

# EXPATHEALTH PLANS – POLICY WORDING

## A Morgan Price International Healthcare Ltd Policy

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Morgan Price International Healthcare Ltd is authorised and regulated by the Financial Services Authority (FSA) under license number 313738



### INTRODUCTION

In consideration of the payment of the Premium, We undertake to reimburse up to the limits detailed in your Certificate of Insurance for Medical Treatment Costs incurred during the Policy Year/Period.

Please read this Policy Wording and keep it in a safe place. Your cover is governed by **all** of the documents listed below. Each document listed below forms part of Your complete **Insurance Contract** and **must** be read as a whole:

- The Policy Wording in Force when Your insurance begins or is renewed.
- The Benefit Schedule in Force when Your insurance begins or is renewed.
- The Application Form and any associated declarations.
- The Certificate of Insurance.
- The Claim form.
- The Payment form.

Any word explained in the Definitions section herein will have the same meaning throughout this document.

A Certificate of Insurance will be issued only when You have completed an Application that has been accepted by Us and the premium has been paid. Any amended Certificate of Insurance replaces any other certificate previously issued to cover the same insurance. Any Benefit not listed on the Certificate of Insurance is not provided.

## Section 1. DEFINITIONS

### ACCIDENT

Any sudden and unforeseen event occurring during the Policy Year/Period, resulting in bodily injury, the cause or one of the causes of which is external to the victim's own body and occurs beyond the victim's control.

### ACUPUNCTURE

Therapy of a medical condition by needles or laser provided by, or ordered by a licensed Physician as defined.

### ASSISTANCE COMPANY

Cega Air Ambulance Limited which has been appointed by Morgan Price International Healthcare Ltd to perform all assistance services under this policy.

### BENEFITS

A covered expense that We will pay under this policy for Medical Treatment and other costs incurred during the Policy Year/Period.

### CERTIFICATE OF INSURANCE

The Certificate of Insurance is issued by Morgan Price International Healthcare Ltd and will confirm:

The plan type	Special terms and/or conditions
The period of cover	The deductible portion
The Country of residence	The chosen benefit list
The policy number	The geographical area of cover

### CHRONIC CONDITION

A Chronic condition is defined as a sickness, illness, disease or injury which has one or more of the following characteristics:

- is recurrent in nature
- is without a known, generally recognised cure
- is not generally deemed to respond well to treatment
- requires palliative treatment
- requires prolonged supervision or monitoring
- leads to permanent disability

### CO-INSURANCE

The portion of the Reasonable and Customary Costs You must pay for any eligible expenses.

### COMPLICATIONS OF CHILDBIRTH

refers to the following conditions that arise during childbirth that require a recognised obstetric procedure; post-partum haemorrhage and retained placental membrane. Where the insured's plan also includes a routine maternity benefit, complications of childbirth shall also refer to medically necessary caesarean sections.

### COMPLICATIONS OF PREGNANCY

refers to the following conditions that arise during the antenatal stages of pregnancy; ectopic pregnancy, miscarriage, stillbirth, hydatidiform mole.

### COUNTRY OF RESIDENCE

The Country in which You live most of the time and which is declared on the Application as Your "Country of Residence".

### DAILY CASH BENEFIT

Payable where treatment is received in a government or charitable hospital and where no costs are incurred under this policy, and no other claims are made.

## DAY PATIENT

A patient who is admitted and occupies a Hospital bed or is charged for Hospital accommodation in the course of Medical Treatment but does not remain for more than 24 hours.

## DEDUCTIBLE/EXCESS

The monetary amount for which You are responsible (either the first [\$50, \$70, \$100, \$250, \$500, \$1,000] as indicated in Your Certificate of Insurance [or Membership Card] before any remaining eligible expenses are covered under this policy.

### DEDUCTIBLE / EXCESS OPTIONS

Annual Premium loading / discount	Excess Amount	Frequency
Standard	\$50/£30/€40	Per claim
+25%	Nil	Per claim
10% discount	\$70/£40/€60	Per claim
15% discount	\$100/£75/€125	Per claim
25% discount	\$250/£130/€200	Per claim
30% discount	\$500/£270/€400	Per claim
45% discount	\$1000/£535/€800	Per claim

## DEPENDANT

The spouse or partner of an Insured Person (but excluding those legally separated), and/or unmarried children, step-children, foster children and legally adopted children, who are dependant on the Insured Person for support, provided that such children are not less than 15 days old and not more than 17 years old at the date the plan was purchased (or not more than 24 years old provided it can be proven that the child is continuing in full-time education).

## DUE DATE

The date of renewal of cover as shown on the Certificate of Insurance, or the date on which any subsequent premium installment falls due.

## EVACUATION

Evacuation applies where the necessary treatment for which the insured person is covered is not available locally or if adequately screened blood is unavailable in the event of an emergency. We will evacuate the insured person to the nearest appropriate medical centre. Please note that the nearest appropriate medical centre may not be located in your home country. The medical evacuation will be carried out in the most economical way having regard to the medical condition.

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

## EFFECTIVE DATE

The date on which coverage under this policy first begins, as specified on Your Certificate of Insurance.

## GEOGRAPHICAL AREA OF COVER

The coverage zone for which the appropriate premium has been paid. Either:

- 1) Worldwide excluding USA/Canada.
- 2) Worldwide excluding USA/Canada (90 days accident and emergency cover in USA/Canada per annum).
- 3) Worldwide including USA/Canada (Canadians and Americans are restricted to 90 days per annum for accident and emergency cover in their respective home countries).

## HOME COUNTRY

The country for which the Insured Person holds a valid passport. Where the Insured Person holds more than one valid passport, the Home Country will be taken to mean the country that the Insured Person has declared on the Application Form. Where a family is to be covered by the policy, there will be deemed to be one Home Country for that family, which will be the Home Country declared on the Application Form.

## HOSPITAL

Any institution which is legally licensed as a medical or surgical Hospital in the Country in which it is located and whose main activities are not those of a rehabilitation center, spa, hydro clinic, sanatorium, nursing home or home for the aged. It must be under the constant supervision of a resident Physician.

## ILLNESS

Any unexpected and unforeseen illness or disease which requires medical treatment while this policy is in force.

## IMMEDIATE FAMILY MEMBER

Refers to spouse, son, daughter, father, mother, brother, sister, grandson, granddaughter, grandfather or grandmother of the Insured Person.

## INJURY

An unexpected and unforeseen harm to the body caused by an Accident that requires Medical Treatment.

## IN-PATIENT

A patient who occupies a Hospital bed for more than 24 hours for Medical Treatment and whose admission was recommended by a Physician.

## INSURANCE CONTRACT

Your Application Form, Policy Wording, Benefit Schedule, Certificate of Insurance, Payment Form, Claim Form and any endorsements issued by Morgan Price International Healthcare Ltd.

## LABORATORY AND X-RAY SERVICES

Laboratory testing, radiographs and nuclear medicine procedures used to diagnose and treat medical conditions. Laboratory and X-ray Services must be provided by or ordered by a Physician.

## LIFE THREATENING MEDICAL CONDITION

Is a condition that in the opinion of the insured's Physician and the medical director of the Assistance Company requires immediate treatment and/or Emergency Air Evacuation.

## MEDICAL TREATMENT

Surgical or medical procedures the sole purpose of which are the cure or relief of an acute Illness or Injury. An acute Illness or Injury is characterised by an occurrence of brief duration, after which the Insured Person returns to his/her normal or previous state and degree of activity.

## MID WIFE FEES

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

## MINOR AILMENT

Means any condition which does not require the use of medication or treatment for a period of greater than fifteen (15) days, or more than one follow-up visit to a registered Physician, or required hospitalization, surgical intervention or referral to a specialist, and which ends at least thirty (30) consecutive days prior to the Effective Date.

## MORATORIUM

This policy has a two year moratorium. This means that pre-existing conditions will not be covered during the first two years of the policy, after which a pre-existing condition will be covered if a period of two consecutive years has elapsed during which the insured had no symptoms and received no treatment, medication, tests or advice in respect of the condition.

## NEWBORN CARE

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

## OVERALL ANNUAL LIMITS

The total aggregate Benefits that may be claimed in any one Policy Year/Period by an Insured Person. Such limits will be indicated in the Benefit Schedule and on the Certificate of Insurance.

## OUT-PATIENT

Medical treatment provided to an Insured by a Physician but which does not require having a hospital bed made available and does not require an overnight stay at a Hospital.

## PHYSICIAN

A legally licensed medical practitioner recognised by the law of the Country where treatment is provided and who, in rendering such treatment, is practising within the scope of his/her licensing and training. A Physician must be a person other than You or an Immediate Family Member.

## POLICY YEAR/PERIOD

The period of insurance from one Effective Date to the Due Date as specified on Your Certificate of Insurance.

## PRE-AUTHORISED (CLAIMS ORIGINATING OUT OF USA/CANADA ONLY)

Any Medical Treatment of which You have informed the Assistance Company prior to admission, and which We have checked against Your Insurance Contract and to which we have overtly agreed: subject to the terms and conditions of Your Insurance Contract.

## PRE-EXISTING CONDITION

Is any medical condition (or related condition), which was diagnosed, has required medical treatment (including prescribed drugs), or for which medical advice was sought or for which symptoms have occurred, whether investigated or not, but where the insured person would have reasonably been aware of such symptoms, prior to the insured's Effective Date.

## PRE-NATAL CARE

Includes common screening and follow up tests, as required during a pregnancy, amniocentesis for women aged 35 and over and DNA-analysis, if directly linked to an eligible amniocentesis. Triple/bart's or quadruple tests are not covered.

## PRESCRIBED DRUGS

Medications whose sale and use are legally restricted to the order of a Physician and do not include items that may be purchased without a Physician's prescription.

## REASONABLE AND CUSTOMARY COSTS

Costs incurred for eligible Medical Treatment and/or supplies that do not exceed the standard fee of other providers of similar standing in the same region, for the same treatment of a similar Illness or Injury.

*\*If We determine that eligible costs are above what is considered to be Reasonable and Customary for medical procedures and/or supplies in a given region of the world, then We reserve the right to reimburse only the Reasonable and Customary Costs. An assessment of the Reasonable and Customary Costs will be determined solely by the Assistance Company.*

## RENEWAL DATE

The date on which your next year's premium falls due, as specified on Your Certificate of Insurance.

## ROUTINE HEALTH CHECKS

Routine health checks are tests/screenings that are undertaken without any clinical symptoms being present. Such tests include the following examinations performed, at an appropriate age interval, for the early detection of illness or disease:

- vital signs (blood pressure, cholesterol, pulse, respiration, temperature etc.)
- cardiovascular exam
- neurological exam
- cancer screening
- well child test (for children up to the age of 6 years, up to a maximum of 15 visits per lifetime)

## ROUTINE MATERNITY

Refers to any medically necessary costs incurred during pregnancy and childbirth, including Hospital charges, specialist fees, the mother's pre and postnatal care, mid wife fees as well as newborn care. Costs related to complications of pregnancy and childbirth, are not payable under routine maternity.

## YOU/YOUR/INSURED PERSONS

Any person listed on any Certificate of Insurance.

## WE/US/OUR

Means Brit Insurance Limited on behalf of Morgan Price International Healthcare Ltd.

# Section 2. BENEFITS

## 1. CHRONIC CONDITIONS CASH BENEFIT

The following is a list of the Illnesses and related definitions that qualify as part of this Cash Benefit under Gold cover only:

**1.1 Coronary Artery Bypass** – The undergoing of heart surgery to correct narrowing or blockage of two or more coronary arteries with bypass grafts in Insured Persons with limiting anginal symptoms but excluding non-surgical techniques such as balloon angioplasty or laser relief of an obstruction.

**1.2 Major Organ Transplantation** – The actual undergoing as a recipient of a transplant of a heart, lung, liver, pancreas, kidney or bone marrow, specifically excluding transplantation of the skin and cornea.

**1.3 Cancer** – A malignant tumour characterised by the uncontrolled growth and spread of malignant cells and the invasion of tissue. This includes leukemia but excludes non-invasive cancer in situ, Clark Level I or II malignant melanoma, Hodgkin's Disease - Stages I and II, tumours

in the presence of any human immune-deficiency virus and any skin cancer other than Clark Level III or IV malignant melanoma, and non-metastatic breast and prostate cancer.

**1.4 Renal Failure** – End stage renal disease, due to whatever cause or causes, with the Insured Person undergoing regular peritoneal dialysis or haemodialysis or having had renal transplantation.

**1.5 Paralysis** – Complete and permanent functional loss of two or more limbs, resulting in Paraplegia or Quadriplegia.

**1.6 Major Burns** – Third degree burns covering at least 20% of the surface area of the Insured Person's body.

## 2. COMPASSIONATE EMERGENCY TRAVEL

When arranged and approved in advance by the Assistance Company, means either:

2.1 covered economy return expenses for travel to the bedside for an Immediate Family Member of an Insured Person who is or will most likely be hospitalized for seven consecutive days or more, up to the limits specified on the Certificate of Insurance,

or;

2.2 covered economy return expenses for travel back to the Insured Person's Home Country in case of death of an immediate family member up to the limits specified on the Certificate of Insurance. The Immediate Family Member must be under seventy-five (75) years old and must not have been diagnosed or suffer from any Life Threatening Medical Condition at the original purchase date of the plan. Under no circumstances can both compassionate benefits be claimed within the Policy Year/Period.

## 3. COMPLIMENTARY/ALTERNATIVE MEDICINE

Medical Treatment referred by the insured's Physician for the services of registered chiropractors, osteopaths and acupuncturists.

## 4. COMPLICATED MATERNITY CARE

Complicated maternity shall mean pre-natal, childbirth and post-natal treatment for You up to the limit specified. It will only apply to treatment of complicated pregnancies where the Physician has predicted the expected date of birth to be at least 12 months after the Effective Date of the policy.

A caesarean section is deemed by us to be complicated maternity only if a normal delivery was planned and fully expected in good faith, but a complication intervenes and a normal delivery is no longer appropriate. When such an event occurs, cover will be provided up to the limit specified in your Table of Benefits, for Complicated Maternity Care. Where the requirement for a caesarean section was predictable in advance (e.g. twins/triplets, breech/shoulder/face/brow presentation, placenta praevia, eclampsia or pre-eclampsia, maternal diabetes, etc.), it would not be considered by us as Complicated Maternity Care. In addition, caesarean sections planned in advance of labour because of a previous caesarean section etc., are not considered by us to be Complicated Maternity Care. In such instances, cover will be provided up to the limit specified in your Table of Benefits, for Routine Maternity.

## 5. DAILY HOSPITAL CASH BENEFIT

A cash benefit may be paid when treatment and accommodation for a medical condition that would otherwise be covered under the insured's plan, is provided in a government or charitable Hospital where no

charges are billed. This benefit is retroactively paid as of the first day of hospitalization, but payable only if the insured is hospitalized for a continuous period of 72 hours up to a maximum of 30 days.

## 6. EMERGENCY AIR EVACUATION

The medically necessary expense of emergency transportation and medical care in efforts to move an Insured Person who has a Life Threatening Medical Condition to the nearest Hospital where appropriate care and facilities are available. We will not be responsible for any costs arising from any medical and/or Emergency Air Evacuation expenses unless it is approved and arranged in advance by the Assistance Company.

This benefit also includes reasonable transportation costs for only one other person accompanying the patient on an Emergency Air Evacuation when this is deemed necessary by the Assistance Company.

In the event of an Emergency Air Evacuation, We will pay the cost of a return economy air ticket back to Your Country of Residence. This Benefit does not apply in the event of Maternity.

## 7. EMERGENCY DENTAL TREATMENT

Emergency Medical Treatment necessary to restore or replace permanently attached artificial teeth or sound natural teeth lost or damaged as a result of an external blow to the mouth and for which Medical Treatment is initiated within 72 hours following an Accident. Detailed medical documentation from a Physician or dentist must be provided to support Your claim.

## 8. IN-PATIENT HOSPITAL SERVICES

Costs for accommodation, nursing, operating theatres, drugs, dressings, diagnostic procedures or any other necessary costs billed by a Hospital, including specialist In-Patient fees for Medical Treatment as an In-Patient or Day-Patient.

## 9. LOCAL AMBULANCE SERVICES

The necessary emergency medical transportation to the nearest appropriate local Hospital.

## 10. NURSING AT HOME

Medical services of a duly licensed nurse in Your home when prescribed by a Physician and related directly to covered Medical Treatment.

## 11. ORGAN TRANSPLANTATION

Medical Treatment costs incurred with respect to kidney, heart and liver transplants.

## 12. OUT-PATIENT GP & SPECIALIST CARE

Medical Treatment provided to an Insured Person when not a Day-Patient or In-Patient. These services include: specialist consultations, drugs and dressings, physiotherapy, general practitioner consultations, lab and x-ray services, chemotherapy, radiotherapy and pathology received as an Out-Patient.

## 13. PARENT ACCOMPANYING CHILD

Accommodation costs billed by a Hospital for one parent to accompany a child aged 14 years or under when treated as an In-Patient. This policy will also pay for a child to accompany (if necessary) a parent when the parent is treated as an In-Patient.

## 14. POST HOSPITALISATION TREATMENT

All Out-Patient Medical Treatment received within the ninety day period immediately following discharge from Hospital provided by or ordered by the treating Specialist or Consultant, and which directly results from a covered Illness or Injury for which the Insured Person has been treated

as an In-Patient of a Hospital, up to a maximum benefit, as shown on the Certificate of Insurance.

#### 15. REPATRIATION OR LOCAL BURIAL

The expense of preparation and the air transportation of the mortal remains of the Insured Person from the place of death to the Home Country or Country of Residence, or the preparation and local burial of the mortal remains of an Insured Person who dies outside his/her Home Country. The costs for an urn or casket are not covered under this plan. This Benefit is excluded where death occurs in the Home Country.

#### 16. ROUTINE DENTAL

All routine dental care such as preservation and relief of pain including simple fillings, X-rays, scaling, treatment of gums, operative procedures, this also includes one routine check-up per year. Dentures are specifically excluded. Dentures or dental appliances include restoration of the function of dental prostheses and the installation of new prostheses, crowns, bridges and pivot teeth.

The routine dental benefit is only available to Insured Persons who have consulted for dental inspection and concluded all necessary treatment in the twelve month period immediately prior to enrolment in the plan, or immediately prior to claiming Routine Dental Treatment benefit under the plan, whichever is the later. A report from Your dentist may be required.

#### 17. ROUTINE HEALTH CHECKS

Routine health checks are available to members who have completed a continuous period of 24 months cover with us. The tests covered are detailed under the definitions section of this wording. Please contact the helpline prior to incurring any costs under this benefit, to check eligibility.

## Section 3. GENERAL CONDITIONS

(Applicable to all benefits sections)

#### 1. THE CONTRACT

The schedule of benefits, the policy wording, the proposal form and any endorsements issued form part of the contract and should be read together as one.

#### 2. LEGAL PROCEEDINGS AND APPLICABLE LAW

You shall not institute any legal proceedings to recover any amount under the policy until at least sixty days after the claim has been submitted to us and not more than two years from the date of this submission unless otherwise required by mandatory legal regulations. The policy shall be construed in accordance with English law, unless agreed otherwise between You and Us, or required under mandatory legal regulations.

#### 3. DUE CARE AND ATTENTION

The Insured shall at all times act in a prudent manner and shall exercise reasonable care to prevent accidental injury or illness.

#### 4. CLAIMS AND DISPUTE

All claims shall be considered fairly under the terms of the insurance and all such decisions shall rest solely with the Insurer. Any differences in respect of medical opinion in connection with the results of an Accident or illness will be settled between two medical experts appointed by the two parties to the dispute in writing. Any difference of opinion between the two medical experts shall be referred to an umpire who shall have been appointed in writing by the two medical experts at the time of their appointment.

#### 5. MAKING A CLAIM

Original documentation, supporting invoices and receipts and a fully completed claim form must be submitted when making a claim (copies are not acceptable). The claim form must be completed by the treating Physician or specialist. A claim form is not acceptable when completed by a physiotherapist, osteopath or chiropractor or any practitioner not qualified to practise in medicine. The Insured is advised to contact the Morgan Price Claims Department prior to treatment or hospitalisation to determine eligibility of this treatment.

#### 6. PAYMENT OF CLAIMS AND SUBROGATION

- The Insurer is entitled to delay payment of a claim to determine validity, or to request the Insured to furnish them with any necessary additional information or consents, or to examine the Insured whose accidental injury or illness is the subject of the claim at their own expense, or in the event of death to have a post mortem undertaken at their own expense where this is not prohibited by law.
- The Insurer must be advised if the Insured can make a claim on any other insurance policy, e.g. a third party claim, Government department, and the like. The Insurer has full rights of subrogation.

#### 7. ALTERATIONS TO POLICY TERMS

The Insurer is entitled to alter all or any part of the wording and the benefits or to terminate the plan. Notification will be sent to the Insured's last known address and the change will take effect from the next renewal date.

#### 8. ELIGIBILITY

The insurance is available to anyone up to the age of 74 years at the expiry of this insurance.

Newly born children shall be eligible for insurance on the fifteenth (15) day after the date of birth, or on the fifteenth (15) day after discharge from the Hospital where the birth took place, whichever is the later, and as long as the appropriate premium has been remitted and subject to the terms and conditions of the Insurance Contract.

#### 9. MATERIAL RISK

If You or any Insured Person regularly engage in any occupation, sport, pastime or other activity in which materially greater risk may be incurred than previously disclosed in connection with this plan You must notify the Insurer and obtain written agreement to the inclusion under this plan.

#### 10. EMERGENCY ASSISTANCE

The International emergency assistance and claims administration services will be provided by Cega Air Ambulance Limited on behalf of Morgan Price International Healthcare Ltd and all repatriations/evacuations/return of mortal remains will be at the sole discretion of Cega Air Ambulance Limited and no other assistance provided by any other company will be considered a covered benefit.

This benefit does not apply in respect of maternity claims

#### 11. POLICY DURATION AND PREMIUM PAYMENT

- This is an annual contract which is renewable each year subject to the terms and conditions in force at the renewal date and subject to payment of the applicable renewal premium.
- All premiums are payable in advance of cover being provided under this policy.
- Premiums are payable monthly, quarterly, semi annually or annually but this is an annual contract of insurance, so you are still responsible for paying the entire annual premium even if we have agreed you may pay by instalments. If we do agree you can pay by instalments then you must ensure the credit card you supply is valid for the entire period of

the policy.

d. We reserve the right to withdraw frequency payment facilities and/or charge an administration fee for non-payment;

e. The policy will be cancelled if a payment date is missed although we may subsequently reinstate cover if an outstanding payment is received within 30 days of its due date;

f. If we do reinstate cover we reserve the right to reapply exclusion 1;

g. IMPORTANTLY – If a premium is outstanding, any claims will be suspended and will not be settled until the premium is paid up to date;

h. If any premium is unpaid at the end of this 30day period, and the policy is cancelled, it will be cancelled from the date that the unpaid premium was due. Any outstanding premium will be deducted from any valid claim in progress, or will be deducted from the credit card or debit card supplied;

i. Premiums are payable in the currency of the policy which you elected at the effective date of the policy;

j. We reserve the right to alter premiums at any time but if we do so the new premiums will not be effective until your renewal date;

k. We reserve the right to alter the amount of Insurance Premium Tax, government levies or other taxes as and when they change by law and to apply them at the next premium due date.

#### 12. COOLING OFF PERIOD

a. The policyholder may cancel the policy within 14 days of the effective date. If you have not made a claim on the policy we will refund your premiums paid in full.

b. If you have made a claim then we will refund your premium after deducting a charge for the cover provided from the beginning of the contract until the policy is cancelled.

#### 13. CANCELLATION

a. If the policyholder wishes to cancel the policy at any other time you must give us notice in writing at the address shown on the policy documentation. We will cancel the plan 14 days from the date of receipt of such instruction or from a future date – under no circumstances will we backdate any cancellation;

b. All membership cards and policy certificates must be returned to us with your cancellation notification and then a pro rata refund may be applicable provided no claims have been made on the current 12 month policy period. If a claim has been made, then no refund will be payable;

c. If you cancel your plan we reserve the right to charge an administration fee of £30;

d. We will not cancel this policy because of eligible claims made by any Insured Person. However we reserve the right to cancel the policy at any time if any Insured Person has :

i. Misled us by mis-statement or concealment; or

ii. Made or attempted to make a false or fraudulent claim or if any person uses any methods to try to make a fraudulent claim; or

iii. Fails to act with utmost good faith; or

iv. Fails to pay the appropriate premium.

#### 14. OTHER INSURANCE

If there is any other insurance covering the same benefits as provided for under this policy, you must disclose the same to us, and we will not be liable for more than our rateable proportion.

#### 15. CHANGE OF COVER LEVEL

You may change your level of cover and/or any voluntary excess/deductible at your next renewal date. Such changes will apply for the following annual period of cover.

#### 16. CHANGE OF AREA OF COVER

You may change your area of cover at any time. Such change will be effective from the date we are notified subject to the payment of any additional premium due.

#### 17. RENEWAL

(a) We will invite you to renew your plan each year. We will ordinarily do this by email unless you have contacted us to ask for a different method.

(b) You are obliged to ensure that we have current contact details for you (in particular if you have changed your email address during the year) at all times but especially at the renewal date since without these we cannot contact you and your cover may lapse.

(c) The premiums applicable and the benefits in force may be altered at each annual anniversary but we will advise you of any changes in advance.

(d) Your obligations to disclose any changes to material facts reappplies at each renewal, since each annual period of insurance is a separate contract between you and us.

(e) If you pay your premiums by credit card and the card we hold is still valid at renewal, then your plan will be renewed on the anniversary date at the new rates applicable – this means we will automatically debit the card with the applicable payment. If the payment is not accepted by your card issuer then the policy will be suspended and we will attempt to contact you. If we cannot contact you within 30 days of the renewal date then the policy will be lapsed from the renewal date and any claims made after the renewal date will not be valid.

(f) If you do not want to renew your policy you MUST contact us and advise us of this prior to the renewal date shown on your current Certificate of Insurance.

#### 18. PAYMENT OF DEDUCTIBLE/EXCESS

In the event of a claim where we will be billed directly by the provider of medical services, we will pay the provider less the amount of the Deductible/Excess and you will be liable to pay the outstanding amount directly to the provider. For those eligible claims that are paid by the Insured Person and then claimed against Us, we will withhold the Deductible portion from any eligible expenses prior to reimbursement.

#### 19. PRE-AUTHORISATION (USA/CANADA ONLY)

*\*Applicable only to Insured Persons needing covered medical treatment within the USA or Canada.*

Except in the event of a critical emergency, all In-Patient and Day Patient hospitalizations and special Out-Patient Services such as magnetic resonance imaging (MRI), cardiac catheterization, computerized axial tomography (CAT) scans and biopsies must be pre-authorized and arranged in advance by us. Failure to do so will limit your benefits to 80% of eligible expenses, based on Reasonable and Customary Costs, to an overall annual maximum of \$25,000.

In the event of a critical emergency where In-Patient or Day-Patient hospitalization is required, you must contact us as soon as reasonably possible. If You fail to notify the Assistance Company and We determine that You could have reasonably been able to do so, then Your benefits may be limited to 80% of eligible expenses, based on Reasonable and Customary Costs, to an overall annual maximum of \$25,000.

#### 20. TRANSFER TO ANOTHER HOSPITAL (USA / CANADA ONLY)

*\*Applicable only to Insured Persons needing covered medical treatment within the USA or Canada.*

Whether prior to admission, or during a covered hospitalization which

You have pre-authorised, the Assistance Company reserves the right to transfer You, without danger to Your life or health, to one of our preferred health care providers for the Medical Treatment of Your Illness or Injury. If You decline to be transferred when declared medically stable by the Medical Director of the Assistance Company, We will then be released from any liability for expenses incurred for such Illness or Injury after the proposed transfer date. The Assistance Company will choose the Hospital and arrange the transfer of the insured person making every provision for the Medical Condition of the patient.

## Section 4. EXCLUSIONS

We will not pay for the following treatments, conditions, activities, items or their consequences or any related expenses:

1. Pre-existing conditions during the first two years of the policy. After this moratorium period, a pre-existing condition will be covered if a period of two consecutive years has elapsed during which the insured had no symptoms and received no treatment, medication, tests or advice in respect of the condition.
2. AIDS – Acquired Immune Deficiency Syndrome (AIDS), AIDS-related Complex Syndrome (ARCS) and all diseases caused by and/or related to the HIV virus.
3. Alcohol, Drug or Substance Abuse - Medical Treatment for alcoholism, drug or substance abuse or addiction or conditions that may be attributed to alcohol, drug or substance abuse or addictions and direct consequences thereof.
4. Appliances – Prostheses, corrective devices, wheelchairs and medical appliances which are not required intra-operatively including glasses, contact lenses, hearing aids, dentures or dental appliances.
5. Auto Therapy – Medical Treatment performed by an Immediate Family Member and self treatment including prescription of drugs.
6. Birth Control – Costs for birth control devices and/or prescriptions.
7. Birth Defects – Medical Treatment relating to Birth Defects and congenital illnesses. Birth defects are deemed to include hereditary conditions.
8. Care of the Aged – Medical Treatment in any establishment for the care of the aged.
9. Chronic Conditions – Illnesses once they have been diagnosed as either chronic or terminal. However, Acute phases of a Chronic Condition newly diagnosed after the Effective Date are covered.
10. Claims After Renewal Date - Claims and costs for medical treatment incurred after the Renewal Date on the Certificate of Insurance, unless the plan has been renewed. A plan is considered to be renewed if invited by us and if the appropriate renewal premium is received prior to any claim.
11. Cosmetic Treatment - Elective and/or cosmetic surgery, whether or not for psychological reasons or treatment for a medical condition as a result of Cosmetic Surgery.
12. Cryo Preservation – All expenses of any cryo preservation and implantation or re-implantation of living cells.
13. Dental – All dental treatment which is not Emergency Dental Treatment including crowns and root canals, unless the routine dental benefit is included in the purchased plan and is listed as a benefit on the Certificate of Insurance.
14. Emergency Medical Evacuation – All Emergency Medical Evacuation costs not approved or arranged in advance by the Assistance Company or as a result of maternity.
15. Hazardous/Professional Sports – Medical Conditions arising from any professional sports which can include: Motor racing, Motorcycling apart from roadways designed for motor traffic; Polo and steeple chasing; Racing of any kind other than on foot; Abseiling and mountain climbing requiring the use of ropes and/or pitons
16. Maternity –
  - a. Cost of tests or treatment relating to infertility or inability to conceive.
  - b. Termination of pregnancy unless for medically necessary reasons.
  - c. Any Emergency Medical Evacuation costs as a result of maternity.
  - d. Claims, including complications of pregnancy and childbirth, except where shown in the benefits schedule. Where covered, maternity claims in respect of pre and postnatal classes as well as triple/bart's or quadruple tests are not covered.
17. Medically assisted reproduction or any consequence thereof.
18. Treatment required during the first 3 months after birth for any child born as a result of medically assisted conception other than artificial insemination.
19. Military Service - Medical conditions while serving as a member of a police or military force or unit.
20. Organ Transplantation-
  - a. All Organ Transplantations except heart, kidneys and liver.
  - b. Costs resulting from the acquisition of the Organ itself and expenses incurred by the donor.
  - c. Costs for acquisition and implantation of artificial heart and mono - or bi - ventricular devices.
21. Outside Geographical Area - Any costs incurred outside the selected Geographical Area of cover.
22. Outside Policy Year/Period - Any costs incurred arising from any period for which the appropriate premium has not been paid.
23. Psychiatric Disorders –
  - a. Psychiatric conditions except as shown on the benefits schedule;
  - b. We do not cover psychotherapy and counselling;
  - c. We do not cover conditions such as conduct disorder, attention deficit hyperactivity disorder, oppositional defiant disorder, antisocial behaviour, obsessive-compulsive disorder, attachment disorders, adjustment disorders, as well as treatments that encourage positive social-emotional relationships such as communication therapies, floor time, and family therapy.
24. Radioactivity- Medical Conditions caused by or attributed to radioactive contamination.
25. Rehabilitation-Services or treatment in any long term care facility, rehabilitation centre, spa, hydro clinic, sanatorium, nursing home or home for the aged.
26. Repatriation and Local Burial - Any costs when death occurs in the insured's Home Country. Costs for a casket and/or urn are not covered.
27. Routine Examinations - Routine medical examination (including vaccinations, annual check ups, the issue of medical certificates and attestations, and examinations as to suitability for employment or travel). Routine eye and ear examinations, including the cost of spectacles, contact lenses and hearing aids.
28. Self-inflicted Injury - Costs resulting from self-inflicted injuries and/or suicide or attempted suicide whether sane or insane.
29. Sexually Transmitted Diseases - Any Medical Treatment of sexually transmitted diseases and consequences thereof.
30. Transportation Costs - All transportation costs occurring during trips specifically made for the purpose of obtaining Medical Treatment if not part of an Emergency Air Evacuation, except as defined under Local Ambulance Services.
31. Unproven Treatment - Medical Treatment that is not scientifically proven or recognised.

32. War - Treatment resulting from participation in war, riot, civil commotion or any criminal act including resultant imprisonment.
33. Products that can be purchased without a doctor's prescription.
34. Products classified as vitamins or minerals (except during pregnancy or to treat diagnosed, clinically significant vitamin deficiency syndromes), nutritional or dietary supplements, including cosmetic products, even if medically recommended or prescribed or acknowledged as having therapeutic effects.
35. Prescribed physiotherapy refers to treatment by a registered physiotherapist following a referral by a medical practitioner. Physiotherapy is initially restricted to 12 sessions per condition, after which the treatment must be reviewed by the referring medical practitioner. Should further sessions be required, a progress report must be submitted to us, which indicates the medical necessity for any further treatment. Physiotherapy does not include therapies such as Rolwing, Massage, Acupressure, Milta therapy and Kinesotherapy carried out by a non registered physiotherapist.

## Section 5. Claims procedures

### 1. FOR CLAIMS INVOLVING A MEDICAL EMERGENCY

To ensure that you and your family members receive quality support and assistance in the case of an emergency, where possible, you should contact our Helpline within 48 hours of the event. Our 24 hour Helpline can provide you with a wide range of assistance services, from identifying an English-speaking doctor through to arranging a full medical evacuation.

Pre Authorisation for hospitalisation (refer to Pre Authorisation section below) is not required in emergency cases, however, we should be advised within 48 hours of the event. This will ensure that your claim is processed quickly and will also give us an opportunity of settling directly with the provider for the treatment received.

You can contact us by phone 24 hours a day, on our Helpline number +44 1243 621 567

### 2. FOR NON-EMERGENCY MEDICAL CLAIMS

Please follow the guidelines below to help us process your claims promptly and efficiently.

All claims should be submitted to us with original supporting documentation, invoices and receipts within three months of the treatment date or within 3 months after the end of the insurance year, whichever is sooner.

Before you make a claim, it is important to ensure that your plan covers the treatment you are seeking (e.g. out-patient, maternity, dental etc.). Our Helpline staff would be happy to assist with any queries you may have, you can contact our claims department on the following number:

**Morgan Price Claims: +44 1243 621224**

#### 2.1 In-patient claims

In the event of hospitalisation, we will, where possible and with sufficient notice, arrange for direct settlement with providers subject to any co-payments, excess/deductibles and benefit limits.

Our claims department should be contacted prior to commencement of treatment by your physician to have your treatment approved over the telephone. Unless it is an emergency you must contact us at least five working days prior to receiving treatment. We can then ensure there will be no delays at the time of admission and we can advise you regarding cover for your condition.

#### 2.2 Out-patient or dental claims.

Please note that psychiatric treatment and certain other treatments, will need to be pre-authorised with our claims department by your physician prior to the treatment taking place.

Please note that the incurred costs will be reimbursed within the limits of your policy, after taking into consideration any required Pre Authorisation and will be net of any deductibles or co-payments. Unless you have been informed of a different settlement arrangement, out-patient or dental treatment is generally paid for by the patient at the time of receiving treatment and the costs incurred are then recovered from Morgan Price International Healthcare Ltd.

#### We recommend the following steps in making an out-patient or dental claim:

- Whenever you visit a general practitioner, dentist, physician or specialist on an out-patient basis, please make sure you take a Claim Form with you.
- Fill in the section that is assigned to you, then date and sign the Claim Form.
- Make sure that your doctor provides all relevant medical information in the specified section and then dates, signs and stamps the Claim Form. However, if you are in Germany or the USA, or if your invoices contain details of the diagnosis as well as the nature of the treatment, there is no need for your treating doctor to complete this section of the Claim Form.
- Attach all original supporting documentation, invoices and receipts to the Claim Form (e.g. general practitioner/physician invoices, pharmacy receipts with related prescriptions (if available)), and post to the Morgan Price Claims Department at the address indicated on your Claim Form.
- If the amount to be claimed is less than the deductible figure under your plan, remember to retain the claim form and receipts - do not destroy or dispose of them. Keep collecting all out-patient receipts and claim form documents until you reach an amount in excess of your plan deductible. Then forward to us all completed Claim Forms together with original receipts/invoices.
- Remember a separate Claim Form will be required for each person claiming and for each medical condition being claimed for.
- Specify on the Claim Form the currency in which you wish to be paid, otherwise the benefit due to you will be paid in the currency of the invoice.
- Please note that the incurred costs will be reimbursed within the limits of your policy, after taking into consideration any required Treatment Guarantee and will be net of any deductibles or co-payments mentioned in the Table of Benefits.

You can download the Claim Form from our web site [www.morgan-price.com](http://www.morgan-price.com)

#### All documentation should be sent to:

Morgan Price Claims Services  
PO Box 127  
Chichester  
West Sussex  
PO18 8WQ

Morgan Price Emergency Assistance

Telephone: +44 1243 621567

Fax: +44 1243 773169

Email: [mp-assistance@cegagroup.com](mailto:mp-assistance@cegagroup.com)

Morgan Price Claims  
Telephone: +44 1243 621224  
Fax: +44 1243 790265  
Email: mp-claims@cegagroup.com

### 3. Pre Authorisation

#### 3.1 What is Pre Authorisation?

Pre Authorisation must be obtained by your physician from our claims department for approval prior to treatment.

#### 3.2 When is Pre Authorisation required?

Pre Authorisation is required for the following:

- in-patient treatment,
- MRI (Magnetic Resonance Imaging) and PET, (Positron Emission Tomography) scans,
- nursing at home,
- medical evacuation or repatriation,
- repatriation of mortal remains.

#### 3.3 Why is Pre Authorisation required?

In the case of planned hospitalisation, Pre Authorisation gives us an opportunity prior to your admission, to communicate with the hospital to facilitate smooth admission and guarantee direct payment.

This process will ensure that your hospital stay is free from financial worries, allowing you to concentrate on getting better.

#### 3.4 What happens if I don't obtain Pre Authorisation?

In the event that Pre Authorisation is not obtained for any psychiatric treatment or in-patient treatment or for any other treatment or benefit for which this service is a requirement, we reserve the right to decline a claim. If in the aftermath the treatment is proven medically necessary we will pay only 80% of the in-patient expenses and 50% of the eligible amount for all other benefits mentioned above. In the case of an emergency we should be informed within 48 hours of the event to avoid any Pre Authorisation penalty being applied.

## Section 6. Complaints Procedure

If you have a complaint or if you are unhappy with any aspect of our service, please e-mail, telephone or write in the first instance to

The Managing Director  
Morgan Price International Healthcare Ltd  
11a Forge Business Centre  
Palgrave, Norfolk, IP22 1AP  
Telephone: +44 (0)1379 646730  
email: info@morgan-price.com

We will acknowledge receipt of it within 5 working days.

If we do not resolve your complaint to your satisfaction, please e-mail, telephone or write in the second instance to:

Complaints Department  
Brit Insurance Limited  
55 Bishopsgate

London EC2N 3AS  
Telephone: +44 (0)20 7098 6509  
Fax: +44 (0)20 7984 8473  
email: complaints-team@britinsurance.com

If we do not resolve your complaint to your satisfaction, or if we are unable to give you a final response within 8 weeks of our acknowledgement to you, you may contact the Financial Ombudsman service at:

South Quay Plaza, 183 Marsh Wall, London, E14 9SR  
Or contact them on +44 (0) 207 964 1000  
(or from within the UK 0845 080 1800)