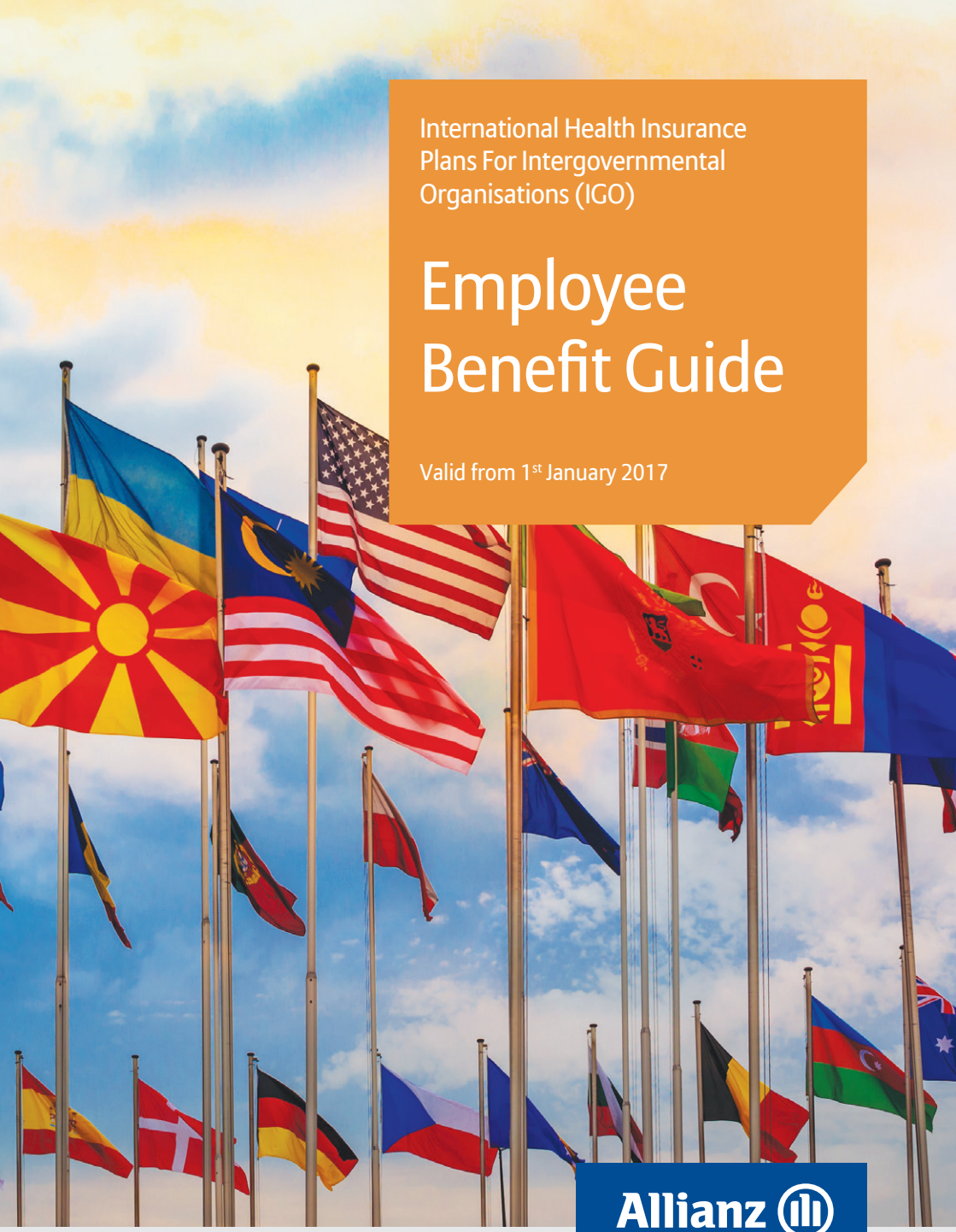

International Health Insurance Plans For Intergovernmental Organisations (IGO)

Employee Benefit Guide

Valid from 1st January 2017

Allianz

Worldwide Care Services

Your healthcare cover

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

Your Insurance Certificate details the plan(s) and geographical area of cover that your company has chosen for you and your dependants (if relevant) as well as the start date and renewal date of your cover. 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 Treatment Guarantee 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 each year by agreement between your company and Allianz Worldwide Care.

The Underwriter of your insurance is AWP Health & Life SA, a limited company with a capital of €65,190,446 governed by the French Insurance Code, with its registered office at 20 place de Seine, Tour Neptune, la Défense 1, 92086 Paris La Défense Cedex, France. Registered in France: 401 154 679 RCS Nanterre. VAT number: FR 84 401 154 679. Allianz Worldwide Care is a registered business name of AWP Health & Life SA.

The Administrator of your insurance is AWP Health & Life Services Limited – Belgium Branch having its branch trading address at 1 place du Samedi, 1000 Brussels, Belgium. VAT: BE 0843.991.159. RPM Bruxelles: 843.991.159. IBAN: BE65363102631696. BIC: BBRUBEBB. Allianz Worldwide Care Services is a registered business name of AWP Health & Life Services Limited.

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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. 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**, is the maximum we will pay for all benefits in total, per member, per Insurance Year, under that particular plan. Some benefits also have a **specific benefit limit**, which may be provided on a "per Insurance Year" basis, a "per lifetime" basis or on a "per event" basis. In some instances we will pay a percentage of the costs for the specific benefit e.g. "90% refund, up to €5,000". 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.

Benefit limits for "Routine maternity" and "Complications of pregnancy and childbirth" are payable on either a "per pregnancy" or "per Insurance Year" basis (this will be confirmed in your Table of Benefits). If your benefit is payable on a "per pregnancy" basis and 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 the costs of a claim are deemed by us to be too high, or the claim is not deemed to be medically necessary we reserve the right to reduce the amount payable by us.

Definitions

The following definitions apply to the benefits included in our range of 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. **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.

2. **Accidental death benefit** refers to an amount shown in the Table of Benefits which shall become payable if an insured member (aged 18 to 70) passes away during the period of insurance as a result of an accident (including industrial injury).

3. **Accommodation costs for one person staying in hospital with an insured child** refers to the hospital accommodation costs of one person 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.

4. **Acute** refers to sudden onset.

5. **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.

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

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.

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, Chinese herbal medicine, homeopathy and acupuncture as practiced by approved therapists.

9. **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.

10. **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.

11. **Co-payment** is the percentage of the costs which the insured person must pay. These apply per person, per Insurance Year, unless indicated otherwise in the Table of Benefits.

12. **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.

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

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

15. **Dental surgery** includes the extraction of teeth, apicoectomy, all diagnostic tests required, 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.

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

17. **Dependant** (also referred to as 'Family Member') shall mean the Eligible Staff Member's spouse and own legitimate child or children, either by birth or by adoption, up to the end of the calendar month in which the child's twenty fifth birthday occurs, or his marriage, whichever occurs first. If declared by the Policyholder, it shall also mean any other child or children, including a step child or children who has with the Eligible Staff Member, a normal child-parent relationship and who is dependent upon the Eligible Staff Member for not less than 50% of his support on a permanent basis up to the end of the calendar month in which the child's twenty fifth birthday occurs, or his marriage whichever occurs first. Dependants must be eligible to join in accordance with the Policyholder's Personnel Rules and Regulations.

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

19. **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 diagnosed medical conditions.

20. **Direct family history** exists where a parent, grandparent, sibling or child has been previously diagnosed with the medical condition in question.

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.

22. **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 accident. 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.

23. **Emergency out-patient dental treatment** is treatment received in a dental surgery/hospital emergency room for the immediate relief of dental pain, including temporary fillings, and/or the repair of damage caused in an accident. The treatment must be received within 24 hours of the accident. This does not include any form of dental prostheses or root canal treatment. If your company also selected a Dental Plan for you, you will be covered under the terms of this plan for dental treatment in excess of the (Core Plan) emergency out-patient dental treatment benefit limit.

24. **Emergency out-patient treatment** is treatment received in a casualty ward/emergency room within 24 hours of an accident or sudden illness, where the insured does not, out of medical necessity, occupy a hospital bed.

25. **Emergency treatment outside area of cover** is treatment for medical emergencies which occur during business or holiday trips outside your area of cover. Cover is provided up to a maximum period of seven weeks per trip within the maximum benefit amount and includes treatment required in the event of an accident, or the sudden beginning or worsening of a severe illness which presents an immediate threat to your health. Treatment by a physician, medical practitioner or specialist must commence within 24 hours of the emergency event. Cover is not provided for any curative or follow-up non-emergency treatment, even if you are deemed unable to travel to a country within your geographical area of cover, nor does it cover charges relating to maternity, pregnancy, childbirth or any complications of pregnancy or childbirth. You should advise your company's Group Scheme Manager if you are moving outside your area of cover for more than seven weeks.

26. **Family history** exists where a parent, grandparent, sibling, child, aunt or uncle has been previously diagnosed with the medical condition in question.

27. **Health and wellbeing checks including screening for the 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. Checks are limited to:

    - Physical examination.
    - Blood tests (full blood count, biochemistry, lipid profile, thyroid function test, liver function test, kidney function test).
    - Cardiovascular examination (physical examination, electrocardiogram, blood pressure).
    - Neurological examination (physical examination).
    - Cancer screening:
        - Annual pap smear.
        - Mammogram (every two years for women aged 45+, or earlier where a family history exists).
        - Prostate screening (yearly for men aged 50+, or earlier where a family history exists).
        - Colonoscopy (every five years for members aged 50+, or 40+ where a family history exists).
        - Annual faecal occult blood test.
        - Bone densitometry (every five years for women aged 50+).
    - Well child test (for children up to the age of six years, up to a maximum of 15 visits per lifetime).
    - BRCA1 and BRCA2 genetic test (where a direct family history exists).

28. **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.

29. **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.

30. **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.

31. **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. If the Table of Benefits does not have 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, if your company selected one. Please note that for multiple birth babies born as a result of medically assisted reproduction, in-patient treatment 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.

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

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

34. **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.

35. **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.

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

37. **Laser eye treatment** refers to the surgical improvement of the refractive quality of the cornea using laser technology, including necessary pre-operative investigations.

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

39. **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.

40. **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 medical and/or scientific knowledge at the time of treatment.
    (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.

41. **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.

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

43. **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.

44. **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. Unless the child is included on the policy as an eligible dependant, 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. Please note that for multiple birth babies born as a result of medically assisted reproduction, in-patient treatment 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.

45. **Non-prescribed physiotherapy** refers to treatment by a registered physiotherapist where referral by a medical practitioner has not been obtained prior to undergoing treatment. Where this benefit applies, cover is limited to the number of sessions indicated in your Table of Benefits. Additional sessions required over and above this limit must be prescribed in order for cover to continue; these sessions will be subject to the prescribed physiotherapy benefit limit. Physiotherapy (either prescribed, or a combination of non-prescribed and prescribed treatment) is initially restricted to 12 sessions per condition, after which the treatment must be reviewed by the referring medical practitioner. Should further sessions be required, a progress report must be submitted to us, which indicates the medical necessity for any further treatment. Physiotherapy does not include therapies such as Rolfing, Massage, Pilates, Fango and Milta therapy.

46. **Nursing at home or in a convalescent home** refers to nursing received immediately after, or instead of, eligible in-patient or day-care treatment. We will only pay the benefit listed in the Table of Benefits where the treating doctor decides (and our Medical Director agrees) that it is medically necessary for the member to stay in a convalescent home or have a nurse in attendance at home. Cover is not provided for spas, cure centres and health resorts or in relation to palliative care or long term care (see definitions 57 and 39).

47. **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).

48. **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 and grooming in order to aid daily living and improve interactions with the physical and social world.

49. **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.

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

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

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

53. **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 and hormones.

54 **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.

55. **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.

56. **Over-the-counter drugs** refer to medication which can be purchased in a pharmacy without a prescription, The drugs must be clinically proven to be effective for the condition and recognised by the pharmaceutical regulator in a given country.

57. **Palliative care** refers to ongoing treatment aimed at alleviating the physical/psychological suffering associated with progressive, incurable illness and maintaining quality of life. It includes 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. We will also pay for physical care, psychological care as well as hospital or hospice accommodation, nursing care and prescription drugs.

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

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

60. **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 before the start date of the policy, will be deemed to be pre-existing. Pre-existing conditions (including any pre-existing chronic conditions) are covered within the limits of your plan(s).

61. **Pregnancy** refers to the period of time from conception to delivery.

62. **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.

63. **Prescribed ancillary nursing care** refers to nursing acts medically prescribed and carried out by a qualified nurse at home or in an appropriate medical centre on an Out-patient basis. This includes but is not limited to, acts such as dressing changes or insulin injections. Only acts that are deemed to be medically necessary will be covered.

64. **Prescribed drugs** refers to products prescribed by a physician for the treatment of a confirmed diagnosis or medical condition, or to compensate vital bodily substances including, but not limited to, insulin, hypodermic needles or syringes. The prescribed drugs must be clinically proven to be effective for the condition and recognised by the pharmaceutical regulator in a given country. Prescribed drugs do not legally have to be prescribed by a physician in order to be purchased in the country where the member is located; however, a prescription must be obtained for these costs to be considered eligible.

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

66. **Prescribed medical aids** refers to any instrument, apparatus or device which is medically prescribed as an aid to the function or capacity of the insured person, such as hearing aids, speaking aids (electronic larynx), crutches or wheelchairs, orthopaedic supports/braces, artificial limbs, stoma supplies, graduated compression stockings as well as orthopaedic arch-supports. Costs for medical aids that form part of palliative care or long term care (see Definitions 57 and 39) are not covered.

67. **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.

68. **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.

69. **Preventive treatment** refers to treatment that is undertaken without any clinical symptoms being present at the time of treatment such as the removal of a mole on the skin.

70. **Principal country of residence** is the country where you and your dependants (if relevant) live for more than six months of the year.

71. **Psychiatry and psychotherapy** is the treatment of mental disorders carried out by a psychiatrist or clinical psychologist. The condition must be clinically significant and not related to bereavement, relationship or academic problems, acculturation difficulties or work pressure. All day-care or in-patient admissions must include prescription medication related to the condition. Psychotherapy treatment (on an in-patient or out-patient basis) is only covered where you or your dependants are initially diagnosed by a psychiatrist and referred to a clinical psychologist for further treatment. In addition, out-patient psychotherapy treatment (where covered) is initially restricted to 10 sessions per condition, after which treatment must be reviewed by the referring psychiatrist. Should further sessions be required, a progress report must be submitted to us, which indicates the medical necessity for any further treatment.

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

73. **Routine maternity** refers to any medically necessary costs incurred during pregnancy and childbirth, including hospital charges, specialist fees, the mother's pre- and post-natal care, midwife fees as well as newborn care. Costs related to complications of pregnancy and complications of childbirth are not payable under routine maternity. In addition, any non-medically necessary caesarean sections will be covered up to the cost of a routine delivery in the same hospital, subject to any benefit limit in place. If the home delivery benefit is included in your plan, a lump sum up to the amount specified in the Table of Benefits will be paid in the event of a home delivery.

74. **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.

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

76. **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).

77. **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.

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

79. **Travel costs of insured members to be with a family member who is at peril of death or who has died** refer to the reasonable transportation costs (up to the amount specified in your Table of Benefits) so that insured family members 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, fostered children or step children. Claims are to be accompanied by a death certificate or doctor's certificate supporting the reason for travel as well as copies of the flight tickets, and cover will be limited to one claim per lifetime of the policy. Cover does not extend to hotel accommodation or other related expenses.

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

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

82. **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..

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

84. **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 is **experimental or unproven**, based on generally accepted medical practice.

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

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

11. **Genetic testing**, except where DNA tests are directly linked to an eligible amniocentesis.

12. **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.

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. The only exception in relation to costs for contraception is where contraceptives are prescribed by a dermatologist for the treatment of acne.

16. Medical evacuation/repatriation from a **vessel at sea** to a medical facility on land.

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

18. **Orthomolecular treatment** (please refer to definition 53).

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

20. Products classified as **vitamins** or **minerals** (except during pregnancy or to treat diagnosed, clinically significant vitamin deficiency syndromes) and supplements, such as 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.

21. Products that can be purchased without a **doctor's prescription**, except where a specific benefit covering these costs appears in the Table of Benefits.

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

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

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

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

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

27. 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.

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

29. 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**.

30. **Treatment in the USA** if we know 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 insured person prior to the purchase of cover.

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

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

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

34. Treatment to change the **refraction of one or both eyes** (laser eye correction).

35. Treatment required as a result of **failure to follow medical advice**.

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

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

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

    38.1 Dietician fees.
    38.2 Expenses for one person accompanying an evacuated/repatriated person.
    38.3 Health and wellbeing checks including screening for the early detection of illness or disease.
    38.4 Home delivery.
    38.5 Infertility treatment.
    38.6 Medical repatriation.
    38.7 Out-patient psychiatry and psychotherapy treatment.
    38.8 Prescribed medical aids.
    38.9 Preventive treatment.
    38.10 Rehabilitation treatment.
    3811 Travel costs of insured family members in the event of an evacuation/repatriation.
    3812 Travel costs of insured family members in the event of the repatriation of mortal remains.
    38.13 Travel costs of insured members to be with a family member who is at peril of death or who has died.
    38.14 Vaccinations.

Additional terms

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

1. **National Law:** It is the parties understanding that no provision of any national law shall affect any clause, even of a general character, of this contract.

2. **Eligibility:** Only those group members (and dependants) as described in the Company Agreement.

3. **Fraud and non-disclosure:** In the event of an incomplete or inaccurate declaration by the Insured Person, the Insurer shall be entitled either to declare the policy null and void if the misrepresentation was deliberate or reckless, or if the misrepresentation was careless, to reduce proportionally the amount to be paid on a claim.

   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, and any pending claims settlements will be forfeited. We reserve the right to inform the company of any fraudulent activity on the part of you or your dependants.

4. **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.

5. **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.

6. **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.

7. **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.

8. **Limitation to actual costs:** The reimbursements or compensations of the costs incurred by an illness, a maternity or an accident shall not exceed the amount of the costs remaining payable by the Insured Person after the payment of the benefits of any type he/she is entitled to. Benefits of the same type taken out with several insuring bodies shall be enforceable up to the limit of each benefit, whatever the date it has been taken out. Within this limit, the policy beneficiary may obtain an additional compensation by submitting the summary of benefit(s) paid by the other insuring body(ies). For the purpose of the aforementioned provisions, the limitation to the costs remaining payable by the Insured Person is determined by the Insurer for each medical procedure or cost item. 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.


INDONESIA
AUSTRALIA
INDIAN OCEAN
ARCTIC OCEAN
CANADA
NORTH AMERICA
UNITED STATES
MEXICO

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.

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. 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.

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

Applying for cover if group membership ends

If your cover under the Company Agreement comes to an end, 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.

Changing country of residence

It is important that you let us know if you change your country of residence 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 two years after the treatment date. 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) 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 2 years after claims settlement, for auditing 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.

d) If the amount to be claimed is less than the deductible figure under your plan, 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 supporting receipts/invoices.

e) 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.

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

g) 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.

In order to process your application, the medical information will be processed electronically. This form, along with any/all attachments, will therefore be transferred to the Medical department of AWP Health & Life SA and if applicable, to it's reinsurer, whilst being compliant with medical secrecy.

Reimbursements of expenses as a result of illness, maternity or an accident, shall not exceed the amount of costs payable by the insured person following reimbursement of any kind to which the insured person is entitled and before any payments are made under the social security system.

Insurance cover of the same kind taken out with multiple insurers will only take effect within the limit of each insurance cover regardless of the date the insurance cover was taken out.

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.

Countries where you can receive treatment

If 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.

If 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.

Please note that 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.

Ending your membership

Your company can end your membership or that of any of your dependants by notifying us in writing. 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.

Making a complaint

The Allianz Worldwide Care Helpline (**+353 1 629 7191**) 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:

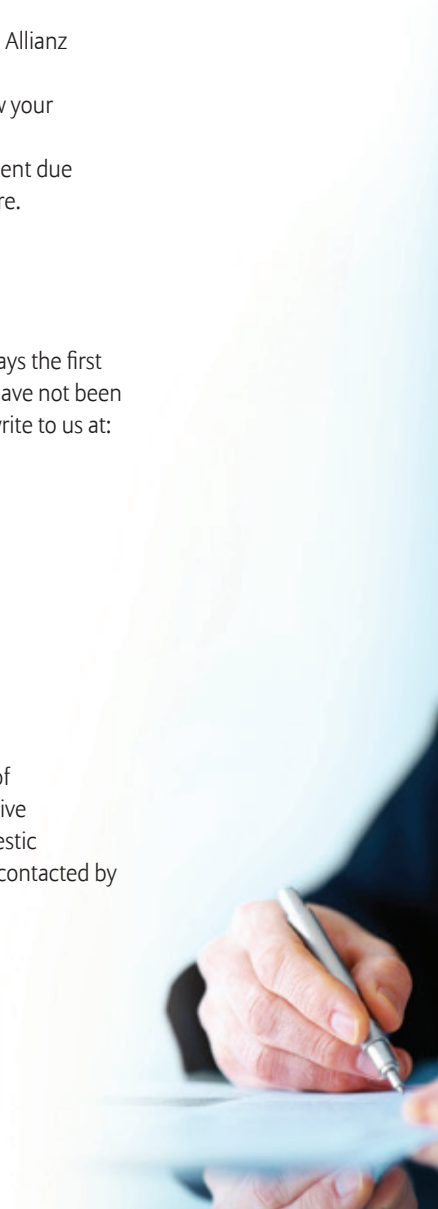
igo.assistance@allianzworldwidecare.com

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

Allianz Worldwide Care is a signatory to the mediation charter of the Insurance. Therefore, in the event of a persistent and definitive disagreement, you have the option, after exhaustion of all domestic remedies, to call for the Mediator of the Insurance, who can be contacted by post at:

TSA 50 110,
75 441 Paris Cedex 09

and without prejudice to other possibilities of legal actions.



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 also covered under the Company Agreement, together with any amount that may be due and payable in respect of membership (such as special tax on insurance contract).

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 two years after the treatment date. However, any on-going or further treatment that is required after the expiry date of your policy will no longer be covered.

Renewing membership

Since your company pays for your 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.

Treatment Guarantee

Your Table of Benefits will confirm which benefits available to you require pre-authorisation through submission of a Treatment Guarantee Form. Please note that unless agreed otherwise between your company and us, if Treatment Guarantee Form is not submitted to us, the following will apply:

- If the treatment received is subsequently proven to be medically unnecessary, **we reserve the right to decline your claim**.
- For the benefits listed in the Table of Benefits with a **1**, **we reserve the right to decline your claim**. If the respective treatment is subsequently proven to be medically necessary, we will pay only **80%** of the eligible benefit.

- For the benefits listed in the Table of Benefits with a 2, **we reserve the right to decline your claim.** If the respective treatment is subsequently proven to be medically necessary, we will pay only **50%** of the eligible benefit.

Treatment in the USA

If you have "Worldwide" cover and wish to locate a medical provider in the USA, simply go to: **www.allianzworldwidecare.com/olympus**. If you have a query about a medical provider, or if you have selected a provider and wish to arrange an appointment, please call (toll-free from the USA) **(+1) 800 541 1983**. 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: **http://members.omhc.com/awc/prescriptions.html** and click on "Print Discount Card".

Please note that treatment may be covered with Worldwide cover, however treatment is not covered if the Insurer knows or suspects that cover was purchased for the purpose of travelling to receive treatment for a condition, when the symptoms of the condition were apparent to the member prior to the purchase of cover. The Insurer reserves the right to claw back any claims amounts from the Insured Person that have been paid by the Insurer already.

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 relevant) 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 to the end of the calendar month in which the child's twenty fifth birthday occurs, provided they have not been married in the meantime. At that time, they may apply for cover in their own right under one of our Healthcare Plans for Individuals, should they wish to do so.

Notes

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

Worldwide Care Services

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 Treatment Guarantee Form:

- All in-patient benefits[1] listed.
- Day-care treatment[2].
- Kidney dialysis[2].
- Out-patient surgery[2].
- MRI (Magnetic Resonance Imaging) scan. Treatment Guarantee may be required for this test if you would like us to settle the bill directly with the medical provider.
- PET[2] (Positron Emission Tomography) and CT-PET[2] scans.
- Nursing at home or in a convalescent home[2].
- Routine maternity[2] and complications of pregnancy and childbirth[2] (in-patient treatment only).
- Oncology[2] (in-patient and day-care treatment only).
- Occupational therapy[2] (out-patient treatment only).
- Rehabilitation treatment[2].
- Medical evacuation[2] (or repatriation where covered).
- Travel costs of insured family members in the event of an evacuation/repatriation[2].
- Repatriation of mortal remains[2].
- Travel costs of insured family members in the event of the repatriation of mortal remains[2].
- Expenses for one person accompanying an evacuated/repatriated person[2].
- Palliative care[2]
- Long term care[2].

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

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

We should be contacted at least five working days before receiving treatment, so that we can ensure that there will be no delays at the time of admission. This will ensure that members benefit from cashless access to hospitals for in-patient treatment, where possible, and have their treatment overseen by our team of medical professionals.

In the case of an emergency, we should be informed within 48 hours of the event to ensure that no Treatment Guarantee penalty will apply to the claim.

Use of the Treatment Guarantee Form helps us to assess each case and facilitate direct settlement with the hospital. Please note that we may decline your claim if a Treatment Guarantee is not obtained.

Getting in-patient treatment

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

If it's an **emergency:**

1. Get the emergency treatment you need and call us if you need any advice or support.
2. Either you, your physician, one of your dependants or a colleague needs to call our Helpline (**within 48 hours** of the emergency) to inform us of the hospitalisation. Treatment Guarantee Form details can be taken over the phone when you call us.

Getting out-patient or dental treatment

When you visit a doctor, dentist, physician or specialist on an out-patient basis, 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/members** and follow the steps below:

1. Get an invoice from the doctor/dentist which states your name, treatment date(s), the diagnosis/ medical condition that you received treatment for, the date of onset of symptoms, the nature of the treatment and the fees charged.
2. Complete sections 1-4 and 7 of the Claim Form. Sections 5 and 6 only need to be completed by the doctor/dentist if their invoice does not state the diagnosis and nature of treatment.
3. Send the Claim Form and all supporting documentation, invoices and receipts to us via:
   - Scan and email to: **igo.claims@allianzworldwidecare.com** or
   - Fax to: **+ 353 1 645 4033** or post to the address shown 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 20 and 21 of this guide for additional important information about our claims process.
You can find information about getting treatment in the USA on page 24.

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/members.** 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. If you are responsible for paying your own premium, you can pay your premiums by credit card and update your credit card details. 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:	igo.assistance@allianzworldwidecare.com
Fax:	+ 353 1 630 1306
Telephone:	+ 353 1 629 7191

Calls to our Helpline may 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

DOC-IGO-EBG-EN-0317

Financial Strength Rating A M BEST A+ Superior

Rating effective from 17th December 2015. For the latest rating, please visit www.ambest.com

INTERNATIONAL ADVISER PRODUCT & SERVICE AWARDS 2016 WINNER

Professional Adviser INTERNATIONAL FUND & PRODUCT AWARDS 2015 WINNER Best International Private Health Insurance Provider

GLOBAL FUND Awards 2015 CorporateLiveWire - WINNER -