Corporate Healthcare Plan for the Channel Islands

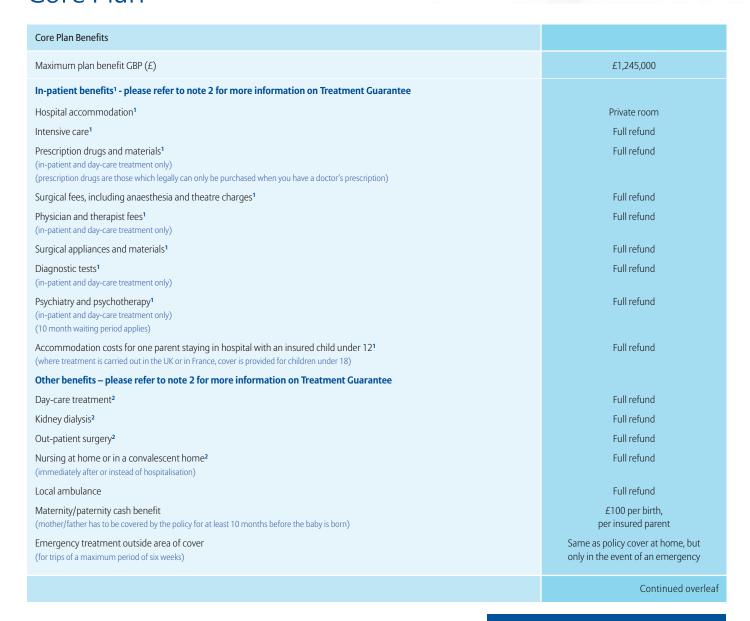
Table of Benefits

Valid from 1st November 2015

The following plans are only available for corporate groups of three employees or more.

Treatment Guarantee is required for all benefits indicated with a ¹ or a ² and may be required for other benefits. Please refer to note 2 within the "Notes" section for more information.

Core Plan





Core Plan Benefits (continued)	
CT and MRI scans (in-patient and out-patient treatment)	Full refund
PET ² and CT-PET ² scans (in-patient and out-patient treatment)	Full refund
Oncology² (in-patient, day-care and out-patient treatment)	Full refund
Purchase of a wig	£165 per lifetime
In-patient cash benefit (per night) (where treatment has been received free of charge)	£156, max. 99 nights
Travel costs² to another Channel Island/UK/France for hospital in-patient or day-care treatment as well as for pre- and post-operative treatment, when the Health and Social Services Department is not providing this service and where: • Your specialist confirms that private treatment is not available locally • You have contacted the Health and Social Services Department who have confirmed that they will not cover the costs • The costs have been agreed by us prior to travel (this benefit is also available for one parent to accompany an insured child under the age of 18)	£310 per return journey includes standard rate air, train, underground and bus fares and a max. of £25 per taxi trip
Palliative care ²	Full refund

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

Out-patient Plan

Out-patient Plan Benefits	
Maximum plan benefit GBP (\pounds)	No limit
Medical practitioner fees	Full refund
Specialist fees	Full refund
Diagnostic tests	Full refund
Prescribed acupuncture, chiropody, chiropractic treatment, homeopathy, osteopathy and podiatry • If referred by a medical practitioner • If referred by a specialist (max. 12 sessions per condition for chiropractic treatment and max.12 sessions per condition for osteopathic treatment, subject to the benefit limit)	£625 Full refund
Prescribed physiotherapy • If referred by a medical practitioner • If referred by a specialist	£310 Full refund, max. 10 visits
Eye test	50% refund, max. £33
Prescribed glasses and contact lenses	50% refund, max. £187
Psychiatry and psychotherapy (10 month waiting period applies)	Full refund, max. 45 visits

Dental Plan

Dental Plan Benefit	
Dental treatment	50% refund, up to £250

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

Notes



1. Area of cover

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



2. Treatment Guarantee

Certain treatments and costs require submission of a Treatment Guarantee Form in advance. Following approval by Allianz Worldwide Care, cover for these required treatments or costs can then be guaranteed. In the Table of Benefits, benefits which require pre-approval through submission of a Treatment Guarantee Form are indicated by either a 1 or a 2. These benefits are listed below, along with further important details:

- All in-patient benefits¹ listed.
- Day-care treatment².
- Kidney dialysis².
- Out-patient surgery².
- Nursing at home or in a convalescent home².
- MRI (Magnetic Resonance Imaging) scan. Treatment Guarantee may be required for this test if you would like us to settle the bill directly with the medical provider.
- PET² (Positron Emission Tomography) and CT-PET² scans.
- Oncology² (in-patient and day-care treatment only).
- Travel costs² to another Channel Island, the UK or to France.
- Palliative care².

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

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

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

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



3. Claims process and turnaround

Allianz Worldwide Care has a simple claims process in place to ensure that members can seek reimbursement for medical expenses. Members with access to our Online Services can avail of our MyHealth app for quick and easy claims submission.

Fully completed claims are processed and payment instructions issued to the member's bank within 48 hours. Where further information is required to complete the claim, the member/medical practitioner will automatically be notified by email or mail within 48 hours of receipt of the claim. An email is sent automatically to the member (where email addresses are provided to us) to advise them when the claim is processed.

This swift claims processing policy ensures that our members receive their claims payment in the most effective and efficient manner.



4. Chronic conditions

Chronic conditions are not covered within the terms of this plan. A 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



5. Benefit limits

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



6. Policy terms and conditions

Please note that cover for smaller groups is subject to underwriting i.e. cover may be excluded for pre-existing conditions, or a higher premium rate may apply to reflect the higher risk due to pre-existing medical conditions or additional risk factors. Cover is conditional upon acceptance of each underwritten member's application, which is only confirmed when an Insurance Certificate is provided. This Table of Benefits provides an outline of the cover we provide under the Corporate Healthcare Plan for the Channel Islands. Cover is subject to our policy terms and conditions, as detailed in our Employee Benefit Guide for the Channel Islands which is issued to members upon policy inception. This Employee Benefit Guide can also be downloaded from our website:

www.allianzworldwidecare.com/channel-islands-plans.

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

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