

EXPATHEALTH PLANS – POLICY WORDING

A Morgan Price International Healthcare Ltd Policy

Registered in England No. 3771138, Registered office:
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IMPORTANT

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 is responsible for the plan design, 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 the benefits provided under the policy;

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

Any word explained in the Definitions section herein will have the same meaning throughout this document. Where words and phrases are not shown, they will take on their usual meaning within the English language.

A Certificate of Insurance will be issued only when You have

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

Section 1. DEFINITIONS

ACCIDENT

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

ACUPUNCTURE

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

AREA OF COVER

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

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

BENEFITS

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

BODILY INJURY

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

CERTIFICATE OF INSURANCE

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

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

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.

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.

COUNTRY OF RESIDENCE

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

DAILY CASH BENEFIT

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

DAY-PATIENT

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

DEDUCTIBLE/EXCESS

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

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 not less than 15 days old and no more than 18 years of age and unmarried (or no more than 25 years of age, unmarried and in full time education) on the date first included under this policy or at any subsequent annual renewal date.

DUE DATE

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

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

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.

HOME COUNTRY

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

HOSPITAL

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

ILLNESS

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

IN-PATIENT

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

INSURANCE CONTRACT

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

LABORATORY AND X-RAY SERVICES

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

LIFE THREATENING MEDICAL CONDITION

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

MEDICAL EXPENSES

Any in-patient, day-patient 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 a medical condition, bodily injury or illness or to provide relief of an acute phase of a chronic condition.

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

NEWBORN CARE

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

OUT-PATIENT

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

OVERALL ANNUAL LIMITS

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

PHYSICIAN

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

POLICY YEAR/PERIOD OF INSURANCE

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

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 date of entry. 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.

PRESCRIBED DRUGS

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

REASONABLE AND CUSTOMARY COSTS

Costs incurred for eligible Medical Treatment and/or supplies that do not exceed the standard fee of other providers of similar standing in the same region, for the same treatment of a similar Illness or Injury. If We determine that eligible costs are above what is considered to be Reasonable and Customary for medical procedures and/or supplies in a given region of the world, then We reserve the right to reimburse only the Reasonable and Customary Costs. An assessment of the Reasonable and Customary Costs will be determined solely by Us.

RENEWAL DATE

The date on which your next year's premium falls due, as specified on

Your Certificate of Insurance.

REPATRIATION

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 HEALTH CHECKS

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

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

ROUTINE MATERNITY

Refers to any medically necessary costs incurred during pregnancy and childbirth, including hospital charges, specialist fees, the mother's pre and postnatal care, midwife 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.

YOU/YOUR/INSURED PERSONS/INSURED

Any person listed on any Certificate of Insurance.

WE/US/OUR/INSURER

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Section 2. BENEFIT EXPLANATIONS

1. Chronic Conditions Cash benefit

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

1.1 Coronary Artery Bypass- The undergoing of heart surgery to correct narrowing or blockage of two or more coronary arteries with

bypass grafts in Insured Persons with limiting anginal symptoms but excluding non-surgical techniques such as balloon angioplasty or laser relief of an obstruction.

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

1.3 Cancer- A malignant tumour characterised by the uncontrolled growth and spread of malignant cells and the invasion of tissue. This includes leukemia but excludes non-invasive cancer in situ, Clark Level I or II malignant melanoma, Hodgkin's Disease - Stages I and II, tumours in the presence of any human immune-deficiency virus and any skin cancer other than Clark Level III or IV malignant melanoma, and non-metastatic breast and prostate cancer.

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

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

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

2. Compassionate Emergency Travel

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

2.1 Covered economy return expenses for travel to the bedside for a Close Family Relative of an Insured Person who is or will most likely be hospitalised for seven consecutive days or more, up to the limits specified on the Certificate of Insurance.

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

3. Complimentary/Alternative Medicine

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

4. Complicated Maternity Care

Complicated maternity shall mean pre-natal, childbirth and post-natal treatment for You up to the limit specified. It will only apply to treatment of complicated pregnancies where the Physician has

predicted the expected date of birth to be at least 12 months after the Effective Date of the policy.

A caesarean section is deemed by us to be complicated maternity only if a normal delivery was planned and fully expected in good faith, but a complication intervenes and a normal delivery is no longer appropriate. When such an event occurs, cover will be provided up to the limit specified in your 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.

5. Daily Hospital Cash Benefit

A cash benefit may be paid when treatment and accommodation for a medical condition that would otherwise be covered under the insured's plan, is provided in a government or charitable Hospital where no charges are billed. This benefit is retroactively paid as of the first day of hospitalisation, but payable only if the insured is hospitalised for a continuous period of 72 hours up to a maximum of 30 days.

6. Emergency Air Evacuation

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

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

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

7. Emergency Dental Treatment

Emergency Medical Treatment necessary to restore or replace permanently attached artificial teeth or sound natural teeth lost or damaged as a result of an extra-oral impact to the mouth and for which Medical Treatment is received within 48 hours following an Accident. Detailed medical documentation from a Physician or dentist must be provided to support Your claim.

8. In-Patient Hospital Services

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

9. Local Ambulance Services

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

10. Nursing at Home

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

11. Organ Transplantation

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

12. Out-Patient GP & Specialist Care

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

13. Parent Accompanying Child

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

14. Post Hospitalisation Treatment

All Out-Patient Medical Treatment received within the ninety day period immediately following discharge from Hospital provided by or ordered by the treating Specialist or Consultant, and which directly results from a covered Illness or Injury for which the Insured Person has been treated as an In-Patient of a Hospital, up to a maximum benefit, as shown on the Certificate of Insurance.

15. Repatriation or Local Burial

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

16. Routine Dental

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

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

17. Routine Health Checks

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

Section 3. GENERAL CONDITIONS

1. The contract

The benefit schedule, the policy wording, the application 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 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 date of entry.

In the case of children, they are eligible to be included for cover on the 15th day after the date of birth, or on the 15th day after discharge from the hospital where the birth took place, whichever is later. Children must also 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 date of entry.

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.

This benefit does not apply in respect of maternity claims.

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-annually or annually but this is an annual contract of insurance, so you are still responsible for paying the entire annual premium even if we have agreed you may pay by instalments. If we do agree you can pay by instalments then you must ensure the credit card you supply is valid for the entire period of the policy 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 certificates 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 cover level

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

16. Change of area of cover

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

17. Renewal

- a. We will invite you to renew your plan each year. We will ordinarily do this by email unless you have contacted us to ask for a different method.
- b. You are obliged to ensure that we have current contact details for you (in particular if you have changed your email address during the year) at all times but especially at the renewal date since without these we cannot contact you and your cover may lapse.
- c. The premiums applicable and the benefits in force may be altered at each annual anniversary but we will advise you of any changes in advance.
- d. Your obligations to disclose any changes to material facts reapplies at each renewal, since each annual period of insurance is a separate contract between you and us.
- e. If you pay your premiums by credit card and the card we hold is still valid at renewal, then your plan will be renewed on the anniversary date at the new rates applicable - this means we will automatically debit the card with the applicable payment. If the payment is not accepted by your card issuer then the policy will be suspended and we will attempt to contact you. If we cannot contact you within 30 days of the renewal date then the policy will be lapsed from the renewal date and any claims made after the renewal date will not be valid.
- f. If you do not want to renew your policy you MUST contact us and advise us of this prior to the renewal date shown on your current certificate of insurance.

18. Payment of Deductible/Excess

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

withhold the Deductible portion from any eligible expenses prior to reimbursement.

19. Pre-Authorisation

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-authorization 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 are rushed into hospital in an emergency, please make sure that you, a member of the hospital staff, your family or a friend contacts 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.

20. Transfer to Another hospital (USA/Canada only)

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

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

Section 4. EXCLUSIONS

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

1. Pre-existing medical conditions during the first two years of the policy. After this moratorium period, a pre-existing medical condition may 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. AIDS - Acquired Immune Deficiency Syndrome (AIDS), AIDS-related Complex Syndrome (ARCS) and all diseases caused by and/or related to the HIV virus.
3. Alcohol, Drug or Substance Abuse - Medical Treatment for alcoholism, drug or substance abuse or addiction or conditions that may be attributed to alcohol, drug or substance abuse or addictions and direct consequences thereof.
4. Appliances - Prostheses, corrective devices, wheelchairs and medical appliances which are not required intra-operatively including glasses, contact lenses, hearing aids, dentures or dental appliances.

5. Auto Therapy - Medical Treatment performed by a Close Family Relative and self treatment including prescription of drugs.
6. Birth Control - Costs for birth control devices and/or prescriptions.
7. Birth Defects - Medical Treatment relating to Birth Defects and congenital illnesses. Birth defects are deemed to include hereditary conditions.
8. Care of the Aged - Medical Treatment in any establishment for the care of the aged.
9. Chronic Conditions - Illnesses once they have been diagnosed as either chronic or terminal. However, acute phases of a Chronic Condition newly diagnosed after the Effective Date are covered as shown on the benefit schedule.
10. Claims After Renewal Date - Claims and costs for medical treatment incurred after the Renewal Date on the Certificate of Insurance, unless the plan has been renewed. A plan is considered to be renewed if invited by us and if the appropriate renewal premium is received prior to any claim.
11. Cosmetic Treatment - 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.
12. Cryopreservation - All expenses of any cryopreservation and implantation or re-implantation of living cells.
13. Dental - All dental treatment which is not Emergency Dental Treatment including crowns and root canals, unless the routine dental benefit is included in the purchased plan and is listed as a benefit on the Certificate of Insurance.
14. Emergency Medical Evacuation - All Emergency Medical Evacuation costs not approved or arranged in advance by the Assistance Company or as a result of maternity.
15. Hazardous / Professional Sports - Claims arising as a result of the Insured Person's participation in (engaging in or practising for) any of the following sports and 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 that 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 specially 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 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); 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).

16. Maternity -

- a. Cost of tests or treatment relating to infertility or inability to conceive.
- b. Termination of pregnancy unless for medically necessary reasons.
- c. Any Emergency Medical Evacuation costs as a result of maternity.
- d. Claims, including complications of pregnancy and childbirth, except where shown in the benefit schedule. Where covered, maternity claims in respect of pre and postnatal classes as well as triple/Bart's or quadruple tests are not covered.

17. Medically assisted reproduction or any consequence thereof.

18. Treatment required during the first 3 months after birth for any child born as a result of medically assisted conception other than artificial insemination.

19. Military Service - 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.

20. Organ Transplantation-

- a. All Organ Transplantations except heart, kidneys and lung
- b. Costs resulting from the acquisition of the Organ itself and expenses incurred by the donor.
- c. Costs for acquisition and implantation of artificial heart and mono- or bi-ventricular devices.

21. Outside Area of Cover- Any costs incurred outside the selected Area of cover.

22. Outside Policy Year/Period - Any costs incurred arising from any period for which the appropriate premium has not been paid.

23. Psychiatric Disorders -

- a. Psychiatric conditions except as shown on the benefit schedule
- b. We do not cover psychotherapy and counselling
- c. We do not cover conditions such as conduct disorder, attention deficit hyperactivity disorder, oppositional defiant disorder, antisocial behaviour, obsessive-compulsive disorder, attachment disorders, adjustment disorders, as well as treatments that encourage positive social-emotional relationships such as communication therapies, floor time, and family therapy.

24. Radioactivity - Any claims 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.

25. Rehabilitation - Services or treatment in any long term care facility, rehabilitation centre, spa, hydro clinic, sanatorium, nursing

home or home for the aged.

26. Repatriation and Local Burial - Any costs when death occurs in the insured's Home Country. Costs for a casket and/or urn are not covered.

27. Routine Examinations - Routine medical examination (including vaccinations, annual check ups, the issue of medical certificates and attestations, and examinations as to suitability for employment or travel). Routine eye and ear examinations, including the cost of spectacles, contact lenses and hearing aids.

28. Self-inflicted Injury - Costs resulting from self-inflicted injuries and/or suicide or attempted suicide whether sane or insane.

29. Sexually Transmitted Diseases - Any Medical Treatment of sexually transmitted diseases and consequences thereof.

30. Transportation Costs - All transportation costs occurring during trips specifically made for the purpose of obtaining Medical Treatment if not part of an Emergency Air Evacuation, except as defined under Local Ambulance Services.

31. Unproven Treatment - Medical Treatment that is not scientifically proven or recognised.

32. War - 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.

33. Products that can be purchased without a doctors prescription.

34. Products classified as vitamins or minerals (except during pregnancy or to treat diagnosed, clinically significant vitamin deficiency syndromes), nutritional or dietary supplements, including cosmetic products, even if medically recommended or prescribed or acknowledged as having therapeutic effects.

35. Prescribed physiotherapy refers to treatment by a registered physiotherapist following a referral by a medical practitioner.

Physiotherapy is initially restricted to 12 sessions per condition, after which the treatment must be reviewed by the referring medical practitioner. Should further sessions be required, a progress report must be submitted to us, which indicates the medical necessity for any further treatment. Physiotherapy does not include therapies such as Roling, Massage, Acupressure, Milta therapy and Kinesiotherapy carried out by a non registered physiotherapist.

36. Intentionally fraudulent, illegal, criminal, deliberately careless or reckless acts on the Insured Person's part and their consequences.

37. Any claim arising in the course of travel undertaken against medical advice.

38. Air travel when the Insured Person is more than 28 weeks pregnant.

39. Drug therapy and/or treatment provided by an unlicensed physician.

40. 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.

41. Medical treatment performed by a physician who is a close relative of the Insured Person, unless previously approved by us.

42. 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.

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

44. 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.

45. Any expenses where no supporting documents are available.

46. Any accounts, bills or invoices received by us more than 3 months after the date of treatment or the date the service was given.

47. 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.

48. 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.

49. 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.

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

51. 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.

52. 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.

53. 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.

54. Any claims directly or indirectly arising from the failure, breakdown or malfunction of any electronic or mechanical item of medical/surgical equipment of any kind.

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 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 ExpatHealth 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

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@ihs.europ-assistance.com

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 received 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) and 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@ihs.europ-assistance.com

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 ExpatHealth 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
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

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.