



Benefit Guide

AON Global Health Supplement Top-up
Powered by Allianz Care
Valid from 1st January 2023

AON

Welcome

Thanks to a comprehensive benefit package created by Allianz Care and AON Health Solutions, you and your family will now have access to the best health care possible – wherever you are in the world. AON Health Solutions created the additional insurance: AON Global Health Supplement on top of the mandatory Dutch health insurance. Since 2023 the insurance AGHS is offered by Allianz Care and Zilveren Kruis.

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

This guide has two parts: "How to use your cover" is a summary of all important information you are likely to use on a regular basis. "Terms and conditions of your cover" explains your cover in more detail.

How to use your cover

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Terms and conditions of your cover

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AWP Health & Life SA, acting through its Irish Branch, is a limited company governed by the French Insurance Code. Registered in France: No. 401 154 679 RCS Bobigny. Irish Branch registered in the Irish Companies Registration Office, registered No.: 907619, address: 15 Joyce Way, Park West Business Campus, Nangor Road, Dublin 12, Ireland. Allianz Care and Allianz Partners are registered business names of AWP Health & Life SA.

How to use your cover



Support services

We believe in providing you with the top-quality service that you deserve. In the following pages we describe the full range of services we offer. Read on to discover what is available to you, from our MyHealth Digital Services to the Employee Assistance Programme.

Talk to us, we love to help!

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

Helpline

☎ Phone: **+ 31 10 44 88 200** (available during Dutch office hours)

@ Email: **ipm@aon.nl**

Did you know...

...that most of our members find that their queries are handled quicker when they call us?

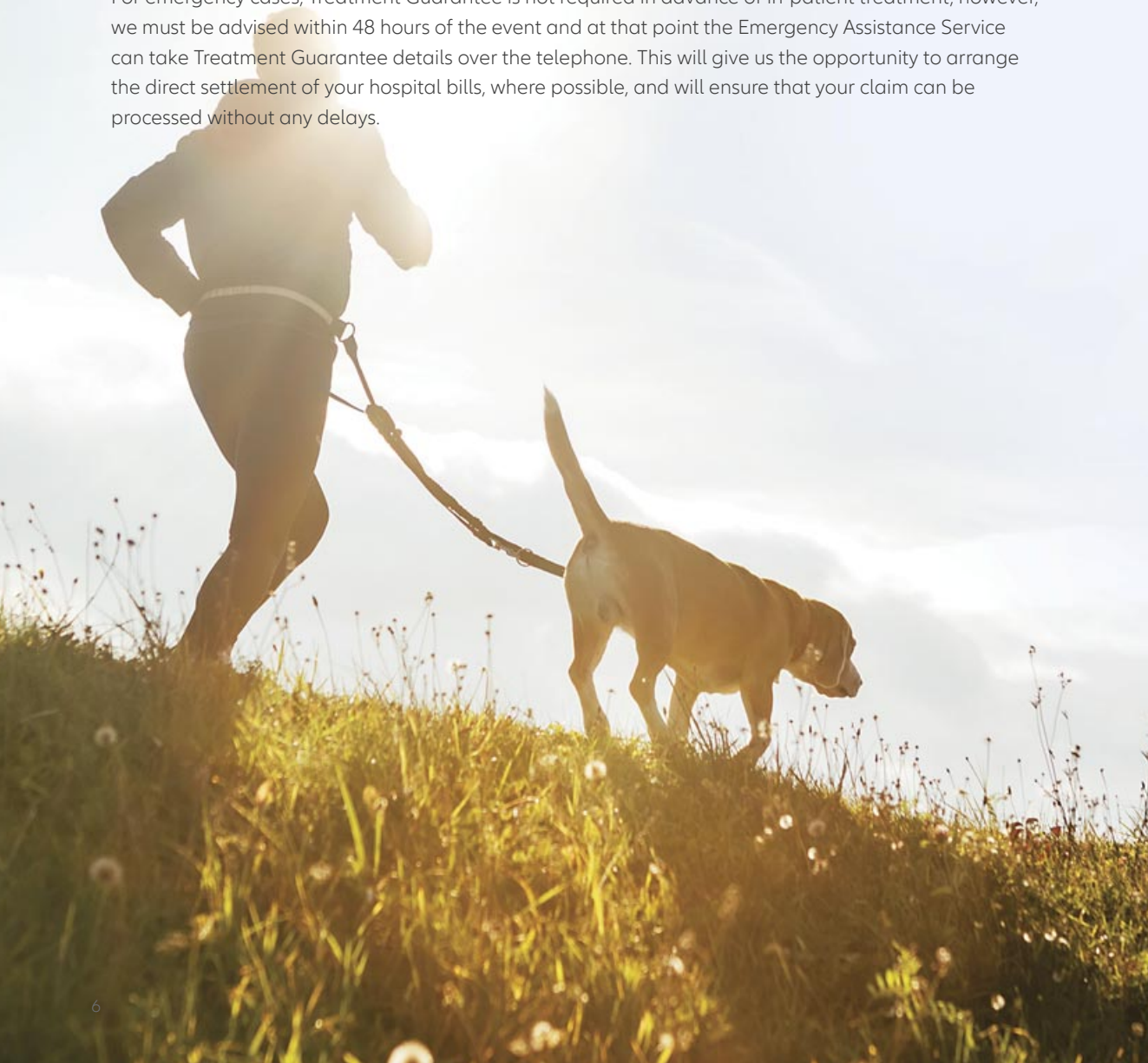
Emergency Assistance Service

If you require emergency medical treatment in a hospital or clinic, you should, where possible, contact the Emergency Assistance Service. The Emergency Assistance Service (provided by Allianz Care) is available 24 hours a day, 365 days a year, to provide you with a range of services e.g. organising an emergency medical evacuation:

☎ Helpline: **+ 31 10 44 88 255**

@ Email: **client.services@allianzworldwidecare.com**

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



MyHealth Digital Services

Through MyHealth, available as a mobile app and online portal, you have easy and convenient access to your cover, no matter where you are or what device you are using.

MyHealth app and online portal features



My policy

Access your policy documents and membership card on the go.



My claims

Submit your claims in 3 simple steps and view your claims history.



My contacts

Access our 24/7 multilingual Helpline. Live chat is also available (in English and on the online portal only).



Symptom checker

Get a quick and easy assessment of your symptoms.



Provider finder

Locate medical providers nearby.



Pharmacy aid

Look up the local equivalent names of branded drugs.



Medical term translator

Translate names of common ailments into 17 languages.



Emergency contact

Access local emergency numbers worldwide.

Additional useful features

- Update your details online: email, phone number, password, address (if it's the same country as the previous address), marketing preferences, etc.
- View the remaining balance of each benefit which is in your Table of Benefits
- Pay your premium online and view payments received
- Add or change your credit card details (if you are responsible for paying your own premium, rather than your employer)

All personal data within MyHealth Digital Services is encrypted for data protection.

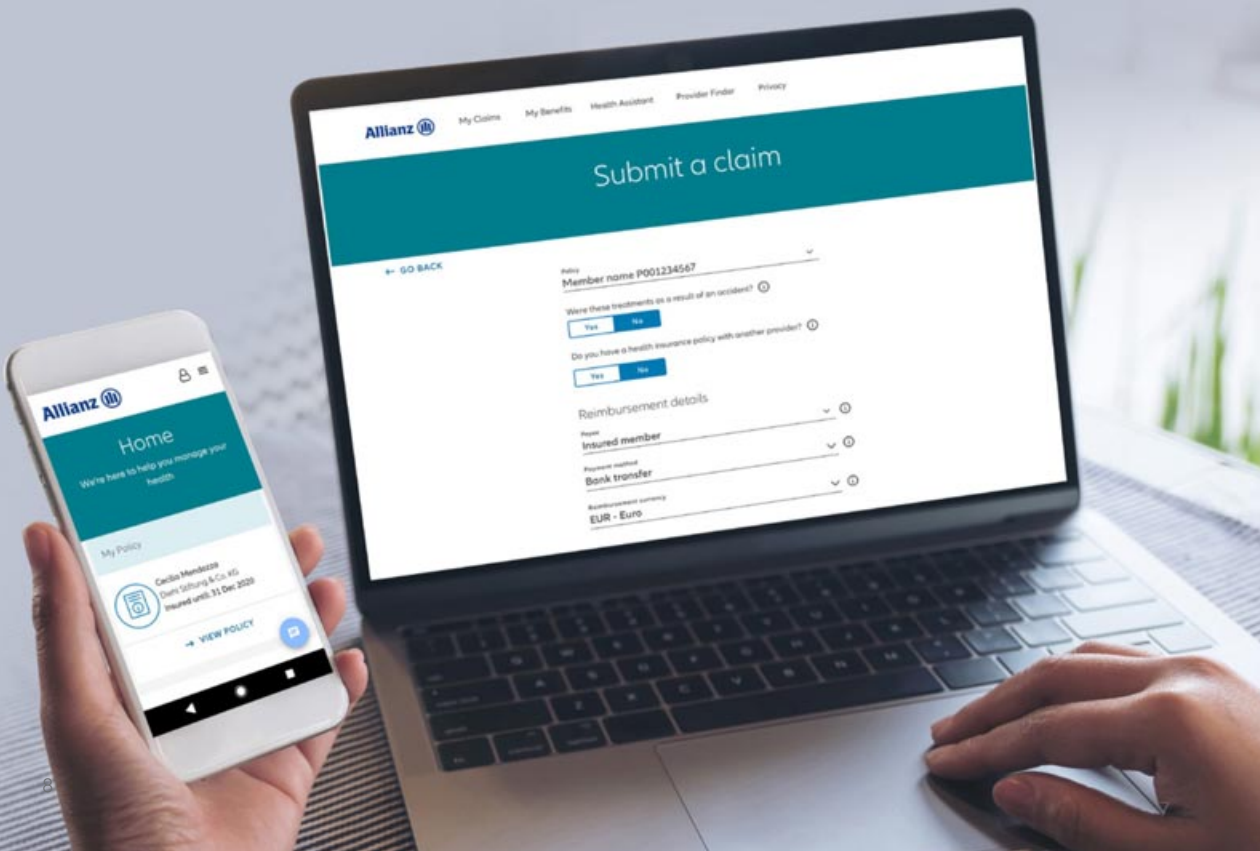
Getting started:

1. Login to MyHealth online portal to register. Go to <https://my.allianzcare.com/myhealth>, click on "REGISTER HERE" near the bottom of the page and follow the on-screen instructions. Be ready to provide your policy number, which you can find in your Insurance Certificate.
2. As an alternative, you can register via our MyHealth App. To download it, search for "Allianz MyHealth" on the Apple App Store or Android's Google Play service.



3. Once setup, you can use the email (username) and password you provided during registration to login to MyHealth online portal or app. The same login details are used for both and in the future, if you change login details for one, it will automatically apply to the other. You don't need to change them in both places. We also offer a biometric login option for the app, for example Touch ID or Face ID, where supported by your device.

For more information, please visit www.allianzcare.com/en/myhealth.html



Web-based services

On www.allianzcare.com/members you can:

- Search for medical providers (you are not restricted to using the providers listed in our directory)
- Download forms
- Access our Health Guides
- Access our "My expat life" hub – from planning to move, to settling down in your new country, you'll find everything you need to know about moving overseas

Second Medical Opinion**

As your health partner, we aim to provide you with peace of mind. Have you been diagnosed with a serious illness or had surgery recommended? Do you want expert help on the best treatment options available and where to get the most appropriate treatment? As part of your cover you have access to our Second Medical Opinion service.

When you access this service, we assign to you a dedicated case manager, i.e. a healthcare professional from our own Medical Team to guide and assist you. Your case manager will ask you to provide all the necessary information about your medical case: then he/she will help you find a hospital, doctor or specialist for the Second Medical Opinion and provide the opinion to you.

To access our service, simply contact us:

☎ **+353 1 630 1301**

@ **medical.smo@allianz.com**

...and ask for the Second Medical Opinion service. You will need to state your policy number for identification.



Olive – Allianz Care's Health & Wellness support program.

Your first steps towards a healthier life.

In today's increasingly busy and ever-changing world we recognise the importance of staying healthy and we firmly believe that prevention is better than cure. Olive**, our proactive care engine, is designed to motivate and guide you towards a healthier life. It includes the Health and Wellness hub and our HealthSteps app.

1. Health and Wellness hub

Our Health & Wellness Hub, accessible via our MyHealth Digital Services (mobile app and portal), offers you a range of services gathered in one convenient place to support you on your journey to a long, happy and healthy life.

On the Hub you will have access to:

- Tips and articles on topics such as sleep, fitness, nutrition and emotional wellbeing.
- Online health assessments**.
- Our BMI calculator.
- Our monthly live health and wellness webinars, with Q&A session, delivered by specialists.



2. HealthSteps app**

Did you know that by maintaining a healthy lifestyle, you may reduce the risk of developing medical conditions? The Allianz HealthSteps app was designed to give personalised guidance and help you reaching your health and fitness goals. By connecting to smart phones, wearable devices and other apps, HealthSteps monitors the number of steps taken, calories burned, sleep schedule and more.

HealthSteps features:



Plan

Choose a health goal and use the action plans to adopt and maintain good health habits:

- Lose weight
- Improve posture
- Sleep better
- Eat healthy
- Get moving and energised
- Stay healthy
- Reduce stress
- Lower blood pressure



Challenges

Join monthly challenges and get encouragement from other HealthSteps users by sharing your performance and competing against each other on group challenges. These challenges are based on steps, calories and distance.



Progress

Connect with popular health and activity trackers and monitor your progress against goals you set for yourself.



Library

Access articles and get tips and advice on how to live and maintain a healthy life.

Download the "Allianz HealthSteps" app from App Store or Google Play.



Video consultation services via Telehealth Hub**

If an Out-patient plan is included in your cover, you have direct access to online doctor appointments (video consultation services) where a provider is available in your geographical location.

With the Telehealth Hub, you can save time by seeing a doctor via video from the comfort of your own home or office. Offering a secure and confidential service, our telehealth network of doctors can provide medical advice, recommend treatments and offer prescriptions for non-emergency concerns.

The service is accessible via MyHealth portal or directly via our TeleHealth platform at:

 www.allianzcare.com/telehealthhub

An appointment can be made to speak to a medical practitioner in English, subject to availability. Some third party providers may offer the service in additional languages.

Depending on your geographical location, local country regulations and insurance plan coverage, the teleconsultation service may also offer prescriptions.

In countries where a teleconsultation service is not yet available, you can always call our 24/7 medical advice helpline – this service is offered in English, German, French and Italian. The phone number is available on TeleHealth Hub.



Employee Assistance Programme (EAP)**

When challenging situations arise in life or at work, our Employee Assistance Programme provides you and your dependants with immediate and confidential support. EAP, where provided, is shown in your Table of Benefits.

This professional service is available 24/7 and offers multilingual support on a wide range of challenges, including:

- Work/Life balance
- Family/Parenting
- Relationships
- Stress, depression, anxiety
- Workplace challenges
- Cross-cultural transition
- Cultural shock
- Coping with isolation and loneliness
- Addiction concerns

Support services include:



Confidential professional counselling

Receive 24/7 support with a clinical counsellor through live online chat, face to face, phone, video or email.



Critical incident support

Receive immediate critical incident support during times of trauma or crisis. Our wide-ranging approach provides stabilization and reduces stress associated with incidents of trauma or violence.



Legal and financial referral services

Whether it's help buying a home, handling a legal dispute or creating a comprehensive financial plan, we will refer you to a third-party advisor who can help answer your questions and reach your goals.



Access to the wellness website and app

Discover online support, tools and articles for help and advice on health and wellbeing.

Let us help:

 **+1 905 886 3605**

This is not a free phone number. If you need a local number, please access the wellness website and you will find the full list of our 'International Numbers'.

Your calls are answered by an English-speaking agent, but you can ask to talk to someone in a different language. If an agent is not available for the language you need, we will organise interpreter services.

 **<https://www.allianzcare.com/eap-login>**

(available in English, French and Spanish)

 **Download the Lifeworks app in Google Play or Apple Store**



Login on the website or the app using the following details:

Username: AllianzCare

Password: Expatriate

Travel Security Services**

As the world continues to witness an increase in security threats, Travel Security Services offer 24/7 access to personal security information and advice for your travel safety queries – via phone, email or website. Your Table of Benefits shows whether your plan includes these services.

You can access:



Emergency security assistance hotline

Talk to a security specialist for any safety concerns associated with a travel destination.



Country intelligence and security advice

Security information and advice about many countries.



Daily security news updates and email travel safety alerts

Sign up and receive alerts about high-risk events in or near your current location, including terrorism, civil unrest and severe weather risks.

- To access the Crisis24 Horizon desktop website, go to <https://crisis24horizon.com/allianztravsec>, add your email address and select Create Account. Enter your details and add the Member ID of ALLIANZTSS**
- To access the Crisis24 Horizon mobile app, download either the Android or iOS version to your mobile device (you can also search for Crisis24 Horizon in either store), then **sign in** using the same email (username) and password you created above. You can also register directly on the mobile app using the Member ID.

🌐 <https://crisis24horizon.com/allianztravsec>

⬇️ Download the Crisis24 Horizon app from App store or Google Play.



All Travel Security Services are provided in English. We can arrange for you to use an interpreter where required.

***Certain services which may be included in your plan are provided by third party providers outside the Allianz Group, such as the Employee Assistance Programme, Travel Security services, HealthSteps app, Second Medical Opinion and tele-medicine services. If included in your plan, these services will show in your Table of Benefits. These services are made available to you subject to your acceptance of the terms and conditions of your policy and the terms and conditions of the third parties. These services may be subject to geographical restrictions. The HealthSteps app does not provide medical or health advice and the wellness resources contained within Olive are for informational purposes only. The HealthSteps app and the wellness resources contained within Olive shouldn't be regarded as a substitute for professional advice (medical, physical or psychological). They are also not a substitute for the diagnosis, treatment, assessment or care that you may need from your own doctor. You understand and agree that AWP Health & Life SA (Irish Branch) and AWP Health & Life Services Limited are not responsible or liable for any claim, loss or damage, directly or indirectly resulting from your use of any of these third party services.*



Cover overview

Here is a summary of your health cover.

What am I covered for?

You are covered for all benefits indicated in your Table of Benefits. Please be aware that this cover is subject to our policy definitions, exclusions and limitations and, for underwritten policies, cover is also subject to any special conditions indicated in the Insurance Certificate (and on the Special Conditions Form issued prior to policy inception).

If you have any queries regarding the cover provided under your plan, simply contact AON Health Solutions Helpline for confirmation of your entitlements.

Where can I receive treatment?

You can receive treatment in any country within your area of cover, as shown in your Insurance Certificate.

If the treatment you need is available locally but you choose to travel to another country in your area of cover, we will reimburse all eligible medical costs incurred within the terms of your policy; except for your travel expenses.

If the eligible treatment is not available locally, and your cover includes 'Medical evacuation', we will also cover travel costs to the nearest suitable medical facility. To claim for medical and travel expenses incurred in these circumstances, you will need to complete and submit the Treatment Guarantee Form before travelling.

You are covered for eligible costs incurred in your home country, provided that your home country is in your area of cover.

What are benefit limits?

There are two kinds of benefit limits shown in the Table of Benefits. The **maximum plan benefit**, which applies to certain plans, is the maximum we will pay for all benefits in total, per member, per Insurance Year, under that particular plan. Some benefits also have a **specific benefit limit**, for example "Nursing at home or in a convalescent home". Specific benefit limits may be provided on a "per Insurance Year" basis, a "per lifetime" basis or on a "per event" basis, such as per trip or per visit.

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.

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

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

Which hospitals can I go to?

You can access an online Hospital, Doctor and Health Practitioner Finder on Allianz Care website to search for providers worldwide. However, you are not restricted to using providers from this directory. Please note that Treatment Guarantee is required before in-patient treatment and certain other treatments as specified in your Table of Benefits. We will organize everything with the hospital and pay directly your hospital bill, where possible.

Is your family growing?

Are you getting married or having a baby? Congratulations!

To add dependants to your policy, simply notify your company in writing. If you are adding a newborn, please include a copy of the birth certificate. You should send your request within four weeks of the date of birth, to ensure that cover starts from birth.

For further information on how to add dependants, please see the 'Adding dependants' section of this guide.

Following acceptance, we will issue a new Insurance Certificate to reflect the addition of a dependant. This new certificate will replace any earlier version(s) you may have from the start date shown on it.

What is a deductible?

A deductible is a fixed amount you need to pay towards your medical bills per period of cover before we begin to contribute. Where applied, deductibles are payable per person per Insurance Year (unless indicated otherwise in the Table of Benefits).

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

Seeking treatment?

We understand that seeking treatment can be stressful. Follow the steps below so we can look after the details – while you concentrate on getting better.

Check your level of cover

First, check that your plan covers the treatment you are seeking. Your Table of Benefits will confirm what is covered. However, you can always call our Helpline if you have any queries.

Some treatments require pre-authorisation

Your Table of Benefits will show which treatments require pre-authorisation (via a Treatment Guarantee Form). These are mostly in-patient and high cost treatments. The Treatment Guarantee process helps us assess each case, organise everything with the hospital before your arrival and make direct payment of your hospital bill easier, where possible.

Getting in-patient treatment (pre-authorisation applies)



Download a Treatment Guarantee Form from AON Health Solutions website:
<https://www.aonexpatinsurance.com/netherlands/outgoing/en/claims/submitting-a-claim/>



Complete the form and send it to us at least **five working days before treatment**.
You can send it by email, fax or post to the address shown on the form.



We contact the hospital to organise payment of your bill directly, where possible.

If the treatment is taking place within 72 hours we can take Treatment Guarantee Form details over the phone. Full details of our Treatment Guarantee process can be found on the “Claims and Treatment Guarantee Process” section of this guide.

If it's an emergency:

Get the emergency treatment you need and call us if you need any advice or support.

If you are hospitalised, either you, your doctor, one of your dependants or a colleague must inform us about the hospital admission within 48 hours of the event. Treatment Guarantee Form details can be taken over the phone if you call the Emergency Assistance Service. This gives us the opportunity to arrange for the direct settlement of your hospital bills, where possible.



Claiming for your out-patient, dental and other expenses

If your treatment does not require our pre-authorisation, you can simply pay the bill and claim the expenses from us. In this case, simply follow these steps:



Receive your medical treatment and pay the medical provider.



Get an invoice from your medical provider. This should state 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.



Claim back your eligible costs via our MyHealth app or online portal (www.allianzcare.com/en/myhealth.html).

Simply enter a few key details, add your invoice(s) and press 'submit'.

Alternatively, you can also download a Claim Form from AON Health Solutions website:



www.aonexpatinsurance.com/netherlands/outgoing/en/claims/claimforms/

You will need to complete sections 1-4 and 7 of the Claim Form yourself. Sections 5 and 6 only need to be completed by your treating doctor if the information requested in those sections is not already provided on your medical invoice.

Please ensure that the **payment details that you supply on the Claim Form are correct**, to avoid delays to claims settlement.

Please send the Claim Form and all supporting documentation, invoices and receipts to us by email, fax or post (details on the form).

Please refer to “Medical Claims” in the Terms and conditions section of this guide for additional information about our claims process.



Quick claim processing

Once we have all the information required, we can process and pay a claim within 48 hours. However, we can only do this if you have told us your diagnosis, so please make sure you include this with your claim. Otherwise, we will need to request the details from you or your doctor.

We will email or write to you to let you know when the claim has been processed.

Evacuations and repatriations

At the first indication that you need medical evacuation or repatriation, please call our 24 hour Helpline and we will take care of it. Given the urgency, we would advise you to phone if possible. However, you can also contact us by email. If emailing, please write 'Urgent – Evacuation/Repatriation' in the subject line.

Please contact us before talking to any providers, even if they approach you directly, to avoid excessive charges or unnecessary delays in the evacuation. In the event that evacuation/repatriation services are not organised by us, we reserve the right to decline the costs.

☎ +353 1 630 1301

@ medical.services@allianzworldwidecare.com



Seeking treatment in the USA

If you have worldwide cover, we offer you simple access to medical care in the USA, through our local third-party partner, supporting your access to medical providers in the country.

To access treatment in the USA, simply show your membership card: your medical provider will then contact our third-party partner to sort any paperwork related to your treatment. We will pay the cost of your eligible treatment directly to your medical provider, if applicable; if you are responsible for any part of the costs, your provider will let you know.

For queries or requests for assistance related to treatment in the USA, please find all contact details on the back of your membership card.

For a prescription

If your plan includes access to the Caremark's pharmacy network, you can obtain certain drugs and pharmacy products at these US pharmacies on a cashless basis. All details you need to access the Caremark pharmacy network will be shown either on your membership card or on a separate Caremark card.

Show your membership card (or the separate Caremark card) to the Caremark network pharmacy. The pharmacist will tell you if you need to pay any part of the costs, for example if there is a co-payment. Please ensure that the prescriptions have the date of birth of the person that the prescription is for.

Whether or not you have a Caremark card, you can also apply for a discount pharmacy card, which you can use for any prescription that is not covered by your plan. To register and obtain your discount pharmacy card, simply go to the following website and click on "Print Discount Card":

 <https://azc.globalexcel.com/find-a-pharmacy/>

Terms and conditions of your cover



Terms and conditions

This section describes the benefits and rules of your health insurance policy. Please read it together with your Insurance Certificate and Table of Benefits.

- Your **Insurance Certificate** details the plan(s) and geographical area of cover that your company chose for you and your dependants (if applicable). It also states the start date and renewal date of your cover. For policies where your medical history is assessed (underwritten policies) this document will state any special terms that may apply to your cover. Please note that we will send you a new Insurance Certificate if we need to record any changes to your policy. These may be changes that your company requests or changes we are entitled to make. They may also be changes that you request (such as adding a dependant) – provided your company approves and we accept.
- Your **Table of Benefits** outlines the plan(s) selected by your company and the benefits available to you. It also specifies any benefits/treatments which require you to submit a Treatment Guarantee Form. It confirms any benefits to which specific benefit limits, waiting periods, deductibles and/or co-payments apply. Your Table of Benefits will be in the currency agreed with your company (or with you, if you pay the insurance premium).

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 cover may be changed from time to time by agreement between your company and us.

Your cover explained

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

Your core plan

IN-PATIENT BENEFITS

In the case of in-patient treatment, you will be reimbursed within the limits of your cover for the benefits included under your Core Plan. In-patient benefits include things like hospital accommodation, anaesthesia and theatre charges, surgical fees, surgical appliances, prostheses and diagnostic tests. Please refer to your Table of Benefits for details of the in-patient benefits available to you. Treatment Guarantee is required *in advance* of all in-patient benefits listed in your Table of Benefits.

HOSPITAL ADMISSION

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

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

ORGAN TRANSPLANT

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

The costs related to the donor are covered as follows:

- Medical care after the date of discharge from hospital, where admission to hospital was exclusively in relation to selection/removal of transplant material. Cover is provided for a maximum of 13 weeks, or six months in the event of a liver transplant.

- Public transport in lowest fare class, or – if and insofar as medically necessary – transport by car in connection with the admission/discharge from a hospital and with the medical care referred to in the previous point.
- Public transport in lowest fare class to and from the country where the transplant takes place (in case of a donor residing abroad) in connection with the transplant of a kidney, bone marrow or liver.
- Other transplant-related costs insofar as these are related to the donor living abroad. These costs do not in any event include hotel accommodation costs and other sundry expenses.

PSYCHIATRY AND PSYCHOTHERAPY

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

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

ACCOMMODATION COSTS FOR ONE PARENT STAYING IN HOSPITAL OR SIMILAR ACCOMMODATION WITH AN INSURED CHILD UNDER 16

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

ACCOMMODATION IN CASE OF MEDICAL TREATMENT RECEIVED OUTSIDE OF PLACE OF RESIDENCE

For the patient:

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

For the parents:

We cover the costs incurred by both parents in case their insured child has to receive medical treatment outside of their city/town. Accommodation in the vicinity of the hospital where the child has been admitted must be declared medically necessary for the wellbeing of the child by the treating authority. If confirmed in your Table of Benefits, we also cover accommodation in a Ronald McDonald House or

similar accommodation affiliated with a hospital, for the duration of the medically necessary admission of the child. The child to be treated must not be older than 16. Treatment Guarantee is required. Please note that this benefit is subject to the limit per person and per calendar year indicated in the Table of Benefits.

Other benefits under your Core Plan

DAY-CARE TREATMENT

You will be covered for planned day-care treatment received in a hospital or day-care facility up to the amount specified in your Table of Benefits. Treatment Guarantee is required.

OUT-PATIENT SURGERY

You are covered for surgical procedures performed in a surgery, hospital, day-care facility or out-patient department up to the amount specified in your Table of Benefits. Treatment Guarantee is required.

NURSING AT HOME OR IN A CONVALESCENT HOME

Where applicable to your Core Plan, you are entitled to claim for nursing received at home or in a convalescent home, if the nursing is provided immediately after, or instead of, hospitalisation, unless agreed otherwise between your company and us. The maximum amount available under this benefit is indicated in the Table of Benefits. Treatment Guarantee is required. This benefit is not payable in respect of palliative care, which is covered under a separate benefit.

REHABILITATION TREATMENT

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

LOCAL AMBULANCE

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

TRANSPORT

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

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

EMERGENCY TREATMENT OUTSIDE AREA OF COVER

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

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 doctor, medical practitioner or specialist must commence within 24 hours of the emergency event.

Cover includes medically necessary treatment needed as a result of complications of pregnancy. This is covered up to the end of the week 34 of pregnancy, or week 28 in the case of multiple-birth pregnancy. The cover relates to the health of the insured mother.

MEDICAL EVACUATION

This benefit provides for ambulance, helicopter or aeroplane transportation to the nearest appropriate medical centre (which may or may not be located in your home country), if the necessary treatment for which you are covered is not available locally, or if adequately screened blood is unavailable in the event of an emergency. If this benefit is included in your Core Plan, you will be covered up to the amount stated in your Table of Benefits. The medical evacuation will be carried out in the most economical way, having regard to your medical condition. Your doctor must request the medical evacuation. Please note that Treatment Guarantee is required.

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

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

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

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

EXPENSES FOR ONE PERSON ACCOMPANYING AN EVACUATED/REPATRIATED PERSON

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

REPATRIATION OF MORTAL REMAINS

Where covered, in the event of death we will provide a maximum benefit as indicated in the Table of Benefits, to cover the cost of transportation of the insured person's mortal remains from the principal country of residence to the country of burial. Covered expenses include, but are not limited to, expenses for embalming, a container legally appropriate for transportation, shipping costs and the necessary government authorisations. Cremation costs will only be covered in the event that this is required for legal purposes. Costs incurred by any accompanying persons are not covered unless this is listed as a specific benefit in your Table of Benefits. All covered expenses in connection with the repatriation of mortal remains must be pre-approved by us, i.e. Treatment Guarantee is required.

CT, MRI, PET AND CT-PET SCANS

CT, MRI, PET and CT-PET scans carried out on an in-patient or out-patient basis are fully covered within the limits of your Core Plan. Treatment Guarantee is not required for CT scans, however, it is required for MRI, PET and CT-PET scans. Please note that cover does not extend to hotel accommodation or other related expenses and that Treatment Guarantee is required.

ONCOLOGY

You will be covered for specialist fees, diagnostic tests, radiotherapy, chemotherapy and hospital charges incurred in relation to the planning and carrying out of treatment for cancer, from the point of diagnosis up to the amount specified in your Table of Benefits. If the patient is a child under 18, we reimburse the central (reference) diagnosis, coordination and registration by Skion (Child Oncology Association of the Netherlands) of physical material submitted.

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

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

ROUTINE MATERNITY

Routine maternity refers to medically necessary costs incurred during pregnancy and childbirth, including hospital charges for a maximum of 10 days from day of delivery, specialist fees, the mother's pre- and post-natal care (including counselling, routine ultrasound examination and combination test), midwife fees as well as newborn care. Any non-medically necessary caesarean sections will be covered up to the cost of a routine delivery in the same hospital, subject to any benefit limit in place. Please note that home delivery is covered within the limits of your plan.

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

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

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

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

ADOPTION MATERNITY SCREENING

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

COMPLICATIONS OF PREGNANCY AND CHILDBIRTH

Complications of pregnancy relates to the health of the mother.

Complications of childbirth refer only to the conditions that arise during childbirth. Treatment Guarantee is required for in-patient treatment only.

CIRCUMCISION ON RELIGIOUS GROUNDS

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

PALLIATIVE CARE

We will cover the costs of ongoing treatment aimed at alleviating the physical/psychological suffering associated with progressive, incurable illness and maintaining quality of life. Please note that cover is limited to the benefit limit stated in your Table of Benefits and Treatment Guarantee is required.

PRESCRIBED INDEPENDENT TREATMENT CENTRE

In the event of treatment at an independent treatment centre, this benefit covers the costs of nursing and care, specialist medical care, paramedic care, medicines, health aids and bandages related to the treatment. This cover is provided only if the treatment is deemed medically necessary by the treating authority and within the duration of the medical necessity. A referral from the GP or other medical specialist is required, as well as submission of a Treatment Guarantee Form in advance of treatment. In addition you will need to provide a medical report from your medical practitioner or specialist, explaining the reasons for admission.

PLASTIC SURGERY

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

- Abnormalities in the appearance that are related to demonstrable problems of physical functioning.
- Disfigurements resulting from disease, accident or medical procedures.

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

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

PRESCRIBED STAY IN THE DUTCH ASTHMA CENTRE IN DAVOS (SWITZERLAND)

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

PRESCRIBED STAY IN A THERAPEUTIC CAMP FOR ASTHMATIC CHILDREN UP TO THE AGE OF 18

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

STAY IN A THERAPEUTIC CAMP FOR DISABLED MEMBERS

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

PRESCRIBED GENETIC TESTING

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

NON-CLINICAL HAEMODIALYSIS AND PERITONEAL DIALYSIS

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

In the case of home dialysis, we also reimburse:

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

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

Your Out-patient Plan

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

- Medical practitioner fees.
- Prescription drugs.
- Specialist fees.
- Diagnostic tests.
- Vaccinations.
- Alternative therapies and treatments.
- Alternative medicines.
- Prescribed physiotherapy.
- Occupational therapy.
- Prescribed speech therapy.
- Prescribed skincare.
- Home help.
- Stutter therapy.
- Prescribed dyslexia care.
- Preventive examinations and screening for early detection of illness or disease.

- Infertility treatment.
- Prescribed chiropodist.
- Prescribed podotherapy and podology.
- Glasses and contact lenses.
- Prescribed medical aids.
- Sterilisation.

Further in this section, some of the above Out-patient Plan benefits are described in more details. Please refer to your Table of Benefits to confirm the Out-patient Plan benefits available to you. Please note that Treatment Guarantee is required for some out-patient benefits: these are indicated in your Table of Benefits.

ACCOMMODATION COSTS FOR INSURED PERSON RECEIVING OUT-PATIENT TREATMENT

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

ALTERNATIVE THERAPIES AND TREATMENTS

We reimburse the costs for consultations provided by:

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

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

ALTERNATIVE MEDICINES

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

PREVENTATIVE CARE VACCINATIONS FOR CHILDREN UNDER 16 YEARS

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

VACCINATIONS FOR TRAVELLING ABROAD

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

PRESCRIBED PHYSIOTHERAPY

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

PRESCRIBED THROMBOSIS TREATMENT

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

The care entails:

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

EXERCISE PROGRAMMES

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

MECHANICAL RESPIRATION

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

PRESCRIBED THERAPEUTIC SWIMMING FOR RHEUMATISM PATIENTS

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

OCCUPATIONAL THERAPY

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

PRESCRIBED SPEECH THERAPY

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

PRESCRIBED SKINCARE

We reimburse the costs of:

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

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

PRESCRIBED VISIT TO A HEARING CENTRE

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

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

PRESCRIBED PSORIASIS TREATMENT

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

HOME HELP

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

STUTTER THERAPY

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

PRESCRIBED DYSLLEXIA CARE

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

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

PREVENTIVE EXAMINATIONS AND SCREENING FOR EARLY DETECTION OF ILLNESS OR DISEASE

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

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

IN VITRO FERTILISATION (IVF) AND OTHER INFERTILITY TREATMENTS

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

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

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

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

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

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

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

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

PRESCRIBED CHIROPODIST

We reimburse the costs of foot care provided by a chiropodist to a member affected by rheumatism or diabetes. The chiropodist must be certified to treat diabetes and rheumatism patients. With the first session, the member must submit a document from the GP, specialist or diabetes nurse which certifies that foot care is medically necessary in connection with diabetes or rheumatism.

PRESCRIBED PODOThERAPY AND PODOLOGY

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

PRESCRIBED DIETICIAN/NUTRITIONIST TREATMENTS

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

OBESITY TREATMENT

We reimburse costs of participation in the part-time day-care programme for obese patients at an obesity clinic, where the programme is focused on behavioural change by means of non-surgical, multidisciplinary treatment. This benefit is eligible only in case of grade 3 obesity, i.e. when the Body Mass Index (BMI) is greater than 40 (a BMI calculator can be found on Allianz Care's website: www.allianzcare.com). The costs of the obesity treatment are covered where the member completes the full programme. Treatment Guarantee is required.

PRESCRIBED MEDICAL AIDS

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

STERILISATION

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

PREVENTATIVE COURSES

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

GLASSES AND CONTACT LENSES

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

MENOPAUSE CONSULTANT

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

LACTATION CONSULTANT CARE

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

SECOND OPINION

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

Your Dental Plan

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

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

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

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

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

- Dental care in the following special cases:
 - Serious development/growth disorder or acquired deviation of the tooth-jaw-mouth system.
Dental care must be needed for the patient to retain or achieve dental functioning equal to what they would have had if the disorder had not occurred.
 - Essential, additional dental care where initial treatment is demonstrably insufficient to retain or achieve dental functioning equal to what the patient would have had if their disorder had not occurred. The treatment must be carried out by a dentist or dental surgeon. We need to grant permission in advance: we will send you an application form on request, which will need to be completed and returned accompanied by a treatment plan drawn up by your care provider. Referral from a GP, dentist or dental specialist is required.

Supplementary Dental Cover

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

Your Repatriation Plan

MEDICAL REPATRIATION

If the necessary treatment for which you are covered is not available locally and you choose to be repatriated to your home country for treatment, rather than to the nearest appropriate medical centre, we will cover the repatriation costs up to the limit indicated in your Table of Benefits. This only applies when your home country is located within your geographical area of cover. Following completion of treatment, we will also cover the cost of the return trip, at economy rates, to your principal country of residence as long as the return journey is made within one month of completion of treatment. Please note that Treatment Guarantee is required.

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

If medical necessity prevents an immediate return trip following discharge from an in-patient episode of care in a hospital outside of the member's city/town of residence, we will cover hotel accommodation costs at the equivalent of a three star hotel daily room. Where the patient is an insured child under 16, we will also cover hotel accommodation costs for both parents at the equivalent of a three star hotel daily room.

In the event of repatriation from the country of residence to the home country, where needed for childbirth but not due to medical necessity, the repatriation costs of the insured mother are covered. Please note that a 25% co-payment applies. The flight costs, at economy rates, of the new born to fly from the home country to the country of residence of the parents are fully reimbursed in accordance with the relevant airline's rate for babies or toddlers.

EXPENSES FOR ONE PERSON ACCOMPANYING A REPATRIATED PERSON

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

TRAVEL AND ACCOMMODATION COSTS OF ONE PERSON TO BE WITH AN INSURED MEMBER WHO IS AT PERIL OF DEATH OR WHO HAS DIED

We will cover reasonable transportation and accommodation costs (up to the amount specified in your Table of Benefits) so that one person can travel to the location of an insured who is at peril of death or who has died. Reasonable transportation costs are considered to be round trip transport costs at economy rates.

Claims are to be accompanied by a death certificate or medical certificate supporting the reason for travelling as well as copies of the flight tickets and hotel accommodation receipt. Cover will be limited to one claim per lifetime of the policy.

Claims and treatment guarantee process

Medical claims

Before submitting a claim to us, please pay attention to the following points:

- **Claiming deadline:** You must submit all claims (via our MyHealth app or online portal) no later than six months after the end of the Insurance Year. If cover is cancelled during the Insurance Year, you should submit your claim no later than six months after the date that your cover ended. After this time, we are not obliged to settle the claim.
- **Claim submission:** You must submit a separate claim for each person claiming and for each medical condition being claimed for.
- **Supporting documents:** When you send us copies of supporting documents (e.g. medical receipts), please make sure you keep the originals. We have the right to request original supporting documents/receipts for auditing purposes up to 12 months after settling your claim. We may also request proof of payment by you (e.g. a bank or credit card statement) for medical bills you have paid. We advise that you keep copies of all correspondence with us as we cannot be held responsible for correspondence that fails to reach us for any reason outside of our control.
- **Deductibles:** If the amount you are claiming is less than the deductible figure in your plan, you can either:
 - Collect all out-patient receipts until you reach an amount that exceeds this deductible figure.
 - Send us each claim every time you receive treatment. Once you reach the deductible amount, we'll start reimbursing you. Attach all supporting receipts and/or invoices with your claim.
- **Currency:** Please specify the currency you wish to be paid in. On rare occasions, we may not be able to make a payment in that currency due to international banking regulations. If this happens, we will identify a suitable alternative currency. If we have to make a conversion from one currency to another, we will use the exchange rate that applied on the date the invoices were issued, or on the date that we pay your claim.

Please note that we reserve the right to choose which currency exchange rate to apply.
- **Reimbursement:** We will only reimburse (within the limits of your policy) eligible costs after considering any pre-approval requirements, deductibles or co-payments outlined in the Table of Benefits.
- **Reasonable and customary cost:** We will only reimburse charges that are reasonable and customary in accordance with standard and generally accepted medical procedures. If we consider a claim to be inappropriate, we reserve the right to decline your claim or reduce the amount we pay.
- **Deposits:** If you have to pay a deposit in advance of any medical treatment, we will reimburse this cost only after treatment has taken place.

- **Providing information:** You and your dependants agree to help us get all the information we need 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 doctor. We may, at our own expense, request a medical examination by our doctors if we think it's necessary. All information will be treated confidentially. We reserve the right to withhold benefits if you or your dependants do not support us in getting the information we need.

Treatment needed as a result of someone else's fault

If you are claiming for treatment that you need when somebody else is at fault, you must write and tell us as soon as possible. For example, if you need treatment following 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. We can then recover from the other insurer the cost of the treatment paid for by us. If you are able to recover directly the cost of any treatment which we have paid for, you will need to repay that amount (and any interest) to us.

Treatment Guarantee

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

WHAT IS TREATMENT GUARANTEE?

We recommend you sending a fully completed Treatment Guarantee Form to us in advance of certain treatments and costs. Following approval by Allianz Care, cover for these required treatments or costs can then be guaranteed. In the Table of Benefits, benefits which require pre-approval through Treatment Guarantee are indicated by either a 1 or a 2.

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

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

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

WHEN IS TREATMENT GUARANTEE REQUIRED?

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

- All in-patient treatments.
- Day-care treatment.
- Out-patient surgery.
- Nursing at home or in a convalescent home.
- Rehabilitation treatment.
- Medical evacuation or repatriation.
- Repatriation of mortal remains.
- MRI (Magnetic Resonance Imaging), PET (Positron Emission Tomography) and CT-PET scans.
- Oncology (in-patient and day-care treatment only).
- Routine maternity.
- Complications of pregnancy and childbirth (in-patient treatment only).
- Palliative care.
- Prescribed Independent Treatment Centre.
- Plastic surgery.
- Prescribed stay in the Dutch Asthma Centre in Davos.
- Stay in a therapeutic camp for disabled members.
- Prescribed genetic testing.
- Prescribed physiotherapy.
- Exercise programme.
- Occupational therapy (out-patient treatment only).
- Prescribed speech therapy.
- Prescribed skincare.
- Prescribed UVB treatment of psoriasis.
- Home help.
- Infertility treatment.
- Prescribed melatonin medicine for sleeping disorder.
- Prescribed therapeutic swimming for rheumatism patients.
- Prescribed dietician/nutritionist treatments.
- Accommodation in case of medical treatment received outside of country of residence.
- Expenses for one person accompanying an evacuated/repatriated person.
- Travel costs of insured family members in the event of an evacuation / repatriation.

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

WHY IS TREATMENT GUARANTEE REQUIRED?

As with all health insurance policies, your plan with us will only cover treatment that is medically necessary and charges that are usual and customary. Therefore, it is vital that you contact us before treatment so that we can confirm medical necessity and appropriateness of costs. In addition, Treatment Guarantee will help us to provide you with a better service in the following ways:

- In the case of planned treatment, we will have time to communicate with the hospital to facilitate smooth admission and where possible, arrange for direct settlement, offering you cashless access to hospitals for in-patient treatment.
- Your treatment can be overseen by Allianz Care's Medical Team.
- In the case of an evacuation/repatriation, we will be able to organise and co-ordinate the evacuation on your behalf.

Paying premiums

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

If you are covered under a group policy

- a) In most cases, your company is responsible for the payment of premiums to us for your membership and for the membership of dependants (if applicable) covered under the Company Agreement, together with the amount of any other payments due (such as Insurance Premium Tax) that may be payable in respect of your or their membership. However, please note that you may be liable for payment of tax in respect of the premiums paid by your company. For details, please check with your company.
- b) If you are responsible for the payment of your premiums to us, you are required to pay the premium due to us in advance, for the duration of your membership. Premiums for each Insurance Year have been agreed between your company and us. The amount your company has agreed with us and the method of payment you have chosen, will be shown on your Insurance Certificate. The **initial premium** or the first premium instalment is payable immediately after our acceptance of your application. **Subsequent premiums** are due on the first day of the chosen payment period. You may choose between monthly, quarterly, half-yearly or annual payments depending on the payment method you choose. Please note that if there is any difference between the agreed quotation and your Payment Details Letter/invoice, you must contact us immediately. We are not responsible for payments made through third parties. Your premium must be paid in the currency you elected to pay when applying for cover. If you are unable to pay your premium for any reason, please contact us. Changes in payment terms can be made at policy renewal via written instructions which must be received by us a minimum of 30 days before the renewal date. Failure to pay an initial premium or subsequent premium on time may result in loss of insurance cover.

 +31 10 44 88 200

If you are covered under an individual policy

Premiums for each Insurance Year are based on each member's age on the first day of the Insurance Year, their area of cover, the policyholder's country of residence, the premium rates in effect and other risk factors which may materially affect the insurance.

You are required to pay the premium due to us in advance for the duration of your membership. The amount you have agreed to pay and the method of payment you have chosen will be shown on your quotation, before the issue of your contract. The initial premium or the first premium instalment is payable immediately after our acceptance of your application.

Subsequent premiums are due on the first day of the chosen payment period. You may choose between monthly, quarterly, half-yearly or annual payments depending on the payment method you choose. Please note that if there is any difference between the agreed quotation and your Payment Details Letter/invoice, you must contact us immediately. We are not responsible for payments made through third parties.

Your premium must be paid in the currency you elected to pay when applying for cover. If you are unable to pay your premium for any reason, please contact us on: + 31 10 44 88 200. Changes in payment terms can be made at policy renewal, via written instructions, which must be received by us a minimum of 30 days before the renewal date. Failure to pay an initial premium or subsequent premium on time may result in loss of insurance cover.

If the initial premium is not paid in time, we are entitled to withdraw from the contract for as long as the payment remains outstanding. The insurance contract is deemed to be null and void unless we assert a claim to the premium in court within three months of the commencement date, the policy start date or the conclusion of the insurance contract.

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

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

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

Paying other charges

In addition to paying premiums, you also have to pay us the amount of any Insurance Premium Tax (IPT) and any new taxes, levies or charges relating to your membership that may be imposed after you join and that we are required by law to pay or to collect from you. The amount of any IPT or taxes, levies or charges that you have to pay us is shown on your Payment Details Letter/invoice.

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

Changes to premiums and other charges

Each year on the renewal date, we may change how we calculate your premiums, how we determine the premiums, what you have to pay and the method of payment. Please be assured that if we do make changes, they will only apply from your renewal date.

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

If we do make any changes to your premiums or to the amount you have to pay in respect of IPT or other taxes, levies or charges, we will write to tell you about the changes. If you do not accept any changes we make, you can end your membership and we will treat the changes as having not been made if you end your membership within 30 days of the date on which the changes take effect, or within 30 days of us telling you about the changes, whichever is later.

Administration of your policy

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

Starting membership

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

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

In the case of individual policies, cover starts on the date reported on the Insurance Certificate as the commencement date and is automatically renewed each year as of 1st January, provided that the plan you and your dependants (if applicable) have is still available, all premiums due to us have been paid and the payment details we have for you are still valid on the policy renewal date. Cover is strictly conditional upon our acceptance of the application, as indicated by your receipt of the Insurance Certificate. No benefit will be payable under your policy until the initial policy premium has been paid, with subsequent premiums being paid when due.

When cover starts and ends for dependants included in your membership

If any other person is included as a dependant in your membership, their membership will start on the effective date stated on your Insurance Certificate, which lists them as a dependant.

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

Child dependants may remain insured under the policy of their parent(s) as long as they are part of the family household and/or are living elsewhere while in full time education. However, their cover will last only until 1st January following their 28th birthday. At that time, they may apply for cover in their own right, if they wish to do so.

Adding dependants

You may apply to include any member of your family as a dependant if you are allowed to under the agreement between your company and us. The process is different for underwritten policies and non-underwritten policies. If you have an underwritten policy (where medical history is assessed), you must have provided health and other relevant information when applying.

Underwritten policies.

How do I add a newborn to my policy?

Please send an email to ipm@aon.nl within four weeks from birth and attach the birth certificate. We will accept the baby without medical underwriting if the birth parent or intended parent (in the case of surrogacy) has been insured with us for a minimum of six continuous months. Cover will start at birth.

What happens if I don't notify you within four weeks?

The newborn child will be underwritten and if accepted, cover will start from the date of acceptance.

What if I am adding multiple birth babies, adopted and fostered children?

Multiple birth babies, adopted and fostered children will be underwritten and if accepted, cover will start from the date of acceptance.

Non-underwritten policies

How do I add a newborn to my policy?

To ensure that cover starts from birth, please notify your company within four weeks from birth.

What happens if I don't notify my company within four weeks?

The newborn child will be underwritten and if accepted, cover will start from four weeks before the date we receive the notification.

What if I am adding multiple birth babies, adopted and fostered children?

Cover will start from four weeks before the date we receive the notification.

Changing country of residence

It is important to let us know when you change your country of residence. This may affect your cover or premium, even if you are moving to a country within your geographical area of cover, as your existing plan may not be valid there. Cover in some countries is subject to local health insurance restrictions, particularly for residents of that country. It is your responsibility to ensure that your health cover is legally appropriate. If you are not sure, please get independent legal advice, as we may no longer be able to cover you. The cover we provide is not a substitute for local compulsory health insurance.

How do I notify you that I am moving country?

If you are part of a group scheme, please notify your company.

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

This arrangement remains in effect for any insured person, regardless of what insurer they have in the Netherlands.

Renewing membership

- a) If you are covered under a group policy and your company is responsible for paying your insurance premium, the renewal of your membership (and that of your dependants, if applicable) is subject to your company renewing your membership under the Company Agreement. If your company renews the contract with us, you will receive a new Insurance Certificate which will cover you (and your dependants, if applicable) until the next renewal date.
- b) If you are covered under a group policy and are responsible for paying your insurance premium, the renewal of your cover is subject to your company renewing your membership (and that of your dependants, if applicable) under the Company Agreement. In this case, your policy will be automatically renewed for the next Insurance Year, provided that we can continue to provide cover in your country of residence, all premiums due to us have been paid and the payment details we have for you are still valid on the policy renewal date. For example, we would need to have up-to-date credit card details for credit card payers. Please note that when you receive a new credit card with a new expiry date or if your bank account details have changed, you will need to notify us of this change.
- c) If you are covered under an individual policy, the policy is automatically renewed for the next Insurance Year provided that the plan you and your dependants (if applicable) have is still available, we can continue to provide cover in your country of residence, all premiums due to us have been paid and the payment details we have for you are still valid on the policy renewal date. Please update us if you get a new/replacement credit card or if your bank account details have changed.

As part of this automatic process, one month before the renewal date, you will receive a new Insurance Certificate along with details of any policy changes. If you do not receive your Insurance Certificate within one month before your renewal date, it is important that you notify us.

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

Please note that if a request is made at renewal to change the policyholder, the proposed replacement policyholder will be required to complete the relevant application form and full medical underwriting will apply. The death of the existing policyholder is the only exception to this rule.

Ending your cover

- If you are covered under a group policy, your company can end your membership or that of any of your dependants by notifying us in writing. We cannot backdate the cancellation of your cover. It will automatically end:
 - At the end of the Insurance Year, if the agreement between your company and us 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 us.
 - If you are an individual payer and you do not pay premiums or any other payment due under the Company Agreement with us.
 - When you stop working for the company or stop working outside your home country.
 - Upon the death of the policyholder.

We can end your cover and that of your dependants if there is reasonable evidence that you or they have misled or attempted to mislead us. For example giving us false information, withholding information, 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.
- If you are covered under an individual policy, your cover will automatically end:
 - If you do not pay any of your premiums on, or before, the date they are due. However, we may allow your membership to continue without you having to complete a new Application Form, if you pay the outstanding premiums within 30 days. If you are unable to pay your premiums for any reason, please contact us.
 - If you do not pay the amount of any IPT, taxes, levies or charges that you have to pay under your agreement with us on or before the date they are due.

- Upon the death of the policyholder. If the policyholder dies, the next named dependant on the Insurance Certificate may apply to us to become the policyholder in his/her own right and include the other dependants under his/her membership. If they apply to do this within 28 days we will, at our discretion, not add any further special restrictions or exclusions to their cover that are personal to them, in addition to those which applied to them under the scheme when the policyholder died.
- If you stop working outside your home country and / or retire.

We can end your cover and that of all the other people listed on the Insurance Certificate if there is reasonable evidence that you or they have misled, or attempted to mislead us. For example, giving us false information or withholding pertinent information from us, or working with another party to give us false information, either intentionally or carelessly, which may influence us when deciding:

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

If your membership ends for reasons other than for fraud/non-disclosure (please see the following section), we will refund any premiums you have paid which relate to a period after your membership has ended. However, we will be entitled to deduct from any refund the money which you owe us.

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

Applying for cover if group membership ends

If your cover under the Company Agreement comes to an end, you can apply for cover under one of our Healthcare Plans for Individuals and Families, by simply sending us an email (details below). You need to submit your application within one month of leaving the group scheme. You may be subject to underwriting. If we accept your application, cover will start on the first day after you leave the group scheme.

@ individual.sales@allianzworldwidecare.com

General information

TABLE OF BENEFITS

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

MAKING CHANGES TO YOUR COVER

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

If you are covered under an individual policy, changes to cover can only be made at policy renewal. If you want to change your level of cover, please contact us before your policy renewal date to discuss your options. If you want to increase your level of cover, we may ask you to complete a medical history questionnaire form, and/or to agree to certain exclusions or restrictions to your cover before we accept your application. An additional premium amount will be payable and waiting periods may apply.

Please notify us as soon as possible if you move country of residence, as this may impact your cover or premium – even if you are moving to a country within your existing area of cover. Please note that cover in some countries is subject to local health regulations, particularly for permanent residents of that country.

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

CHANGES APPLIED BY US (APPLICABLE TO INDIVIDUAL POLICIES ONLY)

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

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

We will not add any restrictions or exclusions to someone's cover that are personal to them for medical conditions that started after they joined the scheme, provided that they gave us the information we asked them for before joining and they have not applied for an increase in their cover.

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

DEATH

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

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

YOUR RIGHT TO CANCEL (APPLICABLE TO INDIVIDUAL POLICIES ONLY)

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

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

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

 AON Health Solutions, International People Mobility Postbus 10053000 BA – Rotterdam Netherlands

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

Upon policy inception/renewal you may also cancel the membership of any dependants listed on your inception/renewal Insurance Certificate, for any reason, within this 30 day period. This can be done by filling out the "Right to change your mind" form, which can be sent to us via email or post.

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

AMENDING YOUR MEMBERSHIP DETAILS

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

- You add a dependant, such as a newborn child, to your membership.
- We need to record any other changes requested by you/your company or which we are entitled to make.

Your new Insurance Certificate will replace any earlier version(s) you possess as from the start date shown on the new Insurance Certificate.

OTHER PARTIES

No other person is allowed to make or confirm any changes to your membership on our behalf, or decide not to enforce any of our rights. No change to your membership will be valid unless it is specifically agreed between you/your company and us: any change will be confirmed to you in writing by AON Health Solutions or us.

POLICY EXPIRY

Please note that upon the expiry of your insurance cover, your right to reimbursement ends. Any expenses covered under the insurance policy and incurred during the period of cover will be reimbursed up to 12 months after the expiry of the insurance cover. However, any on-going or further treatment that is required after the expiry date of your insurance policy will no longer be covered.

IF YOU ARE COVERED BY ANOTHER INSURANCE SCHEME

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

IF YOU CHANGE YOUR ADDRESS/EMAIL ADDRESS

All correspondence will be sent to the details we have on record for you unless requested otherwise. Any change in your home, business or email address should be communicated to AON Health Solutions as soon as possible.

@ ipm@aon.nl

CORRESPONDENCE

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

The following terms also apply to your cover

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

Economic sanctions: Cover is not provided if any element of the cover, benefit, activity, business or underlying business violates any applicable sanction law or regulations of the United Nations, the European Union or any other applicable economic or trade sanction law or regulations.

Who is covered: Only those employees and dependants as described in the Company Agreement (for group policies) or in the Insurance Certificate (for individual policies).

The amounts we will pay: Our liability to you is limited to the amounts indicated in the Table of Benefits and any policy endorsements. The amount reimbursed, whether under this policy, public medical scheme or any other insurance will not exceed the figure stated on the invoice.

Who can make changes to your policy: No one, except an appointed representative or the Group Scheme Manager (if you are part of a group scheme) is allowed to make any changes to your policy on your behalf. Changes are only valid when agreed by your company and us.

When cover is provided by someone else: We may decline a claim if you or any of your dependants are eligible to claim benefits from:

- A public scheme
- Any other insurance policy
- Any other third party

If that is the case, you need to inform us and provide all necessary information. You and the third party cannot agree any final settlement or waive our right to recover expenses without our prior written agreement. Otherwise, we are entitled to get back from you any amount we have paid and to cancel your cover.

We have the right to claim back from a third party any amount we paid for a claim, if the costs were due from or also covered by them. We may take legal proceedings in your name, at our expense, to achieve this. This is called subrogation.

We will not make a contribution to any third-party insurer if the costs are fully or partly covered by that insurer. However, if our plan covers a higher amount than the other insurer, we'll pay the amount not covered by them.

Cancellation and fraud:

- a) For individual policies, we will cancel the insurance where you have not paid the full premium due and owing. We shall notify you of this cancellation and the contract shall be deemed cancelled from the date that the said premium payment became due and payable. However, if the premium is paid within 30 days after the due date, the insurance cover will be reinstated and we will cover any claims which occurred during the period of delay. However, if the outstanding premium is paid after the 30-day limit, you must complete a Health Declaration Form before your policy can be reinstated, subject to underwriting.
- b) For any policy subject to medical underwriting, incorrect disclosure/non-disclosure of any material facts, by you or your dependants, which may affect our assessment of the risk, including, but not limited to, those material facts declared on the relevant application form, may render your cover void from the commencement date. Conditions arising between completing the relevant application form and confirmation of acceptance by our Underwriting Team will be deemed to be pre-existing and will not be covered if not disclosed. If the applicant is not sure whether something is relevant, the applicant is obliged to inform us.
- c) For all policies, if any claim is false, fraudulent, intentionally exaggerated or if fraudulent means or devices have been used by you or your dependants or anyone acting on your or their behalf to obtain benefit under this policy, we will not pay any benefits for that claim. The amount of any claim settlement made to you before the fraudulent act or omission was discovered, will become immediately due and owing to us. For group scheme members, we reserve the right to inform your company of any fraudulent activity.

Making contact with dependants: In order to administer your policy, we may need to request further information. If we need to ask about one of your dependants (e.g. when we need to collect an email address for an adult dependant), we may contact you as the person acting on behalf of the dependant, and ask you for the relevant information, provided it is not sensitive information. Similarly, for the purposes of administering claims, we may send you non-sensitive information that relates to a family member.

Circumstances outside of our control (force majeure): We will always do our best for you, but we are not liable for delays or failures in our obligations to you caused by things which are outside of our reasonable control. Examples are 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 and expropriation by governmental authorities.

Legal action: You shall not institute any legal proceedings to recover any amount under the policy until at least 60 days after the claim has been submitted to us and not more than two years from the date of this submission, unless otherwise required by mandatory legal regulations.

Mediation:

1. Any differences in respect of medical opinion in connection with the results of an accident or medical condition must be notified to us within nine weeks of the decision. Such differences will be settled between two medical experts appointed by you and us in writing.
2. If differences cannot be resolved in accordance with Clause 1 above, the Parties (i.e. you and us) will attempt to settle by mediation in accordance with the Centre for Effective Dispute Resolution (CEDR) Model Mediation Procedure any dispute, controversy or claim arising out of or relating to this Agreement or the breach, termination or invalidity thereof where the value is €500,000 or less and which cannot be settled amicably between the Parties. The Parties will endeavour to agree on the appointment of an agreed Mediator. If the Parties fail to agree the appointment of an agreed Mediator within 14 days, either Party (i.e. you or us), upon written notice to the other Party, may apply to CEDR for the appointment of a Mediator.

To initiate the mediation, a party must give notice in writing ("ADR notice") to the other Party to the dispute, requesting mediation. A copy of the request should be sent to CEDR. The mediation will start no later than 14 days after the date of the ADR notice. No Party may commence court proceedings/arbitration relating to any dispute pursuant to this Clause 2 until it has attempted to settle the dispute by mediation and either the mediation has terminated or the other Party has failed to participate in the mediation (provided that the right to issue proceedings is not prejudiced by a delay). The mediation will take place in Netherlands. The Mediation Agreement referred to in the Model Procedure will be governed by, and construed and take effect in accordance with the laws of Netherlands. The Courts of Netherlands will have exclusive jurisdiction to settle any claim, dispute or matter of difference which may arise out of, or in connection with, the mediation.

3. Any dispute, controversy or claim which is:
 - Arising out of or relating to this Agreement (or the breach, termination or invalidity thereof) with a value in excess of €500,000, or
 - Referred to mediation pursuant to Clause 8.b but not voluntarily settled by mediation within three months of the ADR Notice date

will be determined exclusively by the Courts of Netherlands and the Parties will submit to the exclusive jurisdiction of those courts. Any proceedings brought pursuant to Clause 3 will be issued within nine calendar months of the expiration date of the aforementioned three month period.

Data protection

Our Data Protection Notice explains how we protect your privacy and process your personal data. You must read it before sending us any personal data. To read our Data Protection Notice visit:

 www.allianzcare.com/en/privacy

Alternatively, you can contact us on the phone to request a paper copy.

 **+353 1 630 1301**

If you have any queries about how we use your personal data, please email us at:

 **AP.EU1DataPrivacyOfficer@allianz.com**

Complaints procedure

Our Helpline is always the first number to call if you have any comments or complaints. If we can't resolve the problem on the phone, please email or write to us:

 +353 1 630 1301

 Email: client.services@allianzworldwidecare.com

 Customer Advocacy Team, Allianz Care, 15 Joyce Way, Park West Business Campus, Nangor Road, Dublin 12, Ireland.

We will handle your complaint according to our internal complaint management procedure.
For details see:

 www.allianzcare.com/complaints-procedure

You can also contact our Helpline to obtain a copy of this procedure.

Definitions

The following definitions apply to our Healthcare Plans. The benefits you are covered for are listed in your Table of Benefits. If your plan includes any benefit not listed below, the definition will appear in the “Notes” section at the end of your Table of Benefits. Wherever these words/phrases appear in your policy documents, they will always have the following meanings:

A

Accident

Sudden, unexpected event that causes injury and is due to a cause external to the insured person. The cause and symptoms of the injury must be medically and objectively definable, allow for a diagnosis and require therapy.

Accidental dental treatment for insured persons under 18 years

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

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

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 the daily room rate in a three-star hotel towards any hotel costs incurred. We do not cover sundry expenses such as meals, telephone calls or newspapers.

Acute

Sudden onset of symptoms or a medical condition.

Admission

Admission in a hospital, psychiatric hospital/ward or rehabilitation facility to receive medically necessary nursing, examination or treatment.

Alternative therapy or treatment

Therapeutic and diagnostic treatment that exists outside the institutions where conventional Western medicine is taught. Such medicine includes, for example, chiropractic treatment, osteopathy, Chinese herbal medicine, homeopathy and acupuncture as practiced by approved therapists.

C

Calendar year

Period that runs from 1st January to 31st December.

Centre for genetic testing

Institution recognised by the competent authorities for the performance of clinical-genetic research and genetic advising.

Chronic condition

Sickness, illness, disease or injury that lasts longer than six months or requires medical attention (such as check-up or treatment) at least once a year. It also 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
- Leads to permanent disability

Please refer to the “Notes” section of your Table of Benefits to confirm whether chronic conditions are covered.

Company

Your employer as named in the Company Agreement.

Company Agreement

The agreement we have with your employer, through which you and your dependants are insured with us. This agreement sets out who can be covered, when cover begins, how it is renewed and how premiums are paid.

Company doctor

Medical practitioner recognised by the competent authorities who acts on behalf of the member's employer or the Occupational Health and Safety Service with which the employer is affiliated.

Complications of childbirth

They 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 your plan also includes a routine maternity benefit, complications of childbirth includes medically necessary caesarean sections.

Complications of pregnancy

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

Contraception

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

Co-payment

The percentage of the costs which the insured person must pay.

D

Day-care treatment

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.

Deductible

Part of the cost that is payable by you and that we deduct from the amount we will pay. Where deductibles apply, they are payable per person per Insurance Year, unless your Table of Benefits states otherwise. Deductibles may apply to the Core or to the Out-patient plans.

Dental prescription drugs

Drugs prescribed by a dentist for the treatment of dental inflammation or infection. The prescription drugs must be proven to be effective for the condition and recognised by the pharmaceutical regulator in a given country. They do not include mouthwashes, fluoride products, antiseptic gels and toothpastes.

Dental prostheses

Crowns, inlays, onlays, adhesive reconstructions/restorations, bridges, dentures and implants as well as all necessary and ancillary treatment required.

Dental surgery

Surgical extraction of teeth, as well as other tooth-related surgical procedures such as apicoectomy and dental prescription drugs. All investigative procedures that establish the need for dental surgery such as laboratory tests, X-rays, CT scans and MRI(s) are included under this benefit. Dental surgery does not cover surgical treatment that relates to dental implants.

Dental treatment

An annual check-up, simple fillings related to cavities or decay, root canal treatment and dental prescription drugs.

Dentist

Dentist recognised by the competent authorities of the country in which treatment is provided.

Dependant

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

Diagnostic tests

Investigations such as x-rays or blood tests, undertaken to determine the cause of the presented symptoms.

Doctor

A person who is licensed to practise medicine under the law of the country in which treatment is given and where they are practising within the limits of their licence.

Dyslexia (serious)

Reading and spelling disorder resulting from a neurological impairment that is genetically determined and can be distinguished from other reading and spelling problems.

E

Emergency

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.

Emergency in-patient dental treatment

Acute emergency dental treatment for the relief of pain that is due to a serious accident and requires admission to hospital. The treatment must take place within 24 hours of the emergency event. Cover 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.

EU or EEA state

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

Expenses for one person accompanying an evacuated/repatriated person

Travel costs for one person accompanying the evacuated/repatriated person. If they can't travel in the same vehicle, we will pay for an alternative form of transport at economy rates. Following completion of treatment, we will also cover the cost of the companion's return trip, at economy rates, to the country where the evacuation/repatriation started from. Cover is not provided for hotel accommodation or other related expenses.

G

GP (General Practitioner)

Medical practitioner who is recognised as GP by the competent authorities, or who operates as such in places where the term GP is not used.

Group Scheme Manager

The designated representative of your company, who acts as the point of contact between the company and us for matters relating to the administration of the plan such as enrolment, premium collection and renewal.

Guesthouse accommodation

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

H

Home country

A country for which you hold a current passport or which is your principal country of residence.

Hospital

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 doctor. The following are not considered hospitals: rest and nursing homes, spas, cure-centres and health resorts.

Hospital accommodation

Standard private or semi-private accommodation as shown in the Table of Benefits – deluxe, executive rooms and suites are not covered.

Hospital care

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

I

Independent treatment centre

Centre for specialist medical care (examinations and treatment) recognised as such by the competent authorities.

Infertility treatment

Treatment for the insured person and includes all invasive investigative procedures necessary to establish the cause of infertility such as hysterosalpingogram, laparoscopy or hysteroscopy. We will cover the cost of treatment for the insured member who receives it, up to the limit indicated in the Table of Benefits. You cannot claim under your spouse/partner's cover (if they are included in the policy) for costs that exceed your benefit limit. In the case of InVitro Fertilisation (IVF), cover is limited to the amount specified in the Table of Benefits.

In-patient treatment

Treatment received in a hospital where an overnight stay is medically necessary.

Insurance Certificate

A document we issue that outlines the details of your cover. It confirms that your company has a group insurance policy with us.

Insurance Year

It applies from the effective date of your policy, as shown on the Insurance Certificate and ends at the expiry date of the Company Agreement. The following Insurance Year coincides with the year that is defined in the Company Agreement.

Insured person

You and your dependants as stated on your Insurance Certificate.

K

Kraamzorg

Medical service in the Netherlands where post-natal care is provided to a new mother and her baby in the eight to ten days immediately after birth. The “kraamverzorgster” (professional providing the Kraamzorg consultations) must be registered in the Netherlands and qualified as a maternity nurse or healthcare professional. Cover is only provided in the Netherlands and is limited to visits up to 10 days following birth. This service provides care for the newborn and monitors the baby's development as well as the recovery for the mother.

L

Local ambulance

Ambulance transport that is required for an emergency or out of medical necessity, to the nearest available and appropriate hospital or licensed medical facility.

M

Maternity care

Care provided by a certified maternity carer or a nurse working as such.

Medical advisor

Medical practitioner within our Emergency Assistance Service who advises us on medical matters.

Medical evacuation

It applies in the following scenarios:

- If the necessary treatment you are covered for is not available locally

- If adequately screened blood is unavailable in an emergency

We will evacuate you to the nearest appropriate medical centre (which may or may not be in your home country) by ambulance, helicopter or aeroplane. The medical evacuation should be requested by your doctor, and will be carried out in the most economical way that is appropriate to your medical condition. Following completion of treatment, we will also cover the cost of your return trip at economy rates to your principal country of residence.

If you can't travel or be evacuated for medical reasons following discharge from an in-patient episode of care, we will cover the reasonable cost of hotel accommodation in a private en-suite room for up to seven days. We do not cover costs for hotel suites, four or five-star hotel accommodation or hotel accommodation for an accompanying person.

If you are evacuated to the nearest appropriate medical centre for ongoing treatment, we will cover the reasonable cost of hotel accommodation in a private en-suite room. This cost must be more economical than the cost of a series of journeys between the nearest appropriate medical centre and your principal country of residence. Hotel accommodation for an accompanying person is not covered.

Where adequately screened blood is not available locally, we will, where appropriate, try to locate and transport screened blood and sterile transfusion equipment, if this is advised by the treating doctor and our own medical experts. We and our agents accept no liability if we are unsuccessful or if contaminated blood or equipment is used by the treating authority.

You must contact us at the first indication that you need an evacuation. From this point onwards, we will organise and coordinate the evacuation until you arrive safely at your destination of care. If evacuation services are not organised by us, we reserve the right to decline all costs incurred.

Medical necessity

Medical treatment, services or supplies that fulfil all of the following:

- a) Essential to identify or treat your condition, illness or injury
- b) Consistent with your symptoms, diagnosis or treatment of the underlying condition
- c) In accordance with generally accepted medical practice and professional standards of care in the medical community at the time (this does not apply to complementary treatment methods if they form part of your cover)
- d) Required for reasons other than the comfort or convenience of you or your doctor
- e) Proven and demonstrated to have medical value (this does not apply to complementary treatment methods if they form part of your cover)

- 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 your 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. In respect to in-patient treatment, “medically necessary” also means that diagnosis can’t be made or treatment can’t be safely and effectively provided on an out-patient basis.

Medical practitioner fees

Fees charged for non-surgical treatment performed or administered by a medical practitioner.

Medical practitioners

Doctors who are licensed to practise medicine under the law of the country in which treatment is given and where they are practising within the limits of their licence.

Medical repatriation

An optional level of cover and where provided will be shown in the Table of Benefits. If the necessary treatment for which you are covered isn’t available locally and you choose to be medically repatriated to your home country for treatment, instead of to the nearest appropriate medical centre. This only applies when your home country is within your geographical area of cover. Following completion of treatment, we will also cover the cost of your return trip, at economy rates, to your principal country of residence. The return journey must take place within one month after treatment has been completed.

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

Midwife fees

Fees charged by a midwife or birth assistant, who, according to the law of the country in which treatment is given, has completed the necessary training and passed the necessary state examinations.

Multidisciplinary cooperation

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



Newborn care

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.

Cover doesn’t include further preventive diagnostic procedures, such as routine swabs, blood typing and hearing tests. However, if for medical reasons the child needs any follow-up investigations and treatment, these are covered under the newborn’s own policy (if they have been added as a dependant).

NIPT (Non-invasive pre-natal testing)

A DNA test of the placenta.

Nursing at home or in a convalescent home

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 if the treating doctor decides that it is medically necessary for you to stay in a convalescent home or have a nurse in attendance at home. This benefit also needs to be approved by our Medical Director. This benefit doesn’t cover spas, cure centres, health resorts or palliative care.



Obesity

It is diagnosed when a person has a Body Mass Index (BMI) of over 40 (you can find a BMI calculator at www.allianzcare.com/members).

Occupational therapy

Treatment that helps you develop skills needed for daily living and interactions with other people and the environment. These refer to:

- Fine and gross motor skills (how you perform small, precise tasks and whole-body movement).
- Sensory integration (how the brain organises a response to your senses).
- Coordination, balance and other skills such as dressing, eating and grooming.

Out-patient occupational therapy requires Treatment Guarantee.

Oncology

Specialist fees, diagnostic tests, radiotherapy, chemotherapy and hospital charges related to the treatment of cancer from the point of diagnosis. We also cover the cost of an external prosthetic device for cosmetic purposes, for example a wig for hair loss or a prosthetic bra after breast cancer treatment.

Organ transplant

The following organ or tissue transplants: heart, heart/valve, heart/lung, liver, pancreas, pancreas/kidney, kidney, bone marrow, parathyroid, muscular/skeletal and cornea. We do not reimburse the costs of acquiring organs.

Orthodontics

Use of devices to correct malocclusion and restore the teeth to proper alignment and function.

Orthodontist

Dentist or dental orthopaedic specialist recognised by the competent authorities.

Orthomolecular treatment

Alternative treatment that aims to restore the individual biochemical balance through supplements. It uses natural substances such as vitamins, minerals, enzymes and hormones.

Out-patient surgery

Surgical procedure performed in a surgery, hospital, day-care facility or out-patient department that does not require you to stay overnight out of medical necessity.

Out-patient treatment

Treatment provided in the practice or surgery of a medical practitioner, therapist or specialist that does not require you to be admitted to hospital.

P

Palliative care

Ongoing treatment that aims to alleviate the physical/psychological suffering associated with progressive, incurable illness and to maintain quality of life. It includes in-patient, day-care and out-patient treatment following the diagnosis of a terminal condition. We will pay for physical care, psychological care, hospital or hospice accommodation, nursing care and prescription drugs.

Periodontics

Dental treatment related to gum disease.

Pharmaceutical care

Dispensation of medications recognised and registered by the competent authorities, dispensed on prescription from the treating GP or medical practitioner by a pharmacy.

Pharmacy

It includes (internet) pharmacies, chain pharmacies, hospital pharmacies, out-patient facility pharmacies and dispensing doctors.

Podiatrist

A podiatrist recognised by the competent authorities of the country where treatment is provided.

Policyholder

The person appearing first in the Insurance Certificate.

Post-natal care

Routine post-partum medical care received by the mother for up to six weeks after delivery.

Pre-existing conditions

Medical conditions for which one or more symptoms have presented at some point during the five years before the start of cover. This applies regardless of whether you or your dependants sought any medical treatment or advice. For non-underwritten policies, pre-existing conditions are covered.

However, for underwritten policies, we will also treat as pre-existing any medical conditions that arise between the date you completed the application form and the later of the following:

- The date we issued your Insurance Certificate or
- The start date of your policy

Such pre-existing conditions will also be subject to full medical underwriting and if they are not disclosed, they will not be covered.

Pregnancy

The period of time when you are expecting a baby, from the date of the first diagnosis until delivery.

Pre-natal care

Common screening, NIPT (Non-invasive pre-natal testing) and follow-up tests required during pregnancy. For women aged 36 and over, this includes Triple/Bart's, Quadruple and Spina Bifida tests, amniocentesis and, if directly linked to an eligible amniocentesis, DNA-analysis.

Prescribed glasses and contact lenses including eye examination

Cover for a routine eye examination carried out by an optometrist or ophthalmologist (one check-up per Insurance Year) and for lenses and glasses to correct vision.

Prescribed medical aids

Any instrument, apparatus or device which is medically prescribed as an aid to the function or capacity of the insured person, such as adhesive strips for affixing prosthetic breasts, aerochamber, telemonitoring, vacuum assisted closure system, supportive pessary, arch supports,

bedwetting alarm, neuromodulator and biofeedback equipment, wigs, hearing aids, walking aids, prescribed monitoring equipment or sensormat for the prevention of crib death.

Prescribed physiotherapy

Treatment provided by a registered physiotherapist following referral by a doctor. Physiotherapy (either prescribed, or a combination of non-prescribed and prescribed treatment) is initially restricted to 12 sessions per condition, after which treatment must be reviewed by the doctor who referred you. If you need further sessions, you must send us a new progress report after every set of 12 sessions, indicating the medical necessity for more treatment. Physiotherapy does not include therapies such as Rolfing, massage, Pilates, Fango and Milta.

Prescription drugs

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

Preventive examinations and screening for early detection of illness or disease

Health checks, tests and examinations, performed at an appropriate age interval, that are undertaken without any clinical symptoms being present. Such tests include:

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

Preventive treatment

Treatment you receive without any clinical symptoms being present at the time of treatment (e.g. the removal of a pre-cancerous growth). This benefit is covered when the 'Preventive treatment' benefit is listed in your Table of Benefits.

Principal country of residence

The country where you and your dependants (if applicable) live for more than six months of the year.

Psychiatry and psychotherapy

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

R

Reasonable and customary

Treatment costs that are usual within the country of treatment. We will only reimburse the cost of medical providers where their charges are reasonable and customary and in accordance with standard and generally accepted medical procedures.

Rehabilitation

Treatment aimed at the restoration of a normal form and/or function after an acute illness, injury or surgery. The rehabilitation benefit is only payable for treatment that starts after the acute medical treatment ceases.

Repatriation of mortal remains

Transportation of the insured deceased's remains from the principal country of residence to the country of burial. We cover costs such as: embalming, a container legally appropriate for transportation, shipping and the necessary government authorisations. Cremation costs will only be covered if the cremation is required for legal purposes. We do not cover costs incurred by anyone accompanying the remains unless this is listed as a specific benefit in your Table of Benefits. We must pre-approve all covered expenses in connection with the repatriation of mortal remains through the Treatment Guarantee process.

Routine maternity

Any medically necessary costs incurred during pregnancy and childbirth. This includes hospital charges, specialist fees, the mother's pre-natal and post-natal care, midwife fees (during labour only) and newborn care. Caesarean sections that are not medically necessary are covered up to the cost of a routine delivery in the same hospital, subject to any benefit limits.

S

Specialist

A licensed doctor possessing the additional qualifications and expertise necessary to practise as a recognised specialist in diagnostic techniques, treatment and prevention in a particular field of medicine.

Specialist fees

Non-surgical treatment performed or administered by a licensed doctor. This benefit does not include cover for psychiatrist, psychologist fees or any treatment that is already covered by another benefit under your Table of Benefits. We don't cover specialist treatment that is excluded under your policy.

Speech therapy

Treatment carried out by a qualified speech therapist to treat diagnosed physical impairments. This includes conditions such as nasal obstruction, neurogenic impairment (e.g. lingual paresis, brain injury) or articulation disorders involving the oral structure (e.g. cleft palate).

Supplementary private room

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

Surgical appliances and prostheses

Artificial body parts or devices, which are an integral part of a surgical procedure or part of any medically necessary treatment following surgery.

T

Therapist/alternative therapist

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

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

The reasonable transportation and accommodation costs so that one person can travel to the location to be with an insured who is at peril of death or who has died (up to the amount specified in your Table of Benefits). Reasonable transportation costs are considered to be round trip transport costs at economy rates. When claiming, please include copies of the travel tickets, hotel accommodation receipt and the death certificate or a doctor's certificate supporting the reason for travelling. We will cover one claim per lifetime of the policy.

Treatment

Medical procedure needed to cure or relieve illness or injury.

V

Vaccinations

All basic immunisations required under the Dutch national vaccination programme as well as rabies, rubella, influenza, tetanus and meningococcal vaccination or other vaccination required for travelling abroad as malaria, diphtheria, tetanus and poliomyelitis (DTP), yellow fever, typhus, cholera and hepatitis A/B immunisations.

Video consultation services

They provide direct access to a doctor via a telecommunication platform. This benefit covers the costs of video consultations, as indicated in your Table of Benefits and offers medical advice, diagnosis and issuance of a prescription, if needed, for non-urgent medical care. Access to teleconsultation services and prescriptions will depend on your geographical location and local country regulations. You can make an appointment to speak to a medical practitioner in English, subject to availability. Some third party providers may offer additional core languages. Cost of medicines are not included, but delivery of medicine or referrals may or may not be included under this benefit, even when prescribed or recommended during the video consultation.

W

We/Our/Us

Allianz Care and AON Health Solutions. Allianz Care is the insurer of this policy. Allianz Care and AON Health Solutions are jointly responsible for the policy's administration.

Y

You/Your

The eligible insured person stated on the Insurance Certificate.

Exclusions

Although we cover most medically necessary treatment, we do not cover the following expenses unless indicated otherwise in the Table of Benefits or in any written policy endorsement.

ACCOMMODATION COSTS INCURRED IN THE NETHERLANDS OR IN THE HOME COUNTRY

Accommodation costs incurred in the Netherlands or in the home country are not eligible for reimbursement.

ALTERNATIVE TREATMENT

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

- Treatments, examinations or courses with a social character or focused on wellness and/or prevention.
- Treatment courses and travel-related expenses.
- Alternative treatments or therapies provided by your GP.
- Care related to alternative psychotherapy.
- Work and school related coaching.

COMPLEMENTARY TREATMENT

Complementary treatment, with the exception of those treatments shown in the Table of Benefits.

COMPLICATIONS CAUSED BY CONDITIONS NOT COVERED UNDER YOUR PLAN

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

DEVELOPMENTAL DELAY

Delay in cognitive or physical development, unless a child has not achieved the developmental milestones expected for a child of that age. 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 medical professionals and documented as a delay in development of at least 12 months.

DRUG ADDICTION OR ALCOHOLISM

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

FAILURE TO SEEK OR FOLLOW MEDICAL ADVICE

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

FEES FOR THE COMPLETION OF A CLAIM FORM

Doctor's fees for the completion of a Claim Form or other administration charges.

GENERAL POPULATION SCREENING

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

HELP SUPPLIES

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

INTENTIONALLY CAUSED DISEASES OR SELF-INFLICTED INJURIES

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

LOSS OF HAIR AND HAIR REPLACEMENT

Investigations into and treatment for loss of hair, including hair replacement unless the loss of hair is due to cancer treatment.

MEDICAL ERROR

Treatment required as a result of medical error.

MEDICAL SCREENING OF ADOPTED CHILD WHEN ADOPTION HAS BEEN COMPLETED

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

MISUSE OF ALCOHOL OR DRUGS

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

NURSING COSTS IN CONNECTION WITH ARTIFICIAL RESPIRATION

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

ORTHOMOLECULAR TREATMENT

Please refer to the definition of 'Orthomolecular treatment'.

PARTICIPATION IN WAR OR CRIMINAL ACTS

Death from or treatment for any illnesses, diseases or injuries resulting from active participation in the following, whether war has been declared or not:

- War
- Riots
- Civil disturbances
- Terrorism
- Criminal acts
- Illegal acts
- Acts against any foreign hostility

PHYSIOTHERAPY COSTS

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

PLASTIC SURGERY

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

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

PODIATRIC AND PODOLOGICAL SUPPORTING ARCHES

The costs of podiatric and podological supporting arches prescribed by a podologist are not eligible for reimbursement. We also do not reimburse the costs of shoes or adjustments to shoes.

PRE-EXISTING CONDITIONS

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

PRODUCTS SOLD WITHOUT PRESCRIPTIONS

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

REPAIRS OR REPLACEMENTS OF ORTHODONTIC DEVICES

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

REPATRIATION RELATED TO INFERTILITY TREATMENTS

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

REVERSAL OF STERILISATION

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

SEXUAL DYSFUNCTION

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

SPEECH THERAPY

Speech therapy is only eligible for reimbursement in the context of a diagnosed physical impairment such as, but not limited to, nasal obstruction, neurogenic impairment (e.g. lingual paresis, brain injury) or articulation disorders involving the oral structure (e.g. cleft palate). We do not pay for speech therapy provided by a speech therapist and related to dyslexia or language development disorders in connection with dialect and different mother tongue.

STAYS IN A CURE CENTRE

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

SUPPLEMENTARY DENTAL COVER EXCLUSIONS

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

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

SURROGACY

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

THE BENEFITS COVERED UNDER YOUR PLANS ARE NOT ELIGIBLE IF:

The insured person can claim reimbursement of the insured costs related to nursing, examination or treatment pursuant to:

- Legally regulated insurance.
- Any government scheme.
- Any subsidy scheme.
- Another insurance contract.

They relate to costs of psychoanalysis.

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

They refer to costs for non-show appointments.

TREATMENT IN THE USA IN THE FOLLOWING CASES

Treatment in the USA if we believe that cover was taken out with the purpose of travelling to the USA to get treatment for a condition or symptoms you were aware of:

- before being insured with us
- before having the USA in your region of cover

If we paid any claims in these circumstances, we reserve the right to seek reimbursement from you.

TREATMENT OUTSIDE THE GEOGRAPHICAL AREA OF COVER

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

TRIPLE/BART'S, QUADRUPLE OR SPINA BIFIDA TESTS

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

TUMOUR MARKER TESTING

Tumour marker testing, unless you have previously been diagnosed with the specific cancer in question, in which case cover is provided under the 'Oncology' benefit.

VITAMINS OR MINERALS

Products classified as:

- Vitamins or minerals (except during pregnancy or to treat diagnosed, clinically significant vitamin deficiency syndromes)
- Supplements such as infant formula and cosmetic products

These products are excluded even if they are medically recommended, prescribed or acknowledged as having therapeutic effects.

Talk to us, we love to help!

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

24/7 Helpline for general enquiries and emergency assistance

	English:	+353 1 630 1301
	German:	+353 1 630 1302
	French:	+353 1 630 1303
	Spanish:	+353 1 630 1304
	Italian:	+353 1 630 1305
	Portuguese:	+353 1 645 4040

Toll free numbers: www.allianzcare.com/toll-free-numbers

If you are not able to access the toll-free numbers from a mobile phone, please dial one of the Helpline numbers listed above.

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 identity.

@ Email: client.services@allianzworldwidecare.com

 Fax: + 353 1 630 1306

 Address: Allianz Care, 15 Joyce Way, Park West Business Campus, Nangor Road, Dublin 12, Ireland.

 www.allianzcare.com

 www.facebook.com/allianzcare

 www.twitter.com/AllianzCare

 www.youtube.com/user/allianzworldwide

 www.instagram.com/allianzcare/

 www.linkedin.com/company/allianz-care

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