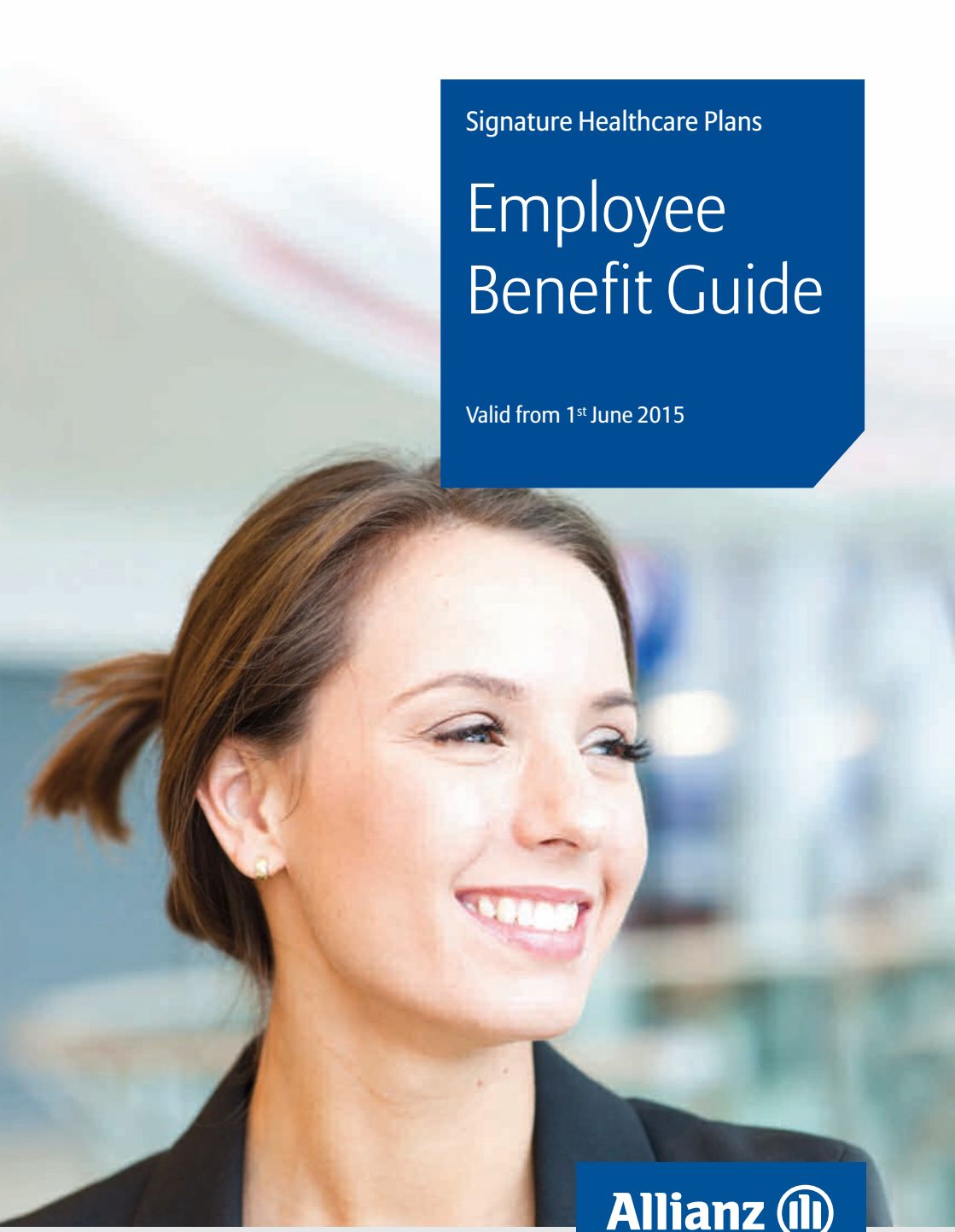

Signature Healthcare Plans

Employee Benefit Guide

Valid from 1st June 2015

Allianz

Allianz Worldwide Care

Your healthcare cover

This Benefit Guide sets out the standard benefits and rules of your group health insurance policy. Please read this guide in conjunction with your Insurance Certificate and Table of Benefits.

Your Insurance Certificate details the plan(s) your company has chosen for you and your dependants (if applicable) as well as the start date and renewal date of your cover. It also indicates that your geographical area of cover is "Worldwide". For underwritten policies, this document will also state any endorsements or special conditions that apply to your cover. Please note that we will send you a new Insurance Certificate if we need to record any changes requested by your company or which we are entitled to make, or if, with your company's approval and our acceptance, you request a change such as adding a dependant.

Your Table of Benefits outlines the plan(s) selected by your company and the associated benefits available to you. In addition, it specifies any benefits/treatments which require submission of a Pre-authorisation Form and confirms any benefits to which specific benefit limits, waiting periods, deductibles and/or co-payments apply. Your Table of Benefits will be issued using the currency agreed with your company.

For full details of your company's insurance contract, please contact your company's Group Scheme Manager. Please note that the terms and conditions of your membership may be changed from time to time by agreement between your company and Allianz Worldwide Care.

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Your cover

Overview

Your Table of Benefits specifies the plan(s) selected by your company and the associated benefits available to you. This could be one of our standard Core Plans, which may have been chosen in combination with one of our standard Out-patient, Maternity, Health Assessment, Private General Practitioner (GP) or Dental and Optical Plans. Alternatively, your plan may have been designed specifically for your company. Cover is subject to our policy definitions, exclusions and benefit limits and for underwritten groups, cover is also subject to any special conditions indicated on the Insurance Certificate (and on the Special Conditions Form issued prior to policy inception).

You will find further details about our benefits in the "Definitions" section of this guide, however if you have any queries regarding what you are covered for, please do not hesitate to call us.

We would like to bring your attention to the following important points:

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**, which 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. "80% refund". 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.

Maternity benefits (where included on your plan) will be payable on a "per pregnancy" basis. If a pregnancy spans two Insurance Years, please note that if a change is applied to the benefit limit at policy renewal, the following will apply:

- All eligible expenses incurred in the first year will be subject to the benefit limit that applies in year one.

- All eligible expenses incurred in the second year will be subject to the updated benefit limit that applies in year two, less the total benefit amount reimbursed in year one.
- In the event that the benefit limit decreases in year two and this updated amount has been reached or exceeded by eligible costs incurred in year one, no additional benefit amount will be payable.

Medical necessity and customary charges

This policy provides cover for medical treatment, related costs, services and/or supplies that we determine to be medically necessary and appropriate to treat a patient's condition, illness or injury. Plus we will only reimburse medical providers where their charges are reasonable and customary 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.

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 your lifetime, irrespective of whether any medical treatment or advice was sought. Any such condition or related condition about which you or your dependants could reasonably have been assumed to have known, will be deemed to be pre-existing.

Pre-existing conditions (including any pre-existing chronic conditions) are generally covered within the limits of your plan(s) unless indicated otherwise on a Special Conditions Form that is issued prior to policy inception. Please refer to the "Notes" section of your Table of Benefits to confirm if pre-existing conditions are covered. For underwritten groups, exclusion number 19 on page 17 of this guide provides details of the scenarios where we would not cover pre-existing conditions.

Medical Provider Network

As an Allianz Worldwide Care member, you have access to leading private hospitals and out-patient facilities throughout the UK, Channel Islands and Isle of Man.

In-patient treatment

With regard to in-patient treatment, your employer will have selected the Premium, Premium Plus or Premium Unlimited Hospital List for your particular scheme – the name of the Hospital List chosen for you will be indicated in your Table of Benefits. Under your plan, you are covered for eligible in-patient and day-care treatment in any of the hospitals on your chosen list. Please note that there are no restrictions on where you can receive out-patient treatment.

The three Hospital List options are as follows:

- **Premium** – offers a great range of private hospitals and NHS private facilities right around the UK.
- **Premium Plus** – in addition to all the hospitals on the Premium list, this more comprehensive list includes a broader range nationally, with a wider range of London based hospitals.
- **Premium Unlimited** – covers all hospitals in the UK.

Full details of the hospitals included in your Hospital List and the out-patient facilities within our Physiotherapy, Health Assessment and Dental Provider Networks can be found on our website at **www.allianzworldwidecare.com/ukmembers**.

Allianz Worldwide Care constantly monitors, evaluates and reviews the services provided by the hospitals included on our lists. Therefore, from time to time, we may amend our Hospital Lists available at the above website. We recommend that you check the lists on the website before accessing treatment, in order to confirm that your chosen medical provider is included in your Hospital List.

Treatment outside of network

You are only eligible for treatment in one of the hospitals on the list chosen by your employer. On the rare occasion that the treatment you require is not available at one of the hospitals on your list, please contact our Helpline (**LoCall 0203 5642 546**) and our Medical Services Team will assist you in arranging an alternative location. Please note that it is not guaranteed that treatment at a specific hospital not on your list will be approved by us. In addition, Pre-authorisation must be sought in advance for treatment at a hospital not on your list as otherwise your claim may not be paid by Allianz Worldwide Care when it is submitted for payment.

If you receive treatment on an in-patient or day-care basis in a hospital that is not included in your Hospital List, we may, at our discretion, calculate the average cost of equivalent treatment across all of the hospitals included on your list and the average cost calculated will be the maximum amount we will pay towards your treatment. This calculated amount may be less than the total costs incurred for treatment and in this case you will be required to pay the difference. However, if the actual cost of the treatment is less than the average cost calculated, we will pay the hospital costs in full, up to the benefit limit stated in the Table of Benefits. Cover for "Specialist fees" as a result of in-patient or day-care treatment received in a hospital that is not included in your chosen Hospital List will also be calculated on this basis.

Treatment in an NHS hospital

Unless stated otherwise, all NHS hospitals are included on all three Hospital Lists (Premium, Premium Plus and Premium Unlimited).

You may be treated as a private patient in a private patient unit or in a pay bed. However, it is important to note that, in some cases, pay beds may not differ from standard NHS accommodation and their availability is at the discretion of the hospital.

Alternatively, you may choose to be treated as a NHS patient. If you chose to have your treatment as a public patient in a NHS hospital, you may be eligible for the "in-patient cash benefit" for each night you are in hospital (subject to the maximum number of nights stated in your Table of Benefits).

Out-patient direct settlement networks

Allianz Worldwide Care has direct settlement agreements in place with a network of out-patient providers for physiotherapy, health assessments and dental treatment. Where these benefits are included in your cover, we can guarantee the direct settlement of your medical bills when you choose to be treated with one of our network providers. Simply call our network providers directly to arrange your treatment and they will take care of the confirmation of membership process.

If you decide to have treatment for physiotherapy, health assessments, or dental treatment with a provider that is not part of our network, you may have to pay for the treatment upfront and subsequently seek reimbursement from us.

Details of the out-patient healthcare providers within our Physiotherapy, Health Assessment and Dental Provider Networks, as well as details about how to book your treatment can be found on our website at: **www.allianzworldwidecare.com/ukmembers**

Overseas treatment

As your geographical area of cover is "Worldwide", you may receive treatment outside of the UK. The following section outlines the overseas treatment cover available to you, where the relevant benefit and/or plan has been selected.

Cover provided by optional plans

Where the optional Out-patient, Health Assessment, Private GP, Dental and Optical Plans are selected, cover is provided "Worldwide" up to the benefit limits stated in your Table of Benefits. The majority of the benefits covered under these optional plans do not require pre-authorisation; please refer to your Table of Benefits for further details.

In the event of planned overseas treatment covered under the Maternity Plan benefits (where a Maternity Plan has been selected), we will calculate the average cost of equivalent treatment across all hospitals included on your UK Hospital List. Your policy will cover the cost of eligible treatment up to this average amount, subject to any benefit limits that apply. Please note that pre-authorisation is required for all in-patient maternity benefits covered under your plan.

Overseas treatment in the event of a planned admission

If the "Overseas treatment in the event of a planned admission" is included in your plan, cover is provided for overseas procedures only when they are planned. The benefit is subject to pre-authorisation. We will calculate the average cost of equivalent treatment across all hospitals included on your UK Hospital List. Your policy will cover the cost of eligible treatment (including professional fees) up to this average amount, subject to any co-payments, deductibles and benefit limits that apply. In some instances this may result in a short-fall: in this case, you will be liable for all costs exceeding the benefit limit, including all travel and accommodation expenses.

The treatment must be carried out by a licensed practitioner in a recognised medical facility and our Medical Director must agree that there is a reasonable prognosis should the treatment be carried out.

Please note that we will require confirmation from your treating physician in the UK that you are fit to travel. Cover will not be provided when the member is travelling against medical advice.

The "Overseas treatment in the event of a planned admission" benefit also covers your repatriation where you have undergone pre-approved medical treatment abroad. Repatriation will happen when the attending doctor advises, and our Medical Director agrees, that you need to be transported back to the UK for further treatment, where it is not available locally. Costs covered will include transportation at economy rates back to the UK. This is only available where all arrangements have been made by Allianz Worldwide Care. The use of an air ambulance to repatriate patients will only be considered where it is deemed by the attending doctor and agreed by our Medical Director, that it is not medically appropriate for the patient to be accommodated on a commercial flight.

Overseas treatment in the event of an emergency

If the "Overseas treatment in the event of an emergency" benefit has been selected by your company, this will cover you and your dependants in the event of an emergency occurring during business and holiday trips outside of the UK. Cover is provided up to a maximum period of 42 days per trip within the maximum benefit amount as stated on your Table of Benefits. You will not be covered for any curative or follow-up non-emergency treatment. If you will be outside of the UK for more than six weeks, you should contact your company's Group Scheme Manager.

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.

This benefit is not intended to, nor does it, take the place of travel insurance and we recommend that you buy travel insurance before you go abroad. The member must indicate at the outset whether they hold separate travel insurance in respect of their trip abroad.

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

Direct settlement for overseas treatment

While Allianz Worldwide Care will propose the option of direct settlement to medical providers abroad, some providers may not accept such a method of payment and therefore, we are unable to guarantee direct payment of your medical bills.

If direct payment is not accepted, the member will have to pay for treatment there and then, upon their return to the UK, submit all relevant receipts to Allianz Worldwide Care. 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.

Definitions

The following definitions apply to the benefits included in our range of Signature Healthcare Plans and to some other commonly used terms. The benefits you are covered for are listed in your Table of Benefits. 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. Wherever the following words/phrases appear in your policy documents, they will always be defined as follows:

1.1 **Accident** is a sudden, unexpected event which causes injury and is due to a cause external to the insured person. The cause and symptoms must be medically and objectively definable, allow for a diagnosis and require therapy.

1.2 **Accommodation costs for one parent staying in hospital with an insured child** refers to the hospital accommodation costs of one parent for the duration of the insured child's admission to hospital for eligible treatment. If a suitable bed is not available in the hospital, we will contribute the equivalent of a three star hotel daily room rate towards any hotel costs incurred. We will not, however, cover sundry expenses including, but not limited to, meals, telephone calls or newspapers. Please check your Table of Benefits to confirm whether an age limit applies with regard to your child.

1.3 **Acute** refers to sudden onset.

1.4 **Acute condition** is defined as a disease, illness or injury that is likely to respond quickly to treatment which aims to return you to the state of health you were in immediately before suffering the disease, illness or injury, or which leads to your full recovery.

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

- Needs ongoing or long-term monitoring through consultations, examinations, check-ups and / or tests.
- Needs ongoing or long-term control or relief of symptoms.
- Requires your rehabilitation, or for you to be specially trained to cope with it.
- Continues indefinitely.
- Has no known cure.
- Comes back or is likely to come back.

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

1.7 **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.

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

1.9 **Completion of Claim Form** is a benefit that, where selected, covers you in the event that you incur a charge from your NHS doctor for the provision of medical reports or for the completion of a Claim Form. This benefit allows you to reclaim these charges, up to the amount stated in your Table of Benefits.

1.10 **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.

1.11 **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.

1.12 **Co-payment** is the percentage of the costs which the insured person must pay and is only applicable to the Dental and Optical Plan. Co-payments apply per person, per Insurance Year, unless indicated otherwise in the Table of Benefits. Some plans may include a maximum co-payment per insured person, per Insurance Year, and if so, the amount will be capped at the amount stated in your Table of Benefits.

1.13 **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.

1.14 **Deductible** is that part of the cost which remains payable by you and which has to be deducted from the reimbursable sum. Where applied, deductibles are payable per person per Insurance Year, unless indicated otherwise in the Table of Benefits. Deductibles may only apply to the Core and the Out-patient Plans, where selected.

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

1.16 **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.

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

1.18 **Dependant** is your spouse or partner (including same sex partner) and/or unmarried children (including any step, foster or adopted children) financially dependant on the policyholder up to the day before their 18th birthday; or up to the day before their 24th birthday if in full time education, and also named in your Insurance Certificate as one of your dependants.

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

1.20 **Dietician fees** relate to charges for dietary or nutritional advice provided by a health professional who is registered and qualified to practice in the country where the treatment is received. If included in your plan, cover is only provided in respect of eligible diagnosed medical conditions.

1.21 **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.

1.22 **Expenses for one person accompanying a repatriated person** 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.

1.23 **General practitioner (GP)** 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.

1.24 **Health assessments including cancer screening** are health checks, tests and examinations, performed at an appropriate age interval, that are undertaken without any clinical symptoms being present. We will fully cover a standard health assessment at any one of our network of assessment centres, up to the limit stated in your Table of Benefits. A standard health assessment includes: BMI, blood pressure, cholesterol, central nervous system, cardiovascular system, abdominal system, musculo-skeletal and testicular or breast

examinations. The assessment also includes time with a doctor, nurse or physiologist to discuss your health and ask any questions you may have. Please note that the insured member must be 18 years of age or older to utilise this benefit.

After attending for assessment, you will receive a personalised report detailing your test results, an explanation of their meaning and some recommendations for reducing health risks linked to your lifestyle.

1.25 **Hospital** is any establishment which is licensed as a medical or surgical hospital under the law of 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.

1.26 **Hospital accommodation** refers to standard private or semi-private accommodation as indicated in the Table of Benefits. Deluxe, executive rooms and suites are not covered. Please note that the hospital accommodation benefit only applies where no other benefit included in your plan covers the required in-patient treatment. In this case, hospital accommodation costs will be covered under the more specific in-patient benefit, up to the benefit limit stated. Psychiatry and psychotherapy, organ transplant, oncology, routine maternity, palliative care and long term care are examples of in-patient benefits which include cover for hospital accommodation costs, up to the benefit limit stated, where included in your plan.

1.27 **Hospital List** refers to the list of hospitals chosen by your company, from which you are eligible to receive treatment.

1.28 **Incidental charges** refers to any costs incurred by you during an eligible in-patient stay including, but not limited to, telephone calls, newspapers and parking.

1.29 **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.

1.30 **In-patient cash benefit** is payable when treatment and accommodation for a medical condition, that would otherwise be covered under the insured's plan, is provided in a NHS hospital where no charges are billed. Cover is limited to the amount specified in the Table of Benefits and is payable upon discharge from hospital. Please note that the "In-patient cash benefit" is not payable for the first three nights following admission in an Accident and Emergency Department of a NHS hospital, or a hospital where no charges have been billed.

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

1.32 **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.

1.33 **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.

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

1.35 **Long term care** refers to care over an extended period of time after the acute treatment has been completed, usually for a chronic condition or disability requiring periodic, intermittent or continuous care. Long term care can be provided at home, in the community, in a hospital or in a nursing home.

1.36 **Medical necessity** refers to medical treatment, services or supplies that are determined to be medically necessary and appropriate. They must be:

(a) Essential to identify or treat a patient's condition, illness or injury.
(b) Consistent with the patient's symptoms, diagnosis or treatment of the underlying condition.
(c) In accordance with generally accepted medical practice and professional standards of medical care in the medical community at the time.

(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.

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

1.37 **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.

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

1.39 **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.

1.40 **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.

1.41 **NICE** refers to the National Institute for Health and Clinical Excellence. NICE makes recommendations to the NHS on new and existing medicines, treatments and procedures, and treating and caring for people with specific diseases and conditions.

1.42 **Nursing at home or in a convalescent home** refers to nursing received immediately after, or instead of, eligible in-patient or day-care treatment. We will only pay the benefit listed in the Table of Benefits where the treating doctor decides (and our Medical Director agrees) that it is medically necessary for the member to stay in a convalescent home or have a nurse in attendance at home. Cover is not provided for spas, cure centres and health resorts or in relation to long term care (see definition 1.35).

1.43 **Obesity** is diagnosed when a person has a Body Mass Index (BMI) of over 30 (a BMI calculator can be found on our website: www.allianzworldwidecare.com).

1.44 **Occupational therapy** refers to treatment that addresses the individual's development of fine motor skills, sensory integration, coordination, balance and other skills such as dressing, eating, grooming, etc. in order to aid daily living and improve interactions with the physical and social world. Out-patient occupational therapy requires pre-authorisation.

1.45 **Oculomotor therapy** is a specific type of occupational therapy that aims to synchronise eye movement in cases where there is a lack of coordination between the muscles of the eye.

1.46 **Oncology** refers to specialist fees, diagnostic tests, radiotherapy, chemotherapy, surgical treatment, subsequent reconstructive surgery (if required) and hospital charges incurred in relation to the planning and carrying out of treatment for cancer, from the point of diagnosis. You are covered for all eligible oncology treatments at any hospital or cancer centre included in your Hospital List, on a in-patient, day-care or out-patient basis. You are also covered for eligible oncology treatments provided at home, provided that the treatment is appropriate, is given by qualified medical staff and is pre-approved by us. Where the "Overseas treatment in the event of a planned admission" benefit is included in your Table of Benefits, you also have the option of seeking oncology treatment abroad, up to the cost of the equivalent treatment and benefit limit that would apply if treatment was received in the UK at one of the hospitals on your Hospital List.

We cover targeted therapies, biological therapies and hormonal therapies, including licensed treatments normally not approved under the National Institute for Health and Clinical Excellence (NICE). Where symptoms exist, we will also cover tests for cancers of unknown origin (where the primary tumour is unknown) which can identify the type of cancer that you may have and assist in identifying the most appropriate treatment for you.

We do not place time limits on cancer treatments and will continue to provide the necessary treatment to relieve symptoms, including pain relief and the side effects of treatments, as long as it is medically necessary and you continue to hold a valid policy, even when a cure is no longer possible.

We will also cover the cost of external prostheses (e.g. wigs in the event of hair loss as a result of cancer treatment or breast prostheses). As your plan covers chronic conditions, we will continue to cover remission maintenance treatments and the ongoing monitoring of your health for a period of five years after cancer treatment has ceased.

1.47 **Oral surgical procedures** are surgical procedures, such as, but not limited to, the removal of impacted wisdom teeth, when carried out in a hospital by an oral or maxillofacial surgeon. We do not cover procedures that can be carried out by a dentist, unless the appropriate dental benefits form part of your cover, in which case, cover will be subject to the limits of your dental benefits.

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

1.49 **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.

1.50 **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.

1.51 **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.

1.52 **Overseas treatment in the event of a planned admission** refers to the option to receive your treatment at an overseas location. Treatment will be covered up to the calculated average cost of equivalent treatment across all of the hospitals included on the member's UK Hospital List. Please note that this amount will be subject to any benefit limits that apply and pre-authorisation is required.

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

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

1.55 **Post-cancer treatment monitoring** refers to the periodic monitoring of cancer patients after the completion of prescribed treatment. The level of cover provided will be in line with internationally recognised guidelines for the frequency of monitoring appropriate to post-cancer treatment.

1.56 **Pre-existing conditions** are medical conditions or any related conditions for which one or more symptoms have been displayed at some point during your lifetime, irrespective of whether any medical treatment or advice was sought. Any such condition or related condition, about which you or your dependants could reasonably have been assumed to have known, will be deemed to be pre-existing. Conditions arising between completing the relevant application form and the start date of the policy will equally be deemed to be pre-existing. Such pre-existing conditions will also be subject to medical underwriting and if not disclosed, they will not be covered. Please refer to the "Notes" section of your Table of Benefits to confirm if pre-existing conditions are covered.

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

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

1.59 **Prescribed glasses and contact lenses including eye examination** refers to cover for an eye examination carried out by an optometrist or ophthalmologist (one per Insurance Year) and for lenses or glasses to correct vision.

1.60 **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 a specialist. 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.

1.61 **Prescription charges** refer to charges paid by patients for drugs or other treatments that are prescribed for them by a NHS medical practitioner.

1.62 **Prescription drugs** refers to products, including, but not limited to, insulin, hypodermic needles or syringes, which require a prescription for the treatment of a confirmed diagnosis or medical condition or to compensate vital bodily substances. The prescription drugs must be clinically proven to be effective for the condition and recognised by the pharmaceutical regulator in a given country.

1.63 **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).

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

1.65 **Psychiatry and psychotherapy** is the treatment of mental or nervous disorders carried out by a psychiatrist or clinical psychologist. The condition must be clinically significant and not related to bereavement, relationship or academic problems, acculturation difficulties or work pressure. All day-care or in-patient admissions must include prescription medication related to the condition. The disorder must meet the criteria for classification under an international classification system such as the Diagnostic and Statistical Manual (DSM-IV), the International Classification of Diseases (ICD-10) or the Clinical Coding and Schedule Development (CCSD) Group.

1.66 **Rehabilitation** is the treatment in the form of a combination of therapies such as physical, occupational and speech therapy and is aimed at the restoration of a normal form and/or function after an acute illness or injury. The rehabilitation benefit is only payable for treatment that starts within 14 days of discharge after the acute medical and/or surgical treatment ceases and where it takes place in a licensed rehabilitation facility.

1.67 **Repatriation of mortal remains** is the transportation of the insured member's mortal remains back to the UK. 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 a Pre-authorisation Form.

1.68 **Routine maternity and childbirth** 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 complications of childbirth are not payable under the routine maternity and childbirth benefit. 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.

1.69 **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.

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

1.71 **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).

1.72 **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.

1.73 **Therapist** is a chiropractor, osteopath, homeopath, acupuncturist, physiotherapist, speech therapist, occupational therapist or oculomotor therapist, who is qualified and licensed by a recognised authority in the country where the treatment is taking place.

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

1.75 **Vaccinations** refer to all basic immunisations and booster injections required under regulation of the country in which treatment is being given, any medically necessary travel vaccinations and malaria prophylaxis.

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

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

1.78 **You/Your** refers to the person working for the Company and stated on the Insurance Certificate.

Exclusions

Although we cover most medically necessary treatment, 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. Any form of **treatment** or **drug therapy** which in our reasonable opinion is **experimental or unproven**, based on generally accepted medical practice. Participation in clinical trials is also excluded.

2. Any **treatment carried out by a plastic surgeon**, whether or not for medical/psychological purposes and any cosmetic or aesthetic treatment to enhance your appearance, even when medically prescribed. The only exception is reconstructive surgery necessary to restore function or appearance after a disfiguring accident, or as a result of surgery for cancer, if the accident or surgery occurs during your membership of the scheme.

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

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

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

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

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

8. **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.

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

10. **Genetic testing**, except where specific genetic tests are included within your plan, or where DNA tests are directly linked to an eligible amniocentesis i.e. in the case of women aged 35 or over.

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

12. Unless the Table of Benefits includes a specific benefit for **infertility treatment**, cover is limited to **non-invasive investigations into the cause of infertility**, within the limits of your Out-patient Plan.

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

14. Investigations into, and treatment of, **obesity**.

15. Investigations into, treatment of and complications arising from **sterilisation, sexual dysfunction** (unless this condition is as a result of total prostatectomy following surgery for cancer) and **contraception** including the insertion and removal of contraceptive devices and all other contraceptives, even if prescribed for medical reasons.

16. Unless stated otherwise in your Table of Benefits, **medical practitioner fees for the completion of a Claim Form** or other administration charges.

17. Organ transplant or the expenses for the **acquisition of an organ** including, but not limited to, donor search, typing, harvesting, transport and administration costs.

18. **Orthomolecular treatment** (please refer to definition 1.49).

19. In relation to underwritten groups, **pre-existing conditions** (including any pre-existing chronic conditions) which are indicated on a Special Conditions Form that is issued prior to policy inception (if relevant) and conditions which have not been declared on the relevant application form. In addition, conditions arising between completing the relevant application form and the start date of the policy will equally be deemed to be pre-existing. Such pre-existing conditions will also be subject to medical underwriting and if not disclosed, they will not be covered.

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

21. Products classified as **vitamins** or **minerals** and supplements including, but not limited to, special infant formula and cosmetic products, even if medically recommended, prescribed or acknowledged as having therapeutic effects. Costs incurred as a result of nutritional or dietary

consultations are not covered, unless a specific benefit is included within your Table of Benefits.

22. Prescription drugs or products that can be purchased without a **doctor's prescription**. However, you may have cover for prescription charges and if so, this will be clearly indicated on your Table of Benefits.

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

24. **Speech therapy** related to developmental delay, dyslexia, dyspraxia or expressive language disorder.

25. Stays in a **cure centre, bath centre, spa, health resort** and **recovery centre**, even if the stay is medically prescribed.

26. Unless stated otherwise in your Table of Benefits, **travel costs** to and from medical facilities (including parking costs) for eligible treatment, except any travel costs covered under "Private ambulance" and "Overseas treatment in the event of a planned admission" benefits.

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

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

29. Treatment for any illnesses, diseases or injuries, as well as instances of death resulting from **active participation in war, riots, civil disturbances, terrorism, criminal acts, illegal acts** or **acts against any foreign hostility**, whether war has been declared or not.

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

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

32. **Treatment in the USA** if we know or suspect that cover was purchased for the purpose of travelling to the USA to receive treatment for a condition, when the symptoms of the condition were apparent to the member prior to the purchase of cover.

33. **Treatment of sleep disorders**, including insomnia.

34. Treatment or diagnostic procedures for **injuries arising from an engagement in professional sports**.

35. **Treatment outside of the UK**, except:
    - Where emergency treatment is required and the "Overseas treatment in the event of an emergency" benefit is included in your Core Plan.
    - For cases of planned overseas treatment, covered under the "Overseas treatment in the event of a planned admission" benefit and Maternity Plan benefits (where a Maternity Plan has been selected). Pre-authorisation is required.
    - Where costs and treatments are covered under one of the optional Signature Out-patient, Health Assessment, Private GP or Dental and Optical Plans included in your cover.

36. Treatment to change the **refraction of one or both eyes (laser eye correction)**, with the exception of costs covered by the "Prescribed glasses and contact lenses including eye examination" benefit, where covered.

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

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

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

40. The following **treatments, expenses, procedures or any adverse consequences** or complications relating to them, unless otherwise indicated in your Table of Benefits:

    40.1 **Dental treatment, dental surgery, periodontics, orthodontics** and **dental prostheses** with the exception of **oral surgical procedures**, which are covered within the overall limit of your Core Plan.
    40.2 Dietician fees.
    40.3 Emergency dental treatment.
    40.4 Expenses for one person accompanying a repatriated person.
    40.5 Health assessments including cancer screening.
    40.6 Home delivery.
    40.7 Infertility treatment.
    40.8 In-patient psychiatry and psychotherapy treatment.
    40.9 Out-patient psychiatry and psychotherapy treatment.
    40.10 Out-patient treatment.
    40.11 Prescribed glasses and contact lenses including eye examination.
    40.12 Prescribed medical aids.
    40.13 Preventive treatment.

40.14 Rehabilitation treatment.
40.15 Routine maternity and childbirth.
40.16 Vaccinations.

Additional terms

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

1. Applicable law: Your membership is governed by the laws of England and Wales unless otherwise required under mandatory legal regulations. Any dispute that cannot otherwise be resolved will be dealt with by courts in England and Wales.

2. Cancellation and fraud:
   a) For **groups that require 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 material facts declared on the relevant application form, may render your cover void from the start date. Conditions arising between completing the relevant application form and the start date of the policy will equally be deemed to be pre-existing. Such pre-existing conditions will also be subject to medical underwriting and if not disclosed, they will not be covered. If the applicant is not sure whether something is relevant, the applicant is obliged to inform us.

   b) 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.

3. Data protection: Allianz Worldwide Care, a member of the Allianz Group, is a French authorised insurance company. We obtain and process personal information for the purposes of preparing quotations, underwriting policies, collecting premium, paying claims and for any other purpose which is directly related to administering policies in accordance with the insurance contract. The confidentiality of patient and member information is of paramount concern to us. 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.

4. Eligibility: Only those group members and dependants as described in the Company Agreement.

5. 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.

6. **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.

7. **Making contact with dependants:** In order to administer your policy in accordance with the insurance contract, there may be circumstances when we will need to request further information. If we need to make contact in relation to a dependant on a policy (e.g. where further information is required to process a claim), the policyholder, acting for and on behalf of the dependant, 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.

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

9. **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.

General information

Adding dependants

You may apply to include any of your family members as a dependant provided that you are allowed to do so under the agreement between your company and us. Notification to add a dependant should be made through your company unless otherwise stated.

For **non-underwritten groups**, 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, including a copy of the birth certificate, to its usual Allianz Worldwide Care contact person for membership changes. If we are notified four weeks or more after the date of birth, newborn children will be accepted for cover from the date of that notification.

For **groups with full medical underwriting**, newborn infants (except multiple birth babies, adopted and fostered children) will be accepted for cover from birth without medical underwriting, provided that we are notified within four weeks of the date of birth and the birth parent or intended parent (in the case of surrogacy) has been insured with us for a minimum of six continuous months. To have a newborn added to the policy, you must ask your company to submit a request in writing, including a copy of the birth certificate, and send it by email to our Underwriting Team at: **underwriting@allianzworldwidecare.com**. If we are notified four weeks or more after the date of birth, newborn children will be underwritten and cover will only start from the date of acceptance. Please note that all multiple birth babies, adopted and fostered children will be subject to full medical underwriting and cover will only commence from the date of acceptance.

In-patient treatment for multiple birth babies born as a result of medically assisted reproduction will be covered up to £24,900 per child for the first three months following birth. Out-patient treatment will be paid within the terms of the Out-patient Plan. These benefits are payable under the child's own plan.

Following acceptance of an additional dependant, we will issue a new Insurance Certificate to reflect the change, and this certificate will replace any earlier version(s) you may have from the start date shown on the new Insurance Certificate

Changing country of residence

It is important that you let us know if you change residence outside of the UK as it may impact the cover or premium, even if you remain within your current geographical region of cover. Cover in some countries is subject to local health insurance restrictions, particularly for residents of that country. It is your responsibility to ensure that your healthcare cover is legally appropriate and we

would recommend that you seek independent legal advice in this regard, as we may no longer be able to provide you with cover. Notification of change of residence should be made through your company unless otherwise stated.

Changing your address/email address

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

Claims

In relation to medical claims, please note that:

a) All claims should be submitted no later than six months after the end of the Insurance Year. If cover is cancelled during the Insurance Year, claims should be submitted no later than six months after the date that your cover ended. Beyond this time we are not obliged to settle the claim.

b) 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, if your company has selected our Online Services facility, members can now avail of our mobile *MyHealth* app for fast and easy claims submission.

c) 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.

d) It is your responsibility to retain any original supporting documentation (e.g. medical receipts) where copies are submitted to us, as we reserve the right to request original supporting documentation/receipts up to 12 months after claims settlement, for fraud detection purposes. In addition, we advise that you keep copies of all correspondence with us as we cannot be held responsible for correspondence that does not reach us for any reason that is outside of our reasonable control.

e) 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 all completed forms together with supporting receipts/invoices to us.

f) Please specify on the Claim Form the currency in which you wish to be paid. Unfortunately, on rare occasions, we may not be able to make a payment in the currency you requested, 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.

g) Only costs incurred as a result of eligible treatment will be reimbursed within the limits of your policy, after taking into consideration any pre-authorisation requirements. Any deductibles or co-payments outlined in the Table of Benefits will be taken into account when calculating the amount to be reimbursed.

h) 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.

i) 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.

Correspondence

Written correspondence between us must be sent by email or post (with the postage paid). We do not usually return original documents to you, unless you specifically request us to do so at the time of submission.

Ending your membership

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.
- 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 their dependants if there is reasonable evidence that the person concerned has misled or attempted to mislead us i.e. giving false information, withholding pertinent information from us, or working with another party to give us false information, either intentionally or carelessly, which may influence us when deciding:

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

Health Assessement Plan

If an Health Assesement Plan is included in your cover and if you choose to have additional tests or screenings that fall outside the Health Assessment Plan, you may be responsible for some or all of any additional charges levied.

We may not be able to facilitate the direct settlement of your costs if you choose to attend a facility outside of our provider network. In this instance, you will be required to pay the bill yourself and claim the cost through our normal "Pay and Claim" process.

Making a complaint

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

Other parties

No other person (except an appointed representative or the Group Scheme Manager) is allowed to make or confirm any changes to your membership on your behalf, or decide not to enforce any of our rights. No change to your membership will be valid unless it is specifically agreed between your company and Allianz Worldwide Care.

Paying premiums

Your company is responsible for the payment of premiums to Allianz Worldwide Care for your membership and for the membership of any dependants (if applicable) covered under the Company Agreement, together with any amount that may be due and payable in respect of membership (such as Insurance Premium Tax). Please be aware 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.

Policy expiry

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

Renewing membership

The renewal of your membership (and that of your dependants, if applicable) is subject to your company renewing your membership under the Company Agreement.

Pre-authorisation

Your Table of Benefits will confirm which benefits available to you require pre-authorisation through submission of a Pre-authorisation Form. If pre-authorisation is not obtained, we cannot guarantee the direct settlement of your healthcare costs. Also, please note that if pre-authorisation is not obtained and **the treatment received is subsequently proven to be medically unnecessary**, we reserve the right to decline your claim.

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

Treatment in the USA

To locate a medical provider in the USA, simply go to: **www.allianzworldwidecare.com/olympus**. If you have a query about a medical provider, or if you have selected a provider and wish to arrange an appointment, please call **(+1) 800 541 1983** (toll-free from the USA). Your company may have opted to provide you with a Caremark pharmacy card. 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. You can also apply for a discount pharmacy card which can be used any time your prescription is not covered by your healthcare policy.

To register and obtain your discount pharmacy card, simply go to: www.omhc.com/awc/prescriptions.html and click on "Print Discount Card".

Treatment needed as a result of somebody else's fault

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

When cover starts for you and your dependants

Your insurance is valid from the start date on the Insurance Certificate and will continue until the group renewal date (also stated on the 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.

Cover for dependants (if applicable) will start on the effective date shown on your most recent Insurance Certificate which lists them as a dependant. Their membership may continue for as long as you remain a member of the group scheme and as long as any child dependants remain under the defined age limit. Child dependants can be covered under your policy up until the day before their 18th birthday; or up until the day before their 24th birthday if they are in full time education. At that time, they may apply for cover in their own right under one of our International Healthcare Plans for Individuals, should they wish to do so.

Quick start guide

You can detach this part of the Employee Benefit Guide, if you just wish to have the most commonly referenced information to hand. Your cover remains subject to our policy definitions, exclusions and benefit limits, as detailed in the full Employee Benefit Guide.

Allianz

Allianz Worldwide Care

Getting treatment

First, please check that your plan covers the treatment you are seeking. Your Table of Benefits will confirm which benefits are available to you, however, you can always call our Helpline if you have any queries.

Remember, some treatments require pre-authorisation

The following treatments/benefits require pre-authorisation through submission of a Pre-authorisation Form:

- All in-patient benefits listed (where you need to stay overnight in a hospital).
- Day-care treatment.
- Expenses for one person accompanying a repatriated person.
- Kidney dialysis.
- Long term care.
- Nursing at home or in a convalescent home.
- Occupational therapy (only out-patient treatment requires pre-authorisation).
- Oncology (only in-patient or day-care treatment requires pre-authorisation).
- Overseas treatment in the event of a planned admission (in-patient and day-care treatment only).
- Out-patient surgery.
- PET (Positron Emission Tomography) and CT-PET scans.
- Rehabilitation treatment.
- Repatriation of mortal remains.
- Routine maternity and childbirth, complications of pregnancy and complications of childbirth (only in-patient treatment requires pre-authorisation).

Use of the Pre-authorisation Form helps us to assess each case and facilitate direct settlement with the hospital. Please note that we may decline your claim if Pre-authorisation is not obtained. *You can find full details on page 27 of this guide.*

Getting in-patient treatment

If you have to go to a hospital, and you are attending a hospital within your chosen Hospital List, we will settle the bill directly with the medical provider subject to any co-payments, deductibles and benefit limits. Details of your applicable Hospital List can be found in your Table of Benefits.

For **planned** treatment:

1. Download a Pre-authorisation Form from our website: **www.allianzworldwidecare.com/ukmembers**
2. Send the completed form to us at least **five working days before** treatment, by:
   - Scan and email to: **medical.services@allianzworldwidecare.com**
   - Fax to: **+ 353 1 653 1780** or post to the address shown on the form.
   - Our Helpline can take Pre-authorisation Form details over the phone if treatment is taking place within 72 hours.

For **emergency treatment** in the UK:

Most private hospitals are not set up to deal with emergency admissions. Therefore, in an emergency, you should attend the Accident and Emergency Department at your local NHS hospital.

If your treatment requires an in-patient stay in a NHS hospital – please contact us as you may be entitled to claim the "In-patient cash benefit" where treatment has been provided free of charge.

Emergency Overseas Assistance Service

If you require emergency medical treatment in a hospital or clinic, you should, where possible, contact our Helpline at **+ 353 1 630 1301** as soon as possible. Our Emergency Assistance Service is available 24 hours a day, 365 days a year, to provide you with a range of services.

If you require emergency treatment while in the USA, please contact our US partner, Olympus Managed Healthcare. 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. Olympus will deal directly with medical providers to coordinate the direct settlement of all your eligible medical treatment.

Getting out-patient or dental treatment

For your convenience, Allianz Worldwide Care facilitates the direct settlement of outpatient claims in the UK and Channel Islands. Where direct settlement is available you will not need to pay for outpatient treatment or complete a Claim Form; instead the bill will be settled directly between us and your medical provider. While we can not guarantee that all UK and Channel Islands based treatment providers will be able to settle bills directly with us, the majority of them (including all of the healthcare providers within our out-patient Provider Network and all major private hospitals) will be able to do so. Full details of the hospitals included in your Hospital List and the out-patient facilities within our Physiotherapy, Health Assessment and Dental Provider Networks can be found on our website at **www.allianzworldwidecare.com/ukmembers**.

Confirmation of membership

To avail of direct settlement for out-patient treatment in the UK, simply call our Helpline (**LoCall 0203 5642 546** from the UK) in advance of attending your appointment and ask for a "Confirmation of membership code". Please have your policy number to hand, along with details of the planned treatment, treatment date and the provider's name. We will then be able to check if your policy covers the proposed treatment and send you an email which contains your "Confirmation of membership" code. Simply bring that email with you when you go for treatment.

Please note that:

- This facility relates to non-surgical out-patient treatment only and does not apply to out-patient diagnostic tests which are settled on a "Pay and Claim" basis. For further information please refer to the "Pay and Claim" section below,
- If you prefer, you can pay for out-patient treatment and claim back eligible expenses by completing our Claim Form. Claim Forms are included in your Membership Pack and can be downloaded from the "Documents and Forms" section of our website: **www.allianzworldwidecare.com/ukmembers**

Pay and Claim

When you visit a medical practitioner, dentist, physician or specialist and have not obtained a "Confirmation of membership" code, or where you undergo treatment on an out-patient basis with a provider outside of our out-patient Provider Network, please settle the bill with them and claim back the eligible expenses from us. If your company has selected our Online Services facility, 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 our website: **www.allianzworldwidecare.com/ukmembers** and follow the steps below:

1. Get an invoice from the doctor/dentist/medical 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. Sections 5 and 6 only need to be completed by your treating medical provider.
3. Send the Claim Form and all supporting documentation, invoices and receipts to us. Details of how to submit these are included on the form.

Without the diagnosis, we cannot process your claim promptly, as we will need to request these details from you or your doctor.

We can process a claim and issue payment instructions to your bank within 48 hours, when all required information has been submitted. We will email or write to you to advise you of when the claim has been processed.

Please refer to the "Claims" section on pages 24 and 25 of this guide for additional important information about our claims process. You can find information about getting treatment in the USA on page 27.

Useful services

Please find details below of some useful services available to you:

- You can access our web-based member services at: **www.allianzworldwidecare.com/ukmembers**. Here you can **search for medical providers, download forms and access a range of health and wellbeing resources**. Please be aware that you are not restricted to using the medical providers listed on our website.

- If your company has requested this facility, you will receive a username and password in your Membership Pack giving you access to our **Online Services** at: **my.allianzworldwidecare.com**. Alternatively, on the same page, select "Register" and provide the information requested (available on your Insurance Certificate). Via Online Services you can download key policy documents, check remaining benefit limits and the status of claims. Plus you can also make use of the great range of services available on our *MyHealth* app. **www.allianzworldwidecare.com/myhealth**

- The **24/7 MediLine Medical Advice Service** can be accessed on: **+44 (0) 208 416 3929**. This service, provided by an experienced English speaking medical team, offers 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. For policy or cover related queries, please contact our Helpline.

Contact details

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

24/7 Helpline for general enquiries and emergency assistance

Email:	client.services@allianzworldwidecare.com
LoCall from the UK:	0203 5642 546
Helpline:	+ 353 1 630 1301
Fax:	+ 353 1 630 1306

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

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

Address: Allianz Worldwide Care, 15 Joyce Way, Park West Business Campus, Nangor Road, Dublin 12, Ireland.
www.allianzworldwidecare.com/ukmembers

Download our MyHealth app

- ✓ Quick and easy claims submission
- ✓ Policy documents on the go

www.allianzworldwidecare.com/myhealth

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