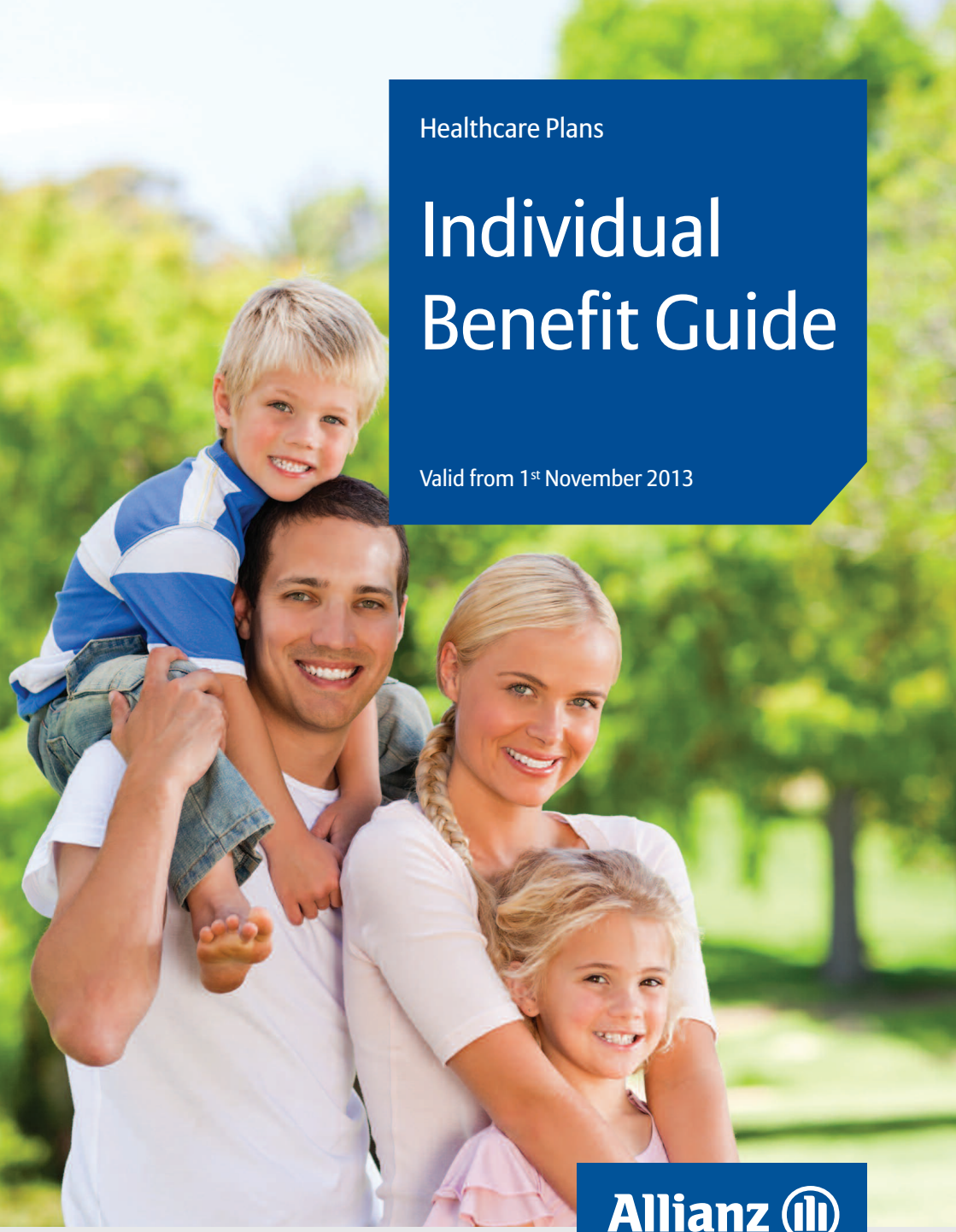

Healthcare Plans

# Individual Benefit Guide

Valid from 1st November 2013

Allianz

Allianz Worldwide Care

# Your healthcare cover

Your health insurance policy is an annual contract between Allianz Worldwide Care and the insured member(s) named on the Insurance Certificate. The contract is composed of:

- The Benefit Guide (this document). This sets out the standard benefits and rules of your health insurance policy and should be read in conjunction with your Insurance Certificate and Table of Benefits.

- The Insurance Certificate. This states the plan(s) chosen, the start date and renewal date of the policy (and effective dates of when dependants were added) as well as the geographical area of cover. Any further endorsements or special conditions unique to your cover will be indicated in the Insurance Certificate (and will have been detailed on a Special Conditions Form issued prior to the inception of your policy). Please note that we will send you a new Insurance Certificate if you request (and we accept) a change such as adding a dependant, or if we apply a change which we are entitled to make.

- The Table of Benefits. This shows the plan(s) selected, the associated benefits available to you, and specifies which benefits/treatments require submission of a Treatment Guarantee Form. It also confirms any benefits to which specific benefit limits, waiting periods, deductibles and/or co-payments apply.

- Information provided to us by, or on behalf of, the insured member(s) in the signed Application Form, submitted Online Application Form, Confirmation of Health Status Form or others (hereafter referred to collectively as the "relevant application form") or other supporting medical information.

# Table of contents

# Your cover

## Overview

Your Table of Benefits specifies the plan(s) selected and the associated benefits available to you. You will find further details about our benefits in the "Definitions" section of this guide. Not all of the benefits listed in our "Definitions" section are necessarily covered under your policy, which is why it's important to check which ones are listed in your Table of Benefits. Your cover is subject to our policy definitions, exclusions, benefit limits and any special conditions indicated on the Insurance Certificate. If you have any queries about what you are covered for, please don't hesitate to call us.

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

## Benefit limits

There are two kinds of benefit limits shown in the Table of Benefits. The **maximum plan benefit**, which applies to certain plans, is the maximum we will pay for all benefits in total, per member, per Insurance Year, under that particular plan. Some benefits also have a **specific benefit limit**, which may be provided on a "per Insurance Year" basis, a "per lifetime" basis or on a "per event" basis, such as per trip, per visit or per pregnancy. In some instances we will pay a percentage of the costs for the specific benefit e.g. "65% refund, up to £4,150/€5,000/US$6,750/CHF6,500". Where a specific benefit limit applies or where the term "Full refund" appears next to certain benefits, the refund is subject to the maximum plan benefit, if one applies to your plan(s). All limits are per member, per Insurance Year, unless otherwise stated in your Table of Benefits.

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

please note that if a change is applied to the benefit limit at policy renewal, the following will apply:

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

In-patient treatment for multiple birth babies born as a result of medically assisted reproduction will be covered up to £24,900/€30,000/US$40,500/CHF39,000 per child for the first three months following birth. Out-patient treatment will be covered under the limits of the Out-patient Plan.

## Change to country of residence

It is important that you advise us when you change country of residence, as it may impact your cover or premium, even if you are moving to a country within your geographical area of cover. If you move to a country outside of your geographical area of cover, your existing cover will not be valid there.

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 healthcare cover is legally appropriate. If you are in any doubt, please seek independent legal advice as we may no longer be able to provide you with cover. The cover provided by Allianz Worldwide Care is not a substitute for local compulsory health insurance.

## Medical necessity and customary charges

This policy provides cover for medical treatment, related costs, services and/or supplies that we determine to be medically necessary and appropriate to treat a patient's condition, illness or injury. Plus we will only pay for medical costs which are fair and reasonable and at the level customarily charged in the specific country and for the treatment provided, in accordance with standard and generally accepted medical procedures. If a claim is deemed by us to be inappropriate, we reserve the right to reduce the amount payable by us.

## Pre-existing conditions

Pre-existing conditions are medical conditions or any related conditions for which one or more symptoms have been displayed at some point during your lifetime, irrespective of whether any medical treatment or advice was sought. Any such condition or related condition, about which you or your dependants could reasonably have been assumed to have known, will be deemed to be pre-existing.

Please refer to the "Notes" section of your Table of Benefits to confirm if pre-existing conditions are covered. Pre-existing conditions which have not been declared on the relevant application form are not covered. Plus, conditions arising between completing the relevant application form and the start date of the policy will equally be deemed to be pre-existing. Such pre-existing conditions will also be subject to medical underwriting and, if not disclosed, they will not be covered.

# Definitions

The following definitions apply to benefits included in our range of Healthcare Plans and to some other commonly used terms. The benefits you are covered for are listed in your Table of Benefits. If any unique benefits apply to your plan(s), the definition will appear in the "Notes" section at the end of your Table of Benefits. Wherever the following words/phrases appear in your policy documents, they will always be defined as follows.

1.1 **Accident** is an injury which is the result of an unexpected event, independent of the will of the insured and which arises from a cause outside the individual's control. The cause and symptoms must be medically and objectively definable, allow for a diagnosis and require therapy.

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

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

1.4 **Acute** refers to sudden onset.

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

- Is recurrent in nature.
- Is without a known, generally recognised cure.
- Is not generally deemed to respond well to treatment.
- Requires palliative treatment.
- Requires prolonged supervision or monitoring.
- Leads to permanent disability.

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

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

1.7 **Complications of childbirth** refer only to the following conditions that arise during childbirth and that require a recognised obstetric procedure: post-partum haemorrhage and retained placental membrane. Complications of childbirth are only payable where your cover also includes a routine maternity benefit. Where your cover includes a routine maternity benefit, complications of childbirth shall also refer to medically necessary caesarean sections.

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

1.9 **Co-payment** is the percentage of the costs which the insured person must pay. These apply per person, per Insurance Year, unless indicated otherwise in the Table of Benefits. Some plans may include a maximum co-payment per insured person, per Insurance Year, and if so, the amount will be capped at the amount stated in your Table of Benefits. Co-payments may apply individually to the Core, Out-patient, Maternity, Dental or Repatriation Plans, or to a combination of these plans.

1.10 **Day-care treatment** is planned treatment received in a hospital or day-care facility during the day, including a hospital room and nursing, that does not medically require the patient to stay overnight and where a discharge note is issued.

1.11 **Deductible** is that part of the cost which remains payable by you and which has to be deducted from the reimbursable sum. Where applied, deductibles are payable per person per Insurance Year, unless indicated otherwise in the Table of Benefits. Deductibles may apply individually to the Core, Out-patient, Maternity, Dental or Repatriation Plans, or to a combination of these plans.

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

1.13 **Dental surgery** includes the extraction of teeth, apicoectomy, as well as the treatment of other oral problems such as congenital jaw deformities (e.g. cleft jaw), fractures and tumours. Dental surgery does not cover any surgical treatment that is related to dental implants.

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

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

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

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

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

1.19 **Emergency** constitutes the onset of a sudden and unforeseen medical condition that requires urgent medical assistance. Only treatment commencing within 24 hours of the emergency event will be covered.

1.20 **Emergency in-patient dental treatment** refers to acute emergency dental treatment due to a serious accident requiring hospitalisation. The treatment must be received within 24 hours of the emergency event. Please note that cover under this benefit does not extend to follow-up dental treatment, dental surgery, dental prostheses, orthodontics or periodontics. If cover is provided for these benefits, it will be listed separately in the Table of Benefits.

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

1.22 **Emergency out-patient treatment** is treatment received in a casualty ward/emergency room within 24 hours of an accident or sudden illness, where the insured does not, out of medical necessity, occupy a hospital bed. If you also selected an Out-patient Plan, you are covered under the terms of this plan for out-patient treatment in excess of the (Core Plan) emergency out-patient treatment benefit limit.

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

1.24 **Expenses for one person accompanying an evacuated/repatriated person** refer to the cost of one person travelling with the evacuated/repatriated person. If this cannot take place in the same transportation vehicle, transport at economy rates will be paid for. Following completion of treatment, we will also cover the cost of the return trip, at economy rates, for the accompanying person to return to the country from where the evacuation/repatriation originated. Cover does not extend to hotel accommodation or other related expenses.

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

1.26 **Health and wellbeing checks including screening for the early detection of illness or disease** are health checks, tests and examinations, performed at an appropriate age interval, that are undertaken without any clinical symptoms being present. Checks are limited to:

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

1.27 **Home country** is a country for which the insured person holds a current passport and/or to which the insured person would want to be repatriated.

1.28 **Hospital** is any establishment which is licensed as a medical or surgical hospital in the country where it operates and where the patient is permanently supervised by a medical practitioner. The following establishments are not considered hospitals: rest and nursing homes, spas, cure-centres and health resorts.

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

1.30 **Infertility treatment** refers to treatment for both sexes including all invasive investigative procedures necessary to establish the cause for infertility such as hysterosalpingogram, laparoscopy or hysteroscopy. In the case of InVitro Fertilization (IVF), cover is limited to the amount specified in the Table of Benefits. If the Table of Benefits does not have a specific benefit for infertility treatment, cover is limited to non-invasive investigations into the cause of infertility, within the limits of your Out-patient Plan (if selected) and this does not apply to members of the Channel Islands Plan, for whom investigation into infertility is excluded. Please note that for multiple birth babies born as a result of medically assisted reproduction, in-patient treatment is limited to £24,900/€30,000/US $40,500/CHF 39,000 per child for the first three months following birth. Out-patient treatment is paid within the terms of the Out-patient Plan.

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

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

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

1.34 **Insurance Year** applies from the effective date of the insurance, as indicated on the Insurance Certificate and ends exactly one year later.

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

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

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

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

1.39 **Maternity/paternity cash benefit** applies to the Channel Islands Plan only and, if provided under your plan, an amount will be paid to each parent insured with Allianz Worldwide Care, following the birth of a child dependant. This benefit is only payable where treatment is received free of charge and the amount payable will be indicated in your Table of Benefits. To claim the maternity/paternity cash benefit, please send us a copy of the baby's birth certificate within three months of the birth. To be eligible for this benefit, the mother/father must be covered under our Healthcare Plan for the Channel Islands for a minimum of 10 continuous months before the baby is born.

1.40 **Medical evacuation** applies where the necessary treatment for which the insured person is covered is not available locally or if adequately screened blood is unavailable in the event of an emergency. We will evacuate the insured person to the nearest appropriate medical centre (which may or may not be located in the insured person's home country) by ambulance, helicopter or aeroplane. The medical evacuation, which should be requested by your physician, will be carried out in the most economical way having regard to the medical condition. Following completion of treatment, we will also cover the cost of the return trip, at economy rates, for the evacuated member to return to his/her principal country of residence.

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

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

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

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

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

(a) Essential to identify or treat a patient's condition, illness or injury.
(b) Consistent with the patient's symptoms, diagnosis or treatment of the underlying condition.
(c) In accordance with generally accepted medical practice and professional standards of medical care in the medical community at the time.
(d) Required for reasons other than the comfort or convenience of the patient or his/her physician.
(e) Proven and demonstrated to have medical value.
(f) Considered to be the most appropriate type and level of service or supply.
(g) Provided at an appropriate facility, in an appropriate setting and at an appropriate level of care for the treatment of a patient's medical condition.
(h) Provided only for an appropriate duration of time.

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

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

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

1.44 **Medical repatriation** is an optional level of cover and where provided will be shown in the Table of Benefits. This benefit means that if the necessary treatment for which you are covered is not available locally, you can choose to be medically evacuated to your home country for treatment, instead of to the nearest appropriate medical centre. This only applies when your home country is located within your geographical area of cover. Following completion of treatment, we will also cover the cost of the return trip, at economy rates, to your principal country of residence. The return journey must be made within one month after treatment has been completed.

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

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

1.46 **Newborn care** includes customary examinations required to assess the integrity and basic function of the child's organs and skeletal structures. These essential examinations are carried out immediately following birth. Further preventive diagnostic procedures, such as routine swabs, blood typing and hearing tests, are not covered. Any medically necessary follow-up investigations and treatment are covered under the newborn's own policy. Please note that for multiple birth babies born as a result of medically assisted reproduction, in-patient treatment is limited to £24,900/€30,000/US$40,500/ CHF39,000 per child for the first three months following birth. Out-patient treatment is paid within the terms of the Out-patient Plan.

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

1.48 **Nursing at home or in a convalescent home** refers to nursing received immediately after or instead of, eligible in-patient or day-care treatment. We will only pay the benefit listed in the Table of Benefits where the treating doctor decides (and our Medical Director agrees) that it is medically necessary for the member to stay in a convalescent home or have a nurse in attendance at home. Cover is not provided for spas, cure centres and health resorts or in relation to palliative care or long term care (see definitions 1.59 and 1.38).

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

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

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

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

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

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

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

1.56 **Orthomolecular treatment** refers to treatment which aims to restore the optimum ecological environment for the body's cells by correcting deficiencies on the molecular level based on individual biochemistry. It uses natural substances such as vitamins, minerals, enzymes, hormones, etc.

1.57 **Out-patient surgery** is a surgical procedure performed in a surgery, hospital, day-care facility or out-patient department that does not require the patient to stay overnight out of medical necessity.

1.58 **Out-patient treatment** refers to treatment provided in the practice or surgery of a medical practitioner, therapist or specialist that does not require the patient to be admitted to hospital.

1.59 **Palliative care** refers to ongoing treatment aimed at alleviating the physical/psychological suffering associated with progressive, incurable illness and maintaining quality of life. It includes in-patient, day-care or out-patient treatment following the diagnosis that the condition is terminal and treatment can no longer be expected to cure the condition. We will also pay for physical care, psychological care as well as hospital or hospice accommodation, nursing care and prescription drugs.

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

1.61 **Podiatry** is covered under the Channel Islands Plans only and refers to medically necessary treatment carried out by a State Registered Practitioner with an Honours degree (BSc Hons) in podiatry as approved by the Chiropodists' board of the Council for the Professions Supplementary to Medicine. The practitioner must also hold a further accreditation such as: MChS (Member of The Society of Chiropodists & Podiatrists), FChS (Fellow of The Society of Chiropodists & Podiatrists) or FCPodS (Fellow of the College of Podiatrists of The Society of Chiropodists & Podiatrists).

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

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

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

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

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

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

1.68 **Prescribed medical aids** refers to any instrument, apparatus or device which is medically prescribed as an aid to the function or capacity of the insured person, such as hearing aids, speaking aids (electronic larynx), crutches or wheelchairs, orthopaedic supports/braces, artificial limbs, stoma supplies, graduated compression stockings as well as orthopaedic arch-supports. Costs for medical aids that form part of palliative care or long term care (see Definitions 1.59 and 1.38) are not covered.

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

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

1.71 **Preventive treatment** refers to treatment that is undertaken without any clinical symptoms being present at the time of treatment. An example of such treatment is the removal of a pre-cancerous growth (e.g. mole on the skin).

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

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

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

1.75 **Repatriation of mortal remains** is the transportation of the insured member'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.

1.76 **Routine maternity** refers to any medically necessary costs incurred during pregnancy and childbirth, including hospital charges, specialist fees, the mother's pre- and post-natal care, midwife fees (during labour only) as well as newborn care. Costs related to complications of pregnancy or complications of childbirth are not payable under routine maternity. In addition, any non-medically necessary caesarean sections will be covered up to the cost of a routine delivery in the same hospital, subject to any benefit limit in place. If the home delivery benefit is included in your plan, a lump sum up to the amount specified in the Table of Benefits will be paid in the event of a home delivery. Please note that for multiple birth babies born as a result of medically assisted reproduction, in-patient treatment is limited to £24,900/€30,000/US$40,500/CHF39,000 per child for the first three months following birth. Out-patient treatment is paid within the terms of the Out-patient Plan.

1.77 **Specialist** is a qualified and licensed medical physician possessing the necessary additional qualifications and expertise to practice as a recognised specialist of diagnostic techniques, treatment and prevention in a particular field of medicine. This benefit does not include cover for psychiatrist or psychologist fees. Where covered, a separate benefit for psychiatry and psychotherapy will appear in the Table of Benefits.

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

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

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

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

1.82 **Travel costs** is a benefit covered under the Channel Islands Plans only. We will pay up to the amount specified in your Table of Benefits for each return journey if you need private hospital day-care, post-operative out-patient consultations or in-patient treatment for which you are covered under your plan and your doctor has confirmed to us in writing that it is medically necessary for you to travel to another Channel Island, to the UK or to France to receive such treatment. You will need to obtain written confirmation from the Department of Health that you are not entitled to a travelling allowance grant in respect of travel and escort costs. We will only pay for the following travel costs under this benefit:

- Standard rate air fares from one Channel Island to another Channel Island, to the UK or to France.
- Standard rate train, underground and bus fares.
- A maximum of £25/€30 per taxi trip.
- Travel costs for one parent to accompany a child under 18, up to the amount specified in your Table of Benefits.
- If medically necessary, we may also pay a contribution of up to £125/€150 per trip towards the cost of nursing care required during the journey.

1.83 **Travel costs of insured family members in the event of an evacuation/repatriation** refer to the reasonable transportation costs of all insured family members of the evacuated or repatriated person, including, but not limited to, minors who might otherwise be left unattended. If this cannot take place in the same transportation vehicle, round trip transport at economy rates will be paid for. In the event of a member's repatriation, the reasonable transportation costs of insured family members will only be covered if the relevant Repatriation Plan benefit forms part of your cover. Cover does not extend to hotel accommodation or other related expenses.

1.84 **Travel costs of insured family members in the event of the repatriation of mortal remains** refer to the reasonable transportation costs of any insured family members who had been residing abroad with the deceased insured member, to return to the home country/chosen country of burial of the deceased. Cover does not extend to hotel accommodation or other related expenses.

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

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

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

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

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

1.90 **You/Your** refers to the eligible individual stated on the Insurance Certificate.

# Exclusions

Although we cover most medically necessary treatment, expenses incurred for the following treatments, medical conditions and procedures are not covered under the policy unless confirmed otherwise in the Table of Benefits or in any written policy endorsement.

## a) The following exclusions apply to **all our plans**, unless stated otherwise:

1. Any form of **treatment** or **drug therapy** which in our reasonable opinion is **experimental** or **unproven** based on generally accepted medical practice.

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

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

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

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

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

7. **Developmental delay**, unless a child has not attained developmental milestones expected for a child of that age, in cognitive or physical development. We do not cover conditions in which a child is slightly or temporarily lagging in development. The developmental delay must have been quantitatively measured by qualified personnel and documented as a 12 month delay in cognitive and/or physical development.

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

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

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

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

12. **Infertility treatment** including medically assisted reproduction or any adverse consequences thereof, unless you have a specific benefit for infertility treatment, or have selected an Out-patient Plan (whereby you are covered for non-invasive investigations into the cause of infertility within the limits of your Out-patient Plan). These exceptions do not apply to members of the Channel Islands Plan, for whom investigation into infertility is excluded.

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

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

15. Investigations into, treatment of and complications arising from **sterilisation, sexual dysfunction** (unless this condition is a result of total prostatectomy following surgery for cancer) and **contraception**, including the insertion and removal of contraceptive devices and all other contraceptives, even if prescribed for medical reasons, unless stated otherwise in your Table of Benefits. The only exception in relation to costs for contraception is where contraceptives are prescribed by a dermatologist for the treatment of acne. (This exclusion extends to include infertility within the Channel Islands Plan).

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

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

18. **Orthomolecular treatment** (please refer to definition 1.56)

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

20. Products classified as **vitamins** or **minerals** (except during pregnancy or to treat diagnosed, clinically significant vitamin deficiency syndromes) and supplements, including but not limited to, special infant formula and cosmetic products, even if medically recommended, or prescribed or acknowledged as having therapeutic effects. Costs incurred as a result of nutritional or dietary consultations are not covered, unless a specific benefit is included within your Table of Benefits. (For members of the Channel Islands Plan, this exclusion extends to include the period of pregnancy).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

    37.1 Complications of pregnancy.
    37.2 Dental treatment, dental surgery, periodontics, orthodontics and dental prostheses with the exception of oral surgical procedures, which are covered within the overall limit of your Core Plan.
    37.3 Dietician fees.
    37.4 Emergency dental treatment.
    37.5 Expenses for one person accompanying an evacuated/repatriated person.
    37.6 Health and wellbeing checks including screening for the early detection of illness or disease.
    37.7 Home delivery.
    37.8 Infertility treatment.
    37.9 In-patient psychiatry and psychotherapy treatment.
    37.10 Laser eye treatment.
    37.11 Medical repatriation.
    37.12 Organ transplant.
    37.13 Out-patient treatment.
    37.14 Out-patient psychiatry and psychotherapy treatment.
    37.15 Prescribed glasses and contact lenses including eye examination.
    37.16 Prescribed medical aids.
    37.17 Preventive treatment.
    37.18 Rehabilitation treatment.
    37.19 Routine maternity and complications of childbirth.
    37.20 Travel costs of insured family members in the event of an evacuation/repatriation.
    37.21 Travel costs of insured family members in the event of the repatriation of mortal remains.
    37.22 Travel costs of insured members to be with a family member who is at peril of death or who has died.
    37.23 Vaccinations.

38. The **accidental death benefit***, in circumstances where the death of an insured member has been caused either directly or indirectly by:

    38.1 Accidents which happen while the insured member is engaged in aviation activities of any description, including entering and alighting from aircraft, other than as a fare paying passenger in a standard multi-engine aircraft operated by a recognised airline or air charter company.
    38.2 Taking part in speed or duration tests or races of any kind.
    38.3 Taking part in motor sports of any kind, including boating, in any boat designed to travel at a speed in excess of 30 knots.
    38.4 Mountaineering including caving and potholing which requires the use of ropes or guides.
    38.5 White water rafting and canoeing, scuba diving and yachting or boating outside coastal waters (12 miles or more from the coast).

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

## b) The following additional exclusions apply to all plans, with the **exception of the Channel Islands Plan** (this plan has its own additional exclusions listed under point c) below):

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

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

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

## c) The following exclusions apply **solely to our Channel Islands Plan**:

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

43. **Dental surgery, dental prostheses, periodontics** and **orthodontic treatment**, with the exception of dental treatment as per definition 1.14.

44. **Human Immuno-deficiency Virus infection, AIDS** or any associated psychiatric condition.

45. **Organ transplant**.

46. **Pre-existing conditions**.

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

48. **Travel benefit** is not available:

    - For any travel costs which are above normal standard fares.
    - For a parent to accompany a child who is 18 years of age or older.
    - For incidental costs of travel, e.g. hotel accommodation or meals.
    - When costs are covered by the Department of Health.
    - When the treatment is not covered under your plan.
    - When travelling has not been recommended by your consultant.
    - When we have not agreed to all costs of travel prior to the journey.

49. **Travel costs** related to out-patient consultations, except for post-operative consultations that cannot be carried out locally by a consultant.

50. **Travel costs to another Channel Island, the UK and France for hospital in-patient or day-care treatment,** if the proposed treatment or any alternative treatment is available locally. However, please note that medical costs incurred will be refunded within the terms of your policy.

51. The **following benefits**:

51.1 Medical evacuation or repatriation.
51.2 Oculomotor therapy.
51.3 Podiatry.
51.4 Repairs to spectacles.
51.5 Repatriation of mortal remains.
51.6 Speech therapy.

# Additional terms

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

1. Applicable law: Your membership is governed by Irish law. Any dispute that cannot otherwise be resolved will be dealt with by courts in Ireland.

2. Arbitration:

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

b) If differences can not be resolved in accordance with Clause 2.a above, the Parties shall attempt to settle by mediation in accordance with the Centre for Effective Dispute Resolution (CEDR) Model Mediation Procedure any dispute, controversy or claim arising out of or relating to this Agreement or the breach, termination or invalidity thereof where the value is €500,000 or less and which cannot be settled amicably between the Parties. The Parties shall endeavour to agree on the appointment of an agreed Mediator. Should the Parties fail to agree the appointment of an agreed Mediator within 14 days, either Party, 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.b until it has attempted to settle the dispute by mediation and either the mediation has terminated or the other Party has failed to participate in the mediation (provided that the right to issue proceedings is not prejudiced by a delay). The mediation will take place in Dublin (Ireland) and the language of the mediation will be English. The Mediation Agreement referred to in the Model Procedure shall be governed by, and construed and take effect in accordance with the laws of Ireland. The Courts of Ireland shall have exclusive jurisdiction to settle any claim, dispute or matter of difference which may arise out of, or in connection with, the mediation.

c) Any dispute, controversy or claim which is:
   - Arising out of or relating to this Agreement (or the breach, termination or invalidity thereof) with a value in excess of €500,000, or
   - Referred to mediation pursuant to Clause 5.b but not voluntarily settled by mediation within three months of the ADR Notice date

   shall be determined exclusively by the Courts of Ireland and the Parties will submit to the exclusive jurisdiction of those courts. Any proceedings brought pursuant to this Clause 2.c shall be issued within nine calendar months of the expiration date of the aforementioned three month period.

3. Cancellation: We will cancel the policy where you have not paid the full premium due and owing. We shall notify you of this cancellation and the contract shall be deemed cancelled from the date that the 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. If the outstanding premium is paid after the 30-day limit, you must complete a Confirmation of Health Status Form before your policy can be reinstated, subject to underwriting.

4. Data protection: Allianz Worldwide Care, a member of the Allianz Group, is an Irish authorised non-life insurance company. We obtain and process personal information for the purposes of preparing quotations, underwriting policies, collecting premium, paying claims and for any other purpose which is directly related to administering policies in accordance with the insurance contract. The confidentiality of patient and member information is of paramount concern to us. You have a right to access the personal data that is held about you. You also have the right to request that we amend or delete any information which you believe is inaccurate or out of date. We will not retain your data for longer than is necessary for the purposes for which it was obtained.

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

6. Fraud:

a) Incorrect disclosure/non-disclosure of any material facts, by you or your dependants, which may affect our assessment of the risk, including, but not limited to, those material facts declared on the relevant application form will render the contract void from the commencement date, unless we confirm otherwise in writing. Conditions arising between completing the relevant application form and the start date of the polilcy will be deemed to be pre-existing and will not be covered if not disclosed. If the applicant is not sure whether something is material, the applicant is obliged to inform us. If the contract is rendered void due to incorrect disclosure or non-disclosure of any material facts, we will refund the premium amount(s) paid to date minus the costs of any medical claims already paid. If the cost of claims exceeds the balance of the premium, we will seek reimbursement of this amount from the principal member.

b) If a claim is, in any respect, false, fraudulent, intentionally exaggerated or if fraudulent means/devices have been used by you or your dependants or anyone acting on your or their behalf to obtain benefit under this policy, we will not pay any benefits for that claim. The amount of any claim settlement made to you, before the fraudulent act or omission was discovered, will become immediately due and owing to us. If the contract is rendered void due to false, fraudulent, intentionally exaggerated claims or if fraudulent means/devices have been used, premium will not be refunded, in part or in whole, and any pending claims settlements will be forfeited. In the event of fraudulent claims, the contract will be cancelled from the date of our discovery of the fraudulent event.

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

8. Liability: Our liability to you is limited to the amounts indicated in the Table of Benefits and any subsequent policy endorsements. In no event will the amount of reimbursement, whether under this policy, public medical schemes and any other insurance, exceed the amount of the invoice.

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

**10. Third party liability:** If you or any of your dependants are eligible to claim benefits under a public scheme or any other insurance policy which pertains to a claim submitted to us, we reserve the right to decline to pay benefits. You must inform us and provide all necessary information if and when you are entitled to a claim from a third party. You and the third party may not agree any final settlement or waive our right to recover outlays without our prior written agreement. Otherwise, we are entitled to recover the amounts paid from you and to cancel the policy. We have full rights of subrogation and may institute proceedings in your name, but at our expense, to recover, for our benefit, the amount of any payment made under another policy.

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

**12. What we cover:**

a) The extent of your cover is determined by your Table of Benefits, the Insurance Certificate, any policy endorsements, these policy terms and conditions, as well as any other legal requirements. We will reimburse, in accordance with your Table of Benefits and individual terms and conditions, medical costs arising from the occurrence or worsening of a medical condition.

b) Treatments and procedures are only covered if they have a palliative, curative and/or diagnostic purpose, are medically necessary, appropriate and performed by a licensed physician, dentist or therapist. Claims/costs will be paid/reimbursed if the medical diagnosis and/or prescribed treatment are in accordance with generally accepted medical procedures.

c) This policy may not provide any cover or benefit to the extent that either the cover or benefit would violate any applicable sanction, law or regulations of the United Nations, the European Union or any other applicable economic or trade sanction, law or regulations.

# General information

## Adding dependants

You may apply to include any of your family members on the policy by completing the relevant application form.

Newborn infants (with the exception of multiple birth babies, adopted and fostered babies) will be accepted for cover from birth without medical underwriting, provided that we are notified within four weeks of the date of birth and the birth parent or intended parent (in the case of surrogacy), has been insured with us for a minimum of six continuous months. To notify us of your intention to have your newborn child included on your policy, please email your request to our Underwriting Team at: **underwriting@allianzworldwidecare.com**

Notification of the birth after four weeks will result in newborn children being underwritten and cover will only commence from the date of acceptance. Please note that all multiple birth babies, adopted and fostered children will be subject to full medical underwriting and cover will only commence from the date of acceptance.

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

## Changes to policyholder

If a request is made at renewal to change the policyholder, the proposed replacement policyholder will be required to complete an application form and full medical underwriting will apply. (Please refer to the section on "Death of the policyholder or a dependant" if this requested change is due to the death of the policyholder).

## Changes to premium, other charges or your cover

We may change the premium, benefits and rules of your membership on your renewal date, including how we calculate/determine premiums and/or the method or frequency of payment. These changes will only apply from your renewal date, regardless of when the change is made and we will not add any restrictions or exclusions which are personal to a member's cover in relation to medical conditions that started after their policy's inception, provided that they gave us the information we asked them for before incepting and they have not applied for an increase in their level of cover.

Please note that we may change the amount you have to pay us in respect of Insurance Premium Tax (IPT) or other taxes, levies or charges at any time, if there is a change in the rate of IPT or any new tax, levy or charge is introduced or changed.

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.

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

## Changing your address/email address

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

## Claims

In relation to medical claims, please note that:

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

b) A separate Claim Form is required for each person claiming and for each medical condition being claimed for.

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

d) If the amount to be claimed is less than the deductible figure under your plan, keep collecting all out-patient receipts and claim forms until you reach an amount in excess of your plan deductible, then forward to us all completed Claim Forms together with original receipts/invoices.

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

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

g) If you are required to pay a deposit in advance of any medical treatment, the cost incurred will only be reimbursed after treatment has taken place.

h) You and your dependants agree to assist us in obtaining all necessary information to process a claim. We have the right to access all medical records and to have direct discussions with the medical provider or the treating physician. We may, at our own expense, request a medical examination by our medical representative when we deem this to be necessary. All information will be treated in strict confidence. We reserve the right to withhold benefits if you or your dependants have not honoured these obligations.

## Claims for accidental death

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

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

Beneficiaries are, unless otherwise specified by the insured:

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

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

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

### Correspondence

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

### Countries where you can receive treatment

If the necessary medical treatment for which you are covered is not available locally, you can avail of treatment in any country within your geographical area of cover (your area of cover is confirmed in your Insurance Certificate). In order to seek reimbursement for medical treatment and travel expenses incurred, Treatment Guarantee is required prior to travel.
If the necessary medical treatment for which you are covered is available locally, but you choose to travel to another country within your geographical area of cover for treatment, we will reimburse all eligible medical costs incurred within the terms of your policy; however, we will not pay for travel expenses.

Please note that you are covered for eligible costs incurred in your home country, provided that your home country is within your area of cover.

### Death of the policyholder or a dependant

We hope you will never need to refer to this section; however, if a policyholder or a dependant dies, please inform us in writing within 28 days.

If the policyholder dies, the policy will be terminated and a pro rata repayment of the current year's premium will be made if no claims have been filed (please note that we reserve the right to request a death certificate before a refund is issued). Alternatively, if they wish to, the next named dependant on the insurance certificate may apply to become the policyholder in his/her own right (if they meet the minimum age requirements), 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 applicable to them, in addition to those which already applied to them at the time of the policyholder's death.

If a dependant dies, they will be taken off the policy and a pro rata repayment of the current year's premium for that member will be made, if no claims have been filed (please note that we reserve the right to request a death certificate before a refund is issued).

## Making a complaint

In the case of complaints, please call, email, fax or write to us. If we have been unable to resolve the matter to your satisfaction and you wish to take it further, you can refer your complaint to the Irish Financial Services Ombudsman, a statutory official who acts as an impartial arbiter of unresolved disputes that customers may have with financial services providers.

Address: Financial Services Ombudsman's Bureau, 3rd Floor, Lincoln House, Lincoln Place, Dublin 2, Ireland

Tel: + 353 1 662 0899
Fax: + 353 1 662 0890
Email: enquiries@financialombudsman.ie
Website: www.financialombudsman.ie

## Other parties

No other person (except an appointed representative) is allowed to make or confirm any changes to your membership on your behalf, or decide not to enforce any of our rights. No change to your membership will be valid unless it is confirmed in writing by Allianz Worldwide Care.

## Paying premiums

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

By accepting cover you have agreed to pay the premium amount shown on your quotation, by the payment method stated. You are required to pay the premium due to us in advance for the duration of your membership. The initial/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 Invoice, you should contact us immediately. We are not responsible for payments made through third parties.

Your premium should be paid in the currency you selected when applying for cover. If you are unable to pay your premium for any reason, please contact us on: **+353 1 630 1301**. Changes in payment terms can be made at policy renewal, via written instructions, which must be received by us a minimum of 30 days prior to the renewal date. Failure to pay an initial premium or subsequent premium on time may result in loss of insurance cover.

If the initial premium is not paid in time, we are entitled to withdraw from the contract for as long as the payment remains outstanding. The insurance contract is deemed to be null and void unless we assert a claim to the premium in court within three months of the commencement date, the policy start date or the conclusion of the insurance contract. If a subsequent premium is not paid in time, we may, in writing and at the policyholder's expense, set a time limit of not less than two weeks for the policyholder to pay the amount due. Thereafter, we may terminate the contract in writing with immediate effect and shall thereby be exempt to pay benefits.

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

## Paying other charges

In addition to paying premiums, you also have to pay us the amount of any Insurance Premium Tax (IPT), taxes, levies or charges relating to your membership (or new taxes, levies or charges that may be imposed after you join) 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 Invoice.

## Policy expiry

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

## Reasons your membership would end

Please remember that your membership will 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 Confirmation of Health Status Form, if you pay the outstanding premiums within 30 days after the due date.

- 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 due date.

- Upon the death of the policyholder. Please see the section on "Death of the policyholder or a dependant" (p. 27) for further details.

- If there is reasonable evidence that the policyholder or any dependants misled or attempted to mislead us i.e. giving false information, withholding pertinent information from us, or working with another party to give us false information, either intentionally or carelessly, which may influence us when deciding whether they can join the scheme, the applicable premium to pay or whether we have to pay a claim. Please see the section on "Additional terms" (p. 20-23) for further details.

- If you choose to cancel your policy, after giving us written notice within 30 days of receiving the full terms and conditions or from the start/renewal date of your policy, whichever is later. Please see section on "Your right to cancel" (p. 32) for further details.

If your membership ends for reasons other than for fraud/non-disclosure, we will refund any premiums you have paid which relate to a period after your membership has ended, subject to the deduction of any money which you owe us.

Please note that if your membership ceases, your dependant's cover will also end.

## Renewing your policy

Your annual policy is automatically renewed for the next Insurance Year provided that the plan/plan combination selected is still available, all premiums due to us have been paid and the payment details we have for you are still valid on the renewal date. Please update us if you get a new/replacement credit card as we will need details of the new card number and/or expiry date etc.

One month before the renewal date, you will receive a new Insurance Certificate indicating the premium for the next Insurance Year. If you do not receive your Insurance Certificate one month before your renewal date, it is important that you notify us.

We have the right to apply revised policy terms and conditions, effective from the renewal date. The policy terms and conditions and the Table of Benefits that exist at renewal will apply for the duration of the Insurance Year.

## Treatment Guarantee

Your Table of Benefits will confirm which benefits available to you require pre-authorisation through submission of a Treatment Guarantee Form. If Treatment Guarantee is not obtained, the following will apply:

- If the treatment received is subsequently proven to be medically unnecessary, **we reserve the right to decline your claim**.

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

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

## Treatment in the USA

If you have "Worldwide" cover and wish to locate a medical provider in the USA, simply go to: **www.allianzworldwidecare.com/olympus**. If you have a query about a medical provider, or if you have selected a provider and wish to arrange an appointment, please call **(+1) 800 541 1983** (toll-free from the USA). You can also apply for a discount pharmacy card which can be used any time your prescription is not covered by your healthcare policy. To register and obtain your discount pharmacy card, simply go to: **www.omhc.com/awc/prescriptions.html** and click on "Print Discount Card".

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

## Treatment needed as a result of somebody else's fault

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

## When cover starts for you and your dependants

Our acceptance of your application for cover is confirmed when we issue your Insurance Certificate and your cover is valid from the start date shown on the certificate. Please note that no benefit will be payable under your policy until the initial premium has been paid, with subsequent premiums being paid when due.

If any other person is included as a dependant under your membership, their membership will start on the effective date as shown on your most recent Insurance Certificate which lists them as a dependant. Their membership 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 can be covered under your policy up until the day before their 18th birthday; or up until the day before their 24th birthday if they are in full time education. At that time, they may apply for cover in their own right, should they wish to do so.

## Your right to cancel

You can cancel the contract in relation to all insured members, or only in relation to one or more dependants, within 30 days of receiving the full terms and conditions of your policy or from the start/renewal date of your policy, whichever is later. Please note that you cannot backdate the cancellation of your membership.

Should you wish to cancel, please complete the "Right to change your mind" form which was included in your welcome/renewal pack. This form can be sent to us via email to: **client.services@allianzworldwidecare.com**. Alternatively, you can post this form to the Client Services Team, on the back cover of this guide.

If you cancel your contract within this 30 day period, you will be entitled to a full refund of the cancelled member(s) premiums paid for the latest Insurance Year, provided that no claims have been made. If you choose not 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.

# Quick start guide

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

Allianz

Allianz Worldwide Care

# Getting treatment

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

## Remember, some treatments require pre-authorisation

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

- All in-patient benefits listed (where you need to stay overnight in a hospital).
- Day-care treatment.
- Expenses for one person accompanying an evacuated/repatriated person.
- Kidney dialysis.
- Long term care.
- Medical evacuation (or repatriation, where covered).
- MRI (Magnetic Resonance Imaging) scan. Treatment Guarantee is not needed for MRI scans unless you wish to have direct settlement.
- Nursing at home or in a convalescent home.
- Occupational therapy (only out-patient treatment requires pre-authorization).
- Oncology (only in-patient or day-care treatment requires pre-authorization).
- Out-patient surgery.
- Palliative care.
- PET (Positron Emission Tomography) and CT-PET scans.
- Rehabilitation treatment.
- Repatriation of mortal remains.
- Routine maternity, complications of pregnancy and childbirth (only in-patient treatment requires pre-authorization).
- Travel costs of insured family members in the event of an evacuation (or repatriation, where covered).
- Travel costs of insured family members in the event of the repatriation of mortal remains.
- Travel costs to another Channel Island, the UK or to France.

*Use of the Treatment Guarantee Form helps us to assess each case and facilitate direct settlement with the hospital. Please note that we may decline your claim if a Treatment Guarantee is not obtained. You can find full details on page 31 of this guide.*

## Evacuations and repatriations

At the first indication that a medical evacuation/repatriation is required, please call our 24 hour Helpline (contact details on the back of this detachable section) and we will take care of everything. Given the urgency of an evacuation/repatriation, we would advise that you call us, however, you can also contact us by email at: **medical.services@allianzworldwidecare.com**. When emailing, please include "Urgent – Evacuation/Repatriation" in the subject line. Please contact us **before** talking to any alternative providers, even if approached by them, to avoid potentially inflated charges or unnecessary delays in the evacuation process. In the event that evacuation/repatriation services are not organised by Allianz Worldwide Care we reserve the right to decline all costs incurred.

## Getting in-patient treatment

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

### If it's an **emergency:**

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

## Getting out-patient or dental treatment

When you visit a doctor, dentist, physician or specialist on an out-patient basis, please settle the bill with them and claim back the eligible expenses from us. Simply download a Claim Form from our website: **www.allianzworldwidecare.com\members** and follow the steps below:

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

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

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

*Please refer to the "Claims" section on page 25 of this guide for additional important information about our claims process. You can find information about getting treatment in the USA on page 31.*

# Useful services

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

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

- Your Membership Pack includes a username and password giving you access to our **Online Services** at **my.allianzworldwidecare.com**. Alternatively, on the same page, select "Register" and provide the information requested (available on your Insurance Certificate). Here you can download key policy documents, check remaining benefit limits, confirm the status of any claims that have been received and uploaded by us and view claims-related correspondence. You can also pay your premiums by credit card and update your credit card details.

- The **24/7 MediLine Medical Advice Service** can be accessed on: **+44 (0) 208 416 3929**. This service, provided by an experienced English speaking medical team, offers information and advice on a wide range of topics including, but not limited to, blood pressure and weight management, infectious diseases, first aid, dental care, vaccinations, oncology, disability, speech, fertility, paediatrics, mental health and general health. For policy or cover related queries, please contact our Helpline.

# Contact details

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

**24/7 Helpline for general enquires and emergency assistance**

Email: client.services@allianzworldwidecare.com
Fax: + 353 1 630 1306

**Telephone:**
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

*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) can make changes to the policy. Security questions will be asked of all callers to verify their identity.*

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

**Address:** Allianz Worldwide Care, 18B Beckett Way, Park West Business Campus, Nangor Road, Dublin 12, Ireland.

www.allianzworldwidecare.com

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Information on the most current rating is available at www.standardandpoors.com or from Standard & Poor's at +44 (0)20 7176 3800. A rating is an opinion of an insurer's financial strength; it is not a recommendation of an insurer's products.