

# MORGAN PRICE INTERNATIONAL HEALTH PLANS POLICY WORDING



## A Morgan Price International Healthcare Ltd Policy

11a Forge Business Centre, Palgrave, Norfolk, IP22 1AP, United Kingdom

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

## PROVISION OF INSURANCE SERVICES AND BENEFITS

So that You are clear as to the different parties providing the insurance services and benefits under this policy:

**This is a Morgan Price International Healthcare Ltd (Morgan Price) policy.** Morgan Price are responsible for the plan design, the sales, administration (including issue of policy documents and collection of premiums) and general management of this policy.

**The Insurer** is named on the Certificate of Insurance and underwrites all of the benefits provided under the policy.

**Europ Assistance, International Health Solutions S.A.S. – a division of Europ Assistance Holdings Limited** provides the management, claims and assistance services under this policy on behalf of the Insurer and Morgan Price.

## Section 1. DEFINITIONS

**The following words or phrases have the meanings given below wherever they appear in Your policy documentation from us. Where words and phrases are not shown, they will take on their usual meaning within the English language:**

### 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.

### ACCIDENTAL DEATH

Means death caused directly as a result of an accident during the Period of Insurance.

### ACUTE

A medical condition of rapid onset resulting in severe pain or symptom which is of brief duration that is likely to respond quickly to medical treatment.

### BENEFITS

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

### BIRTH INJURY / BIRTH DEFECT

A deformity of Medical Condition which is caused during pregnancy and/or childbirth.

### BODILY INJURY

Means identifiable physical injury caused by an accident occurring during the period of insurance.

### CANCER

Any malignant tumour positively diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells and invasion of tissue. The term malignant tumour includes leukaemia, lymphoma and sarcoma.

### CERTIFICATE OF INSURANCE

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

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

### CHRONIC CONDITION

A Medical Condition which has two or more of the following characteristics:

- It has no known recognised cure.
- It continues indefinitely.
- It has come back.
- It is permanent.
- Requires Palliative Treatment.
- Requires long-term monitoring, consultations, check-ups, examinations or tests.
- You need to be rehabilitated or specially trained to cope with it.

### CLAIM

The total cost of treating a single Medical Condition or Bodily Injury.

Morgan Price International Healthcare Ltd

11a Forge Business Centre, Upper Rose Lane, Palgrave, Diss, IP22 1AP, United Kingdom  
Tel: + 44 1379 646730 / Fax: +44 1379 652794 / [www.morgan-price.com](http://www.morgan-price.com) / [www.expathealthfrance.co.uk](http://www.expathealthfrance.co.uk)

## CLOSE FAMILY RELATIVE

Spouse or partner (of the same or opposite sex), mother, mother-in-law, father, father-in-law, stepmother, stepfather, legal guardian, daughter, daughter-in-law, son, son-in-law, (including legally adopted son or daughter), stepchild, sister, sister-in-law, brother, brother-in-law, grandparents, grandchildren or fiancé(e) of an Insured Person.

## CO-INSURANCE

The percentage amount payable by you after the deductible amount has been satisfied against eligible Medical Expenses before we pay our percentage.

## COMPLICATIONS OF PREGNANCY AND CHILDBIRTH

For the purposes of this policy 'Complications of Pregnancy and Childbirth' shall only be deemed to include the following: toxæmia, gestational hypertension, pre-eclampsia, ectopic pregnancy, hydatidiform mole, ante and post partum haemorrhage, retained placenta membrane, stillbirths, miscarriage, medically necessary emergency caesarean sections and medically necessary abortions.

## COMPLEMENTARY MEDICINE

Chiropractic, Homeopathy, Osteopathy, Accupuncture, Ayurvedic, Herbal and Chinese Medicines, provided by a licensed practitioner including prescribed drugs and dressings.

## CONGENITAL ABNORMALITY

Development of an abnormal organ or structure within the foetus whilst in the womb.

## COUNTRY OF RESIDENCE

The country where the Insured Person(s), covered by the policy have their primary residence, and in which they normally live, during each Period of Insurance.

## 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-CARE

Treatment at a hospital where the insured is admitted to a hospital bed, but does not stay overnight.

## 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

Shall mean the amount payable by You against eligible expenses before we pay any eligible expenses. The excess/deductible is applied per Out-Patient Claim per Medical Condition. If an on-going Medical Condition carries on over a policy year then the excess/deductible will be charged again at the start of the new policy year.

## DEPENDANT

The Insured Person's

- Legal spouse or partner of the same or opposite sex
- Child, step-child or legally adopted child provided that he/she is no more than 18 years of age and unmarried (or no more than 25 years of age, unmarried and in full time further education) on the date first included under this policy or at any subsequent annual renewal date.

## EFFECTIVE DATE

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

## EMERGENCY DENTAL

Dental treatment necessary as a result of an Accident caused by an extra-oral impact to: permanently attached artificial teeth, or sound natural teeth, where treatment is received within 48 hours from the date and time of the Accident.

## 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.

## GEOGRAPHICAL AREA

The countries where your policy provides cover, within the scope of this policy wording, terms, conditions and exclusions and as documented on your Certificate of Insurance:

### GlobalHealth Plan:

#### Plans One, Two and Three, Areas of Cover:

**Area 1 (Europe)** - Albania, Andorra, Austria, Belarus, Belgium, Bosnia, Herzegovina, Bulgaria, Channel Islands, Croatia, Czech Republic, Denmark, Estonia, Finland, France, Germany, Gibraltar, Great Britain, Greece, Greenland, Hungary, Iceland, Ireland, all islands of the Mediterranean, Isle of Man, Italy, Latvia, Liechtenstein, Lithuania, Luxembourg, Macedonia, Madeira, Malta, Moldova, Monaco, Montenegro, Netherlands, Norway, Poland, Portugal, Romania, Russia (West of the Urals), Serbia, Slovakia, Slovenia, Spain, Sweden, Switzerland, Turkey, Ukraine, Vatican State.

**Area 2 (worldwide excluding USA/Canada)** – all countries worldwide with the exception of: North America and Canada. Accident and emergency cover is provided outside of the geographical area, up to the maximum number of days specified in the benefit schedule.

**Area 3 – All countries Worldwide.**

## **ExpatHealth Plan:**

### **Plans Bronze, Silver and Gold Areas of Cover:**

**Area 1 (Worldwide excluding USA & Canada)** – all countries worldwide with the exception of North America and Canada.

**Area 2 (Worldwide excluding USA & Canada but with 90 days accident and emergency cover in the USA & Canada)** – all countries worldwide with the exception of North America and Canada but with 90 days A & E cover only in North America and Canada

**Area 3** – All countries worldwide

### **HOME COUNTRY**

Is the country for which the Insured Person holds a valid passport. Where the Insured Person holds more than one passport the Home Country will be considered to be that declared on the proposal form. Where a family is to be included there will be deemed to be one Home Country, as declared on the proposal form.

### **HOSPITAL**

Any institution which is legally licensed as a medical or surgical hospital in the country in which it is located. It must be under the constant supervision of a resident Physician.

### **ILLNESS**

Means a sickness, disease, disorder or alteration in an Insured Person's state of health diagnosed by a Physician which first manifests itself during the Period of Insurance.

### **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.

### **INSURED/ INSURED PERSON/ YOU/YOURS**

Persons who are noted in the Certificate of Insurance as persons to be insured (each person is considered to be separately insured).

### **INSURER/WE/OUR/US**

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**The Insurer** is named on the Certificate of Insurance and underwrites all of the benefits provided under the policy.

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### **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.

### **LIFETIME LIMIT**

The maximum amount of money or number of sessions we will pay in respect of the benefits provided by this policy during the lifetime of this policy including any other policies effected with us.

### **MEDICAL CONDITION**

Any disease or Illness (including psychiatric illnesses) not otherwise excluded by this policy.

### **MEDICAL EXPENSES**

Means In-Patient, Day-Care and Out-Patient fees, Hospital room and board, nursing, diagnosis, treatment and surgery fees, operating theatre fees and intensive care charges, doctors, surgeons and specialist fees, anaesthetics, medication, X-ray, physiotherapy, dressings, drugs and medicines on prescription. Also to include road ambulance charges to nearest Hospital in an emergency.

### **MEDICAL PRACTITIONER**

A person who has the primary degrees in the practice of medicine and surgery following attendance at a recognised medical school and who is licensed to practise medicine in the country where treatment is given.

### **MEDICAL TREATMENT**

The provision of recognised medical and surgical procedures and healthcare services which are administered on the order of and under the direction of a Physician, for the purposes of curing an Acute Medical Condition, Bodily Injury or Illness, or to provide routine management and Palliative treatments of a Chronic Medical Condition.

### **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.

### **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 preventative 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.

## **OPTICAL**

Includes cover for an annual eye examination by an ophthalmologist, and cover for prescription glasses or contact lenses. It does not cover frames or prescription sunglasses.

## **ORGAN IMPLANTATION**

Medical Treatment undertaken to perform the implantation of the following natural human organs: kidney, liver, heart, lung and skin grafts (where medically necessary and not for cosmetic purposes). Please Note: no cover is available for implantation of any other organ either of a natural or artificial nature.

## **OUT-PATIENT**

Treatment including diagnostic procedures, physiotherapy or manipulation when the Insured has not been admitted to a Hospital bed.

## **OVERALL ANNUAL LIMIT**

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.

## **PALLIATIVE TREATMENT**

Is treatment provided to offer temporary relief from the presenting symptoms of a Medical Condition, rather than to cure the actual Medical Condition causing the symptoms.

## **PERIOD OF INSURANCE**

Shall mean the period of time during which cover under this Certificate of Insurance operates. Unless otherwise stated on the Certificate of Insurance, this will be 12 months from the Effective Date.

## **PHYSICIAN**

Is 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 the licence and training. A Physician must be a person other than You or an immediate family member.

## **PHYSIOTHERAPY**

Medical Treatment recommended by a Physician as being medically necessary to treat an Illness, Bodily Injury or Medical Condition where provided by a licensed and qualified physiotherapist. Physiotherapy does not include ante natal and maternity exercises, manual therapy, sports massage or occupational therapy.

## **PLAN TYPE**

The name of the Plan of Benefits that applies as detailed on your Certificate of Insurance, being Expathealth Plans: Bronze, Silver, Gold, and GlobalHealth Plans: One, Two or Three.

## **PRE-AUTHORISED**

Any Medical Treatment of which You have informed Us prior to admission, 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 MEDICAL CONDITION**

Any Medical Condition, psychological condition or 'related condition' for which you have received treatment, suffered any symptoms (whether investigated or not) or sought advice, prior to your Effective Date. A 'related condition' is deemed to be any Medical Condition that our Physicians deem to be either an underlying cause of, or directly attributable to, the Medical Condition subject to Claim.

## **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.

## **PREMIUM DUE DATE**

The date on which a premium or part premium becomes due for payment to us under the policy. This will be in accordance with the following approximate schedule:

- Monthly – every 31 days
- Quarterly – every 91 days
- Semi annually – every 182 days
- Annually – every 365 days

## **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 'over the counter' without a Physician's prescription.

## **RENEWAL DATE**

The annual anniversary of the Effective Date, indicated on the Certificate of Insurance. It is recommended that you re-evaluate your cover in terms of Plan Type, Geographical Area and Deductible/Excess at each Renewal Date.

## **REPATRIATION**

Means the necessary and medically recommended return of an Insured Person to the country for which the passport is held or to the Country of Residence.

## **ROUTINE DENTAL TREATMENT**

Is defined as examinations, tooth cleaning, normal fillings using amalgam or composite material (NOT PRECIOUS METALS), porcelain crowns and extractions.

## ROUTINE HEALTH CHECKS

These 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.

## TRANSPORT OF MORTAL REMAINS

Is 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. Cover is not available where death occurs in the Home Country.

## USUAL, 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 Us

## Section 2. BENEFITS

### General (Applicable to all benefits sections)

Benefits are payable up to the limits shown within your chosen Plan Type for the Usual, Reasonable and Customary costs under each section subject to:  
The eligible claims are incurred during the twelve months for which the premium has been paid and submitted within **3 months** of the date of service or treatment.

The Insurer is entitled to refuse to make payment if:

- a. the premium has not been paid,
  - b. the claim was not incurred within the period of the Insurance Contract,
  - c. the claim was not submitted within 3 months of the date of service or treatment.
1. For claims made where you have incurred expenses in a currency other than the currency which is operative under your policy, settlement will be calculated using the appropriate exchange rate prevailing at the date of processing your Claim.

2. Benefits will be payable in accordance with the information supplied on the Claim form.
3. Territorial limits under this insurance are arranged in Geographical Areas of Cover. The Insured Person will select at inception or renewal, the relevant Geographical Area. Full benefits will be available within the selected Geographical Area, or any lower Geographical Area whilst travelling on holiday, or business trips.

### Medical Benefits

Benefits are payable up to the limits shown within your chosen Plan Type for the reasonable and customary costs of Medical Expenses if an Insured Person shall sustain Bodily Injury or shall suffer Illness, such expenses to be medical, surgical and specialist's fees, Hospital, physiotherapy and manipulative treatment, surgical and medical requisites and the cost of medically necessary repatriation/evacuation subject to:

1. The treatment was given by or under the control of a qualified medical practitioner.
2. Routine maternity benefit will be payable after the first twelve months following the Effective Date where maternity benefits are included in the chosen Plan Type. Complications of Pregnancy and Childbirth (as defined) are also paid after the first 12 months following the Effective Date up to the Overall Annual Limit stated in the benefit schedule.

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 benefit schedule, 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 benefit schedule, for Routine Maternity.

3. Whilst you can have treatment in another country within your chosen Geographical Area (or lower geographical area), this will only be permitted with the prior notification of, and written instruction from us. Benefits payable will be limited to Usual, Reasonable and Customary costs for the relevant treatment within your Country of Residence, and will be determined by us. No cover is provided for the travel expenses incurred between your Country of Residence and your chosen country of treatment.
4. Home Nursing benefit will be available immediately following treatment as an In-Patient or Day-Patient and only on the recommendation of a specialist. This benefit must be provided by a qualified nurse (of a standard recognised by us), and is limited to the period shown under your chosen Plan Type.

5. Parent accommodation benefit is available where a parent is staying overnight in Hospital with another Insured Person being a child under 18 who is admitted as an In-Patient to a Hospital for treatment.
6. Psychiatric treatment under this policy will only be available if it is Pre-Authorised in writing by us prior to any costs being incurred. Any psychiatric treatment provided must be administered by a recognised psychiatrist.
7. Under the Organ Implantation benefit, costs will only be payable for an Insured Person under this scheme, and not for any donor, costs of locating and removing the replacement organ, or transport and administration costs associated with the donor and donor organ.
8. Routine Dental treatment is available (where listed in the benefit schedule) providing that an Insured Person: a) has a normal registered dentist, and b) has visited that dentist within the 12 months prior to the Effective Date (or renewal date) of the policy. Costs incurred within the first 3 months of the Effective Date of the policy under this benefit are excluded.
9. Treatment for Acute episodes of a Chronic Condition which is newly diagnosed after the Effective Date. Where stated, cover is extended to provide routine management and Palliative Medical Treatments of such Chronic Conditions, up to the amounts shown in the benefit schedule. (For insured persons on Plans Silver or Gold, the benefit provided for routine management and Palliative treatments is only operative for Chronic Conditions newly diagnosed after the Renewal Date of the policy following 01 January 2012. No cover is provided for these Medical Treatments of Chronic Conditions which exist prior to the Renewal Date in 2012).
10. Treatment for Human Immunodeficiency Virus (HIV) and or HIV related illnesses including Acquired Immune Deficiency Syndrome (AIDS) or and related derivatives or variations, newly diagnosed after the Effective Date of the policy, will be covered to the limit stated in the benefit schedule where Plan Three cover is purchased.

### Section 3. GENERAL CONDITIONS (Applicable to all benefits sections)

#### 1. The contract

The benefit schedule, 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 including: supporting invoices and receipts; and a fully completed claim form must be submitted when making a claim. The claim form must be completed by the treating Physician or specialist. All documentation must be submitted within **3 months** of the date of service or treatment otherwise they will not be considered for reimbursement.

The Insured should contact us prior to: any admittance to Hospital as an In-Patient or Day-Patient; or if transportation or ancillary services are required, for Pre-Authorisation of expenses.

If expenses are incurred without approval a Co-Insurance of 20% of the eligible costs incurred will apply to your claim.

#### 6. Payment of claims and subrogation

- a. 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 within 28 days of asking for it, 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.
- b. 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

Newly Insured applicants and their Dependants are eligible to be included for cover under this policy providing they are under age 74 years at their Effective Date. In the case of children, they must be no more than 18 years of age and unmarried or no more than 25 years of age, unmarried and in full time further education at their Effective Date. Children can be added from their date of birth provided we receive written notification from you within 14 days of their date of birth. If you notify us after this period, we will add the newborn child from the date we receive written notification and not their date of birth.

## 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 Europ Assistance, International Health Solutions S.A.S. – a division of Europ Assistance Holdings Limited. All repatriations/evacuations/return of mortal remains will be at our sole discretion. No other assistance provided by any other company will be considered a covered benefit.

## 11. Policy duration and premium payment

- a. 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.
- b. All premiums are payable in advance of cover being provided under this policy.
- c. Premiums are payable monthly, quarterly, semi-annual 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 year.
- 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 30 day 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 IPT, 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 cancels the policy at any other time you must give us 14 days notice in writing at the address shown on the policy documentation. We will cancel the plan 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 Certificate of Insurance must be returned to us with your cancellation notification and then a pro rata refund may be applicable provided no claims have been made in the current 12 month policy period. If a Claim has been made, then no refund will be due and any outstanding instalments remain 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 Plan Type

You may change Your Plan Type 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 Geographical Area

You may change Your Geographical Area 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.

## Section 4. EXCLUSIONS (Applicable to all benefits sections)

Benefit is not payable for:

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 medical condition, psychological condition (or any related condition).
2. The Deductible/Excess amount of any claim (where applicable).
3. Routine medical examination (including vaccinations, inoculations, general health or well-person 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 except where shown in the benefit schedule.
4. Spa or hydro treatment, rest cures, long term care, sanatorial or custodial care or periods of quarantine or isolation, nature cures, health farm, rest/retirement/convalescent homes or any similar establishments.
5. Cosmetic surgery or remedial surgery, removal of fat or other surplus body tissue and any consequences of such Medical Treatment, weight loss or weight problems, eating, snoring and sleeping disorders; whether or not for psychological purposes. Cosmetic surgery will be considered where required as a direct result of an Accident, or surgery for Cancer, which occurs during the Period of Insurance and which is covered by this policy.
6. Organ transplant surgery, including bone marrow and stem cell transplants, and any related treatment including the cost of acquisition of the organ, expenses incurred by the donor, or costs for acquisition and implantation of artificial heart and mono- or bi-ventricular devices, except where shown in the benefit schedule.
7. Cryopreservation, implantation or reimplantation of living cells or living tissues whether autologous or provided by a donor and any connected costs.
8. Maternity 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.
9. Psychiatric treatment except as shown in the benefit schedule.
10. Products that can be purchased without a doctor's Prescription.
11. Products classified as vitamins or minerals (except during pregnancy or to treat diagnosed, clinically significant vitamin deficiency syndromes), nutritional or dietary supplements, fibre and fatty acids, amino acids and organic substances including cosmetic products, even if medically recommended or prescribed or acknowledged as having therapeutic effects.
12. 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 Rolfing, Massage, Acupressure, Milta therapy and Kinesiotherapy carried out by a non registered physiotherapist.
13. We do not cover psychotherapy and counselling.
14. 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.
15. Any claims arising from Birth Injuries or defects, Congenital Illness, or a Congenital Abnormality.
16. Dental treatment, except as shown in the benefits schedule.
17. Attempts at suicide, whether successful or not, or any self inflicted injury.
18. Palliative Care and routine management of Illnesses once they have been diagnosed as either chronic or terminal except where shown on the benefit schedule and where the Chronic Condition is newly diagnosed after the policy effective date (or the first renewal date after 01 January 2012 for insured persons who have selected Plans Silver or Gold) Upon diagnosis, all cover under this Policy will be limited to the benefit provided for Chronic Conditions cover only and no claims shall be admissible under any other section of the policy for that chronic or terminal condition.
19. Spectacles, contact lenses, hire of medical/surgical equipment, prostheses (except when required intraoperatively) and appliances (except when required intraoperatively), except as shown in the benefit schedule.
20. Treatment and investigations of allergies.
21. Impotence and fertility/infertility, including sterilisation and reversal of sterilisation (including vasectomy), and contraception/birth control devices or prescriptions. Medically assisted reproduction (including vitro fertilisation) or any consequence thereof, including any resultant pregnancy and childbirth or complications thereof.
22. Treatment required during the first 3 months after birth for any child born as a result of medically assisted conception other than artificial insemination.

23. Treatment of sexually transmitted disease and consequences thereof.
24. Medical Treatment for Human Immunodeficiency Virus or HIV related illness, including Acquired Immune Deficiency Syndrome (AIDS) or AIDS related complex (ARC) including any similar infections, illnesses, injuries or Medical Conditions arising from these conditions, other than if Plan Three cover has been purchased.
25. Treatment which is in any way connected to gender reassignment.
26. Medical Treatment for alcoholism, drug and substance abuse/dependency including any medical condition and/or Bodily Injury directly or indirectly arising therefrom; Medical Treatment for any addictive and/or compulsive disorder; Medical Treatment due to the insured person being under the influence and/or suffering from the effects of alcohol, intoxicants, drugs and narcotics.
27. Treatment of any development delay and/or learning disability, attention deficit disorder, or behavioural problems.
28. Surgery to correct short or long sight or any other eye defect, unless caused as a result of an Accident or Medical Condition occurring during the Period of Insurance.
29. The use, or any treatment therefrom, of any drugs not licensed by the official government control agency of the country in which the drug was given, or drugs used in any circumstances other than in accordance with their licensed indications.
30. Any consequences or use of experimental and/or unproven treatment.
31. Any costs which, in the opinion of our Physicians, are unnecessary or are over and above what we consider in our experience to be Usual, Customary and Reasonable for the services provided.
32. Treatment (including transportation costs) for which the insured has travelled specifically outside the Geographical Area, or travelled against medical advice.
33. Claims arising as a result of the Insured Person's participation in (engaging in or practising for) any of the following sports activities:
  - Aqua –lung diving below 100 metres; shark feeding/ cage diving; white water canoeing (grades 5 and 6); white or black water rafting (grades 5 and 6).
  - Boxing; weight lifting; wrestling; hurling; professional sport; racing or stunting; racing of any kind other than on foot.
  - Solo caving; cave diving or pot holing; solo mountain climbing.
  - Flying or taking part in other aerial activities except whilst travelling as a fare paying passenger on a licensed airplane; solo hang-gliding/para-gliding; high diving; micro-lighting.
  - Helo-skiing; bobsleigh/luge; skeleton; ski jumping.
  - Hunting/shooting; hunting on horseback; horse jumping; polo; point-to-point; safari with guns; steeple chasing or horse-racing of any kind.
  - **Any other hazardous pursuits or activities must be referred to us for advice regarding cover, before the pursuit or activity is undertaken.**

The following activities shall be covered if they are non-professional and at an amateur level if they are non-professional and at an amateur level if they are undertaken under the control and tuition of experts employed by the local organiser, form part of a holiday interest and the correct safety equipment is used for the given activity:

  - Canyoning; white water canoeing (grades 1 to 4); white or black water rafting (grades 1 to 4); parasailing; para-skiing;
  - Tandem hang-gliding/para-gliding (with expert instructor)
  - Quad biking;
  - Karate and any form of martial arts or unarmed combat (covered up to and including age 18 only).
34. Any claims whatsoever, except where injury is sustained as an innocent bystander, resulting from war, invasion, act of foreign enemy hostilities (whether war be declared or not), civil war, rebellion, revolution, insurrection, military or usurped power or, taking part in civil commotion or riot of any kind.
35. Compensation other than on a proportionate basis if the Insured Person or any other person covered under this insurance has any other insurance in force or is entitled to indemnity from any other source in respect of the same Bodily Injury, Illness, disease, death or loss. The insurers have full rights of subrogation.
36. Losses not incurred within the Period of Insurance and claims submitted later than 3 months after the date of service or treatment.
37. Medical Treatment performed by a Physician who is a close relative of the Insured Person, unless previously approved by us.
38. Any claim arising when the Insured Person is under military authority or is engaged in activities involving the use of firearms or physical combat or in an area of military conflict, except in connection with tourist trips made on a private basis during leave.
39. Any claims in any way caused, or contributed to, by the use or release or the threat thereof; any nuclear weapon or device; or, chemical or biological agent.
40. Intentionally fraudulent, illegal, criminal, deliberately careless or reckless acts on the Insured Person's part and their consequences.
41. Air travel when the Insured Person is more than 28 weeks pregnant.
42. Drug therapy and/or treatment provided by an unlicensed Physician.
43. Any expenses relating to 'search and/or rescue' operations to find an Insured Person in mountains, at sea, in the desert, in the jungle and similar remote locations.
44. Any expenses relating to an air/sea rescue operation or an evacuation/transfer from any off shore structure or sea going vessel to shore.
45. Any expense not specifically stated in this policy as being insured and any expenses which exceed the individual benefit limits or overall maximum benefits of your Plan Type.
46. Any expenses where no supporting documents are available.
47. Accommodation and Medical Treatment costs (including rehabilitation) in a Hospital where, the establishment in question has effectively become the Insured Person's

home or permanent residence and where the admission is arranged wholly or partly for domestic or social reasons. Hospitalisation which is not directly connected to the treatment of a Medical Condition.

48. Bodily Injury or Illness caused by an Act of Terrorism, except where such injury/illness is sustained as an innocent bystander, excluding any Act of Terrorism involving the use of nuclear weapons or devices, chemical or biological agents. Benefit is limited to Medical Treatment costs up to a maximum of £30,000/€45,000/\$55,000 each Insured Person, each incident.

For the purposes of this policy, an Act of Terrorism means an act, including but not limited to, the use of force or violence and/or the threat thereof, of any person or group(s) of persons whether acting alone or on behalf of or in connection with any organisation(s) or government(s), committed for political, religious ideological or similar purposes or reasons including the intention to influence any government and/or to put the public or any section of the public, in fear.

49. Costs which you would have otherwise had to pay even if the event which gave rise to a Claim had not occurred.
50. Consequential loss of any kind arising from the provision of, inability or any delay in providing, the services to which this policy relates, unless negligence on our part can be demonstrated.
51. Any costs incurred where the Insured Person has travelled to a country or specific area which their Government or Embassy have advised against travelling to under any circumstances.
52. Any claims directly or indirectly caused or aggravated by the actual or potential inability of any computer, data processing equipment or media, microchip, integrated circuit software or stored programme, to correctly recognise any date as its true calendar date or to continue to function correctly in respect of or beyond that date.
53. Any claims directly or indirectly arising from the failure, breakdown or malfunction of an electronic or mechanical item of medical/surgical equipment of any kind.
54. All Emergency Medical Evacuation costs not approved or arranged in advance by the Assistance Company or as a result of maternity.
55. Any costs incurred arising from any period for which the appropriate premium has not been paid

## Section 5. CLAIMS PROCEDURES

### For claims involving a Medical Emergency

We appreciate that an Illness or Accident can happen at any time and for this reason, we recommend that you carry your membership card with you at all times. If you are rushed into Hospital in an emergency please make sure that you, a member of the Hospital staff, your family, a friend, or a work colleague, contact us within 2 days of you being admitted to Hospital otherwise a Co-Insurance of 20% of the eligible costs incurred will apply to your Claim.

Assistance is available 24 hours a day, 365 days a year for medical emergencies including evacuation and transportation. To obtain Pre-Authorisation for costs in connection with an emergency admission to Hospital or where emergency evacuation and transportation is required please contact us on the following number:

**+44 (0) 844 338 5858 or**

In case of difficulty in contacting us from outside the UK, please dial:

**+ 44 (0) 1444 442865**

### In-Patient or Day-Patient claims

If you know in advance that you:

- Are planning to be admitted to Hospital on either an In-Patient and Day-Patient basis; or
- Require transportation and ancillary services;

You must first contact us for Pre-Authorisation before incurring any such expenses otherwise, if you go ahead without our approval, a Co-Insurance of 20% of the eligible costs incurred will apply to your Claim.

If you know in advance that you will need to incur these types of costs, please contact the claims department on:

**+44 (0) 844 338 5858 or**

In case of difficulty in contacting us from outside of the UK, please dial

**+44 (0) 1444 442865**

With the following information:

- Your full name and date of birth, and
- Your membership number

This information will help us to identify you as a member of the Morgan Price International Health Plan. In the case of an admission to Hospital, we will liaise with them for a cost estimate and details of what Medical Treatment is to be carried out. Where eligible, an agreement will be put in place with them to pay the bill on your behalf.

### Out-Patient treatment

In the unfortunate event of you falling ill and needing to seek medical advice, see your Physician in the usual way taking a Claim form along with you. You can obtain a Claim form by logging onto [www.morgan-price.com](http://www.morgan-price.com)

Please note that any fee that your Physician may charge for completing the claim form is your responsibility.

If you have any treatment on an Out-Patient basis such as a consultation or a test, for example an ECG/Blood/urine test or x-ray, you should pay the bill yourself and obtain a receipted invoice as you will need to include this with the claim form when you send it in.

### Submission of claims documentation

Once your Claim has been fully completed you should send it to us together with all supporting information and bills. You have the choice of either:

- a. Scanning these documents and sending them by email to:

[morganprice@europ-assistance.co.uk](mailto:morganprice@europ-assistance.co.uk)

If you choose to do this, please ensure that all documents are clearly scanned – don't forget to scan both sides of a document if appropriate.

- b. Faxing the documents to us on:

**+44 (0) 1444 45 73 56**

**Please note:** if you choose to send your claim to us by email or fax you must still post all of the original documents to us at the address given below.

- c. Posting the original documents to us at:

Morgan Price Claims Department  
c/o Europ Assistance, International Health Solutions, S.A.S.  
PO Box 637  
Haywards Heath  
West Sussex  
RH16 1WR  
England  
United Kingdom

Whichever method you choose to use, we recommend that you keep copies of all documents that you send to us.

### General Claims Guidance Notes

You only need to complete one claim form for each different Medical Condition, within each Period of Insurance, regardless as to how many bills you have to send in. If, having submitted your claim form you receive further bills for the same Medical Condition, just send them in together with an accompanying letter making sure you quote your membership number. Alternatively, take a copy of your original claim form and attach it to any subsequent bills received.

Please remember that you must submit your Claim, together with all invoices, within **3 months** of the date of service or treatment, otherwise they will not be considered for reimbursement.

You must provide us with written details in response to any request for information regarding a Claim within 28 days of us asking for it or as soon as reasonable possible thereafter. In certain circumstances, we may ask you to undergo a medical examination which we will pay for. You must provide us with a written statement substantiating your Claim together with (at your own expense) documentary evidence, information, certificates, receipts and such like that we require.

How your Claim is refunded is up to you. We can pay you by bank transfer, foreign draft, directly to your credit card or cheque so please make sure you indicate your preferred method on the claim form. We cannot be held responsible for the costs charged by some banks or credit card companies for currency conversion costs.

For claims made where you have incurred expenses in a currency other than the currency which is operative under your policy, settlement will be calculated using the appropriate exchange rate prevailing at the date of processing your Claim.

We may at any time, pay an Insured Person and/or a service provider our full liability under this policy after which no further liability will attach to us in any respect or as a consequence of such action.

### Queries on Your Claims

For any queries regarding your claims you should contact:

Morgan Price Claims Department  
c/o Europ Assistance, International Health Solutions, S.A.S  
PO Box 637  
Haywards Heath  
West Sussex  
RH16 1WR  
England  
United Kingdom

Tel : +44 (0) 844 338 5858

Fax : +44 (0) 1444 45 73 56

Email: [morganprice@europ-assistance.co.uk](mailto:morganprice@europ-assistance.co.uk)

### Pre Authorisation

In-Patient or Day-Patient claims

If you know in advance that you:

- Are planning to be admitted to Hospital on either an In-Patient or Day-Patient basis; or
- Require transportation and ancillary services;

You must first contact us for Pre-Authorisation before incurring any such expenses otherwise, if you go ahead without our approval, a Co-Insurance of 20% of the eligible costs incurred will apply to your Claim.

If you know in advance that you will need to incur these types of costs, please contact the claims department on:

**+44 (0) 844 338 5858** or

In case of difficulty in contacting us from outside of the UK, please dial:

**+44 (0) 1444 442865**

With the following information:

- Your full name and date of birth, and
- Your membership number

This information will help us to identify you as a member of the Morgan Price International Health Plan. In the case of an admission to Hospital, we will liaise with them for a cost estimate and details of what Medical Treatment is to be carried out. Where eligible, an agreement will be put in place with them to pay the bill on your behalf.

## 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, Upper Rose Lane  
Palgrave, Diss, Norfolk. IP22 1AP

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

The Quality Department  
Europ Assistance, International Health Solutions, S.A.S  
PO Box 637  
Haywards Heath  
West Sussex  
RH16 1WR  
England  
United Kingdom

Email: [quality@ihs.europ-assistance.com](mailto:quality@ihs.europ-assistance.com)

If we cannot give you a final decision within 4 weeks from the date we receive your complaint, we will explain why and tell you when we hope to reach a decision. Our decision is final and based on the evidence presented. If you feel that there is any new evidence or fresh information that may change the decision you have the right to make an appeal.

Should you remain dissatisfied or fail to receive a final answer within 8 weeks of us receiving your complaint, you have the right to refer the matter directly to the Insurer as shown on Your Certificate of Insurance who will advise you of the referral procedure, in addition to your contractual rights under this policy.