morganprice international

Evolution Health Plan

Policy wording

morganprice international

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1 Introduction to your policy

Welcome and thank you for choosing the Evolution Health Plan from Morgan Price International Healthcare Ltd to look after your health insurance needs.

Please check your certificate of insurance and membership card(s) to make sure that all of the details shown are correct. If any changes need to be made, please let us know immediately.

Take a few moments to familiarise yourself with your policy to make sure that you fully understand what is covered and what is not covered. Your policy has been written using plain language wherever possible and has been designed to set out all of the features and benefits of the Evolution Health Plan in a straightforward and easy to understand format. If there is any aspect of the Evolution Health Plan that you are unsure about, please let us know.

a. Contract of insurance

The application form you completed, together with any supplementary information provided, this policy wording and the certificate of insurance together with the benefit schedule and any endorsements, are all part of the contract of insurance between you and the insurer and should be read as one document. Provided the required amount of premium is paid on the date due then we will provide you and the persons listed in the certificate of insurance with the benefits set out in this policy wording and within the benefit schedule attached to your certificate of insurance.

The insurance is effective only after we have issued written confirmation that the applicant has been accepted for cover and becomes, and remains, insured in accordance with the terms and conditions set out in this policy.

b. 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 is responsible for the plan design, the sales, administration (including issue of policy documents and collection of premiums) and general management of this policy. Arma Insurance Company Limited of PO Box 511 Town Mills, Rue du Pre, St. Peter Port, Guernsey, GY1 6DU is the insurer and underwrites all of the benefits provided under the policy.

Morgan Price International Healthcare Ltd is the entity appointed by the Insurer to provide the services relating to claims handling and case management, evacuation and assistance under this policy.

c. Understanding the scope of your insurance

You will find details of what is covered and what is not covered by your policy in the relevant sections. Please make sure that you read them and that you fully understand the scope of your insurance cover. You will only be covered for the benefits listed in the benefit schedule attached to your certificate of insurance, as selected by you on your application form, or at a subsequent annual renewal date.

d. Our philosophy

As a valued customer you have important rights and entitlements. You are entitled to expect:

- **Politeness and courtesy.** Your requirements will always be dealt with promptly, politely and with professional courtesy. No query is too trivial or too much trouble to deal with.
- **Helpful advice and guidance.** We are here to help you if you have any doubts or concerns about your cover or if you need advice on how to make a claim and make proper use of your cover.
- **Confidentiality.** Any medical information we hold about you or your family will be treated in the utmost confidence and will not be shared or given to anyone else, other than where we are required to do so by law.
- **Professional and efficient service.** We aim to provide our members with a high standard of service at all times. Any claims submitted will be dealt with promptly and considered fairly and impartially (without any bias or preference) within the terms and conditions of this policy.

e. Our promise of service

At Morgan Price International Healthcare Ltd each of our customers is important to us, and we believe you have the right to a fair, swift and courteous service at all times.

However, we do appreciate that occasionally things go wrong. We take all complaints seriously and aim to resolve them fairly and promptly. The information below explains how you can complain and also how we will deal with it.

How to make a complaint

You can notify us by Telephone, face-to-face or in writing including fax and email.

Complaints Department
Morgan Price International Healthcare Limited
2 Penfold Drive
Gateway 11
Wymondham
Norfolk
NR18 0WZ
United Kingdom

Definition

We consider a complaint to be any oral or written expression of dissatisfaction from a customer to an employee of Morgan Price International Healthcare Ltd, in connection with the provision of, or failure to provide, a service to the customer.

How to deal with your complaint

- We will always respond in a courteous manner and we aim to resolve complaints within three business days following receipt (e.g. received Monday 10am, aim to resolve by Thursday 5:30pm).
- Occasionally, for more complex cases we need additional time to investigate the concerns raised. In such cases we aim to acknowledge the complaint within 5 business days, providing the name of the person dealing with it as well as an indication of when to expect the matter to be concluded.
- If we cannot resolve the matter within 8 weeks we will write explaining why and point out the next steps available to you (i.e. referring your complaint to the Financial Ombudsman Service).
- If more than 8 weeks from the date of your complaint has passed and you haven't received a final response, or you are dissatisfied with the final response you have received (at any stage of the process) you can refer your complaint to the financial ombudsman service (contact details are shown below).

Our Response

- If we can resolve your complaint within three business days following receipt, you will be sent a summary resolution communication which will confirm the matter has been resolved and details of Financial Ombudsman Service.
- Where we have been unable to resolve the complaint within these three days, we will write to you formally providing details of our investigation and outcome. This response will explain our position clearly and in plain language. The response will also detail your rights to refer your complaint to the Financial Ombudsman Service.
- If we agree to pay any redress or compensation we will do so promptly.

Referring a complaint to another firm

Where we have reasonable grounds to be satisfied that another firm is solely or jointly responsible for the issues raised, the complaint will be referred to them promptly on your behalf. We will inform you of the referral, provide their contact details and follow the matter up with them to make sure your concerns are properly addressed.

What to do if you remain dissatisfied with our final response

Having received our final response, if you remain dissatisfied you may be entitled to refer your complaint to the Financial Ombudsman Service. This service is free of charge.

- visit their web-site at www.financial-ombudsman.org.uk
- call on 0800 023 4567 or 0300 123 9123 from within the UK or
- +44 207964 0500 from outside the UK
- write to them or visit them at the Financial Ombudsman Service, Exchange Tower, London, E14 9SR
- Email to complaint.info@financial-ombudsman.org.uk

You can find out more information by following the link here: https://www.financial-ombudsman.org.uk/publications/consumer-leaflet.htm.

For all other complaints, please contact:

Complaints Department
Arma Insurance Company Limited
511 Town Mills
Rue du Pre
St. Peter Port
Guernsey
GY1 6LT

Email: complaints@arma-insurance.com

We will investigate your complaint and issue a final response letter. If you are not satisfied with our final response to your complaint or if your complaint is not resolved within 3 months, you can refer your complaint to the Channel Islands Financial Ombudsman (CIFO). You must contact CIFO about your complaint within six (6) months of our final response, or CIFO may not be able to review your complaint. You must also contact CIFO within 6 months of the event complained about or (if later) 2 years of when you could reasonably have expected to become aware that you had a reason to complain.

You can contact CIFO at:

Channel Islands Financial Ombudsman
PO Box 114
Jersey
JE4 9QG

Telephone: +44 (0) 1534 74 86 10
Email: enquiries@ci-fo.org

Please note that if you wish to refer this matter to the FOS you must do so within 6 months of our final decision. You must have completed the above procedure before the FOS will consider your case.

Your legal rights are not affected.

f. Cooling off period

If having purchased this insurance you decide that it does not meet your requirements then please return your policy documents to us within 14 days of receipt together with written cancellation instructions. Provided no claims have been paid and/or pre-authorisation of claims costs have been issued, we will refund any premium that you have paid.

Queries on your policy

For any queries regarding your policy you should contact:

Morgan Price International Healthcare Ltd
2 Penfold Drive
Gateway 11
Wymondham
Norfolk
NR18 0WZ
United Kingdom

Tel: +44 (0) 1379 64 67 30
Fax: +44 (0) 1379 65 27 94

Email: info@morgan-price.com

g. Data Protection & Privacy Notice

This notice aims to give you information on how we collect and process your personal data when using our insurance product and services, including any data you may provide under this insurance coverage. Personal data, or personal information, means any information about an individual from which that person can be identified. We respect your privacy and we are committed to protecting your personal data. Morgan Price International Healthcare Ltd together with its insurance partner, Arma Insurance Company is the joint controller and processor of your personal data.

We will collect your personal data including but not limited to special categories of Personal Data about you (this includes details about your sex, ethnicity, age, and information about your health and medical conditions). Where we need to collect personal data by law, or under the terms of this policy of insurance we have with you and you fail to provide that data when requested, we may not be able to perform the insurance contract we have with you or provide the insurance services to you (for example, to provide you with medical claims insurance services). In this case, we may have to cancel the insurance product or insurance service you have with us but we will notify you if this is the case at the time. We will only use your personal data when the law allows us to. Under certain circumstances, you have rights under data protection laws in relation to your personal data. More details of these rights can be found within our Privacy Notice and at [www.ico.org.uk]. These rights include: Request access to your personal data; Request correction of your personal data; Request erasure of your personal data; Object to processing of your personal data; Request restriction of processing your personal data; Request transfer of your personal data and Right to withdraw consent.

2 Eligibility

a. Who Can Apply

This is an international policy designed for expatriates (i.e. persons living/working outside their home country) and local nationals (i.e. persons living and/or working inside their home country) and their eligible dependants with the exception of local nationals of the United States of America.

- The policy is not available to persons, or in countries where it would breach any sanction, or where it is prohibited by law or local legislation.

This policy is not available to any applicants whose primary country of residence is Cambodia, China, Hong Kong, Indonesia, Japan, Laos, Macau, Malaysia, Myanmar, Nepal, Philippines, Singapore, South Korea, Taiwan, Thailand, Timor-Leste or Vietnam who should apply for an Evolution Health Plan (Asia Pacific)

Applicants are eligible to be included for cover under this policy providing they are under age 75 at the start date of the policy, or under age 65 at the start date of the policy if applying for Moratorium underwriting. In the case of children, they must be under age 19 and unmarried (or under age 25, unmarried and in full-time further education) at their start date.

Children may remain covered under this policy until the annual renewal date following their 19th birthday (or 25th birthday where in full-time education) or marriage at which time their insurance cover under this policy will end and they may move onto their own policy.

b. Conditions of acceptance

We are entitled to refuse to accept an application from any person without giving a reason. We also reserve the right to ask for evidence of age, state of health, employment status or educational status. We may wish to apply special terms, exclusions or premium increases to reflect any exceptional circumstances regarding your application.

In order to benefit from this policy you must:

- Answer all questions about this policy honestly and fully at all times;
- Not deliberately mislead us by mis-statement;
- Tell us straight away if anything that you have already told us changes;
- Observe and comply with the terms and conditions of this policy;

or your policy may be cancelled and any claim you make may not be paid.

c. Declaration and changes

You must immediately inform us of any change in the information given on the application form, in particular relating to any medical declaration you have made for yourself and any dependants, your address, country of residence, the birth or adoption of a child or any other change involving your insured dependants. If you do not tell us, your policy may be cancelled and any claim you make may not be paid.

3 Underwriting

a. Full medical underwriting

If you select Full medical underwriting (FMU) you must complete the FMU application form. We will review the information provided to ascertain whether you and any eligible dependants will be accepted with or without specific exclusions or terms. You must ensure that the FMU application form is fully and accurately completed. Any pre-existing medical conditions not declared on your FMU application will not be covered by your policy. If specific exclusion or terms will apply to your policy we will advise you in writing and you will need to confirm to us in writing that you accept the terms offered before your policy can start.

b. Moratorium underwriting

Moratorium underwriting is only available if you and any eligible dependants are under age 65 at the start date of the policy. If you select Moratorium underwriting you must complete the Moratorium underwriting application form.

Moratorium underwriting means that you and any eligible dependants will not be covered for any pre-existing medical conditions that have been in existence during the five year period before your start date. After two years of continuous cover, pre-existing medical conditions may become eligible for cover (unless the condition is specifically excluded by the policy) if, at the first time of receiving treatment, you/your dependant has not:

- **Suffered any symptoms**
- **Consulted any medical practitioner for check-ups/ monitoring of a condition, received follow up examinations, medical treatment or advice**
- **Been prescribed or taken medicine, including over the counter drugs, special diets, injections or physiotherapy**

4 How to claim

a. Emergency evacuation claims

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.

Assistance is available 24 hours a day, 365 days a year for medical emergencies including evacuation and transportation.

If you have an emergency, critical or life-threatening medical condition and local facilities may not be available to provide the necessary medical treatment please immediately contact us for assistance as outlined in section 4c.

We will make contact with your treating Physician to obtain the required medical information so that we can assess your medical condition and decide if medical evacuation is required, by what means of transportation and where would be the best place for you to receive the required medical treatment. Arrangements will be made for transportation to the required medical facility, with a medical escort if necessary. We will settle any costs directly with the airline/evacuation company/provider.

In dire emergencies in remote or primitive areas where you cannot make contact with us in advance, you must contact us as soon as practicably possible.

b. Claims requiring pre-authorisation

For claims that require pre-authorisation, as shown in the benefit schedule and section 6 of this policy wording, you must first contact us for pre-authorisation before incurring any expenses. If you go ahead without our approval, a co-insurance of 25% of the eligible costs incurred will apply to your claim.

Please contact us for pre-authorisation as outlined in section 4c.

If you are admitted into hospital in an emergency please make sure that you or your representative, or a member of the hospital staff contacts us within 2 days of you being admitted to hospital otherwise a co-insurance of 25% of the eligible costs incurred will apply to your claim.

In the case of an admission to hospital, we will liaise with the hospital for a cost estimate and details of what medical treatment is to be carried out. Once the medical costs have been agreed as eligible for cover under the policy a Guarantee of Payment will be put in place with the hospital and we will pay the hospital on a direct basis. If your policy has a deductible/excess to be applied, you will be responsible for paying the hospital directly for the costs not covered.

c. Contact details for emergencies, medical evacuation and pre-authorisation

For medical emergencies that may require Emergency Medical Transportation, and any claim requiring pre-authorisation please contact us as follows:

Telephone: +44 (0) 3300 581 668

You will need to provide the following information for the person requiring medical treatment:

- Full name
- Date of birth
- Membership Number (found on the front of your membership card)
- Location
- Name and contact details of treating physician/hospital
- Details of the medical condition

d. Reimbursement claims

For claims not requiring pre-authorisation, you should settle the bills/invoices yourself and then submit the claim for approval.

You must take a claim form with you when you receive medical or dental treatment or advice so that your physician/dentist can complete part of the claim form. You can download a claim form from www.morgan-price.com. **Please note that any fee that your physician may charge for completing the claim form is your responsibility.** Please ensure that all questions are fully answered – if the claim form is not fully completed we will return it to you.

Once your claim form has been fully completed you should send it to us together with all supporting information, original invoices and/or receipts at the following address:

Morgan Price Claims Department
Morgan Price International Healthcare Ltd
2 Penfold Drive
Gateway 11
Wymondham
Norfolk
NR18 0WZ
United Kingdom

Alternatively, you can email the claim form, supporting information, invoices and/or receipts to:
mpclaims@morgan-price.com

Please ensure that all documents are clearly scanned - don't forget to scan both sides of a document if appropriate.

If you choose to send your claim to us by email you must retain the original documents as we reserve the right to request them.

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

If you need to speak to us about your claim, please telephone: +44 (0) 3300 581 668

e. General claims guidance notes

You only need to complete one claim form for each different medical condition, within each period of insurance. 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 and the claim number. Alternatively, take a copy of your original claim form and attach it to any subsequent bills received.

When submitting your first claim, please ensure that you also provide full details of your bank account on the Bank Details Form provided with your policy documentation. You must include an IBAN and SWIFT/BIC where this is required. Please note that we cannot make payments to banks in countries where UK/US Sanctions are in place.

Please remember that you must submit your claim, together with all invoices, **within 6 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 reasonably 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 to substantiate your claim together with (at your own expense) all necessary documentary evidence, information, certificates, receipts and reports that we may reasonably request for you to supply. It may also be necessary to request information such as a police report, death certificate, autopsy report and travel itineraries. Failure to provide us with the information we have reasonably requested will result in us being unable to assess your claim.

If you have chosen a deductible/excess to apply to your policy, it will apply on a per person per period of insurance basis, which means that it will be applied once a year to each insured person. At the start of each period of insurance you are responsible for bearing the eligible costs for any expenses up to the value of your deductible/excess. The eligible costs that exceed the applicable deductible/excess will be covered by the policy.
Please remember to send us a completed claim form together with all bills so that we can work out the amount payable once you have incurred eligible costs up to the level of your deductible/excess.

f. Settlement of your claim

Once we have reviewed the documentation provided and processed your claim, we will send you a Reimbursement Statement and make payment of the covered expenses directly into your chosen bank account. We will pay for any bank charges incurred in submitting the funds into your bank account. We will not pay for any charges made by your bank for receiving the funds.

For claims made where you have incurred expenses in a currency other than the currency of your policy, settlement will be calculated using the appropriate exchange rate prevailing on the date treatment was received.

5 Words and phrases used in this policy

Certain words and phrases used in this policy wording, and the other documentation which forms part of your policy, have specific meanings which are defined below. Where words and phrases are not shown, they will take on their usual meaning within the English language.

Accident
A sudden and unexpected bodily injury caused by violent or external means.

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

Annual renewal date
The day after the expiry date as shown on the certificate of insurance.

Benefit schedule
The schedule included within your certificate of insurance which sets out the benefits available to you and your eligible dependants under this policy, in line with your chosen level of cover.

Birth defect
A deformity or medical condition which is caused during pregnancy and/or childbirth.

Bodily injury
An identifiable physical injury that directly results from an accident.

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 document issued to you which shows the name of the policyholder together with the insured persons, selected geographical area, selected currency (i.e. Great British Pounds, Euros or US Dollars), level of cover, benefit schedule applicable for your chosen level of cover, period of insurance, inception and expiry dates, name of the insurer, and any special terms, conditions and exclusions which apply to your policy.

Chronic medical 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, within one period of insurance.

Close 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 proportion of eligible costs which you are responsible.

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

Confinement to home
When an illness or injury restricts the ability of the insured person to leave their home, except with the assistance of another individual and the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker). Any medically necessary absence from the insured person's home shall not disqualify an insured person from being considered to be confined to home.

Congenital condition
A medical condition or abnormality that is present at birth.

Consultant
A surgeon, anaesthetist or physician who is legally qualified to practice medicine or surgery following attendance at a recognised medical school and is recognised as having a specialist qualification in the field or expertise in the treatment of the disease, illness or injury being treated.

Country of residence
The country where the insured person(s) covered by this policy has their primary residence; and in which they normally live; during each period of insurance.

Critical medical condition
A situation where an insured person is suffering a medical condition, which in the opinion of our physician and in consultation with the local treating doctor, requires immediate evacuation to an appropriate medical facility.

Day-patient
Medical treatment provided in a hospital where an insured person requires a period of recovery in a hospital bed but is not required, out of medical necessity, to stay overnight.

Deductible/excess
The amount of money stated on the certificate of insurance which is payable by the insured person. If you have chosen a deductible/excess to apply to your policy, it will apply on a per person per period of insurance basis, which means that it will be applied once a year to each insured person. At the start of each period of insurance you are responsible for bearing the eligible costs for any expenses up to the value of your deductible/excess.

Dependant
The principal member's:

- legal spouse or partner of the same or opposite sex;
- child, step-child or legally adopted child provided that he/she is under age 19 and unmarried (or under age 25, unmarried and in full-time further education) on the date first included under this policy or at any subsequent annual renewal date.

Emergency dental treatment
Dental treatment necessary as a result of an accident caused by an extra-oral impact, received within 48 hours from the date and time of the accident for the immediate relief of pain caused by natural teeth being lost or damaged.

Emergency treatment
Medical treatment given to evaluate and treat an acute medical condition whether resulting from an accident or a sudden onset of an illness where it is reasonable for the insured person to believe that the symptoms of their condition are of such severity in nature, that failure to seek immediate medical treatment could result in either placing their health in serious jeopardy or causing impairment of bodily function.

Expiry date
The date on which all insurance cover under this policy ends

External prosthesis
An external device (i.e. artificial limbs) that substitutes or supplements a missing or defective part of the body.

Geographical area
One of the four different areas as shown on your certificate of insurance which comprise the following countries:

Area 1 comprises the following countries: Albania, Andorra, Austria, Belarus, Belgium, Bosnia Herzegovina, Bulgaria, Channel Islands, Croatia, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Gibraltar, 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, United Kingdom, Vatican State.

Area 2 comprises all countries worldwide with the exception of United States of America, China, Hong Kong and Singapore.

Area 3 comprises all countries worldwide with the exception of United States of America.

Area 4 comprises all countries worldwide.

Home country
The country for which the insured person holds a current passport. Where an insured person holds dual nationality, their home country will be the one nominated on the application form completed at the start date of your policy.

Hospice
An institution that specialises in the care of people who are terminally ill with special concern for death with dignity.

Hospital
Any institution under the constant supervision of a resident physician which is legally licensed as a medical or surgical hospital in the country where it is located.

Illness
Any sickness, disease, disorder or alteration in an insured person's state of health diagnosed by a physician.

In-patient
Medical treatment provided in a hospital where an insured person is admitted and, out of medical necessity, occupies a bed for one or more nights but not exceeding 12 months in total for any one medical condition.

Insured person/you/your/yourself
The person(s) shown on the certificate of insurance.

Insurer
Arma Insurance Company Limited

Level of cover
One of the five different levels of cover available under the Evolution Health Plan as shown on your certificate of insurance, which shall be one of the following:

- **Standard**
- **Standard Plus**
- **Comprehensive**
- **Premium**
- **Elite**

Lifetime limit
The maximum amount of money we will pay in respect of each of the benefits set out within the benefit schedule of your certificate of insurance, which show as having a lifetime limit, during the lifetime of this policy including any other policies effected with us.

Local ambulance services
Provision of ambulance to transport an insured member to hospital in a medical emergency.

Medical condition
Any disease or illness (including psychiatric illnesses), not otherwise excluded by this policy.

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 a medical condition, bodily injury or illness or to provide relief of a chronic medical condition.

Organ implantation
Medical treatment undertaken to perform the implantation of the following natural human organs: kidney, liver, heart, lung, stem cell, bone marrow 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
Medical treatment provided to the insured person by or on the recommendation of a physician which does not involve an admission to hospital either on an in-patient or day-patient basis.

Overall maximum benefit
The maximum amount of costs that will be paid to or a payment made on behalf of each insured person during each period of insurance.

Palliative treatment
Treatment where the primary purpose is only to offer temporary relief of symptoms rather than to cure the medical condition causing the symptoms.

Period of insurance
The period of time as shown on your certificate of insurance during which this policy is effective, subject to payment of the required premium.

Physician
A legally licensed medical/dental practitioner who is authorised by the appropriate governing authorities to practice medicine in the country where treatment is provided.

Physiotherapy
Medical treatment 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 level of benefits that applies as detailed on your certificate of insurance.

Policyholder
The person who subscribes to this policy, on behalf of each insured person, who is responsible for paying the premium and ensuring that the policy terms and conditions are adhered to.

Pre-existing medical condition
Any medical condition, psychological condition or 'related condition' for which you have suffered any symptoms (whether investigated or not), consulted any medical practitioner for check-ups or monitoring of a condition, received follow up examinations, medical treatment or advice, or been prescribed or taken medicine, including over the counter drugs, special diets, injections or physiotherapy, in the 5 year period prior to your start date. A 'related condition' is deemed to be any medical condition that is either an underlying cause of, or directly attributable to, the medical condition subject to claim.

Premature baby
A baby born before the start of the 37th week of pregnancy.

Prescription drugs
Medications and drugs whose sale and use are legally restricted to the order of a physician. Drugs, medicines and other medicaments purchased 'over the counter' without a physician's prescription are not covered by this policy.

Principal member
The policyholder

Start date
The date that insurance cover under this policy first starts for an insured person.

Subrogation
Our right to act as your substitute to pursue any rights you may have against a third party who is liable for a claim paid by us under this policy.

Usual, customary and reasonable
The charges that would typically be made for the treatment that you receive in the location where your treatment is received. If there is any dispute relating to usual, customary and reasonable, we will identify the amount typically charged by obtaining three quotations for the disputed treatment and we will settle costs based on an average of the three quotations.

Waiting period
The period during which no benefit is payable for treatment costs when a waiting period is shown in the benefit schedule.

We/us/our
Arma Insurance Company Limited in conjunction with Morgan Price International Healthcare, who are responsible for administering this policy on behalf of the Insurer.

6 What is and is not covered

This section outlines the benefits that are available under the Evolution Health Plan, dependent upon your chosen level of cover.

Please refer to the benefit schedule attached to your certificate of insurance for confirmation of the amounts that we will pay for each insured person during each period of insurance, as appropriate to both your elected level of cover and elected currency. Please note that those benefits which are stated within the benefit schedule as being 'Full Refund' are all subject to costs being usual, customary and reasonable for the services provided, and within the Overall Maximum Limit of the policy.

Our liability in respect of all claims will cease immediately upon termination of this policy, deletion of an insured person from this policy or non-payment of premium.

Overall Maximum Benefit

What is covered

This is the maximum amount of costs we will pay in respect of all benefits available under the selected level of cover to each insured person in each period of insurance. All benefits are payable to each insured person in each period of insurance unless otherwise stated. Benefit provisions where the limit is 'Full refund' are collectively subject to the overall maximum benefit applying.

What is not covered

We will not pay for any costs which exceed the overall maximum benefit and/or individual benefit limits of any item for the level selected.

Item 1 - Hospital Benefits

What is covered

Where shown as covered, we will pay for the following benefits, up to the amount shown in your benefit schedule.

A. In-patient Hospital Stay - Pre-authorisation required

All required medical treatment provided to you when you are admitted as a registered in-patient in a hospital for a period of not less than 24 hours, and only when appropriate diagnostic procedures and/or treatment is not available on an out-patient basis.

- It includes the cost of hospital accommodation in a standard single bedded room, nursing, operating theatre fees, high dependency/intensive care/coronary care unit and special nursing fees.
- Surgeons', anaesthetists', consultants' and physician's fees.
- Physiotherapy
- Internal prosthesis, medical aids/devices where used as an integral part of a surgical procedure
- Prescribed drugs and medicines.
- Diagnostic procedures (including X-rays), pathology, MRI/CT/PET scans.

B. Day-patient Treatment - Pre-authorisation required

Any surgical or medical procedures that you receive which are provided on an out-patient basis, but where you require a period of recovery in a hospital bed. It includes the cost of hospital accommodation, operating theatre fees, nursing fees, surgeons' fees, anaesthetists' fees, consultants' fees, physicians' fees, diagnostic procedures and prescribed drugs and medicines.

C. Parental Hospital Stay

Hospital accommodation costs for one insured person to stay with an insured child dependant, who is under age 19, and being admitted to hospital as an in-patient for medical treatment covered by this policy.

D. In-patient Psychiatric Treatment – Pre-authorisation required

Medical treatment provided when you are admitted as a registered in-patient in a recognised psychiatric unit of a hospital. It includes the cost of hospital accommodation, consultant psychiatrist's fees; diagnostic procedures; and prescribed drugs and medicines. Cover is limited to the maximum number of days shown in your benefit schedule.

E. Accident and Emergency Room Treatment

Treatment given in a hospital casualty ward or emergency room immediately following an accident or following the sudden onset of a serious medical condition, resulting in eligible in-patient or day-patient treatment.

F. External Prostheses

An external device (i.e. artificial limbs) that substitutes or supplements a missing part of the body.

G. Rehabilitation Care – Pre-authorisation required

Treatment received on an in-patient basis in a recognised rehabilitation unit, under the supervision and direction of a physician, to restore health and mobility after an accident, injury or illness. This benefit is limited to a maximum of 13 weeks during each period of insurance.

H. Kidney Dialysis Benefit – Pre-authorisation required

Kidney dialysis needed temporarily for sudden kidney failure resulting from a disease or injury, covered by your policy, which affects another part of your body. A lifetime limit applies to this benefit as shown in your benefit schedule.

I. Organ Implantation Benefit – Pre-authorisation required

Costs directly related to the implantation of the following natural human organs: kidney, liver, heart, lung, stem cell, bone marrow and skin grafts (where medically necessary and not for cosmetic purposes).

J. Day-patient Psychiatric Cover

The cost of hospital accommodation in a standard single bedded room in a registered psychiatric unit for a psychiatric illness including; consultant psychiatric fees; diagnostic procedures and prescribed drugs & medicines. Cover is limited to a total of 4 seperate day admissions in each period of insurance.

K. Local Ambulance Services

The cost of provision of ambulance services to transport you to hospital in the event of a medical emergency.

What is not covered

- Rehabilitation other than that covered in Item 1 G.
- The costs associated with locating a replacement organ or any costs incurred for the removal of the organ from the donor, the transportation costs of the organ and all associated administration costs.
- Costs associated with the procurement and/or implantation of an artificial and/or non-human organ.
- Medical treatment associated with cryopreservation, implantation or reimplantation of living cells or living tissues whether autologous or provided by a donor.
- Medical treatment for a medical condition that has qualified under one of the following benefit items:
  Item 2 - Cancer care benefit
  Item 7 - Maternity benefits
  Item 8 - Additional benefits
  Please refer to the relevant item for details of these specific benefits.

Item 2 - Cancer Care Benefits

A. Cancer Treatment - Pre-authorisation required

What is covered

From the date an insured person is diagnosed as suffering from cancer, whether it is in its acute, chronic or terminal stage, all and any treatment received thereafter on an in-patient, day-patient, or out-patient basis involving: consultations, diagnostic tests, scans, investigations, prescribed drugs and dressings, chemotherapy, radiotherapy, stem cell transplants (from either bone marrow or blood), routine management and palliative treatments; will be assessed and paid for under this item.

Eligible costs incurred up until the point of diagnosis are not assessed under this item of your policy.

What is not covered

Treatment of cancer which was diagnosed, or symptoms occurred and existed prior to the insured person's start date.

Item 3 - Out-patient Benefits (A 12 month waiting period applies to benefit I)

What is covered

Where shown as covered, we will pay for the following benefits:

A. Out-patient Minor Surgery

Minor surgical procedures carried out in a doctor's clinic/ consulting rooms or out-patient centre.

B. Out-patient Services

The services ordered by a physician who is licensed as a general practitioner, consultant or physician, including prescribed drugs, medicines and dressings.

C. Diagnostic Tests, X-rays and Pathology

The cost of diagnostic tests, investigations including ECG, x-rays, pathology and histology up to the overall limit as stated in Benefit B.

D. MRI/CT/PET Scans

The cost of MRI/CT/PET scans when ordered by a physician.

E. Physiotherapy

Treatment provided by a licensed Physiotherapist.

F. Medical Aids and Devices

The cost of hiring mobility aids and devices including: walking sticks or frames, wheelchairs, and crutches.

G. Complementary Therapies

Chiropractic, homeopathy, osteopathy, acupuncture, ayurvedic, herbal and Chinese medicines consultations, provided by a licensed practitioner, including prescribed drugs and medicines.

H. Hormone Replacement Therapy

Treatment received to relieve the symptoms of the menopause, including; prescribed medicines, patches and implants.

I. Out-patient Psychiatric Treatment

Treatment of any psychiatric and psychological disorders by a consultant psychiatrist, including consultations and prescribed drugs and medicines, subject to a primary physician referral. Cover is limited to the number of visits shown on your benefit schedule in each period of insurance. A 12 month waiting period applies to this benefit.

J. Home Nursing

Nursing-at-home where prescribed as being medically necessary immediately following a period of in-patient treatment covered by this policy. All nursing must be provided by a qualified nurse and be under the supervision and direction of a physician. Cover is limited to the total number of weeks shown in your benefit schedule in each period of insurance.

What is not covered

In respect of cover for Item 3I above, we will not pay claims for a treatment received within the 12 months period following an insured person's start date.

Medical treatment for a medical condition that has qualified under one of the following benefit items:

- Item 4 - Cancer care benefit
- Item 7 - Maternity benefits
- Item 8 – Additional Benefits

Please refer to the relevant item for details of these specific benefits.

Item 4 - Chronic Condition Benefits (A two year waiting period applies to benefit C)

What is covered

Where shown as covered, we will pay for the following benefits, up to the amount shown in your benefit schedule:

A. Chronic Medical Condition Treatment

Treatment of chronic medical conditions is covered within the benefit levels applicable for Hospital Benefits, Cancer Care Benefits and Out-Patient Benefits.

B. Hospice Care Treatment

Accommodation in a hospice for palliative treatment for an insured person who has been given a terminal prognosis. Cover is available for a maximum number of 14 nights in each period of insurance.

C. HIV and AIDS Treatment – Pre-authorisation required

Medical treatment for HIV and AIDS including related diseases where contracted as a direct result of a blood transfusion received after the insured person's start date. A two year waiting period applies to this benefit. A lifetime limit applies to this benefit.

What is not covered

Treatment of a chronic condition which was diagnosed and existed prior to the insured person's start date, unless otherwise agreed by the insurer in writing.

Chronic or end stage renal failure which requires regular or long-term dialysis.

Medical treatment for a medical condition that has qualified under one of the following benefit items:

- Item 2 - Cancer care benefit
- Item 8 – Additional Benefits

Please refer to the relevant item for details of these specific benefits.

Item 5 - Wellness Benefits (A 12 month waiting period applies to all benefits)

What is covered

We will pay for the following benefits, up to the amount shown in your benefit schedule. Any selected policy deductible/excess will not apply to these benefits.

A. Wellness Screening

Including cancer screening (cervical smears, mammograms and prostate/colon/testicular) and testing for, body temperature, pulse, blood pressure, respiration, full blood count, fasting blood sugar, lipid (fats) profile, kidney function panel, liver function panel and thyroid panel.

B. Travel Vaccinations/Preventative Medications

Vaccinations and immunisations and preventative medications that are directly related to overseas travel requirements.

C. Child Vaccinations

Routine and preventative vaccinations for an insured child up to age 10.

D. Optical Benefit

One annual vision/eye test.

E. Vision Benefit

Contribution towards the cost of glasses or contact lenses where prescribed by an ophthalmologist or optician.

F. Laser Eye Benefit

Treatment and consultations related to corrective laser eye treatment when performed by a qualified ophthalmic surgeon.

G. Hearing Test Benefit

One annual hearing test.

H. Hearing Aid Benefit

Contribution towards the costs of a hearing aid where prescribed by an audiologist/ENT consultant.

What is not covered

Any costs incurred within the initial 12 months from the start date of an insured person.

In respect of 5A (Wellness Screening)

- Screening for any insured persons under the age of 16.

In respect of 5E (Vision Benefits)

- Contact lenses supplied for cosmetic purposes only
- Sunglasses of any kind, including prescription sunglasses
- Replacement spectacles or contact lenses where they were worn prior to the start date of an insured person.

In respect of 5F (Laser eye surgery)

- Laser eye surgery where glasses or contact lenses were worn prior to the insured persons start date.

Item 6 – Dental Treatment Benefits (10% co-insurance and a 6 month waiting period applies to benefits B, C, D and E)

What is covered

Where shown as covered, we will pay for the following benefits, up to the amount shown in your benefit schedule, provided that you have maintained good dental hygiene and attended regular routine check-ups prior to your start date. Any selected policy deductible/excess will not apply to these benefits.

A. Emergency Dental Treatment

Dental treatment for immediate pain relief where required as a direct result of an accident. Only treatment received during the first 48 hours following the date of the accident is covered.

B. Non-Emergency Routine Dental Treatment

Including:

- Routine examinations.
- Cleaning and polishing, fillings using amalgams or composite materials.
- Extractions (other than wisdom teeth).
- X-rays, moulds and treatment for the relief of an infection including prescribed antibiotics and temporary fillings.

C. Non-Emergency Major Dental Treatment

- Root canal treatment; new porcelain crown; new inlay; new bridgework.
- Repairs to crown or inlay.
- Repairs to bridge.

D. Extraction of Wisdom Teeth – Pre-authorisation required for in-patient treatment

Extraction of buried, impacted or un-erupted wisdom teeth on an in-patient, day-patient or out-patient basis.

E. Orthodontic Treatment

Orthodontic dental treatment for insured children under age 19.

What is not covered

Emergency dental treatment where:

- The injury was caused by eating or drinking anything, even if it contained a foreign body;

- The damage was caused by normal wear and tear;
- The damage was caused by tooth-brushing or any other oral hygiene procedure;
- The injury was caused by any means other than extra-oral impact.

Emergency dental treatment shall not include: restorative or remedial work; the use of any precious metals; orthodontic treatment of any kind; or dental surgery performed in a hospital, unless dental surgery is the only treatment available to alleviate the pain.

The cost of precious metals in any dental procedure.

Gingivitis, periodontosis, or gum disease of any kind.

Dental procedures other than those stated in the benefit narrative.

Replacement of existing crowns, inlays, fillings, bridges or missing teeth apparent at the start date of your policy.

In respect of the cover for 'Non-Emergency Routine Dental Treatment', 'Non-Emergency Major Dental Treatment' and 'Orthodontic Treatment', we will not pay any costs incurred within the initial 6 months from the start date of an insured person.

In respect of cover for Orthodontic work', we will not pay claims for:

- Any insured person who was age 19 and over on the date of treatment.
- The cost of any co-insurance applicable under Items 6 B, C, D or E of this benefit.

Item 7 - Maternity benefits – Pre-authorisation is required and a 10 month waiting period applies to all benefits

What is covered

Where shown as covered, we will pay for the following benefits, up to the amount shown in your benefit schedule:

A. Complications of Pregnancy and Childbirth

The costs of treatment for all pre-natal care; delivery costs; hospital accommodation for the newborn immediately following birth; and post-natal care for the mother, where complications occur during the pregnancy or childbirth For the purposes of this policy, 'Complications of pregnancy and childbirth' will only be deemed to include the following: toxaemia, gestational hypertension, pre-eclampsia, ectopic pregnancy, hydatidiform mole, ante and post-partum haemorrhage, retained placenta membrane, stillbirths, miscarriage, caesarean sections where a physician has certified that it is medically necessary and abortions where a physician has certified that is medically necessary.

B. Normal Pregnancy and Childbirth

The costs of treatment for all pre-natal care; delivery costs; hospital accommodation for the newborn, immediately following birth; and post-natal care for the mother.

C. Paediatric Benefit

Contribution towards the costs of an initial paediatric check-up for the newborn.

D. Premature Baby Treatment

The costs of medical treatment for a premature baby where received during the first 2 months following birth. Please note that no cover is available:

- Where the baby has not been added to this policy within 14 days of birth;
- For continuing treatment after expiry of the initial 2 months period other than for new and unrelated medical conditions.

Please note that all benefits under this item are only payable:

- After the expectant mother has been covered under this plan for 10 consecutive months.
- On a 'per pregnancy' basis.
- Benefits under Normal Pregnancy and Childbirth and Paediatric Benefit are also applicable in the case of delivery by elective caesarean section or a planned home birth.

What is not covered

Any costs incurred within the initial 10 months from the start date of an insured person. For the sake of clarity, conception may take place during this initial period but our liability will only commence for eligible costs incurred after the 10 months period has expired.

Terminations of pregnancy on non-medical grounds.

Ante-natal classes and midwifery costs when not directly associated with the childbirth delivery.

Treatment received by the newborn after the initial paediatric check up unless the newborn is added to this policy as an insured person within 14 days of birth.

Item 8 - Additional Benefits (A 12 month waiting period applies to benefits A and B)

What is covered

Where shown as covered, we will pay for the following benefits, up to the amount shown in your benefit schedule:

A. Infertility Benefit

Investigations into the medical cause of infertility, where both members are insured under this policy and when the couple's treating physician believes there are symptoms and/or evidence to suggest a medical cause.

B. Congenital Benefit

The costs of treatment for conditions not discovered at birth but which can be subsequently corrected with surgery. A maximum lifetime limit applies to this benefit as shown in the benefit schedule.

C. Congenital/Birth Defects Benefit

The cost of treatment to relieve the symptoms of, or correct a birth defect, or congenital or medical condition that is diagnosed within one year of birth for babies conceived by natural means. A maximum lifetime limit applies to this benefit as shown in the benefit schedule.

What is not covered

Any costs incurred within the initial 12 months from the start date of an insured person, for items 8 A and 8 B.

Medical treatment for infertility, or any other related condition, once a medical cause has been identified.

Item 8C is only available if the insured person has been covered on the policy since birth.

Item 9 - Cash Benefits (A 10 month waiting period applies to Benefit B)

Any selected deductible/excess will not apply to these benefits.

What is covered

Where shown as covered, we will pay for the following benefits, up to the amount shown in your benefit schedule.

A. Hospital Cash Benefit

The amount payable when in-patient treatment has been received free of any charge within the provision of a state run national health service for which no claim is made/paid under any other item of this policy. This benefit is payable on a 'per night' basis up to a maximum total number of 30 nights in each period of insurance as shown on the benefit schedule.

B. Maternity Cash Benefit

The amount payable on the birth of each child. Payment of this benefit is subject to the child being born at least 10 months after the mother's start date. This benefit is only payable where no claim for pregnancy and/or childbirth has been made/paid against any other item of this policy.

Please note that notification of the addition of a newborn does not constitute formal claim submission for this benefit.

C. Convalescence Cash Benefit

The amount payable for each complete week of confinement to home (excluding the first week), on the instruction of the treating consultant, immediately following a period of in-patient hospital treatment for a medical condition covered by this policy. This benefit is payable up to a total maximum period of 4 weeks in each period of insurance.

What is not covered

If you make claim under this benefit of the policy you are unable to make a further claim under any other benefit on the policy for the same medical condition.

Item 10 - Medical Evacuation and Repatriation Benefits Pre-authorisation is required

What is covered

Where shown as covered, we will pay for the following benefits, up to the amount shown in your benefit schedule. Any selected deductible/excess does not apply to these benefits.

A. Emergency Medical Transportation

The costs of emergency medical transportation, and medical care en route, for an insured person who has a critical medical condition and local medical facilities are inadequate or not available. Transportation will be to the nearest suitable hospital in either their country of residence or a nearby country (not necessarily the home country), returning the insured person to their country of residence after treatment.

B. Companion Travel Costs

Reasonable travelling costs of a friend or close relative, to accompany the insured person during an emergency medical transportation. The friend or close relative must have been in the same location as the insured person at the time of the event necessitating transportation.

C. Companion Accommodation Costs

Overnight accommodation costs for the accompanying friend or close relative, to stay with or near, the insured person while hospitalised. The amounts stated under item 10 C of your benefit schedule are on a 'per night' basis up to a maximum of 10 nights for each new and separate event.

D. Medical Assistance Costs

Medical referral assistance services including the provision of basic medical advice by telephone and assistance in replacing essential prescription drugs.

E. Dependent Child Travel Costs

Following an emergency medical transportation, we will arrange and pay to transport, to a specified destination, any child/ren under age 19 left at home unattended or pay for the travelling costs (one economy class return ticket), of a person to take care of the child/ren at home.

F. Repatriation of the Deceased

The cost of transportation of mortal remains following death, available only when the death of an insured person occurs while outside their home country.

G. Local Burial or Cremation

The costs of local burial or cremation in the country where death occurred and transportation of the urn to either the deceased's home country or country of residence, available only when the death of an insured person occurs while outside their home country.

What is not covered

Any subsequent transfer costs arising as a result of the same medical condition, once we have returned the insured person to their country of residence.

Travel and accommodation costs unless specifically agreed by us and confirmed, in writing, prior to the date of travel.

Emergency medical transportation costs where the insured person is not being admitted to a hospital for medical treatment, or where costs have not been approved by us prior to travel commencing.

The transfer of a pregnant woman to hospital for routine childbirth, unless it is necessary due to medical complications.

Any additional travelling costs incurred by the nominated close relative or friend, if it is necessary for us to arrange for the insured person to be transferred to a second hospital within the same country.

Burial and cremation costs do not include the cost of a religious practitioner, floral tributes, musical provision, hire of funeral vehicles or food and beverages.

Any costs incurred where the insured person has died in their home country.

Any costs incurred under Item 10 G, for transportation, cremation or local burial of mortal remains where death has occurred directly or indirectly as a result of a medical condition, treatment or accident, not covered under this policy.

Item 11 – Out of Area Treatment Benefit

What is covered

Where shown as covered, we will pay for the following benefits, up to the amount shown in your benefit schedule.

A. Emergency Out of Area Treatment

The costs of short term treatment for emergency medical conditions, or acute episodes of existing medical conditions covered by your policy that occur while you are travelling outside of your elected area or cover as shown on your certificate of insurance. This will only operate when you do not travel for more than 30 days in total in each period of insurance.

What is not covered

All non-emergency medical treatment outside your geographical area.

Emergency medical treatment when the total number of days travelling in each period of insurance exceeds 30 days.

Treatment where you have specifically travelled with the purpose of obtaining treatment.

Item 12 - Evacuation to home country – Optional Benefit and Pre-authorisation required

What is covered

Where shown as covered, we will pay for the following benefits, up to the amount shown in your benefit schedule. Any selected deductible/excess does not apply to this benefit.

The costs of emergency medical transportation, and medical care en route, for an insured person who has a critical medical condition and local medical facilities are inadequate or not available.

Transportation will be to the Home Country, provided that this a medically viable option, returning the insured person to their country of residence after treatment.

If your home country is the United States of America, your policy will automatically terminate after 90 days in your home country.

What is not covered

Any subsequent transfer costs arising as a result of the same medical condition, once we have returned the insured person to their home country.

Travel costs unless specifically agreed by us and confirmed, in writing, prior to the date of travel.

Travel costs where the home country falls outside of the geographical area selected and operating under this policy.

Evacuation costs where the insured person is not being admitted to a hospital for medical treatment, or where costs have not been approved by us prior to travel commencing.

The transfer of a pregnant woman to hospital for routine childbirth, unless it is necessary due to medical complications.

7 General exclusions

The following exclusions apply to all benefits of this policy.

We will not pay claims for any of the following:

1. The first 25% of costs for claims for benefits for which pre-authorisation is required but was not sought prior to incurring costs.
2. Any treatment costs that occur after the expiry date of the policy.
3. Any medical condition, psychological condition or 'related condition' for which the insured person has received treatment, suffered any symptoms (whether investigated or not) or sought advice prior to their start date unless such condition has been declared to us and accepted in writing for insurance by us. A 'related condition' is deemed to be any medical condition that is either an underlying cause of or directly attributable to the medical condition subject to claim.
4. Medical treatment for alcoholism, drug and substance abuse/ dependency including any directly or indirectly attributable medical condition and/or bodily injury.
5. Medical treatment for any addictive and/or compulsive disorder.
6. Medical treatment due to the insured person being under the influence and/or suffering from the effects of alcohol, intoxicants, drugs or narcotics.
7. Deliberate self-inflicted injury, needless self-exposure to peril (except in an attempt to save human life), suicide, attempted suicide or self-harm.
8. Dietary supplements, nutritional supplements, bodybuilding supplements and substances, fibre, fatty acids, amino acids, vitamins, minerals and organic substances regardless as to whether prescribed by a physician, except as provided for under item 3 F Complementary Therapies.
9. Contraception, sterilisations or its reversal (including vasectomy), fertilisation, impotence, venereal disease, sexually transmitted diseases, gender reassignment or any other form of sexual related condition.
10. Medical treatment for any form of assisted reproduction (including in vitro fertilisation).
11. Any act that is fraudulent, illegal, criminal, deliberately careless or reckless on the insured person's part and any consequences directly or indirectly resulting from that act.
12. Any claim arising in the course of travel undertaken against medical advice.
13. Air travel when the insured person is more than 28 weeks pregnant.
14. Costs associated with medical treatment of a premature baby after the initial 2 months from date of birth.
15. Any claims arising from birth injuries or defects, congenital illness, or congenital abnormality except where covered under section 6, item 8 B and C.

16. Medical treatment for Human Immunodeficiency Virus (HIV) or HIV related illness, including Acquired Immune Deficiency Syndrome (AIDS) or AIDS related complex (ARC) and any similar infections, illnesses, injuries or medical conditions arising from these conditions, except where covered under section 6, item 4 C and in conjunction with the benefit limit shown within the benefit schedule of your certificate of insurance.

17. Any treatment which is experimental and/or unproven and any consequences resulting directly or indirectly from the treatment. For the purposes of this policy, experimental and unproven treatment is deemed to be any treatment not recognised scientifically by the official government control agency of the country where treatment is received.

18. Any treatment and/or use of drugs/medicines not licensed by the official government control agency of the country where treatment is received or where the drugs/medicines are prescribed or, drugs/medicines not used in accordance with their licensed indications.

19. Drug therapy and/or treatment provided by an unlicensed physician or where the physician is unlicensed in the country where the drug therapy and/ or treatment is received.

20. Routine or preventative medicines, vaccinations of any kind and general health check-ups, unless specifically covered by your selected plan type.

21. Cosmetic surgery, cosmetic treatments or remedial surgery, removal of fat or other surplus body tissue and any consequences of such medical treatment, whether or not for psychological purposes, except when required as a direct result of an illness, injury or accident which occurred whilst the insured person is covered by the policy.

22. Any claims arising from weight loss, weight problems or eating disorders.

23. Any claims arising from snoring, sleep apnoea or sleeping disorders.

24. Surgery (other than laser treatment surgery performed by an ophthalmic surgeon) 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.

25. Stem cell transplants for any medical condition apart from the treatment of cancer where it is pre-authorised.

26. Medical treatment performed by a physician who is a close relative of the insured person, unless previously approved by us.

27. Claims arising from racing, other than on foot, and all professional sports.

28. 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.

29. 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.

30. Any expenses relating to an air/sea rescue operation or an evacuation/transfer from any off-shore structure or sea going vessel to shore.

31. Any expense not specifically stated in this policy as being insured and any expenses which exceed the individual benefit limits or overall maximum benefit of your plan type.

32. Any expenses where no supporting documents are available.

33. Any accounts, bills or invoices received by us more than 6 months after the date of treatment or the date the service was given.

34. Accommodation and medical treatment costs 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 reasons.

35. Accommodation and medical treatment costs in a nursing home, hydro spa, nature clinic, health farm, health spa, rest/ retirement/convalescent home or any similar establishment.

36. Medical treatment for learning difficulties, hyperactivity, attention deficit disorder, speech therapy, behavioural problems or development problems.

37. Any costs which are unnecessary, medically inappropriate or are over and above what is usual, customary and reasonable for the services provided.

38. Any claim in any way caused or contributed to, by the use or release or the threat thereof of: any nuclear weapon or device; or, chemical or biological agent.

39. 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.

40. 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 subject to the individual limits of each item of benefit.

    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.

41. Any expense which at the time of happening is covered by or would, but for the existence of this policy, be covered by, any other existing insurance certificate or policy. If there is cover in force which may pay in respect of the event for which the insured person is claiming, the insured person must tell us at the time they first contact us.

42. Costs which you would have otherwise had to pay even if the event which gave rise to a claim had not occurred.

43. Any loss directly or indirectly 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.

44. Medical treatment related to podiatry and/or chiropody.

45. If you wear glasses or contact lenses prior to the start date of your policy replacement spectacles, contact lenses or laser eye surgery are excluded from cover.

46. Cover for replacement of existing crowns, inlays, fillings, bridges or missing teeth prior to the start date of your policy are excluded; these are classified as pre-existing.

47. No cover is provided under this policy where general medical advice has not been followed.

48. Costs for the provision of medical reports or completion of claim forms or translations.

8 General policy administration

a. Commencement of cover

You and your dependants' cover can start once we have accepted your application form and your first premium payment has been received by us, including any applicable taxes.

Your start date will be shown on your certificate of insurance. Your start date must be within 30 days from the date that you signed your application form.

We will provide you with a certificate of insurance, any relevant endorsements, a benefit schedule and a membership card which includes details of the emergency claims contact details.

b. Adding or removing your dependants

Application to add your eligible dependants may be made at any time during the period of insurance subject to payment of the required premium.

A healthy newborn child may be added to this policy from their date of birth provided we received a completed application form 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 the completed application form and not their date of birth.

Please note that submission of a claim under item 7 – Maternity benefits, does not constitute formal notification for the newborn to be added to the policy. A completed application form is required.

If you wish to delete any of your insured dependants from the policy, then you must make this request in writing. Deletion will be made from the date that written notification is received.

c. Maintaining cover

Subject to satisfying any specific eligibility criteria and payment of the required premium, this policy will remain in force during the period of insurance and is renewable for successive one year periods at the prevailing terms, premium rates and benefits.

We will not cancel this policy because of either a deterioration in the health of any insured person or the number/value of claims the insured makes, unless we are prohibited by insurance law or legislation, or decide not to continue to underwrite this type of insurance in the insured person's country of location.

If we decide to stop underwriting this policy, we shall give the insured not less than 120 days notice in writing prior to your policy's next annual renewal date.

d. Alterations to your policy

We may change the premium rates, terms, conditions and benefits of your policy from time to time but any such changes will not apply until the next annual renewal date first following the introduction of such changes.

No alteration or waiver of the terms, conditions and benefits of this policy shall be accepted unless it is in writing by one of our authorised company officials.

e. Changing your plan type

You may only apply to change your plan type at the annual renewal date of the policy. If we accept your application, we reserve the right to apply a variation in cover to any medical conditions which pre-existed the date of such change.

You may change your geographical area at any time during the period of insurance if you relocate to a country of residence which is located outside of the geographical area chosen at the start date or subsequent annual renewal date.

f. 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 annual 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 can be paid by bank transfer or by debit/credit card.

Premiums (and any applicable taxes) are payable monthly, quarterly, semi-annual or annually but this is an annual contract of insurance. If you elect to pay your premium in instalments, you will be charged an administration fee. 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.

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

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.

If we agree to reinstate cover, we reserve the right to apply revised underwriting terms to your policy.

If a premium is outstanding, any claims will be suspended and will not be settled until the outstanding premium is received by us.

If any premium is unpaid at the end of this 30 day period, we will cancel the policy from the date that the unpaid premium was due. Any outstanding premium will be deducted from the credit card or debit card supplied.

Premiums are payable in the currency of the policy which you elected at the start date of your policy.

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

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.

If having purchased this insurance you decide that it does not meet your requirements then please return your policy documents to us within 14 days of receipt together with written cancellation instructions. Provided no claims have been paid and/or pre-authorisation has been given, we will refund any premium that you have paid.

g. Temporary return to your home country

For nationals of the United States of America, cover can remain in force for temporary return and visits to your home country up to a maximum of 90 days in total during each period of insurance, provided that your home country is included within your selected geographical area. Your policy will automatically terminate after 90 consecutive days in the United States of America – refer to "Termination".

For nationals of all other countries worldwide, there is no restriction for temporary return and visits to your home country, provided your home country is included within your selected geographical area.

Where your home country falls outside of your selected geographical area, please refer to Item 11 A – Emergency Out of Area Treatment.

h. Cancelling your policy

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 policy from the date of receipt of such instruction or from a future date - under no circumstances will we back date any cancellation requested by the policyholder.

Once we have received your cancellation notification and provided no claims or pre-authorisations have been put in place in the current 12 month period of insurance, a pro-rata refund may be applicable. If a claim has been made, then no refund will be due and any outstanding instalment premiums remain payable.

If you cancel your plan we reserve the right to charge an administration fee of £/€/$30.

We will not cancel this policy because of eligible claims made by the insured person. We reserve the right to cancel the policy at any time if any insured person has:

- Misled us by mis-statement or concealment or failed to answer any question about this policy honestly and fully; or
- 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
- Fails to pay the premium due.

i. Termination

This policy will automatically end in any of the following situations:

- Failure to pay the premium on the date due. At our absolute discretion, we may reinstate the cover if the outstanding premiums are paid to us in full, although we reserve the right to apply revised underwriting terms to your policy.
- Where you have acted in a fraudulent manner or deliberately claimed benefit either directly or indirectly, to obtain unreasonable pecuniary advantage which is to our detriment.
- For nationals of the United States of America only, 90 days after you return to your home country.
  This 90 day period shall be reduced by the number of days that have already been spent on temporary return and visits to the United States of America during the period of insurance. If there are less than 90 days to run until the expiry date, then cover shall cease on the expiry date.

On termination of this policy for whatever reason, our liability will immediately cease.

j. Death of a principle member

Should the principle member die, their spouse (provided already insured under your policy) will automatically become the principal member for the remainder of the period of insurance. Should a dependent be left on the policy under the age of 18, a guardian will need to become the policyholder.

k. Other insurance

If there is any other insurance covering any of the benefits that are provided under your policy for which a claim is made, then you must disclose this to us at the time of submitting the claim.

In these circumstances, we will not be liable to pay or contribute more than our proper rateable proportion.

If it transpires that you have been paid for all or some of the claim costs by another source or insurance we have the right to a refund from you. We reserve the right to deduct such refund from you from any impending or future claim settlements or to cancel your policy from the start date or subsequent annual renewal date without a refund of premium.

l. Subrogation

If someone else is responsible, we may take court action in your name to recover any claims we have paid. We will pay for the cost of taking this action and it will be for our benefit. Insured persons, are not authorised to admit liability for any eventuality or give a promise of undertaking to anyone which binds the Insured, an Insured Person, or Us.

m. Help and intervention

Our help and intervention depends upon and is subject to local availability and has to remain within the scope of national and international law and regulations. Our intervention depends upon us obtaining the necessary authorisations issued by the various competent authorities concerned.

n. Compliance

Your full compliance with the terms and conditions of this policy is necessary before a claim will be paid.

o. Governing law

This contract of insurance shall be governed and construed in accordance with English law unless we agree otherwise. The courts of England and Wales alone shall have jurisdiction in any dispute.

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