United Nations Office at Vienna United Nations Office on Drugs and Crime

Division for Management
Human Resources Management Service

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Information circular

Group Medical Insurance and Temporary Disability Insurance Plans

1. General provisions

As a result of the tender on the United Nations Industrial Development Organization (UNIDO) and United Nations Office at Vienna (UNOV) Group Medical Insurance Plan (Full Medical Insurance Plan (FMIP) and Supplementary Medical Insurance Plan (SMIP)) and Temporary Disability Insurance Plan in 2012, UNIDO signed a contract covering the period from 1 January 2013 to 31 December 2015 that allowed for an increase in several benefit ceilings within the existing budget. The contract has now been extended for an additional four years, from 1 January 2016 to 31 December 2019; during that period, Allianz Worldwide Care SA will continue as the insurer and Allianz Worldwide Care Services as the claims administrator.

This circular reflects changes in individual premiums effective 1 January 2016 and includes additional clarifications related to participation in the Group Medical Insurance Plan and the Temporary Disability Insurance Plan (see paragraphs 5-14 below). There are no changes to the eligibility conditions or the plan benefits.

2. Medical insurance (FMIP and SMIP) — individual premiums

(a) The last increase of the individual medical insurance premium percentages took place at the beginning of 2012; it was necessary to adjust the premiums again, effective 1 January 2016. An increase of 2.31 per cent in individual premiums will be required for the Group Medical Insurance Plan (FMIP and SMIP).

(b) As the individual premiums collected by the organizations are expected to be as close as possible to the contractual premiums payable to the insurer — despite the changes in the insured population — the individual premiums will continue to be reviewed on a quarterly basis and adjusted for the next quarter, if required.

(c) Individual premiums are payable per month and are not prorated per working day. As part of its social security policy, the Organization pays half of the total cost of the individual premiums of staff members and eligible dependants. There are three categories of coverage, depending on the number of insured persons. Effective 1 January 2016, the share of the monthly premiums to

be borne by the staff members enrolled in either of the group medical insurance plans, expressed as a percentage of their emoluments,[1] will be as follows:

Category	Insured persons	FMIP	SMIP
		(Percentage)	
I	Staff member only	3.1531	2.4149
II	Staff member and one dependant	4.7296	3.6221
III	Staff member and two or more dependants	6.3056	4.8299

The same share will be borne by the Organization as a subsidy. Staff members employed on a part-time basis are subject to the provisions of ST/AI/291/Rev.1.

3. Temporary Disability Insurance Plan insurance premiums

(a) The Temporary Disability Insurance Plan is supplementary to the Group Medical Insurance Plan. Coverage is voluntary and available to participants in one of the medical insurance plans offered by the Organization who hold fixed-term, probationary, permanent or continuing contracts. Such participants may enrol for temporary disability insurance upon taking up their first appointment of one year or longer or upon completing one year of continuous service. As of 1 January 2016, an increase of 2.01 per cent in individual premiums will be required.

(b) Effective 1 January 2016, the share of the monthly premiums to be borne by staff members enrolled in the plan, expressed as a percentage of their emoluments (net base salary plus post adjustment and all allowances), will be as follows:

0.1652 per cent of emoluments for the first five years of participation in the plan;
0.1326 per cent of emoluments thereafter.

4. Premium structure for "other insured persons"

(a) The individual premiums for "other insured persons", which have not changed for the past four years, will increase by 2.31 per cent from 1 January 2016 and will be as follows (see also paragraph 10 below):

Age	Male	Female
	€	€
16-30	198.48	281.40
31-45	238.54	321.67
46-55	281.40	345.52
56-60	321.67	345.52
61-65	361.96	345.52
over 65	407.36	370.16

[1] (a) Active participants: net base salary plus all allowances received during or projected for the claim period;
(b) After-Service Health Insurance participants: the annual retirement benefit used to calculate After-Service Health Insurance contributions and any emoluments from assignments in an organization of the United Nations system in the calendar year in which the claim period commences.

Children (<16 years)	
Age	**€**
1	144.65
2	284.28
>2	399.25

5. Useful information related to the Group Medical Insurance Plan (FMIP and SMIP)

Claims procedure

(a) Claims can be submitted directly to Allianz Worldwide Care Services (see also the special message on the pilot project on electronic claim submission, issued on 13 March 2015) or in special pre-addressed envelopes through the internal mail service. The envelopes are forwarded to Allianz Worldwide Care Services by DHL twice a week.

(b) Claim forms can be downloaded from the Allianz Worldwide Care Services website at https://my.allianzworldwidecare.com, using the participant's personal login details.

(c) For a full description of the claims procedure, participants can refer to the Benefits Guide at www.unodc.org/intranet_hrms/en/staff_admin/Social_Security_index.html or at https://my.allianzworldwidecare.com (using their personal login details).

The Benefits Guide includes contact information for emergency medical treatment while in the United States of America, namely Olympus Managed Health Care, whose helpline number is (+1) 800 541 1983.

(d) For assistance in case of problems logging in to the Allianz website, participants can contact Allianz Worldwide Care Services by telephone on +800 1 629 1777 (toll free from Australia, Austria, Belgium, Canada, China, France, Germany, Italy, Japan, Spain, Switzerland, the United Kingdom of Great Britain and Northern Ireland and the United States) or +32 2 210 6557 (worldwide). The helpline operates 24 hours a day, seven days a week.

Benefits and reimbursements

(e) Plan benefits are listed in the annex to the present circular.

(f) Medical expenses are reimbursed in accordance with the rates and treatment ceilings indicated in the annex. Full coverage for benefits is provided as of the first day of enrolment; no waiting period applies. Claims must be submitted no later than two years after the treatment date.

(g) Reimbursements are made directly to the bank account provided by the participant on the claim form. In order to avoid delays in the settlement of claims, it is essential to indicate the IBAN and BIC (Swift) codes on the claim form.

Major (catastrophic) medical expenses

(h) Reimbursement of 100 per cent of major (catastrophic) medical expenses applies to the uncovered portion of reimbursable medical expenses incurred during a consecutive 12-month period within the previous two years that exceeds 5 per cent of the annual emoluments on the basis of which the participant's medical insurance contribution is calculated.

(i) Any expenses exceeding the established treatment ceilings, excluded treatments, costs of first-class hospitalization (if this was the patient's own choice) and uncovered costs incurred by "other insured persons" cannot be taken into consideration in calculating eligibility for the reimbursement of major (catastrophic) medical expenses.

(j) Further information on major (catastrophic) medical expenses can be obtained from the Social Security team of the Staff Administration Unit (extensions 4213 and 3087) and from the Benefits Guide, which is available at www.unodc.org/intranet_hrms/en/staff_admin/Social_Security_index.html or at https://my.allianzworldwidecare.com (participant's personal login details required).

Cost containment

(k) Participants are reminded that their choice of medical providers and products, and the choice made by their eligible dependants, has a direct impact on the performance of the Group Medical Insurance Plan. Making an active effort to be cost-conscious with respect to medical expenses therefore remains the most effective means of limiting uncovered expenses and future premium increases. Participants are encouraged to use the providers in Vienna that offer preferential rates to members insured by Allianz Worldwide Care Services.

Preferred providers and others offering discount rates

(l) To find a global list of hospitals, doctors and health practitioners, participants can refer to the "Find a treatment provider" section of the Members Area on the Allianz Worldwide Care Services website (www.allianzworldwidecare.com). A detailed list of preferred providers in Vienna that offer preferential rates can be found by logging in to the website and going to the "Forms and other documents" section.

6. Communications

(a) Participants should address any enquiries concerning coverage and any requests for clarification of reimbursements directly to Allianz Worldwide Care Services. Enquiries concerning hospital bills and their reimbursement should be addressed first to the hospital concerned and then to Allianz Worldwide Care Services.

(b) Participants and their eligible dependants may identify themselves as being insured by Allianz Worldwide Care Services by presenting their membership card. Should that not be considered sufficient by the provider, the Social Security team of the Staff Administration Unit or Allianz Worldwide Care Services can be contacted to issue a certificate of coverage. The certificate can also be printed from the Allianz online services website, which can be accessed by participants using their personal login details at https://my.allianzworldwidecare.com.

(c) Further information on this subject is available in the Benefits Guide (www.unodc.org/intranet_hrms/en/staff_admin/Social_Security_index.html) or on https://my.allianzworldwidecare.com (participant's personal login details required).

7. Allianz Worldwide Care Services contact details

Toll-free hotline for telephone calls made from Australia, Austria, Belgium, Canada, China, France, Germany, Italy, Japan, Spain, Switzerland, the United Kingdom and the United States.	**+800 1 629 1777** ***The helpline operates 24 hours a day, seven days a week***
Telephone number for calls made from anywhere in the world:	**+32 2 210 6557**
Fax number:	**+32 2 210 6594**
E-mail address:	**UNIDO-UNOV@allianzworldwidecare.com**
Allianz Worldwide Care Services website (personal login required):	**https://my.allianzworldwidecare.com**
Address: (until further notice, the address 35 rue de Laeken, Brussels, can still be used) ***Treatment in the United States***: Telephone number of Olympus Managed Health Care:	**Allianz Worldwide Care Services** **1 Place du Samedi** **1000 Brussels** **Belgium** **Olympus Managed Health Care** **(+1) 800 541 1983**

8. Eligibility criteria for enrolment in the Group Medical Insurance Plan

(a) FMIP coverage is mandatory for staff members administered by UNOV who do not have adequate medical insurance coverage, unless they elect to be covered under (i) the Austrian health insurance scheme (Wiener Gebietskrankenkasse (WGKK)) or (ii) another medical insurance scheme that provides adequate coverage. If a staff member elects to be covered under (ii), no contribution or other payments towards medical expenses shall be made by the Organization.

(b) Staff members must hold a fixed-term, permanent or continuing appointment, or a temporary appointment of three months or longer; in the case of shorter appointments, the staff member may enrol upon completing three months of continuous service.

(c) A recognized spouse of the participant may be enrolled. Only one eligible spouse may be recognized for the purposes of coverage.

(d) One or more dependent children (natural or legally adopted children, or stepchildren) who meet the definition under staff rule 3.6 and are registered in Umoja may be enrolled. A child is eligible up to the end of the calendar year in which he or she reaches 25 years of age,

provided that he or she is unmarried and resides with or is financially dependent on the participant. Disabled children may be eligible for continued coverage beyond that age, provided that they are certified disabled by the Vienna International Centre Joint Medical Service (if the parent is an active staff member) or by the United Nations Joint Staff Pension Fund (if the parent is a retiree).

(e) Recognized secondary dependants for whom a dependency allowance is paid can also be co-insured with the participant.

(f) Under certain conditions, participants who separate on account of retirement or disability, as well as the insured spouses and children of participants who have died in service, may continue coverage under the After-Service Health Insurance. Secondary dependants are not eligible for After-Service Health Insurance.

9. Enrolment and late application rules for the Group Medical Insurance Plan

(a) Unless they opt for coverage under the Austrian health insurance scheme (WGKK) or provide written proof of other adequate medical insurance coverage, new staff members are required to enrol in FMIP within 30 days of the date of their appointment.

(b) Coverage commences on the first day of the qualifying appointment. If the first day of the qualifying contract is later than the first day of the month, the participant may opt for coverage to commence on the first day of the following month. In no event may coverage commence prior to the first day of the qualifying contract.

(c) A combination of coverage under WGKK (if the staff member enrols in that scheme through UNOV/UNODC) and SMIP is possible as of the first day of the appointment. Participants who are insured with WGKK are entitled to reimbursement under SMIP only after submission of the medical expenses to WGKK. The applicable reimbursement percentages and ceilings are applied to the difference between the cost actually incurred and the reimbursement obtained from WGKK. It is the responsibility of the participant to ensure that the family members whom he or she enrols under SMIP are actually covered under WGKK or another, similar Austrian social security scheme.

(d) An application for coverage of family members may be made at the time of enrolment of the new staff member or within 30 days of the date of marriage, birth or adoption of a child, or the date a child becomes a dependant. As coverage for eligible family members is optional, participants have to provide the Social Security team with the enrolment form listing the names and birth dates of the eligible dependants they wish to be covered.

(e) Coverage for family members commences on the first day of the qualifying event. If the first day of a qualifying event occurs later than the first day of the month, the participant may opt for coverage to commence on the first day of the following month. In no event may coverage commence prior to the first day of the qualifying event.

(f) In the event that both spouses are employed by UNOV/UNODC and/or UNIDO, each spouse may be individually covered or, where one spouse is co-insured by the other, the higher-salaried staff member must be the main participant. If one spouse retires from service before the other, the spouse who remains in active service should become the main participant, even if the retired spouse had been the main participant, up to the date of retirement and is eligible for After-Service Health Insurance benefits. If both staff members have separated, and if each is eligible

for After-Service Health Insurance, the co-insurance should be carried by the former staff member with the higher pension or theoretical pension, if applicable.

(g) If a participant divorces, coverage for the spouse ceases at the end of the calendar month in which the divorce takes effect. Continued coverage may be arranged under an individual contract with the Insurer (please refer to paragraph 13 (e) below for more details).

(h) In the event that both parents are employed by UNOV/UNODC and/or UNIDO and are individually insured, their child or children must be co-insured with the higher-salaried staff member, i.e. the staff member receiving the dependency allowance for the child.

(i) Co-insured dependent children who reach 25 years of age during the participant's active service and who are still unmarried and financially dependent on the participant may continue coverage, under certain circumstances, as an "other insured person" of the participant's household (please see paragraph 10 below for more details).

(j) Secondary dependants may be enrolled within 30 days following the date on which their status as secondary dependants is recognized by UNOV/UNODC. If a secondary dependant ceases to be recognized by UNOV/UNODC, he or she may continue coverage as an "other insured person" of the participant's household (see section 10 below). Secondary dependants are not eligible for After-Service Health Insurance.

(k) Coverage of eligible staff members and/or dependants may be obtained at a date later than that stated above. In such cases, the application must be supported by a medical questionnaire completed by the applicant. The insurer has the right to ask for additional information. Applicants not meeting the medical requirements of the insurer may be refused coverage. If approved, coverage starts on the first day of the month indicated by the insurer.

(l) Staff members exercising their right to change their health insurance coverage on any of the occasions stated in the Agreement between the Republic of Austria and the United Nations on Social Security, available on the Social Security website of the UNOV Intranet (www.unodc.org/intranet_hrms/en/staff_admin/Social_Security_index.html), by electing for FMIP instead of WGKK participation, are exempt from the requirement to provide evidence of good health as normally necessary in case of a late application.

(m) The Social Security team should be notified immediately if a family or household member has ceased to be eligible, for example, a spouse upon divorce, a child marrying or taking up full-time employment, or the discontinuance of payment of a secondary dependency allowance. Participants who wish to discontinue coverage of a family member for any other reason may do so at any time, although this is discouraged. The responsibility for initiating the resulting change in coverage rests with the participant.

(n) Post-retirement appointees who are covered under the United Nations insurance plans in accordance with the After-Service Health Insurance provisions may continue such coverage, except when their appointment requires re-entry into the United Nations Joint Staff Pension Fund as a contributing participant. In such cases, the post-retirement appointee must enrol in a health plan as an active staff member. After-Service Health Insurance coverage can resume upon separation from service and reapplication within 31 days of separation, but only at the level of coverage provided prior to the reappointment. When this occurs, it is the obligation of the post-retirement appointee to notify the Social Security team immediately and to make the necessary arrangements.

10. "Other insured persons" in the Group Medical Insurance Plan

(a) "Other insured persons" are persons insured in conjunction with a staff member participating in the Group Medical Insurance Plan by virtue of the fact that they are living in the same household and are financially dependent on the staff member. Such persons may comprise (i) unmarried children over 25 years of age (a child away from home for educational purposes shall be regarded as living in the staff member's household); (ii) persons financially dependent on the staff member but not recognized as dependants as defined in the Staff Rules for the purpose of payment of a dependency allowance (i.e. parents, siblings, life companions); or (iii) non-Austrian live-in household help or domestic staff.

(b) Enrolment must be requested by the staff member on the basis of a medical questionnaire completed by the applicant. Persons not meeting the medical requirements of the insurer may be refused coverage. Coverage starts on the first day of the month following acceptance by the insurer.

(c) Persons insured as eligible dependants may convert to coverage as "other insured persons" with uninterrupted entitlement to benefits (e.g. coverage as an eligible dependant may end on 31 December of the calendar year in which a child reaches 25 years of age and coverage as an "other insured person" would commence on 1 January of the following year). No evidence of good health is required for continuous coverage.

(d) Persons whose stay in the staff member's household will be of long duration (at least one year) are entitled to benefits immediately after enrolment. The minimum length of coverage is one year.

(e) Persons whose stay in the staff member's household will be temporary (less than one year but at least six months) are only entitled to benefits three months after enrolment, except for treatment resulting from an accident sustained after the date of enrolment. The minimum length of coverage is six months.

(f) Coverage ceases when the eligibility criteria for the "other insured person" are no longer met, upon request by the staff member after the minimum length of coverage or upon separation from service of the staff member, whichever is earlier. "Other insured persons" are not eligible for After-Service Health Insurance. The Social Security team should be notified immediately of changes that affect the eligibility of "other insured persons". The responsibility for initiating the corresponding change in coverage rests with the staff member.

(g) Fixed premiums according to age and sex are payable as of the date of enrolment. The premiums for "other insured persons" are not subsidized by UNOV/UNODC and are payable in full by the staff member through payroll deduction. Premiums are subject to regular adjustments.

(h) The coverage comprises the benefits as described in the Group Medical Insurance Plan, except that the uncovered expenses in respect of the "other insured person" will not be considered in the calculation of major (catastrophic) medical expenses.

11. Medical insurance coverage during special leave

(a) Staff members on special leave with full or half pay, as well as staff members on special leave without pay not exceeding a complete calendar month, shall continue to be covered under the

health insurance plan in effect prior to their leave period. The applicable premium amount and the Organization's subsidy continue as in full pay status.

(b) In case of special leave without pay for a complete calendar month or more, continued coverage may be retained on a voluntary basis. The participant must pay both the staff member's contribution and the Organization's share as no subsidy is payable during such leave. Failure to pay the required premiums shall result in suspension of coverage. Participants who continue to pay for coverage under SMIP must remain covered by an Austrian social security scheme in order to be eligible for reimbursement.

(c) Should a staff member decide not to retain the Group Medical Insurance, coverage will be suspended for the period of leave without pay. Upon return to duty, the staff member must re-enrol under the same plan that he or she was insured under prior to the leave period.

(d) The Social Security team must be informed in writing by the staff member before commencement of the special leave without pay as to whether he or she wishes to retain or suspend insurance coverage.

12. Employment-related illness or injury

In the event of any illness or injury that may be attributable to the performance of official duties, the resulting reasonable medical, hospital and directly related expenses may be reimbursable under Appendix D to the Staff Rules, which governs compensation in the event of death, injury or illness attributable to the performance of official duties on behalf of the United Nations. In such cases, medical expenses can be paid initially under the health insurance plan of the affected staff member, subject to submission to and approval by the Advisory Board on Compensation Claims of any amount payable under the provisions of Appendix D.

13. Medical insurance coverage after separation

(a) Insurance coverage ceases at the end of the calendar month in which the date of separation occurs.

(b) Participants enrolled in FMIP may request continued coverage for up to two months after the month in which separation occurs. The request must be made to the Social Security team before separation. The period of retention must be stated on the staff separation clearance form, and the unsubsidized premiums for that period of coverage will be deducted from the staff member's final pay. Unless the coverage for a specific period is stated on the staff separation clearance form and premiums are paid, coverage will cease at the end of the month in which the date of separation occurs.

(c) Any expenses, including those related to ongoing treatments, incurred after the expiry of coverage will not be covered under the plan.

(d) Under certain conditions, participants who separate on account of retirement or disability, as well as the insured spouses and children of participants who have died in service, may continue their coverage under the After-Service Health Insurance. Eligibility rules for participation in the UNOV/UNODC After-Service Health Insurance, together with the related administrative procedures, are set out in administrative instruction ST/AI/2007/3 of 1 July 2007 and in office instruction UNOV/ODCCP/OI.1 of 12 September 2002. The combination of periods of participation of staff members exercising their right to change their medical insurance coverage

on the occasions stated in the Agreement between the Republic of Austria and the United Nations on Social Security shall count towards the minimum period of participation required for eligibility for the After-Service Health Insurance, i.e. 10 years for staff members and 2 years for dependants, provided that the other eligibility criteria are met. Further information can be obtained from the Social Security team.

(e) A "conversion privilege" is provided as part of the group medical insurance contract. This privilege allows FMIP participants who cease employment with UNOV/UNODC and do not qualify for the After-Service Health Insurance, or their co-insured dependants and "other insured persons" whose eligibility for coverage in the plan ceases, to arrange for medical coverage under an individual contract without subsidy from the Organization. This means that no evidence of good health is required and the insurer cannot refuse the application. An application must be made directly to the insurer before cessation of coverage under the Group Medical Insurance Plan. The conversion privilege is designed to provide insurance during a period of transition to more permanent medical insurance coverage and is available for a maximum of 24 months. The premiums are fixed by the insurer, taking into account the age and sex of the person to be insured and the rates applicable to individual contracts. Further information can be obtained from Allianz Worldwide Care Services or the Social Security team.

14. Fraud and abuse

(a) Participants are strongly encouraged to review their invoices carefully in order to ensure that only services rendered by their provider are billed, and to report any questionable charges to Allianz Worldwide Care Services so that these charges can be investigated.

(b) Entitlements may be wholly or partially suspended if any claim is false, fraudulent or intentionally exaggerated or if fraudulent means have been used to obtain benefits under the Group Medical Insurance Plan.

(c) Fraud constitutes misconduct under the Staff Rules, and such conduct may result, in case of proven fraud, in administrative and/or disciplinary measures and the discontinuation of the insurance coverage. Responsibility for the accuracy and correctness of claims, including by co-insured dependants and "other insured persons", always lies with the main participant.

15. The present circular is effective 1 January 2016 and supersedes UNOV/INF.251-UNODC/INF.252 of 28 December 2012.

Annex

SUMMARY OF BENEFITS OF GROUP MEDICAL INSURANCE PLAN FROM 1 JANUARY 2016

(Worldwide coverage)

Benefits	*Basic coverage (%)*	*Maximum amount reimbursed (if applicable)*	*Remarks*
1. Medical treatment, surgery, medicines and medical appliances	80		The reimbursement rate of 80 per cent applies to generally recognized medical treatment as long as no other entitlement to reimbursement by another insurer exists. If an entitlement to reimbursement by another insurer exists, the applicable percentages or ceilings are applied to the difference between the cost actually incurred and the reimbursement obtained from other sources. Prescription by a physician does not necessarily create an entitlement to reimbursement of the cost of products such as vitamin and mineral supplements, skin and dental care products or certain drugs that are not provided for by the policy, such as Viagra, Xenical and similar products.
(a) Dental and orthodontic treatment	80	€1 897	Maximum amount is per calendar year, per person, with any unspent balance from the previous year being carried over to the following calendar year. Any reimbursement is first charged to the unspent balance from the previous calendar year. Any unspent balance from one calendar year can be carried over to the next calendar year but not beyond that year. The limit applies to any kind of dental care or dental treatment, such as dental consultations and examinations, gum examinations, X-rays, dental hygiene, scaling and periodontic (i.e. paradontic) treatment, fillings, root treatment, tooth extraction, crowns, bridges, inlays, tooth implantations, treatment of temporomandibular joint diseases, orthodontic treatment and other dental work. Dental treatment also includes dental surgery, performed as part of inpatient or outpatient treatment, such as surgery to remove wisdom teeth and surgery in connection with dental implants. The above limit on reimbursement applies to fees of surgeons and anaesthetists. Hospital costs, however, are reimbursed according to the class of accommodation.

Benefits	*Basic coverage (%)*	*Maximum amount reimbursed (if applicable)*	*Remarks*
			Orthodontic treatment should start before the patient is 14 years of age. If treatment is to start when the patient is between the ages of 14 and 18, medical grounds will be required for approval. If an advance payment is required upon commencement of the treatment, reimbursement will be made in instalments in accordance with submitted proof of services rendered. In the event that the price of the appliance cannot be given separately, the full amount paid to the orthodontist will be reimbursed in instalments. Orthodontic surgery required as a result of an accident is reimbursed at 80 per cent.
			Provisional tooth replacements (provisoria) are not covered. This includes long-term provisional tooth replacements.
			Inpatient periodontal treatment involving an overnight stay in a hospital will not be considered as hospitalization but will be reimbursed in accordance with the above ceiling.
(b) Lenses	80	€390	Coverage is for all types of prescribed lenses (including contact lenses and disposable lenses), whether there is a change in strength or not, per two-year period (calendar years), per person. In the case of disposable lenses, it is necessary to indicate for which period the lenses have been bought. Reimbursement for frames is excluded.
			The cost of laser treatments will be reimbursed depending on the refraction/severity of the eyes and reimbursement will either come under the ceiling for lenses or under day surgery (see subparagraph (g) (iv) below). It is therefore recommended that participants contact Allianz Worldwide Care Services before starting eye laser treatment.
(c) Hearing aids	80	€996	The amount indicated is per ear within a three-year period (calendar years). A prescription and an audiogram are required.
(d) Psychiatric care			Psychiatric care comprises the consultation of a psychiatrist and any treatment prescribed by a psychiatrist. The cost of treatment prescribed by a psychiatrist shall be reimbursable, subject to prior approval, if it is for a defined therapy performed either by a psychiatrist or by a qualified provider.
(i) Psychiatric care	80		Staff member
	80	€1 890	Dependants: within a two-year period (calendar years)
(ii) Psychoanalysis			Excluded.
(e) Radiological treatment	80		If prescribed by a physician.

Benefits	*Basic coverage (%)*	*Maximum amount reimbursed (if applicable)*	*Remarks*
(f) Convalescence and spa cures			Medically prescribed convalescence in a medical or rehabilitation centre within one week following hospitalization is reimbursed as hospitalization.
(i) Therapy	80		If prescribed by a physician.
(ii) Accommodation		€15 per day	If prescribed by a physician for a specified therapy at a registered spa institution and subject to prior approval by the insurer.
(g) Hospitalization			Inpatient treatment involves an overnight stay. Treatment for detoxification for alcoholism or drug abuse is reimbursed as inpatient treatment in a hospital for a maximum of two treatments in total.
(i) Accommodation in a general ward	100		All-inclusive rate per day (hospital costs and doctors' fees).
(ii) Second-class hospitalization (two or three persons to a room)	90		The percentage is applied to the cost of bed and board, tests, general nursing service, use of operating theatre, laboratory tests, X-rays, drugs, medication and all other inpatient costs. The costs of the stay of accompanying persons (see subparagraph (vii) below) and of the use of a telephone, television or other non-medical facilities are excluded.
	100		Hospitalization in semi-private accommodation (same conditions as above) in countries outside Europe, Canada, Israel and the United States (a list of countries considered part of Europe for insurance purposes can be found at the end of the present summary).
(iii) First-class hospitalization (single room)	70		The cost of first-class accommodation does not count towards major (catastrophic) medical expenses if first-class accommodation was the patient's own choice.
(iv) Day surgery	90		Reimbursement is at the rate of 90 per cent if the surgery requires the use of a conventional operating theatre and is being performed in a hospital without entailing an overnight stay.
(v) Surgeons' and anaesthetists' fees	80		With the exception of accommodation in a general ward (see subparagraph (i) above), the fees of surgeons and anaesthetists are paid at the rate of 80 per cent, irrespective of the class of accommodation, whereas fees of other doctors during hospitalization are reimbursed according to the class of accommodation.
(vi) Hospice care			Hospice care is covered subject to prior approval by the insurer as an alternative to hospitalization and subject to reimbursement rates equivalent to hospitalization rates indicated above.

Benefits	*Basic coverage (%)*	*Maximum amount reimbursed (if applicable)*	*Remarks*
(vii) Parent accommodation	80		The cost of accommodating one parent who is accompanying a patient under the age of 12 will be reimbursed at the rate of 80 per cent, provided that a medical certificate justifying the need for such accommodation has been submitted.
(h) Ambulant treatment	80		Coverage is for outpatient treatment (other than day surgery – see subparagraph (g) (iv) above) involving no overnight stay.
(i) Transportation	80		Coverage is for emergency ambulance costs only and does not include taxi fares.
(j) Maternity	80		Coverage is for reasonable treatment relating to pregnancy, as well as up to three applications of conceptive methods leading to pregnancy.
(k) Preventive care			
(i) Medical examination	80	€170	Coverage is per calendar year per person. Increased limit of €562 for men above 40 and women above 35 years of age, per calendar year and per person.
(ii) Birth control devices and medicine	80	€73	Maximum amount is per calendar year per person.
(iii) Induced abortion, salpingectomy, vasectomy or electrocoagulation of fallopian tubes by laparoscopy	80		Once per person.
(iv) Vaccinations and inoculations	80		
(l) Alternative medicine			
(i) Homeopathy, acupuncture	80		Treatment must be performed or prescribed by a physician and carried out by recognized paramedical personnel. Herbal pharmaceuticals that are considered as alternative medicine are excluded.
(ii) Neural therapy, ozone therapy and chiropractic therapy	50		Treatment must be performed or prescribed by a physician and carried out by recognized paramedical personnel. Alternative treatments not covered are: acupressure, anthroposophical medicine, autogenic training, Ayurveda, biofeedback therapy, bioresonance treatment, treatment within the framework of traditional Chinese medicine, colon hydrotherapy, hypnosis therapy, foot reflexology (*Fussreflexzonenmassage*), music therapy, nutrition counselling, shiatsu and Kneipp therapy (the latter may be reimbursed, subject to prior approval, in connection with a prescribed spa cure). This listing is not exhaustive.

List of countries considered part of Europe for insurance purposes[a]

Albania
Andorra
Armenia
Austria
Azerbaijan
Belarus
Belgium
Bosnia and Herzegovina
Bulgaria
Croatia
Cyprus
Czech Republic
Denmark
Estonia
Finland
France
Georgia
Germany
Greece
Hungary
Iceland
Ireland
Italy
Kazakhstan
Latvia
Liechtenstein
Lithuania
Luxembourg
Malta
Monaco
Montenegro
Netherlands
Norway
Poland
Portugal
Republic of Moldova
Romania
Russian Federation
San Marino
Serbia
Slovakia
Slovenia
Spain
Sweden
Switzerland
The former Yugoslav Republic of Macedonia
Turkey
Ukraine
United Kingdom of Great Britain and Northern Ireland

[a] In countries other than Europe (as listed), Canada, Israel and the United States of America, hospitalization in semi-private accommodation is reimbursed at the rate of 100 per cent (see paragraph 1 (g) (ii) of the present annex).