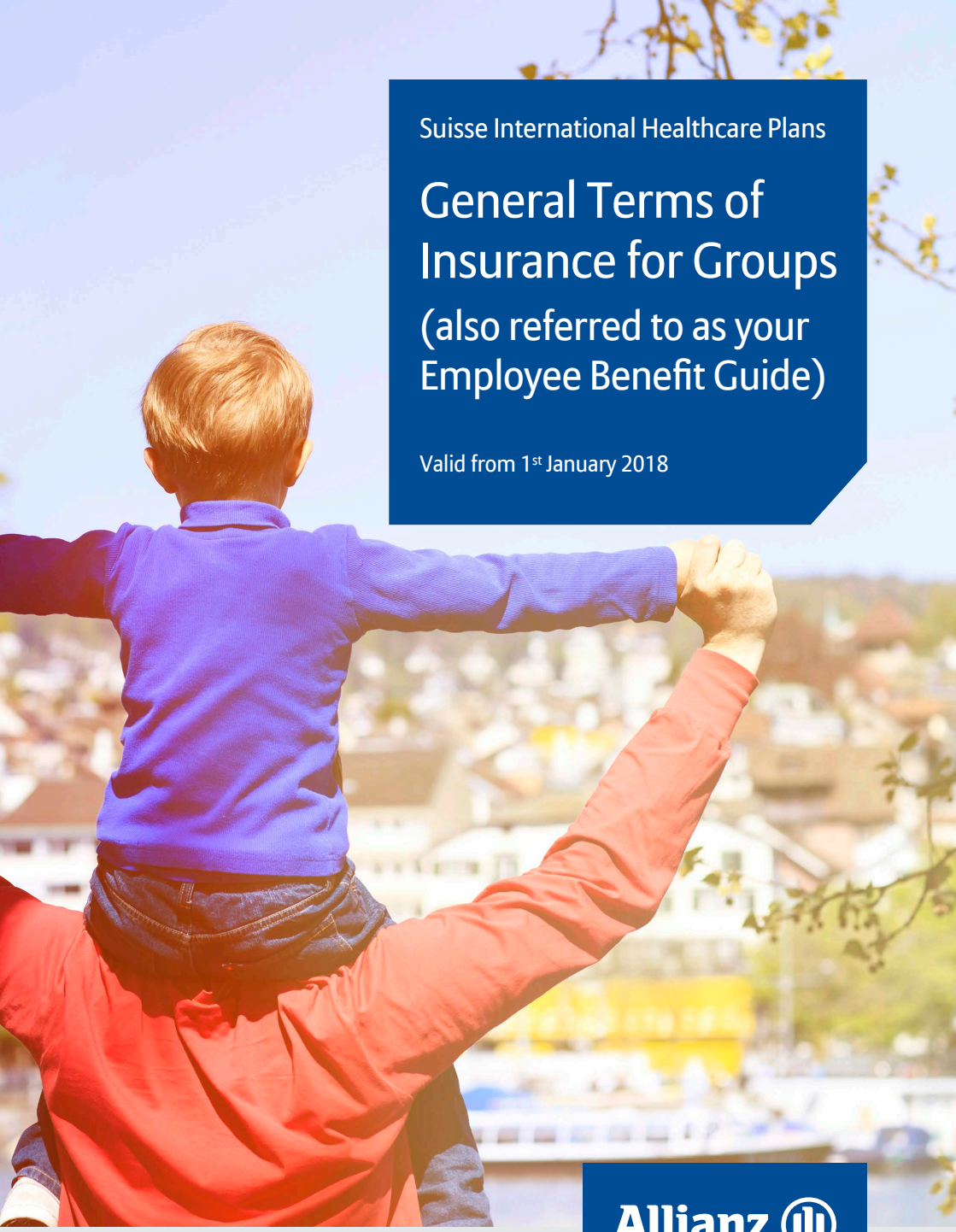

Suisse International Healthcare Plans

# General Terms of Insurance for Groups

## (also referred to as your Employee Benefit Guide)

Valid from 1st January 2018

Allianz

# Welcome

The purpose of this collective health insurance agreement is to provide supplemental medical insurance for the benefit of all insured persons (principal insured employees and their eligible dependants) covered under the Company Agreement between the Policyholder (Company) and AWP P&C S.A., Swiss branch. Benefits are payable in accordance with this Employee Benefit Guide and the Company Agreement.

This Employee Benefit Guide sets out the standard benefits and rules of the collective health insurance agreement. Please read this guide in conjunction with your Insurance Policy and Table of Benefits.

The Insurance Policy details the plan(s) and geographical area of cover that the Policyholder has chosen for the principal insured employee and his/her 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 Policy if we need to record any changes requested by the Policyholder or which we are entitled to make, or if, with the Policyholder's approval and our acceptance, the principal insured employee requests a change such as adding a dependant.

Your Table of Benefits outlines the plan(s) selected by the Policyholder 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. The Table of Benefits will be issued using the currency agreed with the Policyholder.

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 the Policyholder and AWP P&C S.A., Swiss branch.

*This English version is a translation of the original in German and for information purposes only. In case of a discrepancy, the German original will prevail.*

The Underwriter of your VVG insurance is AWP P&C S.A., Saint-Ouen (Paris), Wallisellen Branch (Switzerland), the Swiss Branch of AWP P&C S.A., Saint-Ouen, France, a limited company governed by the French Insurance Code. Registered in France: No. 519 490 080 RCS Paris. Swiss Branch registered in Zurich, registered No.:CHE-115.393.016, address: Hertistrasse 2, 8304 Wallisellen.

KPT Krankenkasse AG, Wankdorfallee 3, CH-3000 Bern 22, registered BAG Nr. 376. KPT provides administration services inside Switzerland.

AWP Health & Life SA, acting through its Irish Branch, is a limited company governed by the French Insurance Code. Registered in France: No. 401 154 679 RCS Bobigny. Irish Branch registered in the Irish Companies Registration Office, registered No.: 907619, address: 15 Joyce Way, Park West Business Campus, Nangor Road, Dublin 12, Ireland. AWP Health & Life SA, acts as the reinsurer of the VVG policies, provides administration services and technical support outside Switzerland. Allianz Worldwide Care is a registered business name of AWP Health & Life SA.

# Table of contents

# I. Your cover

## Overview

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

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

## 1. Medical necessity and customary charges

This policy provides cover for medical treatment, related costs, services and/or supplies that are medically necessary and appropriate to treat a patient's condition, illness or injury, in line with the definition on "Medical necessity". We will only pay for medical costs which are fair and reasonable and at the level customarily charged in the specific country and for the treatment provided, in accordance with standard and generally accepted medical procedures. If the prices are higher than what is common locally, we reserve the right to reduce the amount payable by us.

## 2. Pre-existing conditions

For underwritten groups please refer to the "Notes" section of your Table of Benefits and your Insurance Policy to confirm if pre-existing conditions are covered. Definition 1.61 provides further information on what constitutes pre-existing condition.

## 3. 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 Period, under that particular plan. Some benefits also have a **specific benefit limit**, which may be provided on a "per Insurance Period" basis, a "per lifetime" basis or on a "per event" basis, such as per trip, per visit or per pregnancy. In some instances we will pay a percentage of the costs for the specific benefit e.g. "65% refund, up to CHF 6,500". Where a specific benefit limit applies or where the term "Full refund" appears next to certain benefits, the refund is subject to the maximum

plan benefit, if one applies to your plan(s). All limits are per member, per Insurance Period, unless otherwise stated in your Table of Benefits.

Benefit limits for "Routine maternity" and "Complications of pregnancy and childbirth" are payable on either a "per pregnancy" or "per Insurance Period" basis (this will be confirmed in your Table of Benefits). If your benefit is payable on a "per pregnancy" basis and a pregnancy spans two Insurance Periods, please note that if a change is applied to the benefit limit at policy renewal, the following will apply:

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

## 4. Area of cover

You can avail of treatment in any country within your geographical area of cover (your area of cover is confirmed in your Insurance Policy).

If the necessary medical treatment for which you are covered is not available locally, you can avail of treatment in any country within your geographical area of cover (your area of cover is confirmed in your Insurance Policy). In relation to your travel costs please refer to Paragraph 8 ("Medical repatriation/evacuation").

If the necessary medical treatment for which you are covered is available locally, but you choose to travel to another country within your geographical area of cover for treatment, we will reimburse all eligible medical costs incurred within the terms of your policy; however, we will not pay for travel expenses.

## 5. Accommodation costs for one parent staying in hospital with an insured child

The "**Accommodation costs for one parent staying in hospital with an insured child**" benefit (part of the Core Plan and included in your insurance cover) 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.

## 6. Emergency treatments

Cover under the **emergency benefits** is only for acute emergency healthcare needs in which you may incur. Only treatment necessary to commence within 24 hours of the emergency event will be covered, when deemed medically necessary by a doctor and carried out by a registered physician. Cover is only provided in the event of a medical emergency (see definition 1.19) due to an accident, disaster or any sudden beginning or worsening of a severe unforeseen illness, resulting in a medical condition that presents an immediate threat to the insured's health and which requires urgent medical treatment. Cover under those benefits only include the treatment of the immediate emergency and does not include follow up treatment, which will have to be covered under the regular benefits of your plan. This benefit does not include treatments which are necessary due to a pregnancy or any other exclusion.

## 7. Maternity cover

a. **Routine maternity** refers to any medically necessary costs incurred during pregnancy and childbirth, including hospital charges, specialist fees, the mother's pre- and post-natal care, midwife fees (during labour only) as well as newborn care. Costs related to complications of pregnancy or complications of childbirth are not payable under routine maternity. In addition, any non-medically necessary caesarean sections will be covered up to the cost of a routine delivery in the same hospital, subject to any benefit limit in place. If the home delivery benefit is included in your plan, a lump sum up to the amount specified in the Table of Benefits will be paid in the event of a home delivery.

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

c. **Complications of pregnancy** relates to the health of the mother. Only the following complications that arise during the pre-natal stages of pregnancy are covered:
   - Ectopic pregnancy.
   - Gestational diabetes.
   - Pre-eclampsia.
   - Miscarriage.
   - Threatened miscarriage.
   - Stillbirth and hydatidiform mole.

d. **Newborn care** includes customary examinations required to assess the integrity and basic function of the child's organs and skeletal structures. These essential examinations are carried out immediately following birth. Further preventive diagnostic procedures, such as routine swabs, blood typing and hearing tests, are not covered. Any medically necessary follow-up investigations and treatment are covered under the newborn's own policy.

e. In-patient treatment for **multiple birth babies born as a result of medically assisted reproduction** will be covered up to CHF39,000 per child for the first three months following birth. Out-patient treatment will be covered under the limits of the Out-patient Plan.

## 8. Medical repatriation/evacuation

a. **Medical repatriation** (see definition 1.42) is an optional level of cover and where provided will be shown in the Table of Benefits.

b. **Medical evacuation** (see definition 1.38) forms part of your Core Plan and therefore is included in your insurance cover.

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

d. Where the necessary treatment for which the insured person is covered is not available locally, we will repatriate/evacuate the insured person.

e. The medical evacuation of the insured person will occur to the nearest appropriate medical centre (which may or may not be located in the insured person's home country).
**or**
The medical repatriation of the insured person will occur to their home country to an appropriate medical centre.

f. This can be carried out by ambulance, helicopter or airplane. The medical evacuation, which should be requested by your physician, will be carried out in the most economical way having regard to the medical condition. Cover for any such event refers to the principle of proportionality which takes into account an efficient cost-benefit ratio as well as the safety of all parties involved.

g. Following completion of treatment, we will also cover the cost of the return trip, at economy rates, for the evacuated member to return to his/her principal country of residence.

h. Where adequately screened blood is not available locally, we will, where appropriate, endeavour to locate and transport screened blood and sterile transfusion equipment, where this is advised by the treating physician. We will also endeavour to do this when our medical experts so advise. If adequately screened blood is unavailable in the event of an emergency. We will evacuate or repatriate the insured person, if possible. We and our agents accept no liability in the event that such endeavours are unsuccessful or in the event that contaminated blood or equipment is used by the treating authority.

i. If medical necessity prevents the insured person from undertaking the evacuation or transportation following discharge from an in-patient episode of care, we will cover the cost of hotel accommodation up to a maximum of seven days, comprising of a private room with en-suite facilities. We cover the costs up to a standard three star hotel room and the hotel accommodation for the accompanying person.

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

k. Travel expenses refer to the transportation costs (economy class) if it is not possible to accompany the evacuated or repatriated person in the same transportation, then a round trip transport at economy rates will be paid for. In the event of a member's repatriation/evacuation, the reasonable transportation costs of a person of their choosing/family member will only be covered. Cover does not extend to hotel accommodation or other related expenses.

## 9. Repatriation of mortal remains

The "Repatriation of mortal remains" benefit (part of the Core Plan and included in your insurance cover) 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, unless this is listed as a specific benefit in your Table of Benefits.

# II. Definitions

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

1.01 **Accident** is a sudden, unexpected, unintentional event which causes harm due to an exceptional external cause to the human body which results in an impairment of physical, mental or psychological health or death. (ATSG, Article 4 "Unfall").

1.02 **Acute** refers to sudden onset.

1.03 **Chronic condition** is defined as a sickness, illness, disease or injury that at least once a year, is treated by a doctor, is monitored or controlled (check-up or treatment), is of a recurring nature, for which a generally accepted cure is not known and responds to treatments only to a limited extent.

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

1.04 **Company Agreement** is the collective insurance agreement we have with the Policyholder, which allows the principal insured employees and their 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.

1.05 **Complementary treatment** refers to therapeutic and diagnostic treatment that exists outside the institutions where conventional Western medicine is taught. 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 practiced by approved therapists.

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

1.07 **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.

1.08 **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 Period, unless indicated otherwise in the Table of Benefits. Deductibles may apply individually to the Core, Out-patient, Maternity, Dental or Repatriation Plans, or to a combination of these plans.

1.09 **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.

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

1.11 **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.

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

1.13 **Dependant** is the principal insured employee's spouse or partner (including same sex partner) and/or unmarried children (including any step, foster or adopted child) financially dependant on the principal insured employee 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 the Insurance Policy as one of the principal insured employee's dependants.

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

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

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

1.17 **Disease** is any impairment of physical, mental or psychological health which is not the result of an accident and which requires a medical examination, treatment or results in an incapacity to work. The congenital conditions are the diseases which are existing upon birth of a child. (ATSG, Article 3 "Krankheit").

1.18 **Domicile** is the residence of a person who is located in the place where they are with the intention of staying permanently and is defined in the Swiss Civil Code (Schweizerisches Zivilgesetzbuch) (Articles 23 – 26, SR 210).

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

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

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

1.22 **Family member** is a first degree relative, who is a spouse, parent, brother, sister or a child including adopted children, fostered children or step children.

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

1.24 **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).

1.25 **Home country** is the country of origin or country of citizenship of the insured person.

1.26 **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.

1.27 **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.

1.28 **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. In the case of InVitro Fertilization (IVF), cover is limited to the amount specified in the Table of Benefits. If the Table of Benefits does not have a specific benefit for infertility treatment, cover is limited to non-invasive investigations into the cause of infertility, within the limits of your Out-patient Plan (if selected). Please note that for multiple birth babies born as a result of medically assisted reproduction, in-patient treatment is limited to CHF 39,000 per child for the first three months following birth. Out-patient treatment is paid within the terms of the Out-patient Plan.

1.29 **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 to either the member directly or any insurer. Cover is limited to the amount and maximum number of nights specified in the Table of Benefits and is payable upon discharge from hospital.

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

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

1.32 **Insurance Period** applies from the effective date of the insurance, as indicated on the Insurance Policy, and always ends on the 31st of December. Please refer to Paragraph 8, "Lifecycle of your policy" on page 22.

1.33 **Insured person** is the principal insured employee and his/her dependants as stated on the Insurance Policy.

1.34 **Insurer** is AWP P&C S.A., Saint-Ouen (Paris), Wallisellen Branch (Switzerland).

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

1.36 **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.

1.37 **Long term care** refers to care over an extended period of time after the acute treatment has been completed, usually for a chronic condition or disability requiring periodic, intermittent or continuous care. Long term care can be provided at home, in the community, in a hospital or in a nursing home. Please note that treatments provided in a health resort or spa are excluded.

1.38 **Medical evacuation** is transportation to the nearest suitable medical center by either local ambulance, helicopter or airplane. Please refer to "Your cover" section for further details.

1.39 **Medical necessity** refers to medical treatment, services or supplies that are objectively determined to be medically necessary and appropriate by a medical practitioner. 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. 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 the patient or his/her physician.
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 a patient's medical condition.
h. Provided only for an appropriate duration of time.

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

1.40 **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.

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

1.42 **Medical repatriation** is transportation to your home country for a treatment in a suitable medical centre by either ambulance, helicopter or aeroplane. Please refer to "Your cover" section for for further details.

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

1.44 **Non-prescribed physiotherapy** refers to treatment by a registered physiotherapist where referral by a medical practitioner has not been obtained prior to undergoing treatment. Where this benefit applies, cover is limited to the number of sessions indicated in your Table of Benefits. Additional sessions required over and above this limit must be prescribed in order for cover to continue; these sessions will be subject to the prescribed physiotherapy benefit limit. Physiotherapy does not include the following treatments: Rolfing, Massage, Pilates, Fango and Milta therapy.

1.45 **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 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.

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

1.47 **Occupational therapy** refers to treatment that addresses the individual's development of fine and gross motor skills, sensory integration, coordination, balance and other skills such as dressing, eating, grooming, etc. in order to aid daily living and improve interactions with the physical and social world. A progress report is required after 20 sessions.

1.48 **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.

1.49 **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.

1.50 **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 and orthognathic surgeries for the correction of malocclusion, even if performed by an oral and maxillofacial surgeon, are not covered unless a Dental Plan has also been selected.

1.51 **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.

1.52 **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.

1.53 **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.

1.54 **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.

1.55 **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.

1.56 **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. Please note treatments provided in a health resort or spa are excluded.

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

1.58 **Podiatry** refers to medically necessary treatment carried out by a State Registered Podiatrist with an academic degree.

1.59 **Policyholder** is the employer of the principal insured employee who is a party to the Company Agreement with the insurer. The Policyholder is also referred to as the company.

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

1.61 **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 and which are captured on the Application Form (Articles 4 and 5 VVG). Such pre-existing conditions are subject to full disclosure and medical underwriting. If such pre-existing conditions are not disclosed, your policy will be cancelled (Article 6 and Article 98 VVG). Please refer to your Insurance Policy to confirm which pre-existing conditions are covered.

1.62 **Pregnancy** refers to the period of time from the date of the first diagnosis until delivery. Please refer to "Your cover" section for for further details.

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

1.64 **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 Period) and for lenses or glasses to correct vision.

1.65 **Prescribed medical aids** are prescribed, medically necessary and factual medical devices, which replace, facilitate or supplement impaired body functions, and support the insured in their physical functions in everyday life. In addition to the medical necessity (see definition 1.39), the following criteria must be met:

- Ensuring the success of the treatment and the adjustment of the disability on the one hand.
  **and**
- Whilst supporting the care, alleviating the complaints or facilitating a more independent lifestyle.

Costs for medical aids that form part of palliative care or long term care (see definitions 1.56 and 1.37) are not covered.

1.66 **Prescribed physiotherapy** refers to treatment by a registered physiotherapist following referral by a medical practitioner. Physiotherapy is initially restricted to 24 sessions per condition, after which the treatment must be reviewed by the referring medical practitioner. Should further sessions be required, a new progress report must be submitted to us which indicates the medical necessity for any further treatment. Physiotherapy prescribed following an in-patent treatment will be covered under the Rehabilitation treatment benefit.

1.67 **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.

1.68 **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.

1.69 **Principal insured employee** is the employee of the Policyholder (company) as stated on the Insurance Policy.

1.70 **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.

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

1.72 **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.

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

1.74 **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).

1.75 **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.

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

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

1.78 **Vaccinations** refer to all basic immunisations and booster injections required or recommended by the Authorities (Health Ministry, Foreign Ministry) in Switzerland or the destination of the travel, any medically necessary travel vaccinations and malaria prophylaxis. The cost of the consultation for administering the vaccine, as well as the cost of the drug, is covered.

1.79 **VVG** refers to Versicherungsvertragsgesetz, a federal law for insurance contracts in Switzerland.

1.80 **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.

1.81 **We/Our/Us** is AWP P&C S.A., Saint-Ouen (Paris), Wallisellen Branch (Switzerland).

1.82 **You/Your** refers to the eligible insured person(s) stated on the Insurance Policy.

# III. 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. This does not apply to complementary treatment methods if they form part of your cover.

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.

4. In **case of gross negligence or deliberate cause of an accident**, particularly in the case of abusive use of alcohol and other drugs, benefits may be reduced or refused in serious cases.

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

6. **Complementary treatment**, with the exception of those treatment methods 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 veneers** and related procedures.

10. **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.

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

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

13. **Genetic testing**, except: a) where specific genetic tests are included within your plan; b) where DNA tests are directly linked to an eligible amniocentesis i.e. in the case of women aged 35 or over; c) testing for genetic receptor of tumours is covered.

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. **Infertility treatment** including medically assisted reproduction or any adverse consequences thereof, unless you have a specific benefit for infertility treatment, or an Out-patient Plan has been selected (whereby you are covered for non-invasive investigations into the cause of infertility within the limits of your Out-patient Plan).

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. **Orthomolecular treatment** (please refer to definition 1.53).

22. In relation to underwritten groups, **pre-existing conditions** (including any pre-existing chronic conditions, see definition 1.61) that are expressly excluded in the Insurance Policy.

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

24. 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.

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

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

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

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

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

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

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

32. Treatment for any illnesses, diseases or injuries, as well as instances of death resulting from **active participation in war, warlike acts and incidents (whether war has been declared or not), riots, civil disturbances, terrorism, criminal acts** or **illegal acts.**

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

34. 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.

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

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

37. Treatment **outside the geographical area of cover** unless for emergencies.

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

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

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

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

42. **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.

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

    43.01 Dental treatment, dental surgery, periodontics, orthodontics and dental prostheses with the exception of oral and maxillofacial surgical procedures, which are covered within the overall limit of your Core Plan.
    43.02 Dietician fees.
    43.03 Emergency dental treatment.
    43.04 Expenses for one person accompanying an evacuated/repatriated person.
    43.05 Health and wellbeing checks including screening for the early detection of illness or disease.
    43.06 Home delivery.
    43.07 Infertility treatment.
    43.08 In-patient psychiatry and psychotherapy treatment.
    43.09 Medical repatriation.
    43.10 Organ transplant.
    43.11 Out-patient psychiatry and psychotherapy treatment.
    43.12 Out-patient treatment.
    43.13 Pregnancy and childbirth.
    43.14 Prescribed glasses and contact lenses including eye examination.
    43.15 Prescribed medical aids.
    43.16 Preventive treatment.
    43.17 Rehabilitation treatment.

43.18 Travel costs of insured family members in the event of an evacuation/repatriation.
43.19 Travel costs of insured family members in the event of the repatriation of mortal remains.
43.20 Travel costs of insured members to be with a family member who is at peril of death or who has died.
43.21 Vaccinations.

# IV. General terms

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

1. **Applicable law:** Unless otherwise required under mandatory legal regulations your membership is governed by the Swiss law, in particular the federal law for insurance contracts "Versicherungsvertragsgesetz, VVG". Any dispute that cannot otherwise be resolved will be dealt with by the courts at the Swiss domicile of the insured person (or the person with an entitlement to claim) or at the domicile of the Insurer.

2. **Legal action:** All legal actions arising under this policy shall have a time limit of two years from the date of the event that gave rise to the action (Article 46 VVG).

3. **Applicable sanctions:** This policy may not provide any cover or benefit to the extent that either the cover or benefit would violate any applicable sanction, law or regulations of the United Nations, the European Union, Switzerland or any other applicable economic or trade sanction, law or regulation.

4. **Data protection**
   a. The processing of personal data is essential to the transaction of insurance business. In the processing of personal data, we comply with the Swiss Data Protection Act (DPA). If necessary, we obtain any required permission to data processing from the insured person. The personal data processed by us include data relating to and 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. In the first instance, information on the insured person is taken from the point of application. We also process personal data in connection with product enhancements, as well as for our own marketing purposes.

   b. In order to offer affordable comprehensive insurance cover, our services may partly be provided by legally independent firms both domestically and abroad. These may be Allianz Group companies or partners. For the purposes of fulfilling its contractual obligations, we are bound to exchange data both within the group and outside the group. We store data electronically or physically in compliance with the applicable and relevant legal provisions. Insured persons whose personal data we process, have the right in accordance with the Data Protection Act to ask whether and what data concerning them we actually process and may also request rectification of incorrect data.

## 5. Changes to your policy and unconditional acceptance of policy terms

a. In line with the Company Agreement, we may alter both the Employee Benefit Guide and/or the Table of Benefits from time to time but no alteration shall take effect until the next annual renewal of the Company Agreement. The Insurer shall notify such changes to the insured person in writing at renewal.

b. If the contents of the policy or amendments are inconsistent with what was agreed by the Policyholder and the insurer, the Policyholder must request the correction thereof within four weeks of receipt of the policy terms and conditions. Should the Policyholder fail to request the correction of the content, the content shall be deemed to be accepted by the Policyholder (Article 12 VVG).

## 6. Premium

a. In most cases, the Policyholder is responsible for the payment of premiums to us for the membership of the insured persons covered under the Company Agreement, together with any amount that may be due and payable in respect of membership.

b. Premiums for each Insurance Period are based on several factors which may include the region of cover, the insured person's country of residence, the premium rates in effect and other risk factors which may materially affect the insurance, unless agreed otherwise in the Company Agreement.

c. By accepting cover the Policyholder has agreed to pay the premium amount as per quotation, by the payment method stated. Payments may be made on monthly, quarterly, half-yearly or annual basis depending on the chosen payment method. Please note that we are not responsible for payments made through third parties.

d. The following payment dates apply, unless agreed otherwise in the Company Agreement:

| Payment frequency: | Due date: |
|---|---|
| Monthly | First day of each month |
| Quarterly | First day of each quarter |
| Half-yearly | 1st of July and 1st of January |
| Annual | 1st of January |

e. If your insurance starts in the current year, the premium payment for the first installment or the entire contribution (depending on the chosen payment frequency) is due on the first day of your insurance cover, unless agreed otherwise in the Company Agreement.

f. If the initial or subsequent premium is not paid in time in full, we shall suspend your cover 14 days after we have provided the final written reminder (Articles 20 – 21 VVG). If we do not take legal action to recover the premium, the policy shall be deemed automatically cancelled two months after the expiry of the 14 day notice period (Articles 20 – 21 VVG) and no further termination letter will be issued.

We will inform insured persons if cover is suspended or the policy is cancelled as a result of non payment of premium on the part of the Policyholder in accordance with the paragraph above.

g. The premium can be adjusted annually due to evolving health costs and the costs of claims. We will inform the Policyholder of the new premium by the 31st of October. In the event the Policyholder wishes to cancel your cover with us, the Policyholder will be able to do so by notifying us in writing by the 30th of November.

h. In the case of premature termination or termination of the Company Agreement, Article 24 VVG shall apply.

i. Claims against us can not be offset against the premium.

## 7. Change to country of residence

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

b. Please note that cover in some countries is subject to local health insurance restrictions, particularly for residents of that country. It is your responsibility to ensure that your healthcare cover is legally appropriate. If you are in any doubt, please seek independent legal advice as we may no longer be able to provide you with cover. The cover we provide is not a substitute for local compulsory health insurance e.g. for members resident in Switzerland, our cover is not a legally appropriate substitute for Swiss compulsory health insurance (KVG).

## 8. Lifecycle of your policy

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

b. The insurance contract runs until December 31st of each year. The contract renews on a tacit basis for a further year, unless agreed otherwise in your Company Agreement.

c. Please inform us in the event that you are not covered or no longer covered under compulsory Swiss health and accident insurance (KVG and UVG). Please note that in this instance we reserve the right to cancel your insurance cover.

   We are only liable for the costs which are not covered under compulsory Swiss health and accident insurance. If you do not hold or have ceased to hold such insurance cover or if you are not eligible for cover, we are not liable for costs that would have been covered under compulsory Swiss health and accident insurance.

d. The policy is only valid to those persons as described in the Company Agreement. The Policyholder can end the membership of any insured person by notifying us in writing.

   Your membership will automatically end:
   - At the end of the Insurance Period, if the agreement between the Insurer and the Policyholder is terminated.
   - If the Policyholder decides to end the cover of the insured person.
   - If the Policyholder does not pay premiums or any other payment due under the Company Agreement.
   - When the principal insured employee stops working for the Policyholder.
   - Upon the death of the insured person.

   For rules on continuation of cover please refer to Paragraph 9 on "Continuation of cover".

   The Policyholder shall advise the insured persons immediately if for any reason the Company Agreement should not be renewed or if the Company Agreement should be terminated so that such insured persons are made aware that all cover has ceased and that benefits will not be payable in respect of insured persons. The Policyholder shall also advise the insured persons of any continuation of cover options available to them.

   We shall also inform the insured persons if for any reason the Company Agreement should not be renewed or if the Company Agreement should be terminated as well as any continuation of cover options available to the insured persons.

e. You may terminate your cover by giving three months notice to the end of a calendar year. The notice of termination is valid if it has been received by registered post before expiry of the notice period, at the latest on the 30th of September. Please note any change or cancelation requests in regards to your Policy have to come through the Group Scheme Manager.

   In line with the Company Agreement, the Policyholder or the Insurer can cancel the Company Agreement (and consequently your cover) with effect from the next renewal date by giving three months prior written notice to the other party.

We waive the statutory right to terminate the policy of the insured persons in the event of a claim under Article 42 VVG. The Policyholder's right to termination remains unaffected.

f. In the unfortunate event that a principal insured employee or a dependant passes away, please inform us in writing within 28 days. For premium refunds please refer to Paragraph 6.h on "Premium".

g. We may cancel your insurance contract in the event of fraud or non-disclosure by the insured person, in line with Swiss law. In the event of non-disclosure, we may cancel your insurance contract in accordance with Articles 4 - 6 VVG and Article 40 VVG. We will write to inform you of the cancellation of your policy within four weeks of the date of discovery of the non-disclosure (Article 6 VVG). Please also refer to Paragraph 23 on "Fraud and non-disclosure".

h. Please note that if your membership ceases, your dependants' cover will also end.

i. Any change or cancelation requests in regards to your policy have to come through the Group Scheme Manager.

9. **Continuation of cover:** If a principal insured employee's cover under the Company Agreement comes to an end, for whatever reason (including the termination or non-renewal of the Company Agreement), the principal insured employee can apply for cover under one of the insurer's "Suisse International Healthcare Plans" for Individuals. The individual policy will not be subject to underwriting if insurance coverage is equivalent (i.e. you have the "Suisse Premier" plan then you can choose "Suisse Premier Individual" or if on the "Suisse Club" plan you can be set up on the "Suisse Club Individual"). The application must be submitted within one month of leaving the collective scheme. The commencement date, if accepted for cover, will be the first day after leaving the collective scheme.

10. **Direct right to claim:** The insured person has a direct right to submit a claim to the Insurer as soon as an eligible insured event occurs in line with the terms of the collective health insurance agreement (Article 87 VVG).

11. **Claims process**

a. The insured person shall submit any claim(s) to us no later than two years after the treatment date. Beyond this time we are not obliged to settle the claim (Article 46 VVG).

b. Your claim will be processed within four weeks of receipt (Article 41 VVG).

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

d. 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.

e. 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.

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

g. 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.

h. 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.

i. You and your dependants agree to assist us in obtaining all necessary information to process a claim. With your prior consent 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.

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

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

b. 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.

c. 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.

**13. Complaints:** 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:

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

If we have been unable to resolve the matter to your satisfaction and you wish to take it further, you can refer your complaint to the Stiftung Ombudsman der Privatversicherung und der SUVA / Ombudsman de l'assurance privée et de la SUVA.

Address: Postfach 2646, 8022 Zürich

Please note that this does not affect your statutory rights under Swiss law or your right to refer the matter before the Swiss courts.

**14. 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.

If you wish to contact us via post please write to the following address:
AWP P&C S.A., Wallisellen branch (Switzerland), Hertistrasse 2, 8304 Wallisellen.

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

**16. 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.

**17. 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 principal insured employee, 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 principal insured employee.

**18. Adding dependants**

a. You may apply to include any of your family members on the policy by completing the relevant application form and with the approval of the Policyholder.

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

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

d. For underwritten groups, following acceptance by our Underwriting Team, we will issue a new Insurance Policy 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 Policy.

**19. Changes to principal insured employee:** If a request is made at renewal to change the principal insured employee, the proposed replacement principal insured employee will be required to complete the relevant application form and full medical underwriting will apply (for underwritten groups only). Please refer to Paragraph 8 on "Lifecycle of your policy" if the requested change is due to the death of the principal insured employee.

**20. Force majeure:** We shall not be liable for any failure or delay in the performance of our obligations under the terms of this policy, due to the following unpredictable, unforeseeable and unavoidable events: 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.

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

**22. Double insurance and subsidiarity**

a. We provide our insurance obligations/benefits following reimbursement of benefits by social insurers or other private insurers or other liable parties. If other private insurers are liable to provide benefits following reimbursement of others parties, we shall render benefits based on the amount of the benefit insured by us in proportion to the amount of the benefit insured by all liable insurers (Article 71 VVG). If a social insurer is compulsorily liable and we have provided initial insurance cover, we retain the right of reimbursement from either you or the social insurer.

b. If liable third parties have an obligation to provide benefits for the consequences of illness or accident, we only guarantee to provide our benefits as advance payments and under the condition that the insured person transfers their claims against liable third parties to us up to the amount of the benefits rendered by us. If the insured person makes any agreement with liable third parties, in which they partly or wholly waive their claims to insurance benefits or compensation, without our consent, their entitlement to benefits from us becomes null and void.

**23. Fraud and non-disclosure**

a. Incorrect disclosure/non-disclosure of any material facts, by you or your dependants, which affects our assessment of the risk and which should be captured on the relevant application form may result in the cancellation of the insurance contract. We will write to you to inform you of the cancellation of your policy within four weeks of the date of discovery of the non-disclosure (Article 6 VVG).

b. If the contract is cancelled due to incorrect disclosure or non-disclosure of any material facts (according to Article 6 VVG), the premium will be refunded.

c. If a claim is, in any respect, false, fraudulent, intentionally exaggerated or if fraudulent means/devices have been used by you or your dependants or anyone acting on your or their behalf to obtain benefit under this policy, we will not pay any benefits for that claim.

d. We reserve the right to inform the Policyholder of any fraudulent activity subject to Data Protection obligations.

e. In the event of fraudulent claims, your cover will be cancelled by us in writing from the date of our discovery of the fraudulent event and the amount of any fraudulent claims paid can be reclaimed by the Insurer (Article 40 VVG).

# 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

# Getting treatment

## Treatment within Switzerland

If you need to obtain pre approval for the in-patient treatment, enquire about claim settlement or require assistance with treatments inside Switzerland please contact your local insurer, KPT (contact details can be found at the end of this guide).

## Treatment outside Switzerland

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

### Remember, some treatments require pre-authorisation

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

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

*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 25 and 26 of this guide.*

## Evacuations and repatriations

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

## Getting in-patient treatment

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

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

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

## Getting out-patient or dental treatment

When you visit a doctor, dentist, physician or specialist on an out-patient basis, please settle the bill with them and claim back the eligible expenses from us.

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

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

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

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

*Please refer to the "Claim process" paragraph on page 24 of this guide for additional important information about our claims process.*

## Treatment in the USA

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

# Useful services

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.

# Contact details

**KPT (for information and assistance with treatments inside Switzerland):**

Telephone: + 41 (0)58 310 98 25
Email: awc.member@kpt.ch
Fax: + 41 (0)58 310 88 25

Address: KPT/CPT, Team International 2, Postfach, CH-3001 Bern

**Allianz Worldwide Care (for information and assistance with treatments outside Switzerland, evacuations and repatriations):**

24/7 Helpline: + 353 1 630 1301
Email: client.services@allianzworldwidecare.com
Fax: + 353 1 630 1306

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

www.allianz-assistance.ch/healthcare

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

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