Aon Global Health Complete
Powered by Allianz Worldwide Care

Benefit Guide

Valid from 1st January 2015

AON

Allianz
Allianz Worldwide Care

Your healthcare plan's Benefit Guide

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 health insurance policy. Please read this Benefit Guide in conjunction with your Insurance Certificate and Table of Benefits to ensure that you fully understand your level of cover. If you are part of a group scheme, for full details of your company's insurance contract, please contact your company's Group Scheme Manager.

Thanks to a comprehensive benefit package created by Allianz Worldwide Care and Aon, you and your family will now have access to the best health care possible – wherever you are in the world.

Your insurer, Allianz Worldwide Care, specialises in international health cover and is backed by the resources and expertise of Allianz SE, one of the world's leading insurance companies, providing you with a service that is fast, flexible and totally reliable.

Aon will be your unique contact point for any queries you may have on the day-to-day use of your policy.

Allianz Worldwide Care SA is regulated by the French Prudential Supervisory Authority located at 61, rue Taitbout, 75436 Paris Cedex 09, France.

Allianz Worldwide Care SA, acting through its Irish Branch, is a limited company governed by the French Insurance Code. Registered in France: No. 401 154 679 RCS Paris. Irish Branch registered in the Irish Companies Registration Office, registered No.: 907619, address: 15 Joyce Way, Park West Business Campus, Nangor Road, Dublin 12, Ireland.

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Member services

Please find details of all our member services below.

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

Please note that only the policyholder or an appointed representative (or the Group Scheme Manager in the case of group policies) can make changes to the policy. Security questions will be asked of all callers, in order to verify their identity.

Helpline Service

If you have any questions in relation to your medical policy, your entitlements or your claims, you can contact Aon's Helpline by email or phone as follows:

Email: ipm@aonhewitt.com
Phone: + 31 10 44 88 200
(available during Dutch office hours)

Emergency Assistance Service

If you require emergency medical treatment in a hospital or clinic, you should, where possible, contact the Emergency Assistance Service. The Emergency Assistance Service (provided by Allianz Worldwide Care) 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:

Email: client.services@allianzworldwidecare.com
Phone: + 31 10 44 88 255

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 the Emergency Assistance Service 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.

Evacuations and repatriations

At the first indication that a medical evacuation/ repatriation is required, please call our 24 hour Helpline (details on the back cover of this guide) and we will take care of everything. Given the urgency of an evacuation/repatriation, we would advise that you

call us, however, you can also contact us by email at: **medical.services@allianzworldwidecare.com.** When emailing, please include "*Urgent – Evacuation/ Repatriation*" in the subject line. Please contact us before talking to any alternative providers, even if approached by them, to avoid potentially inflated charges or unnecessary delays in the evacuation process. In the event that evacuation/repatriation services are not organised by Allianz Worldwide Care, we reserve the right to decline all costs incurred.

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 **+44 (0) 208 416 3929**.

Please be advised that **for policy or claims queries you should contact Aon 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 medical practitioner. 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 medical practitioner before beginning any new treatment or if you have any questions regarding a medical condition. You understand and agree that Aon and Allianz Worldwide Care are not responsible or liable for any claim, loss or damage directly or indirectly resulting from your use of this advice line or the information or the resources provided through this service. Calls to the MediLine will be recorded and may be monitored for training, quality and regulatory purposes.

Membership Pack

Once we have confirmed acceptance of your cover, 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 Aon's Helpline via email or telephone and we will arrange for a new card to be sent to you. Alternatively, if you have access to our Online Services, you can simply download a soft copy version of your Membership Card.

- **Your Insurance Certificate**
  Your Insurance Certificate details the plan covering you and your dependants (if relevant) as well as the start date and renewal date of your cover (and effective dates of when dependants were added). For underwritten policies, it will also state 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 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 Benefit Guide
  This guide sets out the benefits and rules of your healthcare policy. The 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 pages 77-79 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 Aon's website: **www.aonexpatinsurance.com/netherlands/outgoing/en/claims/submitting-a-claim/**.

- ### 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 your claim, you/your medical practitioner will be notified by email or mail within 48 hours of receipt of the Claim Form. An email is automatically sent to you (where email addresses are provided to us) to advise you of when a claim has been processed. Please note that the Claim Form is also available on Aon's website: **www.aonexpatinsurance.com/netherlands/outgoing/en/claims/claimforms/**.

- ### Your Online Services username and password
  If this option has been selected, you will receive a username and password allowing you access to our web-based Online Services.

Online Services

If this facility has been selected, you can access Allianz Worldwide Care's secure Online Services through our website: **www.allianzworldwidecare.com/members**.

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" link in the members area. 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 (for group scheme members, this option is available if their group is not using a collective address).
- Securely retrieve a lost or forgotten username and password.
- Download your Insurance Certificate and Benefit Guide. A Membership eCard can also be downloaded in PDF format.
- 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 premiums by credit card and change your credit card details (if you are covered under an **individual policy** or a **group policy where you are responsible for paying your own premium**). In addition, you can download a copy of the

Payment Details Letter/Invoice, view your payment transactions and check the current balance on your account.

For Online Services assistance, please contact Allianz Worldwide Care on +31 10 448 255 (available 24/7).

Hospital, Doctor and Health Practitioner Finder

You can access a Medical Provider directory on the Allianz Worldwide Care website: **www.allianzworldwidecare.com/members**. This online directory allows you to search for hospitals, clinics, medical practitioner 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: your Table of Benefits specifies the benefits available to you. Please be aware that this cover is subject to our policy definitions, exclusions and limitations and, for underwritten policies, cover is also subject to any special conditions indicated in the Insurance Certificate (and on the Special Conditions Form issued prior to policy inception).

If you have any queries regarding the cover provided under your plan, simply contact Aon 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. "75% refund, up to €115". Where a specific benefit limit applies or where the term "Full refund" appears next to certain benefits, the refund is subject to the maximum plan benefit, if one applies to your plan(s). All limits are per member, per Insurance Year, unless otherwise stated in your Table of Benefits.

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.

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 displayed at some point during five years prior to commencement of cover, irrespective of whether any medical treatment or advice was sought.

For **non-underwritten policies**, pre-existing conditions are covered. However, for **underwritten policies**, any pre-existing condition or related condition about which you or your dependants could reasonably have been assumed to have known and/or which have not been declared on the Application Form or Health Declaration Form (hereafter referred to as the 'relevant application form') are not covered by us. **In addition, conditions arising between completing the relevant application form and the start date of the policy will equally be deemed to be pre-existing. Such pre-existing conditions will also be subject to medical underwriting and if not disclosed will not be covered.**

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. Where applied, co-payments and deductibles are payable per person per Insurance Year (unless indicated otherwise in the Table of Benefits).

Please refer to your Table of Benefits to determine where co-payments or deductibles apply to benefits within your plan. They may apply individually to the Core, Out-patient, Dental or Repatriation Plans or indeed, to a combination of these plans.

Where you are covered

We offer two areas of cover: 'Worldwide' and 'Worldwide excluding USA'.

Your geographical area of cover will be specified in your Insurance Certificate.

Your Core Plan explained

The following section gives a summary of the range of benefits that 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.

Hospital admission

We cover the costs for day-care treatment or hospital admission (including admission in rehabilitation centre or psychiatric hospital).

This cover is provided only if the treatment is deemed medically necessary by the treating authority and within the duration of the medical necessity.

Organ transplant

Under this benefit, we cover the costs of organ and tissue transplants performed in a hospital, provided that the transplant is performed in a member state of the European Union or in a country that is party to the Agreement on the European Economic Area (effective 1st January 1994) or in another country if the donor resides in it and is the patient's spouse, registered partner or a first, second or third-degree blood relative. We will also cover the costs of the specialist medical care related to donor selection, organ/tissue removal from the selected donor, testing preservation and removal/transport of the post-mortal transplantation material, in connection with the prospective transplant. Costs for the transplant operation at an independent treatment centre (if this is permitted pursuant to legislation and regulation) will also be covered.

The costs related to the donor are covered as follows:

- Medical care after the date of discharge from hospital, where admission to hospital was exclusively in relation to selection/removal of transplant material. Cover is provided for a maximum of 13 weeks, or six months in the event of a liver transplant.
- Public transport in lowest fare class, or – if and insofar as medically necessary – transport by car in connection with the admission/discharge from a hospital and with the medical care referred to in the previous point.

- Public transport in lowest fare class to and from the country where the transplant takes place (in case of a donor residing abroad) in connection with the transplant of a kidney, bone marrow or liver.
- Other transplant-related costs insofar as these are related to the donor living abroad. These costs do not in any event include hotel accommodation costs and other sundry expenses.

Psychiatry and psychotherapy

Psychiatry refers to in-patient and out-patient psychiatric care provided by a psychiatrist. In order to claim for this benefit, a referral from the GP must be provided with the invoice.

Psychotherapy refers to short term care (limited to six months) for acute conditions following referral from your GP: in order to claim for this benefit, the referral must be provided together with the invoice. This cover is provided only if the treatment is deemed medically necessary by the treating authority and within the duration of the medical necessity.

Accommodation costs for one parent staying in hospital or similar accommodation with an insured child under 16

In the event of an insured child requiring hospitalisation, the cost of one parent's accommodation staying with a child under 16 years of age will be covered for the duration of the admission to hospital. In the event that no suitable bed is available in the hospital, we will cover the equivalent of a three star hotel daily room rate, unless agreed otherwise with us. Please refer to your Table of Benefits to determine the level of cover available under your plan. Please note that Treatment Guarantee is required.

Accommodation in case of medical treatment received outside of place of residence

- *For the patient:* We cover the costs incurred by a patient in connection with medical treatment in a hospital outside of their city/town of residence. Accommodation in the vicinity of the hospital must be deemed medically necessary by the treating authority. Treatment Guarantee is required.

- *For the parents:* We cover the costs incurred by both parents in case their insured child has to receive medical treatment outside of their city/town. Accommodation in the vicinity of the hospital where the child has been admitted must be declared medically necessary for the wellbeing of the child by the treating authority. If confirmed in your Table of Benefits, we also cover accommodation in a Ronald McDonald House or similar accommodation affiliated with a hospital, for the duration of the medically necessary admission of the child. The child to be treated must not be older than 16. Treatment Guarantee is required. Please note that this benefit is subject to the limit per person and per calendar year indicated in the Table of Benefits.

Other benefits under your Core Plan

Day-care treatment

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. Treatment Guarantee is required.

Out-patient surgery

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. 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, unless agreed otherwise between your company and us. The maximum amount available under this benefit is indicated in the Table of Benefits. Treatment Guarantee is required. This benefit is not payable in respect of palliative care, which is covered under a separate benefit.

Rehabilitation treatment

This benefit is for treatment which takes place in a licensed rehabilitation facility, immediately after the acute medical treatment ceases. The level of cover provided is indicated in your Table of Benefits. Treatment Guarantee is required.

Local ambulance

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.

Transport

Cover is provided for medically necessary seated transport required for an emergency or due to a medical necessity, to the nearest hospital or healthcare provider in the country of residence. Transport can be by taxi, private motor vehicle or public transportation, insofar as this is related to nursing, examination or treatment. The costs may be subject to benefit limits, as indicated in your Table of Benefits. The transport needs to be declared medically necessary by your medical practitioner/ specialist. If seated transport by public transportation, taxi or private motor vehicle is not possible, please call Aon Helpline for pre-authorisation of transport by other means.

We also cover the transport costs for a person accompanying the insured patient, provided that accompaniment is medically necessary or that the insured patient is younger than 16. In special cases, we may cover transport for two accompanying persons, provided that we are requested for pre-authorisation (please call Aon Helpline in advance of transport).

Emergency treatment outside area of cover

You and your dependants will be covered for emergencies only, which occur during business and holiday trips outside of your area of cover (where relevant). Cover is provided up to a maximum period of six weeks per trip within the maximum benefit amount. You will not be covered for any curative or follow-up non-emergency treatment, even if deemed unable to travel to a country within your geographical area of cover. If you are moving outside your area of cover for more than six weeks, you should contact Aon.

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 benefit 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. Aon, Allianz Worldwide Care and their agents accept no liability in the event that such endeavours are unsuccessful or in the event that contaminated blood or equipment is used by the treating authority.

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

Expenses for one person accompanying an evacuated/repatriated person

One person will be entitled to travel with the evacuated or repatriated person. If this cannot take

place in the same transportation vehicle, round trip transport at economy rates will be paid for. There may be a maximum amount that can be claimed under this benefit, and if so, this will be indicated in the Table of Benefits. Please note that hotel accommodation or other related expenses are not covered and that Treatment Guarantee is required.

Repatriation of mortal remains

Where covered, in the event of 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 unless this is listed as a specific benefit in your Table of Benefits. 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 are fully covered within the limits of your Core Plan. Treatment Guarantee is not required for CT scans, however, it is required for MRI, PET and CT-PET scans. Please note that cover does not extend to hotel accommodation or other related expenses and that Treatment Guarantee is required.

Oncology

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. In case the patient is a child under 18, we reimburse the central (reference) diagnosis, coordination and registration by Skion (Child Oncology Association of the Netherlands) of physical material submitted.

We may also reimburse the costs of participation in the Recovery and Balance Training for ex-cancer patients offered by institutions under license from the Stichting Herstel en Balans (please check your Table of Benefits to confirm if you are covered for this benefit).

You must be referred by a GP, company doctor or medical specialist. Treatment Guarantee is required for in-patient and day-care treatment only.

Routine maternity

Routine maternity refers to medically necessary costs incurred during pregnancy and childbirth, including hospital charges for a maximum of 10 days from day of delivery, specialist fees, the mother's pre- and post-natal care (including counselling, routine ultrasound examination and combination test), midwife fees 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 and childbirth are not payable under routine maternity. Please note that home delivery is covered within limits of your plan.

Postponed maternity care provided by a birthing centre or independent maternity care professional is covered up to a maximum of 15 hours. The maternity centre must deem the postponed maternity care medically necessary.

We reimburse the costs of renting a TENS unit for pain management operated during delivery by a midwife or GP acting as midwife. The equipment must be requested to the health aid supplier by the midwife or GP, and must be dispensed for temporary use.

Pre-natal screening applies to women aged 36 years or older, or younger than 36 if referred by their GP, midwife or medical specialist.

In case of delivery taking place abroad where the mother is admitted to a hospital, the Treatment Guarantee is a requirement.

Adoption maternity screening

After one or more children are adopted legally during the duration of the insurance, we reimburse the costs of adoption post-natal care occurring during the period of insurance, provided by a maternity centre or the costs of medical screening (preventive examination) of an adoptive child coming from abroad. In order to be eligible for this benefit, the adopted child must be under 12 months at the time of adoption and may not already be a member of the family. The medical screening must be carried out by a paediatrician and must be a required component of the adoption process.

Complications of pregnancy and childbirth

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.

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

Circumcision on religious grounds

We reimburse the costs of circumcision of a male on religious grounds. However, the procedure must take place at a healthcare provider, in an independent treatment centre or in a circumcision clinic.

Palliative care

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 Treatment Guarantee is required.

Prescribed independent treatment centre

In the event of treatment at an independent treatment centre, this benefit covers the costs of nursing and care, specialist medical care, paramedic care, medicines, health aids and bandages related to the treatment. This cover is provided only if the treatment is deemed medically necessary by the treating authority and within the duration of the medical necessity. A referral from the GP or other medical specialist is required, as well as submission of

a Treatment Guarantee Form in advance of treatment. In addition you will need to provide a medical report from your medical practitioner or specialist, explaining the reasons for admission.

Plastic surgery

We reimburse the costs of plastic surgery provided by a medical specialist if the treatment is needed for the correction of:

- Abnormalities in the appearance that are related to demonstrable problems of physical functioning.
- Disfigurements resulting from disease, accident or medical procedures.
- The following congenital defects: cleft lip, jaw or palate, malformations of the facial bone structure, benign growths of blood vessels, lymphatic vessels or connective tissue, birthmarks, malformations of urinary tract and genitals.
- The position of the ears, if surgery is required because of a congenital defect, personal desire, necessity or circumstance.
- Paralysed or slackened upper eye lids resulting from a congenital defect, congenital chronic ailment or in the event of demonstrable physical impairment.
- The stomach wall (abdominal plastic), in case of a mutilation comparable in seriousness to a third degree burn, of untreatable blemishes in skin creases, or of a very serious limitation to the freedom of movement (i.e. in case the omentum extends down beyond at least one quarter of the upper legs).
- Primary sexual characteristics in the case of ascertained transsexuality (including the depilation of the pubic area and beard).

Please note that cover is limited to the benefit limit stated in your Table of Benefits and Treatment Guarantee is required.

Prescribed stay in the Dutch Asthma Centre in Davos (Switzerland)

We reimburse the costs of treatment in the Dutch Asthma Centre in Davos, where similar treatment took place elsewhere without success and we deem the treatment in Davos to be effective. The patient must be referred by a lung specialist or paediatrician. Treatment Guarantee is required in advance.

Prescribed stay in a therapeutic camp for asthmatic children up to the age of 18

We reimburse the costs of a stay at a therapeutic camp for asthmatic children up to the age of 18. The stay must be prescribed by the treating physician. Treatment Guarantee is required.

Stay in a therapeutic camp for disabled members

We reimburse the costs of a stay at a therapeutic camp for insured members with physical and learning disabilities. Treatment Guarantee is required.

Prescribed genetic testing

Upon referral from a treating physician, costs of genetic testing and advising in a centre for genetic testing will be covered. The benefit includes testing for genetic defects by means of family tree research, chromosome testing, biochemical diagnosis, ultrasound and DNA examination, genetic advising and related psychosocial counselling. When relevant, the examination will also include testing of persons other than the patient: they may also be given advice.

Non-clinical hemodialysis and peritoneal dialysis

We reimburse the costs of kidney dialysis in a hospital, dialysis centre or at your home, whether or not accompanied by necessary examination, treatment, nursing and pharmaceutical care, as well as psychosocial treatment for you and the people who assist in carrying out the dialysis, when this is not provided at a dialysis centre.

In the case of home dialysis, we also reimburse:

- The costs related to the training provided by the dialysis centre to those who will carry out or assist with the dialysis.
- The costs of lending the dialysis equipment/ accessories and of their maintenance and replacement, as well as the chemicals and fluids necessary for carrying out the dialysis.
- The costs for home adjustments needed to have the dialysis at home. These costs, as well as the home restoration costs that may incur after the home dialysis, will only be reimbursed if they are deemed reasonable and are not covered under any kind of state cover.
- Other costs that are directly related to the home dialysis insofar as we regard these costs as reasonable and are not covered under any kind of state cover; i.e. the costs of the necessary expert assistance for the dialysis provided by the dialysis centre.

Please note that in the case of home dialysis, a Treatment Guarantee must be submitted in advance of treatment.

Your Out-patient Plan explained

We list below some of the most important benefits included in our Out-patient Plan:

- Medical practitioner fees.
- Prescription drugs.
- Specialist fees.
- Diagnostic tests.
- Vaccinations.
- Alternative therapies and treatments.
- Alternative medicines.
- Prescribed physiotherapy.
- Occupational therapy.
- Prescribed speech therapy.
- Prescribed skincare.
- Home help.
- Stutter therapy.
- Prescribed dyslexia care.
- Preventive examinations and screening for early detection of illness or disease.
- Infertility treatment.
- Prescribed chiropodist.
- Prescribed podotherapy and podology.
- Glasses and contact lenses.
- Prescribed medical aids.
- Sterilisation.

Further in this section, some of the above Out-patient Plan benefits are described in more details. 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 some out-patient benefits: these are indicated in your Table of Benefits.

Accommodation costs for insured member receiving out-patient treatment

We reimburse the accommodation costs in a guesthouse operated by the treating hospital, in the event of out-patient treatment.

Alternative therapies and treatments

We reimburse the costs for consultations provided by:

- Doctors, i.e. alternative healers or therapists who are also recognised medical practitioners.
- Non-doctors, i.e. alternative healers or therapists who are not recognised as medical practitioners but are members of a nationally recognised professional association established for their discipline. A written proof of this membership must be provided on our request, when needed.

Please note that the consultation must be medically necessary under our reasonable opinion, i.e. it must take place in the context of medical treatment. The consultation is covered when it is given on an individual basis.

Alternative medicines

We cover the costs of homeopathic and anthroposophist medicines when these are prescribed by a medical practitioner and provided by a pharmacy.

Preventative care vaccinations for children under 16 years

We reimburse the costs of the following vaccinations: vaccinations included in the Dutch national vaccination programme; vaccinations against rabies and rubella; influenza, tetanus and meningococcus vaccine.

Vaccinations for travelling abroad

We reimburse the costs for consultations, medicines and vaccinations to prevent the following diseases in the event of travelling abroad: malaria, diphtheria, tetanus, poliomyelitis (DTP), yellow fever, typhus, cholera and hepatitis A/B.

Prescribed physiotherapy

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

Prescribed thrombosis treatment

Upon referral by a GP or medical specialist, we reimburse the costs of intensive care for thrombosis patients by the Thrombosis Service. The care entails:

- Regular blood sampling.
- Necessary laboratory tests, which could be performed under the responsibility of the Thrombosis Service, to determine the blood coagulation time.
- Provision of equipment and accessories for you to measure the blood coagulation time.
- Training for you for the use of the equipment indicated in point c) and for the reading of your measurements.
- Advise on the use of medicines to affect blood coagulation.

Exercise programmes

We reimburse the costs of exercise programmes led by a physical therapist and/or remedial therapist. The reimbursement applies for insured members suffering from obesity (i.e. with a body mass index over 40), rehabilitating from heart failure, affected by type 2 diabetes or by chronic obstructive pulmonary disease in Gold 1 and 2 stages, with a lung value of FEV1/FVC under 60%. Referral by a GP, medical specialist or dentist is required.

Mechanical respiration

We reimburse the costs of medically necessary mechanical respiration and specialist medical care connected with this in a respiration centre. If the respiration treatment takes place at the insured member's house by and under the responsibility of a respiration centre, the care consists of preparations by the respiration centre to make the necessary equipment ready for use before each treatment. It also consists of the specialist medical and pharmaceutical care related to the mechanical respiration, to be provided by or on behalf of the respiration centre.

Prescribed therapeutic swimming for rheumatism patients

We reimburse insured members affected by rheumatism for the costs of remedial therapy in heated water in a swimming pool. The patient needs to submit to us once only a document from the GP or medical specialist which certifies that remedial therapy in heated water is medically necessary in connection with rheumatism. The remedial therapy must take place in a group supervised by a physiotherapist or remedial therapist.

Occupational therapy

This benefit covers the advising, instruction, training or treatment by an occupational therapist with the aim of promoting or restoring the insured member's ability to cope independently. Referral by a GP, medical specialist or dentist is required.

Prescribed speech therapy

This benefit covers the costs of treatment by a speech therapist insofar as this care aims to serve a medical purpose and the treatment can be expected to restore or improve speaking ability or functioning. This also includes stuttering therapy by a speech therapist. Referral by a GP, medical specialist or dentist is required.

Prescribed skincare

We reimburse the costs of:

- Acne treatment provided by a beautician or skin therapist including the costs of the substances used for it.
- Camouflage therapy provided by a beautician or skin therapist including the costs of the substances used for this.
- Electric hair removal treatments provided by a beautician or skin therapist.
- Laser hair removal provided by a skin therapist for women who suffer from seriously disfiguring facial hair.

Referral from a GP or medical specialist is required, as well as Treatment Guarantee.

Prescribed visit to a hearing centre

We reimburse the costs of care provided by a hearing centre and consisting of:

- Hearing tests.
- Advice on hearing aids, as well as information on usage.
- Psychosocial care in connection with hearing problems, where necessary.
- Assistance in diagnosing speaking and language disorders in children. Referral from the GP, paediatrician, nose, ear and throat specialist or youth health care doctor is required.

Prescribed psoriasis treatment

We reimburse the cost of UVB light treatment of psoriasis at home or at a facility, upon referral by a medical specialist. For treatment at home, you may claim reimbursement for the rental of the necessary equipment.

Home help

We reimburse insured members who are disabled or chronically ill and who receive home care for the costs of replacement care when home care is not available. Treatment Guarantee is required.

Stutter therapy

We reimburse the costs for treatment and stay at a medical facility for stutter therapy. Referral from a GP, medical specialist or dentist is required.

Prescribed dyslexia care

Under this benefit, we reimburse the costs of any diagnosis tests to determine if the member is affected by dyslexia, provided that a referral for this is provided by a GP or specialist and where there is a suspected case of dyslexia without the existence of other reading or spelling problems. We will reimburse the costs for children starting receiving care in the age span from seven to ten, with particular regard to:

- Diagnostic tests to determine whether there is a case of serious dyslexia for which specialised treatment is necessary.
- Treatments possibly stemming from the diagnosis by a psychologist or special education expert.
- Care provided by other professional groups in the context of the multi-disciplinary cooperation.

Preventive examinations and screening for early detection of illness or disease

Unless agreed otherwise with us, your plan will provide cover for routine health checks, tests and examinations, performed at an appropriate age interval, for the early detection of illnesses or diseases. Tests and exams include:

- Cardiovascular exam.
- Neurological exam.
- Cancer screening:
  - Annual pap smear.
  - Mammogram.
  - Prostate screening.
- Well child test (for children up to the age of six years, up to a maximum of 15 visits per lifetime).

In vitro fertilisation (IVF) and other infertility treatments

Unless agreed otherwise with us, in general your plan provides cover for non-invasive investigations into the cause of infertility, within the limits of your Out-patient Plan.

Additionally, under this specific benefit, you are also covered for three IVF attempts per prospective clinical pregnancy (including medications used). An "attempt" is defined as going through a maximum of the following four phases:

- Maturation of egg cells through hormone treatment in the woman's body.
- Follicle puncture to extract mature egg cells.
- Fertilisation of egg cells and cultivation of embryos in the laboratory.
- Placement of one or two embryos in the uterus in order to achieve pregnancy.

An attempt will only count as an attempt if successful follicle puncture has taken place.

IVF treatment is reimbursed for insured women up to the age of 40. Women over 40 are eligible for IVF treatment as long as the suitability of the treatment has been medically evaluated and determined for the individual situation. In the event of **physiological (spontaneous) pregnancy**, a clinical pregnancy is understood to be a pregnancy of at least twelve weeks counted from the first day after the last pregnancy. For a **pregnancy due to IVF treatment**, a clinical pregnancy is understood to be a pregnancy of at least ten weeks counted from the follicle puncture or, if the IVF took place by means of placing embryos that had been frozen, a pregnancy of at least nine weeks and three days from implantation.

ICSI treatment (intracytoplasmic sperm injection) is equated with an IVF attempt.

We reimburse the costs of fertility treatment for insured women under 40 years of age. Women over 40 are eligible for infertility treatment subject to the effectiveness of the treatment being medically established in each individual situation. We only reimburse the costs of the medicines used, where prescribed for an infertility treatment other than the fourth and next IVF treatment.

With regards to insured men, we reimburse the costs of collecting, freezing and storing sperm as part of specialist medical treatment, if this treatment could unintentionally cause infertility. The care must be part of a specialist oncology care process which comprises of major surgery on/to the genitals, chemotherapeutic treatment and/or radiation therapy during which the genitals are in the radiation field.

Treatment Guarantee is required for IVF and any other covered infertility treatments.

Please note that in-patient treatment for multiple birth babies born as a result of medically assisted reproduction will be covered up to €30,000 per child for the first three months following birth. Out-patient treatment is paid within the terms of the Out-patient Plan.

Prescribed chiropodist

We reimburse the costs of foot care provided by a chiropodist to a member affected by rheumatism or diabetes. The chiropodist must be certified to treat diabetes and rheumatism patients. With the first

session, the member must submit a document from the GP, specialist or diabetes nurse which certifies that foot care is medically necessary in connection with diabetes or rheumatism.

Prescribed podotherapy and podology

We reimburse the costs of treatment by a podiatrist or podologist. In addition to the consultation, the treatment is also deemed to include the costs of measuring, manufacturing and delivering podiatric or podologic soles and orthotics. Podotherapy and podology are only reimbursed under a medical practitioner's referral. The treating podologist must be affiliated with a nationally recognised professional association for his/her field.

Prescribed dietician/nutrionist treatments

We reimburse the costs of dietary preparations where a member cannot manage with adjusted normal food and other special nutrition products and suffers from a metabolic disorder, food allergy, re-absorption disorder, illness-related malnutrition or risk thereof, or is prescribed such preparations in accordance with the guidelines accepted by the relevant professionals in the home country. The dietary preparations must be prescribed by a GP, specialist, dentist or midwife and be part of a medically necessary treatment. Treatment Guarantee is required in advance.

Obesity treatment

We reimburse costs of participation in the part-time day-care programme for obese patients at an obesity clinic, where the programme is focused on

behavioural change by means of non-surgical, multidisciplinary treatment. This benefit is eligible only in case of grade 3 obesity, i.e. when the Body Mass Index (BMI) is greater than 40 (a BMI calculator can be found on Allianz Worldwide Care's website: **www.allianzworldwidecare.com**). The costs of the obesity treatment are covered where the member completes the full programme. Treatment Guarantee is required.

Prescribed medical aids

We reimburse the costs of a range of medically prescribed aids, as follows: adhesive strips for affixing prosthetic breasts, aerochamber, telemonitoring, vacuum assisted closure system, supportive pessary, arch supports, bedwetting alarm, neuromodulator and biofeedback equipment, wigs, hearing aids, walking aids, monitoring equipment or sensormat for the prevention of crib death.

Sterilisation

We reimburse the costs of sterilisation performed during a day-care treatment at a hospital or out-patient facility or independent treatment centre.

Preventative courses

We contribute to the costs of the following preventative courses, provided that you submit to us a proof of registration and payment: weight loss, heart problems, 'Alcohol free lifestyle' training, first aid for child accidents, baby massage, lymph oedema, rheumatoid arthritis, arthrosis or Bechterew's disease, type 2 diabetes, basic CPR and sleep therapy organised by Somnio (this online sleep course offers professional advice and practical solutions to sleep better).

Glasses and contact lenses

We reimburse the costs of glasses or contact lenses supplied by an optician or optical company.

Menopause consultant

We reimburse the consultation fee for a menopause consultant. The menopause consultant must be affiliated with a nationally recognised professional association established for their discipline.

Lactation consultant care

We reimburse female members with breast feeding problems the costs of assistance and advice from a lactation consultant. The lactation consultant must be affiliated with a nationally recognised professional association established for their discipline or be in the employ of a maternity centre.

Second opinion

We reimburse the costs of a second opinion from a medical specialist other than the treating physician. The opinion or advice can be asked either by you or the treating GP. We only reimburse the costs if the diagnosis or treatment falls under the terms and conditions of this health insurance.

Your Dental Plan explained

Your dental cover will be indicated in your Table of Benefits along with the associated benefits, level of refund applied and any maximum plan benefit.

We reimburse the costs of dental care such as that provided by dentists, dental surgeons and orthodontists as follows:

- **Orthodontic treatment for members under 18 years old** provided by a dentist or orthodontist. We do not reimburse the costs of repairs or replacements in the event of loss or damage to orthodontic devices through fault or negligence.
- **Orthodontic treatment for members over 18 years old**, for the costs of orthodontic treatment (relining) administered by an orthodontist or dentist. We do not reimburse the costs of repairs or replacements in the event of loss or damage to orthodontic devices through fault or negligence. Prior to the commencement of orthodontic treatment, the member is required to submit to our medical advisor a treatment plan drawn up by the attending orthodontist or dentist, together with cephalometric images. Treatment in respect of which there is no or insignificant treatment need in line with score 1 or 2 as per guidelines in the 'Index for Orthodontic Treatment Need' (IOTN) is not eligible for reimbursement. The orthodontist or attending dentist can provide information on IOTN guidelines.
- **Costs of dental treatment provided by a dentist to patients under 18 years of age**. The placement of crowns and bridges must not be unnecessarily costly.
- **Removable full prosthetic devices for members over 18 years old**. We reimburse 75% of the costs (up to €500) of manufacture and placement of:
  - A removable full dental prosthesis for upper and/or lower jaw.
  - A removable full immediate fixed temporary prosthesis.
  - A removable full replacement prosthesis.
  - A removable full overdenture.

  The prosthesis must be supplied and invoiced by a dentist or dental prosthetician. We reimburse 100% of the costs of repair or rebasement of an

existing removable full prosthesis or an existing full overdenture supplied and invoiced by a dentist or dental prosthetician.

- **Dental assistance needed by members over 18 as a result of an accident**, where the treatment is provided by a dentist and where the accident occurs during the period of effectiveness of insurance. Treatment must take place within one year after the accident.
- **Dental implants** for a removable full prosthesis (on implants or not) in case of a serious development disorder, growth disorder or acquired deviation of the tooth-jaw-mouth system. These dental implants must be needed for the patient to retain or achieve dental functioning equal to what they would have had if the disorder had not occurred. For removable full prosthesis on implants, a personal contribution of €125 per upper or lower jaw applies. The jaw must be toothless and severely subsided. We need to grant permission in advance of this type of treatment and the request must be submitted by a dentist or dental prosthetician, accompanied by a treatment plan.
- **Dental care for members with a non-dental, physical and/or mental disability** who, without care, cannot retain or achieve dental functioning equal to the dental functioning they would have had without the physical and/or mental disability. Members can claim reimbursement where treatment is administred by a dentist or a dental surgeon. We need to give permission in advance of treatment: we will send you an application form on request, which will need to be completed and returned accompanied by a treatment plan. Referral from a GP, dentist or dental specialist is required.
- **Dental care in the following special cases**:
  - Serious development/growth disorder or acquired deviation of the tooth-jaw-mouth

system. Dental care must be needed for the patient to retain or achieve dental functioning equal to what they would have had if the disorder had not occurred.

- Essential, additional dental care where initial treatment is demonstrably insufficient to retain or achieve dental functioning equal to what the patient would have had if their disorder had not occurred. The treatment must be carried out by a dentist or dental surgeon. We need to grant permission in advance: we will send you an application form on request, which will need to be completed and returned accompanied by a treatment plan drawn up by your care provider. Referral from a GP, dentist or dental specialist is required.

Supplementary Dental Cover

You are covered under a Supplementary Dental Cover if this has been acquired and appears in your Table of Benefits. Cover is subject to T-Start, T-Extra or T-Royal Plans being chosen.

Your Repatriation Plan explained

Medical repatriation

If the necessary treatment for which you are covered is not available locally and you choose to be repatriated to your home country for treatment, rather than to the nearest appropriate medical centre, we will cover the repatriation costs up to the limit represented by the maximum cost we would pay to evacuate you 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. The reimbursement of the return trip will be subject to the limit represented by the maximum cost we would pay to return you from the nearest appropriate medical centre to your principal country of residence. Please note that Treatment Guarantee is required.

We will also reimburse your or your family members for the extension of your flight ticket, at economy rates, in connection with your illness or injury which arises during stay in your home country. Family members are only covered if you are in a life threatening situation.

If medical necessity prevents an immediate return trip following discharge from an in-patient episode of care in a hospital outside of the member's city/town of residence, we will cover hotel accommodation costs at the equivalent of a three star hotel daily room. Where the patient is an insured child under 16, we will also cover hotel accommodation costs for both parents at the equivalent of a three star hotel daily room.
In the event of repatriation from the country of residence to the home country, where needed for childbirth but not due to medical necessity, the repatriation costs of the insured mother are covered. Please note that a 25% co-payment applies. The flight costs, at economy rates, of the new born to fly from the home country to the country of residence of the parents are fully reimbursed in accordance with the relevant airline's rate for babies or toddlers.

Expenses for one person accompanying a repatriated person

One person will be entitled to travel with the repatriated person. If this cannot take place in the same transportation vehicle, round trip transport at economy rates will be paid for. There may be a maximum amount that can be claimed under this benefit, and if so, this will be indicated in the Table of Benefits. Please note that hotel accommodation and other related expenses are not covered and that Treatment Guarantee is required.

Travel and accommodation costs of one person to be with an insured family member who is at peril of death or who has died

We will cover reasonable transportation and accommodation costs (up to the amount specified in your Table of Benefits) so that one person can travel to the location of a first degree relative who is at peril of death or who has died. The first degree relative is a spouse, parent, brother, sister or child, including adopted children or step children, and needs to be insured with us. Claims are to be accompanied by a death certificate or medical certificate supporting the reason for travelling as well as copies of the flight tickets and hotel accommodation receipt. Cover will be limited to one claim per lifetime of the policy.

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 confirmed otherwise in the Table of Benefits or in any written policy endorsement.

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

2. **Pre-existing conditions** (including any pre-existing chronic conditions) are covered under non-underwritten policies. However, if you are covered under a policy that required medical underwriting, any pre-existing conditions that were not declared by you on the relevant application form will not be covered under the policy. In addition, conditions arising between completing the relevant application form and confirmation of acceptance by Allianz Worldwide Care's Underwriting Team will equally be deemed to be pre-existing, and will not be covered if not disclosed.

3. Products classified as **vitamins** or **minerals** (except during pregnancy or to treat diagnosed, clinically significant vitamin deficiency syndromes), and supplements including, but not limited to, special infant formula and cosmetic products, even if medically recommended, prescribed or acknowledged as having therapeutic effects.

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

5. Unless stated otherwise in the Table of Benefits, cover is not provided for investigations into, treatment and complications arising from **sexual dysfunction.**

6. In-patient treatment for **multiple birth babies born as a result of medically assisted reproduction** is limited to €30,000 per child for the first three months following birth. Out-patient treatment is paid within the terms of the Out-patient Plan.

7. Any treatment carried out by a plastic surgeon for the surgical implantation and removal of prosthetic breasts, except:

   - Following a single or double mastectomy, or
   - As part of a medical necessity.

8. Stays in a **cure centre**, **bath centre**, **spa**, **health resort**, **recovery centre**, **independent treatment centre or therapeutic camp**, unless the stay is medically necessary and prescribed by a general practitioner.

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

10. **Care and/or treatment of drug addiction or alcoholism**, including treatments related to the cessation of smoking.

11. 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.

12. **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.

13. **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 provided by a speech therapist and related to dyslexia or language development disorders in connection with dialect and different mother tongue.

14. **Physiotherapy costs** are not covered in case of individual or group treatment aimed only at promoting fitness by means of training or in case of individual treatment for members eligible for exercise programmes.

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. **Orthomolecular treatment** (please refer to Definition 1.59).

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

18. **Triple/Bart's, Quadruple** or **Spina Bifida tests,** except for women aged 35 or over.

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

20. **Complementary treatment**, with the exception of those treatments indicated in the Table of Benefits.

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

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

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

24. **Tumour marker testing** unless you have previously diagnosed with the specific cancer in question, in which case cover will be provided under the Oncology benefit.

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

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

27. Costs of **nursing** required in connection with artificial respiration at home or palliative care.

28. Costs related to the delivery of **help supplies** to the member's home and to their normal usage such as, for example, caps on crutches.

29. Costs of repairs or replacements of **orthodontic devices** in the event of loss or damage through fault or negligence.

30. Costs of **repatriation related to infertility treatments, sterilisation, pregnancy prevention and abortion**, as well as the costs of repatriation related to treatments not covered under this insurance, unless medically necessary.

31. The benefits covered under your plans are not eligible if:

31.1 The insured member can claim reimbursement of the insured costs related to nursing, examination or treatment pursuant to:
- Legally regulated insurance.
- Any government scheme.
- Any subsidy scheme.
- Another insurance contract.

31.2 They relate to costs of **psychoanalysis.**

31.3 They relate to **medical examinations requested by an employer for hiring purposes.**

31.4 They refer to costs for **non-show appointments.**

32. In case of adoption maternity screening, we do not reimburse the costs of medical screening of the adoptive child if the **adoption has already been completed.**

33. In case of **alternative therapies, treatments and medications,** we do not reimburse the costs of:

33.1 **Treatments, examinations or courses with a social character** or focused on wellness and/or prevention.

33.2 **Treatment courses** and **travel-related expenses.**

33.3 **Alternative treatments or therapies provided by your GP.**
33.4 Care related to **alternative psychotherapy.**
33.5 **Work and school related coaching.**

34. In relation to podotherapy and podology, we do not reimburse the costs of **shoes or adjustments to shoes.**

35. In case of preventive examinations, the costs are not reimbursed if the examination is part of a **general population screening.**

36. In the event of sterilisation, the costs of a **reversal** are not reimbursed.

37. The costs of **podiatric and podological supporting arches** prescribed by a podologist are not eligible for reimbursement.

38. **Accommodation costs incurred in the Netherlands or in the home country** are not eligible for reimbursement. This applies to the patient and, in case of patients under 16, to their accompanying parents as well.

Supplementary Dental Cover exclusions

39. Under the Supplementary Dental Cover, we do not reimburse the following costs:

39.1 Inspection reports and no-shows for appointments.
39.2 External whitening of teeth.
39.3 Mandibular Repositioning Device (MRD).
39.4 Orthodontics.
39.5 Subscriptions.

Paying premiums and general information

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

Paying premiums

If you are covered under a group policy

a. In most cases, your company is responsible for the payment of premiums to Allianz Worldwide Care for your membership and for the membership of dependants (if applicable) covered under the Company Agreement, together with the amount of any other payments due (such as Insurance Premium Tax) that may be payable in respect of your or their membership. However, please note that you may be liable for payment of tax in respect of the premiums paid by your company. For details, please check with your company.

b. If you are responsible for the payment of your premiums to Allianz Worldwide Care, you are required to pay the premium due to us in advance, for the duration of your membership. Premiums for each Insurance Year have been agreed between your company and us. The amount your company has agreed with us and the method of payment you have chosen, will be shown on your Insurance Certificate. 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: + 31 10 44 88 200. Changes in payment terms can be made at policy renewal via written instructions which must be received by us a minimum of 30 days prior to the renewal date. Failure to pay an initial premium or subsequent premium on time may result in loss of insurance cover.

If you are covered under an individual policy

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: + 31 10 44 88 200. 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 having not 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 membership

The insurance shall be valid as of the start date on the Insurance Certificate.

In the case of **group policies**, cover will continue until the group renewal date, as detailed in your Insurance Certificate. Generally, this is one Insurance Year, unless agreed otherwise between your company and us or if you started your policy mid-year. At the end of this period, your company can renew the insurance on the basis of the policy terms and conditions applicable at that time. You will be bound by those terms.

In the case of **individual policies**, cover starts on the date reported on the Insurance Certificate as the commencement date and is automatically renewed each year as of 1st January, 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. Cover 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 in your membership, their membership will start on the effective date stated on your Insurance Certificate, which lists them as a dependant.

In the case of **group policies**, the dependant's membership may continue for as long as you remain a member of your group scheme (and as long as any child dependants remain under the defined age limit). In the case of **individual policies**, the dependant's membership may continue for as long as you remain the policyholder (and as long as any child dependants remain under the defined age limit).

Child dependants may remain insured under the policy of their parent(s) as long as they are part of the family household and/or are living elsewhere while in full time education. However, their cover will last only until 1st January following their 28th birthday. At that time, they may 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, provided that you complete the relevant application form (if your policy is underwritten) or that you are allowed to do so under the agreement between your company and

us (if you are covered under a group policy): in the latter case, notification to add a dependant should be made through your company unless otherwise stated.

For **non-underwritten policies**, newborn infants will be accepted for cover from birth, provided that we are notified within four weeks of the date of birth. To have a newborn added to the policy, you must ask your company to submit a request in writing to its usual Allianz Worldwide Care contact person for membership changes. Notification of the birth after four weeks will result in newborn children being accepted for cover from the date of such notification. In-patient treatment for multiple birth babies born as a result of medically assisted reproduction will be covered up to €30,000 per child for the first three months following birth. Out-patient treatment will be paid within the terms of the Out-patient Plan.

For **policies with full medical underwriting**, newborn infants (with the exception of multiple birth babies and adopted children) will be accepted for cover from birth without medical underwriting under submission of a birth certificate, provided that we are notified within four weeks of the date of birth and the birth parent or intended parent (in the case of surrogacy), has been insured with us for a minimum of six continuous months. To have a newborn added to the policy, a written request must be sent to **ipm@aonhewitt.com** by your company (if you are part of a group scheme) or by yourself (if you are an individual). Notification of the birth after four weeks will result in newborn children being underwritten and cover will only commence from the date of acceptance.

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

In-patient treatment for multiple birth babies born as a result of medically assisted reproduction will be covered up to €30,000 per child for the first three months following birth. Out-patient treatment will be paid within the terms of the Out-patient Plan.

Changing country of residence

It is important that we are notified if you change your country of residence as it **may** impact your cover or premium, even if you are moving within your area of cover.

Please note that cover in some countries is subject to local health regulations, particularly for permanent residents of that country. It is your responsibility to ensure that your healthcare cover is legally appropriate and we would recommend that you seek independent legal advice in this regard. For example if you become permanently resident in the United States or Brazil, please note that we can no longer provide you with cover, as our plans do not comply with local laws in these countries.

If you are part of a group scheme, notification of change of residence should be made through your company, unless otherwise stated.

If you permanently return to the Netherlands and for the first 12 months following your return you cannot claim WLZ care/ dispensations, formerly called AWBZ care/ dispensations, we will cover the costs of such care / dispensations.

Renewing membership

(a) **If you are covered under a group policy and your company is responsible for paying your insurance premium**, the renewal of your membership (and that of your dependants,

if applicable) is subject to your company renewing your membership under the Company Agreement. If your company renews the contract with Allianz Worldwide Care, you will receive a new Insurance Certificate which will cover you (and your dependants, if applicable) until the next renewal date.

(b) **If you are covered under a group policy and are responsible for paying your insurance premium**, the renewal of your cover is subject to your company renewing your membership (and that of your dependants, if applicable) under the Company Agreement. In this case, your policy will be automatically renewed for the next Insurance Year, provided that 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.

(c) **If you are covered under an individual policy**, 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.

Ending your membership

(a) **If you are covered under a group policy**, your company can end your membership or that of any of your dependants by notifying us in writing. We cannot backdate the cancellation of your membership.

Your membership will automatically end:

- At the end of the Insurance Year, if the agreement between Allianz Worldwide Care and your company is terminated.
- If your company decides to end the cover or does not renew your membership.
- If your company does not pay premiums or any other payment due under the Company Agreement with Allianz Worldwide Care.

- If you are an individual payer and you do not pay premiums or any other payment due under the Company Agreement with Allianz Worldwide Care.
- When you stop working for the company.
- Upon the death of the policyholder.

Allianz Worldwide Care 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 your company has to pay.
- Whether we have to pay any claim.

(b) **If you are covered under an individual policy**, 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.
- 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.

Insured persons covered under an individual policy can end their membership or that of their dependants if they are no longer residing outside of their home country. To do so, please notify us in writing. We cannot backdate the cancellation of your membership.

Applying for cover if group membership ends

If you are covered under a group policy and this comes to an end under the Company Agreement, you can apply for cover under one of our healthcare plans for individuals. Your policy may be subject to

underwriting. We reserve the right to decide on the acceptance of your application.

The application must be submitted within one month of leaving the group scheme. The commencement date, if accepted for cover, will be the first day after leaving the group scheme.

General information

Table of Benefits

Your Table of Benefits will be issued using the currency agreed with you/your company.

Making changes to your cover

If you are covered under a group policy, the terms and conditions of your membership may be changed from time to time by agreement between your company and Allianz Worldwide Care.

If you are covered under an individual policy, 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.

Please notify us as soon as possible if you move country of residence, as this may impact your cover or premium – even if you are moving to a country within your existing area of cover. Please note that

cover in some countries is subject to local health regulations, particularly for permanent residents of that country.

Should you have any concerns about your premiums, or if your dependant's circumstances have changed, please call the Aon Helpline to discuss the options available to you.

Changes applied by us (applicable to individual policies only)

We may change the benefits and rules of your individual policy 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.

Death

Upon the death of the policyholder or a dependant, we should be notified in writing **within 28 days**.

If the deceased was covered under an **individual policy**, 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 (applicable to individual policies only)

Under the terms of your policy, you can cancel the contract by informing us in writing within 30 days of receiving the full terms and conditions of your policy or from the date of your policy commencement/renewal, whichever is later. Such notification of cancellation should be addressed to AON Helpline. You cannot backdate the cancellation of your membership.

If you cancel your contract within the 30 days cancellation period, you will be entitled to a full refund of premiums paid which relate to the new Insurance Year, provided that no claim has been made under the policy.

Should you wish to cancel, please complete the "Right to change your mind" form which was included in your welcome/renewal pack. This form can be sent to us via email to: **ipm@aonhewitt.com**. Alternatively, you can post this form to the following address:

Aon Hewitt International People Mobility
Postbus 1005
3000 BA – Rotterdam
Netherlands

If you choose not to exercise your right to cancel (or amend) your policy within this 30 day period, the insurance contract will be binding on both parties and the full premium owing for the selected Insurance Year will be due for payment, according to the payment frequency selected by you.

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. This can be done by filling out the "Right to change your mind" form, which can be sent to us via email or post.

If you do so, you will be entitled to a full refund of the premiums paid which relate to the dependant(s) for the new Insurance Year, subject to no claims having been made on their behalf.

Amending your membership details

We will send you 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 requested by you/your company or which we are entitled to make.

Your new Insurance Certificate will replace any earlier version(s) you possess, from the start 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 specifically agreed between you/your company and Allianz Worldwide Care: any change will be confirmed to you in writing by Aon or Allianz Worldwide Care.

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 12 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 Allianz Worldwide Care.

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 Aon at **ipm@aonhewitt.com** as soon as possible.

Correspondence

Written correspondence 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 French law unless otherwise required under mandatory legal

regulations. Any dispute that cannot otherwise be resolved will be dealt with by courts in France.

Cancellation and fraud

(a) For **individual policies**, we will cancel the insurance 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) For any **policy subject to medical underwriting**, 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, may render your cover void from the commencement date. **Conditions arising between completing the relevant application form and confirmation of acceptance by our Underwriting Team will be deemed to be pre-existing and will not be covered if not disclosed.** If the applicant is not sure whether something is relevant, the applicant is obliged to inform us.

(c) For **all policies**, if any claim is false, fraudulent, intentionally exaggerated or if fraudulent means or 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.

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 Aon 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 77 to 79.

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 Aon website: **www.aonexpatinsurance.com/netherlands/outgoing/en/claims/submitting-a-claim/**. 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

- Post to the address shown on the Treatment Guarantee Form.
- If treatment is due to take place **within 72 hours**, the Emergency Assistance Service 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 telephone if you call the Emergency Assistance Service. This gives us the opportunity to arrange for the direct settlement of your hospital bills, where possible.

Out-patient or dental claims

When you visit a medical practitioner, dentist, physician or specialist on an out-patient basis, please settle the bill with them and claim back the eligible expenses from us. Claims can be submitted quickly and easily through our *MyHealth* app: simply provide a few key details, take a photo of your invoice(s) and press 'submit'.
www.allianzworldwidecare.com/myhealth

Alternatively, simply download a Claim Form from Aon website: **www.aonexpatinsurance.com/netherlands/outgoing/en/claims/claimforms/**) and follow the steps below:

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

2. Please complete sections 1-4 and 7 of the Claim Form yourself. Sections 5 and 6 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 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, Treatment Guarantee Forms and medical receipts) as we reserve the right to request these copies at any time for fraud detection purposes, for up to 12 months after claims settlement. In addition, we cannot be held responsible for correspondence that does not reach us for any reason that is outside of our reasonable control.

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**. Please note that as well as our hard and soft copy claim forms, members can now avail of our mobile *MyHealth* app for fast and easy claims submission.

5. Please **specify on the Claim Form the currency in which you wish to be paid**. Unfortunately, on rare occasions, we may not be able to make payment in the currency you have requested, due to international banking regulations. In this instance we will review each case individually to identify a suitable alternative currency option. If we have to make a conversion from one currency to another, we will use the exchange rate that applies on the date on which the invoices were issued, or we will use the exchange rate that applies on the date that claims payment is made.

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 68).

10. All claims should be submitted to us with original supporting documentation, invoices and receipts **no later than 12 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.

11. Please note that if you are required to pay a deposit in advance of any medical treatment, the cost incurred will only be **reimbursed after treatment has taken place.**

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 track your claim through the Online Services section on Allianz Worldwide Care

website (www.allianzworldwidecare.com/members) if this option has been selected.

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?

We recommend you sending a fully completed Treatment Guarantee Form to us *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].

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 the Emergency Assistance Service can accept Treatment Guarantee requests over the telephone **if treatment is due to take place within 72 hours**.

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

When is Treatment Guarantee required?

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

- All in-patient treatments.
- Day-care treatment.
- Out-patient surgery.
- Nursing at home or in a convalescent home.
- Rehabilitation treatment.
- Medical evacuation or repatriation.
- Repatriation of mortal remains.
- MRI (Magnetic Resonance Imaging), PET (Positron Emission Tomography) and CT-PET scans.
- Oncology (in-patient and day-care treatment only).
- Routine maternity.
- Complications of pregnancy and childbirth (in-patient treatment only).
- Palliative care.
- Prescribed Independent Treatment Centre.
- Plastic surgery.
- Prescribed stay in the Dutch Asthma Centre in Davos.
- Stay in a therapeutic camp for disabled members.
- Prescribed genetic testing.
- Prescribed physiotherapy.
- Exercise programme.
- Occupational therapy (out-patient treatment only).
- Prescribed speech therapy.
- Prescribed skincare.
- Prescribed UVB treatment of psoriasis.
- Home help.
- Infertility treatment.

- Prescribed melatonin medicine for sleeping disorder.
- Prescribed therapeutic swimming for rheumatism patients.
- Prescribed dietician/nutritionist treatments.
- Accommodation in case of medical treatment received outside of country of residence.
- Expenses for one person accompanying an evacuated/repatriated person.
- Travel costs of insured family members in the event of an evacuation/repatriation

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 Allianz Worldwide Care's Medical Team.
- In the case of an evacuation/repatriation, we will be able to organise and coordinate the evacuation on your behalf.

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 coordinate 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/medical practitioner'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.

If you are covered under a group policy, your company may have opted to provide you with a plastic Caremark pharmacy card (96% of all retail walk-in pharmacies in the US are participants of Caremark's National Network). When you present this card at the pharmacy they will be able to access details of your prescription drugs cover online, check whether any benefit limits apply and then dispense your medication. If there is any amount to be paid by you, the pharmacy will confirm this. Please ensure that the prescriptions you present have the date of birth of the person that the prescription is for. If you have any queries in relation to using your Caremark card, toll-free numbers are provided on the back of the 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/awc/prescriptions.html and click on “Print Discount Card”.

Please note that treatment in the USA or Canada is not covered, if we know or suspect that cover was purchased for the purpose of travelling to these countries 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.

Q. Am I covered in my home country?

A. As an expatriate living abroad, you are covered for eligible costs incurred in your home country, provided that your home country is within your area of cover.

Q. What happens if I move country or return to my home country?

A. Please contact us as soon as possible if you move country of residence as it may impact your cover or premium, even if you are moving home or to a country within your existing area of cover. If you move to a country outside of your current geographical area of cover, your existing cover will not be valid there and so it is very important that you discuss this with us as early as possible. Please note that cover in some countries is subject to local health insurance restrictions, particularly for residents of that country. It is your responsibility to ensure that your health insurance cover is legally appropriate and we would recommend that you seek independent advice in this regard as we may no longer be able to provide you with cover.

Q. Which hospitals can I go to?

A. You can access an online Hospital, Doctor and Health Practitioner Finder on Allianz Worldwide Care website 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.

Making a complaint

Please find guidelines on our complaints process below.

The Allianz Worldwide Care Helpline (**+353 1 630 1301**) is always the first number to call if you have any comments or complaints. If we have not been able to resolve the problem on the telephone, please email or write to us at:

client.services@allianzworldwidecare.com

Allianz Worldwide Care
15 Joyce Way
Park West Business Campus
Nangor Road
Dublin 12
Ireland

Definitions

These definitions apply to the benefits included in our range of healthcare plans. 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 **Accidental dental treatment for insured members under 18 years** 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.

1.3 **Accommodation costs for one parent staying in hospital or similar accommodation with an insured child under 16** 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 **Admission** refers to admission in a hospital, psychiatric hospital/ward or rehabilitation facility to receive medically necessary nursing, examination or treatment.

1.5 **Alternative therapy or treatment** refers to therapeutic and diagnostic treatment that exists outside the institutions where conventional Western medicine is taught. Such medicine includes, for example, chiropractic treatment, osteopathy, Chinese herbal medicine, homeopathy and acupuncture as practiced by approved therapists.

1.6 **Calendar year** is the period that runs from 1st January to 31st December.

1.7 **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.

1.8 **Company** is your employer and whose name is mentioned in the Company Agreement.

1.9 **Company Agreement** is the agreement we have with your employer, which allows you and your dependants to be insured with us. This agreement sets out who can be covered, when cover begins, how it is renewed and how premiums are paid.

1.10 **Company doctor** is a medical practitioner recognised by the competent authorities who acts on behalf of the member's employer or the Occupational Health and Safety Service with which the employer is affiliated.

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

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

1.13 **Contraception** refers to hormonal contraception and intrauterine devices for female members. In order to be covered, contraception must be prescribed by a GP/specialist, must be dispensed by a pharmacy and must only be for personal use. For birth control pills, a prescription from the GP/specialist is required for the first supply of pills.

1.14 **Co-payment** is the percentage of the costs which the insured person must pay.

1.15 **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.

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

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

1.18 **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.

1.19 **Dental treatment** includes an annual check up, simple fillings related to cavities or decay and root canal treatment.

1.20 **Dentist** is a dentist recognised by the competent authorities of the country in which treatment is provided.

1.21 **Dependant** is your spouse or partner and/or unmarried children (including any step, foster or adopted child) financially dependant on the policyholder and also named in your Insurance Certificate as one of your dependants. Child dependants may remain insured under the policy of their parent(s) as long as they are part of the family household and/or are living elsewhere while in full time education. However, their cover will last only until 1st January following their 28th birthday.

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

1.23 **Dyslexia (serious)** is a reading and spelling disorder resulting from a neurological impairment that is genetically determined and can be distinguished from other reading and spelling problems.

1.24 **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.

1.25 **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.

1.26 **EU or EEA state** refers to the Netherlands and to the following EU countries: Belgium, Bulgaria, Cyprus (Greek), Denmark, Germany, Estonia, Finland, France, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, Austria, Poland, Portugal, Romania, Slovenia, Slovakia, Spain, Czech Republic, United Kingdom and Sweden. Switzerland is equated with this on grounds of treaty provisions. The EEA states (i.e. states that are party to the Agreement of the European Economic Area) are Lichtenstein, Norway and Iceland.

1.27 **Expenses for one person accompanying an evacuated/repatriated person** refer to the refer to the cost of one person travelling with the 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 repatriation originated. Cover does not extend to hotel accommodation or other related expenses.

1.28 **Centre for genetic testing** is an institution recognised by the competent authorities for the performance of clinical-genetic research and genetic advising.

1.29 **GP (General Practitioner)** is a medical practitioner who is recognised as GP by the competent authorities, or who operates as such in places where the term GP is not used.

1.30 **Guesthouse accommodation** is a facility that is part of a hospital complex and provides accommodation for children and their parents while the child undergoes out-patient treatment at that hospital.

1.31 **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.

1.32 **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.

1.33 **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.

1.34 **Hospital care** means admittance to hospital for more than 24 hours, when and as long as, on medical grounds, care, examination and treatment can only be provided in a hospital while constant treatment by a medical specialist or dental surgeon is necessary.

1.35 **Independent treatment centre** is a centre for specialist medical care (examinations and treatment) recognised as such by the competent authorities.

1.36 **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 Fertilisation (IVF), cover is limited to the amount specified in the Table of Benefits.

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

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

1.39 **Insurance Year** applies from the effective date of the insurance, as indicated on the Insurance Certificate and ends at the expiry date of the Company Agreement. The following Insurance Year coincides with the year defined in the Company Agreement.

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

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

1.42 **Maternity care** is the care provided by a certified maternity carer or a nurse working as such.

1.43 **Medical advisor** is the medical practitioner within our Emergency Assistance Service who advises us on medical matters.

1.44 **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.

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

1.45 **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.

1.46 **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.

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

1.48 **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 and you choose to be medically evacuated to your home country for treatment, instead of to the nearest appropriate medical centre, we will cover you up to the limit represented by the maximum amount we would pay to evacuate you 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 and the reimbursement will be subject to the limit represented by the maximum amount we would pay to return you from the nearest appropriate medical centre to your principal country of residence. We will also reimburse your or your family members for the extension of your flight ticket, at economy rates, in connection with your illness or injury which arises during stay in your home country. Your family members will be only covered if you are in a life threatening situation.

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

1.50 **Multidisciplinary cooperation** means integrated (chain) care that is provided in cohesion by several healthcare providers from different disciplinary backgrounds and which requires coordination in order to provide the care process for the insured person.

1.51 **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.

1.52 **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 medical practitioner 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.

1.53 **Obesity** is diagnosed when a person has a Body Mass Index (BMI) of over 40 (a BMI calculator can be found on Allianz Worldwide Care website: www.allianzworldwidecare.com).

1.54 **Occupational therapy** refers to treatment that addresses the individual's development of fine motor skills, sensory integration, co-ordination, 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.

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

1.56 **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.

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

1.58 **Orthodontist** is a dentist or dental orthopaedic specialist recognised by the competent authorities.

1.59 **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.

1.60 **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.

1.61 **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.

1.62 **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.

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

1.64 **Pharmacy** includes (internet) pharmacies, chain pharmacies, hospital pharmacies, out-patient facility pharmacies and dispensing physicians.

1.65 **Pharmaceutical care** means the dispensation of medications recognised and registered by the competent authorities, dispensed on prescription from the treating GP or medical practitioner by a pharmacy.

1.66 **Podiatrist** is a podiatrist recognised by the competent authorities of the country where treatment is provided.

1.67 **Policyholder** is the person appearing first in the Insurance Certificate.

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

1.69 **Pre-existing conditions** are medical conditions or any related conditions for which one or more symptoms have been displayed at some point during the five years prior to commencement of cover, irrespective of whether any medical treatment or advice was sought. For non-underwritten policies, pre-existing conditions are covered. However, for underwritten policies, any pre-existing condition or related condition about which you or your dependants could reasonably have been assumed to have known, or conditions arising between completing the relevant application form and the start date of the policy will equally be deemed to be pre-existing and will not be covered if not disclosed. Such pre-existing conditions will also be subject to medical underwriting and if not disclosed will not be covered.

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

1.71 **Pre-natal care** includes common screening and follow up tests as required during a pregnancy. For women aged 36 and over, this includes Triple/Bart's, Quadruple

and Spina Bifida tests, amniocentesis and DNA-analysis, if directly linked to an eligible amniocentesis.

1.72 **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.

1.73 **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 adhesive strips for affixing prosthetic breasts, aerochamber, telemonitoring, vacuum assisted closure system, supportive pessary, arch supports, bedwetting alarm, neuromodulator and biofeedback equipment, wigs, hearing aids, walking aids, prescribed monitoring equipment or sensormat for the prevention of crib death.

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

1.75 **Prescription drugs** refers to products, including, but not limited to, bandages, insulin, hypodermic needles or syringes, contraception products and intrauterine devices, melatonin medication (for sleeping disorders resulting from DSPS, ADHD and PDD-NOS), which require a prescription for the treatment of a confirmed diagnosis or medical condition or to compensate vital bodily substances. The prescription drugs must be clinically proven to be effective for the condition and recognised by the pharmaceutical regulator in a given country.

1.76 **Preventive examinations and screening for early detection of illness or disease** are health checks, tests and examinations, performed at an appropriate age interval, that are undertaken without any clinical symptoms being present. Such tests include:

- Cardiovascular exam.
- Neurological exam.
- Cancer screening:
  - Annual pap smear
  - Mammogram
  - Prostate screening
- Well child test (for children up to the age of six years, up to a maximum of 15 visits per lifetime).

1.77 **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).

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

1.79 **Psychiatry and psychotherapy** rs the treatment of a mental disorders carried out by a psychiatrist or clinical psychologist recognised by the competent authorities. The condition must be clinically significant. All day-care or in-patient admissions must include prescription medication related to the condition.

1.80 **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.

1.81 **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 unless this is listed as a specific benefit in your Table of Benefits. All covered expenses in connection with the repatriation of mortal remains must be pre-approved by us using Treatment Guarantee.

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

1.83 **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.

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

1.85 **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).

1.86 **Supplementary private room** is a benefit that, if included in the Table of Benefits, will cover the patient for an upgrade of their hospital accommodation from standard to private. This benefit covers the cost difference between the standard accommodation offered by the hospital the insured member is admitted to (room for more than one person) and a private room in the same hospital.

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

1.88 **Therapist/alternative therapist** is a chiropractor, osteopath, Chinese herbalist, homeopath, acupuncturist, physiotherapist, speech therapist, occupational therapist, manual therapist, physical therapist, oedema therapist, skin therapist, who is qualified and licensed under the law of the country in which treatment is being given.

1.89 **Travel and accommodation costs of one person to be with an insured family member who is at peril of death or who has died** refer to the reasonable transportation and accommodation costs (up to the amount specified in your Table of Benefits) so that one person can travel to the location of a first degree relative who is at peril of death or who has died. A first degree relative is a spouse, parent, brother, sister or child, including adopted children or step children, and needs to be insured with us. Claims are to be accompanied by a death certificate or medical certificate supporting the reason for travelling as well as copies of the flight tickets and hotel accommodation receipt. Cover will be limited to one claim per lifetime of the policy.

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

1.91 **Vaccinations** refer to all basic immunisations required under the Dutch national vaccination programme as well as rabies, rubella, influenza, tetanus and meningococcal vaccination or other vaccination required for travelling abroad as malaria, diphtheria,

tetanus and poliomyelitis (DTP), yellow fever, typhus, cholera and hepatitis A/B immunizations.

1.92 **We/Our/Us** is Allianz Worldwide Care and Aon. Allianz Worldwide Care is the insurer of this policy. Allianz Worldwide Care and Aon are jointly responsible for the policy's administration.

1.93 **You/Your** refers to the eligible insured person stated on the Insurance Certificate.

Additional policy terms

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

1. **Eligibility:** Only those employees and dependants as described in the Company Agreement (for group policies) or in the Insurance Certificate (for individual policies).

2. **Liability:** Our liability to the insured person is limited to the amounts indicated in the Table of Benefits and any subsequent policy endorsement. In no event will the amount of reimbursement, whether under this policy, public medical scheme or any other insurance, exceed the amount of the invoice.

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.

   The insured person must inform us and provide all necessary information, if and when entitled to claim from a third party. The insured person and the third party may not agree to 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 the insured person 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. **Data protection:** Allianz Worldwide Care, a member of the Allianz Group, is a French authorised insurance company. Together with Aon, 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 Allianz Worldwide Care and Aon. 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.

5. **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, may be contacted by us and asked to provide the relevant information. Similarly, all information in relation to any person covered by the insurance policy, for the purposes of administering claims, may be sent directly to the policyholder.

6. **Force majeure:** We shall not be liable for any failure or delay in the performance of our obligations under the terms of this policy, caused by, or resulting from, force majeure which shall include, but is not limited to: events which are unpredictable, unforeseeable or unavoidable, such as extremely severe weather, floods, landslides, earthquakes, storms, lightning, fire, subsidence, epidemics, acts of terrorism, outbreaks of military hostilities (whether or not war is declared), riots, explosions, strikes or other labour unrest, civil disturbances, sabotage, expropriation by governmental authorities and any other act or event that is outside of our reasonable control.

The following points 7 and 8 are applicable to individual policies only:

7. **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.

8. **Mediation:**

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

(b) If differences cannot be resolved in accordance with Clause 8.a above, the Parties (i.e. you and Allianz Worldwide Care) shall attempt to settle by mediation in accordance with the Centre for Effective Dispute Resolution (CEDR) Model Mediation Procedure any dispute, controversy or claim arising out of or relating to this Agreement or the breach, termination or invalidity thereof where the value is €500,000 or less and which cannot be settled amicably between the Parties. The Parties shall endeavour to agree on the appointment of an agreed Mediator. Should the Parties fail to agree the appointment of an agreed Mediator within 14 days, either Party (i.e. you or

Allianz Worldwide Care), 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 8.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 Paris (France). The Mediation Agreement referred to in the Model Procedure shall be governed by, and construed and take effect in accordance with the laws of France. The Courts of France shall have exclusive jurisdiction to settle any claim, dispute or matter of difference which may arise out of, or in connection with, the mediation.

(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 8.b but not voluntarily settled by mediation within three months of the ADR Notice date

shall be determined exclusively by the Courts of France and the Parties will submit to the exclusive jurisdiction of those courts. Any proceedings brought pursuant to Clause 8.c shall be issued within nine calendar months of the expiration date of the aforementioned three month period.

Notes

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

Helpline

Email:	ipm@aonhewitt.com
Telephone:	+ 31 10 44 88 200 (available during Dutch office hours)
Emergency Assistance Service:	+ 31 10 44 88 255 (available 24/7)

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