



Healthcare Plans

Individual Benefit Guide

Valid from 1st November 2010

Allianz 
Allianz Worldwide Care

Welcome to Allianz Worldwide Care

This guide describes in detail how we offer you access to the care you need, when you need it most. It sets out the standard benefits and rules of your Allianz Worldwide Care policy. Please read this Individual Benefit Guide in conjunction with your Insurance Certificate and Table of Benefits to ensure that you fully understand your level of cover.

Thank you for selecting Allianz Worldwide Care as your preferred health insurer. It is strongly advised that you read all documentation in relation to your chosen plan, to ensure you are fully satisfied with the selection of cover that you have made.

You and your family can depend on Allianz Worldwide Care, as your health insurer, to give you access to the best care possible. As specialists in health insurance, we can provide you with a service that is fast, flexible and totally reliable.

Allianz Worldwide Care Limited, part of the Allianz Group, is registered in Ireland and regulated by the Irish Financial Regulator. 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 or have queries regarding your cover, please do not hesitate to contact us. Please see page 6 for a 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, the Table of Benefits and any policy endorsements.
- Information provided to Allianz Worldwide Care in the signed Application Form, submitted Online Application Form or the Health Declaration Form (hereafter referred to collectively as the 'relevant application form') or other supporting medical information, by, or on behalf of, the insured persons.

To ensure that you understand the details of your insurance policy, please read this document carefully in conjunction with your Table of Benefits and your Insurance Certificate. Your policy documentation 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.

The plan(s) you have chosen will be indicated in your Insurance Certificate and in your Table of Benefits, which both form part of your Membership Pack. Any further endorsements or special conditions unique to your cover will be indicated in the Insurance Certificate (and will have been detailed in a Special Conditions Form issued prior to the inception of your policy).

Please note that **pre-approval, using Treatment Guarantee, is required for all in-patient benefits, and may be required for other benefits.** If Treatment Guarantee is not obtained 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 64 to 67.

Member services

Please find details of all our member services below.

Helpline Service

Allianz Worldwide Care's in-house team of professional, multilingual staff are available 24 hours a day, 7 days a week to handle your policy enquiries. Our Helpline staff has 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 or an update on the status of your claim. You can contact us by email, phone or fax as follows:

Helpline

Email: client.services@allianzworldwidecare.com

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

Portuguese: + 353 1 645 4040

Fax: + 353 1 630 1306

Calls to our Helpline will be recorded and may be monitored for training, quality and regulatory purposes.

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

www.allianzworldwidecare.com/toll-free-numbers

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

Emergency Assistance Service

If you require emergency medical treatment in a hospital or clinic you should, where possible, contact our Helpline as soon as possible. Our emergency assistance service is available 24 hours a day, 365 days a year, to provide you with a range of services e.g. organising an emergency medical evacuation.

For emergency cases, Treatment Guarantee is not required *in advance* of in-patient treatment, however, we must be advised within **48 hours** of the event and at that point our Helpline can take Treatment Guarantee details over the telephone. This will give us the opportunity to arrange the direct settlement of your hospital bills, where possible, and will ensure that your claim can be processed without any delays.

MediLine Medical Advice Service

This service, provided by an experienced English speaking medical team, provides information and advice on a wide range of topics including, but not limited to, blood pressure and weight management, infectious diseases, first aid, dental care, vaccinations, oncology, disability, speech, fertility, paediatrics, mental health and general health. You can access this medical advice service 24 hours a day, 365 days a year on Tel: **+ 44 (0) 208 416 3929.**

Please be advised that **for policy or claims queries you should contact the Allianz Worldwide Care Helpline directly.**

Please note that the MediLine and its health-related information and resources are not intended to be a substitute for professional medical advice or for the care that patients receive from their doctors. It is not intended to be used for medical diagnosis or treatment and information should not be relied upon for that purpose. Always seek the advice of your doctor before beginning any new treatment or if you have any questions regarding a medical condition. You understand and agree that 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, quality and regulatory purposes.

Membership Pack

Once you and Allianz Worldwide Care have signed an insurance contract guaranteeing health insurance cover for you and your dependants (if applicable), a full Membership Pack will be provided. The Membership Pack contains the following items:

- **Your personalised Membership Card**
We supply a personalised Membership Card to every member, which contains our essential contact numbers and addresses. We suggest that you keep this card with you at all times. If you lose the card, or if a correction is required (e.g. the spelling of a name), don't worry, simply contact our Helpline via email or telephone 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 (if applicable). It states the start date and renewal date of your cover (and effective dates of when dependants were added) as well as any endorsements or special conditions unique to 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 Table of Benefits**

Your Table of Benefits will outline the cover available to you under your chosen plan as well as specify which benefits require pre-approval using the Treatment Guarantee Form. It is important that you read your

Table of Benefits in conjunction with this guide and your Insurance Certificate to ensure that you fully understand your cover.

- **Your Individual Benefit Guide**

This guide sets out the benefits and rules of your healthcare policy. The Individual Benefit Guide should be read in conjunction with your Insurance Certificate and Table of Benefits.

- **A Treatment Guarantee Form**

A Treatment Guarantee Form needs to be submitted for approval prior to any treatments listed on page 65 of this guide and marked with a 1 or a 2 in your Table of Benefits. Please note that the Treatment Guarantee Form is available on our website.

- **A Claim Form**

Fully completed Claim Forms are processed and payment instructions issued to your bank within 48 hours. Where further information is required to complete the claim, you/your medical practitioner will be notified by email or mail within 48 hours of receipt of the Claim Form. Emails are automatically sent to you (where email addresses are provided to us) to advise you of when a claim has been received and when it has been processed. Please note that the Claim Form is available on our website.

- **Your Online Services username and password**

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

Online Services

You can access our secure Online Services through our website:

www.allianzworldwidecare.com

Simply use the login details sent to you in a letter included as part of your Membership Pack.

Alternatively, if you have not already received your login details, you can access your online account by clicking the “register” button on the

login screen. Please type in your policy number, surname and date of birth, exactly as shown on your Membership Pack documents. An automated email containing your login details will then be sent to the email address we have on record for you (if this has been provided to us).

Online Services allows you to:

- View and amend your personal details online.
- Securely retrieve a lost or forgotten username and password.
- Download your Insurance Certificate and Individual Benefit Guide. A Membership eCard can also be downloaded in PDF format for members who joined us from 2007 onwards.

- View your Table of Benefits and check how much remains payable under each benefit limit.
- Confirm the status of any claims submitted to us and view claims related correspondence.
- Pay your full premium online.
- View a statement of your premium transactions and details of any outstanding premiums.
- Update your credit card details, if required.

For Online Services assistance, please contact our Helpline.

Hospital, Doctor and Health Practitioner Finder

Our Medical Provider directory is available on the Allianz Worldwide Care website: www.allianzworldwidecare.com. This online directory allows you to search for hospitals, clinics, doctors and specialists on a country by country basis, with the ability to narrow down the search to specific regions and cities. Users can also search under Medical Practitioner categories e.g. Internal Medicine, as well as on specialism, e.g. General Surgery, Neurosurgery or Traumatology etc. **You are not restricted to using the providers listed in this directory.**

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, policy exclusions and limitations and any special conditions indicated in the Insurance Certificate (and in the Special Conditions Form issued prior to the inception of your policy). If you have any queries regarding the cover provided under your plan, simply contact our Helpline for confirmation of your entitlements.

Benefit limits

There are two kinds of benefit limits shown in the Table of Benefits. The **maximum plan benefit**, which applies to certain plans, is the maximum we will pay for all benefits in total, per member, per Insurance Year, under that particular plan. Some benefits also have a **specific benefit limit**

for example “Nursing at home or in a convalescent home”. Specific benefit limits may be provided on a “per Insurance Year” basis, a “per lifetime” basis or on a “per event” basis, such as per trip, per visit or per pregnancy. In some instances we will pay a percentage of the costs for the specific benefit e.g. “65% refund, up to £3,650/€5,000/US\$7,100/CHF 7,500”. Where a specific benefit limit applies or where the term “Full refund” appears next to certain benefits, the refund is subject to the maximum plan benefit, if one applies to your plan(s).

Medical necessity

As an insurance company, our clients expect us to control medical costs, where possible, in order to maintain affordable health insurance premiums. To do this, our team of highly

experienced medical professionals ensures 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. If a claim is deemed by us to be inappropriate, we reserve the right to reduce the amount payable by us.

Chronic conditions

A 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.

Chronic conditions (including pre-existing chronic conditions) may or may not be covered within the limits of your plan(s). Please refer to

the “Notes” section of your Table of Benefits to confirm if chronic conditions are covered within the limits of your plan(s).

Pre-existing conditions

Pre-existing conditions are medical conditions or any related conditions for which one or more symptoms have been shown at some point during the five 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 could reasonably have been assumed to have known, will be deemed to be pre-existing.

Pre-existing conditions may or may not be covered within your plan(s). Please refer to the

“Notes” section of your Table of Benefits to confirm if pre-existing conditions are covered within the limits of your plan(s). Please note that pre-existing conditions which have not been declared by you on the relevant application form are not covered. In addition, conditions arising between completing the relevant application form and confirmation of acceptance by our Underwriting Team will equally be deemed to be pre-existing.

Waiting period

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

periods. Please note that if plan or region of cover upgrades are requested and agreed to at policy renewal, waiting periods may apply.

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, and if so, the amount you have to pay will be capped at the amount stated in your Table of Benefits.

Please refer to your Table of Benefits to determine if any co-payments or deductibles apply to benefits within your chosen plan(s).

This may apply to the Core, Out-patient or Dental Plans.

Where you are covered

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

Your Core Plan explained

The following section gives a summary of the range of benefits which we offer. Please note that those available to you will be listed in your Table of Benefits.

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. In-patient benefits include things like hospital accommodation, anaesthesia and theatre charges, surgical fees, surgical appliances, prostheses and diagnostic tests. Please refer to your Table of Benefits for details of the in-patient benefits available to you. Treatment Guarantee is required in advance of all in-patient benefits listed in your Table of Benefits.

In-patient psychiatry and psychotherapy

If cover for psychiatry and psychotherapy is included in your plan, this is provided up to the amount specified in your Table of Benefits on an in-patient basis only, unless otherwise specified. A waiting period may apply to this benefit.

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

If this benefit is included under your Core Plan, in the event of an insured child requiring hospitalisation, we will cover the cost of one parent's accommodation staying with the child for the duration of the admission to hospital, up to the amount specified in your Table of Benefits. In the event that no suitable bed is available in the hospital, we will cover the equivalent of a three star hotel daily room rate. Please check your Table of Benefits to confirm whether an age limit applies with regard to your child.

Emergency in-patient dental treatment

If applicable to your Core Plan, this benefit provides you with a refund for emergency dental treatment due to a serious accident requiring hospitalisation, up to the amount stated in your Table of Benefits. Please note that cover under this benefit does not extend to follow-up dental treatment, dental surgery, dental prostheses, orthodontics or periodontics. If cover is provided for these benefits, they will be listed separately in your Table of Benefits.

Other benefits under your Core Plan

Some or all of the following benefits are included in your chosen plan. Please note that

those available to you will be listed in your Table of Benefits.

Day-care treatment

If this benefit is provided under your Core Plan, you will be covered for planned day-care treatment received in a hospital or day-care facility up to the amount specified in your Table of Benefits. Please note that Treatment Guarantee is required.

Out-patient surgery

If this benefit is included in your Core Plan, you are covered for surgical procedures performed in a surgery, hospital, day-care facility or out-patient department up to the amount specified

in your Table of Benefits. Please note that Treatment Guarantee is required.

Nursing at home or in a convalescent home

Where applicable to your Core Plan, 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, up to the amount indicated in your Table of Benefits. Please note that Treatment Guarantee is required. It should also be noted that this benefit is not payable in respect of palliative care or long term care, which, where provided, is covered under a separate benefit.

Rehabilitation treatment

If cover is provided under your plan, this is for treatment which takes place in a licensed rehabilitation facility, immediately after the acute medical treatment ceases. The level of cover provided will be stated in your Table of Benefits. Please note that Treatment Guarantee is required.

Local ambulance

If applicable to your Core Plan, cover is provided for ambulance transport, required for an emergency or due to medical necessity, to the nearest available and appropriate hospital or licensed medical facility, up to the amount specified in your Table of Benefits.

Maternity/paternity cash benefit (Channel Islands Plan only)

If this benefit is provided under your plan, an amount will be paid to each parent insured with Allianz Worldwide Care, following the birth of a child dependant. This benefit is only payable where treatment is received free of charge. The amount payable will be indicated in your Table of Benefits.

To claim the maternity/paternity cash benefit, you need to send us a copy of the baby's birth certificate within three months of the birth.

To be eligible for this benefit, the mother/father must be covered under our Healthcare Plan for the Channel Islands for a minimum of 10 continuous months before the baby is born.

Emergency treatment outside area of cover

Where applicable, you and your dependants will be covered for emergencies only, which occur during business and holiday trips outside of your chosen area of cover (where relevant). Cover is provided for a maximum period of six weeks per trip up to the benefit amount stated in your Table of Benefits.

You will not be covered for any curative or follow-up non-emergency treatment, even if deemed unable to travel to a country within your geographical area of cover. If you are moving outside your area of cover for more than six weeks, please 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 which results in a medical condition that presents an immediate threat to your health. To be considered as emergency treatment, and thus covered under this benefit, please remember that the medical treatment provided by a physician, medical practitioner or specialist should commence within 24 hours of the emergency event.

Charges relating to maternity, pregnancy, childbirth or any complications of pregnancy or childbirth are excluded from this benefit.

Medical evacuation

This provides for ambulance, helicopter or aeroplane transportation to the nearest appropriate medical centre (which may or may

not be located in your home country), 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. If this benefit is included in your Core Plan, you will be covered up to the amount stated in your Table of Benefits.

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 is 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 seven days, comprising of a private room with en-suite facilities. We do not cover costs for hotel suites, four or five star hotel accommodation or hotel accommodation for an accompanying person.

Where an insured member has been evacuated to the nearest appropriate medical centre 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 appropriate medical centre 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

If covered under your Core Plan, this benefit 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. We will cover the expenses up to the benefit amount stated in your Table of Benefits. Please note that accommodation and other related expenses are not covered. Please also note that Treatment Guarantee is required.

Repatriation of mortal remains

Where covered, in the event of a death we will provide a maximum benefit as indicated in the Table of Benefits, to cover the cost of transportation of the insured person's mortal remains from the principal country of residence to the country of burial.

Covered expenses include, but are not limited to, expenses for embalming, a container legally appropriate for transportation, shipping costs

and the necessary government authorisations. Cremation costs will only be covered in the event that this is required for legal purposes. Costs incurred by any accompanying persons are not covered. All covered expenses in connection with the repatriation of mortal remains must be pre-approved by us, i.e. Treatment Guarantee is required.

CT, MRI, PET and CT-PET scans

CT, MRI, PET and CT-PET scans carried out on an in-patient or out-patient basis may be covered within the limits of your Core Plan (please refer to your Table of Benefits). Treatment Guarantee is not needed for CT scans; however, it is required for MRI, PET and CT-PET scans.

Oncology

If included in your Core Plan, you will be covered 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, up to the amount specified in your Table of Benefits. Treatment Guarantee is required for in-patient and day-care treatment only.

Routine maternity

Where covered, routine maternity refers to medically necessary costs incurred during pregnancy and childbirth, including hospital charges, specialist fees, the mother's pre- and post-natal care, midwife fees (during labour

only) as well as newborn care. Any non-medically necessary caesarean sections will be covered up to the cost of a routine delivery in the same hospital, subject to any benefit limit in place. Costs related to complications of pregnancy or complications of childbirth are not payable under routine maternity.

If you are covered for routine maternity, this will be stated in your Table of Benefits along with any benefit limit and/or waiting period which applies. Benefit limits for routine maternity are payable on either a "per pregnancy" or "per Insurance Year" basis (this will also be confirmed in your Table of Benefits).

For routine maternity, please note that Treatment Guarantee is required for in-patient treatment only.

Complications of pregnancy

Where covered, and in relation to the health of the mother, complications of pregnancy refer only to the following conditions that arise during the pre-natal stages of pregnancy: ectopic pregnancy, gestational diabetes, pre-eclampsia, miscarriage, threatened miscarriage, stillbirth and hydatidiform mole.

Please refer to your Table of Benefits to check if you are covered for this benefit and to confirm whether limits or waiting periods apply. Please note that Treatment Guarantee is required for in-patient treatment only.

Complications of childbirth

Complications of childbirth refer only to the following conditions that arise during childbirth that require a recognised obstetric procedure: post-partum haemorrhage and retained placental membrane. Where covered, complications of childbirth will be listed in your Table of Benefits.

Complications of childbirth are only payable where your cover also include a routine maternity benefit. Please note that complications of childbirth includes medically necessary caesarean sections. Please refer to your Table of Benefits to check if you are covered for this benefit and if so, whether a benefit limit and/or waiting period applies. Treatment Guarantee is required for in-patient treatment only.

Home delivery

If applicable to your plan, a lump sum will be paid in the event of a home delivery, as specified in your Table of Benefits.

Cover for newborn children

Newborn infants (with the exception of multiple birth babies) will be accepted for cover from birth without the need for medical underwriting, provided that we are notified within four weeks of the date of birth and that the birth mother has been insured with us for a minimum of six continuous months. Notification of the birth after four weeks will result in newborn children being underwritten and cover will only commence from the date of acceptance. In order to notify us of your

intention to have your newborn child included on your policy, a request should be made in writing and sent by email to our Underwriting Team at:
underwriting@allianzworldwidecare.com.

In-patient treatment for multiple birth babies born as a result of medically assisted reproduction will be covered up to £22,000/€30,000/US\$42,500/CHF 45,000 per child for the first three months following birth. Out-patient treatment will be covered under the limits of the Out-patient Plan.

Please note that all multiple birth babies will be subject to full medical underwriting.

Laser eye treatment

Where covered, laser eye treatment refers to the surgical improvement of the refractive quality of the cornea using laser technology, including necessary pre-operative investigations. Please refer to your Table of Benefits to check if you are covered for laser eye treatment. Where applicable, cover will be provided within the limit specified in your Table of Benefits, on a once per lifetime basis.

In-patient cash benefit

If this benefit appears in your Table of Benefits, a specified amount will be paid to you for each night you spend in hospital, up to a maximum number of nights per Insurance Year. This 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 healthcare plan. The amount payable per night and the maximum number of nights will be indicated in your Table of Benefits.

Travel costs (Channel Islands Plan only)

If you need private hospital day-care, post-operative out-patient consultations or in-patient treatment for which you are covered under your plan and your doctor has confirmed to us in writing that it is medically necessary for you to travel to another Channel Island, to the UK or to France to receive such treatment, we will pay up to the amount specified in your Table of Benefits for each return journey. We

will only pay for the following travel costs under this benefit:

- Standard rate air fares from one Channel Island to another Channel Island, to the UK or to France.
- Standard rate train, underground and bus fares.
- A maximum of £22/€30 per taxi trip.

We also pay travel costs for one parent to accompany a child under 18, up to the amount specified in your Table of Benefits.

If medically necessary, we may also pay a contribution of up to £110/€150 per trip towards the cost of nursing care required during the journey.

Treatment Guarantee is required. You will also need to obtain written confirmation from the Department of Health that you are not entitled to a travelling allowance grant in respect of travel and escort costs.

Emergency out-patient treatment

This includes cover for treatment received in a casualty ward or emergency room, following an accident or sudden illness. To be considered an emergency, the treatment must be received within 24 hours of the emergency event. If you are covered for this benefit, it will be indicated in your Table of Benefits along with the benefit limit.

Please note that if you have also selected an Out-patient Plan, you will be covered under the

terms of this plan for out-patient treatment in excess of the emergency cover benefit limit.

Emergency out-patient dental treatment

If provided within your plan, this includes treatment received in a dental surgery or hospital emergency room for the immediate relief of dental pain. Cover includes 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. Please note that cover does not extend to dental prostheses or root canal treatment.

Cover for emergency dental treatment is limited to the amount stated in your Table of Benefits. However, if you have also selected a Dental Plan,

you will be covered under the terms of this plan for dental treatment in excess of the emergency cover benefit limit.

Palliative care and long term care

If this benefit is included in your Core Plan, we will cover the costs of ongoing treatment aimed at alleviating the physical/psychological suffering associated with progressive, incurable illness and maintaining quality of life. Please note that cover is limited to the benefit limit stated in your Table of Benefits and that Treatment Guarantee is required for long term care as well as for palliative care.

Accidental death

If this benefit is included in your Core Plan, a lump sum will be payable in the event of the accidental death of any adult members aged 18 to 70. The Table of Benefits will state the amount of the lump sum. Insured members wishing to nominate a beneficiary other than those listed in the 'Claims for accidental death' section of this guide (pages 63 to 64) may do so by contacting our Helpline.

Your Out-patient Plan explained

We offer a range of Out-patient Plans, each offering different levels of reimbursements, deductibles and co-payments. Your **Out-patient Plan**, if one has been selected, includes some or all of the following benefits:

- Medical practitioner fees.
- Prescription drugs.
- Specialist fees.
- Diagnostic tests.
- Vaccinations.
- Chiropractic treatment, osteopathy, homeopathy, Chinese herbal medicine and acupuncture.
- Prescribed physiotherapy, speech therapy, oculomotor therapy and occupational therapy.
- Routine health checks including cancer screening.
- Infertility treatment.
- Psychiatry and psychotherapy.
- Prescribed medical aids.
- Prescribed glasses and contact lenses.

Please refer to your Table of Benefits to confirm the Out-patient Plan benefits available to you.

Please note that Treatment Guarantee is required for occupational therapy (out-patient treatment only). A waiting period may also apply to certain benefits

Infertility treatment

You are covered for non-invasive investigations into the cause of infertility within the limits of your Out-patient Plan (please note that this does **not** apply to members of the **Channel Islands Plan**, for whom investigation into infertility is **excluded**).

Should your Table of Benefits include a specific benefit for infertility treatment, you will also be covered for further investigation necessary to establish the cause of infertility, such as hysterosalpingogram, laparoscopy or

hysteroscopy. If a benefit limit and/or waiting period applies, it will be indicated in your Table of Benefits.

However, please note that medically assisted reproduction or any adverse consequence thereof is not covered by us, unless you have a specific benefit for infertility treatment. In addition, in-patient treatment for multiple birth babies born as a result of medically assisted reproduction will only be covered up to £22,000/€30,000/US\$42,500/CHF 45,000 per child for the first three months following birth. Out-patient treatment will be covered under the limits of the Out-patient Plan.

Please note that all multiple birth babies will be subject to full medical underwriting.

Your Dental Plan explained

If you have selected a Dental Plan or have been provided with a dental benefit, this will be indicated in your Table of Benefits along with the level of refund and any waiting periods which apply. Please note that your Dental Plan may contain a maximum plan benefit.

Your Repatriation Plan explained

This is an optional plan and where covered this will be indicated in your Table of Benefits.

If 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 appropriate medical centre. This only applies when your home country is located within your geographical area of cover.

Following completion of treatment, we will also cover the cost of the return trip, at economy rates, to your principal country of residence as long as the return journey is made within one month of completion of treatment. Please note that 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.

a) The following standard conditions, exclusions and limitations apply to [all our plans](#), unless stated otherwise:

(For members of the Channel Island Plan, this exclusion extends to include the period of pregnancy.)

1. Treatment **outside the geographical area of cover**, unless for emergencies or authorised by us.
2. Products classified as **vitamins** or **minerals** (except during pregnancy or to treat diagnosed, clinically significant vitamin deficiency syndromes), nutritional or dietary consultations and supplements, including, but not limited to, special infant formula and cosmetic products, even if medically recommended or prescribed or acknowledged as having therapeutic effects.
3. Products that can be purchased without a **doctor's prescription**.
4. Any treatment carried out by a **plastic surgeon**, whether or not for medical/psychological purposes. The only exception is reconstructive surgery necessary to restore function or appearance after a disfiguring accident, or as a result of surgery for cancer, if the accident or surgery occurs during your membership.

5. Stays in a **cure centre, bath centre, spa, health resort and recovery centre**, even if the stay is medically prescribed.
6. Treatment directly related to **surrogacy**, whether you are acting as a surrogate, or are the intended parent.
7. The **accidental death benefit*** lump sum payment will not be made in circumstances where the death of an insured member has been caused either directly or indirectly by:
 - Accidents which happen while the insured member is engaged in aviation activities of any description, including entering and alighting from aircraft, other than as a fare paying passenger in a standard multi-engine aircraft operated by a recognised airline or air charter company.
 - Taking part in speed or duration tests or races of any kind.
 - Taking part in motor sports of any kind, including boating, in any boat designed to travel at a speed in excess of 30 knots.
 - Mountaineering including caving and potholing which requires the use of ropes or guides.
 - White water rafting and canoeing, scuba diving and yachting or boating outside coastal waters (12 miles or more from the coast).

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

8. Care and/or treatment of **intentionally caused diseases** or **self-inflicted injuries**, including a suicide attempt.
9. Care and/or treatment of **drug addiction** or **alcoholism**.
10. Illnesses, accidents and the consequences thereof, as well as instances of death that are related to the misuse of **alcohol** or **drugs** by the insured person.
11. **Developmental delay**, unless a child has not attained developmental milestones expected for a child of that age, in cognitive or physical development. We do not cover conditions in which a child is slightly or temporarily lagging in development. The developmental delay must have been quantitatively measured by qualified personnel and documented as a 12 month delay in cognitive and/or physical development.
12. We do not cover treatment for conditions such as **conduct disorder, attention deficit hyperactivity disorder, autism spectrum disorder, oppositional defiant disorder, antisocial behaviour, obsessive-compulsive disorder, attachment disorders, adjustment disorders, eating disorders** or treatments that encourage positive social-emotional relationships, such as **communication therapies, floor time** and **family therapy**.
13. **Psychotherapy treatment**, on an in-patient or out-patient basis, is only covered where you or your dependants are initially diagnosed

- by a psychiatrist and referred to a clinical psychologist for further treatment.
14. Where covered, **out-patient psychotherapy treatment** is initially restricted to 10 sessions per condition, after which treatment must be reviewed by the referring psychiatrist. Should further sessions be required, a progress report must be submitted to us, which indicates the medical necessity for any further treatment. Costs in respect of a family therapist or counsellor are not covered.
15. Treatment for any illnesses, diseases or injuries resulting from **active participation in war, riots, civil disturbances, terrorism, criminal acts or acts against any foreign hostility**, whether war has been declared or not.
16. Treatment for any medical conditions arising directly or indirectly from **chemical contamination, radioactivity or any nuclear material** whatsoever, including the combustion of nuclear fuel.
17. Investigations into, or treatment of, **sleep disorders**, including insomnia.
18. Expenses for the **acquisition of an organ** including, but not limited to, donor search, typing, harvesting, transport and administration costs.
19. Treatment or diagnostic procedures of **injuries arising from an engagement in professional sports**.
20. Any form of **treatment or drug therapy** which in our reasonable opinion is **experimental** or

- unproven based on generally accepted medical practice.
21. **Orthomolecular treatment** (please refer to definition 1.47).
 22. **Consultations** performed, as well as any **drugs** or **treatments prescribed**, by you, your spouse, parents or children.
 23. **Medical practitioner fees** for the completion of a **Claim Form** or other administration charges.
 24. **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.
 25. Investigations into, and treatment of, **obesity**.
 26. Investigations into, and treatment of, **loss of hair** and any **hair replacement** unless the loss of hair is due to cancer treatment.
 27. **Complementary treatment**, with the exception of those treatments indicated in the Table of Benefits.
 28. Treatment required as a result of **failure to seek or follow medical advice**.
 29. Treatment required as a **result of medical error**.
 30. **Sex change operations** and related treatments.

- 31. Treatment in the USA** is not covered if we know or suspect that cover was purchased for the purpose of travelling to the USA to receive treatment for a condition, when the symptoms of the condition were apparent to the member prior to the purchase of cover.
- 32.** Expenses incurred because of **complications directly caused by an illness, injury or treatment for which cover is excluded or limited** under your plan.
- 33a.** Unless the Table of Benefits includes a specific benefit for **infertility treatment**, cover is limited to **non-invasive investigations into the cause of infertility**, within the limits of your Out-patient Plan (this applies to **International Healthcare Plans only**).
- 33b.** Unless stated otherwise in the Table of Benefits, cover is not provided for investigations into, treatment and complications arising from **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. (This exclusion extends to include **infertility** within the **Channel Islands Plan**).
- 34. Termination of pregnancy**, except in the event of danger to the life of the pregnant woman.

35. In-patient treatment for **multiple birth babies born as a result of medically assisted reproduction** is limited to £22,000/€30,000/US\$42,500/CHF 45,000 per child for the first three months following birth. Out-patient treatment will be covered under the limits of the Out-patient Plan.
36. **Genetic testing**, except for DNA tests when directly linked to an eligible amniocentesis, i.e. in the case of women aged 35 or over.
37. Pre- and post-natal classes.
38. **Triple/Bart's, Quadruple or Spina Bifida tests**, except for women aged 35 or over.
39. The following treatments, medical conditions or procedures, or any adverse consequences thereof, are **not covered**, unless otherwise indicated in your Table of Benefits:
- 39.1 **Dental treatment, dental surgery, periodontics, orthodontics and dental prostheses** with the exception of **oral surgical procedures**, which are covered within the overall limit of your Core Plan.
 - 39.2 **Out-patient treatment.**
 - 39.3 **Emergency dental treatment.**
 - 39.4 **Routine maternity and complications of childbirth.**
 - 39.5 **Complications of pregnancy.**
 - 39.6 **Home delivery.**
 - 39.7 **Prescribed glasses and contact lenses.**
 - 39.8 **Prescribed medical aids.**
 - 39.9 **Vaccinations.**
 - 39.10 **Preventive treatment.**
 - 39.11 **Routine health checks including cancer screening.**

- 39.12 In-patient psychiatry and psychotherapy treatment.
- 39.13 Out-patient psychiatry and psychotherapy treatment.
- 39.14 Infertility treatment.
- 39.15 Rehabilitation treatment.
- 39.16 Medical repatriation.
- 39.17 Expenses for one person accompanying an evacuated/repatriated person.
- 39.18 Laser eye treatment.
- 39.19 Organ transplant.

b1) The following additional conditions, exclusions and limitations apply to [all plans](#), with the [exception of the Channel Islands Plan](#) (which has its own set of additional exclusions under point b2 on the following page):

- 40. Pre-existing conditions (including any pre-existing chronic conditions) are covered under this policy, unless indicated otherwise in a Special Conditions Form that issues prior to policy inception, if relevant. Please note that any **pre-existing conditions that were not declared by you on the relevant application form will not be covered under the policy.**

Conditions arising between completing the relevant application form and confirmation of acceptance by our Underwriting Team will equally be deemed to be pre-existing, and if not declared, will not be covered.

- 41. 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.

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

b2) The following additional conditions, exclusions and limitations apply [solely to our Channel Islands Plan](#):

40. Pre-existing conditions.

41. Chronic conditions are not covered within the terms of this policy.

However, we do cover short term treatment of **acute episodes of a chronic condition**, the aim of which is to return you to the state of health you were in immediately before suffering the episode, or which leads you to full recovery. We strongly advise you to contact our Helpline to establish the extent of your cover in your particular circumstances before incurring any treatment costs.

42. Prescription drugs and dressings, unless prescribed for use whilst an in-patient or day-patient.

43. Human Immuno-deficiency Virus infection, AIDS or any associated psychiatric condition.
44. Dental surgery, dental prostheses, periodontics and orthodontic treatment, with the exception of dental treatment as per our definition.
45. Organ transplant.
46. Travel costs to another Channel Island, the UK and France for hospital in-patient or day-care treatment will not be reimbursed if the proposed treatment or any alternative treatment is available locally. However, please note that medical costs incurred will be refunded within the terms of your policy.
47. Travel costs related to out-patient consultations are not covered, except for post-operative consultations that cannot be carried out locally by a consultant.
48. Travel benefit is not available:
- When costs are covered by the Department of Health.
 - When the treatment is not covered under your plan.
 - When travelling has not been recommended by your consultant.
 - For a parent to accompany a child who is 18 years of age or older.
 - For incidental costs of travel, for example hotel accommodation or meals.

- When we have not agreed to all costs of travel prior to journey.
- Any of the travel costs where the costs were above normal standard fares.

49. The following benefits are **not included** in your Channel Islands Plan:

- 49.1 Speech therapy.
- 49.2 Oculomotor therapy.
- 49.3 Podiatry.
- 49.4 Medical evacuation or repatriation.
- 49.5 Repatriation of mortal remains.
- 49.6 Repairs to spectacles.

Paying premiums and general information

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

Paying premiums

Premiums for each Insurance Year are based on each member's age on the first day of the Insurance Year, their area of cover, the policyholder's country of residence, the premium rates 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 payable immediately after our acceptance of your application.

Subsequent premiums are due on the first day of the chosen payment period. You may choose

between monthly, quarterly, half yearly or annual payments depending on the payment method you choose. Please note that if there is any difference between the agreed quotation and your Payment Details letter/invoice, you should contact us immediately. We are not responsible for payments made through third parties.

Your premium should be paid in the currency you 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, via written instructions, which must be received by us a minimum of 30 days prior to the renewal date. Failure to pay an initial premium or subsequent premium on time may result in loss of insurance cover.

If the **initial premium** is not paid in time, we are entitled to withdraw from the contract for as

long as the payment remains outstanding. The insurance contract is deemed to be null and void unless we assert a claim to the premium in court within three months of the commencement date, the policy start date or the conclusion of the insurance contract.

If a **subsequent premium** is not paid in time, we may, in writing and at the policyholder's expense, set a time limit of not less than two weeks for the policyholder to pay the amount due. Thereafter, we may terminate the contract in writing with immediate effect and shall thereby be exempt to pay benefits.

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

The **premium** will be adjusted once a year 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 relating to your membership that may be imposed after you join and 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 letter/invoice.

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 we will treat the changes as not having been made, if you end your membership within 30 days of the date on which the changes take effect, or within 30 days of us telling you about the changes, whichever is later.

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 start date on the Insurance Certificate. The cover will continue for 12 months and is strictly conditional upon our acceptance of the application, 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 due.

When cover starts and ends for dependants included in your membership

If any other person is included as a dependant under your membership, their membership will start on the effective date as shown on your most recent Insurance Certificate which lists them as a dependant. Their membership will continue for as long as you remain the policyholder (and as

long as any child dependants remain under the defined age limit). If your membership ceases, your dependant's cover will also end; however, the dependants on the Insurance Certificate can apply for cover in their own right should they wish to do so and if they meet the minimum age requirements. Cover will also cease for any dependants who exceed the defined age limit for a dependant; however they can also apply for cover in their own right, should they wish to do so.

Adding dependants

You may apply to include any of your family members under your membership as one of your dependants, providing you complete the relevant application form.

Newborn infants (with the exception of multiple birth babies) will be accepted for cover from

birth without medical underwriting, provided that we are notified within four weeks of the date of birth and that the mother has been insured with us for six continuous months. Notification of the birth after four weeks will result in newborn children being underwritten and cover will only commence from the date of acceptance. In order to notify us of your intention to have your newborn child included on your policy, a request should be made in writing and sent by email to our Underwriting Team at underwriting@allianzworldwidecare.com

In-patient treatment for multiple birth babies born as a result of medically assisted reproduction will be covered up to £22,000/€30,000/US\$42,500/CHF 45,000 per child for the first three months following birth. Out-patient treatment will be covered under the limits of the Out-patient Plan.

Please note that all multiple birth babies will be subject to full medical underwriting.

Changing country of residence

It is important that you advise us when you change country of residence.

If 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 local health insurance regulations, 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.

If you become permanently resident in the United States please note that we cannot provide

cover as our plans do not comply with local US laws.

Renewing your membership

The duration of the insurance cover is 12 months. The policy is automatically renewed for the next Insurance Year provided that the plan you and your dependants (if applicable) have is still available, all premiums due to us have been paid and the payment details we have for you are still valid on the policy renewal date. For example, we would need to have up-to-date credit card details for credit card payers. Please note that when you receive a new credit card with a new expiry date, you will need to notify us of this change.

One month before the renewal date, you will receive a new Insurance Certificate indicating the premium for the next Insurance Year. If you

do not receive your Insurance Certificate within one month prior to your renewal date, it is important that you notify us.

You may terminate the policy by giving us one month's written notice, from the date that the renewal Insurance Certificate is made available to you. We have the right to make renewal subject to special conditions. The policy terms and conditions, as well as the Table of Benefits existing on the renewal date, will apply for the entire new Insurance Year.

Please note that if a request is made at renewal to change the policyholder, the proposed replacement policyholder will be required to complete the relevant application form and full medical underwriting will apply. The death of the existing policyholder is the only exception to this rule (please see the next section: 'Ending your membership' for further details).

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 policyholder. If the policyholder dies, the next named dependant

on the Insurance Certificate may apply to us to become the policyholder in his/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 policyholder died.

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 withholding pertinent information from us, or working with another party to give us false information, either intentionally or carelessly, which may influence us when deciding:

- Whether 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 reasons other than for fraud/non-disclosure (please see the following section), we will refund any premiums you have paid which relate to a period after your membership has ended. 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 the due date, the insurance cover will be 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 a Health Declaration Form before your policy can be reinstated, subject to underwriting.

- 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 material facts declared on the relevant application form will render the contract void from the commencement date, unless we confirm otherwise in writing. Conditions arising

between completing the relevant application form and confirmation of acceptance by our Underwriting Team will be deemed to be pre-existing. If the applicant is not sure whether something is material, the applicant is obliged to inform us. If the contract is rendered void due to incorrect disclosure or non-disclosure of any material facts, we will refund the premium amount(s) paid to date minus the costs of any medical claims already paid. If the cost of claims exceeds the balance of the premium, we will seek reimbursement of this amount from the principal member.

- 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. If the contract is rendered void due to false, fraudulent, intentionally exaggerated claims or if fraudulent means/devices have been used, premium will not be refunded, in part or in whole, and any pending claims settlements will be forfeited. In the event of fraudulent claims, the contract will be cancelled from the date of our discovery of the fraudulent event.

Death

Upon the death of the policyholder or a dependant, we should be notified in writing

within four weeks. The corresponding insurance will be terminated and a pro rata repayment of the premium will be made if no claims have been filed. We reserve the right to request a death certificate before a refund is issued. Upon the death of the policyholder, a dependant on the policy can apply to become the new policyholder, if they wish to do so, and if they meet the minimum age requirements.

Your right to cancel

Under the terms of your policy, you have 30 days from the date you receive the terms and conditions of your inception/renewal policy documents to change your mind and to cancel the contract. Such notification of cancellation should be addressed to the Client Services Team. You cannot backdate the cancellation of your membership.

Following notification to us, you will be entitled to a full refund of premiums paid which relate to the most recent annual contract period, provided that no claim has been made under the policy. If you choose not to exercise your right to cancel within this 30 day period, the insurance contract will be binding on both parties and the full premium owing for the selected Insurance Year will be due for payment, according to the payment frequency selected by you.

Upon policy inception/renewal, you may also cancel the membership of any dependants listed on your inception/renewal Insurance Certificate, for any reason, within this 30 day period, by writing to us at:

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

If you do so, you will be entitled to a full refund of the premiums paid which relate to the dependant(s) for the most recent annual contract period, 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 renewal date** 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. An additional premium amount will be payable and waiting periods may apply.

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, contact details and bank account/credit card details (depending on how you have opted to pay your premiums) as soon as possible. Your cover will continue as before at no additional cost.

However, if you move to a country outside your area of cover (for example, if your area of cover is 'Africa' and you move to the UK), you will need to contact us to extend your area of cover. An additional premium amount will be payable and waiting periods may apply.

Should you have any concerns about your premiums, or if your dependant's circumstances have changed, please call us on: **+ 353 1 630 1301** and we can discuss the options available to you.

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 that they gave us the information we asked them for before joining and they have not applied for an increase in their cover.

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

Amending your membership details

We will provide you with a new Insurance Certificate if either of the following occurs:

- You add a dependant, such as a newborn child, to your membership.
- We need to record any other changes which you have requested, or that we are entitled to make, such as changing the way you pay your premium.

Your new Insurance Certificate will replace any earlier version(s) 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 us.

Policy expiry

Please note that upon the expiry of your insurance cover, your right to reimbursement ends. Any expenses covered under the insurance

policy and incurred during the period of cover shall be reimbursed up to six months after the expiry of the insurance cover. However, any on-going or further treatment that is required after the expiry date of your insurance policy will no longer be covered.

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

If you are claiming for treatment that is needed when somebody else is at fault, you must write and tell us as soon as possible, for example, if you need treatment for an injury suffered in a road accident in which you are a victim. In this case, you would need to take any reasonable steps we ask of you to obtain the insurance details of the person at fault so that we can recover, from the other insurer, the cost of the treatment paid for by us.

If you are able to recover the cost of any treatment for which we have paid, you must repay that amount (and any interest) to us.

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/email address

Any change in your home, business or email address should be communicated to us as soon as possible.

Correspondence

Letters between us must be sent by post (with the postage paid) or email. We do not usually return original documents to you. However, if you ask us at the time you send the original documents to us 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

Before you make a claim, **please check that your plan covers the treatment you are seeking.** Please refer to your Table of Benefits and call our Helpline if you have any queries.

In-patient claims

If you have to go to a hospital, we will, where possible and with sufficient notice, arrange for direct settlement with the medical provider, subject to any co-payments, deductibles and benefit limits, i.e. where possible, we will settle the bill for you by dealing directly with the hospital.

All in-patient treatment requires Treatment Guarantee to be arranged prior to commencement of treatment. Further important details on **Treatment Guarantee** can be found on pages 64 to 67.

To arrange for direct settlement, we can assist you more quickly and efficiently if the following steps are taken:

For **planned** treatment:

1. Please download a Treatment Guarantee Form from our website: www.allianzworldwidecare.com. You and your physician will need to complete the relevant sections of the Treatment Guarantee Form.
2. Once fully completed, please send the Treatment Guarantee Form to us at least five working days prior to treatment so that we can ensure there will be no delays at the time of admission. You can submit it via:
 - Scan and email to: medical.services@allianzworldwidecare.com
 - Fax to: + 353 1 653 1780 or

Address:

Allianz Worldwide Care
18B Beckett Way
Park West Business Campus
Nangor Road
Dublin 12
Ireland

- Post to the address shown on the Treatment Guarantee Form.
- If treatment is due to take place **within 72 hours**, our Helpline can take Treatment Guarantee Form details **over the telephone** if you have the required information to hand.

For **emergency** treatment:

While Treatment Guarantee is not required *in advance* of emergency treatment, either you, your physician, one of your dependants or a colleague must inform us about the hospital admission within **48 hours** of the event. At that point, please note that we can take Treatment Guarantee details over the phone if you call our Helpline. This gives us the opportunity to arrange for the direct settlement of your hospital bills, where possible.

Out-patient or dental claims

For out-patient or dental treatment, you will need to pay the medical provider for these costs at the time of treatment and then seek reimbursement from us, which will be subject to the benefit limits of your plan.

When you visit a medical practitioner, dentist, physician or specialist on an out-patient basis, please take a Claim Form with you (this form can be downloaded from our website: www.allianzworldwidedcare.com) and follow the steps below:

1. You will need to get an invoice from the doctor/medical provider which states the diagnosis or medical condition treated, the nature of the treatment and the fees charged.

2. Please complete sections 1-5 of the Claim Form yourself. Sections 6-7 will need to be completed by your treating doctor.
3. When submitting your Claim Form to us, please attach all original supporting documentation, invoices and receipts e.g. medical practitioner/physician invoices and pharmacy receipts with related prescriptions (if available).

An email will automatically be sent to you (where email addresses have been provided to us) to advise you of when the claim has been received and when it has been processed. If we do not hold an email address for you, we will write to you at your correspondence address to advise you when your claim has been processed.

Please note the following important points:

1. It is your responsibility to keep 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.
2. Fully completed Claim Forms are processed and payment instructions issued to your bank **within 48 hours**. Where further information is required to complete the claim, you/your medical practitioner will automatically be notified by email or mail within 48 hours of receipt of the Claim Form.
3. **If the amount to be claimed is less than the deductible figure under your plan**, please

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

4. A **separate Claim Form** is required for **each person claiming** and for **each medical condition being claimed for**.
5. Please **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, or we will use the exchange rate that applies on the date that claims payment is made.

6. Please ensure that the **payment details that you supply on the Claim Form are correct**, to avoid delays to claims settlement.
7. Please note that **some out-patient treatments require Treatment Guarantee** to be arranged prior to treatment taking place. Please refer to the Table of Benefits to check which benefits require Treatment Guarantee.

8. Please note that **only costs for incurred treatment will be reimbursed** within the limits of your policy, after taking into consideration any required Treatment Guarantee, and this will be net of any deductibles or co-payments mentioned in the Table of Benefits.
9. **Upon expiry of your insurance cover, your right to reimbursement ends** (for more details, please refer to the section on “Policy expiry” on page 56).
10. All claims should be submitted to us with original supporting documentation, invoices and receipts **no later than six months after the end of the Insurance Year, or if cover is cancelled within the Insurance Year, no later than six months after the end of the**

insurance cover. Beyond this time we are not obliged to settle the claim.

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 check the status of your claim through the Online Services section on our website.

Claims for accidental death

If this benefit is provided on the healthcare plan selected, please note that claims must be reported within 90 working days following the date of death and the following documents must be provided:

- A death certificate.
- A medical report indicating the cause of death.
- A written statement outlining the date, location and circumstances of the accident.
- Official documentation proving the insured member's family status, and for the beneficiaries, proof of identity as well as proof of relationship to the insured member.

Beneficiaries are, unless otherwise specified by the insured:

- The insured member's spouse, if not legally separated.
- Failing the spouse, the insured member's surviving children including step-children, adopted or foster children and children born less than 300 days from the date of the insured member's death, in equal shares among them.
- Failing the children, the insured member's father and mother, in equal shares between them, or to the survivor of them.
- Failing them, the insured member's estate.

If you wish to nominate a beneficiary other than those listed above, please contact our Helpline.

Please note that in the specific case of the death of the insured member and one or all of the beneficiaries in the same occurrence; the insured member shall be considered the last deceased.

Treatment Guarantee

Please refer to your Table of Benefits to check whether Treatment Guarantee applies to any of the benefits available to you.

What is Treatment Guarantee?

Treatment Guarantee is required in advance of certain treatments and costs. Following approval by Allianz Worldwide Care, cover for these required treatments or costs can then be guaranteed. In the Table of Benefits, benefits

which require pre-approval through Treatment Guarantee are indicated by either a 1 or a 2. When required, the relevant sections of a Treatment Guarantee Form need to be completed by you and your physician, and then submitted to us for approval prior to treatment.

Please contact us **at least five working days prior to receiving treatment** so that we can ensure that there will be no delays at the time of admission. We will respond within 24 hours of receipt of a fully completed form.

Please note that our Helpline can accept Treatment Guarantee requests over the phone if **treatment is due to take place within 72 hours**.

When is Treatment Guarantee required?

Treatment Guarantee is required for the following benefits, which may or may not be included in your plan:

- In-patient benefits¹ as listed in your Core Plan.
- MRI² (Magnetic Resonance Imaging), PET² (Positron Emission Tomography) and CT-PET² scans.
- Nursing at home or in a convalescent home².
- Routine maternity², complications of pregnancy² and complications of childbirth² (in-patient treatment only).
- Oncology² (in-patient and day-care treatment only).
- Out-patient surgery².
- Day-care treatment².
- Occupational therapy² (out-patient treatment)

- Rehabilitation treatment².
- Palliative care and long term care².
- Medical evacuation² (or repatriation where covered).
- Expenses for one person accompanying an evacuated/repatriated person².
- Repatriation of mortal remains².
- Travel costs² to another Channel Island, the UK or to France.

Your Table of Benefits will indicate which benefits require Treatment Guarantee prior to treatment.

Why is Treatment Guarantee required?

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 medical necessity and appropriateness of costs.

In addition, Treatment Guarantee will help us to provide you with a better service in the following ways:

- In the case of planned treatment, we will have time to communicate with the hospital to facilitate smooth admission and where possible, arrange for direct settlement, offering you cashless access to hospitals for in-patient treatment.
- Your treatment can be overseen by our Medical Team.

- In the case of an evacuation/repatriation, we will be able to organise and co-ordinate the evacuation on your behalf.

What happens if Treatment Guarantee is not obtained?

It is important to note that if Treatment Guarantee approval is not obtained and the treatment received is subsequently proven to be medically unnecessary, **we reserve the right to decline your claim.**

If Treatment Guarantee is not obtained for benefits listed with a **1**, **we reserve the right to decline a claim.** If the respective treatment is subsequently proven to be medically necessary, we will pay only **80%** of the eligible benefits.

If Treatment Guarantee is not obtained for benefits listed with a 2, we reserve the right to **decline a claim**. If the respective treatment is subsequently proven to be medically necessary, we will pay only **50%** of the eligible benefits.

While Treatment Guarantee is not required *in advance* of emergency treatment, we **must** be informed within **48 hours** of the event. At that point, please note that we can take Treatment Guarantee details over the phone if you call our Helpline. This gives us the opportunity to arrange for the direct settlement of your hospital bills, where possible.

Treatment in the USA

To provide you with a local and efficient service, we have selected Olympus Managed Healthcare to administer your healthcare policy on our behalf within the USA, for members with “Worldwide” cover. Olympus will deal directly with medical providers to co-ordinate the direct settlement of all your eligible medical treatment.

To locate a medical provider in the USA, simply go to: www.allianzworldwidecare.com/olympus. Once you have selected the hospital/doctor's office, please call Olympus who will arrange the appointment for you. Alternatively, you can call Olympus who will be happy to assist you with any questions you may have regarding the choice of a provider. The Allianz Worldwide

Care dedicated **Helpline at Olympus** is available 24/7 on: **(+1) 800 541 1983** (toll-free from the USA). This number is also provided on the back of your membership card.

You can also apply for a discount pharmacy card from Olympus, which can be used any time your prescription is not covered by your healthcare policy. To register and obtain your discount pharmacy card, simply go to: **www.omhc.com/pharmacy** and click on “Print Your Card Now”.

Please note that treatment in the USA is not covered, if we know or suspect that cover was purchased for the purpose of travelling to the USA to receive treatment for a condition, when the symptoms of the condition were apparent to the member prior to the purchase of cover.

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 geographical area of cover (your area of cover is confirmed in your Insurance Certificate). In order to seek reimbursement for medical treatment and travel expenses incurred, Treatment Guarantee is required prior to travel.

Where the necessary medical treatment for which you are covered is available locally, but you choose to travel to another country within your geographical area of cover for treatment, we will reimburse all eligible medical costs incurred within the terms of your policy; however, we will not pay for travel expenses incurred.

Q. Am I covered in my home country?

A. If 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 geographical area of cover. Please note that

cover in some countries is subject to local health insurance regulations, 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. If you become permanently resident in the United States please note that we cannot provide cover as our plans do not comply with local US laws.

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, contact details and bank account/credit card details (depending on your chosen method of premium payment) as soon as possible. Your cover will continue as before at no additional cost until your policy renewal date, at which point your premium will be reviewed in line with your new country of residence. However, if you move to a country outside your geographical area of cover (for example, if your region of cover is "Africa" and you move to the UK),

you will need to contact us to extend your area of cover. An additional premium amount will be payable and waiting periods may apply.

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 your renewal date if such changes are required.

Q. What happens if I don't pay my premiums when due?

A. We will cancel the policy if 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 the 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 a Health Declaration Form before your policy can be reinstated.

Q. Which hospitals can I go to?

A. You can use our online Hospital, Doctor and Health Practitioner Finder to search for providers worldwide. However, you are not restricted to using providers from this directory. Please note that Treatment Guarantee is required prior to in-patient treatment, as well as certain other treatments as specified in your Table of Benefits. We will, where possible, try to arrange the direct settlement of your in-patient medical expenses with your medical provider.

Q. What do I do in an emergency?

A. In case of an emergency, always seek medical care immediately. It is important that we are informed, within **48 hours** of the event.

For more details please visit www.allianzworldwidecare.com

Making a complaint

Please find guidelines on our complaints procedure below.

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

The Allianz Worldwide Care Helpline (+ 353 1 630 1301) is always the first number to call if you have any comments or complaints. In cases where 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 1306
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
3rd Floor, Lincoln House
Lincoln Place
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 or may not form part of your specific policy. Please refer to your Table of Benefits to clarify which benefits apply to your cover with us. Wherever the following words and phrases appear in your policy documentation, they will always have the meanings as defined below. If any unique benefits apply to your plan(s), the definition will appear in the “Notes” section at the end of your Table of Benefits.

- 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 The **accidental death benefit** amount shown in the Table of Benefits shall become payable if the insured member (aged 18 to 70) passes away during the period of insurance as a result of an accident (including industrial injury).
- 1.3 **Accommodation costs for one parent staying in hospital with an insured child** refers to the hospital accommodation costs of one parent for the duration of the insured child’s admission to hospital for eligible treatment. If a suitable bed is not available in the hospital, we will contribute the equivalent of a three star hotel daily room rate towards any hotel costs incurred. We will not, however, cover sundry expenses including, but not limited to meals, telephone calls or newspapers.
- 1.4 **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.
- 1.5 **Complementary treatment** refers to therapeutic and diagnostic treatment that exists outside the institutions where conventional Western medicine is taught. Such medicine includes chiropractic treatment, osteopathy, Chinese herbal medicine, homeopathy and acupuncture as practiced by approved therapists.

- 1.6 **Complications of childbirth** refers only to the following conditions that arise during childbirth and that require a recognised obstetric procedure: post-partum haemorrhage and retained placental membrane. Complications of childbirth are only payable where your cover also includes a routine maternity benefit. Where your cover includes a routine maternity benefit, complications of childbirth shall also refer to medically necessary caesarean sections.
- 1.7 **Complications of pregnancy** relates to the health of the mother. Only the following complications that arise during the pre-natal stages of pregnancy are covered: ectopic pregnancy, gestational diabetes, pre-eclampsia, miscarriage, threatened miscarriage, stillbirth and hydatidiform mole.
- 1.8 **Co-payment** is the percentage of the costs which the insured person must pay.
- 1.9 **Day-care treatment** is planned treatment received in a hospital or day-care facility during the day, including a hospital room and nursing, that does not medically require the patient to stay overnight and where a discharge note is issued.
- 1.10 **Deductible** is that part of the cost which remains payable by you and which has to be deducted from the reimbursable sum.
- 1.11 **Dental prostheses** include crowns, inlays, onlays, adhesive reconstructions/restorations, bridges, dentures and implants as well as all necessary and ancillary treatment required.
- 1.12 **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.
- 1.13 **Dental treatment** includes an annual dental check up, simple fillings related to cavities or decay and root canal treatment.
- 1.14 **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 policyholder up to the day before their 18th birthday; or up to the day before their 24th birthday if in full time education, and also named in your Insurance Certificate as one of your dependants.

- 1.15 **Diagnostic tests** are investigations such as x-rays or blood tests, undertaken in order to determine the cause of the presented symptoms.
- 1.16 **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.
- 1.17 **Emergency in-patient dental treatment** refers to acute emergency dental treatment due to a serious accident requiring hospitalisation. The treatment must be received within 24 hours of the emergency event. Please note that cover under this benefit does not extend to follow-up dental treatment, dental surgery, dental prostheses, orthodontics or periodontics. If cover is provided for these benefits, it will be listed separately in the Table of Benefits.
- 1.18 **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 prostheses or root canal treatment.
- 1.19 **Emergency out-patient treatment** is treatment received in a casualty ward/emergency room following an accident or sudden illness, where the insured does not, out of medical necessity, occupy a hospital bed. The treatment must be received within 24 hours of the emergency event.
- 1.20 **Expenses for one person accompanying an evacuated/repatriated person** refer to the cost of one person travelling with the evacuated/repatriated person. If this cannot take place in the same transportation vehicle, transport at economy rates will be paid for. Following completion of treatment, we will also cover the cost of the return trip, at economy rates, for the accompanying person to return to the country from where the evacuation/repatriation originated. Cover does not extend to hotel accommodation or other related expenses.
- 1.21 **Home country** is a country for which the insured person holds a current passport and/or to which the insured person would want to be repatriated.
- 1.22 **Hospital** is any establishment which is licensed as a medical or surgical hospital in the country where it operates and where the patient is permanently supervised by a medical practitioner. The following establishments are not considered hospitals: rest and nursing homes, spas, cure-centres and health resorts.

- 1.23 **Hospital accommodation** refers to standard private or semi-private accommodation as indicated in the Table of Benefits. Deluxe, executive rooms and suites are not covered.
- 1.24 **Infertility treatment** refers to treatment for both sexes including all invasive investigative procedures necessary to establish the cause for infertility such as hysterosalpingogram, laparoscopy or hysteroscopy. In the case of InVitro Fertilization (IVF), cover is limited to the amount specified in the Table of Benefits.
- 1.25 **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.
- 1.26 **In-patient treatment** refers to treatment received in a hospital where an overnight stay is medically necessary.
- 1.27 **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.
- 1.28 **Insurance Year** applies from the effective date of the insurance, as indicated on the Insurance Certificate and ends exactly one year later.
- 1.29 **Insured person** is you and your dependants as stated on your Insurance Certificate.
- 1.30 **Laser eye treatment** refers to the surgical improvement of the refractive quality of the cornea using laser technology, including necessary pre-operative investigations.
- 1.31 **Local ambulance** is ambulance transport required for an emergency or out of medical necessity, to the nearest available and appropriate hospital or licensed medical facility.
- 1.32 **Long term care** refers to care over an extended period of time after the acute treatment has been completed, usually for a chronic condition or disability requiring periodic, intermittent or continuous care. Long term care can be provided at home, in the community, in a hospital or in a nursing home.
- 1.33 **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 (which may or may not be located in the insured person's 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 principal 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 seven days, comprising of a private room with en-suite facilities. We do not cover costs for hotel suites, four or five star hotel accommodation or hotel accommodation for an accompanying person.

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

1.34 **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/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.

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

- 1.36 **Medical practitioner fees** refer to non-surgical treatment performed or administered by a medical practitioner.
- 1.37 **Medical repatriation** is an optional level of cover and where provided will be shown in the Table of Benefits. This benefit means that if the necessary treatment for which you are covered is not available locally, you can choose to be medically evacuated to your home country for treatment, instead of to the nearest appropriate medical centre. This only applies when your home country is located within your geographical area of cover. Following completion of treatment, we will also cover the cost of the return trip, at economy rates, to your principal country of residence. The return journey must be made within one month after treatment has been completed.
- 1.38 **Midwife fees** refer to fees charged by a midwife or birth assistant, who, according to the law of the country in which treatment is given, has fulfilled the necessary training and passed the necessary state examinations.
- 1.39 **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.
- 1.40 **Nursing at home or in a convalescent home** refers to nursing received immediately after or instead of eligible in-patient or day-care treatment. We will only pay the benefit listed in the Table of Benefits where the treating doctor decides (and our Medical Director agrees) that it is medically necessary for the member to stay in a convalescent home or have a nurse in attendance at home. Cover is not provided for spas, cure centres and health resorts or in relation to palliative care or long term care (see Definitions 1.50 and 1.32).
- 1.41 **Obesity** is diagnosed when a person has a Body Mass Index (BMI) of over 30 (a BMI calculator can be found on our website: www.allianzworldwidecare.com).
- 1.42 **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.

- 1.43 **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.
- 1.44 **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.
- 1.45 **Organ transplant** is the surgical procedure in performing the following organ and/or tissue transplants: heart, heart/valve, heart/lung, liver, pancreas, pancreas/kidney, kidney, bone marrow, parathyroid, muscular/skeletal and cornea transplants. Expenses incurred in the acquisition of organs are not reimbursable.
- 1.46 **Orthodontics** is the use of devices to correct malocclusion and restore the teeth to proper alignment and function.
- 1.47 **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.
- 1.48 **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.
- 1.49 **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.
- 1.50 **Palliative care** refers to in-patient, day-care or out-patient treatment following the diagnosis that the condition is terminal and treatment can no longer be expected to cure the condition. Included within the benefit, we will pay for physical care, psychological care as well as hospital or hospice accommodation, nursing care and prescription drugs.
- 1.51 **Periodontics** refers to dental treatment related to gum disease.
- 1.52 **Podiatry (Channel Islands Plans only)** refers to medically necessary treatment carried out by a State Registered Practitioner with an Honours degree (BSc Hons) in podiatry as approved by the Chiropodists' board of the Council for the Professions Supplementary to Medicine. The practitioner must also hold a further accreditation such as: MChS (Member of The Society of Chiropodists & Podiatrists) or FChS (Fellow of The

Society of Chiropodists & Podiatrists) or FCPoS (Fellow of the College of Podiatrists of The Society of Chiropodists & Podiatrists).

- 1.53 **Post-natal care** refers to the routine post-partum medical care received by the mother, up to six weeks after delivery.
- 1.54 **Pre-existing conditions** are medical conditions or any related conditions for which one or more symptoms have been shown at some point during the five 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 could reasonably have been assumed to have known, will be deemed to be pre-existing. Conditions arising between completing the relevant application form and confirmation of acceptance by the Underwriting Team of Allianz Worldwide Care will equally be deemed to be pre-existing.
- 1.55 **Pregnancy** refers to the period of time, from the date of the first diagnosis, until delivery.
- 1.56 **Pre-natal care** includes common screening and follow-up tests as required during a pregnancy. For women aged 35 and over, this includes Triple/Bart's, Quadruple or Spina Bifida tests, amniocentesis and DNA-analysis, if directly linked to an eligible amniocentesis.
- 1.57 **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.
- 1.58 **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. Costs for medical aids that form part of palliative care or long term care (see Definitions 1.50 and 1.32) are not covered.
- 1.59 **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 Rolwing, Massage, Pilates, Fango and Milta therapy.

- 1.60 **Prescription drugs** refers to products, including, but not limited to, insulin, hypodermic needles or syringes, which require a prescription for the treatment of a confirmed diagnosis or medical condition or to compensate vital bodily substances. The prescription drugs must be clinically proven to be effective and recognised by the pharmaceutical regulator in a given country.
- 1.61 **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).
- 1.62 **Principal country of residence** is the country where you and your dependants live for more than six months of the year.
- 1.63 **Psychiatry and psychotherapy** refers to treatment of a mental or nervous disorder carried out by a 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 triggered by a particular event such as bereavement, relationship or academic problems or 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).
- 1.64 **Rehabilitation** is treatment aimed at the restoration of a normal form and/or function after an acute illness or injury. The rehabilitation benefit is payable only for treatment that starts immediately after the acute medical treatment ceases.
- 1.65 **Repatriation of mortal remains** is the transportation of the deceased's mortal remains from the principal country of residence to the country of burial. Covered expenses include, but are not limited to, expenses for embalming, a container legally appropriate for transportation, shipping costs and the necessary government authorisations. Cremation costs will only be covered in the event that this is required for legal purposes. Costs incurred by any accompanying persons are not covered. All covered expenses in connection with the repatriation of mortal remains must be pre-approved by us by using Treatment Guarantee.

1.66 **Routine health checks including cancer screening** 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 six years, up to a maximum of 15 visits per lifetime).

1.67 **Routine maternity** refers to any medically necessary costs incurred during pregnancy and childbirth, including hospital charges, specialist fees, the mother's pre- and post-natal care, midwife fees (during labour only) as well as newborn care. Costs related to complications of pregnancy or complications of childbirth are not payable under routine maternity. In addition, any non-medically necessary caesarean sections will be covered up to the cost of a routine delivery in the same hospital, subject to any benefit limit in place.

1.68 **Specialist** is a qualified and licensed medical physician possessing the necessary additional qualifications and

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

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

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

1.71 **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.

1.72 **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.

- 1.73 **Treatment** refers to a medical procedure needed to cure or relieve illness or injury.
- 1.74 **Vaccinations** refer to all basic immunisations and booster injections required under regulation of the country in which treatment is being given, any medically necessary travel vaccinations and malaria prophylaxis. The cost of consultation for administering the vaccine, as well as the cost of the drug, is covered.
- 1.75 **Waiting period** is a period of time commencing on your policy start date (or effective date if you are a dependant), during which you are not entitled to cover for particular benefits. Your Table of Benefits will indicate which benefits are subject to waiting periods.
- 1.76 **We/Our/Us** is Allianz Worldwide Care.
- 1.77 **You/Your** refers to the eligible individual stated on 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 and performed by a licensed physician, dentist or therapist. Claims/costs will be paid/reimbursed if the medical diagnosis and/or 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 which pertains to a claim submitted to us, we reserve the right to decline to pay benefits.

You must inform us and provide all necessary information if and when you are entitled to 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 to cancel the policy.

We have full rights of subrogation and may institute proceedings in your name, but at our expense, to recover, for our benefit, the amount of any payment made 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:**
 - a) Any differences in respect of medical opinion in connection with the results of an accident or medical condition must be notified to us within nine weeks of the decision. Such differences will be settled between two medical experts appointed by you and us in writing.
 - b) If differences can not be resolved in accordance with Clause 5.a above, the Parties shall attempt to settle by mediation in accordance with the Centre

for Effective Dispute Resolution (CEDR) Model Mediation Procedure any dispute, controversy or claim arising out of or relating to this Agreement or the breach, termination or invalidity thereof where the value is €500,000 or less and which cannot be settled amicably between the Parties. The Parties shall endeavor to agree on the appointment of an agreed Mediator. Should the Parties fail to agree the appointment of an agreed Mediator within 14 days, either Party, upon written notice to the other Party, may apply to CEDR for the appointment of a Mediator.

To initiate the mediation, a Party must give notice in writing ("ADR notice") to the other Party to the dispute, requesting mediation. A copy of the request should be sent to CEDR. The mediation will start no later than 14 days after the date of the ADR notice. No Party may commence court proceedings/arbitration relating to any dispute pursuant to this Clause 5.b until it has attempted to settle the dispute by mediation and either the mediation has terminated or the other Party has failed to participate in the mediation (provided that the right to issue proceedings is not prejudiced by a delay). The mediation will take place in Dublin, Ireland and the language of the mediation will be English. The Mediation Agreement referred to in the

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

- c) Any dispute, controversy or claim which is:
- Arising out of or relating to this Agreement (or the breach, termination or invalidity thereof) with a value in excess of €500,000, or
 - Referred to mediation pursuant to Clause 5.b but not voluntarily settled by mediation within three months of the ADR Notice date
- shall be determined exclusively by the Courts of Ireland and the Parties will submit to the exclusive jurisdiction of those courts. Any proceedings brought pursuant to Clause 5.c shall be issued within nine calendar months of the expiration date of the aforementioned three month period.

6. **Data protection:** Allianz Worldwide Care, a member of the Allianz Group, is an Irish authorised non-life insurance company. We obtain and process personal information for the purposes of preparing quotations, underwriting policies, collecting premium, paying claims and for any other purpose which is directly related to administering policies in accordance with the insurance

contract. The confidentiality of patient and member information is of paramount concern to us. We comply fully 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. We will not retain your data for longer than is necessary for the purposes for which it was obtained.

7. **Making contact with dependants:** In order to administer your policy in accordance with the insurance contract, there may be circumstances when we will need to request further information. If we need to make contact in relation to a dependant on a policy (e.g. where further information is required to process a claim), the policyholder, acting for and on behalf of the dependant, will be contacted by us and asked to provide the relevant information. Similarly, all information in relation to any person covered by the insurance policy, for the purposes of administering claims, will be sent directly to the policyholder.

Notes

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

Allianz Worldwide Care
18B Beckett Way
Park West Business Campus
Nangor Road
Dublin 12
Ireland

client.services@allianzworldwidecare.com
www.allianzworldwidecare.com

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
Portuguese:	+ 353 1 645 4040
Fax:	+ 353 1 630 1306

For our latest list of toll-free numbers,
please go to:
[www.allianzworldwidecare.com/
toll-free-numbers](http://www.allianzworldwidecare.com/toll-free-numbers)

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