to deal with your enquiry. Our Helpline staff have instant access to your policy details and any historical communication with us so that we can provide you with the assistance you require e.g. confirmation of cover, update on the status of your claim or treatment guarantee request. You can contact us by phone, fax or email as follows:

Helpline

English:	+ 353 1 630 1301
German:	+ 353 1 630 1302
French:	+ 353 1 630 1303
Spanish:	+ 353 1 630 1304
Italian:	+ 353 1 630 1305
Fax:	+ 353 1 630 1306

Toll-free from Singapore:
800 353 1018

Toll-free from Hong Kong:
800 901 705

Toll-free from mainland China:
10 800 441 0115

Toll-free from the USA:
1 866 266 2182

Toll-free from France, Belgium & Switzerland:
00 800 6630 2202

Email:
client.services@allianzworldwidecare.com

Emergency Assistance Service 24/7.

In the event that you require emergency medical treatment in a hospital or clinic you should, where possible, contact our Helpline as soon as possible (as detailed on page 11). Our emergency assistance service is available 24 hours a day, 7 days a week, 365 days a year to provide you with a range of emergency assistance services such as providing treatment guarantees to your hospital or arranging an emergency medical evacuation.

Treatment guarantee for in-patient treatment is not required in emergency cases (for details please refer to pages 51 to 53), however, we should be advised within 24 hours of the event. This will give us the opportunity to arrange the direct settlement of your hospital bills and will ensure that your claim is processed without any delay.

MediLine 24/7.

Our medical advice service, MediLine, offers you immediate telephone access to an experienced, English speaking medical team that provides comprehensive medical advice and information, such as:

- Pre and post-operative treatment advice
- Advice and information on a range of lifestyle issues (e.g. nutrition and dietary information; sports injuries; advice on smoking and alcohol)
- Travel health information pre and post travel (e.g. vaccinations)
- Comprehensive medical information

database
- Patient drug information (e.g. advice on medication usage and reaction)

You can access this member service 24 hours a day, 365 days of the year on
Tel: + 44 (0) 208 403 9970

Please be advised that for policy or claims queries, please contact the allianz Worldwide Care Helpline (contact details on page 11)

Please note that the MediLine and its health-related information and resources are not intended to be a substitute for professional medical advice or for the care that patients receive from their doctors. It is not intended to be used for medical diagnosis or treatment and information should not be relied on for that purpose. Always seek the advice of your doctor before beginning any new treatment or if you should have any questions regarding a medical condition. You understand and agree that Allianz Worldwide Care is not responsible or liable for any claim, loss or damage directly or indirectly resulting from your use of this advice line or the information or the resources provided through this service. Calls to the MediLine will be recorded and may be monitored for training and quality purposes.

Membership Pack.

Once you and Allianz Worldwide Care have signed an insurance contract guaranteeing health insurance cover for you and your dependants, you will receive a Membership Pack consisting of the following items:

- ### Your Personalised Membership Card

  Allianz Worldwide Care supplies personalised membership cards to every member, which contain our essential contact numbers and addresses. This means that you and your family are only a

phone call away from help. We suggest you keep this card with you at all times. If you lose the card, don't worry, simply contact our Helpline and we will arrange for a new card to be sent to you.

- ## Your Insurance Certificate

  Your Insurance Certificate details the plan that you have chosen for you and your dependants. It also states the effective and renewal dates of your cover. It is important that you check that the information is correct. Please let us know, as soon as possible, if any corrections are required.

- ## Your Individual Benefit Guide

  This guide sets out the benefits and rules of your Allianz Worldwide Care plan.

- ## A Treatment Guarantee Form

  It is important that you complete this form for any treatment which requires treatment guarantee. Treatment guarantee is required for all treatments listed on page 52 and listed with [1] or [2] in your Table of Benefits. By following the treatment guarantee process, we can ensure that your treatment will be free from financial worries, allowing you to concentrate on getting better.

- ## A Claim Form

  To ensure that your claim is paid quickly and without delay it is important that you follow the guidelines on how to claim on page 48. All fully completed claims received are processed, you will be notified and payment instructions sent to our payment

Your unique username and password is issued to you in your Membership Pack. For Online Services assistance, please contact our Helpline.

partner, Citibank, within 24 to 60 hours maximum. Where further information is required to complete the claim, you/your medical practitioner will be notified by email and mail within 24 hours of receipt of Claim Form. Automatic emails are sent to you (where email addresses are provided to us) to advise you of the status of your claim at every stage of the process.

- ### Your Online Services Username and Password

  To access our Online Services site, please use the username and password provided in your Membership Pack.

Online Services.

When you visit the Allianz Worldwide Care website, **www.allianzworldwidecare.com**, you can access the secure Online Services area by clicking on the link on the left hand side of the home page. This facility allows you to:

- View your personal details
- Amend you personal details online
- See your Table of Benefits
- Confirm the status of any claims submitted to us
- View correspondence relating to any claims you may have
- Download the Claim and Treatment Guarantee Forms
- Submit your premium payment online (by credit card)

- View a statement of your premium transactions and details of any outstanding premiums
- Update your premium payment details (applicable to credit card payments only)
- Contact Allianz Worldwide Care Client Services via Online Form
- Check how much benefit remains payable under each benefit limit of your Table of Benefits

Your unique username and password is issued to you in your Membership Pack. For Online Services assistance, please contact our Helpline.

Hospital Finder.

Our Hospital Directory is available on the Allianz Worldwide Care website: **www.allianzworldwidecare.com**. This online directory allows you to search for medical facilities by continent and country. You are not restricted to use the hospitals listed in this directory. If you choose to use a hospital not listed in this directory, please contact the Helpline and we will, where possible, try to arrange the direct settlement of your medical expenses.

What you are Covered for.

The following is an overview of your healthcare cover.

This section provides an outline of the cover we provide under each plan. Please be aware that this cover is subject to our Policy Definitions (detailed on pages 56 to 64), as well as our Policy Exclusions and Limitations (detailed on pages 30 to 35). If you have any queries regarding the cover provided under your plan, simply contact us for confirmation of cover. Our Helpline staff are available 24 hours a day, Sunday 6.00pm GMT to Friday 7.00pm GMT, to deal with your policy enquiry.

Your cover will include one of our standard Asian Plans, **Elite, Select, Essential or Vital** and could also include one of our optional Out-patient or Repatriation plans.

To understand the benefits for which you are covered, please read this guide carefully along with your Insurance Certificate.

Medical Necessity.

As an insurance company, our clients expect and want us to control medical costs in order to maintain affordable health insurance premiums.

To do this, our team of highly experienced medical professionals ensure that planned medical interventions are appropriate and medically necessary. By medically necessary we mean treatment that is the most appropriate type and level of service required to treat a patient's condition, illness or injury.

In addition, our team of claims experts will ensure that we only reimburse medical providers where their charges are reasonable and customary. By reasonable and customary we mean that the charges are in accordance

with standard and generally accepted medical procedures.

Chronic Conditions.

Chronic conditions are covered within the limits of your plan unless indicated otherwise on the Table of Benefits or your Insurance Certificate. However, pre-existing chronic conditions are not covered unless they are declared by you on the Individual Application Form and accepted by us in writing.

Pre-existing Conditions.

Pre-existing conditions are medical conditions or any related conditions, for which symptom(s) have been shown at some point during the 5 years prior to commencement of cover, irrespective of whether any medical treatment or advice was sought. Any such condition or related condition about which you or your dependants know, knew or could reasonably have been assumed to have known, will be deemed to be pre-existing.

Pre-existing conditions are not covered under the policy unless declared by you on the Individual Application Form and accepted by us in writing.

Waiting Period.

A waiting period is a period of time from the commencement date of the insurance, during which you and your dependants will not be entitled to certain benefits included in your policy. When this condition is applied to certain benefits within your plan it will be mentioned in the Table of Benefits on pages 6 to 10.

Co-payments or Deductibles

A deductible is an amount which is payable by you and which will be deducted by us from the eligible reimbursable sum. Whereas, a co-payment is a percentage of the eligible costs incurred, which is payable by you. Some plans may include a maximum co-payment per insured person per Insurance Year. This means that any co-payment in excess of the maximum amount, will be reimbursed by us subject to the terms and conditions of your policy.

Please refer to the Table of Benefits on pages 6 to 10 to determine where co-payments or deductibles apply to benefits within your plan.

Where you are Covered.

The two different geographical areas of cover are:

- Worldwide which provides cover anywhere you live in the world
- Worldwide excluding the USA and Canada

Your Insurance Certificate will confirm your chosen geographical area of cover.

Please note that when you return to your home country to make it your principal country of residence, your policy can continue as long as your home country is within your area of cover. Please note that cover in some countries is subject to legal restrictions, particularly for nationals of that country. It is your responsibility to ensure that your health insurance cover is legally appropriate and we would recommend that you seek independent legal advice in this regard.

Your Core Plan Explained.

In-patient Benefits.

In the case of in-patient treatment, you will be reimbursed within the limits of your cover for the benefits included under your Core Plan. This covers hospital accommodation, as well as other benefits such as prescription drugs and materials, anaesthesia and theatre charges, surgeon and anaesthetist fees, surgical appliances and prostheses, diagnostic tests, physiotherapy and organ transplantation.

Treatment guarantee is required for all in-patient benefits listed in the Table of Benefits on pages 6 to 10 (for details of treatment guarantee, please refer to pages 51 to 53).

Benefit limits are per insured person per Insurance Year. Once a benefit limit has been reached, this benefit will no longer be available until your policy has been renewed and a new Insurance Year starts.

In-patient Psychiatry and Psychotherapy.

Cover for psychiatry and psychotherapy is provided on an in-patient basis only. You can claim up to US$25,000 per insured person per Insurance Year under our Elite Plan, US$12,500 under our Select Plan and US$6,250 under our Elite Plan. No cover is provided under our Vital Plan. A waiting period of 10 months applies.

Accommodation costs for one parent staying in hospital with an insured child under 18.

In the event of an insured child requiring hospitalisation, the cost of one parent's accommodation staying with a child under 18

years of age will be covered for the duration of the admission to hospital. In the event that no suitable bed is available in the hospital we will cover the equivalent of a 3 star daily room rate. This benefit is fully covered within the overall maximum limit of the Elite, Select and Essential Plans per insured patient, per Insurance Year. No cover is available under our Vital Plan.

Emergency In-patient Dental Treatment.

You are entitled to full refund for emergency in-patient dental treatment received in a hospital after a serious accident when you are covered under the Elite, Select or Essential Plan. A benefit limit of $5,000 applies when you are covered under the Vital Plan.

Other Benefits under your Core Plan.

To confirm your benefit entitlement and to check when treatment guarantee is necessary, please refer to the Table of Benefits on pages 6 to 10. If you would like any further clarification, simply call our Helpline.

Day-care Treatment.

Cover is provided under our Core Plans for day-care treatment received in a hospital or day-care facility.

Out-patient Surgery.

Cover is also provided for surgical procedures performed in a surgery, hospital, day-care facility or out-patient department.

Nursing at Home or in a Convalescent Home.

You are entitled to claim for nursing received at home or in a convalescent home if the nursing is provided immediately after, or instead of hospitalisation and if you are covered under the Elite, Select or Essential Plan. The maximum amount available under this benefit is US$3,125 per insured person per Insurance Year. Please note that treatment guarantee is required. No cover is available under our Vital Plan.

Local Ambulance.

Cover is provided for ambulance transport, required for an emergency or due to medical necessity, to the next available and appropriate hospital or licensed medical facility. Under our Select and Essential Plans cover provided is limited to US$625 per insured person per Insurance Year. Our Elite Plan provides full cover. Under the Vital plan cover is limited to $400.

Emergency Treatment Outside Area of Cover.

During business and holiday trips you and your dependants will be covered for emergencies only, outside of your chosen area of cover (where relevant).

Under our Select, Essential and Vital Plans, we provide cover for up to 6 weeks (42 nights) emergency treatment, up to a maximum of US$12,500 per insured person per Insurance Year. Under our Elite Plan we provide cover for up to 6 weeks emergency treatment within the overall maximum benefit amount. You will not be covered for any curative or follow-up non-emergency treatment, even if deemed unable to travel to a country in your geographical area of cover. If you are moving out of your area of cover for more than 6 weeks you should contact us.

Not only are you covered in the event of an accident but you are also covered for the sudden beginning or worsening of a severe illness, resulting in a medical condition that presents an immediate threat to your health. To be considered emergency treatment, and thus covered under this benefit, please remember that the medical treatment (through a physician, general practitioner or specialist) should commence within 24 hours of the emergency event.

Medical Evacuation.

This benefit enables ambulance, helicopter or aeroplane transportation to the nearest centre of excellence, if the necessary treatment for which you are covered is not available locally or if adequately screened blood is unavailable in the event of an emergency. The evacuation will be to the nearest appropriate medical centre.

The medical evacuation will be carried out in the most economical way, having regard to your medical condition. Your physician should request the medical evacuation. Please note that treatment guarantee will be required. If medical necessity prevents the insured member from undertaking the evacuation or transportation following discharge from an **in-patient episode of care**, we will cover the reasonable cost of hotel accommodation up to a maximum of 7 days, comprising of a private room with en suite facilities. We do not cover costs for hotel suites, 4 star or 5 star hotel accommodation. Hotel accommodation for an accompanying person is not covered.

Where an insured member has been evacuated to the nearest centre of excellence for **ongoing treatment**, we will also cover the reasonable cost of

hotel accommodation comprising of a private room with en suite facilities. The cost of such accommodation must be more economical than successive transportation costs to/from the nearest centre of excellence and the principal country of residence. Hotel accommodation for an accompanying person is not covered. Please note that treatment guarantee is required.

Where adequately screened blood is not available locally, we will where appropriate, endeavour to locate and transport screened blood and sterile transfusion equipment where this is advised by the treating physician. We will also endeavour to do this when our medical experts so advise. Allianz Worldwide Care and its agents accept no liability in the event that such endeavours are unsuccessful or in the event that contaminated blood or equipment is used by the treating authority.

Expenses for one Person Accompanying an Evacuated/Repatriated person.

This cover is available under all our Core Plans and enables one person to travel with an evacuated or repatriated person. If this cannot take place in the same transportation vehicle, round trip transport at economy rates will be paid for. Under the Elite, Select and Essential Plans. The maximum amount that can be claimed under this benefit is US$3,750. Under the Vital Plan, cover is limited to $2,000. Please note that accommodation and other related expenses are not covered. Please note that treatment guarantee is required.

Repatriation of Mortal Remains.

All our plans provide cover for repatriation of mortal remains. In the event of death we will

provide up to a maximum of US$12,500 under our Elite, Select and Essential Plans to cover the cost of transportation of the insured person's mortal remains from the principal country of residence to the home country. Under our Vital plan, cover is limited to $10,000. Cremation costs will only be covered in the event that this is required for legal purposes. Please note that treatment guarantee will be required.

CT, MRI and PET scans.

CT, MRI and PET scans, carried out on an in-patient or out-patient basis, are fully covered within the limits of your Core Plan. Please note that under our Vital Plan PET scans are not covered and please also note that treatment guarantee is required for all MRI and PET scans.

Oncology.

Our Core Plans provide full cover for specialist fees, diagnostic tests, radiotherapy, chemotherapy and hospital charges incurred in relation to the planning and carrying out of treatment for cancer, from the point of diagnosis. Treatment guarantee is required for in-patient and day-care treatment only.

Routine Maternity.

If this benefit is provided under your plan, cover will include any medically necessary costs incurred during pregnancy and childbirth, including hospital charges, specialist fees, the mother's pre- and post-natal care, midwife fees as well as newborn care. Costs related to complications of pregnancy and childbirth, are not payable under routine maternity.

Cover for routine maternity is limited to, US$10,000 under our Elite Plan and US$5,000 under our standard Select Plan. There is no routine maternity cover under our Essential and Vital Plan.

Please note that a 10-month waiting period applies, unless otherwise agreed between your employer and us. Treatment guarantee is required for in-patient treatment.

Complications of Pregnancy and Childbirth.

Complications of pregnancy refers to the following conditions that arise during the antenatal stages of pregnancy: ectopic pregnancy, miscarriage, stillbirth and hydatidiform mole.

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

Cover for complications of pregnancy and childbirth is limited to US$31,250 under our Elite Plan and US$10,000 under our standard Select Plan. There is no cover under our Essential Plan and cover under our Vital Plan is limited to US$5,000.

A 10-month waiting period applies to complications of pregnancy and childbirth unless otherwise agreed between your employer and us. Treatment guarantee is required.

In-patient Cash Benefit.

This benefit is included in all our plans and pays US $190 or, in case of the Vital Plan, US$75 per night, for each night you spend in hospital, up to a maximum of 25 nights per Insurance Year. The benefit is only payable where treatment is received completely free of charge and in respect of treatment that is covered within the terms of your plan.

Cover for Newborn Children.

Newborn infants will be accepted for cover from birth provided that we are notified within 4 weeks of the date of birth and that the birth mother has been insured with us for 6 continuous months. Notification of the birth after 4 weeks will result in newborn children being accepted for cover from the date of such notification. In-patient treatment for multiple birth babies born as a result of medically assisted reproduction will be covered up to $37,500 per child for the first three months following birth. Out-patient treatment will be covered under the limits of the Out-patient Plan. In addition, multiple birth babies will be subject to full medical underwriting.

Your Out-patient Plan Explained.

Allianz Worldwide Care offers a range of Out-patient Plans, each offering different levels of reimbursements, deductibles and co-payments.

To confirm your exact cover, please **check your plan details on the Table of Benefits.**
Our **Out-patient Plans** include some or all of the following benefits:

- Medical practitioner fees
- Prescription drugs
- Specialist fees
- Diagnostic tests, including X-rays
- Vaccinations
- Chiropractic treatment, osteopathy, homeopathy, Chinese herbal medicine and acupuncture
- Prescribed physiotherapy, speech therapy, oculomotor therapy and occupational therapy
- Emergency dental treatment
- Routine dental treatment
- Prescribed medical aids
- Prescribed glasses and contact lenses

Please note that treatment guarantee may be required for some of these benefits. A waiting period may also apply. For details of cover, please refer to the Table of Benefits on pages 6 to 10 and the “Definitions” section on pages 56 to 64 of this guide.

Emergency Out-patient Dental Treatment.

This benefit, included under our Out-patient Plans OP1 and OP2, provides full cover for treatment received in a dental surgery or hospital emergency room for the immediate relief of dental pain. Cover is extended to include temporary fillings limited to 3 fillings per Insurance Year, and/or the repair of damage caused in an accident. The treatment must be received within 24 hours of the emergency event. Please note that cover does not extend to dental prosthesis and root canal treatment.

Routine Dental Treatment.

Included under our out-patient plan OP1, this benefit provides cover up to US$625 for an annual dental check up, simple fillings related to cavities or decay and root canal treatment. Cover is not provided for dental surgery, periodontics, orthodontic treatment or dental prosthesis.

Your Repatriation Plan Explained.

This is an optional plan and where covered, will be indicated on your Insurance Certificate.

Where the necessary treatment for which you are covered is not available locally, your repatriation plan will enable you to return to your home country for treatment rather than to the nearest centre of excellence. This only applies when your home country is located within your area of cover. Treatment guarantee is required.

What your Healthcare Cover does not Pay for.

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

1. Treatment **outside the geographical area of cover** unless for emergency or authorised by us.

2. **Pre-existing conditions** will not be covered, unless declared by you on the Individual Application Form and accepted by us in writing on or prior to your policy start date as detailed on the Insurance Certificate.

3. Products classified as **vitamins** or **minerals** (except during pregnancy or to treat diagnosed, clinically significant vitamin deficiency syndromes), nutritional or dietary supplements, including cosmetic products, even if medically recommended or prescribed or acknowledged as having therapeutic effects.

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

5. Unless stated otherwise on the Table of Benefits, investigations into, treatment and complications arising from **infertility, sterilisation, sexual dysfunction** and **contraception,** including insertion and removal of contraceptive devices and all other contraceptives, even if prescribed for medical reasons. The only exception is the prescribing of contraceptives for the treatment of acne where prescribed by a dermatologist.

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

7. In-patient treatment for **multiple birth babies**

born as a result of medically assisted reproduction is limited to $37,500 per child for the first three months following birth. Out-patient treatment will be covered under the limits of the Out-patient Plan.

8. **Cosmetic or plastic surgery**, or any treatment arising from it, whether or not for medical/psychological purposes. The only exception is re-constructive surgery necessary to restore function or appearance after a disfiguring accident, or as a result of surgery for cancer, if the accident or surgery occurs during your membership of the scheme.

9. Stays in a **cure centre, bath centre, spa, health resort and recovery centre**, even if the stay is medically prescribed, as well as stays in a **nursing home**.

10. Care and/or treatment of **intentionally caused diseases** or **self-inflicted injuries.**

11. Care and/or treatment of **drug addiction** or **alcoholism**.

12. Illnesses and accidents and the consequences thereof, as well as instances of death, that are caused by the misuse of **alcohol** or **drugs** by the insured person.

13. **Developmental delay** unless a child has not attained developmental milestones expected for a child of that age in one or more of the following developmental areas: cognitive, physical (including vision and hearing), language (communication), social-emotional or adaptive development. We do not cover conditions in which a child is slightly or temporarily lagging in

development. The developmental delays must have been quantitatively measured, by qualified personnel, using informed clinical opinion, appropriate diagnostic procedures and/or instruments and documented as a 12 month delay in one of the above mentioned functional areas or a 33% delay in one functional area or a 25% delay in two or more areas, when expressed as a quotient of developmental age over chronological age.

14. We do not cover treatment for conditions such as **conduct disorder, attention deficit hyperactivity disorder, oppositional defiant disorder, antisocial behaviour, obsessive-compulsive disorder, attachment disorders, adjustment disorders,** as well as all treatments that encourage positive social-emotional relationships, such **as communication therapies, floor time and family therapy.**

15. **Speech therapy** is only eligible for reimbursement in the context of a diagnosed physical impairment such as, 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). We do not pay for speech therapy related to developmental delay, dyslexia, dyspraxia or expressive language disorder.

16. **Psychotherapy treatment** is only covered where you or your dependants are initially diagnosed by a clinical psychiatrist and referred to a clinical psychologist for further treatment.

17. Treatment for any illnesses, diseases or

injuries resulting from **active participation in war, riots, civil disturbances, terrorism**, acts against any foreign hostility, whether war has been declared or not.

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

19. Investigations into or treatment of **sleep disorders.**

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

21. Treatment or diagnostic procedures of **injuries arising from an engagement in professional sports.**

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

23. **Orthomolecular treatment** (please refer to definition 1.38).

24. **Consultations** performed, as well as any **drugs** or **treatments prescribed,** by you, your spouse, parents or children.

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

26. **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.

27. **Genetic testing** except DNA tests which are covered, if directly linked to an eligible amniocentesis (please refer to our definition for **pre-natal care**).

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

29. **Triple/Bart's** or **Quadruple** tests, except for women aged 35 and over.

30. Investigations into and treatment of **obesity.**

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

32. **Complementary treatment** with the exception of those treatments indicated on the Table of Benefits.

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

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

35. Treatment to change the **refraction of one or both eyes (laser eye correction)**, including refractive keratectomy (RK) and photorefractive keratectomy (PRK).

36. **Sex change operations** and related treatments.

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

38. **Dental Surgery, periodontics, orthodontics and dental prosthesis** with the exception of oral

surgical procedures, which are covered within the overall limit of your Core Plan.

39. The following treatments, medical conditions or procedures, or any consequences thereof, are **not covered** unless otherwise indicated on your Table of Benefits:

39.1 Routine dental treatment
39.2 Out-patient treatment
39.3 Routine maternity
39.4 Prescribed glasses and contact lenses
39.5 Prescribed medical aids
39.6 Vaccinations
39.7 Preventive treatment
39.8 Routine health checks
39.9 Rehabilitation treatment
39.10 Medical repatriation

Paying Premiums and General Information.

The following section provides you with general information on paying your premiums and details on important events of your membership.

Paying Premiums.

Premiums for each Insurance Year are based on your age and that of your dependants on the first day of the Insurance Year, the premium table in effect and other risk factors which may materially affect the insurance.

You are required to pay the premium due to us in advance for the duration of your membership. The amount you have agreed to pay and the method of payment you have chosen will be shown on your quotation prior to the issue of your contract. The **initial premium** or the first premium instalment is immediately payable after our acceptance of your Application Form. Subsequent premiums will fall due on the first day of the chosen payment period. You may choose between monthly, quarterly, half yearly or annual payments depending on the payment method you choose.

Your premium should be paid in the currency you elected to pay 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 and with written instructions received by us 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/policy start date/conclusion of the insurance contract.

If a **subsequent premium** is not paid in time, the insurer 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 the insurer 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 time, within one month after the expiration of the time for payment, **provided that no claims have been incurred** in the intervening period.

The **premium** will be adjusted once a year as at the renewal date, at which time we also reserve the right to alter our policy terms and conditions.

Paying Other Charges.

In addition to paying premiums, you also have to pay us the amount of any Insurance Premium Tax (IPT) and any new taxes, levies or charges that may be imposed after you join relating to your membership 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 Payment Details Certificate.

You are required to pay to us any such IPT, taxes, levies and charges when you pay your premiums, unless otherwise required by law.

Changes to Premiums and Other Charges.

Each year on the renewal date, we may change how we calculate your premiums, how we determine the premiums, what you have to pay

and the method of payment. Please be assured that if we do make changes they will only apply from your renewal date.

We may change the amount you have to pay us in respect of IPT or in respect of other taxes, levies or charges at any time if there is a change in the rate of IPT or any new such tax, levy or charge is introduced or there is a change in the rate of any such tax, levy or charge.

If we do make any changes to your premiums or to the amount you have to pay in respect of IPT or other taxes, levies, or charges, we will write to tell you about the changes. If you do not accept any changes we make, you can end your membership and 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, whatever is later

Important Events.

Throughout this guide, you will see references to important events such as when you start, renew or end your membership, or include other people as your dependants. This section explains exactly when - and how - these events take place. Our aim is to continuously improve our service to our members. In order to help us do this, if for any reason, you cancel your membership, please let us know the reason why.

Starting your Membership.

The insurance shall be valid as of the 'effective date' on the Insurance Certificate. The cover will continue for 12 months and is strictly conditional upon our acceptance of the Application Form, as indicated by your receipt of the Insurance

Certificate. No benefit will be payable under your policy until the initial policy premium has been paid with subsequent premiums being paid when owing.

When Cover Starts for Others included in your Membership.

If any other person is included as a dependant under your membership, their membership will start on the 'effective date' on the first Insurance Certificate we sent you for your current continuous period of Allianz Worldwide Care membership, which lists them as a dependant. Their membership may continue for as long as you remain a member of the scheme. If your membership ceases, your dependants can then, of course, apply for membership in their own right.

Adding Dependants.

You may apply to include any of your family members under your membership providing you complete the necessary Application Form.

Newborn infants will be accepted for cover from birth provided that we are notified within 4 weeks of the date of birth and that the mother has been insured with us for 6 continuous months. Notification of the birth after 4 weeks will result in newborn children being accepted for cover from the date of such notification. In-patient treatment for multiple birth babies born as a result of medically assisted reproduction will be covered up to $37,500 per child for the first 3 months following birth. Out-patient treatment will be covered under the limits of the Out-patient Plan. In addition, multiple birth babies will be subject to full medical underwriting.

Renewing your Membership.

Duration of the insurance cover is 12 months. The policy is automatically renewed for the next Insurance Year provided the plan you have is still available. One month before the renewal date, you will receive a new Insurance Certificate indicating the premium for the next Insurance Year.

You may terminate the policy by giving one month's written notice by registered letter to us following the notification to you of the renewal. We have the right to make renewal subject to special conditions. Policy Terms and Conditions as well as the Table of Benefits existing on the renewal date will apply for the entire new Insurance Year.

Ending your Membership.

Please remember that your membership will automatically 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 new Application Form, if you pay the outstanding premiums within 30 days. If you are unable to pay your premiums for any reason, please contact us on +353 1 630 1301
- 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 date they are due
- Upon the death of the principal member. If the principal member dies, the next named dependant on the Insurance Certificate may

apply to us to become a principal member of the scheme in his or her own right 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 to their cover that are personal to them in addition to those which applied to them under the scheme when the principal member died

When you return to your home country to make it your principal country of residence, your policy can continue as long as your home country is within your area of cover. Please note that cover in some countries is subject to legal restrictions, particularly for nationals of that country. It is your responsibility to ensure that your health insurance cover is legally appropriate and we would recommend that you seek independent legal advice in this regard.

We can end a person's membership and that of all the other people listed on the Insurance Certificate if there is reasonable evidence that the person concerned has misled, or attempted to mislead us. By this, we mean giving false information or keeping necessary information from us, or working with another party to give us false information, either intentionally or carelessly, which may influence us when deciding:

- Whether you (or they) can join the scheme
- What premiums you have to pay
- Whether we have to pay any claim

If your membership ends for any reason, we will refund any premiums you have paid which relate to a period after it ends. However, we shall be entitled to deduct from any refund, money which you owe us.

General Information.

Cancellation and Fraud.

a. 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 said premium payment became due and payable. However, if the premium is paid within 30 days after due date, the insurance cover is reinstated and we will cover any claims which occurred during the period of delay. However, if the outstanding premium is paid after the 30-day limit, you must complete an Individual Health Declaration Form before your policy can be re-instated.

b. 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 relating to the questions on the Application Form, will render the contract void from the commencement date, unless we otherwise elect in writing. Conditions arising between signing the Application Form and confirmation of acceptance by the Underwriting Department of Allianz Worldwide Care, will be deemed to be pre-existing. If the applicant is not sure whether something is relevant, the applicant is obliged to inform us. Premium will not be refunded, in part or in whole, and any pending claims settlements will be forfeit.

c. 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.

Death.

Upon the death of the principal member or a dependant we should be notified in writing within 4 weeks. The corresponding insurance will be terminated and a pro rata repayment of the premium will be made if no claims have been filed. Allianz Worldwide Care reserves the right to request a death certificate before a refund is issued. The death of the subscriber where dependants are included in the policy requires a new subscriber to be elected to the policy.

Your Right to Cancel.

On receipt of your Membership Pack, which includes your Insurance Certificate, you are entitled to cancel your membership and/or that of any of your dependants, from the first day of a month, provided that you notify us in writing within 30 days. Such notification of cancellation should be addressed to the Client Services Department. You cannot backdate the cancellation of your membership.

Providing we receive your cancellation notice within the 30 days, you will be entitled to a full refund of premiums paid, provided no claim

has been made under the policy. If you choose not to exercise your right to cancel within the 30 days, the insurance contract will be binding on both parties with the full premium owing for the selected Insurance Year payable according to the payment frequency selected by you.

You may also cancel the membership of any of your dependants for any reason by writing to us at

Client Services Dept, Allianz Worldwide Care, 18B Beckett Way, Park West Business Campus, Nangor Road, Dublin 12

within 30 days below of you receiving your first Insurance Certificate, listing them as dependant. In that case you will be entitled to a full refund of all your premiums paid relating to them, subject to no claims having been made on their behalf.

Making Changes to your Cover.

Changes to cover can only be made at policy renewal. If you want to change your level of cover, please contact us **before your policy renews** to discuss your options. If you want to increase your level of cover we may ask you to complete a medical history questionnaire form, and/or to agree to certain exclusions or restrictions to your cover before we accept your application. Of course should you have any concerns about your premiums or your dependants' circumstances have changed, please call us on **+ 353 1 630 1301** and we can discuss your available options.

If you move to a country within your existing area of cover, there is nothing to do except to inform us of your new address and contact details as soon as possible. Your cover will

continue as before at no additional cost.

If, however, you move to a country outside your area of cover (for example, if you move to the USA or Canada), you will need to contact us to extend your area of cover. An additional premium amount will be payable.

If we make Changes.

We may change the benefits and rules of your membership on your renewal date. Any changes we make will only apply from your renewal date, regardless of when the change is made. These changes could affect, for example:

- How much your premiums will be
- How often you have to pay them
- The cover you receive

We will not add any restrictions or exclusions to someone's cover that are personal to them for medical conditions that started after they joined the scheme, provided:

- They gave us the information we asked them for before joining and
- They have not applied for an increase in their cover

We will of course 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 change takes effect, or
- Within 30 days of us telling you about the changes whichever is later

Amending your Membership Details.

We will send you a new Insurance Certificate if any of the following occur:

- If you are adding another dependant, such as a newborn child, to your membership
- If we need to record any other changes which you have requested, or we are entitled to make, such as changing the way you pay your premium

Your new Insurance Certificate will replace any earlier version you possess as from the issue date shown on the new Insurance Certificate.

Other Parties.

No other person is allowed to make or confirm any changes to your membership on our behalf, or decide not to enforce any of our rights. No change to your membership will be valid unless it is confirmed in writing. Any confirmation of your cover will only be valid if it is confirmed in writing by Allianz Worldwide Care.

If your treatment is needed as a result of somebody else's fault.

You must write and tell us as soon as possible, if you are claiming for treatment that is needed when somebody else is at fault. For example, if you need treatment for an injury suffered in a road accident in which you are a victim. If so, you will need to take any reasonable steps we ask of you to:

- Recover from the person at fault details of their insurance through which the cost of the treatment paid for by us can be received

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.

If you are Covered by Another Insurance Scheme.

You must write to tell us, if you have any other insurance cover for the cost of the treatment or benefits you have claimed from us. If you do have other insurance cover, we will only pay our share of the cost of the treatment.

If you Change your Address.

Any change in your home or business address should be communicated to us as soon as possible. This information will help us to keep in contact with you.

Correspondence.

Letters between us must be sent by post and with the postage paid. We usually do not return original documents to you. However, if you ask us at the time you send the original documents to us, such as invoices, we will of course return them to you.

Applicable Law.

Your membership is governed by Irish law. Any dispute that cannot otherwise be resolved will be dealt with by courts in Ireland.

How to Claim.

Please follow the guidelines below to help us process your claims promptly and efficiently.

All claims should be submitted to us with original supporting documentation, invoices and receipts within six months after the end of the Insurance Year or if cover is cancelled during the Insurance Year, within 6 months after the end of your insurance cover. **Beyond this time we are not obliged to settle the claim.**

Before you make a claim, it is important to ensure that your plan covers the treatment you are seeking (e.g. out-patient, routine maternity, dental etc.). Our Helpline staff would be happy to assist with any queries you may have.

Claims Turnaround.

All fully completed Claim Forms are processed and payment instructions issued to your bank within 24 to 60 hours maximum. Where further information is required to complete the claim, you/your medical practitioner will automatically be notified by email and mail within 24 hours of receipt of Claim Form. An automatic email is sent to you (where email addresses are provided to us) to advise you of the status of your claim at every stage of the process.

To ensure your claim will be paid quickly and without delay, please follow the guidelines of how to claim in the following section.

In-patient Claims.

In the event of hospitalisation, we will, where possible and with sufficient notice, arrange for direct settlement with providers subject to any co-payments, deductibles and benefit limits. If treatment guarantee is required for the treatment you are seeking, your physician will need to complete a Treatment Guarantee Form and send it to us prior to commencement of

You can download the Claim Form and the Treatment Guarantee Form from our website:

www.allianzworldwidecare.com

treatment. It is recommended that you contact us at least five working days prior to receiving treatment so that we can ensure there will be no delays at the time of admission. For more information on treatment guarantee please see pages 51 to 53.

You can download the Claim Form and the Treatment Guarantee Form from our website www.allianzworldwidecare.com

Out-patient or Dental Claims.

Please note that for certain out-patient claims, a **Treatment Guarantee Form may need to be completed by your physician prior to the treatment taking place.** Please refer to the Table of Benefits to check which benefits require treatment guarantee.

Out-patient and dental treatment is paid for by the patient at the time of receiving treatment and the costs incurred are then recovered from Allianz Worldwide Care.

We recommend the following steps in making an out-patient or dental claim:

- Whenever you visit a general practitioner, dentist, physician or specialist on an out-patient basis, please make sure you take a Claim Form with you
- Fill in the section that is assigned to you, then date and sign the Claim Form
- You are responsible for ensuring that your doctor provides all relevant medical information, including diagnosis, in the specified section and then dates, signs and stamps the Claim Form

However, if your invoices contain details of the diagnosis as well as the nature of the treatment, there is no need for your treating doctor to complete this section of the Claim Form

- Attach all original supporting documentation, invoices and receipts to the Claim Form (e.g. general practitioner/physician invoices, pharmacy receipts with related prescriptions (if available)), and post to Allianz Worldwide Care at the address indicated on your Claim Form. It is your responsibility to keep all copies of all correspondence with us (in particular, copies of Claim Forms and medical receipts). We cannot be held responsible for correspondence lost in the post

- If the amount to be claimed is less than the deductible figure under your plan, remember to retain the Claim Form and receipts - **do not destroy or dispose of them.** Keep collecting all out-patient receipts and Claim Form documents until you reach an amount in excess of your plan deductible. Then forward to us all completed Claim Forms together with original receipts/invoices

- Remember a separate Claim Form will be required for each person claiming and for each medical condition being claimed for

- Specify on the Claim Form the currency in which you wish to be paid, otherwise the benefit due to you will be paid in the currency of the invoice. On the rare occasion that the international banking regulations do not allow us to make a payment in the currency you have asked for the benefit due to you will be paid in the currency of your invoice (where possible). 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.

- Please ensure that your payment details on the Claim Form are correct as incorrect details can delay the settlement of your claims

Please note that the incurred costs will be reimbursed within the limits of your policy, after taking into consideration any required treatment guarantee and will be net of any deductibles or co-payments mentioned in the Table of Benefits.

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.

You can download the Claim Form and the Treatment Guarantee Form from our website: www.allianzworldwidecare.com. You can also check the status of your claim through the Online Services section on our website. Please refer to page 15 to find out more about our Online Services.

Treatment Guarantee.

What is Treatment Guarantee?

Treatment guarantee is a process whereby Allianz Worldwide Care guarantees cover for certain treatments and costs. The process requires that a Treatment Guarantee Form is completed by your physician and faxed to our Claims Department for approval prior to treatment. We will respond within 24 hours of receipt of a fully completed form. Your Table of Benefits will indicate where a Treatment Guarantee Form must be completed and sent to us prior to treatment taking place.

When is Treatment Guarantee required?

Treatment guarantee is required for the following:

- In-patient benefits as listed in your Core Plan[1]
- MRI[2] (Magnetic Resonance Imaging) and PET[2] (Positron Emission Tomography) scans
- Nursing at home/in a convalescent home[2]
- Routine maternity including complications of pregnancy and childbirth[2] (in-patient treatment only)
- Oncology[2] (in-patient and day-care treatment only)
- Occupational therapy[2] (out-patient treatment)
- Medical evacuation[2] (or repatriation where covered)
- Expenses for one person accompanying an evacuated/repatriated person[2]
- Repatriation of mortal remains[2]

Why is Treatment Guarantee required?

Treatment guarantee is necessary in order to ensure that all costs are fully covered within your plan. As with all health insurance policies, your plan with us will only cover treatment that is medically necessary and charges that are usual and customary. Therefore, it is vital that you contact us prior to treatment so that we can confirm the medical necessity of your treatment, as well as the appropriateness of costs.

By following the treatment guarantee process, we can ensure that your treatment will be free from financial worries, allowing you to concentrate on getting better.
In addition, treatment guarantee will help us to provide you with a better service:

- In the case of planned treatment, we will have time to communicate with the hospital

to facilitate smooth admission and guarantee direct payment
- In the case of an evacuation/repatriation, we will be able to organise and co-ordinate the evacuation on your behalf. Please contact the Helpline and our officers can talk you through the process

What happens if I don't obtain Treatment Guarantee?

[1] If treatment guarantee is not obtained for benefits listed with [1], we reserve the right to decline a claim. If in the aftermath the respective treatment is proven medically necessary, we will pay only 80% of the eligible benefits.

[2] If treatment guarantee is not obtained for benefits listed with [2], we reserve the right to decline a claim. If in the aftermath the respective treatment is proven medically necessary, we will pay only 50% of the eligible benefits.

In the case of an emergency we should be informed within 24 hours of the event to ensure that no treatment guarantee penalty is applied.

Treatment in the USA.

For treatment in the USA, members with "Worldwide" cover should instruct their medical provider to contact our **toll-free number as indicated on the reverse of your Membership Card**, in order to verify eligibility of cover. We can then arrange direct settlement for in-patient and out-patient treatment.

Questions Answered.

We have selected a few questions which may be of interest to you. If you have further questions, please do not hesitate to contact us.

Q. In which countries can I receive treatment?
A. Where the necessary medical treatment for which you are covered is not available locally, you can avail of treatment in any country within your area of cover. In order to seek reimbursement for medical treatment and travel expenses incurred, you will need to submit a Treatment Guarantee Form for approval prior to travel. Where the necessary medical treatment is available locally but you choose to travel to another country within your area of cover for treatment, we will reimburse all eligible costs incurred within the terms of your plan, however, we will not pay for travel expenses incurred.

Q. Am I covered in my home country?
A. When you return to your home country to make it your principal country of residence, your policy can continue as long as your home country is within your area of cover. Please note that cover in some countries is subject to legal restrictions, particularly for nationals of that country. It is your responsibility to ensure that your health insurance cover is legally appropriate and we would recommend that you seek independent legal advice in this regard.

Q. What happens if I move country?
A. If you remain an expatriate and move to a country within your existing area of cover, there is nothing to do except to inform us of your new address and contact details as soon as possible. Your cover will continue as before at no additional cost.

If, however, you move to a country outside your area of cover (for example, if you move to the USA or Canada), you will need to contact us to extend your area of cover. An additional premium amount will be payable.

Q. When can I make changes to my payment terms?
A. Changes in payment terms (e.g. method or frequency) can only be made at policy renewal. You will need to provide us with written instructions 30 days prior to you renewal date.

Q. What happens if I don't pay my premiums when due?
A. We will cancel the policy where you have not paid the full premium when due. We shall notify you of this cancellation and the contract shall be deemed cancelled from the premium due date. However, if the premium is paid within 30 days after due date, we will reinstate your insurance cover and pay any claims which occurred during the period of delay. However, if the outstanding premium is only paid after this 30-day limit, you must complete an Individual Health Declaration Form before your policy can be re-instated.

Q. Which hospitals can I go to?
A. You can use our online Hospital Finder to search for hospitals worldwide. However, you are not restricted to use hospitals from this directory. If you choose to seek treatment outside this network, please contact the Helpline and we will, where possible, try to arrange the direct settlement of your medical expenses.

Q. What do I do in an emergency?
A. In case of an emergency, always seek medical care immediately. Where possible, you should contact the Allianz Worldwide Care Helpline within 24 hours of the event.

For more details please visit
www.allianzworldwidecare.com

Making a Complaint.

The following is an overview of the Allianz Worldwide Care complaints procedure.

We're always pleased to hear about aspects of your membership that you've particularly appreciated, or that you have had problems with. If something does go wrong, here is a simple procedure to ensure your concerns are dealt with as quickly and effectively as possible.

The Allianz Worldwide Care Helpline is always the first number to call if you have any comments or complaints. Please call us on **+353 1 630 1301** anytime (available 5 days a week between the hours of Sunday 6.00pm GMT and Friday 7.00pm GMT). In case that we were not able to solve the problem on the phone, please email, fax or write to us at:

Allianz Worldwide Care
18B Beckett Way, Park West Business Campus,
Nangor Road,
Dublin 12, Ireland
Fax: **+353 1 630 1399**
Email: **client.services@allianzworldwidecare.com**

If we have been unable to resolve the problem to your satisfaction and you wish to take your complaint further, you can refer your complaint to the **Irish Financial Services Ombudsman.**

The Financial Services Ombudsman is a statutory official who acts as an impartial arbiter of unresolved disputes that customers may have with financial services providers.

Financial Services Ombudsman's Bureau
32 Upper Merrion Street
Dublin 2
Ireland
Tel: + 353 1 662 0899
Fax: + 353 1 662 0890
Email: enquiries@financialombudsman.ie
www.financialombudsman.ie

Definitions.

These definitions apply to the benefits included in our range of healthcare plans and may not necessarily form part of your specific plan, as outlined in your Table of Benefits. Wherever the following words and phrases do appear in your policy documentation, they will always have the meanings as defined below.

1.1 **Accident** is an injury which is the result of an unexpected event independent of the will of the insured and which arises from a cause outside the individual's control. The cause and symptoms must be medically and objectively definable, allow for a diagnosis and require therapy.

1.2 **Accommodation costs for one parent staying in hospital with an insured child under 18** 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 3 star daily room rate towards any hotel costs incurred. We will not, however, cover sundry expenses such as meals, telephone calls, newspapers etc.

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

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

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

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

1.6 **Complications of pregnancy** refers to the following conditions that arise during the antenatal stages of pregnancy: ectopic pregnancy, miscarriage, stillbirth and hydatidiform mole.

1.7 **Day-care treatment** is treatment received in a hospital or day-care facility during the day, including a hospital room and nursing that does not medically require the

patient to stay overnight, and where a discharge note is issued.

1.8 **Deductible** is that part of the cost which remains payable by you and which has to be deducted from the reimbursable sum.

1.9 **Dental prosthesis** includes crowns, inlays, onlays, adhesive reconstructions/restorations, bridges, dentures and implants as well as all necessary and ancillary treatment required.

1.10 **Dental surgery** includes the extraction of teeth, apicoectomy, as well as the treatment of other oral problems such as congenital jaw deformities (e.g. cleft jaw), fractures and tumours. Dental surgery does not cover any surgical treatment that is related to dental implants.

1.11 **Dependant** is your spouse or partner (including same sex partner) and/or unmarried children (including any step, foster or adopted child) financially dependant on the insured person and not more than 18 years old; or not more than 24 years old if in full time education and also named on your Insurance Certificate as one of your dependants.

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

1.13 **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.

1.14 **Emergency out-patient dental treatment** is treatment received in a dental surgery/hospital emergency room for the immediate relief of dental pain, including temporary fillings limited to three fillings per Insurance Year, and/or the repair of damage caused in an accident. The treatment must be received within 24 hours of the emergency event. This does not include any form of dental prosthesis and root canal treatment.

1.15 **Expenses for one person accompanying an evacuated/repatriated person** refers to the cost of one person travelling with the evacuated/repatriated person. If this cannot take place in the same transportation vehicle, transport at economy rates will be paid for. Following completion of treatment, we will also cover the cost of the return trip, at economy rates, for the accompanying person to return to the country from where the evacuation/repatriation originated.

Cover does not extend to hotel accommodation and other related expenses.

1.16 **Home country** is the declared country from which the insured person is expatriated and to which the insured person would want to be repatriated.

1.17 **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 as hospitals: rest and nursing homes, spas, cure-centres and health resorts.

1.18 **Hospital accommodation** refers to standard private or semi-private accommodation as indicated on the Table of Benefits. Deluxe, executive rooms and suites are not covered.

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

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

1.21 **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.

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

1.23 **Insured person** is you and your dependants as stated in your Insurance Certificate.

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

1.25 **Medical evacuation** applies where the necessary treatment for which the insured person is covered is not available locally or if adequately screened blood is unavailable in the event of an emergency. We will evacuate the insured person to the nearest appropriate medical centre. Please note that the nearest appropriate medical centre may not be located in your home country. The medical evacuation will be carried out in the most economical way having regard to the medical condition.

Following completion of treatment, we will also cover

the cost of the return trip, at economy rates, for the evacuated member to return to his/her principle country of residence.

If medical necessity prevents the insured member from undertaking the evacuation or transportation following discharge from an **in-patient episode of care**, we will cover the reasonable cost of hotel accommodation up to a maximum of 7 days, comprising of a private room with en suite facilities. We do not cover costs for hotel suites, 4 star or 5 star hotel accommodation. Hotel accommodation for an accompanying person is not covered.

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

1.26 **Medical necessity** refers to those medical 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.
(d) required for reasons other than the comfort or convenience of the patient or his or her physician.
(e) proven and demonstrated to have medical value.
(f) considered to be the most appropriate type and level of service or supply.
(g) provided at an appropriate facility, in an appropriate setting and at an appropriate level of care for the treatment of a patient's medical condition.
(h) provided only for an appropriate duration of time.

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

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

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

1.29 **Medical repatriation** is an optional level of cover and where provided will be shown on the Insurance Certificate. In the event of a medical evacuation, the insured person with optional repatriation cover, can choose to return to his/her home country for treatment, provided that the home country is located within the insured person's area of cover.

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

1.31 **Newborn care** includes customary examinations required to assess the integrity and basic function of the child's organs and skeletal structures. These essential examinations are carried out immediately following birth. Further preventive diagnostic procedures, such as routine swabs, blood typing and hearing tests, are not covered. Any medically necessary follow up investigations and treatment are covered under the newborn's own policy.

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

1.33 **Occupational therapy** refers to treatment that addresses the individual's development of fine 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. Out-patient occupational therapy requires treatment guarantee.

1.34 **Oncology** refers to specialist fees, diagnostic tests, radiotherapy, chemotherapy and hospital charges incurred in relation to the planning and carrying out treatment for cancer, from the point of diagnosis.

1.35 **Oral surgical procedures** refers to surgical procedures, such as but not limited to the removal of impacted wisdom teeth, when carried out in a hospital by an oral or maxillofacial surgeon.

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

1.37 **Orthodontics** is the use of devices to correct malocclusion and restore the teeth to proper alignment and function.

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

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

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

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

1.42 **Post-natal care** refers to the routine medical care to be received up to six weeks after delivery.

1.43 **Pre-existing conditions** are medical conditions or any related conditions, for which symptom(s) have been shown at some point during the 5 years prior to commencement of cover, irrespective of whether any medical treatment or advice was sought. Any such condition or related condition about which you or your dependants know, knew or could reasonably have been assumed to have known, will be deemed to be pre-existing. Conditions arising between completing the Application Form and confirmation of acceptance by the Underwriting Department of Allianz Worldwide Care, will equally be deemed to be pre-existing.

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

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

1.46 **Prescribed glasses and contact lenses** 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.

1.47 **Prescribed medical aids** refers to any instrument, apparatus or device which is medically prescribed as an aid to the function or capacity of the insured person, such as hearing aids, speaking aids (electronic larynx), crutches or wheelchairs, orthopaedic supports/braces, artificial limbs, stoma supplies, graduated compression stockings as well as orthopaedic arch-supports.

1.48 **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 does not include therapies such as Rolfing, Massage, Acupressure, Pilates and Milta therapy.

1.49 **Prescription drugs** refers to products, including insulin, hypodermic needles or syringes, prescribed by a medical practitioner for the treatment of a confirmed diagnosis or medical condition or to compensate vital bodily substances. The prescribed drugs must be clinically proven to be effective, and recognised by the pharmaceutical regulator in a given country.

1.50 **Preventive treatment** refers to treatment that is undertaken without any clinical symptoms being present at the time of treatment. An example of such treatment is the removal of a pre-cancerous growth (e.g. mole on the skin).

1.51 **Principal country of residence** is the country where you and your dependants live for more than 6 months of the year.

1.52 **Psychiatry and psychotherapy** refers to treatment of a mental, nervous or eating disorder carried out by a clinical psychiatrist or clinical psychologist. The disorder must be associated with present distress, or substantial impairment of the individual's ability to function in a major life activity (e.g. employment). The aforementioned condition must be clinically significant and not merely an expected response to a particular event such as bereavement, relationship or academic problems and acculturation. The disorder must meet the criteria for classification under an international classification system such as the Diagnostic and Statistical Manual (DSM-IV) or the International Classification of Diseases (ICD-10).

1.53 **Repatriation of mortal remains** is the transportation of the deceased's mortal remains from the principle country of residence to the home country. Cremation costs will only be covered in the event that this is required for legal purposes. Costs incurred by any accompanying persons are not covered.

1.54 **Routine dental treatment** includes an annual dental check up, simple fillings related to cavities or decay and root canal treatment.

1.55 **Routine maternity** refers to any medically necessary costs incurred during pregnancy and childbirth, including hospital charges, specialist fees, the mother's pre- and post-natal care, midwife fees as well as newborn care. Costs related to complications of pregnancy and childbirth are not payable under routine maternity.

1.56 **Routine health checks** are tests/screenings that are undertaken without any clinical symptoms being present. Such tests include the following examinations performed, at an appropriate age interval, for the early detection of illness or disease:

- Vital signs (blood pressure, cholesterol, pulse, respiration, temperature etc.)
- Cardiovascular exam
- Neurological exam
- Cancer screening
- Well child test (for children up to the age of 6 years, up to a maximum of 15 visits per lifetime)

1.57 **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, including but not limited to neurology, paediatrics, endocrinology, obstetrics, gynaecology and dermatology.

1.58 **Specialist fees** refers to non-surgical treatment performed or administered by a specialist.

1.59 **Surgical appliances and prostheses** refers to artificial body parts or devices, which are an integral part of a surgical procedure or part of any medically necessary treatment following surgery.

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

1.61 **Treatment** refers to a medical procedure needed to

cure or relieve illness or injury.

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

1.63 **Waiting period** is a period of time commencing on your policy start date, during which you and your dependants are not entitled to cover for a particular benefit. If a waiting period applies to a benefit, it will be indicated accordingly on the Table of Benefits. The waiting period also applies to any extended cover.

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

1.65 **You/Your** s the eligible individual mentioned in the Insurance Certificate.

Additional Policy Terms.

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

1. **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) Treatments and procedures are only covered if they have a palliative, curative and/or diagnostic purpose, are medically necessary, appropriate, performed by a licensed physician, dentist or therapist. Claims/costs will be paid/reimbursed if the medical diagnosis or/and prescribed treatment are in accordance with generally accepted medical procedures. Costs resulting from the insured member knowingly acting against medical advice will not be paid/reimbursed.

   c) Claims will be settled if we deem the charges in the invoices and receipts to be fair and reasonable, and at the level customarily charged in the specific country and for the treatment provided. If a claim is deemed by us to be inappropriate we reserve the right to reduce the amount reimbursed by us.

   d) Where adequately screened blood is not available locally, we will, where appropriate, endeavour to locate and transport screened blood and sterile transfusion equipment where this is advised by the treating physician. We will also endeavour to do this when our own medical experts so advise. Allianz Worldwide Care and its agents accept no liability in the event that such endeavours are unsuccessful or in the event that contaminated blood or equipment is used by the treating authority.

2. **Liability:** Our liability to you 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 schemes and any other insurance, exceed the amount of the invoice.

3. **Third Party Liability:** If you or any of your dependants are eligible to claim benefits under a public scheme or any other insurance policy, pertaining 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 a claim from a 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 cancel the policy.

We have full rights of subrogation and may institute proceedings in your name, but at our expense, to recover, for our benefit, the amount of any payment made under another policy.

4. **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.

5. **Arbitration:** The policy shall be construed in accordance with Irish law, unless agreed otherwise between you and us or required under mandatory legal regulations.

   Any differences in respect of medical opinion in connection with the results of an accident or medical condition will be settled between two medical experts appointed by you and us in writing. Any difference of opinion between the two medical experts shall be referred to an umpire who shall have been appointed in writing at the outset by the two medical experts. The umpire shall act as an expert and the opinion of the umpire will be final and conclusive except in the case of manifest error or the value is in excess of Euro 150,000. All disputes where the value is in excess of Euro 150,000 shall be finally settled under the Rules of Arbitration of the International Chamber of Commerce by one or more arbitrators appointed in accordance with the said Rules.

6. **Data Protection:** The confidentiality of patient and member information is of paramount concern to Allianz Worldwide Care. Allianz Worldwide Care fully complies with European Data Protection Legislation and International Medical Confidentiality Guidelines. You have a right to access the personal data that is held about you. You also have the right to request that we amend or delete any information, which you believe is inaccurate or out of date.

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

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