



Corporate Healthcare Plans for Channel Islands
Valid from 1st November 2019

EMPLOYEE

Benefit Guide

Welcome

You and your family can depend on Allianz Care, as your international health insurer, to give you access to the best care possible.

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

To make the most of your international healthcare plan, please read this guide together with your Insurance Certificate and Table of Benefits.

HOW TO USE YOUR COVER

Support services	5
Cover overview	14
Seeking treatment?	18

TERMS AND CONDITIONS OF YOUR COVER

Your cover explained	26
Claims and Treatment Guarantee process	28
Paying premiums	32
Administration of your policy	34
The following terms also apply to your cover	38
Data protection	40
Complaints procedure	41
Definitions	42
Exclusions	50

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HOW TO USE YOUR COVER



SUPPORT SERVICES

We believe in providing you with the top-quality service that you deserve.

In the following pages we describe the full range of services we offer. Read on to discover what is available to you, from our MyHealth Digital Services to the Employee Assistance Programme.

Talk to us, we love to help!

Our multilingual Helpline is available 24 hours a day, 7 days a week, to handle any questions about your policy or if you need assistance in an emergency.

Helpline

☎ Phone: **+353 1 630 1301**
For our latest list of toll-free numbers, please visit:
www.allianzcare.com/toll-free-numbers

@ Email: client.services@allianzworldwidecare.com

☎ Fax: **+353 1 630 1306**

Did you know...

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

MyHealth Digital Services

If your company has selected MyHealth Digital Services, you will have easy and convenient access to your cover, no matter where you are or what device you are using.

MyHealth app and online portal features

MY POLICY

Access your policy documents and membership card on the go.

MY CLAIMS

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

MY CONTACTS

Access our 24/7 multilingual Helpline.

MyHealth app additional features

- **Symptom checker:** Get a quick and easy assessment of your symptoms.
- **Find a hospital:** Locate medical providers nearby and get GPS directions.
- **Pharmacy Aid:** Look up the local equivalent names of branded drugs.
- **Medical term translator:** Translate names of common ailments into 17 languages.
- **Emergency contact:** access local emergency numbers worldwide.

Most features are available offline but you must be online to submit a claim and use some health services.

MyHealth online portal additional features

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

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

Getting started:



Login to MyHealth Online to register. Go to <https://my.allianzcare.com/myhealth>, click on "REGISTER HERE" near the bottom of the page and follow the on-screen instructions.



Once setup, you can use the email (username) and password you provided during registration to login to MyHealth online portal, or go further and setup the MyHealth app too. The same login details are used for both and in the future, if you change login details for one, it will automatically apply to the other. You don't need to change them in both places.



To download the MyHealth app, search for "Allianz MyHealth" on the Apple App Store or Android's Google Play service.

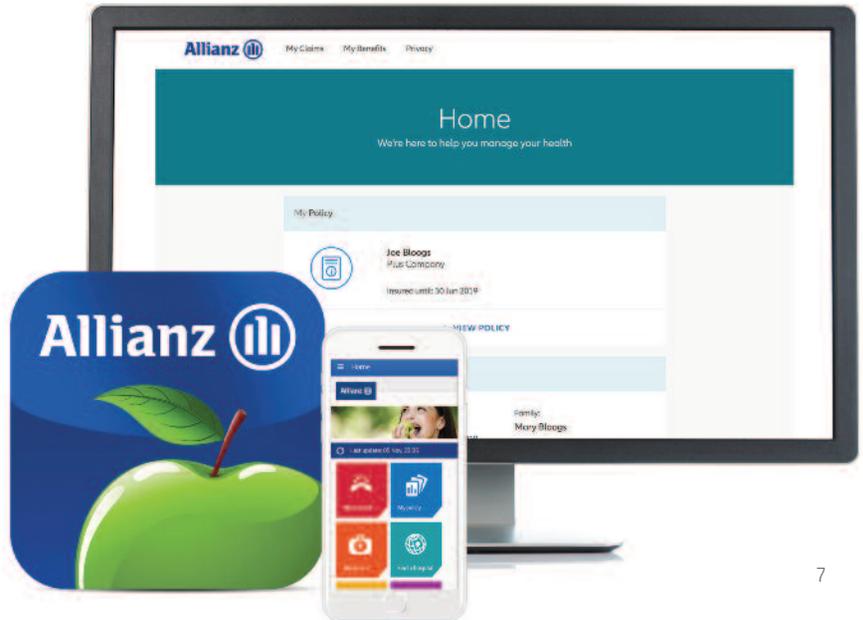


Once installed, follow the on-screen instructions and enter your policy number when prompted. The MyHealth app will ask you for the email (username) and password you provided earlier. Simply enter these details and follow the on-screen instructions.



Set your PIN – finally, set your own unique PIN number. In the future, this PIN number will be all you need to access the Allianz MyHealth app and all its features.

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



Web-based services

On www.allianzcare.com/members you can:

- Search for medical providers. You are not restricted to using the providers listed in our directory
- Download forms
- Access our BMI calculator
- Access our Health Guides

Medi24

Medi24 is a medical advice service provided by an experienced medical team. It provides information and advice on a wide range of topics, including blood pressure and weight management, infectious diseases, first aid, dental care, vaccinations, cancer, disability, speech, fertility, paediatrics, mental health and general health.

Medi24 is available 24/7 in English, German, French and Italian.

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

Remember - for policy or cover-related queries (e.g. benefit limits or the status of a claim), please contact our Helpline.



Employee Assistance Programme (EAP)

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

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

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

Support services include:



CONFIDENTIAL PROFESSIONAL COUNSELLING

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



CRITICAL INCIDENT SUPPORT

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



LEGAL AND FINANCIAL SUPPORT SERVICES

Whether it's help buying a home, handling a legal dispute or creating a comprehensive financial plan, we offer consultations to help you answer questions and reach your goals.



ACCESS TO THE WELLNESS WEBSITE

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



LET US HELP:

 **+1 905 886 3605**

This is not a free phone number. However, local phone numbers may be available. The full list of our 'Worldwide Access Numbers' is available at:

 www.workhealthlife.com/AWC
(available in English, French and Spanish)

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

The EAP is made available by Morneau Shepell Limited, subject to your acceptance of our terms and conditions. You understand and agree that AWP Health & Life SA – Irish Branch and/or AWP Health & Life Services Limited are not responsible or liable for any claim, loss or damage directly or indirectly resulting from your use of EAP services.



Travel Security Services

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

You can access:



EMERGENCY SECURITY ASSISTANCE HOTLINE

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



COUNTRY INTELLIGENCE AND SECURITY ADVICE

Security information and advice about many countries



DAILY SECURITY NEWS UPDATES AND EMAIL TRAVEL SAFETY ALERTS

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

To access the travel security services, please contact us:



+44 207 741 2185

This is not a free phone number



allianzcustomerenquiries@worldaware.com



<https://my.worldaware.com/awc>

Register by entering your policy number (shown in your Insurance Certificate)



Download 'TravelKit' app from App store or Google Play.



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

Travel Security Services are made available by WorldAware Ltd, subject to your acceptance of our Terms and Conditions. You understand and agree that AWP Health & Life SA – Irish Branch and/or AWP Health & Life Services Limited are not responsible or liable for any claim, loss or damage directly or indirectly resulting from your use of the Travel Security Services.

COVER OVERVIEW

Here is a summary of your health cover.

What am I covered for?

You are covered for all the benefits listed in your Table of Benefits. We generally cover pre-existing conditions (including pre-existing chronic conditions) unless we say otherwise in your policy documents. If in doubt, please see the “Notes” section of your Table of Benefits to confirm if pre-existing conditions are covered.

Where can I receive treatment?

You can avail of treatment in Jersey and Guernsey, the UK and the rest of Europe.

What are benefit limits?

Your cover may be subject to a maximum plan benefit. This is the maximum we will pay in total for all benefits included in the plan. Although many benefits included in your Table of Benefits are covered in full, some are capped to a specific amount (e.g. £310). This specific amount is a benefit limit.

For further information on benefit limits please see the ‘Benefit limits’ section of this guide.

Is your family growing?

Are you getting married or having a baby? Congratulations!

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

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

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



What are deductibles and co-payments?

Some plans and benefits may be subject to a deductible or co-payments or both. Your Table of Benefits will show whether this applies to your plan.

A **co-payment** is when you pay a percentage of the medical costs. In the following example, Mary requires several dental treatments throughout the year. Her dental treatment benefit has a 50% co-payment, which means that we will pay 50% of the cost of each eligible treatment.



The total amount payable by us may be subject to a maximum plan benefit limit.

A **deductible** is a fixed amount that the insured person must pay per period of cover (when paying for their medical bills) before we begin to pay for the medical expenses. In the following example, John needs to receive medical treatment throughout the year. His plan includes a deductible.



■ Insurer contribution
■ Insured person contribution

SEEKING TREATMENT?

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

Check your level of cover

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

Some treatments require pre-authorisation

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

Getting in-patient treatment

(pre-authorisation applies)



Download a Treatment Guarantee Form from our website:
www.allianzcare.com/members

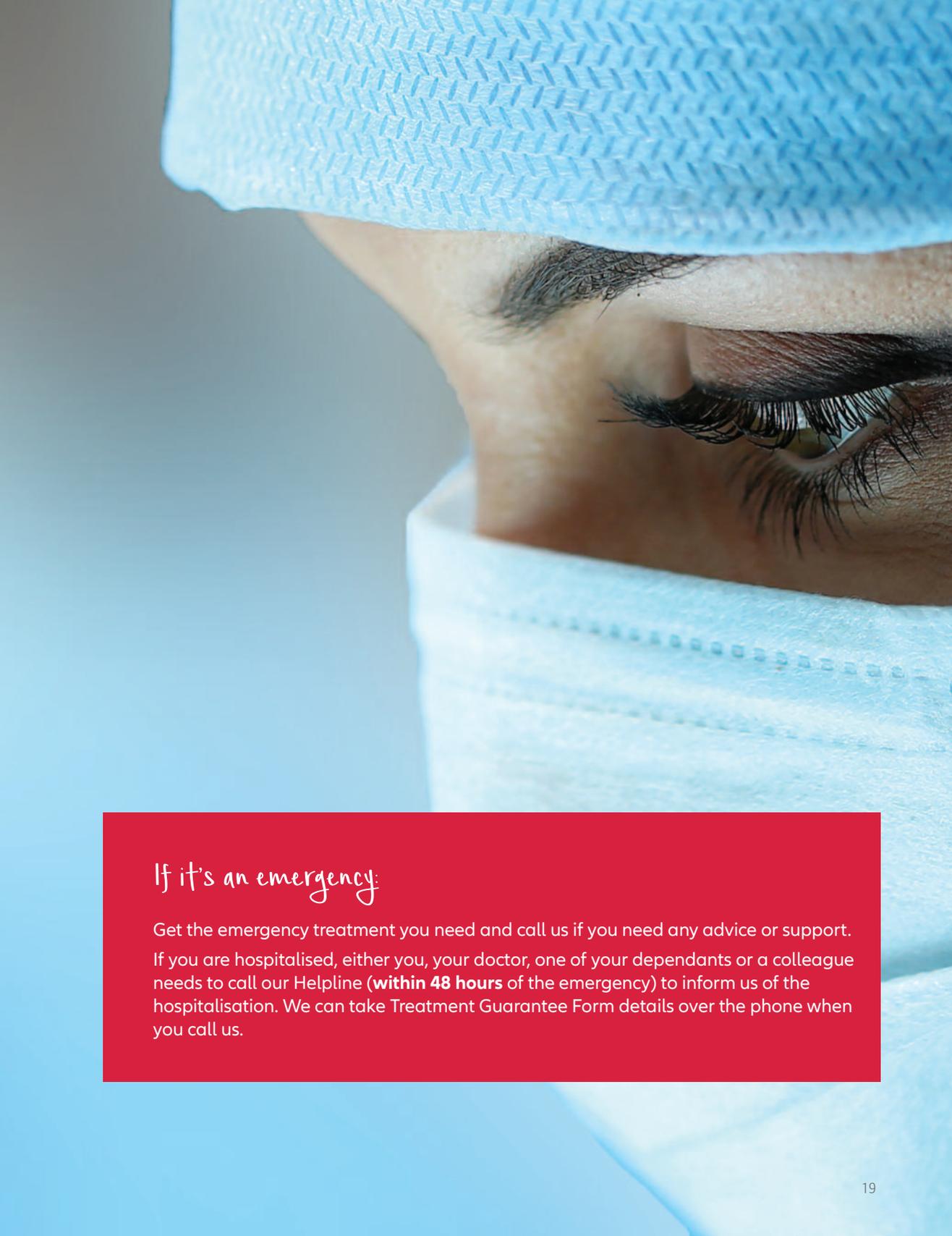


Complete the form and send it to us at least **five working days before** treatment. You can send it by email, fax or post to the address shown on the form.



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

We can also take Treatment Guarantee Form details over the phone if treatment is taking place within 72 hours. Please note that we may decline your claim if Treatment Guarantee is not obtained. For full details of our Treatment Guarantee process, see the 'Terms and Conditions' section of this guide.



If it's an emergency:

Get the emergency treatment you need and call us if you need any advice or support. If you are hospitalised, either you, your doctor, one of your dependants or a colleague needs to call our Helpline (**within 48 hours** of the emergency) to inform us of the hospitalisation. We can take Treatment Guarantee Form details over the phone when you call us.

Claiming for your out-patient, dental and other expenses

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



Receive your medical treatment and pay the medical provider



Get an invoice from your medical provider

This should state your name, treatment date(s), the diagnosis/medical condition that you received treatment for, the date of onset of symptoms, the nature of the treatment and the fees charged.



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

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

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



Quick claim processing

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

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





A hand is visible in the lower-left corner, holding a piece of light-colored, textured fabric. The background is dark with a bright, glowing light source in the upper-left corner, creating a lens flare effect. Numerous small, white, particle-like objects are falling or floating throughout the scene, giving it a dynamic, ethereal feel.

**TERMS AND
CONDITIONS
OF YOUR
COVER**



TERMS AND CONDITIONS

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

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

YOUR COVER EXPLAINED

The plans that your company selected for you are indicated in your Table of Benefits, which lists all the benefits you are covered for and any limits that apply. For an explanation of how your benefit limits apply to your plan, please see the section “Benefit limits”.

Your benefits are also subject to:

- Policy definitions and exclusions (also available in this guide).
- **For underwritten policies:** Any special conditions shown on your Insurance Certificate (and on the Special Condition Form issued before the policy comes into effect, where relevant).

What we cover

Your policy provides you and any named dependants with cover for medically necessary treatment and related costs, services and/or supplies as indicated in the Table of Benefits. We will only reimburse if charges are reasonable and customary and in accordance with standard and generally accepted medical procedures. If we consider a claim to be inappropriate, we have the right to decline or reduce the amount we pay.

When cover starts for you and your dependants

Your insurance is valid from the start date shown on the Insurance Certificate and will continue until the group renewal date (which is also stated on the Insurance Certificate). Generally, this is one Insurance Year, unless we and your company decide otherwise or if you started your policy mid-year. At the end of this period, your company can renew the insurance on the basis of the policy terms and conditions applicable at that time. You will be bound by those terms.

Cover for dependants (if applicable) will start on the effective date shown on the most recent Insurance Certificate which lists them as your dependants. Their membership may continue for as long as you remain part of the group scheme and, for children, as long as they 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.

Benefit limits

The Table of Benefits shows two kinds of benefit limits:

- 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, on a “per lifetime” basis or on a “per event” basis such as per trip or per visit. In some instances,

in addition to the benefit limit, we will only pay a percentage of the costs for the specific benefit e.g. "50% refund, up to £187".

The amount we refund is subject to the maximum plan benefit (if one applies to your plan), even where:

- a specific benefit limit applies
- where the term "Full refund" appears next to the benefit

All limits are per member and per Insurance Year, unless your Table of Benefits states otherwise.

For multiple birth babies born as a result of medically assisted reproduction, in-patient treatment is limited to £24,900 per child for the first three months following birth. Out-patient treatment is paid within the terms of the Out-patient Plan.



CLAIMS AND TREATMENT GUARANTEE PROCESS



Medical claims

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

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

Attach all supporting receipts and/or invoices with your claim.

- **Currency:** Please specify the currency you wish to be paid in. On rare occasions, we may not be able to make a payment in that currency due to international banking regulations. If this happens, we will identify a suitable alternative currency. If we have to make a conversion from one currency to another, we will use the exchange rate that applied on the date the invoices were issued, or on the date that we pay your claim.
Please note that we reserve the right to choose which currency exchange rate to apply.
- **Reimbursement:** we will only reimburse (within the limit of your policy) eligible costs after considering any Treatment Guarantee requirements, deductibles or co-payments outlined in the Table of Benefits.
- **Reasonable and customary cost:** We will only reimburse charges that are reasonable and customary in accordance with standard and generally accepted medical procedures. If we consider a claim to be inappropriate, we reserve the right to decline your claim or reduce the amount we pay.
- **Deposits:** If you have to pay a deposit in advance of any medical treatment, we will reimburse this cost only after treatment has taken place.
- **Providing information:** You and your dependants agree to help us get all the information we need to process a claim. We have the right to access all medical records and to have direct discussions with the medical provider or the treating doctor. We may, at our own expense, request a medical examination by our doctors if we think it's necessary. All information will be treated confidentially. We reserve the right to withhold benefits if you or your dependants do not support us in getting the information we need.



Treatment needed as a result of someone else's fault

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

Treatment Guarantee

Some of the benefits available to you need pre-authorization. These are usually marked with a 1 or a 2 in your Table of Benefits. To get pre-authorization, please send us a Treatment Guarantee Form.

Here are the treatments/benefits which normally need pre-authorization. This may vary depending on your cover, so please check your Table of Benefits to confirm:

- All in-patient benefits¹ listed (where you need to stay overnight in a hospital)
- Day-care treatment²
- Kidney dialysis²
- MRI (Magnetic Resonance Imaging) scan. Treatment Guarantee is only needed for MRI scans if you wish us to settle your bill directly with the hospital.
- Nursing at home or in a convalescent home²
- Oncology² (only in-patient or day-care treatment requires pre-authorization)
- Out-patient surgery²
- Palliative care²
- PET² (Positron Emission Tomography) and CT-PET² scans
- Travel costs to another Channel Island/UK/France

Using the Treatment Guarantee Form helps us to settle your bill directly with hospitals, clinics and other medical facilities.

Unless we and your company agree otherwise, if you make a claim without obtaining Treatment Guarantee, 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 with a **1 in your Table of Benefits**, we reserve the right to decline your claim. If the treatment is subsequently proven to be medically necessary, we will pay **80%** of the benefit.
- For the benefits listed with a **2 in your Table of Benefits** we reserve the right to decline your claim. If the treatment is subsequently proven to be medically necessary, we will pay **50%** of the benefit.



PAYING PREMIUMS

If your company pays your insurance premium

In most cases, your company is responsible for paying the premiums for you and your dependants, covered under the Company Agreement. Your company may also pay other taxes and charges associated with your cover (such as Insurance Premium Tax). However you may be liable to pay tax in respect of the premiums paid by your company. For details, please check with your company.

If you pay your insurance premium

If you are responsible for paying your insurance premium, you need to pay us in advance for the duration of your cover. Your Insurance Certificate shows the amount your company has agreed with us and your selected payment frequency. The **initial premium** or first premium instalment is payable immediately after we accept your application. When you receive your invoice, please check that the premium matches the amount shown on your agreed quotation and contact us immediately if there is any difference. We are not responsible for payments made through third parties. **Subsequent premiums** are due on the first day of the chosen payment period.

If applicable, you may also need to pay the following taxes in addition to your premium:

- Insurance Premium Tax (IPT).
- VAT.
- Other taxes, levies or charges relating to your cover that we may have to pay or collect from you by law.

These charges may already be in effect when you join but they could be introduced (or change) afterwards. Your invoice will show these taxes. If they change or if new taxes are introduced, we will write to inform you. If you do not accept the changes, you can choose to end your cover. We will not apply any of the changes if you end your membership within 30 days of the date they take effect, or within 30 days of us telling you about the changes (whichever is later).

In some countries you may also be required to apply withholding tax. If that is the case, it is your responsibility to calculate and pay this amount to the relevant authorities in addition to payment of your full premium to us.

Each year on the renewal date, we may change how we calculate your premiums and taxes, the amount you have to pay and/or the method of payment. If so, we will inform you of these changes and they will only apply from your renewal date. If you wish, you can change the way you pay at policy renewal. Please write to us to request this at least 30 days before the renewal date.

If you are unable to pay your premium for any reason, please contact us so that we can discuss this with you, as if you don't pay your premiums on time you may lose your cover.



ADMINISTRATION OF YOUR POLICY

Adding dependants

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

Underwritten groups

How do I add a newborn to my policy?

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

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

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

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

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

Non-underwritten groups

How do I add a newborn to my policy?

Please notify your company within four weeks from birth.

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

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

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

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

Returning to your home country

Unless otherwise agreed between your company and us, when you return to your home country to make it your principal country of residence, your policy can continue as long as your home country is within your geographical area of cover, as your existing plan may not be valid there. Cover in some countries is subject to local health insurance restrictions, particularly for permanent residents of that country. It is your responsibility to ensure that your health insurance cover is legally appropriate. If you are not sure, please get independent legal advice, as we may no longer be able to cover you. The cover we provide is not a substitute for local compulsory health insurance.

How do I notify you that I am moving country?

If you are member of an underwritten group (where medical history is assessed), just contact our Helpline.

If you are a member of a non-underwritten group, please notify your company.

Changing your postal address or email address

We will send all correspondence to the address we have on record for you unless requested otherwise. You need to inform us in writing as soon as possible of any change in your home, business or email address.

Correspondence

When you write to us, please use email or post (with the postage paid). We do not usually return original documents to you, but if you ask us to, we will.

Renewal of cover

If your company pays for your premium, the renewal of your cover (and that of your dependants, if applicable) is the decision of your company.

If you pay your premium and your company renews your cover (and that of your dependants, if applicable), your policy will automatically renew for the next Insurance Year, if:

- We can continue to provide cover in your country of residence
- All premiums due to us have been paid
- The payment details we have for you are still valid on the policy renewal date. Please update us if you get a new/replacement credit card or if your bank account details have changed.

Ending your cover

Your company can end your membership or that of any of your dependants by notifying us in writing. We cannot backdate the cancellation of your cover. It will automatically end:

- At the end of the Insurance Year, if the agreement between your company and us is terminated.
- If your company decides to end or not to renew your cover.
- If your company does not pay premiums or any other payment due under the Company Agreement with us.
- If you are an individual payer and you do not pay premiums or any other payment due under the Company Agreement with us.
- When you stop working for your company.
- Upon the death of the insured employee.

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

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

Policy expiry

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

Applying for cover if group membership ends

If your cover under the Company Agreement comes to an end and you remain resident in the Channel Islands, you can apply for cover under the Channel Islands Continuation Plan, by simply sending us an email (details below). You need to submit your application within one month of leaving the group scheme. You may be subject to underwriting and waiting periods may apply. If we accept your application, cover will start on the first day after you leave the group scheme.

@ welcome.back@allianzworldwidedecare.com



THE FOLLOWING TERMS ALSO APPLY TO YOUR COVER

- 1. Applicable law and dispute resolution:** Your membership is governed by French law, unless otherwise required under mandatory legal regulations. Any dispute that cannot otherwise be resolved will be dealt with by courts in France.
- 2. Economic sanctions:** Cover is not provided if any element of the cover, benefit, activity, business or underlying business violates any applicable sanction law or regulations of the United Nations, the European Union or any other applicable economic or trade sanction law or regulations.
- 3. Who is covered:** Only those group members (and dependants) as described in the Company Agreement are eligible for cover.
- 4. The amounts we will pay:** Our liability to you is limited to the amounts indicated in the Table of Benefits and any policy endorsements. The amount reimbursed, whether under this policy, public medical scheme or any other insurance will not exceed the figure stated on the invoice.
- 5. Who can make changes to your policy:** No one, except an appointed representative or the Group Scheme Manager is allowed to make changes to your policy on your behalf. Changes are only valid when agreed by your company and us.
- 6. When cover is provided by someone else:** We may decline a claim if you or any of your dependants are eligible to claim benefits from:

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

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

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

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

- 7. Circumstances outside our control (force majeure):** We will always do our best for you, but we are not liable for delays or failures in our obligations to you caused by things which are outside of our reasonable control. Examples are extremely severe weather, floods, landslides, earthquakes, storms, lightning, fire, subsidence, epidemics, acts of terrorism, outbreaks of military hostilities (whether or not war is declared), riots, explosions, strikes or other labour unrest, civil disturbances, sabotage and expropriation by governmental authorities.

8. Cancellation and fraud:

- a) For medically underwritten policies, the information you and your dependants give us e.g. on the Application Form or supporting documents, needs to be accurate and complete. If it isn't correct or if you don't tell us about things that may affect our underwriting decision, it may invalidate your policy from the start date. You also need to tell us about any medical conditions that arise between completing the application form and the start date of the policy. Medical conditions that you don't tell us about will most likely not be covered. If you're not sure whether certain information is relevant to underwriting, please call us and we'll be able to clarify that.
- b) We will not pay any benefits for a claim if:
- The claim is false, fraudulent or intentionally exaggerated.
 - You or your dependants or anyone acting on your or their behalf use fraudulent means to obtain benefit under this policy.

The amount of any claim we paid to you before the fraudulent act or omission was discovered will become immediately owing to us. We reserve the right to inform your company of any fraudulent activity.

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

10. **Use of Medi24:** The Medi24 advice line and its health-related information and resources is extremely helpful, but it's not a substitute for professional medical advice or for the care that you receive from your doctor. It is not intended to be used for medical diagnosis or treatment and you should not rely on it for that purpose. Always seek the advice of your doctor before beginning any new treatment or if you have any questions about a medical condition. We are not responsible or liable for any claim, loss or damage directly or indirectly resulting from your use of Medi24 or the information or services provided by them. Calls to Medi24 will be recorded and may be monitored for training, quality and regulatory purposes.

DATA PROTECTION

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

 www.allianzcare.com/en/privacy

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

 [+353 1 630 1301](tel:+35316301301)

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

 AP.EU1DataPrivacyOfficer@allianz.com



COMPLAINTS PROCEDURE

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

☎ **+353 1 630 1301**

@ **client.services@allianzworldwidecare.com**

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

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

🌐 **www.allianzcare.com/complaints-procedure**

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



DEFINITIONS

The following definitions apply to the benefits in our standard range of Healthcare Plans for the Channel Islands and to some other commonly used terms. The benefits you are covered for are listed in your Table of Benefits. If any specific benefits apply to your plan(s), the definition will appear in the “Notes” section at the end of your Table of Benefits. Wherever these words/phrases appear in your policy documents, they will always have the following meanings:



A

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

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 the daily room rate in a three-star hotel towards any hotel costs incurred. We do not cover sundry expenses such as meals, phone calls or newspapers. Please check your Table of Benefits to confirm whether an age limit applies with regard to your child.

Acute refers to the sudden onset of symptoms or a medical condition.

C

Chronic condition is defined as a sickness, illness, disease or injury that lasts longer than six months or requires medical attention (such as check-up or treatment) at least once a year. It also has one or more of the following characteristics:

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

Company is your employer as named in the Company Agreement.

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

Complementary treatment refers to therapeutic and diagnostic treatment that exists outside of traditional Western medicine. Please refer to your Table of Benefits to confirm whether any of the following complementary treatment methods are covered: chiropractic treatment, osteopathy, Chinese herbal medicine, homeopathy, acupuncture and podiatry as practised by approved therapists.

Co-payment is the percentage of the costs which you must pay. These apply per person, per Insurance Year, unless the

Table of Benefits states otherwise. Some plans may include a maximum co-payment per insured person, per Insurance Year and, if so, the amount will be capped at the figure stated in your Table of Benefits. Co-payments may apply individually to the Core, Out-patient or Dental Plans, or to a combination of these plans. For more information on co-payments, please refer to "What are deductibles and co-payments" section of this guide.

D

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.

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

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

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

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

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

Dependant is your spouse or partner (including same-sex partner) and unmarried children (including any step, fostered or adopted children) who are financially dependent on you and are named as dependants on your Insurance Certificate. Children are covered up to the day before their 18th birthday; or up to the day before their 24th birthday if they are in full-time education.

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

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

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

E

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

Emergency out-patient dental treatment is treatment received in a dental surgery or hospital emergency room for the immediate relief of dental pain caused by an accident or an injury to a sound natural tooth. Treatment may include pulpotomy or pulpectomy and the subsequent temporary fillings, limited to three fillings per Insurance Year. Treatment must take place within 24 hours of the emergency event. It does not include any form of dental prostheses, permanent restorations or the continuation of root canal treatment.

Emergency out-patient treatment is treatment received in a casualty ward or emergency room within 24 hours of an accident or sudden illness, where there is no medical necessity for you to occupy a hospital bed.

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 for up to six weeks per trip within the maximum benefit amount. It includes treatment required due to an accident or the sudden beginning or worsening of a severe illness which presents an immediate threat to your health. Treatment by a doctor must start within 24 hours of the emergency event. Cover is not provided for curative or follow-up non-emergency treatment, even if you are deemed unable to travel to a country within your geographical area of cover. Nor does it extend to charges relating to maternity, pregnancy, childbirth or any complications of pregnancy or childbirth. Please tell your company's Group Scheme Manager if you are going to be outside your area of cover for more than six weeks.

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

F

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

G

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

H

Health and wellbeing checks including screening for the early detection of illness or disease are health checks, tests and examinations, performed at appropriate age intervals, 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 younger where a family history exists)
 - Prostate screening (yearly for men aged 50+, or from an earlier age 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)

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

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 doctor. The

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

Hospital accommodation refers to standard private or semi-private accommodation as shown in the Table of Benefits - deluxe, executive rooms and suites are not covered. The hospital accommodation benefit only applies when the hospitalisation is not related to any other in-patient benefit shown on the Table of Benefits. For example, if a member is hospitalised for cancer treatment, the hospital accommodation will be covered under the oncology benefit, and not under the hospital accommodation benefit. Examples of benefits that already include hospital accommodation (if included in your plan) are: psychiatry and psychotherapy, organ transplant, oncology, routine maternity and palliative care.

I

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

For multiple-birth babies born as a result of medically assisted reproduction, in-patient treatment is limited to £24,900 per child for the first three months following birth. Out-patient treatment is paid within the terms of the Out-patient Plan.

In-patient cash benefit is payable when you receive in-patient treatment free of charge for a medical condition that is covered by us. Cover is limited to the amount specified in the Table of Benefits and is payable after you are discharged from hospital.

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

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

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

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

L

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

M

Maternity/paternity cash benefit refers to an amount payable for each birth to each parent insured with us, when provided under your Core Plan. This benefit is only payable where treatment is received free of charge. The amount payable will be indicated in your Table of Benefits. To claim the maternity/paternity cash benefit you need to 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 Corporate Healthcare Plan for the Channel Islands for a minimum of 10 continuous months before the baby is born.

Medical necessity refers to medical treatment, services or supplies that fulfil all of the following:

- a) Essential to identify or treat your condition, illness or injury
- b) Consistent with your symptoms, diagnosis or treatment of the underlying condition
- c) In accordance with generally accepted medical practice and professional standards of care in the medical community at the time (this does not apply to complementary treatment methods if they form part of your cover)
- d) Required for reasons other than the comfort or convenience of you or your doctor
- e) Proven and demonstrated to have medical value (this does not apply to complementary treatment methods if they form part of your cover)
- f) Considered to be the most appropriate type and level of service or supply
- g) Provided at an appropriate facility, in an appropriate setting and at an appropriate level of care for the treatment of your medical condition
- h) Provided only for an appropriate duration of time

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

Medical practitioners are doctors who are licensed to practise medicine under the law of the country in which treatment is

given and where they are practising within the limits of their licence.

Medical practitioner fees refers to non-surgical treatment performed or administered by a medical practitioner.

Medical underwriting is the assessment of insurance risk based on information that you give us when applying for cover. Our underwriting team uses this information to decide the terms of our offer.

N

Non-underwritten groups are groups where the members' health information is not assessed.

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 pay the benefit listed in the Table of Benefits if the treating doctor decides that it is medically necessary for you to stay in a convalescent home or have a nurse in attendance at home. The stay also needs to be approved by our Medical Director. This benefit doesn't cover spas, cure centres, health resorts, palliative care or long term care (see Palliative care definitions).

O

Obesity is diagnosed when a person has a body mass index (BMI) of over 30 (you can find a BMI calculator at: www.allianzcare.com/members).

Oculomotor therapy is a specific type of occupational therapy that aims to synchronise eye movement when there is a lack of coordination between eye muscles.

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

Oral and maxillofacial surgical procedures refers to surgical treatment on the mouth, jaws, face or neck performed in a hospital by an oral and maxillofacial surgeon for: oral pathology, temporomandibular joint disorders, facial bone fractures, congenital jaw deformities, salivary gland diseases and tumours.

Unless you hold a Dental Plan, we do not cover the following procedures even if they are performed by an oral and maxillofacial surgeon:

- Surgical removal of impacted teeth

- Surgical removal of cysts
- Orthognathic surgeries for the correction of malocclusion

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

Orthodontics is the use of devices to correct malocclusion (misalignment of your teeth and bite). We will ask you to submit supporting information with your claim to show that your treatment is medically necessary and therefore eligible for cover. The information we ask for may include, but is not limited to:

- A medical report issued by the specialist, stating the diagnosis (type of malocclusion) and a description of your symptoms caused by the orthodontic problem.
- A treatment plan showing the estimated duration and cost of the treatment and the type/material of the appliance used.
- The payment arrangement agreed with the medical provider.
- Proof of payment for orthodontic treatment.
- Photographs of both jaws clearly showing dentition before the treatment.
- Clinical photographs of the jaws in central occlusion from frontal and lateral views.
- Orthopantomogram (panoramic x-ray).
- Profile x-ray (cephalometric x-ray).
- Any other document we may need to assess the claim.

We will only cover the cost of standard metallic braces and/or standard removable appliances. However, we'll cover cosmetic appliances such as lingual braces and invisible aligners up to the cost of metallic braces, subject to the "Orthodontic treatment and dental prostheses" benefit limit.

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

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

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

P

Partner refers to a person you have lived with in a conjugal relationship for a continuous period of 12 months.

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

Periodontics refers to dental treatment related to gum disease.

Podiatry refers to medically necessary treatment carried out by a State Registered podiatrist.

Pre-existing conditions are medical conditions for which one or more symptoms presented at some point during your or your dependants' lifetime. This applies regardless of whether you or your dependants sought any medical advice or treatment. We would deem any such condition to be pre-existing if we could reasonably assume you or your dependants would have known about it. Your policy will cover pre-existing conditions unless we tell you otherwise in writing.

We will also treat as pre-existing any medical conditions that arise between the date you completed the application form and the later of the following:

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

Such pre-existing conditions will also be subject to full medical underwriting and if they are not disclosed, they will not be covered. Please refer to the "Notes" section of your Table of Benefits to confirm if pre-existing conditions are covered.

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

Prescribed medical aids refers to any device which is prescribed and medically necessary to enable you to carry out everyday activities. Examples include:

- Biochemical aids such as insulin pumps, glucose meters and peritoneal dialysis machines.
- Motion aids such as crutches, wheelchairs, orthopaedic supports/braces, artificial limbs and prostheses.
- Hearing and speaking aids such as an electronic larynx.
- Medically graduated compression stockings.
- Long-term wound aids such as dressings and stoma supplies.

We do not cover costs for medical aids that form part of palliative care (see the definitions of palliative care).

Prescribed physiotherapy refers to treatment provided by a registered physiotherapist following referral by a doctor. Physiotherapy does not include therapies such as Rolwing, massage, Pilates, Fango and Milta.

Prescription drugs refers to products which you can't buy without a prescription and are to treat a confirmed diagnosis or medical condition or to compensate a lack of vital bodily substances. Examples are antibiotics, sedatives, etc. Prescription drugs must be clinically proven to be effective for the diagnosed condition. They must also be recognised by internationally accepted medical guidelines.

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

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

Psychiatry and psychotherapy refers to 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
- Work pressure

All day-care or in-patient admissions must include prescription medication related to the condition. We will cover psychotherapy (on an in-patient or out-patient basis) in cases where you or your dependants are initially diagnosed by a psychiatrist and referred to a clinical psychologist for further treatment. Out-patient psychotherapy treatment (where covered) is for 10 sessions per condition initially. After every 10 sessions, the referring psychiatrist must review the treatment. If you need more sessions, you must send us a progress report that indicates the medical necessity for further treatment.

R

Reasonable and customary charge refers to the average fee charged by the medical provider within a geographic area. In determining the reasonable charge for a service or supply that is unusual, not often provided in the area or provided by only a small number of providers in the area, the Insurer will observe: the complexity; the degree of skill needed; the type of specialty of the provider; the range of services or supplies provided by the facility; and the prevailing charge in other areas. This also applies for vision and dental care.

Rehabilitation is treatment that combines therapies such as physical, occupational and speech therapy. It aims to restore original form or function after an acute illness, injury or surgery. Treatment must take place in a licensed rehabilitation facility and start within 14 days of discharge from acute medical and/or surgical treatment.

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

S

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

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

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

Surgical appliances and materials are those required for surgeries. They include artificial body parts or devices such as joint replacement materials, bone screws and plates, valve replacement appliances, endovascular stents, implantable defibrillators and pacemakers.

T

Therapist refers to a chiropractor, osteopath, Chinese herbalist, homeopath, acupuncturist, physiotherapist, speech therapist, occupational therapist or oculomotor therapist, who is qualified and licensed under the laws of the country in which treatment takes place.

Travel costs relate to the cost of a return journey to another Channel Island, to the UK or to France to receive treatment. If covered under your policy, this benefit will apply when you need private hospital day-care or in-patient treatment (including pre- and post-operative consultations) and your doctor confirms 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. Please note that we will pay up to the amount specified in your Table of Benefits for each

return journey and we will only pay for the following travel costs under this benefit:

- Standard rate air fares from the Channel Islands to another Channel Island, to the UK or to France
- Standard rate train, underground and bus fares
- A maximum of £25 per taxi trip

We also pay travel costs for a parent to accompany a child. Please refer to your Table of Benefits to determine the level of cover available under your plan and to confirm whether an age limit applies with regard to your child.

If medically necessary, we may also pay a contribution of up to £125 per trip towards the cost of nursing care required during the journey. Please note that Treatment Guarantee is required.

You will also need to obtain written confirmation from the Health and Social Services Department that you are not entitled to a travelling allowance grant in respect of travel and escort costs.

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

U

Underwritten groups are groups where members' medical history is assessed.

V

Vaccinations refer to:

- All basic immunisations and booster injections that are required by law in the country in which they are administered.
- Medically necessary travel vaccinations.
- Malaria prevention tablets.

We cover the cost of consultation for administering the vaccine and the cost of the drug.

W

Waiting period is a period of time that begins 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 shows which benefits are subject to waiting periods.

We/Our/Us is Allianz Care.



You/Your refers to the person working for the company and any dependants named on the Insurance Certificate.

EXCLUSIONS

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



Behavioural and personality disorders

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

Chemical contamination and radioactivity

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

Chronic conditions including any pre-existing chronic conditions

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.

Complementary treatment

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

Complications caused by conditions not covered under your plan

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

Consultations performed by you or a family member

Consultations performed and any drugs or treatments prescribed by you, your spouse, parents or children.

Dental surgery, dental prostheses, periodontics and orthodontic treatment

Dental surgery, dental prostheses, periodontics and orthodontic treatment, with the exception of dental treatment as defined.

Dental veneers

Dental veneers and related procedures, unless medically necessary.

Developmental delay

Delay in cognitive or physical development, unless a child has not achieved the developmental milestones expected for a child of that age. We do not cover conditions in which a child is slightly or temporarily lagging in development. The developmental delay must have been quantitatively measured by qualified medical professionals and documented as a delay in development of at least 12 months.

Drug addiction or alcoholism

Care and/or treatment of drug addiction or alcoholism (including detoxification programmes and treatments to stop smoking), death associated with drug addiction or alcoholism, 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).

Experimental or unproven treatment or drug therapy

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

Failure to seek or follow medical advice

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

Family therapy and counselling

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

Fees for the completion of a Claim Form

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

Health and wellbeing checks

Health and wellbeing checks including screening for the early detection of illness or disease, unless otherwise agreed between your company and us, and indicated accordingly in the Table of Benefits.

Home visits

Home visits, unless they are necessary after the sudden onset of an acute illness that leaves you incapable of visiting your doctor or therapist.

HIV

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

Injuries caused by professional sports

Treatment or diagnostic procedures for injuries arising from taking part in professional sports.

Intentionally caused diseases or self-inflicted injuries

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

Laser eye treatment

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

Loss of hair and hair replacement

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

Medical error

Treatment required as a result of medical error.

Obesity treatment

Investigations into and treatment for obesity.

Organ transplant

Organ transplant as well as expenses for the acquisition of an organ including, but not limited to, donor search, typing, transport and administration costs.

Orthomolecular treatment

Please refer to the definition of Orthomolecular treatment.

Participation in war or criminal acts

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

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

Plastic surgery

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 period of cover.

Pre-existing conditions

For underwritten groups, pre-existing conditions (including pre-existing chronic conditions) when:

- Indicated on a Special Conditions Form that we issue before your policy starts
- Conditions were not disclosed on the application form
- Conditions arise between completing the application form and the later of the following:
 - The date we issue your Insurance Certificate or
 - The start date of your policy

Such conditions will also be subject to medical underwriting and if not disclosed, will not be covered.

Pregnancy and childbirth

Treatments and/or examinations related to pregnancy and childbirth and any complications thereof are not covered.

Prescription drugs and dressings

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

Sex change

Sex change operations and related treatments.

Sleep disorders

Treatment of sleep disorders, including insomnia, obstructive sleep apnoea, narcolepsy, snoring and bruxism.

Stays in a cure centre

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

Sterilisation, sexual dysfunction and contraception

Investigations into, treatment of and complications arising from:

- Sterilisation.
- Sexual dysfunction (unless as a result of a total prostatectomy following cancer surgery).
- Contraception (including the insertion and removal of contraceptive devices and all other contraceptives, even if prescribed for medical reasons). The only exception is where contraceptives are prescribed by a dermatologist for the treatment of acne.

Surrogacy

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

Travel cost benefit

Travel cost benefit is not available:

- When costs are covered by the Health and Social Services Department.
- When the treatment is not covered under your plan.
- When travelling has not been recommended by your consultant.
- For a parent to accompany a child who is 18 years of age or older.
- For incidental costs of travel, for example hotel accommodation or meals.
- When we have not agreed to all costs of travel prior to the journey.
- For any of the travel costs where the costs were above the standard fares.
- For travel to and from medical facilities, if the proposed treatment or any alternative treatment is available locally.

Travel costs when treatment is available locally

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.

Treatment outside the geographical area of cover

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

Tumour marker testing

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

Vessel at sea

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

Vitamins or minerals

Products classified as:

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

These products are excluded even if they are medically recommended, prescribed or acknowledged as having therapeutic effects. Costs incurred as a result of nutritional or dietary consultations are also not covered, unless a specific benefit shows in your Table of Benefits.

Benefits not included in your plan

The following benefits are not included in your plan:

- Medical evacuation or repatriation
- Oculomotor therapy
- Prescribed medical aids
- Preventive treatment
- Rehabilitation treatment
- Repairs to spectacles
- Repatriation of mortal remains
- Speech therapy
- Vaccinations

Talk to us, we love to help!

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

24/7 Helpline for general enquiries and emergency assistance

 **English: +353 1 630 1301**

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

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

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

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

 **Fax: + 353 1 630 1306**

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

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