International cover for serious illness for the UK – Individual Benefit Guide
Valid from 1st May 2021

Avenue

for your life journey

Allianz

Welcome

You and your family can depend on Allianz Assistance as your insurer to give you access to the best care possible. Because our goal is providing you with the best possible service, your policy will be administered by Allianz Care, a leading expert in international health insurance services.

This guide has two parts: "How to use your cover" is a quick summary of all important information you may want to read before using your cover; "Terms and conditions of your cover" explains the rules of your cover in more details.

To make the most of your Avenue cover, please read this guide together with your Insurance Certificate and Table of Benefits.

The insurer is AWP P&C SA, registered as a foreign company in England and Wales with foreign company n. FC030280. Registered office: 7 Rue Dora Maar, 93400 Saint-Ouen, France. AWP P&C SA acts through its UK branch AWP P&C UK, registered in the United Kingdom as a branch of AWP P&C SA (registered branch number: BR015275, registered office: 102 George Street, Croydon, Surrey CR9 6HD). AWP P&C SA is authorised by L'Autorité de Contrôle Prudentiel et de Résolution in France. Deemed authorised by the Prudential Regulation Authority. Subject to regulation by the Financial Conduct Authority and limited regulation by the Prudential Regulation Authority. Details of the Temporary Permissions Regime, which allows EEA-based firms to operate in the UK for a limited period while seeking full authorisation, are available on the Financial Conduct Authority's website. This policy is supported by AWP Health & Life SA, a limited company governed by the French Insurance Code and acting through its Irish Branch. Part of the Allianz Group. AWP Health & Life SA is registered in France: No. 401 154 679 RCS Bobigny. Irish Branch is registered in the Irish Companies Registration Office, registered No.: 907619, address: 15 Joyce Way, Park West Business Campus, Nangor Road, Dublin 12, Ireland. Allianz Care and Allianz Partners are registered business names of AWP Health & Life SA.

HOW TO USE YOUR COVER

COVER OVERVIEW

What am I covered for?

Avenue covers you (and any family members, if you included them in your policy as your dependants) if you ever require treatment for any of the below serious medical cases:

Medical cases covered for both adults and children (under 18):
- Bone marrow transplant
- Cancer (includes all solid organ cancers, lymphomas and leukaemia)
- Heart valve replacement or repair (for children, only when it's needed as a result of rheumatoid fever)
- Neurosurgery
- Severe epilepsy

Medical cases covered for adults only:
- Coronary artery angioplasty/stenting
- Coronary artery bypass surgery
- Living organ transplant
- Major vascular surgery

Medical cases covered for children (under 18) only:
- Artificial limbs needed after a limb loss in an accident
- Kawasaki syndrome
- Meningitis/encephalitis

Where can I receive treatment?

We hope you will never need treatment for the medical cases listed above – but if you ever do, you can receive it at the hospitals and medical facilities that are included in your selected type of Avenue medical network. This will be indicated in your Table of Benefits.

We will send you a list of those hospitals and medical facilities included in your selected network which specialise in your type of medical case. For example, if your medical case is cancer, we will send you a list of hospitals in your selected network that specialise in cancer treatment. You can choose the hospital where you want to be treated from that list.

We carefully select the hospitals and medical facilities included in our Avenue network based on their medical expertise and international service standards. Depending on the level of cover chosen, you can access our Avenue network hospitals and medical facilities in Europe, Asia, Middle East, Africa and North America.

If your plan is Avenue 1 Plus, you are also covered for eligible treatment in your principal country of residence. If your plan is Avenue 2 Plus or Avenue 3 Plus, you are covered for eligible treatment in your principal country of residence and in your declared home country, if that is different than where you reside.

When can I start accessing benefits and services under my plan?

You can start accessing benefits and services from when your doctor confirms that you (or any of your family members included in your policy as dependants) require treatment for any of the covered medical cases. You can start using your cover from that point onwards – this means that the cost of getting the initial diagnosis of your medical case is not covered by your plan. Cover is subject to the terms and conditions of your plan as described in this Benefit Guide, in your Table of Benefits and Insurance Certificate.

How do I access cover and how does it work?

All you need to do is call us as soon as possible, after your doctor has confirmed that you (or any of your dependants) require treatment for any of the covered medical cases.

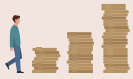
Our Helpline is open day and night, all days of the year – we are always here to take your call:

0203 5642 546
For our latest list of toll-free numbers, please visit: www.allianzcare.com/toll-free-numbers.

client.services@allianzworldwidecare.com

When you call us, we will ask you to provide supporting information on your diagnosis, which will be evaluated by our Medical Team. If needed, we will organise your second medical opinion with an external international specialist to verify your diagnosis. Once your initial diagnosis is confirmed and you have served the relevant waiting period, you can access our medical case management service and benefits immediately. In addition, you have the option to receive the payment of a lump sum, rather than accessing our medical case management services. Please check your Table of Benefits to confirm the waiting period that applies to each option.

Here is what the two options mean:



Payment of a lump sum
There is a lump sum benefit in your plan (check the amount in your Table of Benefits). If you choose the lump sum, we will pay it into your personal bank account. If you choose this option, you will not be able to access any of the services provided via our medical case management process, nor you will be able to claim for any treatment benefit included in your policy for that specific type of medical case.
However, if in the future you have a different type of medical case which is covered under your policy, you will have again the opportunity to choose between lump sum payment and access to medical case management.

Medical case management service
If you choose this option, we will assign a personal medical case manager to you – this is a medical expert from our own Medical Team. Your personal medical case manager will be responsible for administering a number of services for you (for example, initial medical appointment booking).
Choosing this option will also entitle you to claim for the eligible costs of your medical treatment. Your treatment costs will be covered by us until you reach the Maximum Limit indicated in your Table of Benefits – at that point, your cover for that specific type of medical case will end. However, if in the future you have a different type of medical case which is covered under your policy, the Maximum Limit will become available for you again, for your new medical case.

Please see the 'Medical case management service' section for more details. The value of the lump sum available on your Avenue plan may be less than the value of medical case management and benefits that we pay for under your policy. Please check your Table of Benefits to understand the differences in value between the two options.

We are responsible for organising access to treatment only. The medical case management services does not provide medical or health advice and is not a substitute for professional advice, diagnosis or treatment. We are not liable for any claim, loss or damage directly or indirectly resulting from any act or omission of any third party medical providers including treatment, advice, diagnosis, misdiagnosis or failure to diagnose.

Counselling service and legal and financial advisory services

We understand that a serious illness diagnosis can be worrying. With Avenue, you have access to psychological counselling and legal and financial advisory services to help you and your family cope with any challenges you may face following a serious illness diagnosis. These services offer multilingual support and are available 24/7.

The confidential professional counselling service provides you and your family with access to a clinical counsellor through in-person consultation, live online chat, phone, video or email – for your convenience.

The legal and financial advisory services offered through Avenue will refer you to an appropriate financial advisor and/or legal professional to help you find answers to questions you may have through your treatment.

Let us help:

+1 905 886 3605
This is not a free phone number. However, local phone numbers may be available. The full list of our 'Worldwide Access Numbers' is available at:

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

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

The counselling and advisory services are made available through Lifeworks by Morneau Shepell, subject to your acceptance of our terms and conditions. You understand and agree that AWP P&C UK and its third party administrators and reinsurers are not responsible or liable for any claim, loss or damage directly or indirectly resulting from your use of the counselling and advisory services. This service may also be subject to geographical restrictions.

How do I add a family member to my policy?

You can apply to include your partner/spouse or your child on your policy as a dependant by simply completing our Application Form, available at:

www.allianzcare.com/personal-avenue.html

Please note that children can be added to your policy once they are at least 90 days old.

For further information on how to add dependants, including important information on how to add multiple babies, adopted and foster children, please see the 'Adding dependants' section of this guide.

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

MEDICAL CASE MANAGEMENT SERVICE

We understand that seeking treatment can be stressful. Let us handle the administration for you – so you can concentrate on getting better.

How it works

Your medical case manager is an expert from our own Medical Team. Here is what he/she will do for you:

01

First, he/she will review the details of your medical case (e.g. medical reports, tests results, etc.). If required, your medical case manager will help you organise a second medical opinion with an external international specialist, to verify your diagnosis. Once your diagnosis is confirmed, your medical case manager will discuss with you to agree on a treatment plan.

02

Your medical case manager will suggest three countries included in your selected network as possible treatment destinations. Once you agree on the countries for treatment, he/she will identify a list of suitable hospitals in those countries that are included in our Avenue network. Saving you time on research!

You will need to let your medical case manager know which hospital from the provided list you wish to choose for your treatment.

Please note:

If your plan is Avenue 1 Plus, you are also covered for eligible treatment in your principal country of residence. If your plan is Avenue 2 Plus or Avenue 3 Plus, you are covered for eligible treatment in your principal country of residence and in your home country (if this is different than where you reside). Let your medical case manager know if you prefer to be treated in-country, so to receive a list of hospitals that are located in your principal country of residence (or home country, for Avenue 2 Plus and Avenue 3 Plus).

If your principal country of residence (or home country) is in an area where we don't have a network of medical facilities, you can identify a suitable hospital yourself and inform your medical case manager of your choice. Your medical case manager will help you complete a Treatment Guarantee Form, which he/she will need when contacting your chosen hospital and organising payment of your in-patient treatment directly (where possible).

03

Your medical case manager will liaise directly with your chosen hospital to schedule the initial appointment for you (so you can start your treatment). He/she will also liaise directly with the hospital to pay all eligible in-patient treatment costs for you.

Where the hospital is over 50 km from your home, your medical case manager will organise travel (except train or taxi journeys) and accommodation for you, your accompanying person and any donor (if applicable). These travel costs are covered up to the benefit limits for your chosen plan. If you require any taxi or train journey to reach your treatment destination, please discuss your travel plan with your medical case manager. Once agreed, you can book the taxi or train journeys yourself and claim back the cost of the fares afterwards.

For overseas treatments within our Avenue network, your medical case manager will also organise the medical concierge service for you, which may include escort service in the destination country and/or language support in the treating hospital during your overseas treatment.

Unfortunately certain things will not be under your medical case manager's control, including but not limited to:

• Organising visa or other travel documents that may be required for your overseas treatment – unfortunately we are not legally entitled to do this for you, so you will need to organise these documents yourself.

• Liaising with relevant authorities if you are refused necessary travel documents or detained by border control at entry into the destination country for treatment. We will not be liable for this.

However, if you know or become aware that obtaining the relevant travel documents for treatment in a specific country is a problem for you, your medical case manager will suggest suitable medical facilities in a different country for your consideration – so your treatment will not be delayed.

04

Throughout your treatment, your medical case manager will contact you periodically to:

- Check on the progress of your treatment.
- Provide information on treatment alternatives available for you.

Please note that the medical case management service is intended to assist you in the coordination of your treatment journey and to ease the administrative burden. It does not provide medical or health advice and it is not a substitute for professional advice, diagnosis or treatment.

We are not liable for any claim, loss or damage directly or indirectly resulting from any act or omission of any third party medical providers including, treatment, advice, diagnosis, misdiagnosis or failure to diagnose.

How to claim for your medical expenses

We have processes in place with the hospitals in our Avenue network. This means that your medical case manager will be able to organise payment for your eligible in-patient treatment costs directly to your hospital – so you won't need to handle invoices.

However, not all the costs related to your treatment will necessarily be paid directly by us. This will happen when:

Your costs are not related to in-patient treatment. For example, you may need to buy prescribed drugs from a pharmacy or attend consultations on an out-patient basis. These out-patient costs are covered under your plan up to the limits shown on your Table of Benefits (if they are for medical services and products included in your treatment plan agreed with your medical case manager). For these eligible out-patient costs, you will need to pay upfront and then submit a claim to us to receive a reimbursement.

You have agreed with your medical case manager to receive **treatment in your principal country of residence or home country, at a hospital that is not included in our network**. On rare occasions, it may happen that your chosen hospital refuses to accept the direct payment from us for in-patient treatment. In this case, you will need to pay your hospital bills upfront and then claim back the amounts from us.

You require any taxi or train journeys to reach your treatment destination, as agreed with your medical case manager. Agreed taxi and train journeys are not organised by us, but we will reimburse the costs up to the benefit limits indicated in your Table of Benefits.

You can use our MyHealth app or online portal to claim back your eligible costs. To access MyHealth, go to:

https://my.allianzcare.com/myhealth

Simply enter a few key details, take a photo of your invoice(s) and press 'submit'. Once we have all the information required, we can process and pay your claim within 48 hours.

The content of the MyHealth app and online portal is for information purposes only and users remain responsible for their own health decisions. The MyHealth app and online portal do not provide medical or health advice and it is not a substitute for professional advice, diagnosis or treatment. Users understand and agree that Allianz Care and all companies within the Allianz Group are not responsible or liable for any claim, loss or damage, directly or indirectly resulting from use of the MyHealth app and online portal.

Claiming where a child is the policyholder

For policies where only a child or children are insured, claiming via our MyHealth app or online portal is not available. One of their parents or their legal guardian needs to submit their eligible out-patient claims via Claim Form. You can find our Claim Form here:

www.allianzcare.com/cfq

If you have any claims related queries or simply want to check the progress on any submitted claims, please contact our Helpline:

0203 5642 546

Please refer to "Medical claims" in the "Terms and conditions" section of this guide for more information about our claims process.

Please also note that limits apply to the medical costs that we cover and pay for you. For further information please see the 'Benefit limits, Maximum Limit and Maximum Ceiling' section of this guide.

The full details on the medical case management service are available in the "Terms and conditions" section.

TERMS AND CONDITIONS OF YOUR COVER

TERMS AND CONDITIONS

This section describes the standard benefits and rules of your Avenue health insurance policy.

Your Avenue health insurance policy is an annual contract between Allianz Assistance and the insured person(s) named on the Insurance Certificate. The contract is made up of:

- The **Benefit Guide** (this document), which explains the standard benefits and rules of your policy. It should be read together with your Insurance Certificate and Table of Benefits.
- The **Insurance Certificate**. This states the plan(s) chosen, together with the start date and renewal date of the policy (and effective dates of when dependants were added). If any other terms apply which are specific to your cover, these will be stated in the Insurance Certificate. They will also have been detailed on a Special Conditions Form which we send you before you're placed on cover. We'll send you an updated Insurance Certificate if you request a change which we accept, such as adding a dependant, or if we apply a change that we're entitled to make.
- The **Table of Benefits**. This shows the plan(s) selected, the applicable type of network, the benefits and services available to you. It also confirms any benefits where specific benefit limits and/or waiting periods apply. Finally, it indicates the Maximum Limit and Maximum Ceiling that apply to your plan.
- **Information provided to us** by (or on behalf of) the insured person(s) in the signed Application Form, submitted Online Application Form, Confirmation of Health Status Form or others (we'll refer to all of these collectively as the "relevant application form") or other supporting medical information.

YOUR COVER EXPLAINED

The plan that you selected is indicated in your Table of Benefits, which lists all the benefits you are covered for, the services which are included, and any limits that apply. For an explanation of how your benefit limits apply to your plan, please see the section "Benefit limits, Maximum Limit and Maximum Ceiling".

Your cover is also subject to:

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

What we cover

a) The scope of what's covered in your policy is set out on your Table of Benefits, Insurance Certificate, any policy endorsements, these policy terms and conditions and any other legal requirements. We will reimburse medical costs in accordance with your Table of Benefits and terms and conditions.

b) Within the scope of your policy, you are covered for medical treatment, costs, services or supplies that:

   - We determine to be medically necessary, appropriate for the patient's condition, illness or injury.
   - Have a palliative, curative and/or diagnostic purpose.
   - Are performed by a licensed doctor or a medical therapist.

   Costs will be covered if they are reasonable and customary, this means that they are usual within the country of treatment. We will only reimburse medical providers where their charges are reasonable and customary and in accordance with standard and generally accepted medical procedures. If we consider that a claim is inappropriate, we reserve the right to reduce or decline the amount we will pay.

Medical cases that have been diagnosed or treated during the waiting period are not covered under your Avenue Plan, unless they are a direct result of an accident that happened during the waiting period. Such accident related medical cases will be evaluated and covered after the relevant waiting periods are served.

Cover is not provided for travel insurance. If you wish to have additional cover for travel insurance, it is your responsibility to ensure that you, your dependants, accompanying persons, or donors have adequate cover for the purposes of travelling during your treatment covered under your Avenue plan.

The cover provided by Avenue is not suitable as a substitute for local compulsory health insurance. Cover in some countries may be subject to local health insurance restrictions and it is your responsibility to ensure that your health cover is legally appropriate. Cover is not provided if any element of the cover, benefit, activity, business or underlying business violates any applicable sanction law or regulations of the United Nations, the European Union or any other applicable economic or trade sanction law or regulations.

When cover starts

When you receive the Insurance Certificate, this is our confirmation that the persons listed on it have been accepted onto the policy. The Insurance Certificate will confirm the start date of the cover. Please note that no benefit will be payable under the policy until the initial premium has been paid, with subsequent premiums being paid when due.

For policies where the policyholder is an **adult**:

a) If any dependants are included in the policy, they will be listed in the Insurance Certificate together with the policyholder, along with the start date of their cover.

b) All adults included in the policy can remain on cover until they reach the age of 70 years old. If they reach this age when the insurance year is still rolling, cover will end for them on the policy renewal date following their 70th birthday.

c) Any children included in the policy can remain on cover until the day before their 18th birthday, or until the day before their 24th birthday if they are in full time education. After that point, they can apply for their own policy.

For policies where only a **child or children** are insured:

a) Only their names will be listed in the Insurance Certificate, along with the start date of their cover. The name of the parent or guardian will not appear. The first child named on the Insurance Certificate will be the policyholder.

b) The child policyholder can remain on cover until they reach the age of 70 years old. If they reach this age when the insurance year is still rolling, cover will end for them on the policy renewal date following their 70th birthday.

c) Any other children included as dependants on the policy can remain on cover until the day before their 18th birthday, or until the day before their 24th birthday if they are in full time education. After that point, they can apply for their own policy.

d) Until the child policyholder and any children dependants reach their 18th birthday, one of their parents or their legal guardian will be the legal owner of the policy and will be responsible for the policy administration, for understanding and acting according to the policy terms and conditions, and will be required to complete and sign the policy documents on behalf of the minor(s). However, the parent or legal guardian will not be insured under the policy. Once the child policyholder turns 18, he/she will become responsible to act on their own policy documents.

Benefit limits, Maximum Limit and Maximum Ceiling

Your plan includes benefit limits, a Maximum Limit and a Maximum Ceiling (please see your Table of Benefits).

A **benefit limit** is the maximum amount that we will pay for a specific benefit, e.g. "Targeted drug therapy" is covered up to £31,540/€38,000/US$51,300/CHF49,400 under certain plans.

The **Maximum Limit** is the maximum amount that we pay for any one type of medical case listed in the Table of Benefits. Please note:

- The Maximum Limit applies per medical case: it means that once you reach the Maximum Limit amount, your cover for that specific type of medical case will end. For example, if your medical case is "cancer", you will no longer be covered after you use up the amount of your Maximum Limit – even if in the future you are diagnosed with a new, different cancer medical case. However, if in the future you have a different type of medical case that is covered by your plan (e.g. living organ transplant), your Maximum Limit amount will be available again for the new medical case.
- If you only use part of your Maximum Limit amount for your medical case, you will still be able to use the remainder in the future, if you have a new medical case of the same type. For example, if your medical case is "cancer" and you only use part of your Maximum Limit amount for your treatment, you will still be able to use the remainder should you have cancer again in the future.
- The Maximum Limit also applies per person: this means that, if you included dependants under your policy, each dependant will have access to their own Maximum Limit, separate to other dependants.

The **Maximum Ceiling** is the maximum amount that we will pay in total under your policy for all the medical cases covered. The Maximum Ceiling applies individually to each person insured under your policy. Once any of the persons included in your policy reaches the Maximum Ceiling amount, their cover will end and their policy will no longer be renewed, nor will they be able to buy a new policy.

Waiting periods

Waiting periods apply to the benefits covered under this policy. A waiting period is the time that you need to wait from the start of your policy until you can access the benefits covered. Medical cases that have been diagnosed or treated during the waiting period are not covered under your Avenue Plan, unless they are a direct result of an accident that happened during the waiting period. Such accident related medical cases will be evaluated and covered after the relevant waiting periods are served. Please check your Table of Benefits to see what waiting period applies.

What happens when you call to inform us about your medical case

When you call to tell us that you have a diagnosis or treatment plan for one of the medical cases covered under your policy, we will apply the following process and terms:

- **Pre-authorisation**: This is a prerequisite to access cover under our Avenue plans. The pre-authorisation process is organised by us as soon as you call and tell that you have a diagnosis or a treatment plan for one of the medical cases covered under your policy. To complete the pre-authorisation process, we will need you to provide us with the medical documentation that describes your diagnosis and treatment plan (e.g. tests results etc.). It is your responsibility to provide such documentation to initiate the pre-authorisation process. We may not provide cover if we don't obtain this documentation from you.

  If for any reason, following the pre-authorisation process, we identify that your condition or the medical procedures required are not within the scope of this cover, we will inform you immediately and explain the reasons why. In this case, cover will not be available for your specific medical case.

- **Second medical opinion**: Where required, we will organise your second medical opinion via external international medical experts. The second medical opinion is to confirm your initial diagnosis and the treatment plan proposed. This service is available either if you prefer to be paid the lump sum or access the medical case management service. Please note that the second medical opinion is provided by a third party provider outside of the Allianz Group. Allianz Care, Allianz Assistance and all companies within the Allianz Group are not responsible and/or liable for any claim, loss, damage directly or indirectly resulting from your use of this services. This service may be subject to geographical restrictions.

- **Your preference**: Once you have obtained pre-authorisation for your medical case and you have received your second medical opinion (where applicable), you can access our medical case management service and benefits immediately. In addition, you have the option to receive the payment of a lump sum, rather than accessing our medical case management services. Please check your Table of Benefits to confirm the waiting period that applies to each option.

If you wish to apply for the lumpsum payment, please refer to the section "Lump sum Payment - Process and Terms".

LUMP SUM PAYMENT – PROCESS AND TERMS

If you choose to be paid the lump sum available on your plan, please note that the person who the lump sum is claimed for (i.e. either the policyholder or any of the dependants on the policy) must be alive to claim for this benefit.

Once you confirm that you prefer being paid the lump sum available on your Avenue Plan, you will not be able to access any other service available via our medical case management for that particular medical case. Also, you will not be able to claim any treatment benefit for that particular medical case.

The value of the lump sum available on your Avenue plan may be less than the value of medical case management and benefits that we pay for under your policy. Please check your Table of Benefits to understand the differences in value between the two options.

We will send you a lump sum claim form (together with a list of supporting documents that you need to provide for the payment). You will need to complete the claim form and send it back to us together with the supporting documents. You may need to provide further information, if requested. The lump sum will be paid to you within 5 working days from the date of approval.

For security reasons, before paying the lump sum benefit to you, we will ask you to provide evidence of your identity. We reserve the right to confirm the authenticity of supporting documents prior to making any payments.

MEDICAL CASE MANAGEMENT

Process and terms

Once the pre-authorisation process is complete, you have access to our medical case management service for your treatment. Please note that the following process and terms and conditions apply:

- **Treatment path**: Once we have received all the medical information required to assess your case and the second medical opinion has been provided where applicable, your medical case manager will discuss possible options for your treatment plan with you, taking your personal preferences into consideration. Your medical case manager will explain to you the pros and cons of all options. You will need to confirm which treatment option you wish to choose: once this is confirmed, your personal case manager will agree with you on the whole treatment plan, including which part of the treatment will be carried out on in-patient or out-patient basis, as well as in-country or overseas (depending on the Avenue plan you have chosen).
- **Selection of hospital for treatment**: If you choose to access our medical case management service, you will be bound to receive your treatment at a hospital included in our Avenue network. Your medical case manager will suggest three countries included in your network as possible treatment destinations. Once you agree on those countries, your medical case manager will identify a list of suitable hospitals from our Avenue network in those countries, for you to choose from. When your medical case manager selects the hospitals for this list, he/she takes into consideration your medical situation, the type of treatment that you need and your preferred location.

  We will need to receive confirmation from you on the hospital that you have chosen within the timeframe that your medical case manager will confirm when sending the list to you. If we don't receive your confirmation within this timeframe, the original hospital list and treatment plan agreed with us will no longer be valid. However, if you request it again, we will re-evaluate your treatment path and hospital list based on your health condition at that time.

  If you have Avenue 1 Plus, you can also access treatment at hospitals in your principal country of residence. If you have Avenue 2 Plus or Avenue 3 Plus, you can access treatment at hospitals in your principal country of residence and in your home country. If we don't have Avenue network hospitals in your specific principal country of residence or home country, you will need to identify a suitable hospital yourself and inform your medical case manager.

  Please note that the concierge services such as local escort and medical translation are only offered for overseas treatments within the Avenue network.
- **Covered medical costs**: we will cover all the eligible costs for in-patient treatment received by you, at the hospital chosen from our Avenue network (subject to the terms and conditions and limits of your policy). We will pay these costs directly to your hospital.

If your chosen Avenue plan includes the option of receiving treatment in your principal country of residence or home country, depending on what that country is, we may not have Avenue network hospitals there which have a direct payment agreement in place with us. In that case, you can agree with your medical case manager to receive treatment at a hospital that is not included in our network. Your medical case manager will help you complete a Treatment Guarantee Form. We will need this form when contacting the agreed hospital to organise payment of your in-patient treatment directly (where this is possible). On the rare occasion where your chosen hospital refuses to accept the direct payment from us, you will need to pay the hospital upfront and claim back the costs from us afterwards.

Please note that certain costs are not covered by your policy – for example:

- Medical costs for in-patient treatments that you receive at hospitals other than the specific one agreed with your medical case manager.
- Costs incurred before a hospital is agreed with your medical case manager and before we organised your initial consultation to start treatment at your chosen hospital.
- Treatment costs that are over and above the reasonable and customary charges within the country of treatment.

For the full list of things that your policy does not cover, please see the "Exclusions" section.

Medical claims

This section refers to:

a) **The eligible out-patient medical costs that you pay upfront to your medical provider and then claim back from us**. The eligible out-patient medical costs are those related to out-patient treatments/consultations and the purchase of medication, drugs and materials, as agreed on your treatment plan with your medical case manager. We will reimburse these costs up to the limits indicated in your Table of Benefits and according to the terms and conditions of your plan.

b) **In-patient treatment costs charged at a hospital** in your principal country of residence or home country **that is not included in our network**, where you have agreed with your medical case manager to receive treatment there. On rare occasions, it may happen that your chosen hospital doesn't accept the direct payment from us for in-patient treatment: where this happens, you will need to pay your hospital bills upfront and then claim these costs from us.

c) **Train or taxi journeys that you may require to reach your agreed treatment hospital, where this is located over 50 km from your home**. Once the travel plan is agreed with your medical case manager, you will need to pay upfront for your train or taxi journey, and then claim these costs from us, attaching the invoices, proof of payment, and the written agreement with your medical case manager on your travel plan. We will reimburse these costs up to the limits in your Table of Benefits.

With regard to the above costs, please pay attention to the following conditions:

- **Claiming deadline**: You must submit all eligible claims (via our MyHealth app or portal, or via Claim Form) no later than six months after the end of the Insurance Year, unless otherwise required by law. If cover is cancelled during the Insurance Year, you should submit your claim no later than six months after the date that your cover ended. After this time, we are not obliged to settle the claim.
- **Claim submission**: You must submit a separate claim for each person claiming and for each medical condition being claimed for.
- **Supporting documents**: When you send us copies of supporting documents (e.g. medical receipts), please make sure you keep the originals. We have the right to request original supporting documents/receipts for auditing purposes up to 12 months after settling your claim. We may also request proof of payment by you (e.g. a bank or credit card statement) for medical bills you have paid. We advise that you keep copies of all correspondence with us as we cannot be held responsible for correspondence that fails to reach us for any reason outside of our control.
- **Currency**: Please specify the currency you wish to be paid in. On rare occasions, we may not be able to make a payment in that currency due to international banking regulations. If this happens, we will identify a suitable alternative currency. If we have to make a conversion from one currency to another, we will use the exchange rate that applied on the date the invoices were issued, or on the date that we pay your claim.

  Please note that we reserve the right to choose which currency exchange rate to apply.

- **Reimbursement**: We will only reimburse eligible costs within the limit of your policy outlined in the Table of Benefits.
- **Reasonable and customary cost**: We will only reimburse charges that are reasonable and customary in accordance with standard and generally accepted medical procedures. If we consider a claim to be inappropriate, we reserve the right to decline your claim or reduce the amount we pay.
- **Deposits**: If you have to pay a deposit in advance of any medical treatment, we will reimburse this cost only after treatment has taken place.
- **Providing information**: You and your dependants agree to help us get all the information we need to process a claim. We have the right to access all medical records and to have direct discussions with the medical provider or the treating doctor. We may, at our own expense, request a medical examination by our doctors if we think it's necessary. All information will be treated confidentially. We reserve the right to withhold benefits if you or your dependants do not support us in getting the information we need.

PAYING PREMIUMS

Premiums for each Insurance Year are based on each member's age on the first day of the Insurance Year, their region of cover, the policyholder's country of residence, the premium rates in effect and other risk factors which may materially affect the insurance.

By accepting cover you have agreed to pay the premium amount shown on your quotation, by the payment method stated. You need to pay us in advance for each Insurance Year of your policy. The premium is payable immediately after we accept your application. When you receive your invoice, please check that the premium matches the amount shown on your agreed quotation and contact us immediately if there is any difference. We are not responsible for payments made through third parties.

Your premium should be paid with annual frequency. If you are unable to pay your premium for any reason, please contact us on:

0203 5642 546

Failure to pay your premium on time may result in loss of insurance cover.

If the premium is not paid in time, we are entitled to withdraw from the contract for as long as the payment remains outstanding. The insurance contract is deemed to be null and void unless we assert a claim to the premium in court within three months of the commencement date, the policy start date or the conclusion of the insurance contract.

The effects of termination will cease if the policyholder makes a payment within one month after the termination or, if the termination was combined with the setting of a time limit, within one month after the expiration of the time for payment, provided that no claims have been incurred in the intervening period.

Paying other charges

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

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

These charges may already be in effect when you join but they could be introduced (or change) afterwards. Your invoice will show these taxes. If they change or if new taxes are introduced, we will write to inform you.

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

ADMINISTRATION OF YOUR POLICY

Adding dependants

You may apply to include your partner/spouse or your child(ren) (or your siblings, if you are a child policyholder) as dependants by completing the relevant application form – which can be downloaded from this page:

www.allianzcare.com/personal-avenue.html

Your dependants will be underwritten and, if accepted, cover will start from the date of acceptance.

Please note that babies can only be included in your policy after they are 90 days old. We do accept applications for children born from a multiple pregnancy and for adopted or fostered children.

Changes to policyholder

If a request is made at renewal to change the policyholder, the proposed replacement policyholder will need to complete an application form and full medical underwriting will apply. Please refer to the section on "Death of the policyholder or a dependant" if the requested change is due to the death of the policyholder.

Death of the policyholder or a dependant

We hope you will never need to refer to this section; however, if a policyholder or a dependant dies, please inform us in writing within 28 days.

If the policyholder dies, the policy will be terminated and a pro rata repayment of the current year's premium will be made if no claims have been filed. We may request a death certificate before a refund is issued. Alternatively, if they wish to, the next named dependant on the Insurance Certificate can apply to become the policyholder and keep the other dependants on their policy. If they apply to do this within 28 days, we will, at our discretion, not add any further special restrictions or exclusions that didn't already apply at the time of the policyholder's death.

If a dependant dies, they will be taken off the policy and a pro rata repayment of the current year's premium for that person will be made, if no claims have been filed. We may request a death certificate before a refund is issued.

Changing your level of cover

If you want to change your level of cover, please get in touch with us before your policy renewal date to discuss your options. Changes to cover can only be made at policy renewal. If you want to increase your level of cover, we will ask you to complete an Application Form as such requests are subject to medical underwriting. We may apply certain exclusions or restrictions to your cover and new waiting periods may apply. Once we approve your request, we will advise you in writing.

Changing principal country of residence

It is important to let us know when you change your principal country of residence. This may affect your cover, the availability of the services included in your plan or your premium, even if you are moving to an area within your network, as your existing plan may not be valid there. 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 health cover is legally appropriate. If you are not sure, please get independent legal advice, as we may no longer be able to cover you. The cover we provide is not a substitute for local compulsory health insurance.

Changing your postal address or email address

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

Correspondence

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

Renewing your cover

Subject to "Reasons your membership would end", your policy will automatically renew at the end of every Insurance Year, if:

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

As part of this automatic process, one month before the renewal date, you will receive a new Insurance Certificate along with details of any policy changes. If you don't receive your Insurance Certificate one month before your renewal date, please notify us.

Changes that we may apply at renewal

We have the right to apply revised policy terms and conditions, effective from the renewal date. The policy terms and conditions and the Table of Benefits that exist at renewal will apply for the duration of the Insurance Year. We may change the premium, benefits and rules of your membership on your renewal date, including how we calculate/determine premiums and/or the payment method. These changes will only apply from your renewal date, regardless of when the change is made and we will not add any restrictions or exclusions which are personal to a member's cover in relation to medical conditions that started after their policy's inception, provided that they gave us the information we asked them for before incepting and they have not applied for an increase in their level of cover.

We will write to tell you about any changes. If you do not accept any of the changes we make, you can end your membership and we will treat the changes as not having been made if you end your membership within 30 days of the date on which the changes take effect, or within 30 days of us telling you about the changes, whichever is later.

Your right to cancel

You can cancel the contract in relation to all insured persons, or only in relation to one or more dependants, within 30 days of receiving the full terms and conditions of your policy or from the start/renewal date of your policy, whichever is later. Please note that you cannot backdate the cancellation of your membership.

If you wish to cancel, please complete the "Right to change your mind" form which was included in your welcome/renewal pack. You can send us this form via email:

@ underwriting@allianzworldwidecare.com

Alternatively, you can post this form to the Client Services Team, using the address provided at the back of this guide.

If you cancel your contract within this 30 day period, you will be entitled to a full refund of the cancelled member(s) premiums paid for the new Insurance Year, provided that no claims have been made. If you choose not to cancel (or amend) your policy within this 30 day period, the insurance contract will be binding on both parties and the full premium owing for the selected Insurance Year will be due for payment.

Reasons your membership would end

Please remember that your membership (and that of all the other people listed on the Insurance Certificate) will end:

- If you do not pay any of your premiums on, or before, the date they are due. However, we may allow your membership to continue without you having to complete a Confirmation of Health Status Form, if you pay the outstanding premiums within 30 days after the due date.
- If you do not pay the amount of any IPT, taxes, levies or charges that you have to pay under your agreement with us on or before the due date.

- Upon the death of the policyholder. Please see the section on "Death of the policyholder or a dependant" for further details.
- If there is reasonable evidence that the policyholder or any dependants misled or attempted to mislead us. Examples are: giving false information, withholding pertinent information from us, working with another party to give us false information – either intentionally or carelessly – which may influence us when deciding:
  - Whether we accept the application for cover
  - The applicable premium to pay
  - Whether we have to pay a claim

  Please see the section on "The following terms also apply to your cover" for further details.
- If you choose to cancel your policy, after giving us written notice within 30 days of receiving the full terms and conditions or from the start/renewal date of your policy, whichever is later. Please see the section on "Your right to cancel" for further details.

If your membership ends for the reasons (other than for fraud/non-disclosure) listed above, we will refund any premiums you have paid which relate to a period after your membership has ended, subject to the deduction of any money which you owe us.

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

Cover will end also in the following cases:

- If you or any of your dependants reach the Maximum Ceiling amount indicated on your Table of Benefits.
- If you or any of your dependants reach the age of 70. In this case, the cover will end on the renewal date following their 70th birthday.

If a dependant reaches the Maximum Ceiling and/or turns 70 (or 18 for children dependants, or 24 if they are full-time students), he/she will simply be removed from your policy, while your own cover (or that of any other dependant on your policy) will continue. However, if you, as the policyholder, reach the Maximum Ceiling and/or turn 70, your cover will end and the next named dependant on the Insurance Certificate will need to apply to become the new policyholder, to keep the policy in force for themselves and any other dependants who are already on the policy when your cover ends. If they apply to do this within 28 days, we will, at our discretion, not add any further special restrictions or exclusions that didn't already apply at the time when your membership ends.

Policy expiry

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

THE FOLLOWING TERMS ALSO APPLY TO YOUR COVER

1. **Administrator:** The administrator of your policy is AWP Health & Life Services Limited. Registered Office: 15 Joyce Way, Park West Business Campus, Nangor Road, Dublin 12. Registered No. 509216. Allianz Partners and Allianz Care are registered business names of AWP Health & Life Services Limited.

2. **Applicable law:** Your membership is governed by the laws of England and Wales unless otherwise required under mandatory legal regulations. Any dispute that cannot otherwise be resolved will be dealt with exclusively by the courts of England and Wales.

3. **Economic sanctions:** Cover is not provided if any element of the cover, benefit, activity, business or underlying business violates any applicable sanction law or regulations of the United Nations, the European Union or any other applicable economic or trade sanction law or regulations.

4. **The amounts we will pay:** Our liability to you is limited to the amounts indicated in the Table of Benefits and any policy endorsements. The amount reimbursed, whether under this policy, public medical scheme or any other insurance will not exceed the figure stated on the invoice.

5. **Who can make changes to your policy:** No one, except an appointed representative is allowed to make changes to your policy on your behalf. Changes are only valid when confirmed in writing by us.

6. **When cover is provided by someone else:** We may decline a claim if you or any of your dependants are eligible to claim benefits from:

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

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

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

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

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

8. **Fraud:**

a) The information you and your dependants give us, e.g. on the Application Form or supporting documents, needs to be accurate and complete. If it isn't correct or if you don't tell us about things that may affect our underwriting decision, it may invalidate your policy from the start date. You also need to tell us about any medical conditions that arise between completing the Application Form and the start date of the policy. Medical conditions that you don't tell us about will most likely not be covered. If you're not sure whether certain information is relevant to underwriting, please call us and we'll be able to clarify that. If the contract is rendered void due to incorrect disclosure or non-disclosure of any material facts, we will refund the premium amount(s) paid to date minus the cost of any medical claims already paid. If the cost of claims exceeds the balance of the premium, we will seek reimbursement of this amount from the principal member.

b) We will not pay any benefits for a claim if:

- The claim is false, fraudulent or intentionally exaggerated.
- You or your dependants or anyone acting on your or their behalf use fraudulent means to obtain benefit under this policy.

The amount of any claim we paid to you before the fraudulent act or omission was discovered will become immediately owing to us. If the contract is rendered void due to false, fraudulent, intentionally exaggerated claims or if fraudulent means/devices have been used, premium will not be refunded, in part or in whole, and any pending claims settlements will be forfeited. In the event of fraudulent claims, the contract will be cancelled from the date of our discovery of the fraudulent event.

9. **Cancellation:** We will cancel the policy where you have not paid the full premium due and owing. We will notify you of this cancellation and the contract will be deemed cancelled from the date that the premium payment became due and payable. However, if the premium is paid within 30 days after the due date, the insurance cover will be reinstated and we will cover any claims which occurred during the period of delay. If the outstanding premium is paid after the 30-day limit, you must complete a Confirmation of Health Status Form before your policy can be reinstated, subject to underwriting.

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

11. **Services provided by third parties:** Certain services included in your plan (e.g. second medical opinion, accommodation and travel booking, concierge, counselling, legal and financial referral services) are offered through third party providers outside of the Allianz Group. These services are subject to the conditions outlined in this Benefit Guide and on your Table of Benefits. Allianz Assistance, Allianz Care and all companies within the Allianz Group are not responsible or liable for any claim, loss or damage, directly or indirectly resulting from your use of these services. These services may be subject to geographical restrictions.

12. **Services we provide:** The medical case management and hospital booking services are provided by us. These services are intended to assist you in the coordination of your treatment journey and to ease the administrative burden. They do not provide medical or health advice and are not a substitute for professional advice, diagnosis or treatment.

    We are not liable for any claim, loss or damage directly or indirectly resulting from any act or omission of any third party medical providers including, treatment, advice, diagnosis, misdiagnosis or failure to diagnose.

DATA PROTECTION

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

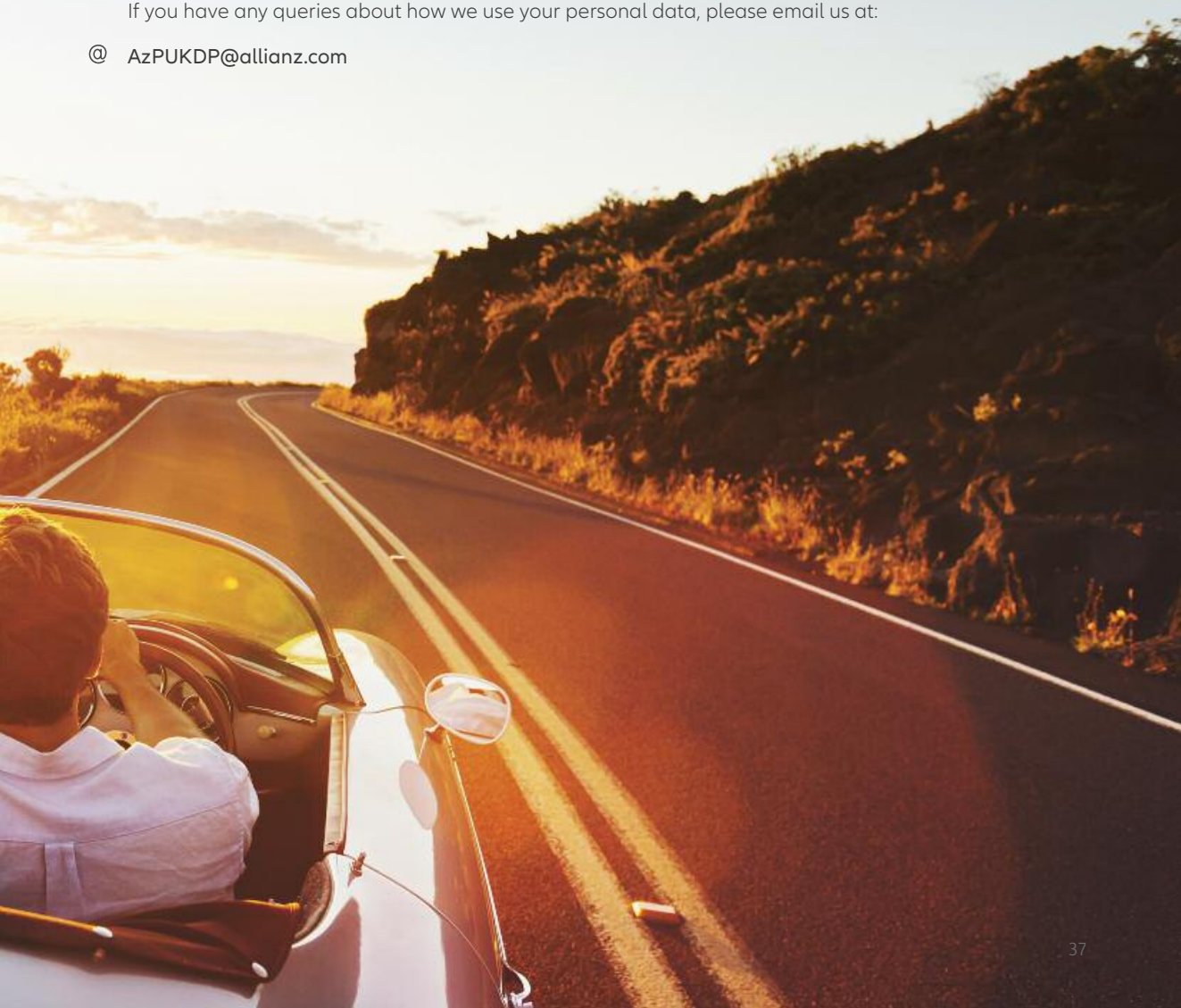
www.allianzcare.com/uk-privacy-notice

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

0203 5642 546

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

AzPUKDP@allianz.com



COMPLAINTS AND DISPUTE RESOLUTION PROCEDURE

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

0203 5642 546

client.services@allianzworldwidecare.com

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

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

www.allianzcare.com/en_GB/uk-complaints.html

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

Mediation

1. Any differences in respect of medical opinion in connection with the results of an accident or medical condition must be notified to us within nine weeks of the decision. Such differences will be settled between two medical experts appointed by you and us in writing.

2. If differences cannot be resolved in accordance with Clause 1 above, the parties will attempt to settle by mediation in accordance with the Centre for Effective Dispute Resolution (CEDR) Model Mediation Procedure any dispute, controversy or claim arising out of or relating to this Agreement or the breach, termination or invalidity thereof where the value is £500,000 or less and which cannot be settled amicably between the parties. The parties will endeavour to agree on the appointment of an agreed Mediator. If the parties fail to agree the appointment of an agreed Mediator within 14 days, either party, upon written notice to the other party, may apply to CEDR for the appointment of a Mediator.

   To initiate the mediation, a party must give notice in writing (Alternative Dispute Resolution (ADR) Notice) to the other Party to the dispute, requesting mediation. A copy of the request should be sent to CEDR. The mediation will start no later than 14 days after the date of the ADR notice. No Party may commence court proceedings/arbitration relating to any dispute pursuant to this Clause 2 until it has attempted to settle the dispute by mediation and either the mediation has terminated or the other Party has failed to participate in the mediation (provided that the right to issue proceedings is not prejudiced by a delay). The mediation will take place in the country of the Applicable Law. The Mediation Agreement referred to in the Model Procedure will be governed by, and construed and take effect in accordance with the laws of the country of the Applicable Law. The Courts of the country of the Applicable Law will have exclusive jurisdiction to settle any claim, dispute or matter of difference which may arise out of, or in connection with, the mediation.

3. Any dispute, controversy or claim which is:

   - Arising out of or relating to this Agreement (or the breach, termination or invalidity thereof) with a value in excess of £500,000, or

   - Referred to mediation pursuant to Clause 2 but not voluntarily settled by mediation within three months of the ADR Notice date

   will be determined exclusively by the Courts of the country of the Applicable Law and the parties will submit to the exclusive jurisdiction of those courts. Any proceedings brought pursuant to this Clause 3 will be issued within nine calendar months of the expiration date of the aforementioned three month period.

Legal action

You will not institute any legal proceedings to recover any amount under the policy until at least 60 days after the claim has been submitted to us and not more than six years from the date of this submission, unless otherwise required by mandatory legal regulations.

DEFINITIONS

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

A

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

Accommodation costs for a companion staying in hospital with an insured person refers to the hospital accommodation costs for one person to be with the insured person who is hospitalised for an eligible treatment. These costs are covered through the duration of the insured person's treatment; they are covered for only one hospitalisation case per Insurance Year. If a suitable bed is not available in the hospital, we will contribute the equivalent of the daily room rate in a three-star hotel towards any hotel costs incurred. We do not cover sundry expenses such as meals, phone calls or newspapers.

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

Artificial limbs needed after a limb loss in an accident refers to cases where, due to an accident or surgery, the patient requires an artificial device that replaces the lost limb or part of it. The loss of a limb is not covered if it is due to a congenital disease.

We cover the following types of prosthesis:

- Passive devices
- Body-powered devices
- Bionic devices

B

Bone marrow transplant (allogenic) refers to transplant of healthy blood stem cells from a donor's bone marrow to a patient who has diseased or damaged bone marrow.

We cover allogenic bone marrow transplant when required for the following conditions:

- Leukaemia
- Myelodysplastic syndrome
- Lymphomas
- Neuroblastoma
- Ewing sarcoma
- Aplastic anaemia
- Paroxysmal nocturnal haemoglobinuria

Donor costs relating to the allogenic bone marrow procedures will be covered as follows:

- HLA typing for the proposed donor
- Bone marrow harvesting procedure
- Recovery of the donor

Please check your Table of Benefits for the benefit limits applicable to the living donor medical costs.

Please note that your policy does not guarantee the availability of donor bone marrow. Bone marrow transplant can only be performed when donor bone marrow is available and in accordance to the rules and regulations which apply in the country where the treatment is carried out.

C

Cancer refers to a malignant growth or tumour resulting from an uncontrolled division of cells, which spreads into and invade other tissues. It can come in the form of a solid tumour, or it can be in the blood or lymph system (as leukaemia or lymphomas). Cancer always requires treatment as it presents a risk to life.

We cover the following treatments for cancer (check your Table of Benefits for the applicable benefit limit):

- Surgery to remove a tumour and/or affected tissue from the body.
- Radiation therapy.
- Chemotherapy.
- Immunotherapy.
- Targeted drug therapy.
- Hormone therapy.
- Stem cell transplant.

We also cover the cost of an external prosthetic device for cosmetic purposes, for example a wig for hair loss or a prosthetic bra after breast cancer treatment.

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

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

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

Concierge service refers to the set of services that are provided to the insured person who receives treatment overseas within the Avenue network. The concierge service may include, for example, 'meet and greet' service at the hospital or hotel, and translation and interpretation services during your treatment. It can be provided by the hospital directly or by a third party organised by us.

Coronary artery angioplasty/stenting is a procedure used when there is a narrowing coronary artery. The surgeon uses a specially designed balloon catheter to reach the point of narrowing of the coronary artery, then inflates the balloon to stretch the artery and restore optimum blood flow. A wire mesh (stent) might be inserted to avoid re-occlusion.

We cover the coronary artery angioplasty/stenting if it is required to treat a coronary artery disease (we will adhere to the indications published by the American Heart Association and the European Society of Cardiology).

Coronary artery bypass surgery (CABG) is required to improve blood flow to the heart muscle when there is a blocked artery. A healthy blood vessel from the leg, arm or chest is used to build a bypass, re-directing the blood flow around the section of blocked artery.

We cover CABG when at least one of the following situations apply:

- There is a left main coronary artery stenosis of over 50%.
- There is a diameter reduction of over 70% in the left anterior descending artery.
- There is a three-vessel disease in asymptomatic or mild stable angina pectoris.

D

Day-care treatment is planned treatment received in a hospital or day-care facility during the day, including a hospital room and nursing, that does not medically require the patient to stay overnight and where a discharge note is issued.

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

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

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

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

E

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

F

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

H

Heart valve replacement or repair refers to surgery required when one of the four valves that keep the blood flowing in the right direction through the heart does not work properly. The heart valve replacement or repair is covered for both adults and children – however, cover for children is provided when their valve damage is acquired (not congenital).

The surgical intervention can range from a minimally invasive repair via a catheter to open heart surgery. It can either be aimed at repairing the damaged valve or at replacing it with an artificial valve or a bioprosthesis.

We cover heart valve surgery if it is required for any of the following conditions:

- Aortic valve stenosis or insufficiency
- Mitral valve stenosis or insufficiency
- Tricuspid valve stenosis or insufficiency
- Pulmonary valve stenosis or insufficiency

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

Hospital is any establishment which is licensed as a medical or surgical hospital in the country where it operates and where the patient is permanently supervised by a doctor. The following are not considered hospitals: rest and nursing homes, spas, cure-centres and health resorts.

Hospital accommodation refers to in-patient stay in a private or public hospital. If available, the insured person will be offered a private or semi-private room. If these are not available, public ward will be offered until a private/semi-private room becomes available. In this case, costs (if any) incurred in the public ward will be reimbursed by the insurer. Deluxe, executive rooms and suites are not covered.

Hotel accommodation costs refers to the hotel costs for:

- The insured person receiving eligible medical treatment on a day-care basis, at a hospital over 50 km from his/her home.
- The insured person who, following discharge from in-patient treatment received at a hospital over 50 km from his/her home, is not fit to travel back home for medical reasons.
- One person accompanying an insured person receiving eligible treatment at a hospital over 50 km from his/her home. If the insured person is a child under 18, hotel accommodation costs are covered for both accompanying parents, where accommodation in the same hospital is not available for one of them.
- Any living donor required for the eligible treatment that the insured person receives in a hospital over 50 km from his/her home.

For the insured person and any companion, the accommodation costs are covered from when the insured person arrives to the location of the hospital until:

- The treatment is complete (and the treating doctor confirms that the insured person is fit for travel), or
- The benefit limit indicated in your Table of Benefits is reached.

The hotel costs will be covered up to the equivalent of the daily room rate in a three-star hotel for Avenue 1 and Avenue 1 Plus plans, four-star hotel for Avenue 2 and Avenue 2 Plus plans, and five-star hotel for Avenue 3 and Avenue 3 Plus Plans. If the insured person requires several trips to the hospital's location for eligible medical treatments required within the same medical case, we will cover the accommodation costs up to the benefit limit indicated in your Table of Benefit. We do not cover sundry expenses such as meals, phone calls or newspapers.

The above accommodation costs are covered only if the hotel is booked by us. Subject to availability, when we book the hotel we will try to ensure that it is within 10 km from the hospital where the insured person will receive treatment. We will decide the hotel booking dates based on the approved treatment schedule. If you, any dependants, accompanying person or donor are a 'no show' or cancel the hotel accommodation we book, the amount of any cancellation fees will be deducted from the relevant Benefit Limit indicated on your Table of Benefits. We are not responsible or liable for any claim, loss or damage, directly or indirectly resulting from the cancellation of accommodation. We are also not responsible and/or liable in the event that the member is not satisfied with the accommodation standard, room size, layout or bed configuration.

I

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

Insurance Certificate is a document we issue that outlines the details of your cover. It confirms that an insurance relationship exists between you and us.

Insurance Year applies from the effective date of your policy, as shown on the Insurance Certificate and ends exactly one year later.

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

K

Kawasaki syndrome is also called mucocutaneous lymphoid syndrome. It is a rare disease primarily affecting children under the age of five. It involves inflammation of the blood vessels, the lymph nodes and the mucous membranes inside the nose, mouth, eyes and throat, fever and at a later stage joint pain. Complications as involvement of the coronary arteries can occur.

Children insured under this plan will be covered for treatment in either private or public hospitals within our Avenue network.

L

Living organ transplant refers to surgery, to replace a terminally damaged organ with a (portion of or entire) functioning one donated by a living person (the donor).

These are the organ transplants that we cover:

- Kidney (entire organ)
- Liver (partial organ)
- Pancreas (partial)
- Lung (partial)
- Intestine (partial)

We will cover the following treatments and procedures relating to the above organ transplants:

- HLA typing for both the insured person (the patient) and their potential donor.

- Any required travel costs/travel management for both the donor and the patient, where they need to receive the surgery or treatments in another country.
- Surgery to harvest the living organ from the donor, including any pre-operative testing.
- Surgery to remove the damaged organ from the patient (including any pre-operative testing) and to transplant the newly donated organ.
- After-care/recovery procedures for both the donor and the patient until they are medically fit to travel home (where surgery has been received overseas).
- After-care/recovery procedures for both the donor and the patient when treatment is received in their home country.

Please note that your policy does not guarantee the availability of donor organ. Living organ transplant can only be performed when donor living organ is available and in accordance to the rules and regulations which apply in the country where the treatment is carried out.

Long-term care refers to care provided over a period of time after the acute treatment has been completed, usually for a condition 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.

Lump sum payment refers to the payment we offer to you as per your Table of Benefit if you are diagnosed with one of the medical cases covered under your policy. It is an alternative benefit you can claim for each confirmed medical case instead of the medical case management service and medical treatment benefits. The terms and process for claiming for this benefit is outlined in the 'Terms and conditions of your cover' section of this guide. A waiting period applies for this benefit.

M

Major vascular surgery refers to the surgical repair of major vessels affected by a disease. It entails excision and replacement of the damaged portion of the vessel with a graft, stenting and/or endovascular repair via catheter.

We cover major vascular surgery when it affects the following arteries:

- Thoracic and abdominal aorta
- Iliac and femoral arteries
- Renal arteries

Medical case refers to the combination of treatments, procedures, medications, tests and medical services required to treat a specific condition or injury. Your treating doctor will propose a treatment plan for a medical case, which must be reviewed and agreed with your medical case manager. Each of the following conditions or surgical procedures is considered as a separate medical case in this plan.

- Artificial limbs needed after a limb loss in an accident
- Bone marrow transplant
- Cancer (includes all solid organ cancers, lymphomas and leukaemia)
- Coronary artery angioplasty/stenting
- Coronary bypass surgery
- Heart valve replacement or repair (for children, only when it's needed as a result of rheumatoid fever)
- Kawasaki Syndrome
- Living organ transplant
- Major vascular surgery (including aortic surgery)
- Meningitis/encephalitis
- Neurosurgery
- Severe epilepsy

Medical case manager is a person who assists in the planning, coordination, monitoring, and evaluation of medical services on your behalf, with emphasis on quality of care, continuity of services, and cost-effectiveness.

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

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

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

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

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

Medical underwriting is the assessment of insurance risk based on information that you give us when applying for

cover. Our underwriting team uses this information to decide the terms of our offer.

Meningitis/encephalitis refers to conditions that affect the brain. Meningitis is an acute inflammation of the membranes covering the brain and spinal cord, usually presenting with fever, severe headache and neck stiffness. Encephalitis is an inflammation of the brain, usually caused by a viral infection or an autoimmune disorder.

We cover acute treatment for meningitis or encephalitis (either in Intensive Care Unit or not), excluding rehabilitation and long-term care.

N

Neurosurgery refers to the surgical treatment of conditions of the brain and the spinal cord. We cover neurosurgery for the following cases:

- Brain tumours (benign or malignant)
- Brain artery aneurysms
- Brain arteriovenous malformations
- Spinal cord tumours (benign or malignant)

O

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

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

Overseas treatment refers to treatment provided in a country which is different than the country of principal residence. Overseas treatments can only be received at a hospital included in our Avenue network and need to be pre-approved by our Medical Team to be covered.

P

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

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

Policyholder is the person appearing first in the Insurance Certificate. For child-only policies, one of the parents or legal guardian of the child/children will be the legal owner of the policy and will be responsible for the policy administration, for understanding and acting according to the policy terms and conditions, and will be required to complete and sign the policy documents on behalf of the minor(s). However, the parent or legal guardian for child-only policies will not be insured under the policy.

Pre- and post-hospitalisation out-patient consultation refers to doctor's consultation fees, diagnostic scans and tests that are required on an out-patient basis, to prepare for in-patient or day-care treatment and, afterwards, to check recovery from the in-patient or day-care treatment received. These are covered when the in-patient or day-care treatment received is eligible under your plan.

Pre-existing conditions are medical conditions for which one or more symptoms presented in the 10 year period up to the start date of your policy. This applies regardless of whether you or your dependants sought any medical advice or treatment, irrespective of whether any diagnosis was made. We would deem any such condition to be pre-existing if we could reasonably assume you or your dependants would have known about it.

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

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

Such pre-existing conditions will also be subject to full medical underwriting. Therefore, it is important that in the periods outlined above, you inform us if there is any change to your and your dependants' health status. If they are not disclosed, they may invalidate your policy from the start date.

We will take into consideration any declared pre-existing conditions and decide the terms of acceptance for the medical cases defined in this Benefit Guide. We will only consider medical conditions that happened in the 10 year period up to the start date of your policy.

If you declare any pre-existing conditions in your application, we may exclude certain medical cases from your cover. If that happens, we will tell you in writing.

Failing to tell us about any pre-existing conditions may invalidate your policy from the start date.

Prescription drugs refers to products which you can't buy without a prescription and are to treat a confirmed diagnosis or medical condition or to compensate a lack of vital bodily

substances. Examples are antibiotics, sedatives, etc. Prescription drugs must be clinically proven to be effective for the diagnosed condition. They must also be recognised by internationally accepted medical guidelines.

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

R

Reasonable and customary refers to treatment costs that are usual within the country of treatment. We will only reimburse the cost of medical providers where their charges are reasonable and customary and in accordance with standard and generally accepted medical procedures.

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

Repatriation of mortal remains is the transportation of the deceased insured person's remains from the country where he/she was being treated to the country of burial. This is covered in the unfortunate event that the insured person passes away for causes directly related to an eligible medical case, while receiving treatment outside of his/her country of residence. The repatriation of mortal remains is also covered where the insured person's living donor (required as part of eligible treatment) passes away outside of his/her country of residence, for causes directly related to the procedure of donating the organ. We cover costs such as: embalming, a container legally appropriate for transportation, shipping and the necessary government authorisations. Cremation costs will only be covered if the cremation is required for legal purposes.

S

Second medical opinion is the evaluation of symptoms, medical tests results and records by an external, independent medical expert. This is required to confirm and/or add to an initial medical diagnosis and treatment plan proposed by a doctor previously consulted. The second medical opinion can also offer an alternative diagnosis and treatment approach.

Severe epilepsy refers to refractory/drug-resistant epilepsy – it is a form of epilepsy that does not respond to at least two anti-seizure medications. We cover the following surgical interventions to remove the brain tissue in the area where the seizures originate:

- Resective surgery
- Laser interstitial thermal therapy
- Deep brain stimulation
- Corpus callosotomy
- Hemispherectomy
- Functional hemispherectomy
- Surgery for sequelae from encephalitis

Specialist is a licensed doctor possessing the additional qualifications and expertise necessary to practise as a recognised specialist in diagnostic techniques, treatment and prevention in a particular field of medicine. This benefit does not include cover for psychiatrist or psychologist fees.

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

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

T

Travel costs refers to the reasonable and customary transportation costs required to travel from your home to the agreed location where you will receive in-patient treatment for an eligible medical case. Travel costs are covered for the insured member (the patient), one accompanying person if medically necessary (or both parents if the patient is a minor) and any living donor (if the overseas treatment includes an eligible organ transplant).

All travel arrangements (except taxis and train journeys) must be made by us: we will not cover any other travel costs where arrangements are made by you or any third party on your behalf.

For taxis and train journeys, you will be responsible to organise those yourself (once you have agreed them with us on your travel plan) - you will be required to pay for those costs upfront and claim them back from us.

We cover travel costs for journeys by plane, train and taxi (as required and agreed in advance with us), up to the benefit limit indicated in your Table of Benefits and according to the following conditions:

- Flights: standard economy class (unless your plan is Avenue 3 or Avenue 3 Plus, in which case flights are covered up to business class)
- Trains: standard bed/seat (unless your plan is Avenue 3 or Avenue 3 Plus, in which case train fares are covered up to first class)
- Taxis: standard rate

The 'Travel cost' benefit does not include hotel accommodation or other related expenses. If you, your dependants, accompanying person and/or donor (if applicable) are a 'no show' or cancel the travel arrangements we make, the amount of any cancellation fees will be deducted from the relevant Benefit Limit indicated on your Table of Benefits. We are not responsible or liable for any claim, loss or damage, directly or indirectly resulting from the cancellation of flights, accommodation, taxis and/or train bookings.

Cover is not provided for travel insurance. If you wish to have additional cover for travel insurance, it is your responsibility to ensure that you, your dependants, accompanying persons, or donors have adequate cover for the purposes of travelling during your treatment covered under your Avenue plan.

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

W

Waiting period is a period of time that begins on your policy start date (or effective date if you are a dependant), during which you are not entitled to cover for particular medical cases. Your Table of Benefits shows which medical cases are subject to waiting periods.

We/Our/Us is Allianz Assistance in its role as insurer and Allianz Care in its role as administrator.

Y

You/Your refers to the policyholder and any dependants named on the Insurance Certificate.

EXCLUSIONS

We do not cover the following expenses unless indicated otherwise in the Table of Benefits or in any written policy endorsement.

a) The following exclusions apply to all our medical cases covered under your plan, unless stated otherwise:

Benefits that are not in your Table of Benefits
Benefits, medical conditions, treatments, medical procedures and medications that are not listed in your Table of Benefits.

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

Complementary treatment
Complementary treatment that exists outside of traditional Western medicine, for example chiropractic treatment, osteopathy, Chinese herbal medicine, homeopathy, acupuncture and podiatry as practised by approved therapists.

Complications caused by conditions not covered under your plan
Expenses incurred because of complications directly caused by an illness, injury or treatment for which cover is excluded or limited under your plan.

Consultations performed by a doctor outside the type of network available on your plan
In-patient or out-patient consultations and any drugs or treatments that are:

- Performed/prescribed by a doctor that is not part of the network indicated on your Table of Benefits, unless authorised in writing by us, and
- Not agreed in writing with us before the start of your treatment, or at any following stage of your treatment.

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

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

Expenses of non-medical nature
Any non-medical expense (for example: interpreter's fees, hospital Wi-Fi connection costs, meals, phone calls, etc.) incurred by the insured person or their accompanying persons, except those non-medical expenses listed in your Table of Benefits.

Experimental or unproven treatment or drug therapy
Any form of diagnostic procedure, treatment or drug therapy which in our reasonable opinion is experimental or unproven, based on generally accepted medical practice – i.e.:

- Not licensed for your condition by either the FDA, EMA or NICE, or
- Not part of internationally recognised clinical practice guidelines, as issued by other global expert medical organisations.

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

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

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

Genetic testing
Genetic testing, except testing for genetic receptor of tumours.

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

Injuries caused by professional sports or hazardous activities
Treatment or diagnostic procedures for injuries arising from taking part in professional sports or hazardous activities including, but not limited to, mountain sports, snow sports, equestrian sports, water sports, car or motorcycle sports, combative sports, air sports, and dangerous recreational activities such as bungee jumping.

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

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

Medical cases that have been diagnosed or treated during the waiting period
Medical cases that have been diagnosed or treated during the waiting period are not covered under your Avenue Plan, unless they are a direct result of an accident that happened during the waiting period. Such accident related medical cases will be evaluated and covered after the relevant waiting periods are served. Please check your Table of Benefits to see what waiting period applies.

Medical error
Treatment required as a result of medical error.

Non-medical equipment
Any expense incurred in the purchase or hire of wheelchairs, special beds, air purifiers and any other similar items or equipment.

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

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

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

Pre-existing conditions
Pre-existing conditions (including pre-existing chronic conditions) presented in the 10 year period up to the start date of your policy.

Products sold without prescriptions
Products that can be purchased without a doctor's prescription.

Reproduction treatments
Any treatment in relation to reproduction and fertility.

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

Sterilisation, sexual dysfunction and contraception
Investigations into, treatment of and complications arising from:

- Sterilisation.
- Sexual dysfunction (unless as a result of a total prostatectomy following cancer surgery).
- Contraception (including the insertion and removal of contraceptive devices and all other contraceptives, even if prescribed for medical reasons).

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

Termination of pregnancy
Termination of pregnancy, except where the life of the pregnant woman is in danger.

Travel and accommodation costs
Accommodation cost and travel costs to and from medical facilities (including parking costs) for treatment, except when approved by our medical team and organised by us, up to the limit specified in your Table of Benefits. Also, any expenses in respect of transport (e.g. taxi fare) from the hotel we booked for you to the medical provider you chose for the treatment will not be covered.

Treatment in the USA
Treatment in the USA if we believe that cover was taken out with the purpose of travelling to the USA to get treatment for a condition or symptoms you were aware of:

- before being insured with us
- before having the USA in your region of cover

If we paid any claims in these circumstances, we reserve the right to seek reimbursement from you.

Treatment outside the type of network available on your plan
Treatment outside the type of network available on your plan, unless authorised by us.

Tumour marker testing
Tumour marker testing, unless you have previously been diagnosed with the specific cancer in question, in which case cover may be provided as part of the treatment plan for the 'Cancer' medical case.

Vessel at sea
Travel/repatriation from a vessel at sea to a medical facility on land.

Visa and Visa services
Visa and Visa services required for the insured person or any accompanying person when treatment is to be received overseas. Your plan doesn't cover the costs related to obtaining the Visa – also, liaising with the competent authority to obtain the appropriate Visa will be under your responsibility, as Visa service is not included in your cover.

Vitamins or minerals
Products classified as vitamins and minerals (except to treat diagnosed vitamin deficiency syndromes). These products are excluded even if they are medically recommended, prescribed or acknowledged as having therapeutic effects. Costs incurred as a result of nutritional or dietary consultations are also not covered.

b) The following additional exclusions apply to specific medical cases:

1) Cancer

Cancer arising from AIDS
Cancer that in our reasonable opinion is caused directly or indirectly by Acquired Immune Deficiency Syndrome (AIDS) or by any Human Immunodeficiency Virus (HIV) infection. For this reason, if a cancer is diagnosed to you, we will ask you to undergo a blood test for HIV, before we can confirm if you are covered for treatment. If the blood test results indicate the presence of any Human Immunodeficiency Virus (HIV) or antibodies such as a virus, we will consider that there is an AIDS or HIV infection and therefore you will not be covered. Please note that for the purpose of this policy, the definition of AIDS is the one issued by the World Health Organization in 1987, or any subsequent revision of the same definition by the World Health Organization.

Cancer arising from pre-existing conditions
Cancer that arises directly or indirectly from a pre-existing condition or cancer that is pre-existing (this means that you already had this type of cancer in the past, even if it was before the start of your policy).

Cervical dysplasia
Cancer arising from cervical dysplasia.

Skin cancer
Skin cancer, with the exception of melanomas and squamous cell carcinomas.

2) Living organ transplant

Acting as a donor
Any transplant where the insured person is the donor for a person who is not insured under his/her policy.

Alcoholic liver disease
Any transplant needed as a consequence of alcoholic liver disease.

Self-transplant
Any self-transplant, with the exception of bone marrow transplants.

Transplant from a deceased donor
Any transplants from a deceased donor.

Transplant of purchased organs
Any transplant made possible through the purchase of the required organs from a donor.

Talk to us, we love to help!

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

24/7 Helpline

LoCall number: 0203 5642 546

Other toll-free numbers (for outside of UK calls): www.allianzcare.com/toll-free-numbers

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 identity.

Email: client.services@allianzworldwidecare.com

Fax: + 353 1 630 1306

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

www.allianzcare.com/personal-avenue.html

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