Corporate Healthcare Plans for Channel Islands

Employee Benefit Guide

Valid from 1st November 2016

Allianz Worldwide Care

Your healthcare cover

This Benefit Guide sets out the standard benefits and rules of the Healthcare Plan for the Channel Islands. Please read this guide in conjunction with your Insurance Certificate and Table of Benefits.

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

Your Table of Benefits outlines the plan(s) selected by your company and the associated benefits available to you. In addition, it specifies any benefits/treatments which require submission of a Treatment Guarantee Form and confirms any benefits to which specific benefit limits, waiting periods, deductibles and/or co-payments apply. Your Table of Benefits will be issued 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 membership may be changed from time to time by agreement between your company and Allianz Worldwide Care.

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Your cover

Overview

Your Table of Benefits specifies the plan(s) selected by your company and the associated benefits available to you. This could be one of our standard plans, or your plan may have been designed specifically for your company. Cover is subject to our policy definitions, exclusions and benefit limits and for underwritten groups, cover is also subject to any special conditions indicated on the Insurance Certificate (and on the Special Conditions Form issued prior to policy inception).

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

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

Benefit limits

There are two kinds of benefit limits shown in the Table of Benefits. The **maximum plan benefit**, which applies to certain plans, is the maximum we will pay for all benefits in total, per insured person, 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 or per visit. In some instances we will pay a percentage of the costs for the specific benefit e.g. "50% refund, max £187. 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.

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.

Medical necessity and customary charges

This policy provides cover for medical treatment, related costs, services and/or supplies that we determine to be medically necessary and appropriate to treat a patient's condition, illness or injury. Plus we will only reimburse medical providers where their charges are reasonable and customary in accordance with standard and generally accepted medical procedures. If a claim is deemed by us to be inappropriate, we reserve the right to reduce the amount payable by us.

Pre-existing conditions

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

Pre-existing conditions (including any pre-existing chronic conditions) are generally covered within the limits of your plan(s) unless indicated otherwise on a Special Conditions Form that is issued prior to policy inception. Please refer to the "Notes" section of your Table of Benefits to confirm if pre-existing conditions are covered. For underwritten groups, exclusion number 23 on page 12 of this guide provides details of the scenarios where we would not cover pre-existing conditions.

Definitions

The following definitions apply to the benefits included 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 unique benefits apply to your plan(s), the definition will appear in the "Notes" section at the end of your Table of Benefits. Wherever the following words/phrases appear in your policy documents, they will always be defined as follows:

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

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

1.3 **Acute** refers to sudden onset.

1.4 **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.

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

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

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

1.8 **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 or Dental Plans, or to a combination of these plans.

1.9 **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.

1.10 **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 or Dental Plans, or to a combination of these plans.

1.11 **Dental prescription drugs** are those prescribed by a dentist for the treatment of a 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. This does not include mouthwashes, fluoride products, antiseptic gels and toothpastes.

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 surgical extraction of teeth, as well as other tooth related surgical procedures such as apicoectomy and dental prescription drugs. All investigative procedures necessary to 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 any surgical treatment that is related to dental implants.

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

1.15 **Dependant** is your spouse or partner (including same sex partner) and/or unmarried children (including any step, foster or adopted children) financially dependent 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 **Direct family history** exists where a parent, grandparent, sibling or child has been previously diagnosed with the medical condition in question.

1.18 **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.

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

1.20 **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.

1.21 **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 non-emergency treatment, even if you are deemed unable to travel to a country within your geographical area of cover, nor does it cover charges relating to maternity, pregnancy, childbirth or any complications of pregnancy or childbirth. You should advise your company's Group Scheme Manager if you are moving outside your area of cover for more than six weeks.

1.22 **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.

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

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

1.25 **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).

1.26 **Home country** is a country for which the insured person holds a current passport or is their principal country of residence.

1.27 **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.

1.28 **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.

1.29 **Infertility treatment** refers to treatment for the insured person including all invasive investigative procedures necessary to establish the cause for infertility such as hysterosalpingogram, laparoscopy or hysteroscopy. If the Table of Benefits does not have a specific benefit for infertility treatment, cover is limited to non-invasive investigations into the cause of infertility, within the limits of your Out-patient Plan, if your company selected one. If however, there is a specific benefit for infertility treatment, the cost for infertility treatment will be covered for the insured member who receives the treatment, up to the limit indicated in the Table of Benefits. Any costs exceeding the benefit limit cannot be claimed under the cover of the spouse/partner (if included in the policy). In the case of InVitro Fertilisation (IVF), cover is limited to the amount

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

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

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

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

1.33 **Insurance Year** applies from the effective date of the insurance, as indicated on the Insurance Certificate and ends at the expiry date of the Company Agreement. The following Insurance Year coincides with the year defined in the Company Agreement.

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

1.35 **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.

1.36 **Maternity/paternity cash benefit** refers to an amount payable for each birth to each parent insured with Allianz Worldwide Care, 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.

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

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

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

1.38 **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.

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

1.40 **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 insured person 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 (see definition 1.50).

1.41 **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**).

1.42 **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.

1.43 **Oncology** refers to specialist fees, diagnostic tests, radiotherapy, chemotherapy and hospital charges incurred in relation to the planning and carrying out of treatment for cancer, from the point of diagnosis. We will also cover the cost of a wig in the event of hair loss as a result of cancer treatment.

1.44 **Oral and maxillofacial surgical procedures** refer to surgical treatment performed by an oral and maxillofacial surgeon in a hospital as a treatment for: oral pathology, temporomandibular joint disorders, facial bone fractures, congenital jaw deformities, salivary gland diseases and tumours. Please note that surgical removal of impacted teeth, the surgical removal of cysts and orthognathic surgeries for the correction of malocclusion, even if performed by an oral and maxillofacial surgeon, are not covered unless the "Dental surgery" benefit forms part of your cover.

1.45 **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.

1.46 **Orthodontics** is the use of devices to correct malocclusion and restore the teeth to proper alignment and function. We only cover orthodontic treatment where the standard metallic braces and/or standard removable appliances are used. Cosmetic appliances such as lingual braces and invisible aligners are covered up to the cost of metallic braces, subject to the "Orthodontic treatment and dental prostheses" benefit limit.

1.47 **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.

1.48 **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.

1.49 **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.

1.50 **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.

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

1.52 **Podiatry** 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); FCPodS (Fellow of the College of Podiatrists of The Society of Chiropodists & Podiatrists).

1.53 **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.

1.54 **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.

1.55 **Prescribed medical aids** refers to any device which is prescribed and medically necessary to enable the insured person to function to a capacity consistent with everyday living where reasonably possible. This includes:

- 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.

Costs for medical aids that form part of palliative care or long term care are not covered.

1.56 **Prescribed physiotherapy** refers to treatment by a registered physiotherapist following referral by a medical practitioner or specialist. Physiotherapy does not include therapies such as Rolfing, Massage, Pilates, Fango and Milta therapy.

1.57 **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.

1.58 **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.

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

1.60 **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.

1.61 **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, injury or surgery. 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.

1.62 **Repatriation of mortal remains** is the transportation of the insured person's mortal remains from the principal country of residence to the country of burial. Covered expenses include, but are not limited to,

expenses for embalming, a container legally appropriate for transportation, shipping costs and the necessary government authorisations. Cremation costs will only be covered in the event that this is required for legal purposes. Costs incurred by any accompanying persons are not covered. All covered expenses in connection with the repatriation of mortal remains must be pre-approved by us using Treatment Guarantee.

1.63 **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.

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

1.65 **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).

1.66 **Surgical appliances and materials** are those which are required for the surgical procedure. These include artificial body parts or devices such as joint replacement materials, bone screws and plates, valve replacement appliances, endovascular stents, implantable defibrillators and pacemakers.

1.67 **Therapist** is a chiropractor, osteopath, 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.

1.68 **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.
- 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.

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

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

1.71 **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.

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

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

Exclusions

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

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

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

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

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

5. **Chronic conditions including any pre-existing chronic conditions** and any associated or related treatment, with the exception of the short term treatment of an acute episode of a chronic condition.

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

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

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

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

10. **Dental veneers** and related procedures.

11. **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.

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

13. **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.

14. **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.

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

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

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

18. Investigations into, treatment of and complications arising from **sterilisation, sexual dysfunction** (unless this condition is as a result of total prostatectomy following surgery for cancer) and **contraception** including the insertion and removal of contraceptive devices and all other contraceptives, even if prescribed for medical reasons. The only exception in relation to costs for contraception is where contraceptives are prescribed by a dermatologist for the treatment of acne.

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

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

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

22. **Orthomolecular treatment** (please refer to definition 1.47).

23. In relation to underwritten groups, **pre-existing conditions** (including any pre-existing chronic conditions) which are indicated on a Special Conditions Form that is issued prior to policy inception (if relevant) and conditions which have not been declared on the relevant application

form. In addition, conditions arising between completing the relevant application form and the start date of the policy will equally be deemed to be pre-existing. Such pre-existing conditions will also be subject to medical underwriting and if not disclosed, they will not be covered.

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

25. 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, 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.

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

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

28. **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.

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

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

31. 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.

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

33. 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**, unless indicated otherwise in the Table of Benefits.

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

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

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

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

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

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

40. **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.

41. The following benefits are not included in your plan:

    41.1 Repairs to spectacles.
    41.2 Prescribed medical aids.
    41.3 Vaccinations.
    41.4 Speech therapy.
    41.5 Oculomotor therapy.
    41.6 Rehabilitation treatment.
    41.7 Preventive treatment.
    41.8 Medical evacuation or repatriation.
    41.9 Repatriation of mortal remains.

Additional terms

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

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. **Cancellation and fraud:**

a) For **groups that require medical underwriting**, incorrect disclosure/ non-disclosure of any material facts, by you or your dependants, which may affect our assessment of the risk, including, but not limited to material facts declared on the relevant application form, may render your cover void from the start date. Conditions arising between completing the relevant application form and the start date of the policy will equally be deemed to be pre-existing. Such pre-existing conditions will also be subject to medical underwriting and if not disclosed, they will not be covered. If the applicant is not sure whether something is relevant, the applicant is obliged to inform us.

b) If any claim is false, fraudulent, intentionally exaggerated or if fraudulent means or devices have been used by you or your dependants or anyone acting on your or their behalf to obtain benefit under this policy, we will not pay any benefits for that claim. The amount of any claim settlement made to you before the fraudulent act or omission was discovered, will become immediately due and owing to us. We reserve the right to inform your company of any fraudulent activity.

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

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

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

6. **Liability:** Our liability to the insured person is limited to the amounts indicated in the Table of Benefits and any subsequent policy endorsement. In no event will the amount of reimbursement, whether under this policy, public medical scheme or any other insurance, exceed the amount of the invoice.

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

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

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

General information

Adding dependants

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

For **non-underwritten groups**, newborn infants will be accepted for cover from birth, provided that we are notified within four weeks of the date of birth. To have a newborn added to the policy, you must ask your company to submit a request in writing, including a copy of the birth certificate, to its usual Allianz Worldwide Care contact person for membership changes. If we are notified four weeks or more after the date of birth, newborn children will be accepted for cover from the date of that notification.

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

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.

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. Your policy may be subject to underwriting and waiting periods may apply. We reserve the right to decide

on the acceptance of your application. The application must be submitted within one month of leaving the group scheme. The commencement date, if accepted for cover, will be the first day after leaving the group scheme.

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. Please note that 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 and we would recommend that you seek independent legal advice as we may no longer be able to provide you with cover.

Changing your address/email address

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

Claims

In relation to medical claims, please note that:

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

b) A separate Claim Form is required for each person claiming and for each medical condition being claimed for. Please note that as well as our hard and soft copy claim forms, if your company has selected our Online Services facility, members can now avail of our mobile MyHealth app for fast and easy claims submission.

c) 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 auditing purposes. We also reserve the right to request a proof of payment by you (e.g. bank or credit card

statement) in respect of your medical receipts. We advise that you keep copies of all correspondence with us as we cannot be held responsible for correspondence that does not reach us for any reason that is outside of our reasonable control.

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

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

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.

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

Your geographical area of cover is Jersey and Guernsey, the UK and the rest of Europe.

Ending your membership

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

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

Allianz Worldwide Care can end a person's membership and that of their dependants if there is reasonable evidence that the person concerned has misled or attempted to mislead us i.e. giving false information, withholding pertinent information from us, or working with another party to give us false information, either intentionally or carelessly, which may influence us when deciding:

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

Making a complaint

The Allianz Worldwide Care Helpline (**+353 1 630 1301**) is always the first number to call if you have any comments or complaints. If we have not been able to resolve the problem on the telephone, please email or write to us at:

client.services@allianzworldwidecare.com

Customer Advocacy Team, Allianz Worldwide 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 detailed at: www.allianzworldwidecare.com/complaints-procedure. You can also contact our Helpline to obtain a copy of this procedure.

Other parties

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

Paying premiums

In most cases, your company is responsible for the payment of premiums to Allianz Worldwide Care for your membership and for the membership of any dependants also covered under the Company Agreement, together with any amount that may be due and payable in respect of membership (such as Insurance Premium Tax). Please be aware that you may be liable for payment of tax in respect of the premiums paid by your company. For details, please check with your company.

If you are responsible for paying your insurance premium

If you are responsible for paying your insurance premium, you are required to pay the premium due to us in advance, for the duration of your membership. The amount your company has agreed with us and the payment frequency you have chosen, will be shown on your Insurance Certificate. The **initial premium** or the first premium instalment is due immediately after our acceptance of your application. 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. **Subsequent premiums** are due on the first day of the chosen payment period.

Please note that you also have to pay us the amount of any Insurance Premium Tax (IPT), other taxes, levies or charges relating to your membership that we are required by law to pay or to collect from you. These may already be in effect when you join but they could also be introduced (or change in the future) after you join. Any such charges will be shown on your invoice.

If you are unable to pay your premium for any reason, please contact us so that we can discuss this with you, as failure to pay premiums on time may result in loss of insurance cover.

If any changes are applied to your premiums, IPT, other taxes, levies or charges, we will write to inform you. If you do not accept any of these changes, you can choose to end your membership. We will treat the changes as having not been made if you end your membership within 30 days of the date the changes take effect, or within 30 days of us telling you about the changes, whichever is later.

Each year on the renewal date, we may change how we calculate or determine your premiums, the amount you have to pay and/or the method of payment. If so, you will be informed of these changes and they will only apply from your renewal date. Changes in payment terms can be made by you at policy renewal. Please write to us to request this at least 30 days before the renewal date.

Policy expiry

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

Renewing membership

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

If you pay for your premium and your company renews your membership (and that of your dependants, if applicable) under the Company Agreement, your policy will be automatically renewed for the next Insurance Year, provided that we can continue to provide cover in your country of residence, all premiums due to us have been paid and the payment details we have for you are still valid on the policy renewal date. Please update us if you get a new/replacement credit card or if your bank account details have changed.

Treatment Guarantee

Your Table of Benefits will confirm which benefits available to you require pre-authorisation through submission of a Treatment Guarantee Form. Please note that unless agreed otherwise between your company and us, if Treatment Guarantee 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 needed as a result of somebody else's fault

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

When cover starts for you and your dependants

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

Cover for dependants (if applicable) will start on the effective date shown on your most recent Insurance Certificate which lists them as a dependant. Their membership may continue for as long as you remain a member of the group scheme and as long as any child dependants remain under the dependant age limit (unless agreed otherwise between your company and us). 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.

Quick start guide

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

Allianz
Worldwide Care

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.
- Kidney dialysis.
- 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.
- Oncology (only in-patient or day-care treatment requires pre-authorisation).
- Out-patient surgery.
- Palliative care.
- PET (Positron Emission Tomography) and CT-PET scans.
- Travel costs to another Channel Island/UK/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 Treatment Guarantee is not obtained. You can find full details on pages 23 and 24 of this guide.

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. If your company has selected our Online Services facility, claims can be submitted quickly and easily through our MyHealth app: simply provide a few key details, take a photo of your invoice(s) and press 'submit'. **www.allianzworldwidecare.com/myhealth**

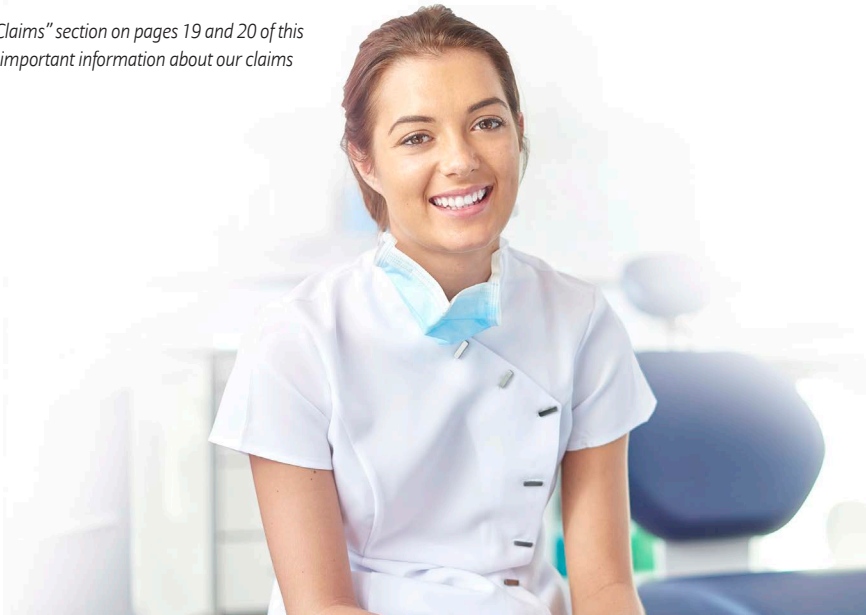
Alternatively, simply download a Claim Form from our website: **www.allianzworldwidecare.com/members** and follow the steps below:

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

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

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

Please refer to the "Claims" section on pages 19 and 20 of this guide for additional important information about our claims process.



Useful services

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

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

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

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

Contact details

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

24/7 Helpline for general enquiries and emergency assistance

Email: client.services@allianzworldwidecare.com
Fax: + 353 1 630 1306
Telephone: + 353 1 630 1301

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

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

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

DOC-EBG-CI-EN-0816

Financial Strength Rating A M BEST A+ Superior
Rating effective from 17th December 2015. For the latest rating, please visit www.ambest.com

INTERNATIONAL ADVISER PRODUCT & SERVICE AWARDS 2016 WINNER International health insurer LAST WORD

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

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